

# UHC2030's Contributions to Global Health Governance that Advance the Right to Health Care: A Preliminary Assessment

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## Abstract

The September 2019 United Nations High Level Meeting on Universal Health Coverage (UHC) aims to mobilize top-level political support for action on UHC to advance the health Sustainable Development Goal (SDG). A driving force behind this meeting is the “UHC Movement,” led by UHC2030, which focuses on coordinating and amplifying efforts by WHO, the World Bank, civil society, and the private sector to strengthen health systems and achieve UHC. In line with Horton and Das, this paper contends that while the argument about UHC is won, it is crucially important to focus on “how” UHC will be delivered, and specifically, whether ongoing efforts to advance UHC align with efforts to realize the right to health. This paper offers a preliminary assessment of how UHC2030's contributions to global health governance advance, or not, the right to health care. It builds on a 2014 Go4Health study which identified key normative overlap and gaps in UHC and right to health care principles. Given the importance of civil society participation in advancing health rights, this analysis is complemented by an examination of how UHC2030 might amplify ongoing efforts to advance the right to health care in two UHC2030 partner countries, Kenya and Uganda.

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## Introduction

As jockeying for political priority in the Sustainable Development Goals (SDGs) era escalates, attention to the health goal (SDG 3) and the right to health at the United Nations level is largely focused on target 3.8, universal health coverage (UHC).<sup>1</sup> The World Health Organization (WHO) claims that “UHC is, by definition, a practical expression of the concern for health equity and the right to health.”<sup>2</sup> In line with Horton and Das, this paper contends that while the argument about UHC has been won it remains crucially important to focus on “how” UHC will be delivered, specifically whether ongoing efforts to advance UHC align with efforts to realize the right to health, thus advancing rights based global health governance.<sup>3</sup> The relationship between the realization of the right to health—or even the acknowledgment of the existence and importance of the right to health—and the global fight against HIV/AIDS is widely acknowledged. Civil society played a crucial role in advancing the right to health for people living with HIV.<sup>4</sup> Therefore, if one posits that UHC can play a similar role in the realization of the right to health, one should not only look at the roles of WHO and the World Bank, key global health governance institutions, but also at how these organizations interact with civil society. One of the driving forces behind the September 2019 United Nations High-Level Meeting on Universal Health Coverage (“UN UHC meeting”) was the “UHC Movement,” led by UHC2030, a multi-stakeholder partnership which focuses on coordinating and amplifying efforts by WHO, the World Bank, national governments, civil society, and the private sector to strengthen health systems and achieve UHC.<sup>5</sup> As UHC2030 acts as a link between national governments, civil society, and key global health actors, like the World Bank and WHO, the extent to which it advances an approach to UHC that aligns with health rights is important for advancing rights based global health governance. This paper offers a preliminary assessment of how UHC2030’s contributions to global health governance advance, or not, the right to

health care in the SDG era.<sup>6</sup>

In April 2019, UHC2030 launched its six key asks for the UN UHC meeting. The first asks governments to “Commit to achieve UHC for healthy lives and wellbeing for all at all stages, as a social contract.”<sup>7</sup> This language in this document echoes that used by the Goals and Governance for Global Health consortium (Go4Health), whose research analyzed the development of the health SDG and made the case for a new global social contract that advanced the right to health comprising two key components; UHC anchored in the right to health and a healthy natural and social environment.

This article builds on a 2014 Go4Health study which identified key normative overlap and gaps in the principles embedded in the right to health care and UHC.<sup>8</sup> That study focused on the right to health care—narrower than the right to health—because UHC, notwithstanding the inclusion of ‘preventive’ and ‘promotive’ efforts in many of its definition, actually focuses on access to health care. Therefore, it would be somewhat unfair to expect UHC to drive the realization of the broader right to health. This article explores how UHC2030’s approach to advancing UHC addresses, or not, these gaps to better understand how its normative underpinnings align with those of the right to health care, thus allowing us to assess whether it contributes to advancing rights-based global health governance. Given the importance of civil society participation in advancing the right to health care, this analysis is complemented by a brief examination of how UHC2030 might amplify ongoing efforts to advance the right to health in two UHC2030 partner countries, Kenya and Uganda. These countries were selected because key national civil society actors have recently published extensive studies on efforts to realize the right to health in each.<sup>9</sup>

Section one reviews the shift from the Millennium Development Goals (MDGs) to the SDG era, examining how this shift suggests a more comprehensive approach to advancing health rights. Section two draws on the 2014 Go4Health analysis to summarize the overlap and gaps between UHC and the principles underpinning the right

to health care. Section three introduces UHC2030, an increasingly influential global health actor, and examines key UHC2030 documents to assess how its goals and approach to advancing UHC address gaps related to the right to health. Section four turns to Kenya and Uganda to illustrate how UHC2030 efforts influence national and local level actions to close these gaps by focusing on community participation, and how this can amplify ongoing efforts to advance the right to health care.

