Political Declaration of the High-Level Meeting on Universal Health Coverage
Three Critical Elements to Achieving UHC
HIV civil society and global networks reaction to the Zero Draft
7 June 2019

This paper was prepared by the Free Space Process together with the PITCH Programme[1] to inform the negotiations of the Zero Draft of the Political Declaration of the High-Level Meeting on UHC.

1. Reaffirming a rights-based approach in delivering health for all

Whereas the zero draft starts by reaffirming the right of every human being to the enjoyment of the highest attainable standard of physical and mental health, without distinction of any kind, it lacks concrete commitments to progressively realising the right to health.

Universal Health Coverage (UHC) should be founded in the understanding that health is not a commodity or privilege. Health is a human right of each and every person, regardless of their social or political status, or their ability to pay. UHC will never be realised without the full political and financial commitment to fulfil the right to health. The needs of the poorest and most marginalised members of society should be addressed first and remain centre stage throughout. This includes communities, who, throughout the world, are systematically denied their rights, and face stigma, discrimination, violence, and criminalisation, in health care settings and beyond. Key populations[2] that are at higher risk of HIV and other diseases, are particularly affected by such barriers to realising their right to health and require particular attention in UHC plans.

Our asks:

- Maintain paragraph 1 on the reaffirmation of the right to health without distinction of any kind and (add): "*and commit to intensifying national efforts to create enabling, legal, social and policy frameworks in each national context in order to eliminate stigma, discrimination, and violence in health care settings".*[3]

- Paragraph 22 on accelerating high impact interventions should reaffirm the human rights-based approach: "*Implement most effective, high impact, people-centred, (add) rights based, gender-responsive and evidence-based interventions to meet the health needs of all…"*;

- Paragraph 50 on training and education of health workers should include a reference to anti-stigma and anti-discrimination training of health workers as it is the responsibility of health care workers to provide stigma-free and unbiased services: "*develop, improve, and make available evidence-based and (*delete: *culture) and gender-sensitive training, (add) including training in non-discrimination, confidentiality and informed consent*[4]*, skills enhancement and education of health workers"…*

- The section on Mainstreaming gender, equity and human rights should be entitled: *Promoting gender, equity and human rights, instead of mainstreaming.* A new paragraph should be added to this section that recognises the negative impact of punitive and discriminatory laws and policies: *(add) 58(a): "Review and reform, as needed, legislation that create barriers to accessing health services or reinforce stigma and discrimination in health care settings.*[5] *This should include laws that criminalize HIV transmission, exposure, and non-disclosure, consensual same-sex sexuality, gender identity, sex work, and drug use",*

[1] The Partnership to Inspire, Transform and Connect the HIV Response (PITCH) is a strategic partnership between Aidsfonds, Frontline AIDS and the Ministry of Foreign Affairs of the Netherlands

[2] The WHO defines key populations as including people living with HIV, men who have sex with men, people who inject drugs, sex workers, transgender people, and people in prisons and other closed settings. It recommends that states decriminalise sex work, same-sex sexuality and drug use. It also recommends funding a package of interventions to specifically reach key populations.

[3] From 2016 Political Declaration on HIV and AIDS paragraph 63 (c).

[4] From 2016 Political Declaration on HIV and AIDS paragraph 63 (e).

[5] From 2016 Political Declaration on HIV and AIDS paragraph 63 (b).

- Paragraph 58 should refer to populations bearing disproportionate burden and experience inequities across diseases worldwide: "*Ensure that no one is left behind , especially those who are vulnerable, stigmatized or marginalized (add) or criminalized, among others, children, youth, women, older persons, persons with disabilities, migrants, refugees, people on the move, people with mental health problems or pre-existing medical conditions, (add) prisoners, lesbian, gay, transgender, and intersex people, people who use drugs, and sex workers*[6]*, regardless of race, religion and political belief or economic and social conditions (add) or other status*;"[7]

2. Recognising the critical role of communities in the design and implementation of UHC

The zero draft fails to recognise the essential role of civil society and communities, including faith communities, in the promotion and roll out of UHC and in ensuring better health outcomes for all. Movements such as those around HIV, sexual and reproductive health and rights, women's health, and mental health have each successfully relied on the leadership of communities to expand equitable access to health. It is communities who innovate and deliver services especially to the most marginalized; advocate for more domestic and international funding for health and better quality of services; and confront stigma, discrimination, human rights violations and closing civic space.

To be effective, UHC strategies must build upon these learnings by integrating and fully resourcing community responses as an essential component of health systems.

