

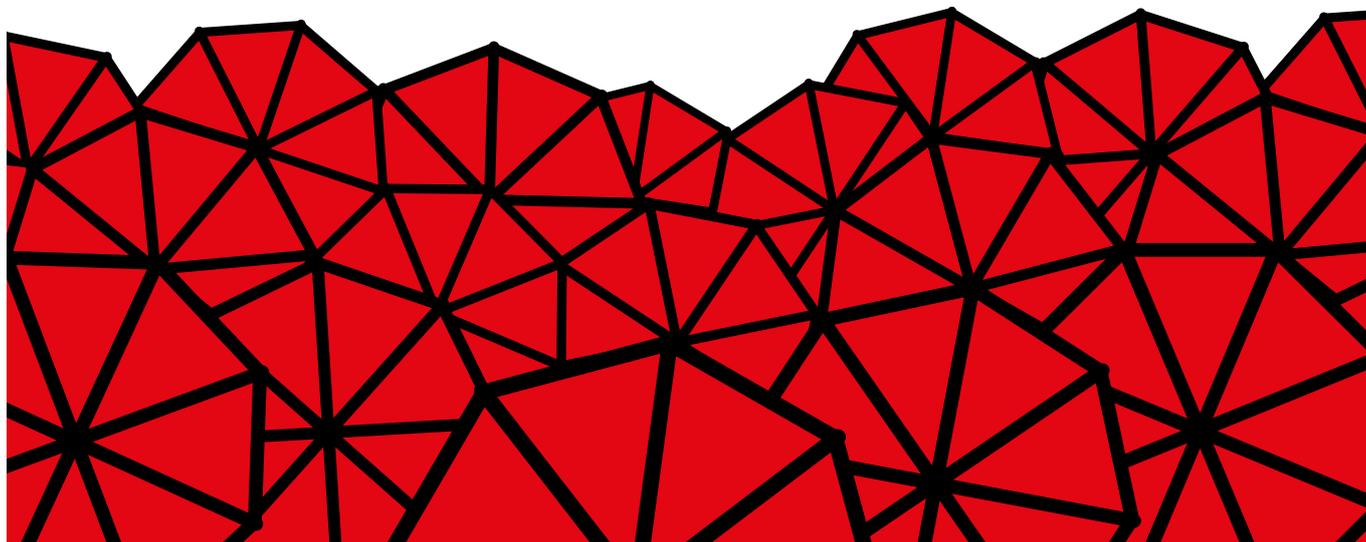


**nswp**

**Global Network of Sex Work Projects**  
Promoting Health and Human Rights

**BRIEFING  
PAPER**

# **Universal Health Coverage: Putting the Last Mile First**



# Universal Health Coverage: Putting the Last Mile First

## Introduction

*“The 2030 Agenda reminds us that the only way to ensure that no one is left behind is to begin by reaching those most marginalized first.”*

ELIE BALLAN OF MCOALITION ON BEHALF OF KEY POPULATIONS AT THE UNITED NATIONS UNIVERSAL HEALTH COVERAGE MULTI-STAKEHOLDER HEARINGS, 29 APRIL 2019.<sup>1</sup>

The World Health Organization (WHO) reports that all countries are making some progress towards Universal Health Coverage (UHC). However, an analysis of health data for 204 countries during the period 1990–2019 sounded an urgent warning that:

*“If current trends hold, the world will fall short of delivering on its UHC ambitions for [Sustainable Development Goals]. Although this outcome is not yet inevitable, the window for meaningful action and health-system changes is rapidly narrowing.”<sup>2</sup>*

**Far too many people continue to face challenges in accessing basic health care – particularly in the Global South.**

Far too many people continue to face challenges in accessing basic health care – particularly in the Global South. Current predictions warn that 3.1 billion people will still lack UHC effective coverage by the year 2023, nearly a third of whom live in south Asia.<sup>3</sup>

Some commentators point out that strategic opportunities have opened to change the status

quo. Commitment on the part of governments towards achieving the Sustainable Development Goals (SDGs), alongside an increased focus on resilient health systems to combat global pandemics following the COVID-19 crisis, and additional resources potentially being made available for health offer a window of opportunity for sex workers and sex workers’ rights organisations to strongly advocate for decades-long demands on sex workers’ health and human rights, the repeal of the criminalisation and other legal oppression of sex work, and meaningful inclusion in UHC planning, financing and services. At the same time, serious concerns have been raised about the broader global health apparatus, politics and funding. These include fears over a new strategy for The Global Fund to Fight AIDS, Tuberculosis and Malaria that could potentially divert funding away from HIV/AIDS,<sup>4</sup> the restructuring of DFID, and cuts to UK aid.<sup>5</sup> Similarly, President Trump’s decision for the US to withdraw from the WHO and direct funds to other global public health organisations,<sup>6</sup> as well as increasing funding restrictions based on ideology over substantiated evidence, such as the Global Gag Rule and the PEPFAR’s Anti-Prostitution Loyalty Oath<sup>7</sup>, illustrate how the laudable goals of UHC should be seen against the complex interplay of geo-political politics, the devastation of the COVID-19 pandemic and increasing global inequalities.