### Shifting goals and governance: from the MDGs to the SDGs

The impact of the MDGs on advancing global health goals by focusing on components of the right to health was impressive, but progress was uneven. The shift in global burden of disease from communicable to non-communicable was a factor in mobilizing support for a broader post-MDG health agenda.<sup>10</sup> The impact of uneven global attention and progress was evidenced by the large upswing in funding to communicable diseases in contrast to smaller increases to non-communicable diseases (see Table 1.<sup>11</sup>) While efforts to advance on broader areas like health systems strengthening were funded, other vital areas, such as primary health care and the importance of addressing the interconnected nature of rights, were not prioritized for funding or institution-building.

The global consultations on the MDGs' successors saw a shift in the approach to global health, with countries embracing a universal goal: one for all countries, within a global framework that recognized the interconnected nature of rights.<sup>12</sup> The ensuing negotiations presented countries with an opportunity to recommit to their legal

obligations under the International Covenant on Economic, Social and Cultural Rights (ICESCR), including Article 12, the right to the highest attainable standard of physical and mental health (right to health).<sup>13</sup> As Brolan et al.'s research documents, the combination of political misgivings and concerns about the practical translation of the right to health into measurable targets contributed to it lacking sufficient political traction to become the post-2015 health goal.<sup>14</sup>

In September 2015, the United Nations General Assembly (UNGA) agreed on the post-2015 development agenda, with a broadly framed health goal, SDG 3, "Ensure healthy lives and promote well-being for all at all ages," and UHC as a target (3.8) committing states to "Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all."<sup>15</sup>

Although the right to health did not emerge as the post-2015 health goal, many global health and rights scholars welcomed the new health goal, focusing on the potential of UHC to deliver progress on the right to health.<sup>16</sup> Some, including many Go4Health members, urged caution, noting the importance of anchoring UHC in the right to health to ensure that the process of delivering UHC to diverse communities is aligned with rights-based approaches.<sup>17</sup> Such an approach addresses the tension between the aim of an internationally agreed goal, UHC, with the expectation that health efforts will be responsive to the specific needs identified by a given community. The importance of anchoring UHC in the right to health is that while it allows progress adapted to national circumstances it requires a human rights-based ac-

TABLE 1. Development assistance for health (DAH) by health focus area, 1990-2017

Health focus area	Total in US dollars (billions)
Maternal, newborn, and child health	173.8
HIV and AIDS	141
Health systems strengthening/SWAPs	81.3
Malaria, TB, and other infectious diseases	69.3
Non-communicable diseases	9.6

countability framework, community participation in priority setting, and an overarching commitment to non-discrimination.

## UHC versus UHC anchored in the right to health

This section draws on the 2014 Go4Health analysis summarizing the overlap between the normative elements of UHC and the obligations arising under the right to health care. It highlights the areas that UHC2030 needs to address to ensure that the UHC priorities it advocates for are consistent with advancing the right to health care, thus contributing to rights-based global health governance.

### *UHC: A powerful concept with no single definition*

Despite numerous UN resolutions, widespread commitments to and praise for UHC, there is no universally agreed definition; as Go4Health concluded, “there is no single authoritative formulation of UHC.”<sup>28</sup> The flexibility of the concept is an advantage, allowing it to garner support from diverse actors, but it also carries the risk that more politically and financially powerful voices, who may not support a rights-based agenda, will exercise greater influence over the priorities and process of advancing UHC.

### *The right to health in international law: Key principles*

State obligations to safeguard and realize health-related rights are enshrined in WHO’s Constitution and in Article 12 of ICESCR. These obligations are further clarified in General Comment 14, which affirms that the right to health is a “fundamental human right indispensable for the exercise of other human rights,” and that “every human is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity.”<sup>29</sup>

The right to health is not a right to be healthy but the universal right to accessible, affordable, and acceptable health care and the underlying determinants of health. It imposes both national and international legal obligations on States parties re-

