UHC Civil Society Meeting Report

Building the Universal Health Coverage We Want

Enhancing Inclusion of African key and vulnerable populations in the UHC agenda.

Johannesburg, South Africa

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Contents

Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ARASA	AIDS & Rights Alliance of Southern Africa
AU	African Union
CCM	Country Co-ordinating Mechanism
CSO	Civil Society Organisation
HIV	Human Immunodeficiency Virus
HLM	High-Level Meeting
ICASA	International Conference on AIDS and STIs in Africa
LGBTIQ+	Lesbian, gay, bisexual, transgender, intersex, queer persons
NAC	National AIDS Commission
NHI	National Health Insurance
PEPFAR	President's Emergency Plan for AIDS Relief
PITCH	Partnership to Inspire, Transform and Connect the HIV response
REC	Regional Economic Communities
SDGs	Sustainable Development Goals
SRHR	Sexual and Reproductive Health and Rights
TB	Tuberculosis
UHC	Universal Health Coverage
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization

Background to the Meeting

Achieving Universal Health Coverage

In recent years, the international community's health focus has shifted from achieving disease-specific targets towards reaching the goal of universal health coverage (UHC), which is prominently featured in the Sustainable Development Goals (SDGs) adopted in 2015. The World Health Organization (WHO) defines UHC as a situation in which "all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship."

Forty years after the signing of the Alma Ata declaration on meeting the essential health needs of people through primary health care, the UHC agenda has become a renewed focus for the global health debate at global, regional and country level. It is shaping health system reform agendas in countries across the world.

UHC implementation is moving forward rapidly, and important decisions and choices will have to be made in each country regarding how HIV treatment and prevention services will continue to be funded, in particular in countries with reduced or diminishing donor funding for HIV and health. There is an urgency for communities of people living with HIV, key and vulnerable populations,[1] and other civil society actors, to engage with the UHC agenda, so as not to not lose the successes achieved with HIV and to ensure that UHC covers all people who need services, including key populations.

Applying lessons learnt from the HIV, Tuberculosis (TB) and Malaria responses into UHC has the potential to transform systems for health. However, integration into UHC also runs the risk of reversing years of effective disease-specific responses, if systems for health fail to adopt a rights-based approach, strong community-led components, inclusive civil society and community-based monitoring mechanisms, and effective ways to meet the needs of key, vulnerable and underserved populations.

A regional approach to UHC

In addition to geographic proximity, countries in sub-Saharan Africa experience similar HIV-related challenges due to various political, cultural, economic, epidemiological and historical reasons. A regional approach to addressing UHC, HIV and AIDS-related challenges is preferred when it presents a niche opportunity to add value to activities that are done at national or global levels. In addition, there is a financial benefit to being able to realize economies of scale and cost effectiveness.

Regional workshops are able to bring together participants from various countries which have common development, economic or other interests to expand their knowledge and skills on a specific topic; learn from the experiences of their peers in similar contexts; and openly discuss sensitive subjects in a safe environment without fear of retribution in a more cost-effective manner than efforts focused on individual countries.

It is also important to be able to come together to strategize opportunities for influencing sub-regional and regional bodies in the move towards UHC, and ensure a regional civil society

[1] Key populations defined here as being transgender people, men who have sex with men, people who sell sex, people who use drugs, and adolescent girls and young women.

organisation (CSO) coordination approach, or strategy when possible, to ensure accountability and oversee debates in the African Union (AU) around UHC.

African Regional Civil Society Meeting on UHC

ARASA, together with Aidsfonds and Frontline AIDS and with the support of the Partnership to Inspire, Transform and Connect the HIV response (PITCH), the Joint United Nations Programme on HIV/AIDS (UNAIDS) Regional Service Team and Health Gap, convened a 3-day African regional civil society meeting to discuss and reflect on the challenges and opportunities that the move towards UHC poses for HIV, and key and vulnerable populations, in order to consider priority country, regional and global level advocacy and action required to bring about corrective action by duty bearers.

Meeting participants included representatives of regional organisations and community representatives of key populations, people living with HIV and young women from 10 African countries, namely Botswana, Kenya, Malawi, Mozambique, Namibia, Nigeria, South Africa, Tanzania, Uganda and Zimbabwe.

ARASA, Aidsfonds, Frontline AIDS and UNAIDS welcomed workshop participants, noting that many of these organisations have already begun work around UHC in their respective countries, allowing participants to share their learnings from country-based experiences. The Meeting also provided an opportunity for countries to reflect on global commitments, including the September 2019 High-Level Meeting on UHC and its Political Declaration, and to discuss and translate these into focussed advocacy agendas at regional and country level to ensure an inclusive UHC that reaches key populations.

See Appendix A: Participant List for further details.

Aim of the Meeting

The main aim of the civil society meeting was to provide a space for strengthening capacities and understanding of UHC; facilitate information-sharing among countries; and support the development of key elements for African-led advocacy for inclusive, rights based Universal Health Coverage at country, sub-regional, regional and global level.

Objectives of the Meeting:

Specific objectives of the Meeting included the following:

i. Increase the knowledge and understanding of threats and opportunities of the implementation of UHC in the region, particularly for key and vulnerable populations, HIV and sexual and reproductive health and rights (SRHR), while focusing on the contextual issues underpinning its effective delivery at country level.
ii. Identify specific challenges impacting the delivery of UHC in African countries while identifying realistic and proactive solutions.
iii. Strengthen knowledge of and coordination with other civil society initiatives advocating for a UHC that works for key and vulnerable populations in the region
iv. Discuss and identify key elements to develop an advocacy and activist strategy to track the implementation of UHC in AU Member States and regional economic commissions (RECs), and ensure it works for key populations and people living with HIV.
v. Share case studies and best practices from across the African continent on effective and innovative strategies to promote inclusive UHC.

vi. Discuss campaigning and lobbying strategies to advocate for corrective action by duty bearers in order to shift outcomes at the country level as well as global civil society demands.
vii. Empower activists from key populations and people living with HIV with the tools to effectively engage in and advocate for inclusive and robust national UHC strategies.

