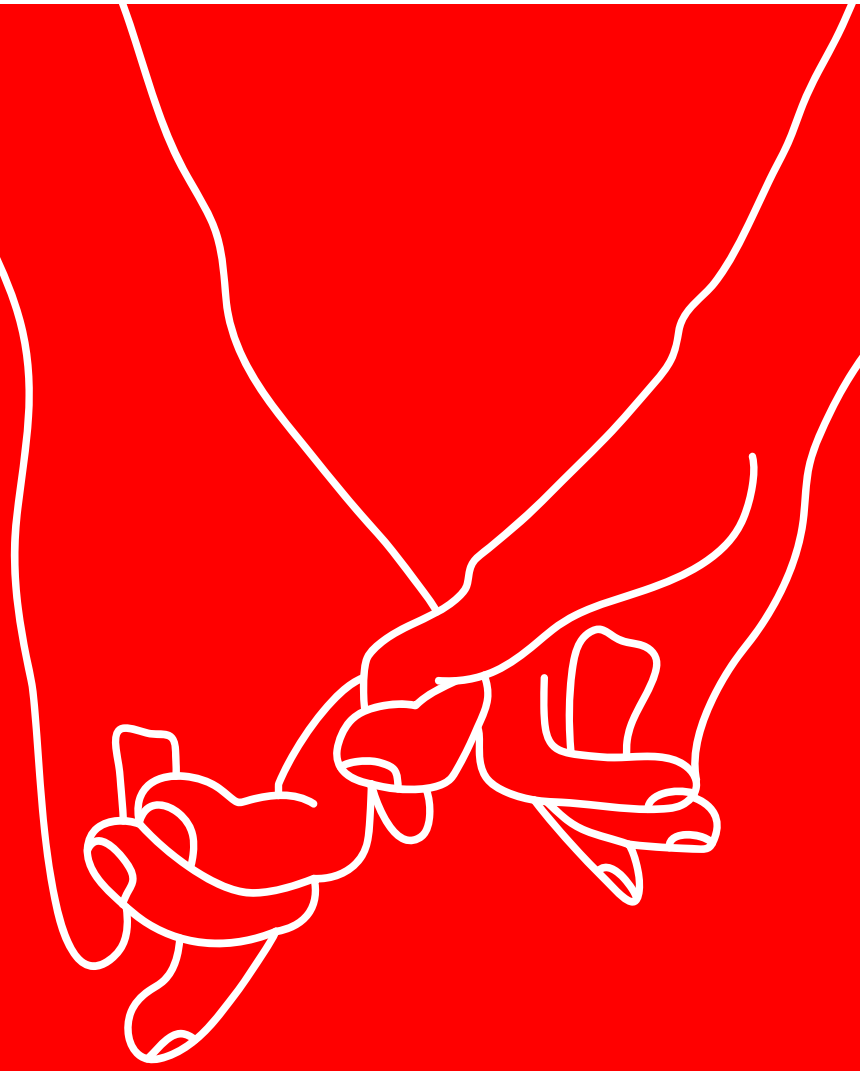
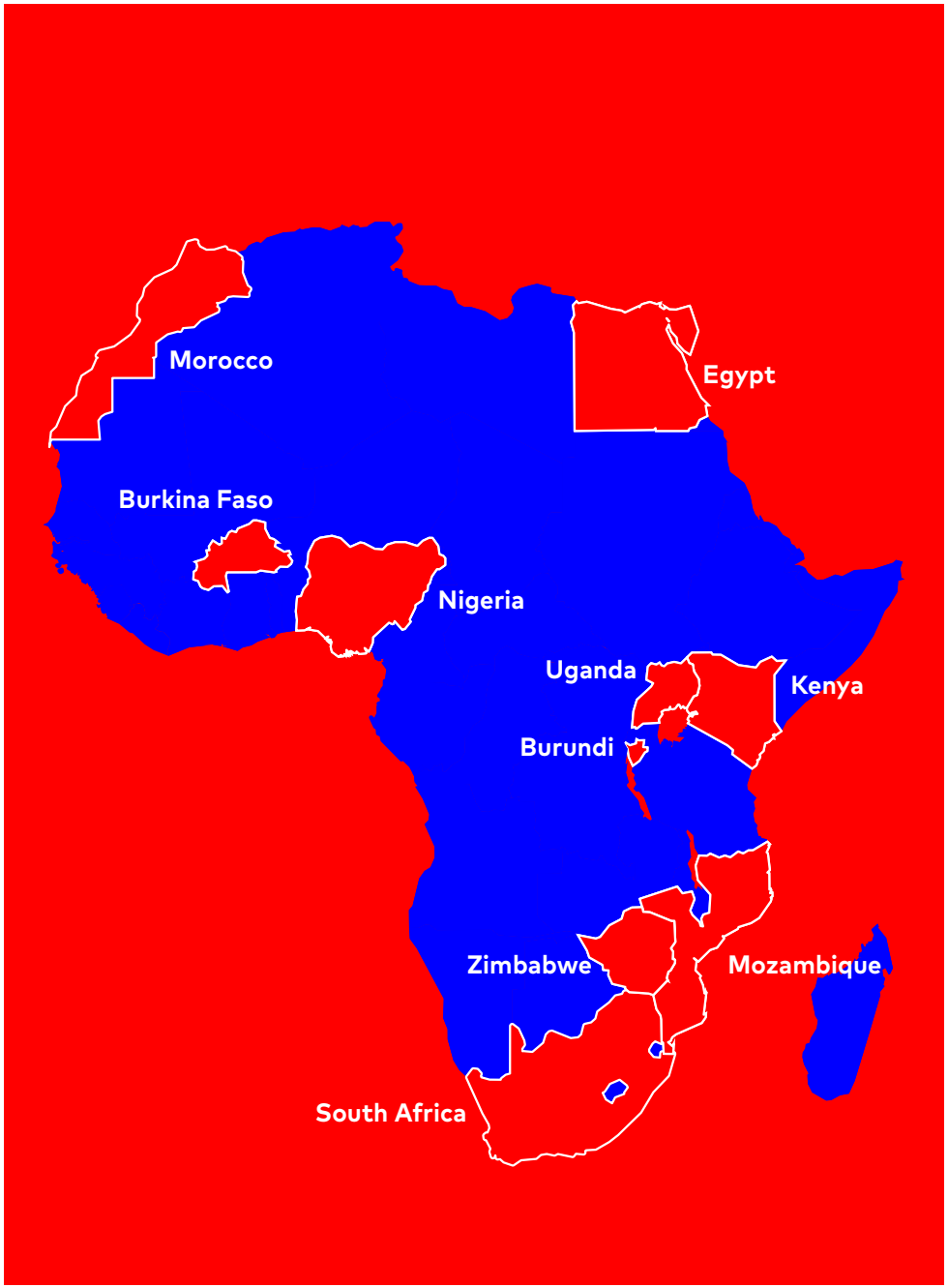
The State of Universal Health Coverage Implementation in Africa



Multi-country case study: Burkina Faso, Burundi, Egypt, Kenya, Morocco, Mozambique, Nigeria, South Africa, Uganda and Zimbabwe

WACI HEALTH

Love Alliance
Together for health and human rights



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List of Acronyms

ALM	Africa Leadership Meeting
ART	Antiretroviral therapy
ARV	Antiretrovirals
AU	African Union
AUC	African Union Commission
CSO	Civil society organisation
GAP	Global Action Plan for Health Lives and Well-being for All
GDP	Gross domestic product
GNP+	Global Network of People Living with HIV
HLTF	WHO High Level Task Force on Innovative International Financing for Health Systems
KVP	Key and vulnerable populations
LGBTQI+	Lesbian, gay, bisexual, transgender, queer and intersex
MoH	Ministry of Health
MoHP	Ministry of Health and Population
NGO	Non-governmental organisation
NHI	National health insurance
PEPFAR	President's Emergency Plan for AIDS Relief People living with HIV
PHC	Primary health care
PrEP	Pre-exposure prophylaxis
SRHR	Sexual and reproductive health and rights
TB	Tuberculosis
UHC	Universal health coverage
UHI	Universal health insurance
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization

Photo: Cynthia R Matonhodze

1. Background

Health is a fundamental human right that governments have the duty to fulfil for all. Yet the poorest, the most vulnerable and the marginalised currently lack access to adequate health care. Government and civil society have a critical role to play to ensure that health programmes pay systematic attention to such population groups and communities, ensuring that they have the necessary access to equitable health services of good quality, without facing financial hardship; are informed of health policies; and can give input into efforts to strengthen their country's health systems so that no one is excluded.

Universal health coverage (UHC) means that everyone receives quality health services, when and where they need them, without incurring financial hardship. UHC is a political choice. At the United Nations General Assembly in September 2019, just a few months before the emergence of the COVID-19 pandemic, UN Member States made that choice by endorsing the Political Declaration on UHC.[1] The pandemic illustrated why this commitment is so important, and why, as the world responds to and recovers from COVID-19, we must pursue UHC with more determination, innovation and collaboration.

Most African countries have integrated UHC as a goal in their national health strategies. Yet progress in translating these commitments into expanded domestic resources for health, more effective development assistance and, ultimately, equitable and quality health services and increased financial protection, has been slow. Without much international financial support, governments are turning towards national health insurance (NHI) schemes to finance UHC, making access to health care dependent on regular financial contributions. The provision of UHC for key populations[2] has mainly been taken up by civil society organizations (CSOs) and private healthcare providers.

UHC covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care across the life course.[3] Yet essential health services remain unavailable to at least half of the world's population. More than 800 million people bear the burden of catastrophic spending on health care, accounting for at least 10% of their household income, and out-of-pocket expenses drive almost 100 million people into poverty each year.In Africa, only 48% of people receive the health care they need.[4] This is further exacerbated by the socioeconomic impact of HIV/AIDS, as approximately 39 million people are currently living with HIV, and tens of millions have died of AIDS-related causes since the beginning of the epidemic. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS),[5] in sub-Saharan Africa in 2023, 25.8 million people were living with HIV, 660,000 became newly infected with HIV and 380,000 died from AIDS-related illnesses. The percentage of people living with HIV who were on antiretroviral therapy (ART) was 83% in Eastern and Southern Africa, and 78% in Western and Central Africa. Globally, median HIV prevalence among the adult population (ages 15-49) was 0.7%. However median prevalence was significantly higher among key populations:

2.5% among sex workers
7.7% among gay men and other men who have sex with men
5.0% among people who inject drugs
10.3% among transgender persons, and
1.4% among people in prisons.