quiring that health care is both comprehensive and progressive in accordance with seven principles. These include, first, the principle of progressive realization, which requires that each state employs the maximum of its available resources to advance the right for all. Second, the principle of non-discrimination requires that the availability, accessibility, and quality of health care is universal and sufficiently adaptable to suit all. Third, the public health principle of cost-effectiveness, which needs to be read in conjunction with non-discrimination, and requires that states make choices about the health care provided by allocating health resources so that they benefit a larger part of the population (that is, primary and preventive health care). Fourth, participatory decision-making requires that states develop a national public health strategy and plan of action through an inclusive, participatory, transparent process. General Comment 14 spells out obligations regarding non-state actors including the obligation to ensure that “coordinated efforts for the realization of the right to health are maintained to enhance the interaction among all the actors concerned, including the various components of civil society.”<sup>20</sup> Fifth, the process for developing the national strategy and plan of action requires that special attention be paid to the needs of those made vulnerable or marginalized. This principle ensures that if a particular health condition disproportionately affects a vulnerable or marginalized segment of the population it may be incumbent on the state to include this condition in its health care strategy, even if it fails the cost-effectiveness test. Sixth, the minimum core obligations established in General Comment 14 apply to all states, high or low income, and include providing essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs and ensuring equitable distribution of all health facilities, goods, and services. The seventh principle is shared responsibility, enshrined in Article 2(1) of ICESCR, according to which States parties commit to “take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization

of the rights recognized in the present Covenant by all appropriate means...".<sup>21</sup> This requires that states in a position to assist are legally obliged to engage in international assistance and cooperation that prioritizes advancing, at a minimum, the core obligations under the right to health.<sup>22</sup> This reflects the understanding that development assistance for health is an international human rights obligation, not a matter of charity.<sup>23</sup>

### *Overlap between UHC and the right to health care*

Drawing on the key international legal documents and authoritative opinions outlined above, Go4Health members compared the key normative elements of the right to health care with those of UHC and concluded that there was overlap on the key right to health principles of progressive realization, non-discrimination, and cost effectiveness. In assessing how UHC tracks with the right to health principles of participatory decision making and prioritization of vulnerable and marginalized groups, there was less overlap. Specifically, the 2012 UNGA Resolution is imprecise regarding how to ensure the relevant decision-making processes will be participatory or that these processes will include and prioritize the needs of vulnerable or marginalized groups.<sup>24</sup>

UHC and the right to health care diverge most with respect to the right to health care principles of core obligations and shared responsibility. In terms of minimum core obligations, the UNGA resolutions and WHO documents are ambiguous as to what framework should guide country decision making when public funding shortfalls require decisions as to what health care or medicines are to be included in the national UHC plan. The 2012 WHO

Discussion Paper notes that UHC implies that people "have access to all the services they need." This definition is too vague. Even in a high income country like Canada, with a long UHC history, the absence of universal coverage for necessary medicines continues to create barriers to access and is arguably a violation of the country's minimum core obligations tied to the right to health.<sup>25</sup>

The commitment to the international legal obligation of shared responsibility to realize the right to health care is largely absent from UHC documents. The preamble of the 2005 UNGA Resolution includes a reference to international assistance and the 2012 UNGA Resolution makes a vague and non-committal reference to "universal health coverage on the basis of solidarity at national and international levels." Go4Health analysis clarifies that a definition of UHC that does not include a commitment to shared responsibility means that "in low and lower middle income countries, UHC could mean access to a very cheap and incomplete package, not including antiretroviral AIDS treatment, for example."<sup>26</sup> The risk of such an approach to UHC is that it may deliver less for People Living With HIV and AIDS in those countries than under the MDGs.

### **UHC2030: Origins, goals, and efforts to advance the right to health**

#### *Coordinating global health efforts: evolving from the MDG to the SDG era*

In an effort to tackle problems related to diverse, uncoordinated approaches to advancing human rights and development in the MDG era, countries agreed upon five aid effectiveness initiatives between 2005 and 2011. The first was the 2005 Paris Declaration

TABLE 2. Comparing right to health care principles to UHC commitments

Right to health care principles	UHC commitments
Progressive realization	Yes
Non-discrimination	Yes
Cost-effectiveness	Yes
Participatory decision making	Not so clear
Prioritizing vulnerable and marginalized groups	Not so clear
Minimum core obligations	Unrealistically broad (all health care needed)
Shared responsibility	Absent

on Aid Effectiveness (Paris Declaration), which prioritized country ownership and accountability, clearer targets and indicators of success, a commitment to harmonization among partners, alignment with nationally prepared country strategies, and mutual accountability for measurable outcomes.<sup>27</sup>

The 2007 International Health Partnership (IHP+) aimed to put the principles of the Paris Declaration into action by improving DAH coordination and effectiveness through bringing together diverse actors committed to advancing on the health MDGs in low income countries, including countries in a position to assist, countries needing assistance, civil society organizations, and multilateral organizations.<sup>28</sup> It launched a global compact aimed at building confidence among these stakeholders by encouraging broad support across all partners for a single national health strategy, a single monitoring and evaluation framework, and a strong emphasis on mutual partner accountability.<sup>29</sup>

IHP+ members, including WHO and the World Bank, championed UHC as the SDG health goal for advancing greater accountability, alignment, participation, and effectiveness. Following the SDG launch, the IHP+ transformed into the International Health Partnership for Universal Health Coverage 2030 (UHC2030), a new global health governance actor, aiming to

