Connecting responses to UHC, PPR and TB in the 2023 High-Level Meetings
Briefing 4: Anti-oppression in the Context of UHC, PPR and TB.

The COVID-19 pandemic and the resulting global economic recession have significantly increased inequality worldwide. It has exacerbated existing disparities while highlighting systemic issues that have contributed to it, both between and within countries, now and in the past. However, these events and movements, such as Black Lives Matter, Me Too, and calls for decolonisation, have also further galvanised action against inequality and oppression. These efforts have led to increased advocacy for social justice and policy changes to address systemic issues.

Health inequities are manifested as avoidable and unfair differences in health outcomes between different groups of people.[1] These differences are often driven by inequities in social determinants for health, such as income, education, and access to healthcare. These social determinants also have a strong influence on both marginalised and criminalised communities' healthcare access and risk of exposure to certain diseases.

Key populations are defined groups who, due to specific higher-risk behaviours, are at increased risk of acquiring or transmitting certain diseases or facing specific health challenges, irrespective of the epidemic type or local context. However, the challenges they face are not solely due to their behaviours but are exacerbated by society's response to these behaviours. Society's reaction often manifests as legal and social issues that these groups encounter, amplifying their vulnerability to negative health outcomes. Consequently, it is the societal response to their behaviour rather than the behaviour itself that becomes a significant problem, hindering their access to appropriate healthcare and support systems. These populations often require targeted interventions and tailored healthcare services to address their unique needs. Examples of key populations include gay men and other men who have sex with men, sex workers, transgender people, people who inject drugs and prisoners and other incarcerated people. Recognizing and addressing the health needs of key populations is essential for addressing health inequalities.

The Kampala Initiative is a democratic civil society community that aims to decolonise health cooperation, decolonise the critique of aid and decolonise the promotion of solidarity. The Kampala Initiative Declaration highlights that development assistance for health often reinforces the power imbalances that underpin health inequities.[3] The Declaration highlights that the priorities of northern donors dictate the aid agenda, priorities that often clash with the needs and concerns of communities, civil society and/or governments in low- and middle-income countries around the world.[4] However, it is important to note that societies in countries receiving aid are not homogeneous. Marginalised communities in these countries are also frequently

side-lined in consultations on donor funding. In-country human rights activists need support advocating for the inclusion of marginalised groups in the monitoring and evaluation of health and other development programmes.

Only by identifying and addressing the systemic root causes of inequality and oppression can we reduce health inequities, better understand and respond to the health needs of marginalised communities, and ensure that disease responses are effective and equitable. This is essential if we want to create a more just and equitable society. However, the Kampala Initiative highlights that the social, commercial, economic and political determinants of health have largely been ignored by overseas development aid. As a result, key health inequities are maintained or reinforced rather than addressed by aid. Addressing inequality and the wider determinants of health will deliver effective disease prevention and responses, promote social justice, and achieve sustainable development. This must guide all our work and the global commitments we make. Therefore, we must ensure that the 2023 UN High-Level Meetings (HLM)[5] on tuberculosis (TB), Pandemic Prevention, Preparedness and Response (PPPR) and Universal Health Coverage (UHC) have declarations and commitments that are grounded in and centred on values that are pro-equity and anti-oppressive. Only then will we collectively reduce health inequities, improve health outcomes, and create a society where all people are treated with dignity and respect.