The Love Alliance partnership[6] is based on an unwavering commitment to protecting, promoting and fulfilling sexual and reproductive health and rights (SRHR) globally, unifying people who use drugs, sex workers and LGBTQI+ movements, and amplifying the diversity of voices in these communities. Funded by the Dutch Ministry of Foreign Affairs, Love Alliance brings together national thought leaders GALZ (an association of LGBTI people in Zimbabwe), SANPUD (South African Network of People who Use Drugs) and Sisonke (a sex-worker-led organisation), regional grant-makers UHAI, ARASA (AIDS Rights Alliance for Southern Africa) and ISDAO (Initiative Sankofa d'Afrique de l'Ouest), with the Global Network of People Living with HIV (GNP+) and the Netherlands-based administrative lead, Aidsfonds.

This five-year programme aims to achieve a significant reduction in HIV incidence by influencing policies, organising communities and raising awareness on rights and health in Burkina Faso, Burundi, Egypt, Kenya, Morocco, Mozambique, Nigeria, South Africa, Uganda and Zimbabwe. The Love Alliance occupies a critical space in promoting SRHR by unifying marginalised populations in a strong pan-African activist movement, led by young people, and bringing local voices to a global audience to influence decisions that affect their rights, health and lives. With a specific focus on people who use drugs, sex workers, LGBTQI+ people and people living with HIV, it aims to achieve the following goals:

- Capable, inclusive, influential and mutually supportive key population movements in unrestricted civic space.
- An end to sexual and gender-based violence, stigma and discrimination against key populations.
- Equal access to inclusive, people-centred, accountable and integrated HIV services and comprehensive sexual and reproductive health services.

The Love Alliance global advocacy leads, Aidsfonds and GNP+, have a long-standing partnership with WACI Health and commissioned WACI Health to develop this report on the state of UHC implementation in Africa, focusing on the 10 Love Alliance countries.

The study utilised desk review to examine the status of UHC and assess the extent of access provided to key and vulnerable populations (KVP), and to understand levels of participation by CSOs in the implementation of UHC. Additionally, Love Alliance partners and CSOs were interviewed as key informants to collect communities' experience, opinions and recommendations on UHC.

This report highlights the background, status and financing of UHC, HIV/AIDS strategy within UHC, access to UHC services for KVP, and engagement mechanisms for CSOs and communities in the design, implementation and monitoring of UHC in Africa and in the 10 countries where the Love Alliance is present. Sources for the information provided are listed in the table at the end of the report.

2. African Union Policy Frameworks and Initiatives on Universal Health Coverage

In 2001, the African Union (AU) committed, through the Abuja Declaration, to allocate at least 15% of national budgets to health care as one of the pathways to achieve UHC.[7] However, only South Africa has achieved this commitment so far. Although a few other countries managed to allocate 15% of their national budget to health, they have not maintained the commitment.[8]

In 2015, the Global Financing Facility was established by the World Bank Group and partners as a multi-stakeholder initiative to help countries improve maternal, child and adolescent health services. In addition, during the UN High-Level Meeting on UHC in 2019, member states unanimously adopted a Political Declaration affirming political commitment to UHC and outlining a number of actions. These included increasing funding for UHC and formulating and strengthening policies for equitable and integrated UHC for all, including vulnerable groups. Furthermore, the Global Action Plan for Healthy Lives and Well-being for All (GAP) was launched in January 2020. Its aim is to support countries in delivering Sustainable Development Goal 3 on health and well-being for all. GAP involved agencies committing to align their work to provide more streamlined support to countries and reduce inefficiencies. Moreover, the second UHC Forum, held in Bangkok in 2022, pledged to enhance political momentum on UHC in international forums, particularly concerning approaches to mobilising and pooling funds to pay for primary health care (PHC).

Health funding poses a significant challenge to UHC, as many countries rely on external sources of funding. This raises concerns about the sustainability of health systems, as external funding may not be reliable to support UHC. According to the Africa Scorecard on Domestic Financing for Health 2023 (presenting data from 2020), only South Africa has achieved the Abuja Declaration target of 15% of the national budget spent on health. Only three countries (Lesotho, South Africa and Seychelles) have achieved the benchmark of 5% of gross domestic product (GDP) spent on health, as recommended by the Centre on Global Health Security at Chatham House;[9] and 10 countries (Algeria, Botswana, Cabo Verde, Eswatini, Gabon, Mauritius, Namibia, South Africa, Seychelles and Tunisia) are spending more than US$86.30 per capita annually on health, the figure based on the recommendations of the World Health Organization (WHO) High Level Task Force on Innovative

International Financing for Health Systems (HLTF).[10] Consequently, citizens are burdened with high out-of-pocket fees to cover their healthcare needs. The Global Fund and the United States President's Emergency Plan for AIDS Relief (PEPFAR) are the main external funders for health in most African countries.

During the 32nd Ordinary Session of the Assembly of Heads of State and Government in 2019, AU Member States adopted two declarations in support of the recommendations of the Africa Leadership Meeting (ALM) and tasked the African Union Commission (AUC) with coordinating partners and overseeing implementation:

- **Assembly/AU/Decl.1 (XXXII):** Declaration on the progress report of AIDS Watch Africa (AWA): Outcome of the Leadership in Health-financing Funds High-Level Meeting

- **Assembly/AU/Decl.4 (XXXII):** Declaration on the Africa Leadership Meeting – Investing in Health: "Addis Ababa Commitments towards Shared Responsibility and Global Solidarity for Increased Health Financing"

Both declarations reaffirmed the AU's commitment to increase domestic resources for health and agreed that investment in health drives human-capital development, which is the basis upon which Africa's sustainable economic growth will be built. The ALM's commitments can be divided into four pillars:

Pillar 1: Generate or mobilise new domestic resources for health.

Pillar 2: Free up more resources by improving the efficiency and effectiveness of spending.

Pillar 3: Advocate for increased domestic investment in health and champion improved efficiency and greater effectiveness of health spending.

Pillar 4: Improve measurement and enhance accountability.

The more detailed commitments of the ALM are:

- **Increase domestic investment in health** and review country performance annually – at the level of the Heads of State – against the benchmarks of the Africa Scorecard on Domestic Financing for Health.

- **Digitise the Africa Scorecard on Domestic Financing for Health** so that the data used to review performance is more widely disseminated.

- **Complement the Scorecard with a domestic Health Financing Tracker** that will track more granular "enablers" of progress towards the desired Scorecard outcomes.

- **Establish Regional Health Financing Hubs in each of Africa's five regions,** to drive country implementation of the AU Assembly resolutions and coordinate the alignment of development partner efforts with Africa's priorities.

- **Convene African Ministers of Finance and Health every two years** to discuss health financing and review progress against benchmarks.

- **Improve public financial management capacity** to help improve tax collection and/or increase the proportion of tax revenue collected as a percentage of GDP, through equitable and efficient general taxation and improved revenue collection, and strengthen the capacities of Ministries of Finance and tax revenue authorities to achieve this.

- **Enhance national health-financing systems**, including by exploring options to reduce fragmentation, explore NHI (where appropriate), strengthen capacity to purchase services effectively and increase efforts to improve prevention, cost-effectiveness and allocative efficiency.

- **Reorient health spending and health systems** to target the diseases and conditions across the lifecycle that have the greatest impact on mortality and human-capital development, with the mix of interventions that will deliver the greatest impact in combatting them.

- **Increase coherence** through improved alignment of multilateral, bilateral and private-sector efforts with the continent's priorities.

- **Attract further private capital into the health sector** by creating conducive investment climates, and increase Member State stewardship of private-sector support so that such efforts strengthen public health systems and expand access to health services.

- Continue **advocacy for health financing in Africa,** prioritising investments made for health and increasing efficiency in allocation and utilisation of the resources pooled for health. Investment in health as a driver of human capital, not a cost.

Progress in implementing the ALM Declaration:

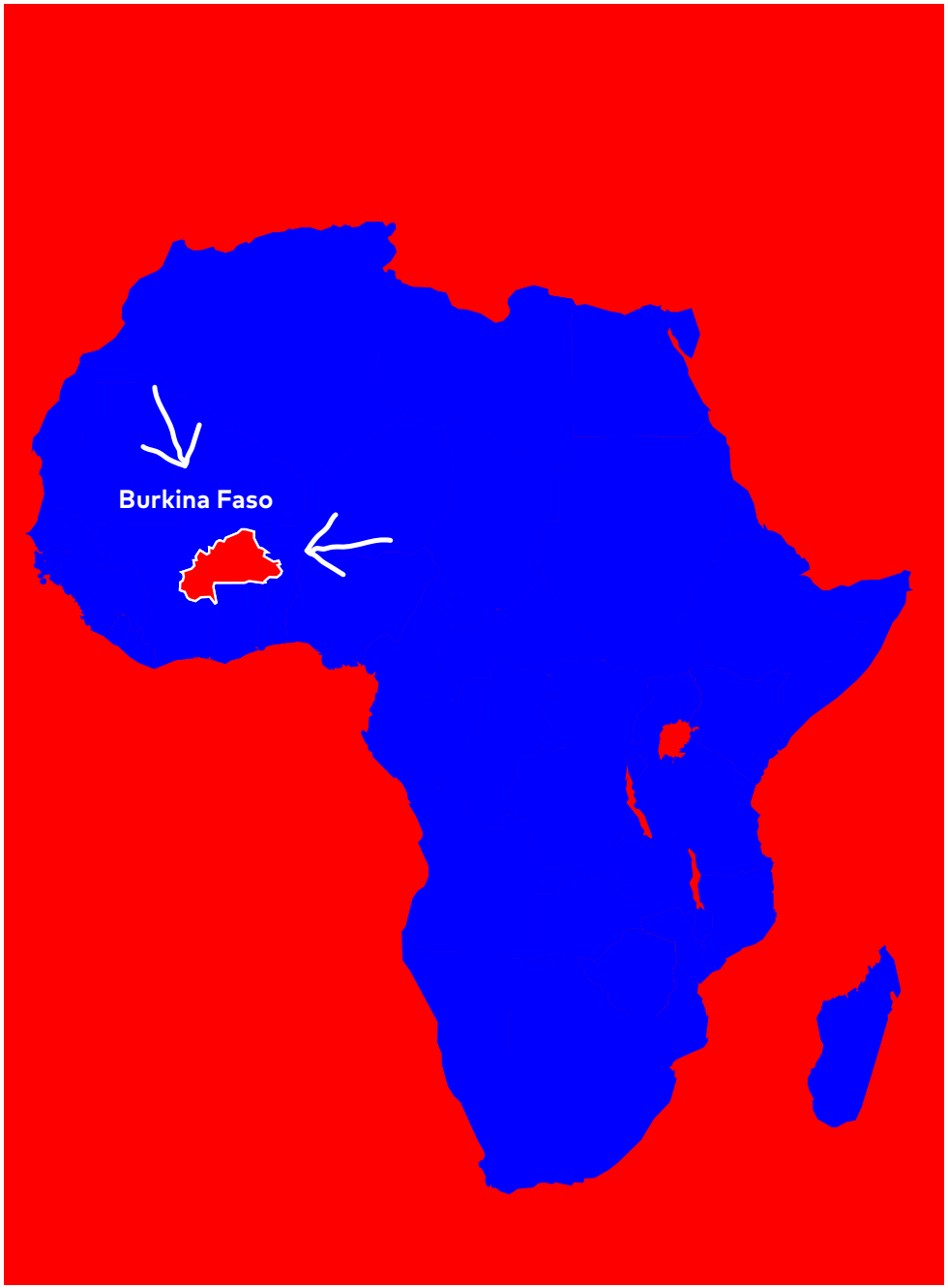
- The inaugural **Ministers of Health and Finance Meeting** took place in 2020 and reiterated the importance of prioritising health financing in Africa and re-convening biannually to address impending matters on domestic resource mobilisation.

- Piloting of the **Regional Health Financing Hubs** began with an **assessment exercise** in the East African Community (EAC) Region in 2020 and the Southern African Development Community (SADC) Region in 2021. The hubs are intended to provide technical and practical expertise to support countries as they implement the reforms directed by the Tracker. So far, country dialogues on health financing have taken place in eight countries: Burundi, Kenya and Rwanda from the EAC, and Malawi, Mauritius, Mozambique, Zambia and Zimbabwe from the SADC.

- **Annual production of the Africa Scorecard on Domestic Financing for Health** is ongoing. The 2023 edition was digitised after endorsement by ministers of health and finance.

- The **Health Financing Tracker** assessment mission was concluded in 2022 in South Africa under the leadership of the AUC and the AU Development Agency. The Tracker is intended to build on the Scorecard by providing more granular "enablers" of progress towards Scorecard outcomes.

Photo: Cynthia R Matonhodze



3. Burkina Faso

3.1. Background

Burkina Faso is a low-income Sahelian country with limited natural resources. Its economy is largely based on agriculture, although gold exports are on the rise. More than 40% of the population live below the poverty line. Burkina Faso ranks 184 out of 191 countries on the 2021-2022 Human Development Index of the United Nations Development Programme (UNDP). After a sharp decline in economic growth in 2022 to 1.5%, caused by a combination of new shocks, both domestic (coups d'état, insecurity in mining areas) and external (the Russian invasion of Ukraine), a clear economic rebound in 2023 is projected at 4.3%.

On Dec 31st, 2021, Burkina Faso's Ministry of Health (MoH) reported that 444 health facilities (30.7% of the total) had been impacted by insecurity in the regions most affected by the humanitarian crisis. 149 facilities are completely closed, depriving around 1.8 million people of access to health care.[11]

In 2022 there were 1,900 new HIV infections among individuals of all ages, a reduction of 39% compared with 2017.

3.2. State of UHC

Burkina Faso scores 40 out of a possible 100 on the WHO UHC service coverage index.[12] In 2012 the government of Burkina Faso began implementation of universal health insurance (UHI). However, dialogue among policymakers in interrelated sectors was suboptimal, discussing trade-offs was challenging and progress was slow. In March 2012, the government requested the support of the Social Health Protection

Network (P4H), the global network for social health protection and health financing. In addition, WHO, through the UHC Partnership, supported the validated national health-financing strategy in 2017, following a participatory and inclusive decision-making policy dialogue. All of this led to the development of the Health Finance Strategy for UHC (2018-2030) and a law on UHI.

The Régime d'Assurance Maladie Universelle (RAMU) was established in 2015 as a compulsory health insurance scheme for workers in the formal sector, with the intention of gradually becoming compulsory for actors in the informal and the agricultural sectors.[13] The Gratuité programme funded by the government budget to replenish health financing allows all pregnant and lactating women, and children under five, to access services free of charge.[14,15] It covers services for children, antenatal and postnatal care, deliveries, emergency obstetric care, and Caesarean section, as well as treatment of obstetric fistulas, screening for precancerous cervical lesions and breast cancer for all women. In addition, there are two types of voluntary schemes: Community Based Health Insurance (CBHI) and private insurance, which provide financial protection based on socioeconomic criteria, covering 0.9% of the population.[16]

3.3. Finance

Burkina Faso's government spends 11.5% of the national budget on health (against the 15% Abuja target), spends 2.9% of GDP (against the 5% Chatham House recommendation) and allocates US$24.00 per capita (against a WHO HLTF recommendation of US$86.30). Of total spending on health, the government contribution is 43%, household out-of-pocket spending is 35% (the World Bank characterises spending above 10% as catastrophic),[17] the development partner contribution is 18%, other private health spending stands at 2% and voluntary pre-paid insurance spending is 2%. The percentage of government spending on health aligns with the Global Fund co-financing targets and has achieved the target for adequate tax revenue to align with the Global Fund tax-to-GDP ratio co-financing targets.[18]

Burkina Faso contributed US$1 million to the Sixth Global Fund Replenishment (2020-2022), and PEPFAR contributed US$10.1 million to continue building on reducing HIV indicators in Burkina Faso in 2022-2023.

3.4. HIV/AIDS within UHC

People are required to pay for PHC services in public facilities, but HIV services are available without user fees. Antiretrovirals (ARVs) are covered by the national health system, but there is a lack of data to evaluate the coverage for HIV pre-exposure prophylaxis (PrEP). Although the country has adopted a national policy to publicly share disaggregated HIV data by geographic region, age and gender (at least), this does not occur frequently, which means that data can quickly become outdated.

National policies include multiple options for differentiated service delivery, including community ART distribution and maximum flexibility for clinic visits (allowed every 6 months or less frequently for people established on ART) and multi-month dispensing (which allows people established on ART to receive 6-month refills of ART). National policy approves HIV self-testing and prohibits compulsory testing, but requires adolescents to obtain parental/guardian consent to access HIV testing and/or treatment.

NHI covers HIV treatment, and Burkina Faso has adopted laws that support HIV treatment. Despite these policies, the government still experiences challenges in fully offering HIV testing and prevention services and has prevented the adoption of policies that address age restrictions on testing and treatment, comprehensive sexuality education and HIV prevention for incarcerated people.

As of 2023, among people living with HIV, 86% are aware of their HIV status; 81% of those who know their status are receiving ART; and 69% of those on ART have achieved viral-load suppression.

3.5. Access to services for key and vulnerable populations

The National Strategic Plan defines KVP as sex workers, men who have sex with men, people living with HIV and people living with disabilities. Services provided to KVP include preventive services and HIV testing and treatment. There are also campaigns on HIV and tuberculosis (TB) for community sensitisation. However, there is no special approach or service provided to KVP, who receive the same mainstream service as the rest of the population. As a result, KVP have been subject to stigma and discrimination based on their HIV status and sexual orientation, and they are afraid to go to health-service providers to get services. There is a lack of basic understanding among the health workforce towards KVP, and at times they refuse to provide services, especially for men who have sex with men and transgender people. National (or subnational) laws and policy make PHC and HIV services accessible to all migrants under the same conditions as citizens.

Harm reduction services for people who inject drugs are not included in national policy and service packages, even though possession of syringes and associated paraphernalia is not criminalised. Neither condoms/lubricants nor syringe access/exchange programmes are available to prisoners.

National law does not criminalise consensual same-sex sex acts, and there are no reports of people being prosecuted for consensual same-sex sex acts in recent years. However, sex work and activities associated with the buying or selling of sex are considered crimes, as is personal drug use/possession. Burkina Faso criminalises non-intentional HIV exposure/transmission, but there are no reports of people being arrested or prosecuted for it in recent years.

National law does not have provisions to protect people from discrimination based on sexual orientation and gender identity/diversity, including in employment, but it does protect people from discrimination based on their HIV status, including in employment. Burkina Faso does not have a national human rights institution to which violations can be reported in compliance with the Paris principles.[19] Health is included as a right in the national constitution. The country takes limited steps to encourage secondary-school retention among girls. Burkina Faso has domestic violence legislation with enforceable penalties.

The country does not utilise unique IDs (or another method of de-duplicating data) that allows for continuity of care across multiple facilities, but does include legally enforceable protections against disclosure of individually identifiable health data, including HIV status.

3.6. Engagement mechanisms for CSOs and communities

Under national law/policy there are provisions for social contracting or other mechanisms by which the government finances CSOs to provide health services; but there are also legal barriers to the free operation of NGOs/CSOs, including those working with key populations.

There is no formal CSO engagement mechanism on UHC with the MoH. However, there are some ad hoc engagements for joint resource mobilisation, proposal-writing and capacity-building, but organisations that represent key populations are usually not involved. There is also an association of CSOs that work on HIV/AIDS prevention programmes, yet even here key populations are not involved. There is a network of sex workers which was established with the support of Global Fund grants for key populations to make sure they receive medical services.

CONCLUSION

Burkina Faso faces significant challenges in achieving UHC, including for KVP. Despite some progress with the implementation of the Gratuité scheme, which has improved access to health services for pregnant women and children under five, there is still no formal UHC in the country. The RAMU (NHI) has shown promise, but coverage remains low.