- improve coordination of health systems strengthening (HSS),

- strengthen and coordinate multi-stakeholder dialogue and adhere to IHP+ principles,
- facilitate accountability for progress toward HSS for UHC, and
- build political momentum for a shared vision and advocate for sufficient, appropriate, and well-coordinated resource allocation to HSS.<sup>30</sup>

### Unpacking the UHC2030 approach

The UHC2030 Global Compact (Global Compact) was launched in 2017 and requires UHC2030 partners to advance the SDG objective of leaving no one behind, by, *inter alia*, committing to equity, non-discrimination, and a rights-based approach, and secondly, assuring transparency and accountability for results.<sup>31</sup> As Ogbuoji and Yamey observe, the 2015 Addis Ababa Action Agenda and the Global Compact take the aid effectiveness agenda into the SDG era.<sup>32</sup>

In April 2019, UHC 2030 issued its Six Asks for the UN UHC Meeting (see Table 4), which echo the language of the principles underpinning the right to health (as explored in section 2).<sup>33</sup>

To dig deeper into the Six Asks, we examine two key UHC2030 documents, the Global Compact and the Joint Vision.<sup>34</sup> Given the importance of civil society participation in advancing the right to health care, we also examine the contributions of the Civil Society Engagement Mechanism for UHC2030 (CSEM), entitled “Civil society per-

TABLE 3. From IHP+/MDG era to UHC2030/SDG era

	IHP+	UHC2030 Global Compact
Objective	The health MDGs	The health SDG (focus on health systems strengthening and UHC)
Scope	Low- and middle-income countries	All countries (universal)
Goals	1. Ensuring DAH is: effective aligned coordinated 2. Accountability	1. Leave no one behind: a commitment to equity, non-discrimination, and a rights-based approach 2. Transparency and accountability for results 3. Evidence-based national health strategies and leadership 4. Making health systems everybody’s business, through engagement of citizens, communities, civil society, and private sector 5. International cooperation based on mutual learning, progress in achieving and sustaining UHC, and development effectiveness principles.
Signatories and partners	Primarily partner countries and bilateral donors, with multilaterals, philanthropic foundations. Civil society is represented on the Steering Committee but cannot sign the compact.	Open for signature by all countries, governments, parliaments, multilaterals, civil society, philanthropies, and the private sector.

spective on how UHC can be reached by 2030” (CESM-P).<sup>35</sup> The objective is to unpack how the commitments and approaches to advancing UHC in these documents address, or not, the key normative gaps outline in section 2, specifically the right to health principles of participatory decision making, prioritization of vulnerable and marginalized groups, minimum core obligations, and shared responsibility. This allows us to assess the extent to which UHC2030 advances, or not, global health governance that advances health rights.

*Participatory decision making and prioritizing vulnerable and marginalized groups*

The right to health care requires that a national health strategy and plan of action (a core obligation) is formulated through an inclusive, participatory decision making process that prioritizes the participation and needs of vulnerable and marginalized groups.

The Joint Vision document highlights that a human rights-based approach to promoting UHC must address inequalities and exclusion, include inclusive health policies and programs, and mobilize civil society (page 11). It emphasizes the importance of systematically anchoring civil society participation in health systems-strengthening activities to enable people-centered health services (page 22). Additionally, it references the importance of multi-stakeholder dialogue with communities and civil society, “including in particular organizations representing disease-affected or marginalized and vulnerable groups, as well as the private sector for developing implementing and monitoring national health strategies.” (page 22) Thus the norms advanced in the Joint Vision do not fully reflect the human rights principle of prioritizing vulnerable and marginalized groups because, as noted above,

vulnerable and marginalized groups are listed as one of several stakeholders to be consulted, which is not the same as prioritization.

The Joint Vision states that “progressive pathways towards universality may require policies and strategies addressing trade-offs between coverage and equity to ensure that people who have not access to affordable quality services gain at least as much as those who are better off at every step of the way toward universal coverage.” (page 10) Progressive pathways towards universality is not the same as committing to policies and programs that deliver the “progressive universalism” referenced by Horton and Das, which aligns with the right to health principle of prioritizing vulnerable and marginalized groups.

The Global Compact reiterates the principle that “progressive pathways towards universality that endeavor to first reach the most vulnerable and marginalized population groups are key to ensure no one is left behind.” However, Global Compact signatories do not commit to put in place an inclusive participatory process to develop a national strategy that reflects the essential health needs of the vulnerable and marginalized. They do commit to “evidence-based national health strategies and leadership, with government stewardship to ensure availability, accessibility, acceptability and quality of service delivery,” and making “health systems everybody’s business” through engaging with citizens, communities, civil society, and the private sector.