1 “Ensuring UHC for Key Populations,” Mpnact.

2 GBD 2019 Universal Health Coverage Collaborators, “Measuring universal health coverage based on an index of effective coverage of health services in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019,” *The Lancet* (27 August 2020).

3 GBD 2019 Universal Health Coverage Collaborators, “Measuring universal health coverage based on an index of effective coverage of health services in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019,” *The Lancet* (27 August 2020).

4 NSWP, 2020, “Briefing Note: Global Fund Strategy Development.”

5 “Coronavirus: UK foreign aid spending cut by £2.9bn amid economic downturn,” BBC, 23 July 2020.

6 Lawrence O Gostin et al. “US withdrawal from WHO is unlawful and threatens global and US health and security,” *The Lancet* 396 (2020).

7 NSWP, 2018, “Briefing Paper: Sex Workers’ Access to Comprehensive Sexual and Reproductive Health Services.”

**...the paper highlights some of the consequences of being side-lined at the planning stages of UHC and the continued challenges sex workers face accessing health services.**

Echoing Ballan's remark above, this Briefing Paper examines the implications of UHC for sex workers specifically. Drawing on an exploration of sex workers' current experiences with UHC at country-level, the paper highlights some of the consequences of being side-lined at the planning stages of UHC and the continued challenges sex workers face accessing health services. It concludes with recommendations on how to strategically engage with UHC processes and structures.

## Methodology

This Briefing Paper is based on in-depth research conducted in seven countries, a global e-consultation with NSWP member organisations, and interviews with Key Informants in international health organisations, sex worker-led organisations, and civil society pressure groups involved in UHC. Primary data was supplemented with a rapid desktop review of key UHC materials from WHO, global health groups and preparatory material for the 2019 Political declaration of the high-level meeting on UHC (the "Political Declaration").

National Consultants conducted interviews and focus groups with sex workers using a standardised questionnaire, and produced national case studies on Mexico, Russia, Democratic Republic of Congo (DRC), Nepal, Zambia, Zimbabwe and Guyana. Using a similar questionnaire, a global e-consultation with NSWP member organisations was conducted that included responses from Germany, El Salvador, Mexico, France, Republic of North Macedonia, Senegal and the DRC. Primary data was thus drawn from countries on a spectrum of progress towards UHC – for example, only France, Germany, Guyana, Mexico, Russia and Zambia<sup>8</sup> of the countries included here had universal health care policies in place by 2020.

In total, 202 female, male and transgender sex workers participated in focus group discussions, which included migrant sex workers, sex workers living with HIV, LGBT sex workers as well as sex workers who use drugs.

The research was conducted from March to July 2020 during the rapid spread of COVID-19 and the accompanying restrictions on movement, travel and commerce across much of the globe. This meant that researchers experienced greater challenges in conducting face-to-face meetings with sex workers due to COVID-19 restrictions, at a time when sex workers' lives, safety and livelihoods were under immense strain. We would like to acknowledge the extra effort and innovation that was required to reach respondents, including through virtual means and thank all the researchers and respondents for their efforts, time and commitment to this project during an international crisis.

<sup>8</sup> "Countries with Universal Health Care 2020," World Population Review.

# Universal Health Coverage

## What is Universal Health Coverage?

Put simply, UHC speaks to the global goal of providing all people with the health care they need without creating undue financial burdens on the individual.

While some countries – generally high-income countries<sup>9</sup> – already have comprehensive, publicly funded health systems in place that meet key aspects of UHC, others are making slower progress towards this SDG,

including increasing the range of services covered by the state and reducing the user fees needed to pay for them. In many parts of the world, health provision and access to health services remains extremely poor, particularly for criminalised and marginalised populations such as sex workers and other key populations. This also holds true for high-income countries. Canada, for example, has reported substantial progress towards UHC, but research shows that sex workers<sup>10</sup>, indigenous populations and other marginalised groups<sup>11</sup> still face a range of barriers to accessing health care.

**In many parts of the world, health provision and access to health services remains extremely poor, particularly for criminalised and marginalised populations such as sex workers and other key populations.**

## What about key populations?

*“[T]he most vulnerable people should have access to the health services they need without restrictions”<sup>12</sup>*

WHO

WHO is clear that vulnerable populations should be of particular concern in UHC and asserts that “equity is paramount” in “providing special interventions for stigmatized populations”.<sup>13</sup> This approach was confirmed by the WHO Director-General in a tweet immediately after a side-meeting during 72nd World Health Assembly:

*“If universal health coverage is to be truly universal it must encompass everyone, especially those who have the most difficulty accessing health services, such as migrants, rural populations, people in prison, LGBT community, sex workers, drug users, poor people #Healthforall”<sup>14</sup>*

In 2019, WHO confirmed that it is those most vulnerable to poor health outcomes who often do not have the ability to pay for health care:

- At least half of the world’s population still do not have full coverage of essential health services.
- About 100 million people are still being pushed into extreme poverty (defined as living on 1.90 USD or less a day) because they have to pay for health care.
- Over 930 million people (around 12% of the world’s population) spend at least 10% of their household budgets to pay for health care.<sup>15</sup>

9 Adam Wagstaff & Sven Neelsen, “A comprehensive assessment of universal health coverage in 111 countries: a retrospective observational study,” *The Lancet Global Health* 8: 1 (2020); e39–49.

