

# THE UHC THAT WE WANT



A POSITION STATEMENT FROM THE “ASIA-PACIFIC COMMUNITY AND CIVIL SOCIETY UNIVERSAL HEALTH COVERAGE CAUCUS” CONVENED BY THE GLOBAL FUND ADVOCATES NETWORK ASIA-PACIFIC (GFAN AP) AND CO-ORGANISED BY APCASO.



When adopting the Sustainable Development Goals (SDGs), world governments committed to:

- a. Target 3.8 – “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”; and
- b. Target 3.3 – “By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases”.

The SDGs and their targets are interdependent – achieving one is reliant on achieving the others. In the case of UHC and the unfinished global HIV, TB, and malaria agenda, it will take effective implementation of UHC to help end the three diseases. At the same time, the inclusion of key and vulnerable communities living with and affected by the three diseases is needed to attain UHC and the SDGs.

Achieving UHC is not only a technical or fiscal challenge, but is also a political one. At the Second UHC Forum which takes place from the 11<sup>th</sup> – 15<sup>th</sup> December 2017 in Tokyo, Japan, we share with government leaders, technical and development partners, academics, and communities and civil society our vision of the UHC that we want – one that lives true to the global aspirations of leaving no one behind.

## 1. A PEOPLE-CENTERED UHC

We want health responses and systems that are centred to the health needs of individuals and communities, rather than focused on diseases. We want a UHC that takes a holistic approach to health care provision, promotion, and disease prevention.

A holistic and equitable health system needs to recognise that access to healthcare is affected and determined by multiple social identities of people (e.g. gender, age, marginalised group) at one, some, or all points of their life. Thus, healthcare provision needs to be comprehensive, tailored and differentiated accordingly. This means integrating services where it makes the most sense, and providing specialised care for aspects of health that need specialised approaches. Strategies that focus on engaging and empowering underserved and marginalised subpopulations are essential to inform policy and decision-makers on how they can improve access to quality health services and financial protection, and address broader societal goals such as equity, social justice, solidarity, and social cohesion<sup>1</sup>.

Stigma and discrimination against some communities pose huge barriers to their access to health services. Programmes that sensitise service providers (e.g. health professionals and community workers) and that raise community awareness on their rights, are needed to be part and parcel of UHC packages.

### The Asia-Pacific Region

#### HIV/AIDS

- Has the third largest population of people living with HIV after Eastern and southern Africa and Western and central Africa, having an estimated 3.9 - 7.2 million people living with HIV<sup>2</sup>.
- The gap to reach the 90-90-90 targets of people living with HIV who know their status, people living with HIV on treatment and people living with HIV who are virally suppressed are 980,000, 1.7 million, and 1.7 million respectively<sup>3</sup>; and only 47% of adults and 40% of children are on antiretroviral treatment<sup>4</sup>.
- Key affected populations must be the focus of HIV interventions through the removal of punitive legal barriers and creating supportive and safe environments for these groups to seek prevention, treatment, care and support.

#### Tuberculosis

- The top 5 countries with 56% of estimated cases are all in the Asia-Pacific region – (in descending order) India, Indonesia, China, the Philippines and Pakistan<sup>5</sup>.
- The most economically affected region, TB will cost the Asia-Pacific an estimated \$573 billion from 2015 to 2030, excluding drug resistance costs<sup>6</sup>.
- Persistent barriers to TB control in the South-East Asia region include the absence of UHC, as well as limited access to quality health services and fully subsidised treatment for chronic diseases<sup>7</sup>.

#### Malaria

- Carries the second largest burden of malaria behind Africa – with 16,200 estimated cases in 2016 and with 5,345 cases of *P. vivax* estimated, more than the rest of the world totaled<sup>8</sup>.
- The emergence of artemisinin resistance poses a significant global public health threat due to the risk of the spread from the Greater Mekong Subregion to Africa<sup>9</sup>.