An evidence-based national health strategy is not the same as a national health strategy that has been developed in partnership with diverse communities, including those that are marginalized. Further, government stewardship does not ensure that the needs of vulnerable and marginalized

TABLE 4. The Six Asks

Ensure political leadership beyond health	Commit to achieve UHC for healthy lives and well-being for all at all stages, as a social contract
Leave no one behind	Pursue equity in access to quality health services with financial protection
Regulate and legislate	Create a strong, enabling regulatory and legal environment responsive to people’s needs
Uphold high-quality health	Uphold quality primary health care (PHC) as the backbone of UHC and an entity that creates trust in public institutions
Invest more, invest better	Sustain public financing and harmonize health investments
Move together	Establish multi-stakeholder mechanisms for engaging the whole of society for a healthier world

populations will be prioritized. In some countries, the relationship of minority communities with the government may be tainted by the legacy of oppression, and/or the government may be the source of their exclusion and vulnerability, as is the case with many migrant communities the world over. The commitment to “engagement of citizens, communities, civil society and private sector” is weaker than the requirements of the right to health. In the absence of a commitment to meaningful, inclusive broad-based consultation processes and input into designing a national health strategy, the priorities in the national health strategy risk reflecting and amplifying entrenched asymmetries of power. The commitment to making health systems everybody’s business is not the same as committing to the right to health care principle of a national public health strategy and plan of action that is “devised, and periodically reviewed, on the basis of a participatory and transparent process” as required under General Comment 14.

In line with the Global Compact and Joint Vision, the CSEM-P insists on the importance of accountability and emphasizes that because health is a human right, policies to advance UHC must ensure that no one is left behind. It goes further in its commitment to progressive universalism, stating “civil society groups believe that UHC policies need to ensure that populations most in need are targeted first, with appropriate and inclusive services.” It also argues for multi-level (local to global) advocacy and engagement with marginalized groups to ensure that “future national health plans and policies assess which populations are currently left behind and have insufficient access to health services and explicitly target those populations most in need.” The CSEM-P therefore calls for civil society across all sectors (not just health- or UHC-focused) to engage in ensuring that national health plans are clearly focused on the multiple barriers that obstruct access to health care.

Significantly, the CSEM-P highlights that the importance of community involvement goes beyond informing health decision making, but that it should also contribute towards accountability and transparency across all the stakeholders. Such

involvement should see civil society engaged in decision making processes across the different levels, including national and district, “to monitor progress against outcomes towards UHC including the health budget and ensure adherence to commitments.”<sup>36</sup> The CSEM-P also raises the mechanism of social-led accountability, advocating for its strengthening to contribute towards the integrity of the health system and to deal with the problem of corruption, which drains resources.

The CSEM-P document is the only UHC2030 document that reflects the transformation in thinking required to implement a rights-based approach to advancing the right to health care, as it recognizes the depth and breadth of engagement needed. The commitments and processes outlined in the Joint Vision, Global Compact, and Six Asks do not yet make this transformative leap but are steps on the path.

#### *Minimum core obligations*

Like UHC, the concept of minimum core obligations has its own conceptual and definitional challenges.<sup>37</sup> Clearly it is not within UHC2030’s mandate to engage in the discussion on the scope of the minimum core obligations under the right to health. However, to advance the right to health care, UHC2030’s approach to advancing UHC should advocate prioritizing the minimum core obligations under the right to health. The Six Asks is silent on this. The Joint Vision highlights the importance of a rights-based approach, noting that “a human rights-based approach provides not only a framework for accountability but also for development of inclusive health policies and programs, and for mobilizing civil society to achieve the right to health” (page 11), and the Global Compact commits signatories to a rights-based approach. The CSEM-P emphasizes the importance of increasing budgets for health needs through mandatory and fair pooling mechanisms and removing financial barriers to accessing essential care packages. Accordingly, the CSEM-P argues that “primary health care linked to essential health services packages should be given priority.” Countries need to define their essential care packages at the national level,



and these should be accompanied with “a concrete plan to ensure the removal of direct cash payments as an urgent measure.” The key questions to address here are: how will UHC2030 engage with the issue of what health care services and medicines are included? *Who* is covered?<sup>38</sup> We shall use the example of HIV and AIDS to unpack this challenge.

Many HIV and AIDS advocacy and empowerment groups are concerned with the extent to which HIV and AIDS programming and services will be integrated into national UHC benefits packages.<sup>39</sup> Two key interrelated issues impact on how this question is answered. The first is who decides and the second is how they decide, which brings us back to the interrelated human rights principles of participatory decision making and prioritization of vulnerable and marginalized groups. The second issue, addressed below, centers around shared responsibility and the extent and reliability of global commitments to fund UHC that includes access to treatment for HIV and AIDS.

