Global Network of Sex Work Projects
Promoting Health and Human Rights

BRIEFING NOTE: Universal Health Coverage

What is Universal Health Coverage?

Universal Health Coverage (UHC) is not a new idea, health advocates have been calling for all people to have access to affordable, quality, comprehensive health services for a long time, and there is not one single strategy that will achieve it. Some countries already have comprehensive, publicly funded health systems in place that meet the key aspects of UHC, and more countries have been moving towards increasing the range of services covered and reducing the user fees needed to pay for them.

However, in many parts of the world, access to health services remains extremely poor, particularly for criminalised and marginalised populations such as sex workers and other key populations. It is those most vulnerable to poor health outcomes that often do not have the ability to pay. According to the World Health Organization (WHO) and the World Bank's 2017 report:

> **"…at least half the world's population still lacks access to essential health services. Furthermore, some 800 million people spend more than 10 per cent of their household budget on health care, and almost 100 million people are pushed into extreme poverty each year because of out-of-pocket health expenses."**[1]

WHO defines UHC as follows:

> **"Universal health coverage means that all people have access to health services they need (prevention, promotion, treatment, rehabilitation and palliative care) without the risk of financial hardship when paying for them.**
>
> **Access to health services ensures healthier people; while financial risk protection prevents people from being pushed into poverty. Therefore, universal health coverage is a critical component of sustainable development and poverty reduction, and a key element to reducing social inequities."**[2]

UHC is part of the Sustainable Development Goals (SDGs) set by the United Nations General Assembly in 2015, for the year 2030. SDG 3 relates to good health and well-being and under this, **Target 3.8** aims to:

> **"Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all."**[3]

The Seventy-first World Health Assembly approved a target that **by 2023 1 billion more people are benefitting from UHC.**[4]

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[1] World Health Organization/World Bank, 2017, "Tracking universal health coverage: 2017 Global Monitoring Report", v.
[2] WHO, "Questions and Answers on Universal Health Coverage".
[3] WHO, "Sustainable Development Goals".
[4] WHO, 25 May 2018, "Thirteenth general programme of work 2019–2023", 7.

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What is needed to achieve it?

WHO summarises the elements that need to be in place in order to achieve UHC:

- A strong efficient, well-run health system
- Affordability
- Availability of essential medicines and technologies
- Well-trained, motivated health workers
- Actions to address the social determinants of health

Importantly, WHO confirm that essential services (including HIV, TB, malaria, non-communicable diseases and mental health, sexual and reproductive health and child care) **should be available to all who need them.** They further outline that:

- The goal should be to provide an increasing number of services over time while at the same time reducing out-of-pocket costs to patients.
- A key element of financing for universal health coverage is sharing resources to spread the financial risks of ill-health across the population.
- The countries that have made the most progress on providing universal health coverage have implemented mandatory contributions for people who can afford to pay through taxation, and/or compulsory earmarked contributions for health insurance.
- Reducing the reliance on direct, out-of-pocket payments lowers the financial barriers to access and reduces the impoverishing impact of health payments.[5]

"A clear commitment to "leaving no-one behind" must be applied to all communities. Reaching marginalized communities requires partnership and collaboration with those affected communities and with broader civil society"

- Statement by Dr Tedros Adhanom Ghebreyesus, WHO Director-General, to the Civil Society meeting on UHC, 22 March 2018[6]

"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, drug users, poor people #Healthforall"

- Tweet by Dr Tedros Adhanom Ghebreyesus, immediately after a side-meeting during 72nd World Health Assembly organised by GNP+, NSWP, and Aidsfonds[7]

What are the big challenges?

In September 2019, at a high-level meeting, the UN General Assembly will agree a political declaration on UHC.

Financing UHC

One of the major challenges will inevitably be finance, as the political declaration is unlikely to include specific domestic commitments.