Anti-Oppression/ pro-equity

Anti-oppression is the philosophy, strategies, theories, actions and practices that actively identify and challenge systems of oppression on an ongoing basis in one's daily life and in social justice/change work. Anti-oppression work seeks to recognise the oppression that exists in our society and attempts to mitigate its effects and address its systemic causes in order to eventually equalise the power imbalance in our communities.[6]

The term anti-oppression entered the lexicon of academia in the mid-1990s with professor Derek Clifford writing that “anti-oppression is an explicit evaluative position that constructs social divisions (especially ‘race’, class, gender, disability, sexual orientation and age) as matters of broad social structure at the same time as being personal and organisational issues. It looks at the use and abuse of power not only in relation to individual or organisational behaviour, which may be overtly, covertly or indirectly racist, classist, sexist and so on but also in relation to broader social structures, for example, the health, educational, political and economic, media and cultural systems and their routine provision of services and rewards for powerful groups at local as well as national and international levels. These factors impinge on people’s life stories in unique ways that have to be understood in their socio-historical complexity”.[7]

Anti-Oppression in civil society

Anti-oppression values (or pro-equity practices) can vary between individuals and organisations, but they are commonly aimed at identifying and dismantling systems of oppression and creating more equitable and just societies. While civil society has advocated for equality and social justice for decades, more organisations are explicitly using anti-oppressive values in their strategies and structures. We believe that it is necessary to focus on being anti-oppressive first because it is only by understanding and deconstructing oppressive belief systems and practices that

we can fully understand and deliver pro-equity practice. The values of anti-oppression and their names may vary between organisations, but they are all rooted in recognising and dismantling abusive or oppressive power structures and practices in global health and international development. They are often person-centred and focused on lessening the negative impact of social structures.[8]

Examples of anti-oppression frameworks by different names

- Health Equity Principles [9]
- Behaviours Framework [10]
- Statement of Solidarity [11]
- Anti-Racism And Justice, Equity, Diversity, Inclusion (JEDI) Policy [12]
- Health Equity Impact Goals [13]
- Race Equality Framework [14]
- Accountability Framework [15]

Examples of organisational anti-oppressive frameworks and commitments (from high-income countries)

STOPAIDS - Anti-Oppression Framework

Considering the importance of anti-oppression approaches, STOPAIDS' 2022-2025 strategy is framed by their living anti-oppression framework. [16] This is grounded in four key values of humility, shifting power, solidarity and co-ownership:

HUMILITY: Ways of working that show self-restraint but also ask you to reflect on your positionality, the power dynamics involved, and the value of / need for your contribution in an activity or setting.

SHIFTING POWER: Ways of working that seek to halt exploitative practices and address the cumulative disadvantages that exploitation has left behind by redistributing power.

SOLIDARITY: Ways of working that ask you to take as many opportunities as possible to 'spend' your social capital or use your position/resources to challenge stigmas and the continued demonisation of certain people/groups.

CO-OWNERSHIP: Ways of working that don't presume the superiority of your approach and instead create opportunities to benefit from missing insights and skills by engaging in collective work.

RESULTS UK - Anti-oppression commitments

As an organisation committed to ending poverty and one working in a sector that still grapples with damaging practices and narratives of development, including that of the 'white saviour', RESULTS UK is committed and motivated to do more and better. RESULTS UK anti-oppression commitments include:[17]

Committing to improve diversity and inclusion: This includes establishing an Inclusivity Working Group to analyse biases and striving for greater diversity and inclusion on their Board of Trustees.

Embedding justice in our policy, parliamentary and grassroots advocacy: This includes taking steps to address anti-racism in their grassroots network and initiating an internal anti-racist narrative change project.

Amplifying voices: This includes collaborating with organisations to amplify the voices of people with lived experiences of poverty and TB.

Nurturing global partnerships: This includes acknowledging the importance of collaborations with lower-middle-income country-led advocacy organisations rooted in their communities and building more equitable systems that centre their expertise.

Examples of organisational anti-oppressive frameworks and commitments (from low and middle-income countries)

The Other Foundation - Code of Values & Practice [18]

The Other Foundation is an African trust that advances equality and freedom in southern Africa with a particular focus on sexual orientation and gender identity.