Expected Outcomes

The Meeting expected to achieve a number of outcomes. Most importantly, it hoped to result in the development of a civil society advocacy agenda, including:

- Key advocacy asks and principles for people living with HIV and key populations on UHC beyond the UN High-Level Meeting (HLM) on UHC
- Campaigning and lobbying strategies for achieving corrective action by duty bearers in order to shift outcomes at country and global level
- Key elements for action planning in country and at regional levels to respond to emerging threats, track the implementation of UHC in countries, and ensure it works for key populations and people living with HIV.

See Appendix B: Agenda for further details.

Framing the Conversation: Understanding UHC

Based on inputs and discussions, the meeting discussed a common understanding of what UHC is and where the UHC agenda comes from, within the current global health ecosystem. Participants also shared information and experiences regarding the current state of UHC in their respective countries, what services were provided, what funding was available and where it comes from, the gaps and challenges and rallying points for achieving UHC. While the following does not purport to be a full report on UHC, the report highlights the following key points discussed by speakers and participants:

Countries are currently being supported to identify their critical health issues and establish what should form the 'key elements' of UHC for inclusion in an essential package of services at different health facility levels and in guidelines for providing quality health programmes, and how these should be financed.

Competing interests within resource constrained settings will always require rationalising healthcare services to balance the need for both primary and secondary health care services in each context. This balancing is both a technical but also highly political and negotiated process, driven by various social forces, with no single pathway that fits across all countries. It needs to include government commitment as well as civil society advocacy. It requires an understanding of and consideration of difficult issues including disease burdens, prioritisation of populations, cost-effectiveness, the outcomes and impact of services and the impact of prioritising one set of services over another.

Over and above defining critical services, defining UHC in order to reach all populations requires understanding and identifying those populations that are marginalised, excluded and most in need for whatever reasons. Ensuring these populations are specifically included is vital to guaranteeing they are not ignored and remain invisible in the determination of UHC. This requires 'unpacking' what exclusion means so as to ensure populations in need are identified and prioritised. E.g. in the case of key and vulnerable populations for HIV and TB, their vulnerability

and exclusion may be on the basis of their health risks, legal, social and human rights barriers (such as criminalisation in law or discrimination) that create barriers to services or even financial vulnerability. UHC requires the provision of programmes to not only deliver health services but reduce these inequalities and discrimination and to remove legal, social and human rights barriers to health care for marginalised populations.

UHC does not mean free services; it rather aims to ensure that populations are not crippled with out of pocket costs for healthcare – which is currently a real threat in low and middle-income countries where out-of-pocket spending on health care is increasing. UHC requires funding from domestic sources, which requires consideration of innovative solutions such as public-private partnerships and taxation. Donor funding may also be necessary in countries where domestic financing cannot meet needs, but an over-reliance on dwindling donor funding may be dangerous. Given these resource constraints and limited funding, this requires discussions around how to achieve a progressive realisation of health rights within resource constraints, to achieve UHC and to balance equity and accessibility with available funds.

The role of communities

Communities, particularly key and vulnerable populations, have a central role in advocacy for the SDGs in general and including in realising UHC. Community engagement and participation in UHC, including through regional and national independent technical and advisory groups, is critical to ensure the voices of marginalised populations are heard and to support the provision of leadership on health matters. It allows for multi-sectoral collaboration and consensus in decision-making around UHC – including for determining health and related law and policy, the definition and prioritisation of accessible, acceptable, affordable and quality services and the identification of targets, geographic locations, and priority populations to ensure that no-one is 'left behind' – and promotes accountability. It also creates partnerships for joint action, amongst other things. Countries should ensure commitment to developing long-term relationships with communities, building community engagement into national health and broader development plans, to achieve health and other SDG goals, including social justice, inclusion and economic development.

Community engagement may include (i) ensuring accountability for UHC, including through defining what UHC means at country and regional level, monitoring and developing advocacy on priority issues; (ii) delivering services; (iii) developing community-led evidence on how people access health (with a focus on people left behind); (iv) community financing for UHC.

Promoting community engagement requires, first and foremost, increasing community capacity to understand UHC and what it means for communities, in all their diversity, to participate in UHC decision-making, to advocate for UHC, including financing for UHC, as well as to support the implementation of services. It also requires communities to understand the various commitments made by their government and the resources available – including domestic and donor funding.

The Political Declaration on UHC presents an opportunity for advocacy within the region and within countries to advocate for accountability on UHC (although it also includes limitations and challenges, discussed in further detail, below, which need to form part of an advocacy agenda). However, global commitments such as the Political Declaration only have meaning if translated into action at country level. Partners need to co-ordinate their advocacy, defining what the Declaration means for them, what kind of services are required and for whom, according to their local contexts.

UHC Accountability

Government accountability to UHC requires that governments take responsibility for their commitments. Communities need to build alliances at the country level, as well as the sub-

regional, regional and global level, to advocate for an accountability framework for UHC, pushing governments to develop concrete, time-bound and costed plans and targets, in consultation with CSOs and communities, as well as to set in place inclusive mechanisms including at the level of the AU, for reviewing these plans and targets set.

The UHC Actions Framework in the African region set regional milestones for UHC which may help. CSOs can work together, using their various skills and expertise, to monitor and hold governments accountable by ensuring transparency, collecting, reviewing and analysing data on how government funds are spent and the extent to which governments have met their UHC commitments – for example, in terms of scorecards reflecting policy and programme development, implementation and monitoring and evaluation of services – and effective advocacy for required action. Watchdog CSOs are critical for this work, but partnerships between all CSOs are important. For instance, service delivery CSOs are well placed to monitor and collect evidence from work with communities. Accountability for UHC requires partnerships between CSOs with various skills and expertise, including technical, legal, medical, health systems strengthening, advocacy etc.

See folder of presentations, including presentations by UNAIDS, WHO, Health Gap, Ready4UHC and Accountability International, for further details.

