**Promote health, keep the world safe, serve the vulnerable:**

HIV, Viral Hepatitis, Tuberculosis, Sexually Transmitted Infections and Universal Health Coverage

Civil Society Meeting | 22-23 March 2018
Meeting Report

**Background**

In March 2018 40 civil society leaders from around the world were invited to the World Health Organization (WHO) headquarters by the Department of HIV and Global Hepatitis Programme, together with the Global Tuberculosis Programme and the Department of Reproductive Health and Research. While each department actively engages civil society it was the first time WHO convened a joint meeting of civil society representatives from HIV, tuberculosis (TB), viral hepatitis and sexually transmitted infection (STI) backgrounds. In recent years civil society groups and other stakeholders increasingly requested opportunities for discussion across these areas, given commonalities in modes of transmission, populations affected, interventions and models of service delivery, and structural determinants.

The meeting was organized to strengthen ongoing efforts to ensure disease-focused programmes continue to progress and strengthen in the context of an increasing global and country focus on universal health coverage.

Participants were drawn from existing WHO Civil Society Reference Groups on HIV and Hepatitis; civil society representatives from the Strategic and Technical Advisory Committee on HIV and Viral Hepatitis (STAC-HIVHEP) and the Strategic and Technical Advisory Group for Reproductive Health and Research (STAG-RHR); members of the TB Civil Society Taskforce; civil society representatives from UHC2030; youth participants nominated by the Partnership for Maternal, Newborn and Child Health (PMNCH); and individuals who have supported other key WHO events and consultations. A List of Participants is annexed to this report.

The meeting agenda was organized around 12 sessions – half of the sessions were moderated by civil society representatives. Sessions were a mixture of presentations and panels with discussion time. To maximise the short period of time together all participants were asked to prepare interventions for at least one specified session. The meeting’s objectives were to:
– identify opportunities to strengthen HIV, hepatitis, TB and STI integration across the health system in the context of universal health coverage;
– identify opportunities for WHO and civil society collaboration to maximize public health impact in the context of the Global Health Sector Strategies on HIV, Viral Hepatitis and STIs, the End TB Strategy and the 13th WHO General Programme of Work 2019-2023;
– orient key civil society partners on the strategic priorities and organizational and strategic shifts of WHO;
– improve WHO-wide responsiveness to, and engagement with, civil society.

There was significant senior level WHO representation at the meeting – the Deputy Director-General for Programmes and three Assistant Directors-General joined different sessions. The WHO Director-General also shared a statement of support with participants.

Soumya Swaminathan, the WHO Deputy Director-General for Programmes, highlighted the timeliness of the meeting which was taking place during a high profile year for global health – the 70th anniversary of WHO and the 40th anniversary of the Declaration of Alma-Ata, which championed service delivery through primary health care. She noted the importance of community involvement and community-led TB interventions from her previous experiences in India.

Ren Minghui, the WHO Assistant Director-General for Communicable Diseases, reiterated the importance of a people-centred human-rights based approach and of breaking down silos to support everyone’s efforts to bring health to all those who need it.

Nono Simelela, the WHO Assistant Director-General for Family, Women, Children and Adolescents, reminded the meeting that while new leadership creates opportunities, challenges around social injustice, inequalities and inequities remain considerable and would not be overcome without strong collaboration from civil society.

Naoko Yamamoto, the WHO Assistant Director-General for Universal Health Coverage and Health Systems, encouraged a sustainable and holistic approach to universal health coverage that was inclusive of health promotion and prevention and that covered all health issues. She stressed the importance of engaging civil society especially at the country level and invited civil society organizations from disease-focused backgrounds to engage in the UHC2030 movement through its civil society engagement mechanism.

Recommendations from the meeting will inform the implementation of the 13th WHO General Programme of Work 2019-2023, WHO’s medium-term strategy, which will be considered for adoption by the World Health Assembly in May 2018.

Key Summary Points

– Senior WHO leadership stressed the importance of ensuring civil society perspectives shape frameworks to guide work towards universal health coverage;
– The UHC2030 movement offers useful opportunities through its civil society engagement mechanism.
Introduction and scene-setting

WHO set the scene of the meeting by focusing on the work required to end the epidemics of HIV, viral hepatitis, tuberculosis and sexually transmitted infections by 2030.

WHO made clear that universal health coverage will not be achieved without civil society engagement to ensure interventions meet the health needs of all people through a strong focus on sustainable financing, country delivery, implementation and impact. Participants were invited to make initial comments, or raise concerns or questions they would like addressed during the two-day meeting.