The Foundation contributes to building just and caring societies in southern Africa and gathers under its organisational umbrella, a community that shares a basic core of values based on respect for the **dignity of every human person, including social equality, inclusion, human progress, and freedom.**

Above all else, the Foundation and those associated with it will strive to be **authentic**. The Foundation will gather a team of personnel who are:

• In touch with themselves, and who do not 'cover' at work or in the social settings that they engage;

• In touch with the realities of the region in which they work and the groups that they work with;

• Conscious of the Foundation's identity and culture as a community Foundation; and

• Comfortable with their and the Foundation's role in a bigger world of other actors.

The main ways that the Foundation will develop its authenticity will be by being **accountable** through **transparent** and **participatory** processes in the various aspects of its work, whether it be philanthropy development, grant making, convenings, or research.

Urgent Action Fund (UAF) Latin America and the Caribbean - Ethical and Political Commitment to Care [19]

As a feminist Fund operating in the Global South, particularly in Latin America, UAF is deeply committed to addressing the challenges faced by marginalised women within a highly unequal society influenced by class, gender, and race.

UAF Recognises the strong connection between defending human dignity and resistance with the embodied experiences of activists, shaped by intersecting inequalities. To address this, UAF is dedicated to developing a comprehensive sustainability approach hat considers the diverse needs and circumstances of the women activists they support. Upholding feminist values, UAF advocates for a holistic care and protection framework that integrates the inseparable nature of care and protection, recognizing their interconnectedness in practice. By centering a politics of care, UAF emphasises the following key aspects in ensuring protection and safety:

Emphasising Contextual Factors: UAF acknowledges that risks and threats are influenced by contextual elements such as class, race, age, skills, sexual preference, and gender identity, alongside organisational responses.

Ensuring Comprehensive Well-being: UAF recognizes that protection goes beyond physical safety and extends to emotional, material, and spiritual well-being, aiming to restore and safeguard all dimensions of women defenders' lives.

I**ntegrating Care and Protection:** UAF underscores the inseparability of care and protection, understanding that effective protection strategies must be rooted in caring practices, creating a supportive environment that nurtures women defenders.
UAF asserts that adopting a feminist perspective, placing a politics of care at the centre of protection and safety entails:

1. Focusing on the personal, that is on each activist's personal experience (how she experiences threats, risk, or vulnerability, and how this affects her relationships and emotions);
2. Questioning the division between public and private realms in care practices, revealing who is in charge of care in both spheres and what this means in terms of emotional burden and workload.
3. Reviewing power relationships within organizations and activist practices in order to identify internal risk factors.

Anti-oppression in the HIV and TB responses

In the context of healthcare, anti-oppression values promote health equity, inclusion, and access to care for all individuals. This particularly focuses on those who are, and/or have historically been, excluded or marginalised (historically because trauma in earlier life and past generations manifests in people's bodies, health and lives today).[20]

TB and HIV disproportionately impact people marginalised by structural barriers. Structural barriers are human-made aspects of the external environment that limit an individual's ability to negotiate options for their own healthcare. For example, a lack of local clinics in rural areas can lead to barriers in accessing services; unequal access to social housing can lead to homelessness and an increased vulnerability to infection and lack of access to services; criminalisation of drugs can lead to incarceration for drug use where health services may be limited; a lack of meaningful social protection can lead to poverty and an increase in risk-taking behaviour; and a lack of education can lead to lack of choice and knowledge about HIV. Vulnerable and marginalised groups are less likely to have the power, information and resources required to manage their health. TB and HIV increase the vulnerability of people, which can threaten their rights, leading to harmful measures (involuntary treatment, detention, isolation) and stigma and discrimination. This can, in turn, have a significant impact on employment, housing and access to social/health services, creating a vicious cycle.[22] One high-profile recent example has been in Uganda, where the new 'anti-gay' legislation will essentially criminalise inclusive HIV programs and undermine the country's HIV response.