For example, financial constraints and out-of-pocket expenditure limit progress towards UHC, as well as the lack of essential policies to improve access to HIV testing and prevention services. The ongoing humanitarian crisis and insecurity in certain regions have also disrupted healthcare access for millions of people. Efforts to engage CSOs and communities in UHC planning and implementation have been ad hoc and lack a formal and robust mechanism. This lack of structured engagement leaves key populations marginalised and reinforces stigma and discrimination.

KVP will continue to face limitations in accessing UHC unless the country adopts policies to remove legal, structural and social barriers to their health care, such as comprehensive sexuality education, an HIV prevention policy for prisoners, non-criminalisation of drug use and sex work, and engaging CSOs that represent KVP.

Photo: Cynthia R Matonhodze

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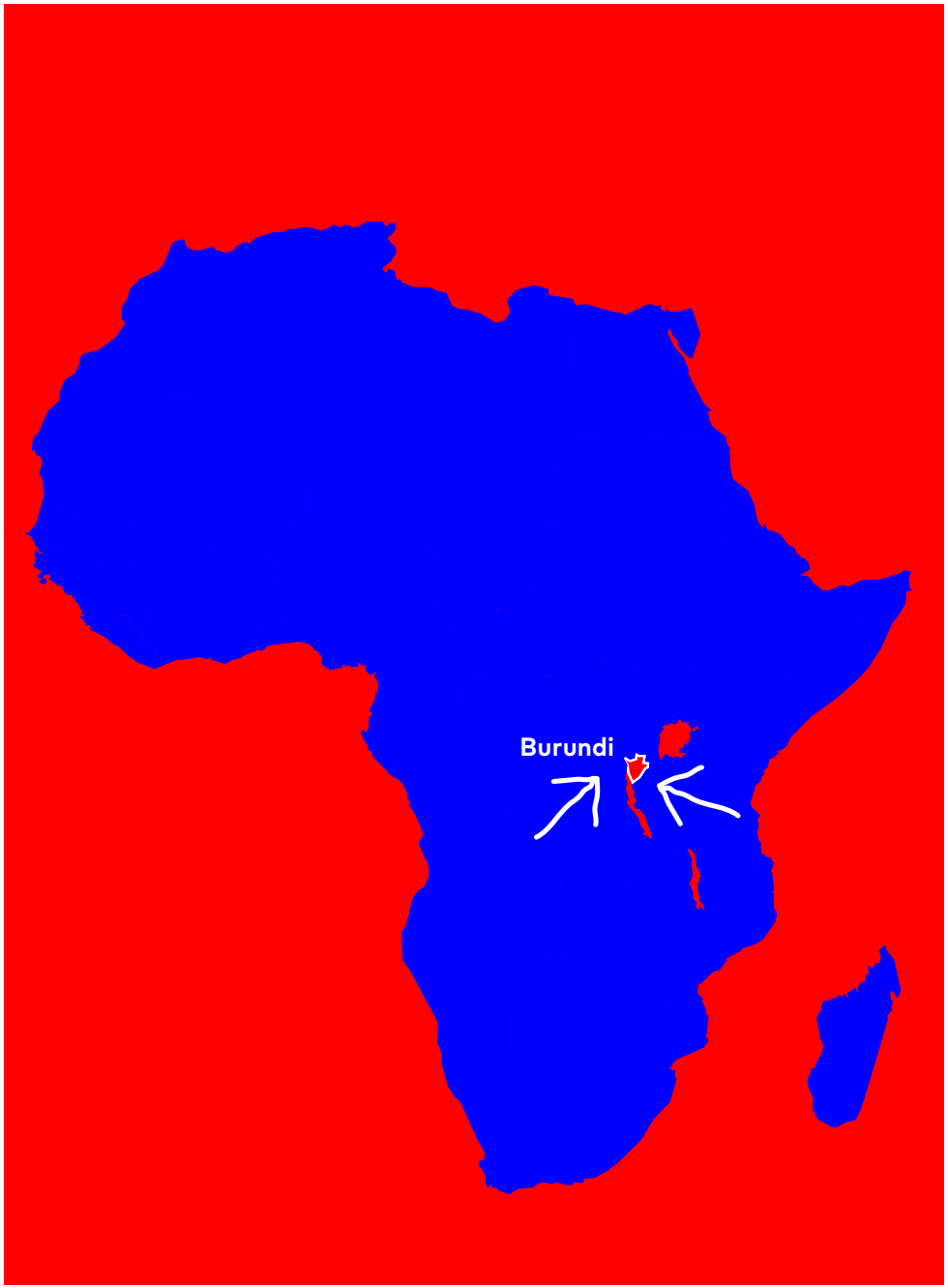


4. Burundi

4.1. Background

A landlocked country in East Africa, Burundi is a low-income economy, with 80% of the population employed in the agricultural sector. With a population of 12.8 million people (2022), 50.3% of whom are women and 41.5% young people under 15, Burundi is one of the most densely populated countries in the world, with a density ratio of 442 people per square kilometre. Burundi's economic activity remains fragile and vulnerable to shocks. GDP growth is projected to be 2.9% in 2023, up from 1.8% in 2022, driven by agriculture and services.

Headline inflation accelerated to 26% in July 2023, driven by increases in food and fuel prices. The price of basic foodstuffs increased, bringing food inflation to 35.8% in July 2023, compared with 24.5% in July 2022. Fuel shortages worsened in June 2023 due to supply disruptions caused by the war in Ukraine. The fiscal deficit is projected to decline to 6.7% of GDP in 2023 from 12.1% in 2022, due to cuts in current expenditure and small increases in revenues. Public debt is expected to reach 72.7% of GDP in 2023, from 68.4% of GDP in 2022, driven by disbursements under the International Monetary Fund's Extended Credit Facility Program.

The number of new HIV infections among individuals of all ages in 2022 was 1,300, a reduction of 38% compared with 2017.

4.2. State of UHC

Burundi scores 41 on the WHO UHC service coverage index. The basic minimum UHC package offers treatment for reproductive, maternal, neonatal and child health, infectious diseases and non-communicable

diseases. Additionally, the package aims to offer accessible services to the whole population, and specifically to the most vulnerable groups.

The National Health Development Plan (PNDS in its French abbreviation) of 2018 served as a strategic framework for strengthening health systems, especially during the political unrest, in line with Burundi's national health development policy 2016-2025.[20] There is a health service gap, primarily because at least 77% of clinical doctors are in managerial positions as opposed to medical service delivery. As a result, the country is way below the WHO-recommended 1:1,000 doctor-to-patient ratio, exacerbating poor service delivery. Furthermore, 35.5% pregnant women do not receive free health care, and 23.6% of under 5-year-olds and 17% of generally sick individuals do not have access to healthcare services.

4.3. Finance

Burundi's government spends 8.3% of the national budget on health (against the 15% Abuja target), which is 2.4% of GDP (against the 5% Chatham House recommendation), and it allocates US$6.00 per capita (against the WHO HLTF recommendation of US$86.30). The government contribution to total health spending is 35%, household out-of-pocket spending is 30% (the World Bank characterises spending above 10% as catastrophic), the development partner contribution is 31%, other private health spending stands at 3% and voluntary pre-paid insurance spending is 1%. The percentage of government spending on health aligns with the Global Fund co-financing targets, but has not achieved the target for adequate tax revenue to align with Global Fund tax-to-GDP ratio co-financing targets.

Burundi received US$44 million for HIV/AIDS and TB interventions, US$65 million for malaria and US$8 million to strengthen health systems from the Global Fund for the budget period 2021-2023. Burundi pledged US$1 million for the Global Fund's Sixth Replenishment, covering 2020-2022. PEPFAR support for the 2022-2023 budget totalled US$25.7 million. There is also the Expanded Programme on Immunization financed by GAVI, UNICEF, and WHO, covering 90% of immunisation costs, with the remaining 10% financed by the government of Burundi.

4.4. HIV/AIDS within UHC

Both ARVs and PrEP services are covered by the national health system, and the country has adopted a national policy to publicly share HIV data, disaggregated by geographic region, age and gender (at least), and shared on a quarterly basis. Burundi's national policy allows for community ART distribution and reduced frequency of clinical visits, but a policy for multi-month dispensing has only been partially adopted, giving access to 3-5-month refills of ARVs. Self-testing is approved by national policy, which also prohibits compulsory testing, but requires adolescents to obtain parental/guardian consent to access HIV testing and/or treatment.

As of 2023, among people living with HIV, 87% are aware of their HIV status; 85% of those who know their status are receiving ART; and 79% of those on ART have achieved viral-load suppression.

4.5. Access to services for key and vulnerable populations

Burundi's National Development Plan (2018-2027) specifies "vulnerable populations" as girls and young women, children under 5 years and those at risk of malnourishment, orphans and the elderly. According to the Integrated National Strategic Plan for HIV/AIDS, Sexually Transmitted Infections and Viral Hepatitis (2023-2027) three groups of people are considered highly exposed to STI/HIV, including viral hepatitis: men who have sex with men, sex workers and drug users, including injecting drug users. Certain population groups have been identified as most vulnerable; (i) personnel in uniform, (ii) people affected by population movements, such as internally displaced persons and returnees, (iii) refugees and asylum-seekers, (iv) people suffering from food and/or nutritional insecurity, including pregnant and breastfeeding women, (v) children and (vi) people at risk and survivors of gender-based violence, (vii) people living with disabilities and (viii) adolescent girls and young people.

Users are required to pay for PHC services in public facilities, but HIV services are available without user fees. The national policy restricts access to PHC for migrants, but makes HIV services accessible to all migrants under the same condition as citizens.

The national law and HIV policy includes harm reduction services packages for people who inject drugs, but possession of syringes and associated paraphernalia is criminalised. Condoms/lubricants are available in prisons, but needles/syringes are prohibited as a matter of national policy.