For many civil society members, universal health coverage was seen as an important opportunity, albeit an opportunity combined with certain challenges. Challenges expressed include:

- how to use universal health coverage to appropriately meet the needs of marginalized communities including, among others, indigenous people, transgender people, men who have sex with men, people who use drugs, young people and sex work communities, and how to bring these communities into decision making;
- how to stimulate the development and use of innovative financing in an era of dwindling investment in public health;
- how to ensure comprehensive price reduction strategies are applied to address market barriers and failures related to access to treatment and other commodities;
- how to overcome structural, gender and legal barriers to health while strengthening the focus on human rights and the eradication of stigma and discrimination;
- how to ensure links with mental health and services for psychosocial wellbeing and strong links across relevant areas such as TB and HIV and sexual and reproductive health and rights;
- how to secure inclusion of communicable diseases in collaborative processes being launched towards achieving universal health coverage;
- how to strengthen community-based groups and services; and
- how to find the “missing millions” who are unaware that they may be impacted by communicable diseases.

Participants also felt that universal health coverage presented an important opportunity to re-politicize health through a focus on vulnerability and inequity and bring visibility to the holistic needs of individuals and communities. Views also included the importance of establishing a clear monitoring and evaluation framework for universal health coverage at country level and the importance of establishing global, regional and country mechanisms for collaboration.

A recurring concern involved the importance of strategic implementation of universal health coverage, which should not undermine or dilute progress made through vertical programmes especially in countries with weak health systems. Increased integration should be managed thoughtfully and should not be mistaken as the main goal of universal health coverage.

It was noted that significant progress has already been made in bringing disease areas together in many contexts but much more can be achieved. The challenge now lies in invigorating a human-rights based approach, that addresses the criminalization and marginalization of key populations, and ensuring everyone, across all communities, has access to the preventive and health services they need. Furthermore, global discussions should be mirrored at country level, where universal health coverage
is key and where all global commitments have to be translated. WHO should be instrumental in ensuring governments support country-level dialogue.

In an opening presentation WHO concurred that strong, resilient health systems should provide people-centered quality services with equitable access supported by a strong health workforce and transparent and accountable governance systems and processes. WHO noted that a critical challenge will be to ensure that all essential health services and interventions for communicable diseases that are of high quality are included in health budgets and programmes. Decision-makers should ensure that all people are considered, specifically key, overlooked and underserved populations and that an understanding of financial hardship and risk is built in to decision-making processes. Finally WHO concluded that addressing health determinants should be considered a critical component of universal health coverage and that strengthened mechanisms for collaboration between WHO and civil society should be encouraged to help ensure that the health sector delivers interventions for impact that are anchored in human rights.

Two civil society discussants shared perspectives on universal health coverage arguing for the same kind of strong civil society leadership and activism that helped drive the HIV response. Much can be learned from the HIV response, including an awareness of the social fabric and its marginalized and criminalized groups, its insistence on leaving no one behind, and its technical experience and abilities in the areas of price and medicines. The clear message was that “together, we are stronger.”

Corruption was raised as a serious threat to universal health coverage in many country contexts and WHO was challenged to be more rigorous and more proactive in addressing corruption which considerably weakens efforts to reach the most vulnerable in society. Discussion also noted issues concerning the integrity of data and statistics in some contexts which often misrepresent reality and skew policy decisions and resource allocations. The importance of anchoring all public health efforts in a human rights based approach, including those linked to the generation of evidence was well noted.

The UHC2030 Civil Society Engagement Mechanism (UHC2030 CSEM) was introduced and civil society members were encouraged to get involved, including through participation at a side event planned for the World Health Assembly in May 2018.

Finally, WHO’s efforts to support civil society in engagement around universal health coverage were acknowledged, yet WHO was challenged to provide incentives for civil society by setting clear milestones to drive success and by clarifying the path and shape any joint advocacy will take.

**Key Summary Points**

- Universal health coverage offers an opportunity to re-politicize health;
- Universal health coverage implementation must not dilute disease-specific programmes and priorities;
- A concerted effort is required to ensure that key populations are not neglected and that funding for community based and nongovernmental organizations is not diverted;
- Community-led interventions need to prioritised within universal health coverage;
- Country level action is crucial – including through strengthened WHO country offices.
Understanding Universal Health Coverage: the view from across WHO

This session set out to provide an overview of how WHO approaches universal health coverage from various perspectives within the organization. A statement from Dr Tedros Adhanom Ghebreyesus, WHO Director-General, was shared with participants and a series of WHO presentations explored key concepts, definitions and examples of cross-organizational collaboration.

“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. We need to ensure community perspectives inform our understanding of essential packages of services, commodities and interventions; we need to work with communities to better understand who is being left behind and how to ensure universal health coverage can address disparities and gaps; we need to recognize and support the role of communities in service delivery and in strengthening broader health systems; we need to do more to enable your advocacy and activism efforts, to support of universal health coverage and to increase access to essential medicines and health commodities.” Statement by Dr Tedros Adhanom Ghebreyesus, WHO Director-General, 22 March 2018.

WHO highlighted three dimensions of universal health coverage:

1) **Interventions for impact** - improving the range, quality and availability of essential health interventions and services;
2) **Delivering for equity** – improving the equitable and optimal uptake of services across populations and locations in relation to need; and
3) **Financing for sustainability** – allocating adequate resources, reducing costs and providing financial protection for those who need services.