Criminalisation refers to the process of making certain behaviours, activities, or groups of people illegal and subject to legal penalties or restrictions. It is a legal approach that aims to address social issues by using the criminal justice system as a means of control and punishment.[23] In the specific case of Uganda, the enactment of the 'anti-gay' legislation represents a form of criminalisation. This legislation targets and penalizes individuals based on their sexual orientation or gender identity, making consensual same-sex relationships or homosexual acts illegal. By criminalizing homosexuality, this law not only infringes upon the human rights and personal freedoms of LGBTQ+ individuals but also has broader implications for public health. The criminalisation of same-sex relationships can undermine trust in healthcare systems, lead to the concealment of sexual practices, and deter individuals from seeking HIV-related services for fear of legal consequences. As a result, inclusive HIV programs become compromised, and the overall country's response to HIV/AIDS is weakened.

Therefore, the 'anti-gay' legislation in Uganda not only infringes upon human rights but also has a detrimental impact on public health efforts to combat HIV/AIDS. It highlights the intersection between criminalisation, human rights, and public health, emphasizing the need for inclusive and evidence-based approaches and the urgent need to reform punitive laws.

The HIV movement has long recognised the disproportionate impact of HIV on many of the poorest and most marginalised in society. The movement has advocated that in order to successfully address HIV, it would be necessary to adopt values and build a response that challenges systemic forms of oppression and is grounded in human rights. In 2006

UNAIDS published International Guidelines on HIV/AIDS and Human Rights[24] and was followed up more recently by the Global Commission on HIV and the Law which produced its main report in 2012 and a supplement in 2018. Both reports focus on the need to repeal punitive laws and enact protective laws that support public health and enable the realisation of human rights that underpin the HIV response.[25] Other important intersecting work addressing criminalisation includes the International Guidelines on Drug Policy and Human Rights. A focus on human rights has been supported also through the UNAIDS HIV and Human Right Reference Group which also made recommendations for the UHC HLM in 2019 that are relevant to this briefing.[26]

Case Study

The International Community of Women Living with HIV (ICW) is a civil society organisation working on reforming punitive laws related to HIV and TB. ICW is a global network of women living with HIV that advocates for the rights of women living with HIV and works to eliminate gender-based discrimination in HIV-related policies and practices. ICW has advocated for repealing HIV criminalisation laws in several countries, including Uganda and Kenya. In Kenya, ICW played a key role in advocating for repealing the HIV and AIDS Prevention and Control Act, which criminalised HIV transmission and imposed mandatory HIV testing for certain groups, such as pregnant women.[27]

The TB response has also recognised the importance of and focus on human rights. For example, The Declaration of The Rights of People Affected by TB[28] acknowledges that a purely medical or public health approach to TB is not enough to fight the disease. A rights-based, gender-sensitive, people-centred approach to TB care that is integrated within UHC is essential to ending TB.

We have taken these guidelines and other recent work by leading human rights proponents in the HIV and TB responses and matched them against our anti-oppression values and commitments to develop recommendations that could be made to each of the three High-Level Meetings. We have tried to generalise each recommendation to ensure it is relevant to all disease responses and essential to creating a healthcare system that serves everyone.

Anti-oppression, UHC and PPR

For key populations, the Covid-19 pandemic brought unprecedented challenges and not only created new vulnerabilities but exacerbated existing ones. For example, people who use drugs have experienced unique risks and disproportionate burdens due to criminalisation and its impacts. These included stigma and discrimination, rights violations, exacerbated health problems, barriers to health care access, increased surveillance and policing, punitive approaches to enforcement measures, social marginalisation and higher economic and
social vulnerabilities.[29]

Organizations representing key populations have emphasized the significant influence of

criminalisation on healthcare access and the differential experiences of pandemics. The technical brief on UHC by the International Network of People who Use Drugs (INPUD) outlines the essential requirements for people who use drugs to be encompassed within UHC. These requirements include equity, quality-driven-community-based and people-centred care and appropriate health financing.[30]