National law criminalises consensual same-sex sex acts, and there are reports of people being prosecuted in recent years. In addition, the national law criminalises sex work and the use or possession of drugs for personal consumption. Burundi has adopted HIV exposure non-criminalisation laws and does not criminalise non-intentional HIV exposure/transmission, and there are no reports of people being arrested/prosecuted for HIV exposure/transmission in recent years. The national law does not have provisions to protect people from discrimination based on sexual orientation and gender identity/diversity, including in employment, but it does protect people from discrimination based on their HIV status, including in employment. Burundi has an independent national human rights institution to which violations can be reported and which is fully compliant with the Paris principles. Health is included as a right in the national constitution.

The national policy encourages secondary-school retention among girls. Burundi has domestic-violence legislation with enforceable penalties. Burundi neither utilises unique IDs nor has legally enforceable data-privacy protections.

4.6. Engagement mechanisms for CSOs and communities

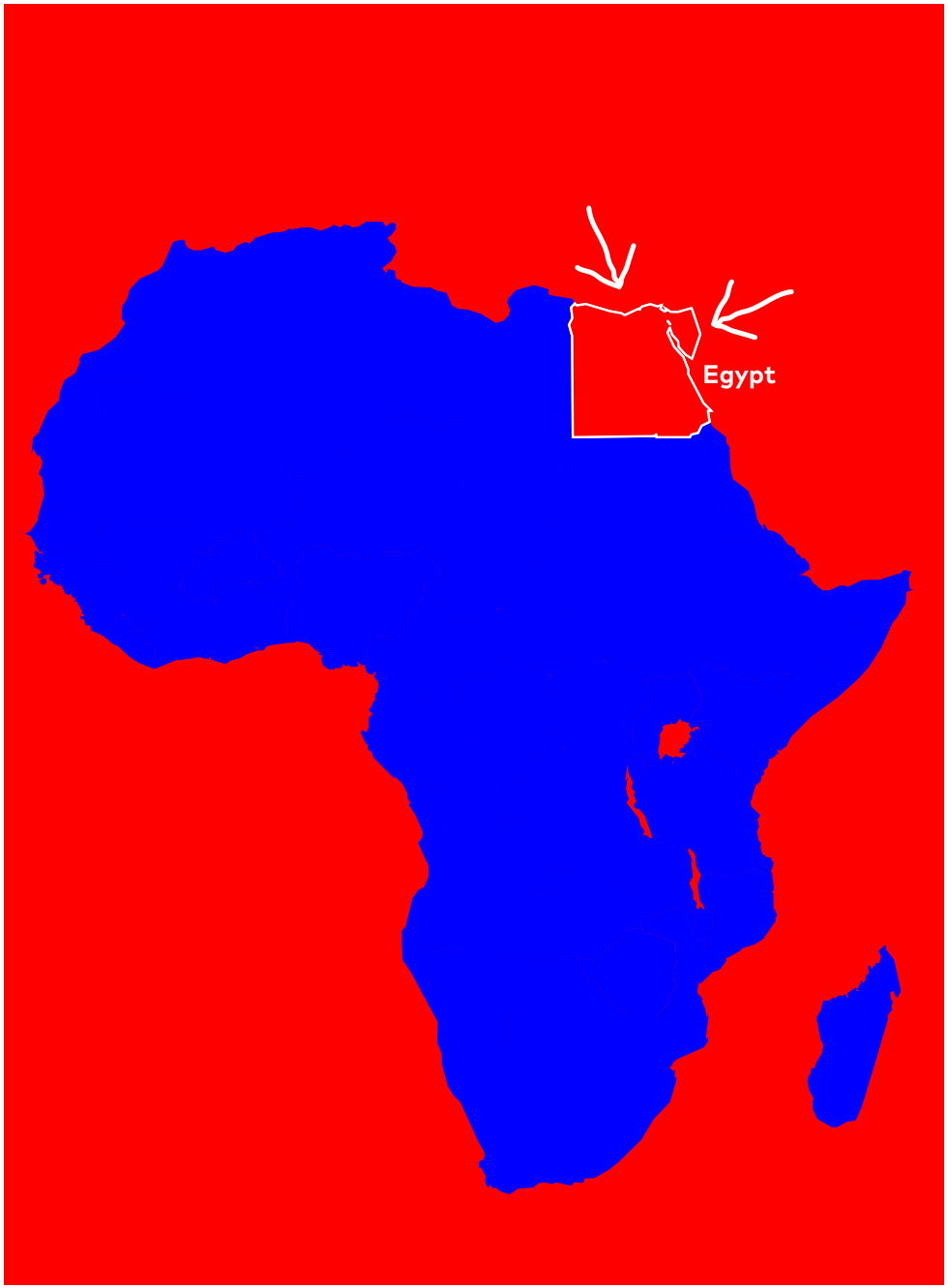
The MoH has established national-level councils or committees that bring together government representatives, CSOs and community members to discuss and plan healthcare projects, including UHC initiatives. There are also public consultations and technical meetings which bring together MoH, health practitioners and other project implementers and funders (international NGOs, foreign diplomatic missions), and to gather feedback and ideas from CSOs and community members on UHC-related interventions. These forums foster direct participation and engagement in planning processes.

Under national law/policy there are provisions for social contracting or other mechanisms by which the government finances CSOs to provide health services; but there are also legal barriers to the free operation of NGOs/CSOs, including those working with key populations.

CONCLUSION

Burundi's journey towards UHC faces considerable challenges that impact the health and well-being of its population. The non-universalisation of health insurance has resulted in significant disparities in access to health care, particularly affecting vulnerable groups such as adolescents and youth. Inadequate allocation of the national budget to health, falling short of the Abuja Declaration target, hinders the expansion of healthcare services. There is a shortage of clinical doctors in medical service delivery roles, exacerbating poor service delivery and leading to a doctor-to-patient ratio well below the WHO-recommended standard. Moreover, a substantial proportion of pregnant women, under-five-year-olds, and generally sick individuals lack access to free healthcare services, and the burden of out-of-pocket spending falls heavily on patients.

Commendable progress has been made in HIV/AIDS management, with Burundi achieving the UNAIDS 95-95-95 targets. However, the current health financing system, lack of essential policies (TB diagnostics, unique identifiers with data protections, and non-criminalisation of drug use and sex work) and inadequate engagement mechanism for CSOs and communities are preventing the realisation of UHC.



5. Egypt

5.1. Background

Egypt's longstanding challenges have intersected with multiple global shocks, causing a foreign exchange crisis, historically high levels of inflation, and pressures that have worsened the already stretched fiscal and external accounts. While triggered by the global poly-crisis, the rising macroeconomic imbalances in Egypt reflect pre-existing domestic challenges, including sluggish non-oil exports and foreign direct investment, constrained private-sector activity and job creation (notably for youth and women), as well as the elevated and rising government debt. Below-potential revenue mobilisation is further limiting the fiscal space required to advance human and physical capital for the Egyptian population, which exceeds 105 million, almost 30% of whom are below the national poverty line, according to 2019 official estimates.

In 2022 there were 5,100 new HIV infections among individuals of all ages, an increase of 70% compared with 2017.

5.2. State of UHC

Egypt scores 70 on the WHO UHC service coverage index. In 2018 Egypt adopted a Universal Health Insurance law, which has been rolled out in 4 out of 27 governorates, with the anticipation of reaching all governorates by 2032 to cover all Egyptians with adequate financial protection. In 2023, the Ministry of Health and Population (MoHP) launched the One Health National Strategic Framework 2023-2027, which recognised the close connection between human, animal and environmental health. Its goal is to create joint action between

these sectors to achieve better health outcomes that can effectively contribute to preventing, predicting and responding to global health threats such as the COVID-19 pandemic. UHC in Egypt is in its very early stages and there is no coverage for the whole population for now. UHC covers 68% of the total population. It covers everything from medical examinations to tests such as X-rays and scans, treatments and surgery, where 80% of services are free.[21]

A challenge in creating a database for the One Health National Strategic Framework was that initially it was designed for individuals only, rather than families. Now efforts are underway to create a family folder system. For health service providers to be part of the framework, they must undergo a quality assessment from the Commission for Accreditation to offer healthcare services within the Universal Health Coverage network. Many are struggling to reach the level required for accreditation. Here it is important to consider proper remuneration for doctors as they are not allowed to be part of the UHC network if they work in private facilities.

5.3. Finance

Government spending on health stands at 5.2% of the national budget (against the 15% Abuja target), with spending of 1.4% of GDP (against the 5% Chatham House recommendation) and an allocation of US$48.00 per capita (against the WHO HLTF recommendation of US$86.30 per capita). There is insufficient data to evaluate the sources of health spending, i.e. the percentage of government contributions, household out-of-pocket spending, development-partner contributions or other private health spending and voluntary pre-paid insurance. Overall, the proportion of government spending that goes towards health does not align with the Global Fund co-financing target, but Egypt's tax-to-GDP ratio does meet the Global Fund co-financing target. Egypt received US$5.27 million from the Global Fund for 2022-2025.

5.4. HIV/AIDS within UHC

Most patients are well able to access both PHC and HIV services in public facilities without having to pay user fees. There is no data on whether health coverage includes medications for HIV treatment and PrEP, and whether there is a national policy to publicly share disaggregated HIV data on a regular basis. Egypt's national policies do not allow for community ART distribution, but allow for clinical visits every 3-5 months for people established on ART, and for them to receive 3-5-month refills of ART. Self-testing is not approved according to the national policy. In addition, the law does not prohibit compulsory HIV testing, and requires adolescents to obtain parental/guardian consent to access HIV testing and/or treatment.

All HIV services are provided in the package, including voluntary counselling and testing, a full sexual and reproductive health package including distribution of condoms, mental health support, harm reduction, family planning, and testing for HIV and treatment for those living with HIV. But there is no clarity as to when it will be rolled out at the national level. CSOs believe there needs to be advocacy for this, and to ensure the sustainability of services for key populations, people living with HIV, and those who have financial and geographical barriers.

Egypt is a low-risk country for HIV/AIDS, according to UNAIDS data. However, the number of people living with HIV has increased by around 25-35% per year over the past decade, mainly due to a lack of knowledge and awareness. The government's National AIDS Strategy 2018-22 aimed to raise HIV/AIDS prevention, diagnosis and treatment to global standards. The government has created other programmes in partnership with the Dutch government, the UN and WHO to raise awareness of the disease and reduce the stigma associated with it.