Progressive realization of universal health coverage requires simultaneous strategic focus and action in all three dimensions with a focus on reaching those in most need first.

It was noted that agreement on a “minimum service package” is typically made by society as a whole through political processes and public debate. As part of this process an emphasis should be given to hearing the perspectives of all affected communities. However, broader politics and power dynamics can inhibit debate and so a focus on reducing exclusion is required to ensure all critical stakeholders have a voice. A dialogue based on data is essential to reach the decision. While significant work has already been done in HIV and tuberculosis to determine benefit packages this is not necessarily the case for many other health areas.

During discussion participants explored how to ensure the right data are available to inform decisions. WHO described how the “data space” is populated by experts and the “decision space” is populated by politicians. WHO stressed the importance of bridging these two spaces with dialogue to ensure transparency, accountability and legitimacy.

It was noted that the 2016-2021 strategies for HIV, viral hepatitis and sexually transmitted infections, were developed by WHO through a consultative process informed by data and evidence and adopted in 2016 by the World Health Assembly as the body with the authority to approve and adopt such
strategies. Each of the strategies applies the three dimensions of universal health coverage as three central strategic directions of five strategic directions common to the three strategies (Fig.3).

A series of WHO interventions stressed the importance of leveraging universal health coverage to advance momentum and coherence for disease focused efforts while also encouraging strengthened linkages and integration where it makes sense. WHO recognized the importance of building momentum and coherence for viral hepatitis while recognizing that fragmented financing presents a barrier to sustainability. While momentum has also been growing in the area of sexual and reproductive health and rights (SRHR) and HIV linkages, fragmentation remains a barrier and SRHR outcomes are suboptimal in many communities.

Equally important is moving HIV and tuberculosis collaboration beyond its focus on co-infection as proposed in the End TB strategy. The pervasiveness of tuberculosis makes universal health coverage all the more important for this disease, which will be in the political spotlight throughout 2018.

Human rights are a critical underpinning factor that goes beyond disease prevention into improving health, rights and wellbeing. Working together was recognized as essential across the diseases and in collaboration with other areas of health with the understanding that reaching one billion benefitting from universal health coverage cannot be achieved in isolation, within disease silos. An enabling environment is essential if barriers like stigma, mental health or violence are to disappear, as is the direct involvement of communities in decision making, for which resources will have to be found.

It was again noted that universal health coverage has politicized health in a way not seen since the AIDS movement. It goes beyond services and medicines into the highly political areas of accessibility, non-discrimination and equality. It has also opened doors to engagement with new partners including ministers of finance and heads of state. The shrinking of civil society space makes it all the more important to integrate civil society into building universal health coverage.

It was again noted that a mechanism was established in 2016 to represent civil society at the UHC 2030 Summit, a global movement to accelerate equitable and sustainable progress towards universal health coverage and all members of civil society are invited to join the movement and become active partners.

Key Summary Points

- Key strategic and partnership frameworks are already in place and should be further leveraged to ensure strong disease outcomes through universal health coverage;
- Data driven dialogue and stakeholder engagement at all levels is key – as “society” will help determine what universal health coverage looks like in different contexts;
- WHO should continue to ensure civil society is engaged in key decision-making platforms.

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1 The WHO GPW13 contains three strategic priorities to be achieved by 2023: 1 billion more people benefiting from UHC; 1 billion more people protected from health emergencies; and 1 billion people benefiting from better health.
Civil Society Panel: ensuring a people-centred approach to universal health coverage

This session set out to explore the opportunities and challenges posed by universal health coverage from the perspectives of civil society representatives. Discussion raised a number of questions and challenges, especially around the importance of community engagement if the most marginalized groups are to be successfully included in key processes. It was noted that there were different interpretations of universal health coverage.

Issues of racism and stigma were frequently raised, with calls to take special care not to side-line the health issues of the most marginalized and to ensure the inclusion of indigenous people, transgender persons, sex workers, men who have sex with men, people who use drugs, youth, refugees, migrants and other vulnerable and marginalized groups. Keeping key “marginalized issues” – including advocating for comprehensive harm reduction provision – at the forefront of public debate may help guarantee equitable and comprehensive access although concerns were raised that some politically difficult issues might be subsumed under a broader health approach. Meeting the health needs of transgender people was noted as particularly sensitive given the lack of political will to provide transgender people with adequate services and the challenges faced by many individuals in confronting stigma when seeking care.

Lack of knowledge among health care professionals, including around viral hepatitis, needs to be addressed, both to eliminate stigma and improve services, while strengthening health provision. The links between poverty, health and gender were highlighted, especially the need for gender equality to achieve universal health coverage. The need to gather better data was voiced repeatedly, especially data disaggregated by age, gender and ethnicity and within certain diseases. Concerns were also raised around fragmentation at various levels and there was a call for unified indicators to track universal health coverage. The need for awareness was emphasized, especially around advocacy for testing and the challenge of an often poorly informed and ill-trained health workforce that creates additional stigma. There is also continued need for advocacy around bilateral and multilateral funding and around the removal of punitive laws. Additional concerns included the burden of out-of-pocket expenses, gaps in the continuity of care, the lack of referral systems and the need for a life course approach.