Anti-oppression values are crucial for achieving UHC and PPPR. UHC ensures that everyone, regardless of their socio-economic status, has access to quality healthcare services without financial hardship.[31] Similarly, PPPR requires equitable access to healthcare services to prevent, contain, and manage disease outbreaks.[32] Incorporating anti-oppression values in healthcare systems and policies can help reduce health disparities and improve health outcomes for marginalised communities.[33]

During the COVID-19 pandemic, countries that prioritised anti-oppression values in their pandemic response were better able to contain the spread of the virus and provide equitable access to healthcare services.[34] For example, in Rwanda, the government's pandemic response included measures to provide food and financial support to vulnerable populations, including people living with HIV, to ensure they could adhere to their treatment and maintain their health.[35]

Case Study: The State of Kerala, India, anti-oppressive approach to the COVID-19 pandemic.

Kerala has been praised for its quick and efficient response to the pandemic, which included the prioritisation of anti-oppression values in its pandemic response.

Kerala's approach emphasised community engagement, trust-building, and culturally appropriate messaging that took into account its population's diverse linguistic and cultural backgrounds. The state government ensured the availability of testing and treatment facilities in marginalised communities, such as migrant workers and indigenous communities, and provided them with essential commodities during the lockdown. Kerala also implemented an inclusive quarantine policy that allowed patients to quarantine at home, thus minimising the stigma associated with the disease.[36] Furthermore, Kerala has the highest literacy rate in the country, thanks to the efforts of the state government’s efforts towards democratisation and dissemination of education.[37] This contributes to the high trust in the government, which played a crucial role in successful public health communication.

These efforts resulted in Kerala's successful containment of the virus's spread, with one of the lowest death rates and highest recovery rates in India.[38] Kerala's approach has been credited to its history of prioritising public health, investing in social welfare, and a participatory decision-making process that included diverse stakeholders.[39]

One limitation of the Kerala model is that it may not be easily replicable in other regions or countries due to their different social, cultural, and economic contexts. While Kerala's emphasis on community engagement and trust-building was effective in its context, it may not be feasible in regions with weaker health systems, more significant social disparities, or a lack of political will.

Case study: Belarus's oppressive approach to the pandemic
The government of Belarus was accused of using the COVID-19 pandemic to further restrict its citizens' rights, including infringing on citizens' right to health.

During the height of the pandemic, the quality and availability of healthcare remained severely compromised, including by the continued exodus of medical workers dismissed on political grounds, as well as shortages of certain drugs and medical equipment as a result of international sanctions. Medical professionals sacked for supporting peaceful protests in 2020 were arbitrarily refused re-employment. The authorities suspended the licences of at least seven large private medical clinics in what appeared to be a coordinated campaign targeting independent providers of health services.[40]

These actions have been seen as a violation of human rights and a form of oppression against vulnerable groups, and this oppression contributed to the high rates of new infection during the height of the pandemic.[41]

An important aspect of anti-oppression is the realisation of sexual and reproductive health rights (SRHR). SRHR are essential for both PPR and UHC. Ensuring access to comprehensive sexual and reproductive health services and information is critical to promoting health equity and addressing the disproportionate impact of infectious diseases on marginalised communities. By prioritising marginalised communities' needs, recognising their agency and self-determination, and eliminating barriers to healthcare access, anti-oppression values can inform policies and strategies that ensure SRHR, promote UHC and strengthen PPR.

Case study:
The Texas Policy Evaluation Project (TxPEP) is a research initiative that examines the impact of reproductive health policies on the lives of people in Texas, particularly those who are marginalised due to race, ethnicity, gender, or socio-economic status.[42] Their research has shown that policies that restrict access to reproductive healthcare services, such as abortion and contraception, disproportionately impact communities of colour and low-income individuals.[43] By centering the experiences and needs of marginalised communities, the TxPEP has been able to advocate for policies that promote reproductive justice and healthcare equity.