As of 2023, among people living with HIV, 74% are aware of their HIV status; 47% of those who know their status are receiving ART; and 39% of those on ART have achieved viral-load suppression.

5.5. Access to services for key and vulnerable populations

KVP are identified as men who have sex with men, sex workers and their clients, and people who use drugs. Those who are at risk of HIV because of their sexual partners are considered as indirectly most-at-risk. So far, UHC treats all citizens alike, but there have been no studies to understand how key populations are accessing services. It is important to conduct studies because the HIV package is at the pilot stage, and research can inform and support the government for a national rollout. There is no information available regarding migrant access to health care (including to PHC and HIV services).

Harm reduction services are included in the national policy and service packages for people who inject drugs. However, the national law criminalises possession of syringes and associated paraphernalia. Neither condoms/lubricants nor syringe access/exchange programmes are available to prisoners.

Egypt's national law criminalises consensual same-sex sex acts, and there are reports of people being prosecuted in recent years. Similarly, the government criminalises sex work and drug use or possession of drugs for personal consumption. National law does not criminalise non-intentional HIV exposure/transmission, and there are no reports of people being arrested/prosecuted for HIV transmission in recent years. The government does protect people from employment discrimination based on gender identity/diversity and of their HIV status, but not based on their sexual orientation. The country has a national human rights institution that is fully compliant with the Paris principles, with a national constitution that includes the right to health.

There is no data on whether Egypt's national policy encourages secondary-school retention among girls. However, the HIV Policy Lab confirms that Egypt has domestic violence legislation with enforceable penalties. The country uses unique IDs and has legally enforceable data-privacy protections.

Egypt's youth and key populations are more affected by inadequate care because they do not get full-service coverage from government health facilities. This is because the law criminalises certain groups within the key populations.[22] Additionally, Egypt has not yet adopted policies to increase access to UHC services for KVP, such as policies on self-testing, compulsory testing, PrEP for prisoners, and non-criminalisation of same-sex sex, drug use and sex work.[23]

5.6. Engagement mechanisms for CSOs and communities

Together with the MoHP, CSOs play a major role in the regulation, financing and provision of health care. However, there has not been an opportunity for a CSO platform or for consultation with the government on UHC.

There is an ongoing effort to launch a CSO initiative with organisations led by people living with HIV and key populations, but without legalisation it cannot go ahead. There is no dedicated CSO platform for health. This is partly due to the complicated legal procedure. However, there is a Memorandum of Understanding (MoU) between Al-Shehab Institution for Promotion and Comprehensive Development and the MoHP to establish an observatory focused on monitoring cases of stigma and discrimination within government health facilities during service provision.

Egypt does not have a social contracting policy for financing NGO/CSO-provided services, nor are NGOs/CSOs (including those that work with key populations) able to register, seek funding and operate freely under national laws and policies.

CONCLUSION

There is a need for greater advocacy and policy changes to ensure equitable and accessible health care for all Egyptians, regardless of their background or identity. Indeed, UHC only covers 68% of the population, and further advocacy could facilitate a national-level rollout to ensure accessibility and sustainability of services for all. Currently, UHC services are not universally available to the general public or key populations, leaving much of the population without access to differentiated services. CSOs play a vital role in addressing these issues, working with the MoHP to report cases of discrimination against key populations in public health facilities. The MoHP and CSOs have established a MoU to facilitate this collaboration.

Despite the collaboration between CSOs and the government, the full recognition and inclusion of key populations in UHC services remain a challenge, and discrimination based on their identities persists within the healthcare system. In addition to these obstacles, public health facilities in Egypt provide low standards of care, leading many Egyptians who can afford it to opt for private healthcare facilities. Unfortunately, this disparity in care disproportionately affects youth and key populations due to discrimination in public health facilities based on same-sex practices, sex work and drug use, all of which are criminalised. To advance UHC, Egypt must address these challenges and work towards full-service coverage for all citizens, particularly KVP.

Photo: Cynthia R Matonhodze

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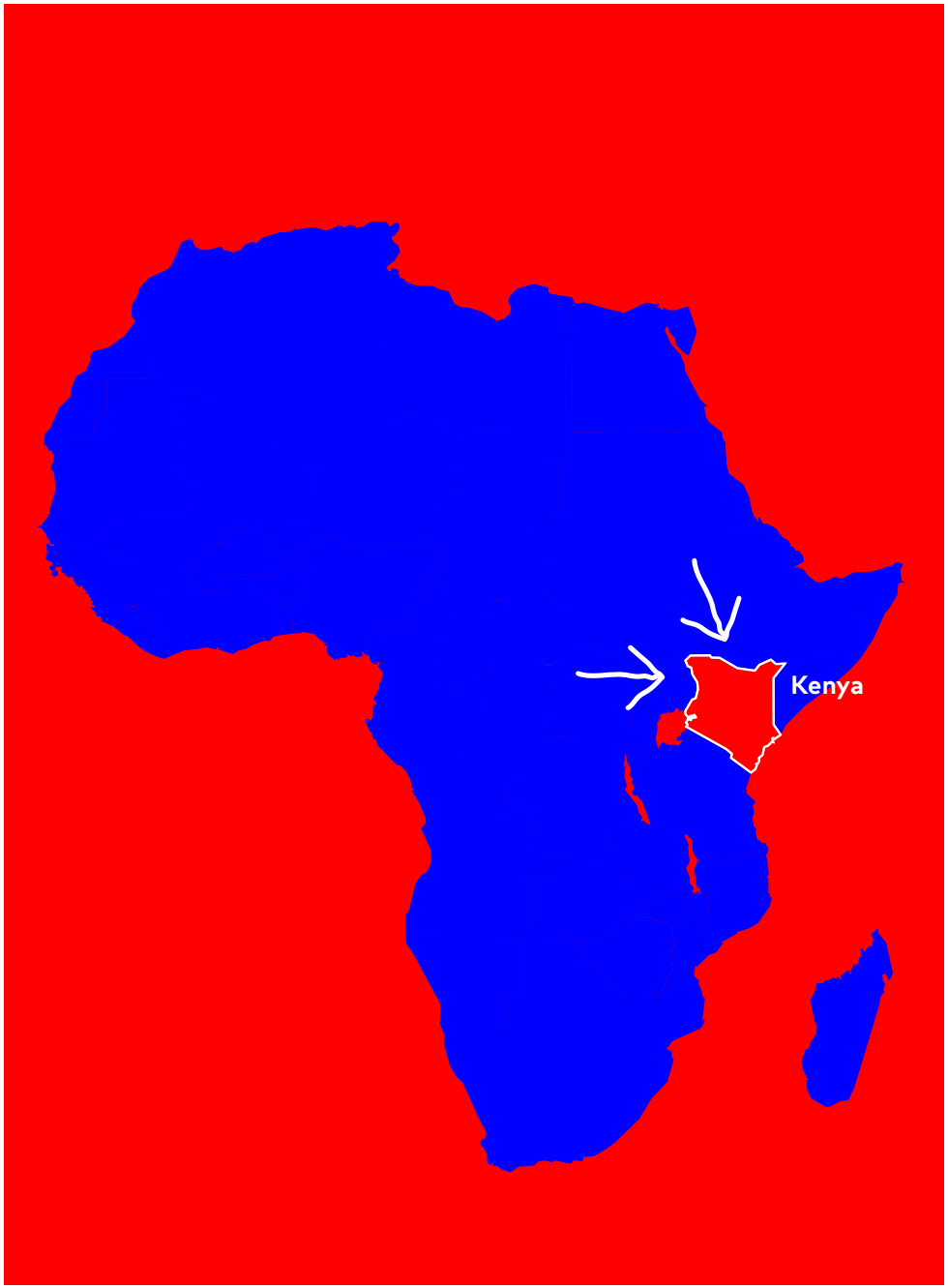

6. Kenya

6.1. Background

Kenya is a lower-middle-income country with a gross national income per capita of US$1,840.70. The World Bank estimated a 4.9% year-on-year increase in GDP over 2022-2023 based on anticipated normal rates, with agricultural output predicted to decrease by 0.5%. Kenya's economy achieved broad-based growth, averaging 4.8% per year between 2015 and 2019, significantly reducing poverty (from 36.5% in 2005 to 27.2% in 2019 (US$2.15/day poverty line).

Kenya's population is 54 million, of whom 1.4 million are living with HIV, including 83,000 are children below the age of 15 years. There were 22,000 new HIV infections among individuals of all ages in 2022, a reduction of 35% compared with 2017.

6.2. State of UHC

Kenya scores 53 on the WHO UHC service coverage index. UHC was part of President Uhuru Kenyatta's "Big Four priority agenda" during his time in office (2013-2022) to develop the capacity and resources of the healthcare sector. The harmonised health benefits package (HBP) was finalised in 2020, funded through the NHIF and including curative and preventive services to be delivered across all levels of care. The package focused on all aspects of the UHC policy, from resource mobilisation to implementation.[24] HBP entitlements include outpatient services, inpatient services, maternal care, reproductive health services, renal dialysis, overseas treatment for specialised surgeries, rehabilitation for drugs and substance abuse, all surgical procedures including transplants, emergency road evacuation services, radiology imaging services, and cancer treatment.[25]

The Kenya Health Strategy Plan (2018–2023) has a focus on achieving UHC.[26] The Kenya Universal Health Policy 2020-2030 looks to progressively expand health insurance coverage among Kenyans, particularly among the poor and vulnerable groups, to improve the quality of health services for better health outcomes. UHC has not formally begun in Kenya, but there are pilots in four counties (Isiolo, Kisumu, Machakos and Nyeri) providing the basic package of HIV services, i.e. prevention and treatment services (condoms and sometimes lubricants). This is intended for the general population; so far there is no package for key populations, and there is a need to advocate for inclusion of key populations in service delivery.

There have been instances where UHC was confused with the National Hospital Insurance Fund (NHIF), a mandatory contribution scheme for the employed. Because some people thought that UHC was replacing the NHIF, there was less interest from the community.