The World Bank in June 2019 estimated that:

> "By 2030, the gap in financing UHC in the **54 poorest countries** will be about **$176 billion per year.**"[8]

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[5] WHO, "Questions and Answers on Universal Health Coverage".
[6] WHO, 2018, "HIV, hepatitis, TB, STIs and UHC, Promote health, keep the world safe, serve the vulnerable Civil society meeting | 22-23 March 2018".
[7] Dr Tedros Adhanom Ghebreyesus, WHO Director-General, Twitter, 24 May 2019.
[8] Word Bank, 2019, "High-Performance Health-Financing for Universal Health Coverage: Driving Sustainable, Inclusive Growth in the 21st Century".

Persuading governments to allocate such significant levels of funding to meet the essential health needs of their populations, and in particular criminalised populations such as sex workers, will be challenging and will involve tough political leadership and bold choices, particularly in countries in the global south. Long-term commitments are often a challenge that short-term politicians back away from, for fear of unpopularity amongst their electorates. Even in high-income countries UHC is not guaranteed. In 2017 in the USA, 28.5 million people did not have health insurance at any point during the year.[9]

The issue around financing UHC is not only a matter of where the money comes from, but also how the money is distributed. For example, in a decentralised health system, communities need to investigate how resources are being distributed, because the more management layers, the less money goes to actual service provision.

Health Systems versus Systems for Health

UHC requires wide-ranging and well-run systems for health. These go beyond government-run and facility-based health systems to incorporate community-led and based systems for the delivery, management and monitoring of health education, prevention, support and treatment services.

Community responses complement other sectors. They bring unique added value – notably their reach to, and acceptability among, those most marginalised and vulnerable who have specific needs that are unmet by others. Community responses are dynamic – able to respond to immediate challenges and actual needs, and to make the best use of available resources. HIV-affected communities have: mobilised millions of individuals; influenced policies and laws; improved access to services; and challenged stigma and discrimination. This has, in turn, led to better health outcomes. Community responses have also demonstrated their ability to deliver the type of wider, integrated programmes that are essential to the scale-up and cost efficiencies required by UHC. For example, interventions originally focused on HIV and TB have already evolved to add other critical concerns, such as gender-based violence and sexual and reproductive health and rights. Many community-run HIV testing programmes have expanded their scope to include testing for diabetes and high blood pressure.

To be effective, UHC strategies must be based on diverse and multi-sectoral systems for health which integrate and resource community responses as an essential component, rather than 'optional extra'.

Who, and what, is included in UHC?

> "The challenge now lies in invigorating **a human-rights based approach, that includes a focus on the decriminalization of key populations**, and ensuring everyone, across all communities, has access to the preventive and health services they need."[10]

The Global Network of People Living with HIV (GNP+) has demanded[11] that UHC **"Puts the last mile first"**, stating:

> **"The logic, and moral obligation, is clear. If Universal Health Coverage works for the poorest and most marginalised – including people living with HIV and other key and vulnerable communities (who are directly and disproportionately affected by disease and poor health) - it will work for everyone."**

Ensuring that governments put the last mile first and that **key populations**, including sex workers, are not left behind under UHC, as a result of criminalisation, stigma and discrimination, is the biggest challenge.

[9] US Census Bureau, 2018, "Health Insurance Coverage in the United States: 2017".
[10] WHO, 2018, "HIV, hepatitis, TB, STIs and UHC, Promote health, keep the world safe, serve the vulnerable Civil society meeting | 22-23 March 2018".
[11] Global Network of People Living with HIV, 2019, "Universal Health Coverage: Putting the Last Mile First".

Many governments historically have had a tendency to 'look the other way' when it comes to the needs of sex workers and other key populations. Government ministers know that prejudice, stigma and discrimination against gay men and other men who have sex with men, people who use drugs, sex workers and transgender people remains high amongst the public in many countries. This has meant that there is no incentive for politicians to persuade their own public to support policies aimed at improving health outcomes for key populations. In many low and middle-income countries, the majority of funding for services provided to key populations come from external sources, such as The Global Fund, with governments being reluctant to support programmes that target stigmatised and criminalised communities. A move towards UHC could jeopardise these services further, with a reduced focus on disease-specific funding, if external funding is not maintained or prioritised.