Broader structural reform relevant to all three HLMs

UHC, PPPR, and global disease responses require structural changes that can move us past outdated concepts of aid and binary global North-South relations to a more inclusive and equitable alternative. UHC requires addressing social determinants of health and promoting health equity. This includes ensuring access to quality health services for all, regardless of their social and economic status.[44] However, achieving UHC and PPR cannot be done in isolation as it is interconnected with broader global health governance. This includes funding mechanisms and power relations.[45]

One of the critical structural changes required to achieve UHC and PPR is shifting from a top-down approach of aid and charity to a more inclusive and equitable approach that prioritises community engagement and ownership such as with community-led service delivery. Another structural change required is adopting a human rights-based approach to healthcare that focuses on the underlying structural determinants of health, including addressing inequality. These changes should be central to reforming the global health architecture and governance.

Additionally, it is imperative to address the detrimental impact of criminalizing laws and policies, which hinder equitable access to healthcare and perpetuate social disparities. Reforming the global health architecture and governance should encompass the abolition or reform of such laws to promote inclusive and rights-based healthcare systems.

Achieving UHC and PPR requires reforming the global health architecture and governance and addressing the power imbalances inherent in the current North-South relations.[46] This means recognising the historical and ongoing legacies of colonialism and imperialism in global health and centring the voices and experiences of those most affected by health inequities. Moreover, it is crucial to acknowledge that the criminalisation of certain behaviours is often rooted in colonial legacies,[47] highlighting the need to challenge and dismantle systems that perpetuate these historical injustices and prioritize the voices and experiences of communities disproportionately impacted by health inequities.

For the global health community to be better prepared to respond to future health crises and provide health services for all, the UN High-Level Meetings should propose implementing new, participatory and community-led funding, decision-making and governance models for driving more equitable outcomes across health and human development for all people.

Case study: GPI, a model for broader structural reform

Global Public investment (GPI) is a new paradigm of international public finance in which all governments cooperate to secure international public policy outcomes via fractional contributions from general government revenue. The mechanism for financing these agreed global public policy outcomes would not be a singular fund; rather, marked GPI contributions would be channelled through existing funding infrastructure overseen at the regional and global levels.[48]

GPI proposes a transformation in international cooperation that enables all countries to converge with relatively high living standards and improve the quality of life of the global population.[49] GPI can be used as a tool to achieve decolonisation because GPI proposes a complete reform of global health architecture that would ensure all contribute, all decide, and all benefit. The central ambition of GPI is reducing inequality within and between countries and regions, giving all countries equal influence on the eligibility and allocation of global health finance regardless of their geopolitical position in the world.

The GPI approach puts social justice at the centre of global governance and international solidarity. It offers a solution for addressing the systemic barriers that disproportionately impact marginalized communities—an aspect that conventional aid has struggled to achieve. GPI provides a means to realize social protection by establishing a framework where the social policy efforts of all states to protect the human rights of their citizens are actively encouraged, mandated, and incentivised without facing punishments from global markets. The core vision of GPI revolves around fostering "social cohesion," with the ultimate goal of promoting enhanced cooperation, democratic participation, and social productivity. By prioritising social cohesion, societies can enhance their capacity to safeguard the well-being of all individuals, mitigate disparities, and prevent marginalization.

GPI provides a solution to addressing the health inequalities that leave the world vulnerable to devastation from pandemics and perpetuate the barriers to accessing healthcare for marginalised communities and should be used as a framework to develop policies for UHC, PPR, and all disease responses.