6.3. Finance

Kenya's government spends 8.2% of the national budget on health (against the 15% Abuja target), which is 2% of GDP (against the 5% Chatham House recommendation), and it allocates US$40.00 per capita (against the WHO HLTF recommendation of US$86.30). The government contribution to total health spending is 46%, household out-of-pocket spending is 24% (the World Bank characterises spending above 10% as catastrophic), the development partner contribution is 18%, other private health spending is 2% and voluntary pre-paid insurance spending is 10%. Kenya's national budget and fiscal policy includes sufficient health spending and adequate tax revenues to meet international targets (the Global Fund co-financing targets, including the tax-to-GDP ratio).

The NHIF is mainly fuelled by revenue collection through payroll deductions for formal-sector employees (mandatory health insurance), voluntary insurance (Ksh. 500, equivalent to US$3.50 per month for principal members and beneficiaries) and government contributions to cover indigents under the Health Insurance Support Programme.

HIV/AIDS response remains heavily donor-funded, at 63.5% in 2021/2022. PEPFAR is the largest donor to HIV programmes, contributing 37% of annual total investments across all HIV programmes. The 2022-2023 PEPFAR Kenya Operational Plan approved US$345 million to support the HIV response. On the other hand, Kenya's contribution as part of Global Fund counterpart financing is approximately US$19 million for the financial year 2022-2023. The roadmap for transition[27] highlights that in programmes for routine immunisation, family planning, TB, HIV/AIDS, malaria and nutrition, domestic funds make up 7-23% of total financing.

6.4. HIV/AIDS within UHC

ARVs are not covered by the national health system, and there is a lack of data to evaluate PrEP coverage. The country has adopted a national policy to share disaggregated HIV data by geographic region, age and gender at least quarterly. Kenya's national policy includes multiple options for differentiated service delivery, including community ART distribution and maximum flexibility for clinic visit and multi-month dispensing. Self-testing is approved by the national policy, but the law does not prohibit compulsory testing. The national policy requires adolescents to obtain parental/guardian consent to access HIV testing and/or treatment.

The UHC basic package in Kenya offers promotive, preventive, curative, rehabilitative and palliative healthcare services for HIV, malaria, TB and non-communicable diseases to KVP.[28] The government has not been clear about sustaining community-led services or the availability of these services to those who cannot contribute to any potential insurance scheme.

As of 2023, among people living with HIV, 95% are aware of their HIV status; 94% of those who know their status are receiving ART; and 89% of those on ART have achieved viral-load suppression.

6.5. Access to services for key and vulnerable populations

For the HIV response, key populations are identified as men who have sex with men, male and female sex workers, transgender people, and people who use and inject drugs. Vulnerable populations are identified as sero-discordant couples, fishers, women who do fish and sex work, truck drivers, and incarcerated persons. There is also a basic "test and treat" programme run by the government. Most patients can access both PHC and HIV services in public facilities without having to pay user fees. Kenya national policy restricts access to PHC for migrants, and there is insufficient data on whether HIV services are made accessible to them.

Harm reduction services are included in the national policy and service packages for people who inject drugs, and syringe possession is not criminalised. Neither condoms/lubricants nor syringe access/exchange programmes are available to prisoners.

Kenya national law criminalises consensual same-sex sex acts, and there are reports of people being prosecuted in recent years. Similarly, the government criminalises sex work, and drug use or possession of drugs for personal consumption. The law criminalises non-intentional HIV exposure/transmission, and there are reports of people being arrested or prosecuted for it in recent years. The government does partially protect people from discrimination, including employment discrimination based on sexual orientation and HIV status, but not based on gender identity/diversity. The country has a national human rights institution that is fully compliant with the Paris principles, and the national constitution includes the right to health.

National policies strongly encourage secondary-school retention among girls, and the law explicitly addresses domestic violence with enforceable penalties. The country utilises unique IDs and has legally enforceable data-privacy protections.

Key populations are disproportionately affected by HIV services and care delivery, yet there is limited understanding of the challenges they encounter. Identifying as a man who has sex with men or as a sex worker can lead to stigma, and only a few hospitals offer integrated services for key populations. Structural barriers also impede KVP from accessing health services. Laws and policies that do not accept homosexuality, abortion procedures and sex work further marginalise these groups.

6.6. Engagement mechanisms for CSOs and communities

While national policy provides for social contracting, NGOs and CSOs, including those working with key populations, are not able to officially register, seek funding and operate. There have been a few meetings and workshops on UHC in which CSOs participated. Some of the initiatives were hosted by UNAIDS to help CSOs and communities understand the benefits package and the implementation of UHC. Similar engagement has happened under the PITCH programme, funded by the government of the Netherlands and implemented by Aidsfonds. However, there are no proper mechanisms for CSO and community engagement with the government.

CONCLUSION

Kenya has made progress in expanding health insurance coverage through the NHIF, but there is still a need for further resources and clarity on UHC's scope and benefits. There is a need to formulate a UHC governance mechanism that includes key population groups, and for civil society to be meaningfully engaged in the UHC implementation process.

The HIV/AIDS response within UHC has not been fully integrated, with KVP such as LGBTQI+ individuals, sex workers and drug users facing discrimination and limited access to UHC services due to their criminalisation under Kenyan law. The prevalence of HIV among certain groups remains high, making it essential to address their unique healthcare needs. The government further exacerbates the barriers to achieving UHC through its ambiguity in supporting community-led services and ensuring access for those unable to contribute to potential insurance schemes.

For further uptake of UHC by KVP, its benefits for the community and how it is implemented need to be explained more clearly. Part of the confusion is a result of politics, since UHC was a priority for the previous President and now less is heard about it. There also needs to be clarity on how it will be resourced; donor or domestic. There is also a need to define the range of clinical services as the incidence of non-communicable diseases is on the rise. There should be a serious discussion on the structuring of the basic minimum package of services for all populations.

Overall, realising UHC in Kenya requires addressing structural barriers, adopting appropriate policies, securing sufficient financial resources, and fostering meaningful engagement between stakeholders, including CSOs and communities. CSOs play a crucial role in providing UHC services directly to these populations, but their engagement and involvement must be more substantial and sustained.

Photo: Cynthia R Matonhodze

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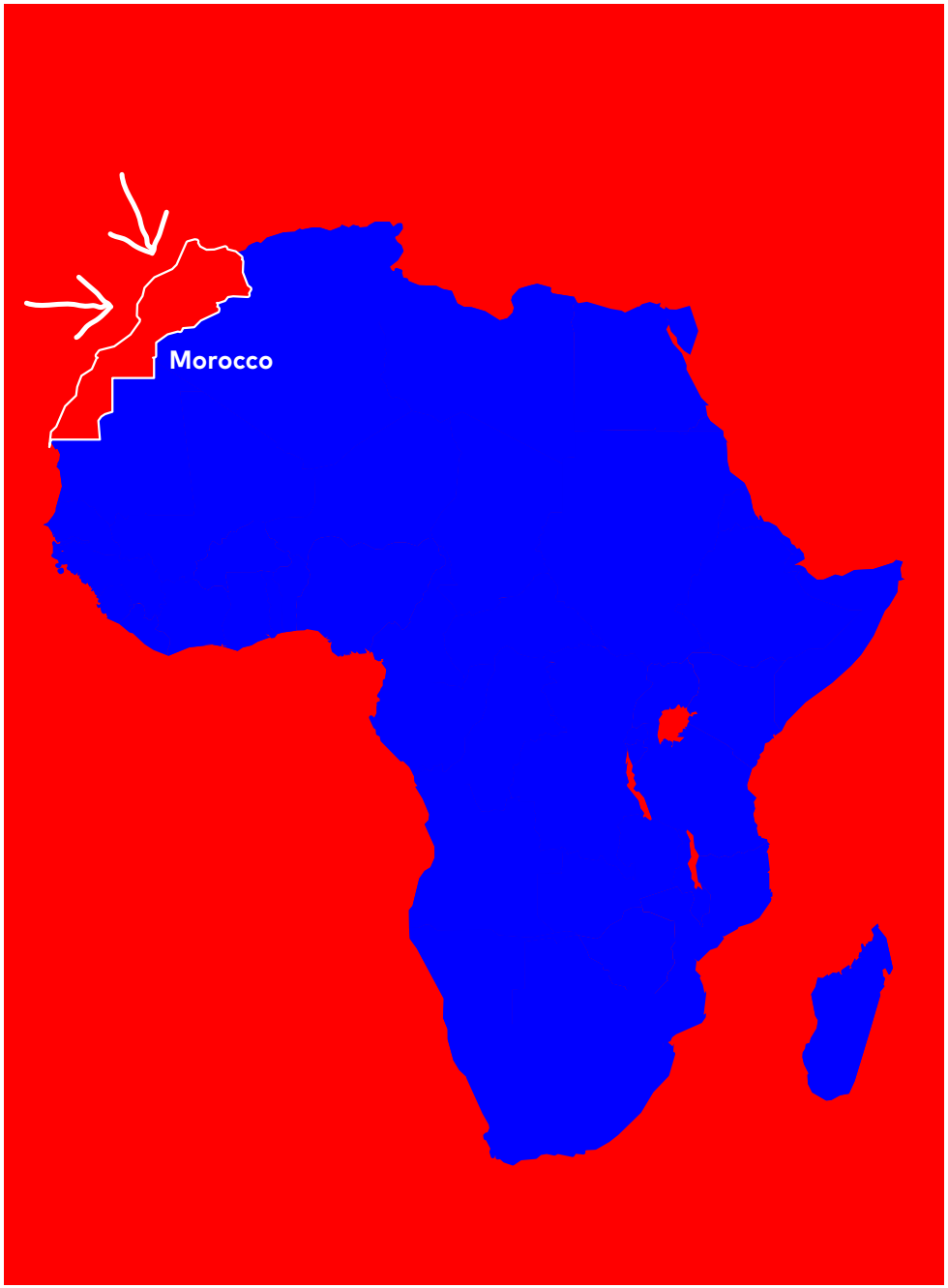


7. Morocco

7.1. Background

Morocco suffered mutually reinforcing shocks in 2022, marked by a severe drought that explains almost half of the 2022 deceleration in economic growth. This coincided with a global economic slowdown and rising international commodity prices, fuelled by Russia's invasion of Ukraine. In this context, real GDP growth fell from 8% in 2021 to 1.3 % in 2022. As the effects of these shocks fade away, growth is accelerating in 2023, supported by the partial recovery of agricultural production, the rebound of the tourism sector and the positive contribution of net exports. Real GDP annual growth increased to 3% in the first half of 2023. Morocco's GDP stands at US$142.9 billion, a per-capita figure of $3,795. The poverty level is 2.42%.[29]The country's population is 38,086,231.