Some civil society organizations have moved forward in adapting their work to universal health coverage by creating working groups for underserved communities, increasing opportunities for visibility, including in the case of viral hepatitis, thinking about and shifting their perspectives away from a single disease, and advocating for universal health coverage. There was clear willingness among civil society participants to work together towards universal health coverage as long as the needs of the most vulnerable were kept front and centre.

Learning from existing successes is essential, for example the HIV movement, or through the successes of the Global Fund’s community involvement model.

While WHO would like to build on the HIV model, some diseases, including sexually transmitted infections, don’t lend themselves as readily to community mobilization or joint advocacy approaches. Developing participatory processes around them is more challenging, although constituencies do exist. WHO is conscious of these challenges and of the need for critical processes to be funded, especially around political advocacy and community engagement, if serious inroads are to be made.
WHO reiterated the pivotal role of civil society involvement in the evolution of health systems and recommitted to not leaving the most vulnerable behind. WHO recognized the challenge of making sure civil society is systematically represented in policy-making groups and will advocate for that, along with ensuring WHO’s partnership with civil society is strengthened. WHO stressed that there was no “either/or” option on the table related to universal health coverage and vertical approaches to diseases. Under SDG Target 3.3 WHO will continue to target specific diseases while pursuing comprehensive people-centred care, with specialized services of high quality in place to achieve impact. To ensure funds are not redirected from individual diseases, WHO is involving ministries beyond health in universal health coverage discussions and advocating at the highest level with those who will be making funding decisions.

**Key Summary Points**

- There is a need for greater clarity around how universal health coverage is understood and monitored – unified indicators that include a focus on equity are needed;
- WHO needs to ensure marginalized communities and marginalized issues are not lost in the discourse around universal health coverage;
- WHO should accelerate efforts to ensure stigma and discrimination are addressed within health settings including through promoting training for health workers.
Partnersviews of universal health coverage

Universal health coverage implementation requires commitment not only from WHO, civil society and governments but also from key development and assistance partners. A number of partners were invited to share their experiences of how they are orienting their work in HIV, tuberculosis, viral hepatitis and sexually transmitted infections in the context of universal health coverage.

The Global Fund has included civil society in its governance from the beginning and while largely focused on a three-disease framework also grapples with issues common to disease efforts when working to strengthen systems for health - including the impact of exclusion, discrimination, human rights and gender dynamics on health. The Global Fund focus on universal health coverage includes strengthening community response systems, working to meet the needs of the most marginalized when transitioning out of countries, involving communities where possible, building sustainability into its funding model, and pushing for greater data disaggregation by age and gender to dismantle many existing barriers. The Global Fund seeks to ensure that it does not invest in parallel systems for example in strategic information and supply chain management. During the discussion participants asked whether the Global Fund could do more to use all aspects of comprehensive price reduction strategies to drive down the costs of programme implementation – including through the application of TRIPS flexibilities. A number of advisers are available in the Global Fund to support countries and communities on all aspects of sustainable financing and transition. The Global Fund has also developed guidance on insuring communities are not placed at risk through data generation.

The Stop TB Partnership is already extremely active around universal health coverage and supporting activities in a number of areas including extending services and removing barriers for key populations, a small grant programme for civil society working in tuberculosis, improvement and innovation in the quality of services, community monitoring, promoting innovative financing, and leveraging 2018 as the “political year” for tuberculosis. The high-level meeting at the United Nations General Assembly in September offers an important opportunity for greater involvement by civil society and the Stop TB Partnership called on representatives to join their country delegations. It was noted that change may be more challenging in the ‘conservative’ world of tuberculosis than in HIV, a far younger programme, and breaking down silos may require greater effort. Those challenges are gradually being met, however, with decentralization efforts, integration at family health care level, linking services and closer collaboration with HIV and other health areas.

UNAIDS is also working to break away from a silo approach and its advocacy role within the UNAIDS family complements other partners’ work. UNAIDS recognizes that community responses to HIV have an impact beyond the epidemic and that communities should be integrated in broader health efforts from the beginning. UNAIDS supports WHO’s work to ensure universal health coverage efforts are “HIV-responsive” including through building essential intervention packages that do not undermine successes gained through vertical approaches, an emphasis on human rights and equity, and through strategic information and guidance on social exclusion, vulnerability and models of financing. UNAIDS proposed that up to 30% of HIV services will be community-led by 2030 offering an opportunity to ensure that community responses have impact beyond HIV – on human rights, social justice and broader health. Country presence of partners will be critical to the success of universal health coverage.
Drugs for Neglected Diseases initiative (DNDi) stressed the importance of including neglected diseases and neglected interventions within the overall focus of universal health coverage. DNDi reported some successes in addressing major gaps in treating paediatric HIV which lags behind adult treatment efforts. DNDi has also addressed market failures in getting new life-saving medicines for hepatitis C treatment to people in need. Direct-acting antivirals (DAAs) are still for the most part very expensive and nearly half of the world’s HCV patients live in low- and middle-income countries (LMICs) excluded from current licensing agreements. Innovation in treatment is critical to financial sustainability and health impact.