National level determinations of what falls into the category of UHC risk undermining the progress on access to HIV and AIDS services and medicines. If national health plans to advance UHC include and prioritize the concerns of vulnerable and marginalized groups, then affordability and access to HIV and AIDS-related services should continue to be prioritized.

## Shared responsibility

Go4Health research identified the human rights obligation of shared responsibility for advancing the right to health as a lacuna in UHC definitions and programming. Clearly, the importance of DAH for advancing UHC in many countries will continue to decrease throughout the SDG era. Yet, for the foreseeable future, many low-income countries will need to rely on DAH to fund efforts to advance on UHC. A July 2019 World Bank study argues that closing the substantial UHC financing gap in 54 low- and lower middle-income countries will require a strong mix of domestic and international investment, including a sizable increase in DAH.<sup>40</sup> In addition, many countries will be facing the chal-

lenge of increased reliance on domestic financing for their entire health budget as they “transition” to middle-income status and lose access to DAH and international funding for their HIV and AIDS response.<sup>41</sup> The human rights obligation of shared responsibility for advancing the right to health is not acknowledged in either the Six Asks or the three UHC2030 documents.

With regards to domestic financing, the UHC2030 Compact and the Joint Venture take their lead from the Addis Ababa Agenda for Action, which focuses on the importance of mobilizing domestic resources and increasing public financing. These commitments are in line with domestic component of the right to health. The CSEM-P highlights that “civil society strongly supports progressive domestic resource mobilization to ensure progress towards UHC and Health System Strengthening ” The CSEM-P requires governments to “progressively increase their investment in health and move towards the proposal of allocating at least 5% of annual GDP as government health care expenditure.” This suggests a shift away from the Abuja approach that required governments to commit 15% of the national budgets towards health. This is a significant change that deserves monitoring, as many African countries have been pushed to focus on the Abuja target, which is not yet achieved by many.

With respect to the international component of shared responsibility, the Six Asks and the Joint Vision (page 17) recognize that DAH is complementary to domestic resources, noting the importance of alignment and effectiveness. This is in contrast to the weak language in the UHC2030 Compact, where partners simply reiterate their “commitment to the principles and behaviours of effective development cooperation.” No attention is paid to the obligation of engaging in technical assistance and cooperation as required under the right to health. The documents are also silent on the Overseas Development Assistance commitment of 0.7% of GNI and the consequences of the flat-lining of the volume of DAH in combination with the ability (or inability) of countries to mobilize more domestic resources.<sup>42</sup> As Haakenstad et al note, “a large gap

exists between available financing and the funding needed to achieve global HIV/AIDS goals, and sustained and coordinated effort across international and domestic development partners is required to end AIDS by 2030.<sup>43</sup>

The Six Asks move even further from a rights-based approach, stating, “Countries need to adapt to transition from external funding that aim to increase effective coverage of priority interventions toward achieving and sustaining UHC.” Further, it advocates for a global public goods approach as opposed to a rights-based approach when it states that countries should “Invest in global and regional public goods including universal access to essential medicines, vaccines, technology and emergency preparedness.” If countries use a global public goods framework to establish health funding priorities, then the funding of health programs and policies will reflect the interests of wealthy countries, rather than those of countries requiring assistance. This is at odds with the human rights-based approach.<sup>44</sup>

The CSEM-P also remains stuck in the logic of donors and aid, as opposed to the recognition of shared responsibility as a human rights obligation. It states: “Donor governments, however, also have a crucial role to play in providing their fair share to achieve SDG 3.8 fully aligned with countries’ plans, in line with the aid effectiveness principles and the WHO recommendation of funding levels not below 0.1% of GNI.” This language does not reflect a right to health understanding of the legally binding obligations of countries in a position to assist.

### How UHC2030 can amplify Ugandan and Kenyan UHC efforts

This assessment now turns to examining how the UHC2030 commitments and approach to advancing UHC can complement efforts to advance the right to health in Uganda and Kenya. Both are UHC2030 partner countries and States parties to numerous international human rights treaties, including ICESCR. We draw on two recent civil society studies on health rights, which focused on the challenges related to advancing on the principles of participatory decision making, prioritization

of vulnerable and marginalized groups, and the minimum core, and supplement these with developments in 2019.<sup>45</sup>

### *Kenya*

In Kenya, access to health care is both a constitutional imperative and an administrative policy; this offers a unique opportunity to interrogate how the current administration has interpreted its constitutional obligation in light of its UHC2030 engagement. The right to health is enshrined in the Kenyan Constitution, which states: “Every person has the right to the highest attainable standard of health, which includes the right to healthcare services, including reproductive health.”<sup>46</sup> To achieve this right, the current government adopted UHC as one of four priority agendas, aiming for all persons in Kenya to be able to use the essential services they need for their health and wellbeing through a single unified benefit package, without significant financial risk, by 2022.<sup>47</sup> Through UHC, the state has committed to subsidize 100% of costs on essential services and reduce medical out of pocket expenses by 54% as a percentage of household expenditure.<sup>48</sup>

In December 2018, the first phase of UHC rolled out in four counties (Kisumu, Nyeri, Machakos, and Isiolo) with the goal of scaling up to all 43 counties after the first year.<sup>49</sup> The rollout of the pilot phase has resulted in the Kenyan president, Uhuru Kenyatta, receiving the UHC Political Leadership award.<sup>50</sup> Despite this international acclaim, we shall outline below how both the priority setting and pilot phase selection process fell short in terms of the imperative of participatory decision making processes.