Rallying Points for UHC

- Equality and Non-discrimination
- Enabling legal and policy environment and efforts to eliminate social and structural barriers to health care
- Financial sustainability through domestic, international and private sector
- Political willingness to implement commitments set out in UHC High Level Meeting Political Declaration
- Awareness raising and capacity building of communities
- Community involvement, including key populations, and participation in decision-making, implementation, monitoring
- Accountability in terms of an accountability framework

Opportunities & Threats for UHC advocacy strategies

Participants discussed various opportunities as well as threats for civil society engagement and advocacy on UHC, including opportunities presented by global and regional commitments, country actions and the work of partners. Some of the key issues arising included the following:

Opportunities

The Political Declaration of the High-Level Meeting on Universal Health Coverage provides an opportunity for advocating and holding governments accountable to their commitments and to influence political and technical decisions going forward, both at country and regional level. However, the Political Declaration also includes various challenges: (i) it doesn't include a clear definition of key populations, despite the fact that various organisations advocated for this inclusion; (ii) there is no concrete commitment to community involvement in UHC (beyond service delivery); (iii) it doesn't include concrete targets that can be used to track and hold governments accountable; (iv) there are no ambitious investments targets; and (v) the goal of leaving no-one behind requires robust country-level accountability in order to ensure services in fact reach all

those most in danger of being left behind. Organisations involved in advocacy around the Political Declaration were left feeling frustrated by its failure to live up to its promises.

Participants also discussed the various opportunities provided by donor funding in countries, and the importance of knowing what funding is available for services e.g. for key populations through, for instance the President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, TB and Malaria, how it works, who receives funding, for which programmes, and the process in terms of which allocations are determined. This is critical to ensure that specific requests to achieve UHC within programmes, targets, populations and locations are included within these funding allocations.

Various stakeholders have begun advocacy around UHC both at country, sub-regional and regional level. This is critical to ensure partners start to define the UHC they wish to achieve, rather than being caught off-guard by others' definitions and demands and having to face difficult choices between services. It is important to learn from, support and use these opportunities for joint advocacy – the International Conference on AIDS and STIs in Africa (ICASA) was discussed as a potentially a good opportunity for doing so in 2019 and beyond. Participants recommended they use the opportunity to reflect on current movements and leverage their inputs, conduct further research where required to develop a common position on UHC for ICASA and to challenge government presentations that fail to showcase the barriers key and vulnerable populations, including young people face in accessing services.

For instance, the Ready for UHC campaign is a movement led by youth organisations, involving young people (including young key populations) at the forefront of building awareness around UHC, consulting with young people, designing, implementing, monitoring and evaluating and advocating for UHC at the regional and global level. It is critical that the movement finds ways to engage with and include the voices of young people on the ground, at country-level, to articulate the priorities of young people in realising their rights to health. The campaign provides opportunities for young people to be mentored around UHC and creates spaces for advocacy at country, regional (e.g. ICASA) and global level. It provides an opportunity to be clear about the minimum standards / interventions needed for young people, in terms of both preventive and curative services, and the way they should be delivered. It is important that young people also identify the legal, human rights, social, cultural and religious barriers to access to services and how these barriers may be overcome to achieve UHC.

Various partners have also begun supporting community engagement on UHC, including through capacity development, supporting communities to gather evidence of how they experience health and supporting their identification of advocacy priorities based on this evidence. This provides strengthened opportunities for community engagement on UHC.

Challenges

Participants discussed challenges with government commitment to UHC. UHC requires involvement from government in order to succeed. It requires sustainable domestic financing, and political leadership beyond health. In some countries, there may be indications of political will for UHC in the health sector, but not beyond. In other countries – e.g. Kenya – government speaks of commitment to UHC but the reality on the ground is different. These are key challenges. It is critical that National AIDS Commissions (NACs) are pushed to engage with other ministries in delivering on UHC commitments.

Financing for UHC is a major challenge. International donor funding for health is dwindling. In terms of the Abuja Declaration, African states committed to allocate 15% of annual domestic budgets to health, but very few countries have been able to meet these targets. Funding UHC services will require discussions regarding various possible revenue streams for health, including

taxation, national health insurance and private-public healthcare partnerships – all of which have proven to include difficulties. It is critical to incorporate these financial discussions into advocacy agendas and to discuss how to overcome financing obstacles in the face of competing needs.

The private sector invests substantial funds in health care in the region and many key populations are in fact already accessing health care from the private sector out of necessity. This can be seen as an opportunity, and also a threat. It may be possible to work with the private sector in delivering on UHC – e.g. in some countries, the private sector have arrangements to collaborate with public health care facilities to provide needed services. However, there is inadequate regulation of the private sector and exorbitant pricing may result in financial hardships for vulnerable and marginalised populations. There is currently limited engagement with the private sector, who may have a critical influence on the roll-out of UHC – and resisting UHC – which needs to be considered.

Participants also reflected on their experiences in countries and regional work and discussed various challenges to advocating for UHC. UHC discourse is intimidating for many communities who are not aware of what UHC entails and who struggle to participate in the discussions; it may be challenging to develop ways to build capacity and increase meaningful community engagement in UHC discussions, including with young people. Participants noted that it is critical to simplify and localise the discourse in order to promote community engagement. This also requires leveraging country-level structures to ensure that the voices of communities at country level are heard and are included, in country-level, regional and global debates around UHC.

A further challenge is that communities are not aware of government commitments to UHC and there is no accountability framework to hold governments to account for UHC.

Defining UHC and what services are required for which populations is also a difficult process, particularly for communities. Experience shows that there is no single 'recipe' for UHC and how to achieve it; it is a negotiated and political process that countries design in different ways, including varied negotiations around what populations to target, what services to include and how to finance it. This makes it difficult to identify a 'single pathway' for each country to follow. Equally, this makes it critical for communities to identify what they need and to push for it before these choices are made in their absence. However, it is challenging to ask communities to make economic choices between primary health care services that they may personally need and secondary care for e.g. cancer. Ideally, UHC 'packages' should be defined at country-level in a way that does not pit primary and secondary health care services against each other. Communities also need to ensure that they define key populations, rather than leave this to governments to do. Current global monitoring frameworks are often unable to capture data on populations left behind, which requires that organisations representing key and vulnerable populations ensure that these issues are brought to the fore in all UHC discussions and that the available tools and data to reflect access to services are interrogated.

A further challenge to UHC is that expanding service delivery needs to ensure that everyone knows what services are available and is able to access health services. Where certain populations are discriminated against or experience legal, human rights and social barriers to services (e.g. because of laws that, for instance, criminalise key populations and prevent young people from accessing services without parental consent, or because of social norms that discourage key and vulnerable populations from using services), UHC will never be achieved. Where governments are still pushing for punitive and discriminatory laws and policies (e.g. laws that criminalise same-sex sex), UHC will be impossible to achieve. Advocacy for UHC needs to include these issues; it cannot simply focus on issues around e.g. financing of health services.