The UNITAID-funded Medicines Patent Pool (MPP), has succeeded in significantly lowering prices of tuberculosis and viral hepatitis drugs and believes achieving universal health coverage requires expanding access to essential medicines in addition to strengthening health systems, including adequate financing and good government. The MPP believes universal health coverage requires the collaboration of all stakeholders and will therefore continue strengthening its relationships with WHO, civil society, patent holders, governments and beyond. MPP has secured licenses for thirteen antiretrovirals, two hepatitis C direct-acting antivirals, one tuberculosis medicine and an HIV technology platform. Licenses enable the manufacture and distribution of generic versions of patented medicines in developing countries.

UNICEF sees universal health coverage as an important opportunity to push the issue of excluded populations, especially adolescents and young people. UNICEF’s extensive work in procurement helps build the capacity of civil society and governments to advocate for better procurement because without drugs and diagnostics, there can be no universal health coverage. UNICEF prioritizes the populations excluded in the context of HIV to its broader approach to universal health coverage including through a focus on ensuring the same access for women who use drugs to maternal and child health services as other women. During the discussion UNICEF noted that the anti-vaccine movement had generated fake data and fake news that was undermining vaccine scale-up - efforts to address this should be considered legitimate interventions under universal health coverage.

The International AIDS Society (IAS) concurred that universal health coverage is fundamentally a political decision which is key to people on the edges of society, and confirmed its willingness to act to bring marginalized people more towards the centre of decision making. The IAS called on interested participants to expand the inter-disease dialogue by becoming involved in a number of activities – bringing HIV activism to the TB community, exploring with WHO what the HIV community can bring to STIs, and organizing a hepatitis meeting in Mexico next year. Its IAS Commission on Public Health, to be launched with The Lancet, will look at potential lessons from HIV, including promoting better coverage for people who are most left behind.

UNITAID’s mandate is to catalyse innovation and find new ways to treat diseases – HIV, tuberculosis, malaria and HIV co-infections, including hepatitis – cheaply and effectively. It helps make sure new medicines reach people as quickly as possible – down to three years from ten – and helps make products affordable, key to achieving universal health coverage. UNITAID is working on scaling up access to a range of medicines and recognizes the importance of working with civil society to drive the work, especially in the areas of intellectual property, generics and stimulating the use of TRIPS and generic manufacturers. Currently UNITAID, like other funders, can only expand into other disease areas through a focus on co-infection because of restrictions applied by their donors. It is hoped that
universal health coverage will facilitate the discussions required to expand the focus to cover critical additional diseases in their own right and without a focus on co-infection. Participants shared intelligence that some multi-disease diagnostic platforms, promoted by partners as part of their approach to universal health coverage, remain underused. UNITAID is working to ensure the platforms are optimized.

Discussion reflected civil society's wide-ranging concerns on a number of issues with potential impact including:

- large investments in HIV in comparison with other diseases, especially viral hepatitis, and the limitations imposed on funding hepatitis treatment to cases of co-infection;
- the challenges faced by marginalized groups in Global Fund transition countries;
- the dangers of limiting gender to binary discussions;
- the key role of data, especially when disaggregated;
- the importance of bringing prices down to ensure universal health coverage works.

Participants also requested greater flexibilities in grant management to ensure resources funded for one area can also be used to support impact in other areas.

**Key Summary Points**

- **Partners noted the importance of civil society engagement, are actively engaged in universal health coverage and are increasingly exploring health beyond vertical disease programmes;**
- **A number of partners oversee initiatives focused on innovation, cost effectiveness, quality and affordability with long term goals of encouraging the sustainable financing of health systems.**
**Re-orienting WHO disease programmes in the context of universal health coverage**

This session examined the steps WHO is taking to align disease programmes to universal health coverage including through ensuring this reorientation is reflected in its new overarching strategy, the 13th General Programme of Work (GPW13). Feedback provided at the meeting will help inform implementation of the GPW13 and ongoing structural changes within the organization.

The GPW13, to be considered at the World Health Assembly in May 2018, provides clear strategic direction to the organization, its partners and member states.

A presentation by WHO described the GPW13 and its three strategic priorities and associated targets: 1 billion more people benefiting from UHC; 1 billion more people protected from health emergencies; and 1 billion more people benefiting from better health. Achieving these results requires strategic shifts within the organization, focused on: strengthening country impact, strengthening the normative agenda and strategic information for global public goods, and strengthening leadership and management capacity.