A final draft[12] of the political declaration reveals **not one single mention of key populations**, including sex workers, gay men and other men who have sex with men, transgender people or people who use drugs, nor does it address their criminalisation. They are 'sanitised' and made invisible, within vague language such as "vulnerable" and "marginalised" groups, leaving far too much latitude for governments to ignore their needs and fail to act.

This unfortunately has familiar echoes of the 2016 Political Declaration[13] on ending the AIDS epidemic by 2030. That declaration failed to meaningfully address the HIV epidemic among key populations, and lacked any explicit commitment to support and finance key population-led and tailored prevention, treatment, care and support services. Immediately following its adoption, numerous delegations including those from Egypt, Iran, Saudi Arabia, Sudan, Indonesia, and the Holy See made statements condemning the (two) explicit mentions of key populations in the declaration, and expressed dismay that the 2016 Declaration no longer called for abstinence and fidelity to be included in HIV prevention programmes.[14]

Emerging reports of the negotiations with nation states developing the draft UHC declaration, already expose the disputes about the detail and language that will be included.

One particularly controversial area concerns the language around **sexual and reproductive health and rights** (SRHR). *Health Policy Watch* reported that:

> **"That language has been controversial in light of opposition by the US as well as some developing countries to any references to sexual and reproductive health that could imply access to abortion. Additionally, the Group of 77 (G77), a coalition of 134 developing nations, have experienced sharp differences of opinion on both access to abortion and contraception."** [15]

This has raised concerns amongst community-led organisations and many health providers globally, who are already struggling with the damaging restrictions placed upon their funding, subsequent to the USA's re-instatement of the Mexico City Policy ('Global Gag' Rule) in 2017.[16] This policy bans awarding US international development and health funds to non-US organisations that perform, actively give information about, or promote the decriminalisation of abortion.

At the World Health Assembly meeting on UHC in May 2019, the USA had already pushed for the forthcoming declaration to emphasise that a country "should develop approaches to make progress on UHC within its own cultural, economic, political and structural realities and priorities."[17]

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[12] United Nations, July 2019, "Political Declaration of the High-level Meeting on Universal Health Coverage".
[13] UN General Assembly, 2016, "Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030".
[14] NSWP, 2016, "A High-Level for the United Nations on Key Populations".
[15] Health Policy Watch, 19 July 2019, "Drug R&D, Sexual & Reproductive Health Scrutinised In Draft UHC Declaration".
[16] NSWP, 2017, "US Global Gag Rule Expansion".
[17] Health Policy Watch, 19 July 2019, "Drug R&D, Sexual & Reproductive Health Scrutinised In Draft UHC Declaration".

UHC already allows each country to decide what the UHC 'care package' will contain. At a national level, this could be very problematic for key populations who are already deliberately excluded in many countries. Sex workers and other key populations are still not invited to the table where discussions about health strategy are held, and where the decisions on those care packages will be made.

Sex worker-led organisations are still fighting to have the international normative guidance that already exists, such as the SWIT[18], rolled-out and implemented at national level to any great extent. UHC **must not** mean a watering down of the international commitments and the few hard-fought gains that have been made. We still have 'Miles to Go'[19] on ensuring the principles contained within international normative guidance such as community-led programming and meaningful participation in service design, implementation and delivery, are actually adhered to. Sex workers in many countries still have major challenges in accessing ARVs, testing facilities, and stock-outs of medication and prevention tools/condoms.[20]

UNAIDS Global AIDS Update 2019[21], released in July 2019, alarmingly revealed that:

- Key populations and their sexual partners now account for more than half (54%) of new HIV infections globally
- In 2018, key populations accounted for around 95% of new HIV infections in eastern Europe and central Asia and in the Middle East and North Africa
- Less than 50% of key populations were reached with combination HIV prevention services in more than half of the countries that reported.[22]

That report states clearly that the "pace of progress in reducing new HIV infections, increasing access to treatment and ending AIDS-related deaths is slowing down." Given the financial and political challenges outlined above, it is vital that UHC delivers for sex workers and other key populations, that the HIV response is not further diluted and the legal and structural barriers that result in poor health outcomes and limit sex workers' access to health services are addressed and removed.