Often it is assumed that we can transfer many skills and learnings from our advocacy and activism around HIV; however advocacy for HIV-related health care has many challenges and will still require a lot of work, including work on addressing human rights- and gender-related barriers, and the fact that current HIV and AIDS targets might not be reached.

Participants also noted that where health systems are weak and failing, advocacy for UHC needs to begin with advocacy for strengthening health systems. As long as health systems remain weak, people will not choose to access health care services. UHC may be a way to ensure that health systems are strengthened.

See folder of presentations, including presentations by UNAIDS, WHO, Health Gap, Ready4UHC and Accountability International, for further details.

Key Summary Points

- There are various opportunities, as well as challenges, for advocating for UHC in the current context
- The UHC Political Declaration provides an opportunity for advocating and holding governments accountable to their commitments and to influence political and technical decisions regarding UHC. However, it has limitations that pose challenges.
- Various PITCH and Health Gap partners have begun capacity building, discussions with communities and civil society advocacy for the UHC we want, both at country and regional level. These provide opportunities to learn from experiences and to support existing efforts through joint advocacy strategies.
- Political will and financing for UHC are major challenges across the region.
- Civil society's and communities' limited awareness and understanding of UHC, what it means for them and what governments have committed to is also a challenge. It requires ongoing capacity building to ensure the meaningful participation of communities in decision-making, implementation and accountability for UHC.
- Defining UHC, determining priority populations to ensure key and vulnerable populations are not left behind, accessing data on these populations and ensuring UHC includes efforts to remove legal, structural and social barriers to health for these populations remains an ongoing challenge.
- Overcoming this challenge requires ongoing advocacy for appropriate data collection tools to gather information on access to services for key populations and removing legal, human rights and social barriers to services receives ongoing support.
- Where health systems are weak and failing, advocacy for UHC needs to begin with advocacy for strengthening health systems.

Lessons Learned for UHC advocacy strategies

Participants discussed their various experiences and tried to identify and pull out lessons learned (including from HIV and SRHR work) for achieving the UHC we want to see and ensuring that key and vulnerable populations are not left behind. Key points included the following:

Advocacy for HIV-related health care has shown that Political Declarations and documented commitments are important but need to be followed by commitments to action, including

financial commitment, in order to bring about meaningful change. Countries that have shown progress on UHC reflect two core elements – (i) they promote a rights-based framework to health and fulfil the right to health care, including for those ordinarily left behind; and (ii) they protect persons from financial hardship.

Lessons learned from health financing options around the world have shown the need to keep analyzing what we're doing and where we are inefficient, in searching for innovative financing models. Taxation as a means for financing UHC, for instance, has not worked in many countries, and the tax systems are not always able to collect finances efficiently and effectively in many instances. Procurement and drug pricing is not always effective and uniform. National health insurance debates in South Africa have become highly politicized and are still being resolved to try to ensure they reduce inequalities. Public-private partnerships – e.g. in Kenya – have sought innovative ways to increase financing for public health facilities, but nevertheless still reflect underlying inequities in public and private service provision.

Evidence has been critical to advocating for financial commitments to HIV-related services with governments – e.g. evidence of the disease burden, the impact of HIV and AIDS, the cost-effectiveness of prevention, treatment and care services and the broader health outcomes – as well as referring to rights-based approaches to health care, political considerations and developmental commitments to leaving no one behind. Lessons from some work done (e.g. CHAI) reflect the progress that can be achieved by working with governments, gaining their trust with initial programme requests and then seeking to expand programmes, their scope, benefits and populations covered, based on evidence of the cost-effectiveness of the initial measures.

Technical expertise has also been critical to HIV-related advocacy – HIV activists ensured they had sufficient technical, scientific and medical knowledge to participate in decision-making forums to advocate for their policy and programme goals. They also used activist strategies 'outside' of decision-making forums to call for change – these mass movements were generated without the social media we have today and we need to learn lessons from their successes.

Community 'watchdog' monitoring and advocacy for inclusion has also shown success with various donor programmes – such as PEPFAR – where activists have won commitments to increase programmes for key populations and to change the way resources have been allocated.

HIV-related advocacy strategies have also had benefits beyond the HIV sector and have helped to build evidence on the cost-effectiveness of acting sooner rather than later, with both prevention and treatment. There are various lessons to be learned from the HIV and SRHR movements that reflect how advocacy issues may be integrated within and are equally important for other health issues, including for work on UHC. Important broad advocacy strategies we can take from these, for UHC include (i) the importance of strengthening health systems; (ii) promoting rights-based responses to health (iii) increasing access to affordable medicines; (iv) prioritizing marginalised populations and ensuring that no-one is left behind; and (v) ensuring the meaningful engagement of communities at all levels, not only for monitoring accountability.

Advocacy strategies require co-ordination across communities, countries and regions, so that we are able to speak with a common voice in engaging with various regional bodies and reflect the voices of affected communities. The Key Population Consortium in Kenya provides good learning on the benefits of working together to build a structure, now respected by government and able to participate at decision-making level, to contribute to a common advocacy agenda for key populations, as well as on how to promote the meaningful participation and engagement of key populations (e.g. sex workers in Kenya) in dialogues around UHC, to ensure that key populations' voices are heard.

Key Summary Points

- Commitments require follow up with action and financing in order to become real.
- Ongoing efforts to monitor and address financing for UHC and inefficiencies in expenditure is critical to ensuring sustainable financing for UHC.
- Technical expertise, community monitoring, the use of evidence and strong activism has been critical to successful advocacy efforts in HIV and SRHR advocacy and is equally important for UHC advocacy strategies.
- Advocacy strategies for UHC should incorporate key asks including (i) health systems strengthening as a whole; (ii) rights-based responses to health (iii) increased access to affordable medicines; (iv) the prioritisation of marginalised populations and ensuring that no-one is left behind; and (v) ensuring the meaningful engagement of communities at all levels, not only for monitoring accountability.