There are work streams organized under each of these areas with opportunities for community engagement throughout. Work underway to define each one billion and to determine baseline measurements is being led by a WHO metrics working group – representation from the HIV department is striving to ensure that critical indicators for equity, integration and key populations are included. Country level impact is at the heart of the GPW13. Therefore empowering WHO country offices to work more effectively with civil society will be important and is likely to require shifts in resources, staffing and training to build capacity around civil society engagement.

WHO stressed the importance of avoiding fragmentation in financing health at the country level. And finally, the importance of prevention was emphasized, with recognition by WHO that any essential health benefit package would include critical interventions for such areas as harm reduction, pre-exposure prophylaxis (PrEP) and condoms. The greater challenge, however, would be around securing support for interventions designed to improve legal frameworks and address criminalization, stigma and human rights.

**Key Summary Points**

- *Civil society views on the need for the inclusion of critical universal health coverage indicators for equity, integration and key populations will be shared with WHO working groups;*
- *WHO recognises the need to build the capacity of WHO country offices to engage more effectively with civil society organisations;*
- *Special attention is required to encourage the inclusion of interventions including harm reduction and PrEP in essential health benefit packages.*
Ensuring sustainable access to goods and services in the context of universal health coverage

Financial sustainability is shaped around three interrelated approaches in the context of universal health coverage: revenue raising and fair allocation of resources to pay for essential interventions and services; financial risk protection and pooling – including establishing equitable mechanisms to pool funds across the health system; and improving efficiency to enable greater effective coverage of services including through the reduction of the costs of medicines, diagnostics and other commodities.

Participants agreed that universal health coverage must support disease-specific programmes and commodities and community-based and population-specific services. While populations most affected by communicable diseases are often prioritized on paper, reality may be different and it is important to communicate to policy makers the cost-benefits and public health imperative of including these populations.

Success in achieving universal health coverage will only be achieved through actions at country level. Governments need deliberate context-based sustainable financing strategies that set out to secure the greatest public health impact possible from health investments. For most countries this is likely to include efforts to secure efficiencies and maximum return on investments across different sectors contributing to the delivery of health interventions: the public or government sector; the private or for-profit sector; and the non-profit or nongovernmental sector including through community organizations. The complexity of systems and health cover arrangements should not be a barrier to coordinated strategic approaches at country level.

Advocacy to increase revenue for public sector services should not be undertaken in isolation and should also support: fair salaries for health workers, including those working at the community level; pooled procurement initiatives; comprehensive price reduction strategies to drive down the cost of essential commodities; and innovative service redesign approaches to secure optimal health impact across a range of health issues. Clear definitions of coverage and shared understandings of the status of existing benefits packages at country level are crucial to accountability and driving progress towards the progressive realization of universal health coverage. WHO should be more proactive in addressing market failures and stay vigilant to the actions of pharmaceutical companies in relation to their product licensing arrangements.

High prices of medicines and other commodities are a significant barrier to universal health coverage and multiple strategies should be considered depending on the context. While a welcome addition to the options for securing fairer commodity pricing voluntary mechanisms do not work for all countries. WHO is planning an access roadmap that will lead to an increased focus on access and intellectual property. WHO offers advice to countries on the use of TRIPS flexibilities at their request - some participants expressed disappointment that WHO was not more proactive in the promotion of TRIPS flexibilities. WHO normative guidance is based on the latest evidence and promotes the best treatment options and the best models of service delivery. WHO also works to anticipate and avert unnecessary costs on the health system - for example without action to address HIV related drug resistance 450,000 new HIV infections could occur in the next 15 years resulting in 890,000 deaths and nearly $6.5 billion additional treatment costs.
Additional challenges to ensuring access and appropriate financing include the importance of out-of-pocket expenses, the very low rates of existing coverage in some countries, lack of sustainability even where some resources exist, the costs of incorporating preventive efforts despite their cost effectiveness, the improvement of health equity, strengthening local systems and infrastructure and the importance of social determinants such as nutrition and poverty. Procurement of PrEP medicines was cited frequently in discussion as an example of a cost effective intervention often “outside” essential intervention packages. In many contexts PrEP use requires individual out-of-pocket expenditure or support through the community or nongovernmental sectors.

Also key is the establishment of a baseline for measurement and cohesion around an essential benefits package and, of course, ensuring population-specific perspectives are not lost. High-level advocacy could also help change the pricing system and edge it towards greater fairness.

A number of participants stressed the importance of looking at health service design from the perspective of service users when considering resources. They are often forced to dedicate considerable time and out-of-pocket expenditure to attend poorly coordinated health appointments. An example was shared of a person living with HIV and TB coinfection who needed to travel 60 km once a week to get medicines for tuberculosis and 30 km once a month to collect ARVs.