10 M. Eugenia Socías, et al, “Universal Coverage without Universal Access: Institutional Barriers to Health Care among Women Sex Workers in Vancouver, Canada,” *PLoS ONE*, 11:5 (2016).

11 Danielle Martin et al, “Canada’s universal health-care system: achieving its potential,” *The Lancet*, 391:10131 (2018), 1718–1735.

12 “Questions and Answers on Universal Health Coverage,” WHO.

13 “Questions and Answers on Universal Health Coverage,” WHO.

14 Dr Tedros Adhanom Ghebreyesus, WHO Director-General, *Twitter*, 24 May 2019.

15 “Universal Health Coverage,” WHO, 24 January 2019.

Through the official ratification of the SDGs in 2015, all countries belonging to the UN committed themselves to UHC by 2030. SDG 3 relates to “Ensuring healthy lives and promoting wellbeing for all at all ages”. Target 3.8 under SDG3 commits 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>16</sup>*

In 2018, the World Health Assembly approved a target that by the year 2023, one billion more people should be benefitting from UHC.<sup>17</sup> In 2023, a high-level meeting will take place in New York to review progress toward this goal.<sup>18</sup>

## What is needed to achieve UHC?

In order to achieve UHC the WHO highlights the following elements that need to be in place:

- A strong, efficient, well-run health system
- Affordability
- Availability of essential medicines and technologies
- Well-trained, motivated health workers
- Actions to address the social determinants of health

UHC therefore presents an important opportunity for health care services to be truly inclusive and appropriate to sex worker needs and shaped in consultation with sex workers and other groups at the country-level. See the NSWP Briefing Note on UHC for more details on what UHC would entail<sup>19</sup>.

## The Political Declaration

In September 2019, the UN General Assembly agreed to an important political declaration on UHC, which describes the approach and values towards UHC at country-level. This includes important provisions on equity and non-discrimination:

*“Recognize that universal health coverage implies that all people have access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative, rehabilitative and palliative essential health services, and essential, safe, affordable, effective and quality medicines and vaccines, while ensuring that the use of these services does not*

*expose the users to financial hardship, with a special emphasis on the poor, vulnerable and marginalized segments of the population;” (s. 9)*

And

*“Ensure that no one is left behind, with an endeavour to reach the furthest behind first, founded on the dignity of the human person and reflecting the principles of equality and non-discrimination” (s. 70)*

***“...universal health coverage implies that all people have access, without discrimination, [...] with a special emphasis on the poor, vulnerable and marginalized segments of the population;”***

<sup>16</sup> “Sustainable Development Goals,” WHO.

<sup>17</sup> WHO, 2018, “Thirteenth general programme of work 2019–2023,” 7.

<sup>18</sup> United Nations, July 2019, “Political Declaration of the High-level Meeting on Universal Health Coverage,” Section 83.

<sup>19</sup> NSWP, 2019, “Briefing Note: Universal Health Coverage.”

However, the final Declaration had a mixed reception from advocates for key populations. While HIV advocates welcomed the references to HIV and its recognition that marginalised and vulnerable groups face various barriers to health care, including stigma and discrimination, the failure to specifically identify key populations by name received much criticism and concern.<sup>20</sup> The Declaration only defines “those who are vulnerable or in vulnerable situations” as “all children, youth, persons with disabilities, people living with HIV/AIDS, older persons, indigenous peoples, refugees and internally displaced persons and migrants” (s.70). Equally troublingly, the far-reaching impact of criminalisation on sex workers and other key populations, including on their access to health care, is not recognised. Other criticisms levelled at the Declaration include inadequate provision for community involvement in achieving UHC and failure to reaffirm health as a human right.<sup>21</sup>

## What are the big challenges in achieving UHC?

### Erasing key populations

Key Informants in the study warned how the lack of explicit mention of sex workers, the LGBT community and people who use drugs, as well as the silence about the importance of repealing criminal laws significantly weaken the Political Declaration and endangers the success of UHC and other health goals. Vague language such as “vulnerable” and “marginalised” groups renders key populations invisible from UHC and allows latitude for national governments, who can themselves determine what their UHC “care package” contain, to ignore their needs and fail to act.

**Vague language such as “vulnerable” and “marginalised” groups renders key populations invisible from UHC...**

Despite well-documented systematic hostilities faced by sex workers in public health systems, sex workers and other key populations are still regularly side-lined in consultations during national health strategy deliberations.<sup>22</sup> As a result, many sex workers rely on health care services provided by non-governmental organisations (NGOs) funded by foreign donors, particularly in the Global South, to meet their health needs. A number of Key Informants expressed fears that foreign donors might withdraw from such countries in expectation that UHC will require governments to address the health needs of all populations in their countries. This will likely have a devastating impact on key populations by “threatening the availability and quality of comprehensive health and HIV and AIDS services”.<sup>23</sup> Subsequently, not only is there a strong risk of continued marginalisation of key populations, but the important gains made thus far in providing health care for sex workers is jeopardised while the central role of community organisations is undermined.