<sup>1</sup> WHO. *The contribution of integrated people-centred health services, and leaving no one behind in the SDG era*. (accessed 5 Dec 2017)

<sup>2</sup> UNAIDS. (2017). p.12. *UNAIDS Data 2017*.

<sup>3</sup> UNAIDS. (2017). p.76. *UNAIDS Data 2017*.

<sup>4</sup> UNAIDS. (2017). p.76. *UNAIDS Data 2017*.

<sup>5</sup> WHO. (2017). p.21. *Global Tuberculosis Report 2017*.

<sup>6</sup> Devex. (14 November 2017) *“TB to cost world economy \$1 trillion by 2030, warns report”*.

<sup>7</sup> WHO Regional Office for South-east Asia. (2017). p.15. *Bending the Curve: ending TB. Annual Report 2017*.

<sup>8</sup> WHO. (2017). p.34. *World Malaria Report 2017*.

<sup>9</sup> *The New York Times*. (21 November 2017). *“As Malaria Resists Treatment, Experts Warn of Global Crisis”*.

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## 2. AN EQUITABLE AND RIGHTS-AFFIRMING UHC

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UHC is impossible without the political internalisation that the right to health is truly the right of each person – regardless of their ability to pay, where they are, and their socio-political identity. Equal access to health could not be achieved without first enabling equitable access to the most excluded communities, among them: lesbian, gay, bisexual, trans, queer communities; migrant, mobile, and displaced people; people in prisons and other enclosed settings; indigenous people; people with disabilities; sex workers; people who use drugs.

We want a UHC that recognises that the world is not an equal playing field. Beyond equality, we call for equity. We want a UHC that prioritises communities that have the least access to programmes and services due to reasons of financial, social, or other exclusion(s).

In addition, the UHC that will work for us is one that provides for an enabling environment for people to access health programmes and services. This entails including as part and parcel of UHC the removal of punitive laws against key populations on the basis of their sexual orientation, gender identity or expression; drug use; engagement in sex work; or HIV, migrant, and other status(es).

Lastly, UHC will not be achieved without the full inclusion of Sexual Reproductive Health and Rights (SRHR) as a key element. SRHR is at the core of the right to health and of sustainable development, and a necessary precondition for gender equality and non-discrimination.

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## 3. A UHC THAT MEANINGFULLY ENGAGES THE PARTICIPATION OF COMMUNITIES AND CIVIL SOCIETIES

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Communities have a huge stake on if and how UHC is implemented and achieved. Simply put, it is our health and lives at stake. As such, we dream of a UHC where we are equal partners of government and development partners in designing, implementing, budgeting for, and reviewing health policies and plans that affect us.

Community and civil society mobilisation and advocacy; community-based service provision; community outreach; community-based monitoring of policy, programme and service effectiveness; community-led research are all essential in achieving the right kind of UHC – one that reaches and responds to the needs of hard to reach communities. They are the only way to scale up health programmes and services at the level necessary, and to keep costs sustainable.

We want a UHC that considers community and civil society participation as an essential element of health programme and policy planning, decision-making, and implementation. Such involvement needs to be meaningful, sufficiently resourced, legally enabled, and include key and vulnerable populations.

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## 4. AN EFFECTIVELY AND SUSTAINABLY FINANCED UHC

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WHO defines the goal of UHC as ensuring that “all people obtain the health services they need without suffering financial hardship when paying for them”.<sup>10</sup> Public financing is essential to achieving UHC and needs to be directed to priority populations and services, including for HIV, TB, malaria and Hepatitis C, to ensure equitable access to quality health services and financial protection for all.