**Key Summary Points**

- **Advocacy for sustainable financing requires collaboration beyond disease-specific silos;**
- **Strategies for reducing commodity prices should be multi-pronged;**
- **Baseline data are needed if communities are expected to track progress towards financial sustainability and expanding coverage.**
Community Panel: Essential Interventions for inclusion in essential health benefit packages

Identifying the essential health interventions, services and commodities to be provided through universal health coverage should involve affected communities and other key stakeholders and consider: effectiveness, cost, cost-effectiveness, acceptability, feasibility, relevance, demand and ethics.

Civil society representatives highlighted successful models of effective interventions including: the use of music and visual media in community outreach activities to raise awareness in Egypt; involving the LGBT community in service delivery across African countries; a nationwide consultation of transgender people in Thailand to determine the minimum health service package required; and educating young people in Europe on sexual health. Discussions concluded that health system design did not usually encourage or facilitate sufficient community involvement at the decision making and the service provision levels and a deliberate effort was required to make it happen. Qualitative research and social science was recognised as important in informing community approaches to universal health coverage.

Young people were recognized as key to shaping the universal health coverage process and their involvement requires a greater awareness and understanding on their part of sexual health and gender issues, along with the creation of child and young-person centred health services and the removal of age barriers to service access.

Including communities can be achieved in a variety of ways, for example through: supporting existing networks of people living with diseases; reviving the relevance of sexual health among young people; acquiring the right kind of data that can support targeting of services and interventions; improving the education and training of the health workforce; supporting community health workers including in their efforts for fair pay; ensuring sufficient screening of common STIs so no disease is left behind; clearer integration of human rights; and taking health services to communities rather than the other way around. Finally, participants expressed the need for a multi-sectoral approach that goes beyond health into finance and other fields, as well as increased accountability and a clearer definition of the role of civil society in the various processes driving universal health coverage.

Key Summary Points

- Communities are diverse and should be engaged in all aspects of universal health coverage, including advocacy, accountability and service delivery efforts;
- Community health workers should be adequately recognized and remunerated for their work and universal health coverage should be used as an opportunity to challenge an over-reliance on volunteers that exists in various settings and situations.
Leaving No One Behind: Reaching Key Populations, Overlooked and Underserved Populations

While WHO’s new strategic vision and mission seeks to “serve the vulnerable” there are challenges in making sure no one is left behind and that all population needs are addressed. Many factors contribute to these populations being overlooked and underserved. Barriers to health services include criminalization, stigma and discrimination, as well as out-of-pocket expenses, such as transport, lack of documentation for mobile populations, and geographic isolation.

Legal and regulatory frameworks require review when criminalization and/or social marginalization of groups and behaviours compromise human rights and prevent people from seeking care in the face of stigma and discrimination. Documenting these cases and submitting them to treaty bodies is one area in which WHO could be more proactive alongside clear guidelines and definitions addressing legal barriers.

The added value of communities was emphasized, especially in the area of research and data collection, which should be leveraged and funded. Communities should also be part of any decisions that affect them. While advocating for national resources is important, WHO can help by encouraging donors to include community-led services and advocacy in their funding. WHO can also help by supporting communities at a local level and act as a bridge with government. Communities should be held accountable for their commitments and actions in the same way as governments and partner organizations.

Other factors contributing to the exclusion of certain populations include territoriality and fear of change on the part of both civil society and international organizations. It was felt that sometimes a lack of data is used as an excuse for inaction and that a focus on targets rather than people’s needs can be counterproductive. It was recognized that a health workforce should be fully costed and budgeted to eliminate the dependence on volunteers for work in communities.

An ongoing concern was the risk of dilution faced by vertical programmes at a time when the various diseases are far from their elimination targets. WHO reiterated the need to maintain vertical programmes within universal health coverage approaches. Civil society groups felt much thought would be needed on how to integrate universal health coverage into their work, while WHO would strive to ensure there was a common understanding of universal health coverage and its benchmarks at global and national levels.

It was recognized that WHO’s role is particularly potent at country level where it can open doors often closed to civil society and help influence priorities. When affected populations are not invited to the decision-making table, the role of WHO becomes even more central. Amid the many suggestions was a top line recommitment to decriminalization of vulnerable populations, a greater emphasis on intersectorality, a push to empower key populations, bringing existing good practices into universal health coverage, greater accountability on the part of WHO and the courage to change what isn’t working, for example – as WHO is doing now – making structural changes in the way it communicates to better disseminate information. A multisectoral response would be most appropriate to secure the gains required through universal health coverage.

Key Summary Points
WHO was urged to be more active, especially at the country level, in addressing health determinants including through a focus on legal barriers to access, including addressing the criminalization of vulnerable populations.
Collaborating, Monitoring and Advocating for Progress

While achieving universal health coverage requires overcoming several challenges, robust collaboration, effective advocacy and an adequate monitoring framework will be critical to success. WHO’s ‘triple billions’ 2023 targets and associated methodologies provide important opportunities for measuring progress yet require further work to effectively address key equity issues.

A common thread throughout discussions was the development of a monitoring framework that would ensure no one is left behind and that would bring together the breadth and variety of indicators now measuring the various health targets and goals. The need for national indicators was stressed, along with calls for specific indicators, for example on population-based equity or overlooked diseases like hepatitis B.