20 Frontline AIDS, 2019, “Does the UN’s Universal Health Coverage declaration fail the most vulnerable people?”

21 “Key Populations are Left Behind in the 2019 Political Declaration on Universal Health Coverage,” Mpact.

22 INPUD, Mpact, NSWP, 2018, “Briefing Paper: The Impact of Stigma and Discrimination on Key Populations and Their Families.”

23 PITCH, Aidsfonds, Frontline AIDS, 2019, “Towards transformative integration of the HIV/AIDS response into Universal Health Coverage: experiences from Indonesia, Kenya, Uganda and Ukraine,” p.5.

## Financing UHC

One of the challenges to UHC will be persuading national governments to allocate significant levels of funding to meet the essential health needs of their populations for UHC. The Political Declaration did not include specific financial commitments by governments often contained in other declarations, despite the World Bank's estimation in June 2019 that: "By 2030, the gap in financing UHC in the 54 poorest countries will be about \$176 billion per year".<sup>24</sup>

To address this, principled political leadership and bold choices will be needed to raise finances and importantly address how funds

are distributed. This will have a significant impact on who UHC would reach and whether criminalised populations such as sex workers are taken into consideration while progress towards UHC is made.

To be effective, UHC strategies must be based on diverse, multi-sectoral systems for health which integrate and resource community responses as an essential component, rather than an "optional extra". This approach has demonstrated success in terms of HIV and other STI programmes with sex workers:

**...UHC strategies must be based on diverse, multi-sectoral systems for health which integrate and resource community responses as an essential component, rather than an "optional extra".**

*"From Kenya to Ukraine, Brazil to Thailand, India to the Dominican Republic, investment in community-led organizations of sex workers has resulted in improved reach, access, service quality, service uptake, condom use and engagement by sex workers in national policies and programmes."*

SEX WORKER IMPLEMENTATION TOOL<sup>25</sup>

## Health Systems versus Systems for Health

UHC requires wide-ranging, well-run and efficient systems for health, extending beyond state-based and state-run facilities. These include community-led and community-based systems for the delivery, management and monitoring of health education, prevention, support and treatment services.

Rico Gustav, Executive Director of the Global Network of People Living with HIV (GNP+), noted that:

*"We need to speak about systems for health and not just about health system strengthening. Merely strengthening existing health systems will not help sex workers and other criminalised populations who are stigmatised and often excluded from the benefits of such health systems. We need robust social and legal systems that supports rights and health, and at a fundamental level do not criminalise key populations."*

<sup>24</sup> World Bank, 2019, "High-Performance Health-Financing for Universal Health Coverage: Driving Sustainable, Inclusive Growth in the 21st Century".

<sup>25</sup> WHO, UNPF, UNAIDS, NSWP, World Bank & UNDP, 2013, "Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions."

## Lack of recognition of the importance of human rights and the legal determinants of health

While the Political Declaration recognises that health “significantly contributes to the promotion and protection of human rights and dignity”(s. 8), it is silent on a rights-based approach to health and the intersection between criminalisation of key populations and poor health outcomes. It mentions the “social, economic and environmental and other determinants of health”, but overlooks the importance of structural barriers and the legal determinants of health. The links between global health and the legal determinants of health are vital.<sup>26</sup>

## Losing focus of HIV

The 2020 World AIDS report warned that all global HIV targets for that year would be missed and that the ultimate aim of ending AIDS by 2030 had been off-track, even before the outbreak of the COVID pandemic. At the same time, the funding gap for HIV responses has been growing. The report underscored the importance of key populations, pointing out that 62% of all new adult HIV infections are among key populations and their sexual partners in 2019.

**...UNAIDS stressed again the importance of law reform, specifically the decriminalisation of sex work as a “key component for securing rights, health and safety at work for sex workers...”**

In this report, UNAIDS stressed again the importance of law reform, specifically the decriminalisation of sex work as a “key component for securing rights, health and safety at work for sex workers...” as well as significantly reducing the risk of HIV infection “by 33–46% over 10 years”.<sup>27</sup>

Historically, some of the global successes of HIV are attributable to disease-specific funding and programmes. UNAIDS warned that the integration of HIV services into

UHC – particularly the integration of donor funds and funding by governments – should not erode earlier gains, and warned that:

***“...expansion of health coverage needs to be accompanied by intensified community outreach, advocacy and law and policy reform to ensure that key populations have meaningful access to good-quality, culturally appropriate, non-discriminatory services under UHC.”<sup>28</sup>***

Similarly, a multi-country study on the integration of HIV into UHC points out that risks include poor-quality health services (including HIV services), the exclusion of groups who cannot access health insurance and a loss of focus on human rights and engagement with civil society.<sup>29</sup>

26 Lawrence O Gostin et al., “The legal determinants of health: harnessing the power of law for global health and sustainable development,” *The Lancet* 393:10 (2019).