Advocacy Priorities at Country and Regional level

Participants identified civil society advocacy priorities for UHC at country and regional level, based on discussions in group work regarding what was taking place in various countries and in the region, what the vision was for the work ahead and how to get there, including how to hold leaders accountable to UHC commitments to ensure available, accessible, acceptable and quality health care services. Through various group work sessions that looked at investments for health, systems for health, human rights and inclusion and community engagement issues, participants discussed and refined their advocacy priorities for ensuring

(i) Access to quality health care services to attain UHC;
(ii) Funding for UHC; and
(iii) Community engagement and accountability for UHC.

Access to Quality Health Care Services

Goal

The goal was identified as having access to quality health services that:

- Provide for communities that are left behind or likely to be left behind (e.g. people living with HIV, key populations, young people); puts the last mile first and embraces diversity;
- Is free of stigma
- Overcomes social and legal barriers to quality and timely access to care
- Is affordable
- Provides comprehensive care, treatment and prevention that is people-centred as opposed to disease focused.

Key Advocacy Asks

The meeting prioritised the following key advocacy asks:

- The roll-out of national guidelines, training curricula, continuous professional development and performance / sanctions systems for medical staff and the inclusion of paid community health workers to have adequate, skilled and youth- and key population-friendly services at all times, everywhere
- That UHC coverage provides for the full package of integrated and comprehensive services (for HIV, SRHR and beyond) in a person-centered approach.
- That inclusivity and non-discrimination be central to the roll-out of UHC; requiring states to prioritize policies and laws that protect and promote the rights of key and vulnerable populations, including decriminalisation of key populations and laws protecting informed consent, confidentiality and ensuring zero discrimination in health care settings.

During the course of the Meeting, the following additional key elements were discussed as being critical to ensuring available, accessible, acceptable and quality health care services that do not exclude marginalised populations:

- **Available** services should include access to health information, medicines, infrastructure and equipment sufficient to meet the physical and mental health needs of various populations; skilled, trained health personnel; effective referral systems as well as the relevant policies, guidelines and systems to ensure quality service delivery. They should provide integrated, ccomprehensive and people-centered prevention, treatment and care.

- **Accessible** services should ensure access for communities that are in danger of being left behind, such as key populations, people living with HIV, young people, without discrimination. They should be rights-based and inclusive, protecting rights to equality and non-discrimination; be free of stigma; safe and secure for key populations who are at risk e.g. of violence, arrest; and ensure efforts to overcome social and legal barriers to access to care (e.g. age of consent laws, criminal laws). Service providers should be sensitized to the needs of key and vulnerable populations.

  Services should be decentralised, fairly and equitably distributed across geographical regions and within reach of and accessible to all communities (e.g. rural communities, people with disabilities, available on electronic platforms). They should include flexible, sensitive and responsive service delivery hours. They should also be affordable (ideally free at point of care) and should include national health insurance schemes. They should be delivered through a multi-sectoral approach – e.g. delivery of health information and services (such as immunization) through education sector.

- **Acceptable:** UHC services need to respect rights, medical ethics and cultural norms, including (i) ensuring that age of consent laws do not create barriers to access to services for young people (ii) ensuring respect for the rights to autonomy, liberty and security of the person (e.g. prohibiting compulsory HIV testing, forced anal testing; ensuring non-rehabilitative, affirming services are provided); and (iii) promoting patient-centred, community led-approaches to care that is not undermined by cultural, religious and social norms.

- **Quality:** Quality services should seek to ensure that services are provided of an acceptable standard, agreed in consultation with communities, and delivered in accordance with

standard guidelines, by experienced, sensitized, professional health care workers who treat patients with dignity. Training and sensitisation on key populations should be integrated within health workers' training curricula and carried out with the involvement of key populations. Professionalization of community-led services is also required, to develop community skills to provide a range of health services. Quality control and assurance of procurements process and commodities is required to ensure quality medicines, adequate infrastructure and equipment. Mechanisms for complaints and recourse are needed. Community monitoring of quality control, including access by key populations, human rights violations against key populations, the availability of commodities and alert to stock-outs etc., should take place.

- **Essential package of services:** CSOs need to develop a comprehensive, citizens-centered checklist of the package of services that is wanted, tailored to the needs and priorities of all, and that seeks to ensure the integration of health services that build on existing strengths, links across sectors and develops new services, where required.

  An essential 'package' should be shaped to ensure that it demands universal access to essential services and that certain elements (e.g. free services for key populations) are non-negotiable, when rationalization begins to take place. It should be an activist, rather than a technocrat tool, which aims for as much as possible.

  The development of this package of services should be done based on key principles – e.g. consultation, evidence (in-country data, cost-benefit analyses), objectivity and seeking to expand services to meet the needs of the most marginalised populations. Participants noted that whether this is seen as a contradiction or not, if CSOs don't develop their essential requirements, they will not ensure these are met.

Allies

Allies in attaining access to quality health care services include the Ministry of Health; Members of Parliament; the World Health Organization; multilaterial agencies; other CSOs working on public health issues; health care professionals; trade unions and key populations, people living with HIV and young people.

Opponents

Opponents in attaining access to quality health care services include some of those in the private sector; pharmaceutical companies; broader civil society organisations can be opponents (or allies); religious leaders (those opposed to certain services offered to key populations) and traditional institutions (those opposed to key populations).

Targets

Targets for achieving access to quality health care services include relevant Ministers and Parliamentarians, depending on country context.

Tactics

Tactics could include the following:

- Petitions to and meetings with Ministers, Parliamentary Committees, other policy makers and donors
- Field visits with Ministers
- Advocacy for civil society inclusion in decision-making spaces

- Technical advisory and technical working groups to discuss data and quality of services.
- Press conferences, press visits to health facilities on international days or other key events
- Social media to build momentum around UHC
- Community monitoring and evaluation frameworks to collect data on services, key populations; documenting evidence through case studies
- Strategic litigation on quality of services
- Funding / budget advocacy

Funding – Increased Resources for UHC

Goal

The goal is to have a sustained prioritized pool of funding for UHC at country level. An intermediate goal is for countries to adopt UHC recommendations for allocation of resources to UHC.