Summary of recommendations

1. Commit to urgent and transformative action to end the social, economic, racial and gender inequalities, restrictive and discriminatory laws, policies and practices, stigma and multiple and intersecting forms of discrimination, and human rights violations that perpetuate global health inequalities.
2. Commit to prioritising people who are left behind due to their gender, age, drug use, sexual orientation or gender identity or occupation. Ensure that women and girls who face intersecting forms of discrimination and violence (e.g. indigenous women, women with disabilities, women who use drugs, women in prison, female sex workers and transgender women) receive the tailored services and support they need, and ensure that they are meaningfully engaged in universal health coverage-related decision-making. Ensure access to rights literacy and meaningful complaint and redress mechanisms for violations of their human rights in health care settings.
3. Commit to allocating funds to community-led and community-based organisations to lead on activities to implement societal enablers, particularly those targeting key and vulnerable populations. *2022 OHCHR Annual Report on Human Rights and HIV/AIDS (paragraph 54(c))[50]*
4. Commit to the repeal of harmful criminal laws, including the removal of all policies and practices associated with the criminalisation of populations such as sex workers, men who have sex with men, trans people and people who use drugs and of health services they need, and the introduction of legal protections against discrimination for such populations. (2021 Global AIDS Strategy 2021-2026 (paragraph 144(c)).[51]
5. Build effective, accountable, transparent and inclusive institutions at all levels to end corruption and ensure social justice, the rule of law, good governance and health for all. (2019 Political declaration of the HLM on UHC (paragraph 56))
6. Encourage the development of multisectoral public policies that create equitable health-promoting environments that empower individuals, families and communities to make healthy choices and lead healthy lives. (2011 Political Declaration of the HLM on NCDs (paragraph 43(a)).

Analysis of the zero drafts

Upon our analysis of all 3 zero drafts we found several favorable provisions.[52] For instance, the PPPR zero draft incorporates new language that acknowledges the imperative of enhancing efforts to reduce disparities in OP01. Similarly, the UHC zero draft PP5 acknowledges the importance of reasserting robust commitments made during the HLM on HIV/AIDS, while the TB zero draft OP34 underscores the commitment to addressing inequalities.
However, all three zero drafts missed an opportunity to explicitly acknowledge marginalized and criminalised groups experiencing health inequities. Moreover, they inadequately addressed funding and sustainability measures for community-led services. It is disheartening to observe that none of the drafts mention the need for reforming punitive laws or global health reform.

Expanded Recommendations

Adopting a human rights approach to healthcare

The World Health Organisation (WHO) describes that a human rights-based approach to health provides a set of clear principles for setting and evaluating health policy and service delivery, targeting discriminatory practices and unjust power relations that are at the heart of inequitable health outcomes.[53] The UNAIDS Guidelines on HIV/AIDS and Human Rights recommends that states ensure monitoring and enforcement mechanisms to protect HIV-related human rights, including those of people living with HIV, their families and communities.[54] STOP TB states that promoting and protecting human rights is central to ending TB.[55]

The idea of UHC is based on the WHO constitution of 1948, declaring health a fundamental human right.[56] Therefore a human rights approach should be the foundation of all UHC policy. The OHCHR states that future efforts to prevent, prepare for, respond to and recover from pandemics be fully grounded in States' human rights obligations.[57]

The Political Declarations of the three HLMs should:

1. Commit to urgent and transformative action to end the social, economic, racial and gender inequalities, restrictive and discriminatory laws, policies and practices, stigma and multiple and intersecting forms of discrimination, and human rights violations that perpetuate the global health inequalities.

Existing text: Commit to urgent and transformative action to end the social, economic, racial and gender inequalities, restrictive and discriminatory laws, policies and practices, stigma and multiple and intersecting forms of discrimination, including based on HIV status, and human rights violations that perpetuate the global AIDS epidemic. (2019 Political Declaration on HIV and AIDS (appx C))[58]

2. Commit to prioritising people who are left behind due to their gender, age, drug use, sexual orientation or gender identity or occupation. Ensure that women and girls who face intersecting forms of discrimination and violence (e.g. indigenous women, women with disabilities, women who use drugs, women in prison, female sex workers and transgender women) receive the tailored services and support they need, and ensure that they are meaningfully engaged in universal health coverage-related decision-making. Ensure access to rights literacy and meaningful complaint and redress mechanisms for violations of their human rights in health care settings.