27 UNAIDS, 2020, “Global AIDS Update 2020: Seizing the Moment – Tackling entrenched inequalities to end epidemics,” p.29.

28 UNAIDS, 2019, “Delivering on SDG3: Strengthening and integrating comprehensive HIV responses into sustainable health systems for Universal Health Coverage,” UNAIDS/PCB (44)/19.21, p.15.

29 PITCH, Aidsfonds, Frontline AIDS, 2019, “Towards transformative integration of the HIV/AIDS response into Universal Health Coverage: experiences from Indonesia, Kenya, Uganda and Ukraine.”

## Sex worker experiences with UHC

### Lack of consultation and engagement with sex workers during the development and implementation of UHC

*“During surveys identifying the needs of the Congolese populations in terms of UHC in general and vulnerable populations in particular, sex workers and other key populations were neither consulted nor contracted. This is why their UHC needs have not been taken into account in the process of developing and implementing UHC.”*

SEX WORKER, DRC

The experiences shared in the consultations reiterated the challenges that sex workers face, both when accessing health care and attempting to engage on their health care needs. The side-lining of the voices of

**The side-lining of the voices of sex workers and sex worker-led organisations during the development, planning and implementation of UHC is evident...**

sex workers and sex worker-led organisations during the development, planning and implementation of UHC is evident in the rolling out of health care systems that, while aspiring to offer affordable and equitable care, continue to stigmatise and discriminate against sex workers and other key populations. Drawing on their experience of systematic exclusion and marginalisation, some respondents relayed their disillusionment with consultation processes:

*“who is going to ask us, we are nothing more than ‘prostitutes’.”*

SEX WORKER, RUSSIA

In Zambia, ZASWA highlighted the extent to which they were side-lined in the development of the National Health Insurance plan (NHIMA) and how decisions were made on their behalf by those in positions of power, “considered as experts on sex workers issues”:

*“As an organisation, we were not consulted until the point where NHIMA was marketing its insurance products. At which point it was pointless. Besides, we were not even directly invited...that’s not engagement and it was too late to think about us.”*

ZAMBIAN SEX WORKERS ALLIANCE (ZASWA), ZAMBIA

This view was echoed by the majority of the other sex worker-led organisations, who indicated that opportunities to engage were, in fact, indirect (through other civil society organisations) or tokenistic (used by larger organisations and governments to secure funding). Tokenistic inclusion as “superficial engagement” is also highlighted in the NSWP Briefing Paper on this subject.<sup>30</sup>

30 NSWP, 2020, “Briefing Paper: Shrinking Spaces and Silencing Voices.”

## HIV as only entry point for sex worker engagement

Opportunities for sex workers to provide input during UHC planning stages were also largely restricted to HIV and Sexual and Reproductive Health and Rights (SRHR) issues, as a sex worker in Guyana noted:

*“The members of GSWC and GTU that participated in the interview indicated that to their knowledge their only inclusion in health-related issues is that of HIV and AIDS”.*

In Mexico, Colectivo Seres AC noted that states such as Michoacan, Chihuahua and Mexico City “...have only participated in forums and activities promoted by local/municipal governments regarding STI prevention...”. In the Republic of North Macedonia, the sex worker-led organisation STAR-STAR described how their involvement in a state-funded HIV-prevention programme (Platform for Sustainability of HIV prevention programmes), meant they were able to strategically find spaces and build alliances to push forward their health needs.

Yet, in reality, sex workers experience a diverse and complex range of health concerns and needs, extending far beyond STIs:

**...sex workers experience a diverse and complex range of health concerns and needs, extending far beyond STIs.**

*“Coming out of the discussions, it was learnt that sex workers are concerned about their overall health and not just HIV.”*

SEX WORKER, GUYANA

In Mexico where UHC (known as “Seguro Popular” or “INSABA”) has made important progress, sex workers demonstrated these broad needs through demanding health services ranging from:

*“...gynaecological and urological services, medical appointments for chronic and degenerative ailments” to “conditions orthopaedic (due to long periods of time sex workers are on their feet)” and, “psychological and medical health services.”*

SEX WORKER, MEXICO.

The neglect of these issues, however, points back to the lack of consultation and engagement with sex workers at the development stage of UHC. It also illuminates the weaknesses in the implementation of UHC at all stages; the failure to inform sex workers about UHC and to provide adequate health care that is responsive to what they say they need is indicative of continued challenges.