Priority setting is a key component of UHC because states have to make choices about what and how to finance health.<sup>51</sup> From a human rights perspective, this process should be equitable, non-discriminatory, participatory, transparent, and accountable.<sup>52</sup> The health system has to be understood as part of democratic governance and thus the questions to be answered are not merely technical but require active participation of citizens in decisions regarding their health, a key principle of the right to health care.<sup>53</sup> In this respect, the Ken-

yan experience of rolling out UHC is illustrative of the normative gaps between the commitments under UHC2030 (Joint Vision and the Global Compact) and the international framework on the right to health, as well as the Kenyan framework on participatory decision making as captured in national values.<sup>54</sup> The decision as to what should form a priority when selecting pilot counties was not taken in a participatory manner and the basis for the decisions was communicated mainly after the pilot counties had been chosen. The choice of the UHC pilot counties suggests selection criteria that lean heavily towards curative medicine, a legitimate choice but one taken without appropriate consultation.<sup>55</sup> The counties selected for the pilot phase include one with a prevalence of communicable diseases (malaria and HIV in Kisumu); one with non-communicable diseases (hypertension, diabetes, and cancer in Nyeri); another with a high incidence of injuries caused by road accidents (Machakos); and one with a high maternal mortality ratio (Isiolo).<sup>56</sup> Many Kenyan government UHC documents refer to essential health care services, however; the definition of essential health care service remains unclear and was not communicated before the rollout of UHC. Enabling citizens and civil society to meaningfully participate in ranking and criteria for priorities is time consuming, expensive, and challenging given the information asymmetries and the diverse interests, but it is fundamental to a rights-based approach and necessary for accountability, transparency, and legitimacy in decision making.<sup>57</sup> At present, there is no guidance on definitions, and no public discourse to outline the essential components of health care in Kenya.

The consequences of failing to democratize the process of priority setting and decision making regarding the right to health and access to health care were apparent at the Third UHC Conference in Kisumu County on May 15-17, 2019. The first problem relates to participatory decision making. The final conference communique seeks to demonstrate that a consensus was reached between the government and other stakeholders, including civil society, yet many civil society participants were prevented from participating. Further, the final

communique did not take into account the position statement of 26 civil society organizations working with Kisumu County communities, who were not given the opportunity for meaningful participation in the process.<sup>58</sup>

The second problem relates to the sequencing of the rollout of UHC in Kisumu. The conference took place in May 2019, yet residents had begun registering for UHC in January 2019.<sup>59</sup> In January, the policy basis for the registration process was not in place and the government had not shared any information to allow residents to make an informed decision on their health.

Finally, the participation of marginalized and vulnerable groups was lacking. Kisumu County was chosen as a pilot county because of the high burden of communicable diseases (HIV and malaria), but there is no evidence from the communique to underscore or amplify the voices of marginalized groups (such as women, sex workers, adolescent girls and young women, and men who have sex with men). This notable exclusion raises concern that the needs of these communities will not be prioritized and the objective of addressing health equity may fall short as a result.

One of the primary reasons for the devolution of health in Kenya was to bring decision making closer to those affected by the decision. However, the manner in which UHC has thus far rolled out mimics the paternalistic past, with the national government making decisions and merely communicating them to counties for implementation. The counties also appear to be playing the role of implementer and not assuming their role as a separate government responsible for delivering on the right to health and respecting the national values.

The failure to engage in the appropriate county-level consultations risks the legitimacy of the entire UHC campaign. This approach is not in line with UHC2030 commitments, and UHC2030 could play a role in bringing diverse stakeholders together to try to reorient the Kenyan UHC2030 on a legitimate path that reflects the right to health commitments in the constitution. As currently framed, the path to UHC in Kenya is a heavily politicized objective that has been prioritized without

consultations at the appropriate political level.