Key Advocacy Asks

The meeting prioritised the following key advocacy asks:

- A stronger role for civil society in budget formulation, prioritisation and accountability and for government to be more transparent and accountable for budget processes, priority setting and spending
- Adequately funded UHC that is free at the point of care, funded through efficiencies in current spending and prioritisation as well as through untapped funding sources

Other key issues discussed during the meeting in relation to financing for UHC included:

Health access should be seen as a public resource for the common good, in which all people have equal access to services, without barriers, regulated by policies that enable and frame health as a public resource and a right. It should be free at the point of care, adequately funded, equitable and comprehensive.

CSOs need to become involved at the outset, in the process of budget formulation and prioritisation – they need to build capacity to understand the budgeting process and the impact of budget allocations, so that organisations are able to make concrete, time-bound demands, driven by community priorities, and propose evidence-informed alternatives to budget allocations. Addressing inefficiencies is critical to the call for increased funding.

In order to address efficiencies, governments should be transparent regarding financing processes and spending on UHC. CSOs should strengthen their capacity to become involved in ensuring accountability for efficiencies within the entire health system – including private health care. This includes examining spending on UHC – as well as other non-health related spending. This may include community health committees auditing health facilities, examining expenditure allocations, examining excessive expenditure or inappropriate / unrelated expenditure across the system and providing information to re-allocate funding and improve efficiencies, where possible. Cost-benefit analyses should include looking at issues such as the costs of criminalisation – e.g. of sex work, same-sex sex – and how these funds may be redirected. Participants suggested that it may be useful to identify and develop a database of any existing case studies on how auditing can best be done and research on cost-benefits, for organisations to review and adapt where useful.

Increased investments in human resources are required, to strengthen the availability of qualified health personnel, to ensure better placement of health workers, based on skills and

disease burden, and to reduce loss of human resources. Investments in addressing structural issues that impact on health– such as social welfare and housing – are equally critical to and should form part of investments in UHC.

In terms of financing for UHC, development partners should continue to support UHC, without conditions (e.g. in the case of abortion). It is also important to invest in strategies to enable community funding of UHC, e.g. through community savings and health schemes, to contribute to the health funding pool.

Constituents and Allies

Constituents include networks, Country Co-ordinating Mechanisms (CCMs) and communities.

Allies include the Global Fund, CCMs, UHC2030 Civil Society Engagement Mechanism, Ambassadors, Tax Justice Movement.

Opponents

Opponents include some lawmakers of Members of Parliament (MPs) and the private sector. The Ministry of Finance may be 'in-between'.

Targets

Targets should include Presidents, First Ladies, Minister of Finance, donors (multi and bilateral), Minister of Health, Budget and Planning; other line ministries.

Tactics

Tactics include

- Raising consciousness of communities and networks on UHC, including funding, and mobilising the movement.
- Media engagement
- Tying the issue to votes when engaging politicians
- Face to face meetings
- Naming and shaming
- Lobbying for funds for activism and advocacy
- Understanding progressive taxation.

Community Engagement and Accountability

Goal

Everyone should be included in access to a comprehensive package of quality services. There should be (i) space for community monitoring and influencing; and (ii) the creation of an accountability framework encompassing the most marginalised (including key populations, young people, vulnerable populations).

Key Advocacy Asks

The meeting prioritised the following key advocacy asks:

- The availability of data and transparency of government decision-making on systems for health
- Community and government-led research on health delivery to inform future programming needs for health systems
- Accountability systems to be in place to track policies, laws, human rights violations and data in relation to key and vulnerable populations in accessing health care.

Communities

During the course of the meeting, the following communities were identified as needing to be part of UHC and engaged through existing community structures:

Adolescents and young people; sex workers; the LGBTIQ+ community; people who use drugs; people living with HIV; vulnerable women and girls and the general population

Accountability frameworks and mechanisms should:

- Set high aims
- Be aligned to and harmonized with existing commitments, policies, donor funding etc. They should also be linked to key milestones, such as electioneering periods, presidential terms, the review of the SDGs
- Include community monitoring mechanisms for tracking the implementation of UHC at health facilities.
- Be based on specific targets and measurements (e.g. Community Scorecards)

An accountability framework should track various elements of UHC, including policies, the extent to which they are implemented by and with the inclusion of key populations and the extent to which they are included in political parties' commitments; (ii) budgets and (iii) inefficiencies and corruption.

Allies

Allies were identified as key population networks, CSOs and non-governmental organisations; other networks (TB, malaria, HIV, maternal and child health); social justice movements; United Nations (UN) agencies; donors including PEPFAR and the Global Fund; harm reduction champions; academic communities; religious leaders.

Opponents

Opponents may include religious leaders; finance departments; government 'culture' and sometimes the community itself (due to competing interests).

Targets

Targets include the NAC, donors, WHO, law and policy makers; the Ministry of Health and Health Commission; the finance and budget office; the Human Rights Commission; religious leaders and regional and global bodies.

Tactics

Tactics include

- Building a critical mass of voices to engage with decision-makers
- CSO representation on CCMs

- Peaceful processions to advocate for key asks
- Advocacy on international days
- Advocacy with duty-bearers through international conferences
- Use of media / talk shows etc.

Key Country Action Points

Country partners identified various action points to take home to continue advocacy for UHC. Key actions included the following:

- Bring conversations to country level, bringing together key stakeholders to define UHC in-country, include key populations and to influence decision-makers (e.g. Ministers of Health, CSOs, key population networks)
- Integrate awareness-raising and advocacy for UHC into existing platforms and work (e.g. PLHIV action plans) and continue to advocate for UHC e.g. with PITCH partners, using key opportunities to advocate for increased commitment and financing for UHC.
- Support advocacy for UHC amongst young people, including support for the Ready4UHC campaign and inclusion of discussions on UHC in inclusive youth symposium (Uganda)
- Undertake sensitivity training for health workers.
- Engage media for positive reporting to increase understanding of UHC and the roles of various stakeholders
- Create awareness amongst key population communities, health care workers, religious leaders to develop an accountability framework for UHC and monitor implementation of UHC.
- Host a webinar on UHC and share with countries in region, to share documents, develop joint statements into Call to Action