## Sex workers remain largely unaware and uninformed of UHC in their countries

*“When asked if they were aware of the government’s efforts to inform the sex worker population about the implementation of universal health coverage in their area, they [sex workers] all replied that they had NOT seen anything like this. Some shared that they had seen a few street signs or advertisements in traditional media, such as television, talking about what Seguro Popular is, but they DO NOT have a deep understanding of its role, requirements or procedures.”*

SEX WORKER, MEXICO

As a result of being largely excluded from health or UHC engagements and the subsequent inadequate provision of services, sex workers indicated that they had little or no awareness of UHC, both on a conceptual level and in terms of implementation. Even in countries where UHC is being actively implemented, such as Mexico, only a few sex workers knew about it – and still then had no idea that it was currently being rolled out. Likewise, in Russia, half of the respondents claimed to have very limited awareness of UHC while the other half refused to answer the question, one sex worker claiming, “this study will not be able to change anything”. While this statement attests to specific powerlessness and anger expressed by sex workers in Russia, it also reflects the broader picture of sex worker exclusion and disillusionment.

## Supportive of UHC but sceptical of practical implementation

Many sex workers agreed with the concept of UHC yet struggled to envisage how, in reality, it could provide better access to health care without further stigmatising them. In Zambia a sex worker explained, “I go to the clinic for help but keep out my [sex ]work...that way I am not judged”.

In Russia, sex workers explained that although they would like to have “special services for sex workers”, these should not be provided separately due to the risk of stigmatisation and a risk of breaching confidentiality. They also argue that “[D]octors should provide equal services – for free or for a small fee – to all citizens. Doctors should

respect ethical norms and treat all patients with respect irrespective of the occupational status”. This statement ironically reiterates what UHC stands for, while simultaneously highlighting the current failure to actually deliver accessible health care for sex workers.

In Mexico, sex workers explained that although they support UHC in principle, they felt they would not benefit for the following reasons: a lack of awareness amongst sex workers as to whether UHC has been implemented in their states; a mistrust of medical services, and a preference for private health care where they knew they could get treated:

*“[I]n the province where the Seres Collective operates, no strategies have been implemented for people who do sex work to know the programme.”*

COLECTIVO SERES, AC, MEXICO

**Many sex workers agreed with the concept of UHC yet struggled to envisage how, in reality, it could provide better access to health care without further stigmatising them.**

These reasons are also supported by the findings from other countries, where stories of mistreatment, a mistrust of health care workers and being forced to make strategic choices to circumvent the public health system run alongside claims of being unaware or not informed about UHC.

## Continued reliance on the Private sector and NGOs

The majority of sex workers reported accessing private health care as a strategy to avoid the public health care system in general and as a consequence of challenges faced when trying to access the health care to which they are entitled:

*“[T]he sex worker population also prefers to purchase their sexual and reproductive health supplies (condoms, lubricants, etc) or to obtain them through the civil society organisations...A large number of those interviewed do not trust the private sector due to shortage of medicines and supplied, and the series of requirements in person...”*

COLECTIVO SERES, AC, MEXICO.

However, many sex workers are not able to access private health services due to their low economic status:

*“if you need access to quality health care services that usually is stigma free, you must have the economic power to be able to afford it at a private medical facility. This is not the case with many sex workers.”*

SEX WORKER, GUYANA

These continued challenges therefore make it difficult for sex workers to envisage how UHC would actually lead to better access and care, especially since they have had little say at the planning and implementation stages.

## The introduction of UHC has not improved access to health care for sex workers

Sex workers were clear that criminalisation directly impacts their health care access regardless of whether UHC has been implemented or not.

In countries where sex work is criminalised, sex workers reported having far less opportunity to engage in discussions about UHC, thus continue to face challenges of access and feel little hope that this can change for the better.

In Mexico City, a sex worker stated that the failure to approve the “non-salaried work and sex work recognition law” has meant that “medical care for sex workers continues to be deficient.”

**Sex workers were clear that criminalisation directly impacts their health care access regardless of whether UHC has been implemented or not.**

Meanwhile, in countries where health care is chronically under-funded, under-resourced and affected by shortages of medical professionals, equipment and medicines, the introduction of UHC is unable to positively impact the general population, let alone marginalised and criminalised populations such as sex workers:

*“The lack of financial resources continues to seriously hamper the implementation of the public health policies. More than one third of all health services are paid out of pocket, indicating the quality of health care, and creating social discrepancies.”*

SEX WORKER, REPUBLIC OF NORTH MACEDONIA

In Zambia and Zimbabwe, where health care is not adequately funded, and where rural areas are particularly underserved, sex workers describe how they have no access unless they can find the money to cover health care privately:

*“Many people still purchase medicines and health services because the government funded health centres run out of essential drugs or are not fully stocked to cater for all kinds of ailments.”*

SEX WORKER, ZAMBIA.

In the DRC as well as in Mexico, respondents identified the role of the Catholic church as central to the implementation of health care and therefore in blocking criminalised groups such as sex workers from receiving support:

*“Given the dilapidated state of our health structures, the churches and individuals have taken over these structures, for this reason the structures controlled by the churches and private are excluded from public funding. Unfortunately, at the present stage no state structure is likely to function without the influence of the churches especially Catholic.”*

HOMME POUR LES DROITS ET LA SANTÉ SEXUELLE (HODSAS), DRC

## Compounded access challenges

Sex workers also reported that technical issues with the implementation of UHC impacted them negatively. In Germany, the introduction of health insurance as a key mechanism of UHC has created new barriers to access. The health insurance is mandatory, requires people to register proactively, and people can be forced to make payments retrospectively for periods during which they had no insurance cover. This discourages those who have not had health insurance for some time from re-joining the system. The system includes the self-employed, which incorporates

most sex workers. Migrant sex workers who have recently arrived in Germany and do not understand health insurance requirements face particular barriers to inclusion.