Our asks:

- Paragraph 36 on exploring ways to provide adequate, predictable and sustainable finances should include a reference to funding for community action and community-led organisations: *explore ways to provide adequate predictable and sustainable finances to support national efforts in achieving UHC, (add) including support to civil society and communities, through domestic, bilateral, regional and multilateral channels… …"*

- Paragraph 43 on governance and participatory approach should include a reference to building on existing multi-sectoral platforms and ensuring engagement of marginalised and vulnerable communities. "*Engage all relevant stakeholders, including the civil society, and those who are most marginalized, vulnerable, criminalized and hard-to-reach, private sector, philanthropic foundations, academic institutions and community, as appropriate, through the establishment of participatory governance platforms and multi-stakeholder partnerships, and utilizing existing mechanisms, in the development and implementation of health- and social-related policies and progress monitoring to the achievement of national objectives for UHC, while giving due regard to managing conflicts of interest*".

- Paragraph 44 on strengthening the capacity of national governments and local authorities should also include wording on strengthening the capacity of civil society and communities: "*Strengthen the capacity of national government authorities to exercise strategic leadership and coordination role and strengthen the capacity of local authorities to engage with their respective communities and (add) strengthen the capacity of civil society and communities to promote, implement and monitor UHC plans and strategies."*

- Paragraph 45 on building effective, accountable and inclusive institutions should include the need to address the closing civic space: "*build effective, accountable and inclusive institutions at all levels to ensure social justice, rule of law, and health for all as well as (add) invest in national, regional and international consortia and networks that convene and are led by civil society and communities, including the most marginalised."*

[6] In May 2019, ahead of the World Health Assembly Dr Tedros Adhanom Ghebreyesus, WHO Director-General, emphasised that "*if universal health coverage is to be truly universal it must encompass everyone, especially those who have the most difficulty accessing health services, such as migrants, rural populations, people in prison, LGBT community, sex workers, people who use drugs, poor people*".
[7] From SDG target 10.2.

- Add a paragraph in the section on governance and participatory approach: *We commit to strengthen the capacity of Ministries of Health to exercise a strategic leadership and coordination role in policy development that engages all stakeholders across government, non-governmental organizations, civil society, FBOs, and the private sector, with the emphasis on the centrality of roles of those who are most marginalized, vulnerable, criminalized and hard-to-reach, in addressing national targets for 2030 by means of an appropriate, coordinated, comprehensive and integrated response*

- Paragraph 49 on strong health and social workforce should recognise community-led and based responses as essential to the achievement of UHC. "*Scale up efforts to promote the recruitment and retention of competent health workers and encourage incentives to secure the equitable distribution of qualified health workers especially in rural and hard-to-reach areas; (add) and commit to build people-centred systems for health including by expanding community-led service delivery to cover at least 30% of all service delivery by 2030".*[8]

3. Reaffirming international solidarity and international funding commitments for UHC

While the zero draft refers to a minimum target of 5% of GDP for public spending on health, there is no concrete commitment regarding international solidarity and the role of development assistance for health in realising UHC in low-income and lower middle-income countries, which face significant health financing gaps.

In recent years, donors have begun to terminate or reduce their development assistance to middle-income countries, many of which criminalise key populations and exclude other marginalised groups and where health services for these groups have been dependent on international funding. Just because a country has reached middle-income status, it does not mean there are enough domestic resources to achieve UHC or a supportive political environment within the country to fund health services for criminalised and stigmatised groups.

UHC will never become a reality without donors committing to providing continued investments in global public goods such as health, particularly in countries which face significant health financing gaps and in countries where domestic resources do not reach criminalised and stigmatised populations.

Our asks:

- Add a paragraph in the section on health financing to include specific commitments on development assistance to health: 36(a): "*Reiterate that the fulfilment of all official development assistance (ODA) commitments remains crucial. International development partners reaffirm their respective ODA commitments, including the commitment by many developed countries to achieve the target of 0.7 per cent of gross national income for official development assistance (ODA/GNI)*[9] *as well as the target of a minimum of 0.1% of their gross national income to global health.*[10] *International development partners commit to not abruptly terminate support for health when transitioning out of middle income countries and ensure responsible transition plans are in place. This is particularly important for health programmes that lack confirmed alternative funding sources, in particular those designed to reach marginalised, criminalised and stigmatised populations."*

[8] From 2016 Political Declaration on HIV and AIDS paragraph 60 (d).
[9] From 2016 Political Declaration on HIV and AIDS paragraph 59 (h).
[10] Recommended by the WHO Commission on Macroeconomics and Health to bridge the financing gap between current health expenditure and the $86 per capita needed to achieve UHC.

Organisations supporting this letter