Some questions remain unanswered – for example, how will WHO track access to services for affected and criminalized populations? And how will civil society be involved? Country reporting and indicators will be needed to measure progress. WHO understands it will not be possible to cover every issue but believes choosing a few sensitive indicators relevant to civil society engagement and equitable access will be critical for an effective monitoring system. Advocacy for the inclusion of affected populations will be crucial to universal health coverage success yet the focus and approach of such advocacy requires further development. Mechanisms like the UHC 2030 CSEM offer opportunities for civil society to collaborate and coalesce around this issue.

Strengthening accountability frameworks will be critical. Despite the many commitments already made by governments on health to date, few have been reached. Strengthening accountability and good governance – through civil society partnerships with parliamentarians or collaboration with the media or human rights mechanisms – is an area in which WHO can support governments in reviewing public health policies. Success should include measurement of whether the most vulnerable and in need are actually reached under universal health coverage.

In her closing remarks, Naoko Yamamoto, WHO’s Assistant Director-General for Universal Health Coverage and Health Systems, affirmed that universal health coverage is possible but could be compromised without adequate community engagement. She noted the critical role of civil society, with whom WHO needs to ensure ongoing collaboration and communication, especially in ensuring actions and programmes are monitored from multiple perspectives.

Key Summary Points

- WHO was challenged to develop a monitoring framework to ensure no one is left behind.
Next steps and looking forward

While the two-day meeting was extraordinarily rich in content and engagement it was recognized that universal health coverage introduces new levels of complexity when compared to discussions organized in the context of single diseases. It was noted that two days are insufficient to address all critical issues in detail. To this end civil society was invited to comment on a draft discussion paper “Universal health coverage: an opportunity to reach key, overlooked and underserved populations” that informed the meeting, which would be finalized and made available for discussions during major events later in the year, including the World Health Assembly, AIDS 2018 and the High Level Meeting on Tuberculosis.

The following key points emerged in the concluding session:

General

- Universal health coverage and communicable diseases is not an “either/or” agenda and universal health coverage does not mean the end of vertical programming but will require a rethinking of how disease programmes are delivered;
- Work is required towards the capacity strengthening of WHO country offices for stronger civil society engagement and improved processes at headquarters to better engage civil society.

Essential package and service access

- Universal health coverage requires close collaboration to rethink how disease programmes are designed and delivered in the future;
- Strong recommendations were made for strengthening essential intervention packages, stronger community services and ideas to increase access to affordable and essential medicines and commodities including through the notion of “entry point” packages for different populations;
- Structural interventions should be included in the essential package – including a commitment to tackling punitive laws that exclude affected populations;
- Community services should be costed and work at community level should be adequately remunerated;
- Clearer definitions are required including for “health system” and what it includes;
- At country level, there may be incentives for marginalized groups to collaborate to influence essential health benefit packages – rather than doing this through an individual issue or population focus.

Sustainable financing

- WHO will seek to continue to leverage its high-level advocacy to drive down commodity prices – applying aspects of comprehensive price reduction strategies including those that encourage local production of key medicines and commodities;
- WHO will strongly support the development of investment case approaches;
- WHO and stakeholders should invest in “systems literacy” that encourages affected communities and civil society groups to understand and appreciate opportunities to advocate for sustainable and effective health systems;
• WHO and civil society should seize universal health coverage as an opportunity to build unprecedented political momentum based on a strong sense of injustice – *Leave No One Behind*;

**Accountability, advocacy and monitoring**

• The political dimension of universal health coverage was emphasized and such political considerations should be grounded in a human-rights framework;
• WHO will continue to pursue appropriate data disaggregation in monitoring progress in health responses, including through the identification of indicators that enables accountability for all populations - a single indicator to track marginalized and overlooked populations is recommended;
• The possible broader application of an approach similar to that of the national composite policy index in HIV will be explored;
• Organizations in official relations with WHO were encouraged to make statements at the World Health Assembly in May in support of the new GPW13, requesting specificities focused on equitable impact during implementation;
• WHO will report back about the outcomes of this meeting internally with WHO senior leadership, including the Director-General, and externally through existing civil society mechanisms; WHO will support linking these groups with civil society representatives from UHC2030 including through civil society led platforms;
• WHO committed to ensuring that key points from the discussions and recommendations are fed into the various working groups convened to guide the 2018 year of WHO organizational transition;
• It was noted that the meeting generated important documents, some of which can be used as advocacy tools – including the draft discussion paper, the statement by the WHO Director-General and social media posts.

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*WHO Civil Society Reference Groups on HIV and Hepatitis; the Strategic and Technical Advisory Committee for HIV and Viral Hepatitis (STAC-HIVHEP) and the STAG (RHR); the TB Civil Society Taskforce; and Partnership for Maternal, Newborn and Child Health (PMNCH).*