In the Republic of North Macedonia, due to criminalisation, sex workers also fall under a category of people who do not have health insurance. Even where sex workers have health

insurance, existing stigma and discrimination serve as a barrier to access. Instead, they rely on the support of STAR-STAR and Community Service Organisations (CSOs) to provide health care.

**Even where sex workers have health insurance, existing stigma and discrimination serve as a barrier to access.**

In Mexico, a lack of clear operational rules in the transition from Popular Insurance to the new national health system (INSABI) has meant that certain diseases and conditions are left without cover. This has:

*“disproportionately affecting high priority groups; the elderly, people with disabilities, women and LGBTI people. Within these groups, sex workers are most at risk, not only because of the current [COVID] pandemic, but also because of the lack of free, quality health care for sex workers in most parts of the country.”*

SEX WORKER, MEXICO.

Migrant sex workers generally face additional barriers to accessing health care, often because they lack the correct documents proving their residency status or right to work in a country, and the implementation of UHC could exacerbate this. For example, a sex worker in Mexico noted that “...there are still no clear operating rules at the national level that consider the migrant population within the new INSABI health scheme for their comprehensive medical care”.

### **Ensuring sex workers are not left behind: what more can sex workers do?**

Sex workers recognised the opportunities and benefits that UHC could bring if developed and implemented in accordance with their needs

and based on their meaningful involvement. However, the fact that sex workers are still saying that they are not listened to and face continuing stigmatisation and violence within the health care system begs the question of *when* and *how* will their voices count?

**...sex workers are still saying that they are not listened to and face continuing stigmatisation and violence within the health care system...**

*“How can I, a sex worker, influence health care in Russia? Even regular people have no such possibilities. If there are any surveys, I can participate and say that I would like to have a*

*gynaecologist who knows about my work and is not judging me. I would also like to be able to get tested for HIV and STIs any time for free or for a small fee.”*

SEX WORKER, RUSSIA

Conversely, there were several examples of sex worker-led organisations that have engaged and pushed for better representation and were able to raise their voices about specific concerns of sex workers. For example, in Nepal:

*“grassroot activists together with their allies and partners are constantly and diplomatically seeing audience with influential state and non-state actors to ensure their voices are heard and interventions respond to their health and other human rights challenges, particularly their right to health.”*

SEX WORKER, NEPAL

**Sex workers clearly report a largely negative experience with UHC thus far and highlight the failure of UHC to provide health care that is equitable, accessible or universal in practice.**

In Mexico as part of the State Human Rights Network of the Guanajuato State Attorney's Office, the sex worker-led organisations were able to address the needs of sex workers and the LGBT population. This included training the Education Staff on "Inclusive Health Services for Sex Workers, free of stigma and discrimination":

*"[W]ith this small participations, we have been able to work on the construction of actions, programs and services in favour of sex workers in the state of Guanajuato, we have been able to advance the issue of the Right to Health and Human Rights, however we must still make more use of these spaces so that the VOICE of people is heard by themselves."*

COLECTIVO SERES, AC, MEXICO.

The last sentence of this quote emphasises the fact that despite these examples of how sex worker-led organisations navigate exclusion and proactively negotiate their way into engagements, they continue to be left behind. Sex workers clearly report a largely negative experience with

UHC thus far and highlight the failure of UHC to provide health care that is equitable, accessible or universal in practice.

## Going forward on UHC and sex work

In 2018, a civil society meeting on HIV, hepatitis, TB, STIs and UHC incisively noted that:

*"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."*<sup>31</sup>

This vital emphasis on human rights and health equity was also underscored by the call by GNP+, "Putting the Last Mile First". It stated that:

*"The logic, and moral obligation, is clear. If Universal Health Coverage works for the poorest and most marginalised – including people living with HIV and other key and vulnerable communities (who are directly and disproportionately affected by disease and poor health) – it will work for everyone."*<sup>32</sup>

One of the biggest challenges to the success of UHC is to ensure that governments "reach the furthest behind first", and that key populations, including sex workers, are not left behind because of criminalisation, stigma and discrimination. It is now up to individual national governments to determine their "care packages" under UHC, and to implement these in line with UHC commitments before 2030.

<sup>31</sup> WHO, 2018, "HIV, hepatitis, TB, STIs and UHC Promote health, keep the world safe, serve the vulnerable Civil society meeting | 22-23 March 2018," p.3.

<sup>32</sup> GNP+, 2019, "Putting the Last Mile First: Position Statement on Universal Health Coverage."