Call to Action

Participants noted that there was still much work ahead in order to continue to develop ideas and further clarity on the UHC they want to see and also to ensure that UHC goes beyond decision-making to implementation, particular for those most in danger of being left behind. A Call to Action was developed, based on the discussions of the three-day meeting, towards an inclusive, person-centred and equitable UHC:

Towards the Universal Health Coverage We Want:
Inclusive, Person-centered and Equitable
Enhancing Inclusion of Key and Vulnerable populations in the UHC agenda:
An African Civil Society Call to Action

On the 5th to the 7 November 2019, the AIDS and Rights Alliance for Southern Africa (ARASA), UNAIDS, Aidsfonds and Frontline AIDS through the Partnership to Inspire, Transform and Connect the HIV Response (PITCH), together with Health GAP, hosted a two and a half day workshop titled: Building the Universal Health Coverage We Want - Enhancing Inclusion of African key and

Vulnerable populations in the UHC Agenda. Over 50 representatives of civil society, including key populations and young people, from 10 countries across sub-Saharan Africa came together to reflect on the challenges and opportunities that Universal Health Coverage (UHC) poses for HIV and key and vulnerable populations.

Why a Call to Action?

This Call to Action summarises key consensus and recommendations from the meeting, for the UHC we want. The Call to Action aims to galvanise momentum among sub-Saharan African Civil society, communities of people living with and affected by HIV and key and vulnerable populations whose meaningful participation and leadership has progressed the fight to end HIV and other health-related challenges in Africa.

Background

Recognising that health is central to development as a precondition for, as well as an indicator and an outcome of, sustainable development, United Nations Member States committed to "Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe and effective quality and affordable essential medicines and vaccines for all in the 2016 Sustainable Development Goals (SDGs). According to the WHO, "UHC is, by definition, a practical expression of the concern for health equity and the right to health."

Striving to re-envisage the availability, accessibility, acceptability and quality of health service delivery in a way which meets the needs and rights of all and especially key, marginalised and vulnerable populations is an urgent imperative. As it stands, UHC is not being conceptualised by many high burden countries as the vehicle to deliver this imperative.

While the recent adoption of the Political Declaration on UHC represents an important commitment to the achievement of health access for all, we are gravely concerned that the final Declaration is missing hard targets and milestones, such as financial targets, specific service delivery targets, and sexual and reproductive health and rights of key populations. This, despite the fact that countries claim to be focused on reaching those most left behind. As UHC roll out begins at country level, there is an urgent need to ensure that the UHC agenda builds upon principles and successes achieved by the HIV response – like ambitious and accountable service delivery and engagement of communities in advocacy and service delivery. UHC will not be truly focused on the most marginalised unless it includes key, marginalised and vulnerable populations, youth and the poor.

The UHC We Want!

The UHC we want is premised on the right of everyone, everywhere to the highest attainable standard of physical and mental health. To achieve this, underlying determinants of health must be included and health services must be available, accessible and acceptable and equitably distributed.

We, as civil society organisations across sub-Saharan Africa, including people living with HIV; sex workers; gay men and men who have sex with men; transgender people; people who use drugs; and young people, are in agreement that there are basic non-negotiable principles and values that must define UHC.

We call on all stakeholders (government, development partners and communities) working towards the attainment of UHC in sub-Saharan Africa to prioritise the following in order to ensure the UHC Africa needs:

1. Put the last mile first: human rights and inclusion

Governments must fulfil the true meaning behind the pledge to leave no one behind and reach those most in need first by taking explicit action to end inequalities, confront discrimination and fast-track equitable access to services. Only when UHC is designed to cater for all including key, criminalized, marginalised and vulnerable populations will it truly be universal.

Key actions:

- Enact and implement laws and policies that protect and promote the rights of key and vulnerable/marginalised populations. This includes the decriminalisation of homosexuality, gender identity and expression, HIV transmission, sex work and drug use and possession for personal use, among others. It also includes enacting laws protecting informed consent and confidentiality.
- Ensure that the health workforce and other duty bearers are sensitised and trained to provide high quality services to key, marginalised and vulnerable populations and that there is zero tolerance for stigma and discrimination in health care settings.
- Put in place accountability frameworks and systems to track and review policies and their implementation, laws, and human rights violations affecting key and vulnerable populations' access to health and related services.

2. Nothing for us without us: Greater involvement of key, marginalised and vulnerable groups

UHC cannot be achieved without the meaningful involvement of key, marginalised and vulnerable populations. These communities must be engaged at every level including in planning, research, design, implementation, financing and monitoring of UHC interventions.

Key actions:

- Ensure that UHC builds on key principles for engagement of key and vulnerable populations, as it was the case of the GIPA Principles for the HIV responses and a recognition of the rights of key and vulnerable populations, including their right to self-determination and participation in decision-making processes. Key, marginalised and vulnerable populations including gay men and men who have sex with men, trans people, young people in all their diversity, sex workers and people who use drugs must have the right to organise, mobilise and be legally recognised and protected to ensure that their communities are represented in key decision-making platforms and processes.
- Communities have a strong role to play in monitoring health spending and auditing efficiencies, and must be seen as part of the health management system.
- Ensure full representation of key and vulnerable people in mechanisms for planning, implementation and oversight at local, district and national levels- this includes on clinic boards, in quality control mechanisms, supply chain of medicine management and in the allocation and use of funds.
- Ensure the roll out of national guidelines, training curriculum, continuous professional development and performance systems for health care workers which include sanctions for breaching such standards.

- Recognise and support the vital contribution of community groups to service delivery by funding community service delivery, community health workers' remuneration and ensuring adequately skilled youth and key population friendly services at community level.
- Civil society is a critical stakeholder and must play a stronger role in budget formulation, prioritisation and accountability on UHC and should also advocate for these spaces to be inclusive, representative and accessible.
- Prioritize work to address harmful social norms and work with communities to address discriminatory practices at community level.

3. Show us the money for health! Scale up investments for health to ensure the universality of UHC

Whatever is not funded is not prioritised. We want a fully funded universal health coverage that is free at the point of care. This will require a marked increase in political will from donors and implementing country governments and urgent action to remedy the debt crisis that many Southern and Eastern countries face, for them to commit to increase domestic resource mobilization for health.