Ensuring sex workers are not left behind in UHC

UHC will not be achieved unless the legal, political and social determinants of health are addressed. The right to health has been recognised as a basic human right, articulated in many international declarations and covenants. Therefore, UHC must take a human rights-based approach, that ensures equitable access to health services for all. To do this, we must put the last mile first, and ensure that sex workers and other key populations will not be left behind.

UNAIDS have publicly recognised the potential challenges UHC poses for key populations and people living with HIV. At a meeting of the Programme Coordinating Board in June 2019[23] they noted that:

> **"The HIV response has prioritized the removal of legal and policy obstacles to healthcare access and to realization of the rights and dignity of all people, including for marginalized key populations."**

[18] WHO, UNFPA, UNAIDS, NSWP, The World Bank, and UNDP, 2013, "Implementing Comprehensive HIV/STI Programmes with Sex Workers"
[19] UNAIDS, 2018, "Global AIDS Update: Miles to go – closing gaps, breaking barriers, righting injustices".
[20] NSWP, 2018, "Briefing Paper: Sex Workers' Experiences of Stock-outs of HIV/STI Commodities and Treatments".
[21] UNAIDS, 2019, "Global AIDS Update 2019 – Communities at the centre".
[22] UNAIDS, 16 July 2019, "Press Release: UNAIDS calls for greater urgency as global gains slow and countries show mixed results towards 2020 HIV targets".
[23] UNAIDS Programme Coordinating Board, 25-27 June 2019, "Delivering on SDG3: Strengthening and integrating comprehensive HIV responses into sustainable health systems for Universal Health Coverage", 19 (38), 25 (51).

UNAIDS identified that as a key action, to actively engage with UHC processes, the Joint Programme should:

> **"Support countries in enacting and enforcing non-discriminatory laws and policies, repealing punitive laws and ensuring access to justice"**

Sex workers and the other key populations need their allies and partners in the UN system and broader civil society to speak-up, loudly and clearly, to support the call to put the last mile first in the UHC negotiations and implementation.

This should involve demanding that **UHC has, as 'top-line' demands**:

- A public and unambiguous re-commitment to the recommendations for decriminalisation of sex work and other key populations, as well as the decriminalisation of HIV transmission, exposure and non-disclosure.
- A clear re-affirmation that the legal and structural barriers to health, including punitive laws, policies and practices, violence, stigma & discrimination **must** be addressed in a rights-based approach, **or UHC will fail**
- A commitment to investment in sex worker and other key population-led health services, including technical and financial support and capacity-building
- The inclusion of key HIV services in the UHC benefit package, including prevention services and community-led services, with effective targeting of HIV services by and for key populations and people living with HIV
- A commitment that sex workers and other key populations, and people living with HIV, will be meaningfully involved in the planning of national health responses, in the discussions where UHC 'care packages' will be decided upon, and in the monitoring of the UHC response to ensure governments are held to account.

What can sex workers do?

- **Stay informed**. Find out what UHC planning is taking place in your country
- **Hold your governments to account.** Demand a seat at the table where discussions about UHC are taking place
- **Promote knowledge** about UHC in your community
- **Build partnerships** with other key population-led organisations, people living with HIV organisations and other allies to demand inclusion within the UHC agenda.

Project supported by:

NSWP is an alliance partner of Bridging the Gaps – health and rights for key populations. This unique programme addresses the common challenges faced by sex workers, people who use drugs and lesbian, gay, bisexual and transgender people in terms of human rights violations and accessing much-needed HIV and health services. Go to: www.hivgaps.org for more information.