### *Uganda*

In Uganda, both participation in decision making and the prohibition of discrimination against vulnerable and marginalized groups are constitutional rights.<sup>60</sup> The National Health Policy and the Health Sector and Development Plan call upon the government to actively promote community participation in health service delivery and management by empowering communities, households, and individuals to take greater responsibility for their own health and the management of local health services. Despite these progressive constitutional and policy provisions, sections of the Ugandan population continue to witness and experience discrimination and poor service delivery. As Mulumba et al. have noted, a key reason for the poor health of persons with disabilities and the elderly is “political sidelining, discrimination and inequitable access to health services.”<sup>61</sup> It is therefore important that the commitments towards nondiscrimination and addressing the needs of the vulnerable move beyond policy commitments to actualization.

For Uganda, the value of UHC 2030 is tied to how it “cements the role of civil society in holding governments to account for what they have promised to deliver” vis à vis financing, as called for in the CSEM-P.<sup>62</sup> The principles included in the Joint Vision and Global Compact need to move from theory to implementation at the country level, including through means like the CSEM.

The participatory structures for communities in the health system in Uganda include health committees for the management of health facilities which Mulumba et al. have described as “having a potentially significant role in ensuring effective participation of communities in the provision of health services.”<sup>63</sup> However, these committees “can only play their role of promoting participation as an integral part of the right to health and improve health care delivery where they have the requisite education, training, and tools.”<sup>64</sup> This suggests that UHC2030 needs to pay special attention to the role of such participatory structures at the national level.

With respect to the principle of minimum

core obligations, Uganda’s national health policy provides for the Uganda National Minimum Health Care Package (UNMHCP) defined as “the most cost-effective priority healthcare interventions and services addressing the high disease burden that are acceptable and affordable within the total resource envelope of the sector.”<sup>65</sup> The government’s policy objective is ensuring “universal access to quality UNMHCP consisting of promotive, preventive, curative and rehabilitative and palliative services for all prioritized diseases and conditions, to all people in Uganda, with emphasis on vulnerable populations.”<sup>66</sup> While the policy does not present the UNMHCP as a rights issue, it emphasizes the need to ensure that “all people in Uganda, both users and providers of health services, understand their health rights and responsibilities through implementation of comprehensive advocacy, communication and social mobilization programs.”<sup>67</sup> This has various implications for the UHC 2030 agenda. For example, UHC2030 efforts need to connect with the country level to ensure progressive and sustained implementation of the UNMHCP as spelled out in the national constitution, policies, and plans.

Active engagement of UHC2030 with the Global Compact pledge of

*building and expanding equitable, resilient and sustainable health systems, funded primarily by public finance, and based on primary health care, that deliver integrated, comprehensive people-centered and quality health services for all, while taking necessary measures to protect households from financial hazards due to health expenditures*

could help Uganda advance on its core right to health commitments related to maternal mortality. The Ugandan government is subject to a constitutional challenge for failure to provide the essential maternal health commodities listed in the UNMHCP. Through a constitutional petition, the Ugandan civil society group CEHURD and others have argued that the non-provision of basic indispensable maternal health commodities in government health facilities is inconsistent with the constitution and a violation of its right to health obligations.<sup>68</sup> This

case also argued that the high number of preventable maternal deaths (the 2015 maternal mortality ratio stood at 343 deaths per 100,000 live births) is also caused by the government's non-provision of the basic minimum maternal health care packages, constituting a violation of the right to health.<sup>69</sup> While the Constitutional Court upheld a preliminary objection on the courts incapacity to interpret the matter before it because of the 'political question doctrine', the Supreme Court overturned this decision and held that it was the duty of the court to "to interpret what amounts to taking all practical measures to ensure the provision of basic medical services."<sup>70</sup> The Supreme Court further argued that "the court should be able to receive evidence on the measures being taken by government to satisfy itself that they fall within objective XX."<sup>71</sup>

While this matter is still before the court, the Supreme Court decision suggests how UHC2030 could work with civil society and the Ugandan government to ensure that the government prioritizes what needs to be done at the country level to fulfill its constitutional right to health obligation to provide basic medical care. In this way, UHC2030 could demonstrate leadership in global health governance that advances health rights.

## Conclusion

From a health rights perspective, there is a need to continue interrogating how progress on UHC will be pursued by different global health actors to assess whether or not it advances rights-based global health governance. If embedded in the right to health and subjected to the constant interrogation of civil society partners, it has the potential to transform the lives of millions of people by ensuring that no one is left behind. Without the anchor of rights, a purely technical approach to advancing UHC risks mirroring the global and national patterns of exclusion and injustice that flow from the colonial era. The nature of the process of deciding national UHC packages, ongoing shortfalls in domestic financing, and a retreat from international engagement and funding from wealthy countries are likely to become the key points of struggle around issues

of affordability and inclusion. From a human rights perspective, this is where civil society will be very important in ensuring that UHC is compliant with demands regarding the right to health. The challenge for UHC2030 partners in the coming years will be overcoming the gaps between UHC, and UHC anchored in the right to health care, so that it ensures that its demands for UHC contribute to advancing the right to health care for all.

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