We demand accountable and transparent health sector spending, and improved health sector performance including disease specific investments, so that government funding priorities match the health priorities and demands of communities. Donors who have played a critical role in the success of HIV, tuberculosis, malaria, gender, human rights and SRHR response will need to increase those investments and continue to partner with countries as they implement UHC.

Key actions:

- Increase domestic funding for health
- Mobilise continued donor and other investments for health, through global and regional solidarity.
- Ensure efficacies in current funding by curbing corruption and fraud and putting in place accountability and recovery mechanisms.
- In analysing funding efficiencies and untapped sources of funding, private health care must be included in a financial analysis.
- Governments must be more transparent and accountable on health financing, priority setting and spending.
- Adequate budget should be allocated to addressing social barriers to health services within UHC, which disproportionately affect key, marginalised and vulnerable populations.
- Governments must make use of TRIPS flexibilities available to ensure that they can be able to afford the cost of drugs needed to implement quality health services.

4. Enhanced systems for health

Strengthened and resilient systems for health are essential to deliver health care for all – the institutions and mechanisms for organising, resourcing and delivering health care must recognise the imperative to deliver services to and partner with key and vulnerable populations.

Key actions:

- Enact data policies that ensure the safe collection and storage of data on key and vulnerable populations and ensure availability of disaggregated data.
- Enact and implement policies that standardize, guide and ensure inclusive health systems e.g. health financing policies and implementation and procurement policies.

- Ensure transparency of government decision making on systems for health.
- Build a capacitated, well-resourced human resource management system with the necessary mechanisms to provide quality health services.
- Build an evolving evidence base for future programming needs, recognizing community generated data and research on the determinants of health and health service delivery.
- Strengthen community health systems, including by ensuring that they are adequately funded.
- Strengthen differentiated service delivery, to ensure a client-centred approach to health.

This call is endorsed by the following organisations:

AIDS and Rights Alliance for Southern Africa
Frontline AIDS
Aids Fonds
Health Gap KESWA
Global Network of Young People Living with HIV
Ready Movement
Y+Kenya
KP Consortium of Kenya
PITCH CFP
N'weti Health Communication
Lambda
UNIDOS
Muleide
EVA
NSWA
HERFON
CHEDRES – Centre for Healthworks, Development and Research initiative
PITCH CFP
Team Leader UNYPA
PITCH coordinator at ICWEA
PITCH Lead at SMUG
PHAU
PITCH CFP
Pan African Positive Women's Coalition
GALZ
SAfAIDS
SAT Regional
FACT
WACI Health/UHC2030
ASWA
Accountability International
BONELA
ITPC
GNP+
EANNASO
Pakachere
Greater Women Initiative For Health and Right Rivers State Nigeria

Appendix A: Participant List

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Appendix B: Agenda (as updated)

Building the Universal Health Coverage We Want - Enhancing Inclusion of African Key and Vulnerable Populations in the UHC Agenda

PITCH Regional Workshop

5 – 7 November 2019. Hotel the Aviator, Johannesburg, South Africa

Main Facilitator: Felicita Hikuam

Day 1 (5 November 2019)

9:00 **Registration**

9:15 **Welcome** *by PITCH, ARASA and UNAIDS*

9:30 **Who is who – introduction of participants** *(by ARASA)*

10:00 **Presentation of the agenda and main outcomes of the meeting, and sharing expectations** *(by Wanja Ngure)*

10:30 – 12:30 **PART I – FRAMING THE CONVERSATION** *(Session lead: David Ruiz Villafranca)*

- Creating a common understanding of the technical elements of UHC and framing the movement towards UHC in the current global health ecosystem. Resource persons: *Belete Mihretu* (*WHO, South Africa) and Chris Mallouris (UNAIDS RST, southern African countries)*

11:00 Coffee Break

11:30 – 12:30 **PART I – FRAMING THE CONVERSATION (continuation)**

- Political elements of universal health coverage. Resource persons*: Rosemary Mburu (Waci Health), Maureen Milanga (Health Gap and Aparna Kamath (CHAI)*
- Outcomes from the UN high level meeting on UHC and what they mean for our advocacy work.
  Resource persons: *Wanja Ngure (PITCH CFP), Friedel Dausab (GNP+) and Aanu Rotimi (HERFON)*

12:45 – 14:00 Lunch

14:00 **PART II – "Reality check": UHC IN THE AFRICAN REGION** *(Session leads: Cecilia Kihara, Sally Shackleton and Seb Rowlands)*

Including Coffee Break

19:00 **Group dinner**

Day 2 (6 November 2019)

9:00 – 9:45 **REFLECTION ON DAY 1**

9:45 – 11:00 **PRESENTATION OF A YOUTH LED CAMPAIGN ON UHC.** *led by Cedric Nininahazwe and T*inashe *Rufurwadzo*

11:00 – 12:30 **PART IV – WHAT DOES THE UHC WE WANT LOOK LIKE AND HOW TO GET THERE?** *(Session lead: Felicita Hikuam)*
Establish common civil society advocacy demands regarding UHC, based on country evidence and road maps. This session will also provide space to identify and prioritise advocacy actions and what needs to happen in order to get us there.

CONSIDERATIONS FOR MOVING FORWARD
Presentation on Accountability in UHC (*Phillipa Tucker)*

12:30 – 13:30 ***Lunch***

14:00 – 17:00 **PART IV – WHAT DOES THE UHC WE WANT LOOK LIKE AND HOW TO GET THERE? [cont]** *(Session lead: Felicita Hikuam)*
Establish common civil society advocacy demands regarding UHC, based on country evidence and road maps. This session will also provide space to identify and prioritise advocacy actions and what needs to happen in order to get us there.

Day 3 (7 November 2019)

9:00 – 11:00 **PART V – COUNTRY AND REGIONAL CAMPAIGN PLANNING** *(Session leads: Asia Russell, Maureen Milanga and Richard Lusimbo).*

Working groups session. In several small groups, advocates will begin to map out action plans to support the roll out of UHC and fight for priority improvements needed

11:00 – 12:00 **PART VI – CALL TO ACTION. Moving forward together (***Session lead: Sally Shackleton)*
This is a section to bring the two-day discussion together and identify priorities for advocacy in country and regionally and explore ways to move together.

12:00 – 12:30 **EVALUATION AND CLOSING**