Existing text: Prioritize people who are left behind due to their gender, age, drug use, sexual orientation or gender identity or occupation. Ensure that women and girls who face intersecting forms of discrimination and violence (e.g. indigenous women, women with disabilities, women who use drugs, women in prison, female sex workers and transgender women) receive the tailored services and support they need, and ensure that they are meaningfully engaged in HIV-related decision-making. Ensure access to rights literacy and meaningful complaint and redress mechanisms for violations of their human rights in the context of HIV (2021 Global AIDS Strategy 2021-2026 (paragraph 153(f)).[59]

Meaningful community engagement and participatory approaches to healthcare
This means involving the affected communities in decision-making and valuing their input and knowledge. The Declaration of The Rights of People Affected by TB states that every person affected by tuberculosis has the right to take part in public affairs, directly or through their organisations and freely chosen representatives. This includes the right to participate meaningfully in all processes and mechanisms for the development, implementation, monitoring and evaluation of laws, policies, regulations, guidelines, budgets, and programs related to tuberculosis, health care for tuberculosis, and medical research for tuberculosis at all levels of governance.[60]

UNAIDS states that community-led organisations must be fully included and integrated into national pandemic responses. The views of community-led organisations are essential at the level of policy development, planning, design and evaluation of interventions.[61] Furthermore, a human rights perspective on universal health coverage by PITCH called for the meaningful engagement of communities most affected by HIV in UHC debates and in the planning, implementing and evaluating of the UHC rollout.[62]

The Political Declarations of the three HLMs should:
3. Commit to allocating funds to community-led and community-based organizations to lead on activities to implement societal enablers, particularly those targeting key and vulnerable populations. *(2022 OHCHR Annual Report on Human Rights and HIV/AIDS (paragraph 54(c)).[63]*

Existing text: Mobilize funding for sustainable community-led responses, ensuring financial support and equitable pay for community-led work and funding for activities led by networks of people living with HIV and key populations, including those led by women and young people (2021 UNAIDS Global AIDS Strategy Paragraph 137(a)).

Reforming punitive laws
Discriminatory laws can hinder access to prevention, testing, treatment, and care services. This leads to worse health outcomes for marginalised groups such as drug users or sex workers. The UNAIDS Reference Group on HIV and Human Rights states that UHC includes reaching all populations with effective, evidence- and human rights–based interventions. This requires work towards ending stigma and discrimination and the reform of harmful criminalisation and other punitive laws.[64] The OHCHR states that non-discrimination should be a fundamental principle of all strategies for PPR, with special attention given to the protection of groups and populations in vulnerable situations, including persons in detention, LGBTIQ+ people and migrants.[65]

The Political Declarations of the three HLMs should:
4. Commit to the repeal of harmful criminal laws, including the removal of all policies and practices associated with the criminalisation of populations such as sex workers, men who have sex with men, trans people and people who use drugs and of health services they need, and the introduction of legal protections against discrimination for such populations (2021 Global AIDS Strategy 2021-2026 (paragraph 144(c)).[66]

Reforming global health

This involves acknowledging the historical and structural factors contributing to health disparities and prioritising the voices and leadership of communities most affected by health inequalities. The Independent Panel for Pandemic Preparedness and Response identifies participation of those affected by policies, laws, and decisions as one of the key elements of pandemic governance.[67] UHC2030 states that health system strengthening to achieve UHC should involve reforming the architecture that determines how different parts of the health system operate and interact.[68]

Political Declarations of the three HLMs should:

5. Build effective, accountable, transparent and inclusive institutions at all levels to end corruption and ensure social justice, the rule of law, good governance and health for all. (2019 Political declaration of the HLM on UHC (paragraph 56))[69]

6. Encourage the development of multisectoral public policies that create equitable health-promoting environments that empower individuals, families and communities to make healthy choices and lead healthy lives. (2011 Political Declaration of the HLM on NCDs (paragraph 43(a)).[70]

End Notes

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