## Recommendations: Ensuring sex workers are not left behind in UHC

*“The [WHO] Secretariat’s efforts are focused on helping Member States to implement universal health coverage in ways that best suit the needs of their populations, especially those left furthest behind. Equity, gender- and rights-based programming is needed to reach those with least access to effective health interventions and hardest hit by financial hardship.”*

WHO BOARD<sup>33</sup>

UHC will not be achieved unless the legal, political and social determinants of health are addressed, and health equity is achieved.

**It is vital that UHC takes a human rights-based approach, that it ensures equitable access to health services for all and proactively includes the voices and needs of those who have been traditionally underserved.**

The right to health has been recognised as a basic human right, articulated in many international declarations and covenants. It is vital that UHC takes a human rights-based approach, that it ensures equitable access to health services for all and proactively includes the voices and needs of those who have been traditionally underserved.

To this end, sex workers and other key populations urgently need their allies and partners in the UN system, in government and in broader civil society, to speak-up, loudly and clearly and to support the call as articulated in the Political Declaration to “to reach the furthest

behind first” in national-level UHC negotiations and implementation.

To achieve this goal, the following recommendations are made:

### **To international human rights and health bodies and to national governments**

The following demands should be included in all UHC international and national-level documents and frameworks by no later than the 2023 High-level meeting on UHC:

- A public and unambiguous commitment to the decriminalisation of sex work and other key populations, as well as the decriminalisation of HIV transmission, exposure and non-disclosure
- A clear re-affirmation that the legal and structural barriers to health, including punitive laws, policies and practices, violence, stigma and discrimination must be addressed in a rights-based approach, or UHC will not be achieved
- A commitment to invest in sex worker and other key population-led health services, including technical and financial support and capacity-building
- The inclusion of key HIV and SRHR in the UHC benefit package, including prevention services and community-led services, with effective targeting of HIV services by and for key populations and people living with HIV
- A commitment that sex workers and other key populations will be meaningfully involved in the planning of national health responses, in the discussions where UHC “care packages” are decided, and in the monitoring of the UHC response to ensure governments are held to account.

<sup>33</sup> WHO, 2019, “Universal health coverage: moving together to build a healthier world – Report by the Director-General,” EB146/6, 146th session of WHO Executive Board.

## To sex worker-led organisations

- Learn about UHC and advocate for the inclusion of sex workers. Like many HIV activists and people living with HIV/AIDS who became treatment literate and experts on the transmission, prevention and treatment of HIV in order to demand their health rights, sex workers' rights activists have to become proficient in terminology, processes, indicators, financing and modelling in order to challenge any injustices within UHC
- Become involved in national planning processes on UHC in your country. Find out how your department of health and other government structures are engaging on UHC, and what opportunities exist for civil society consultation and engagement. Ensure that sex workers are meaningfully involved and represented in these forums
- Join forces with other civil society groups locally and internationally that advocate for health equity and a human rights-based approach to UHC and ensure that sex workers' voices and demands are included in such processes
  - One such example is Civil Society Engagement Mechanism (CSEM) of UHC 2030. Its stated aims include the building of "a broad and inclusive UHC movement, which can influence policy design and implementation and facilitate citizen-led accountability [while] ensuring systematic attention is paid to the needs of the most marginalised and vulnerable populations so that 'no one is left behind'"<sup>34</sup> CSEM, and UHC2030 should actively facilitate the inclusion of robust sex worker participation and leadership in these mechanisms
- Strategically utilise advocacy opportunities like the annual International Universal Health Coverage Day (12 December) to call for greater sex worker participation in UHC planning and decision-making forums.

## Conclusion

*"We believe that the implementation of UHC in the DRC could have positive effects on this obstacle IF and only IF the specific needs of sex workers and other key populations were taken into account in the various sectoral policies and by the health system."*

SEX WORKER, DRC

Sex workers are clear that they believe in the potential benefits of UHC, provided they are explicitly and meaningfully included in discussions and planning at all levels, and in the implementation of UHC. An important opportunity exists now to not only push national governments to involve sex workers in their development of UHC "care packages", but also to proactively reform the criminal law to ensure that health care services for all will be a reality by 2030. Indeed, we will only be able to reach the SDGs if we put "the last mile first".

**...we will only be able to reach the SDGs if we put "the last mile first".**

<sup>34</sup> "Civil Society Engagement," UHC2030.

The Global Network of Sex Work Projects uses a methodology that ensures the grassroots voices of sex workers and sex worker-led organisations are heard. The Briefing Papers document issues faced by sex workers at local, national, and regional levels while identifying global trends.

The term 'sex workers' reflects the immense diversity within the sex worker community including but not limited to: female, male and transgender sex workers; lesbian, gay and bi-sexual sex workers; male sex workers who identify as heterosexual; sex workers living with HIV and other diseases; sex workers who use drugs; young adult sex workers (between the ages of 18 and 29 years old); documented and undocumented migrant sex workers, as well as and displaced persons and refugees; sex workers living in both urban and rural areas; disabled sex workers; and sex workers who have been detained or incarcerated.



The Matrix, 62 Newhaven Road  
Edinburgh, Scotland, UK, EH6 5QB  
+44 131 553 2555  
secretariat@nswp.org  
[www.nswp.org](http://www.nswp.org)

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