We therefore call for governments to:

- a. Increase their domestic resource allocations on health, allocating a minimum of 5% of the Gross Domestic Product (GDP) for this;
- b. Implement concrete plans to remove out-of-pocket payments for essential drugs and services;
- c. Work towards greater technical and allocative efficiency in health spending;
- d. Ensure earmarking of funds for community mobilisation and community-based and -led health approaches; and

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<sup>10</sup> WHO. What is universal health coverage? [http://www.who.int/features/qa/universal\\_health\\_coverage/en/](http://www.who.int/features/qa/universal_health_coverage/en/) (accessed 5 Dec 2017)

- e. Support efforts to challenge and oppose trade agreements that enable large pharmaceutical corporations to control patents, dictate the prices of drugs and diagnostics of people<sup>11</sup>.

We call for global solidarity to achieve the UHC that we want, not just in words, but more importantly through action and financial contributions. We call on the international donor community to deliver on their ODA commitments, and support implementing countries to achieve UHC without strings attached, i.e. through aid rather than loans.

We call for a fully funded Global Fund as the largest financing mechanism for HIV, TB, and malaria that has institutionalised funding of community, rights, and gender responses and resilient and sustainable systems for health as central to its overall strategy. The Global Fund has set a norm the involvement of key and vulnerable populations in the highest level of its decision-making, and demonstrated the effectiveness of such approaches.

We call on international donors and global solidarity to ensure that marginalised populations and communities are not left behind by ensuring that bilateral and/or multilateral resources are allocated to these groups.

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## 5. ACCOUNTABILITY MECHANISMS TO GET US THE UHC THAT WE WANT

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The UHC that we want without the political will of governments and accountability mechanisms to translate this into action will remain a lofty goal. These accountability mechanisms need to adhere to the principles of transparency, the primary role and accountability of governments, and the meaningful engagement of community and civil society which entails respect for diversity and enabling various spaces for, and forms of, engagement.

Communities and Civil Society in the Asia-Pacific:

- a. Call on governments to set clear, concrete, time-bound, operationalised, costed, and publicly communicated UHC plans and targets. We urge for each country to establish a community-inclusive and multi-stakeholder country dialogue to develop these, and request for the international community to help support the processes;
- b. Call for setting in place mechanisms for national and regional reviews of the achievement of the plans and targets led by the government, but with the meaningful participation of all stakeholders; and
- c. Call for global UHC processes to be then informed by national and regional processes and driven the plans and targets set.

We look at the Second UHC Forum as the avenue for inspiring greater global solidarity towards the UHC that we want, for inclusive but high-level stock-taking of progress and gaps in achieving national UHC plans and targets, including its financing, for the renewal of political and financial commitments, and sharing of plans to address barriers and gaps.

*This statement is an outcome of the “Asia-Pacific Communities and Civil Society Universal Health Coverage Caucus” convened by GFAN AP and co-organised and hosted by APCASO, held on the 26<sup>th</sup> & 27<sup>th</sup> November 2017 in Bangkok, Thailand and attended by more than 30 representatives from national and regional networks of community and civil society organisations. [#theuhcthatwewant](#)*

**Global Fund Advocates Network Asia-Pacific (GFAN AP)** is a platform of community and civil society advocates for a fully funded Global Fund. It supports community and civil society mobilisation in the areas of increased domestic financing for HIV, TB and malaria responses; increased donor contributions towards the Global Fund; and ensuring that policy frameworks on health financing take into account community, rights and gender issues. For more information, please visit <https://www.facebook.com/afanasiapacific>

**APCASO** is a regional civil society network of health and social justice community-based and non-government organisations, with a focus on advocacy and community capacity development in Asia and the Pacific. APCASO envisions just and inclusive societies that respect, fulfil and advance the rights of communities most in need – thereby hastening the end of the AIDS epidemic and other health challenges. For more information, please visit [www.apcaso.org](http://www.apcaso.org)

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<sup>11</sup> 18 May 2015 Statement of the HIV Constituency at the AP-RCEM CSO Forum of the Asia-Pacific Forum on Sustainable Development: [The world we want is a world that does not leave people living with and affected by HIV behind](#)