In 2022 there were 750 new HIV infections among individuals of all ages, a reduction of 24% compared with 2017.

7.2. State of UHC

Morocco scores 69 on the WHO UHC service coverage index. The 2011 constitution addresses health in seven articles, among which Article 31 states the right to universal access to health services, and Article 154 the right to access quality health services. These articles refer directly to the three objectives of UHC as recommended by WHO – to achieve universal access to the effective health services people need without exposing them to financial hardship.[30] In 2005, the country introduced a mandatory health insurance scheme, the Assurance Maladie Obligatoire (AMO) for the formal sector, which since 2012 has been complemented

by a non-contributory basic coverage scheme, the Régime d'Assistance Médicale (RAMED) for the informal sector. In addition, the health insurance scheme offers free health insurance to those who are not employed or are under-employed.

Maternal health is among the prioritised services within UHC, which allows pregnant women access to free obstetric care regardless of their socioeconomic status. More than 60% of the population have access to basic medical coverage;[31] however, there is a geographical barrier for communities living in rural areas to access health facilities on time, which results in higher maternal and child mortality rates in rural than urban areas (111.1 versus 44.6 per 100,000 live births, respectively).[32]

7.3. Finance

Morocco's government spends 7.2% of the national budget on health (against the 15% Abuja target), which is 2.6% of GDP (against the 5% Chatham House recommendation), and it allocates US$82.00 per capita (against the WHO HLTF recommendation of US$86.30). The government contribution to total health spending is 25% household out-of-pocket spending is 42% (the World Bank characterises spending above 10% as catastrophic), the development partner contribution is 2%, other private health spending stands at 29% and voluntary pre-paid insurance spending is at 1%. The percentage of government spending on health does not align with Global Fund co-financing targets, but has achieved the target for adequate tax revenue to align with Global Fund tax-to-GDP ratio co-financing targets.

Morocco currently administers HIV prevention and treatment programmes with a Global Fund grant worth US$9.2 million over five years. The new grant is intended to contribute to reductions in HIV/AIDS transmission among vulnerable populations and to aid in decreasing illness and death among people living with HIV/AIDS by strengthening and expanding medical and psychosocial care. Morocco for the first time has also pledged 1.29 million Euros for the Global Fund's Seventh Replenishment, covering 2023-2025.

7.4. HIV/AIDS within UHC

ARVs are covered by the national health system, but PrEP is not. There is no HIV data disaggregated by geographic region, age or gender. Morocco's national policy does not allow for community ART distribution, but allows for reduced frequency of clinical visits (every 6 months or less frequently). The national policy allows for multi-month dispensing, which gives access to 6-month refills of ART. HIV self-testing is approved by national policy, which also prohibits compulsory testing, but policy requires adolescents to obtain parental/guardian consent to access HIV testing or treatment.

As of 2023, among people living with HIV, 79% are aware of their HIV status; 74% of those who know their status are receiving ART; and 69% of those on ART have achieved viral-load suppression.

7.5. Access to services for key and vulnerable populations

Morocco is scaling up UHC efforts to reach key populations through combined prevention programmes implemented by CSOs. Programmes include L'Association de Lutte Contre le Sida (ALCS), substitution treatment for people who use drugs, and increasing HIV testing.[33] However, adoption of key policies that enable access to UHC has not yet taken place. Most patients can access PHC and HIV services in public facilities without having to pay user fees. The national policy restricts access to PHC for migrants, but makes HIV services accessible to all migrants under the same condition as citizens.

The national law and HIV policy includes harm reduction services packages for people who inject drugs, and possession of syringes and associated paraphernalia is not criminalised. However, condoms/lubricant and needles/syringes are not allowed for prisoners as a matter of national policy.

National law criminalises consensual same-sex sex acts, and there are reports of people being prosecuted in recent years. The national law also criminalises sex work and the use or possession of drugs for personal consumption, but Morocco adopted HIV exposure non-criminalisation laws and does not criminalise non-intentional HIV exposure/transmission, and there are no reports of people being arrested/prosecuted for HIV exposure/transmission. National law has no provisions to protect people from discrimination based on sexual orientation and HIV status, including in employment, but it does protect people from discrimination based on their gender identity/diversity, including in employment. Morocco has an independent national human rights institution to which violations can be reported that is fully compliant with the Paris principles. Health is included as a right in the national constitution.

Morocco does not have a national policy to encourage secondary-school retention among girls. There is domestic violence legislation with enforceable penalties. The country utilises unique IDs and has legally enforceable data-privacy protections.

7.6. Engagement mechanisms for CSOs and communities

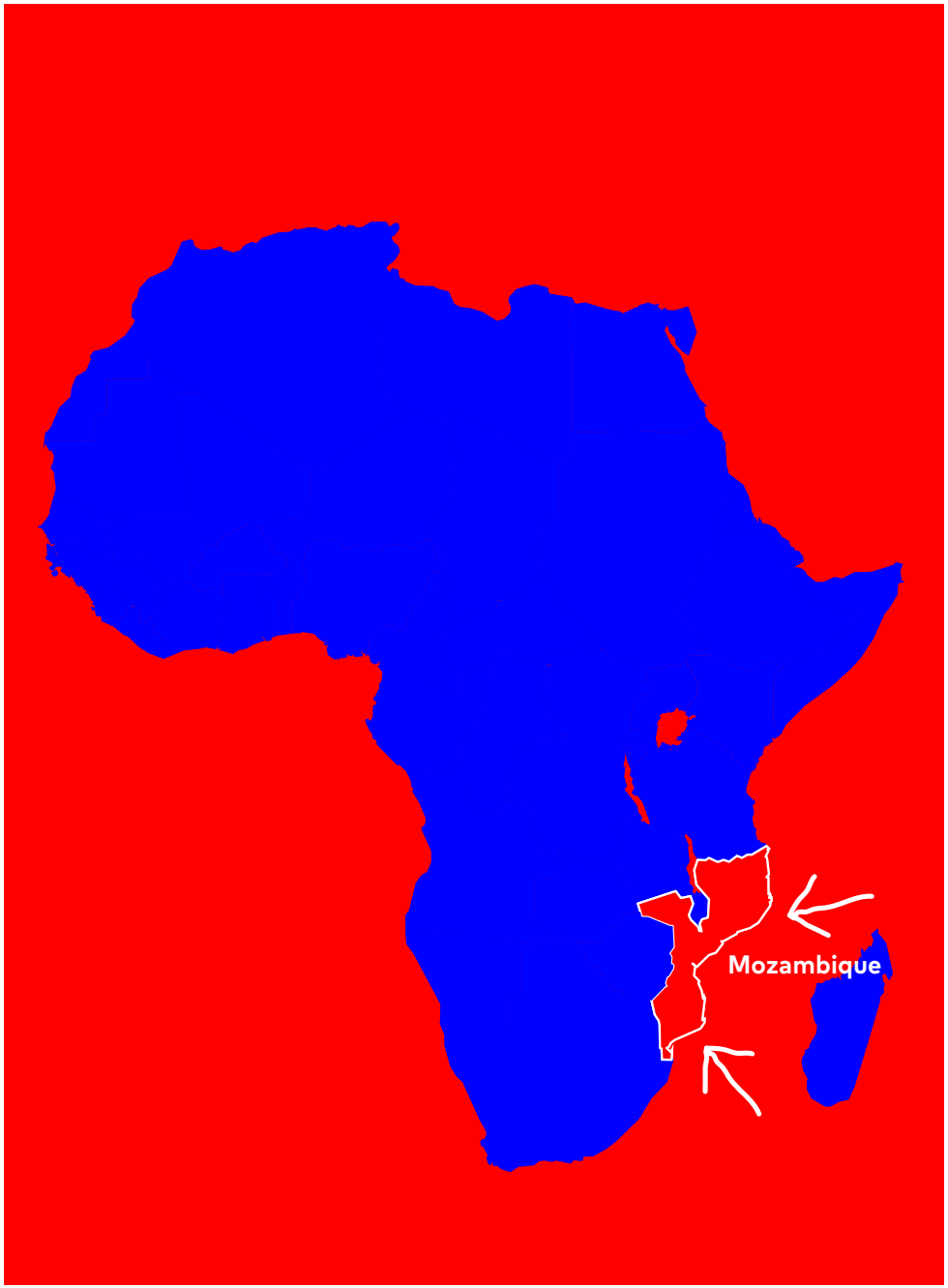
Morocco's 2011 constitution granted CSOs a more formal role in the enactment, implementation and evaluation of the government's decisions and initiatives. Articles 12 and 13 elaborate on the right to participate in the conduct of public affairs.[34] As such, CSOs in Morocco engage in public participation, civic participation and citizen participation. CSOs and key populations engage with the MoH under the National AIDS Programme, which was a result of the recommendation of the Global Fund; even though this is a good start, CSOs, and key populations especially, are not involved in decision making processes.

Under national law/policy there are provisions for social contracting or other mechanisms by which the government finances CSOs to provide health services; but there are legal barriers to the free operation of NGOs/CSOs, including those working with key populations.

CONCLUSION

Morocco has made significant strides in advancing UHC through its 2011 constitution, which explicitly recognises the right to universal access to health services and the right to access quality health services. These constitutional articles align with the WHO's for UHC, aiming to provide effective health services to all without financial hardship, and the AMO health insurance scheme covers approximately 70% of the population. The strides that Morocco has made include improvements to maternal health, with the Maternal and Child Health policy granting pregnant women access to free obstetric care, irrespective of their socioeconomic status. However, access to health care remains a challenge for rural communities, leading to higher maternal and child mortality rates in rural areas compared with urban regions.

CSOs have played a vital role in Morocco's UHC journey, with the 2011 Constitution granting them a formal role in influencing government decisions and initiatives. However, there is little literature on CSOs' output in delivering UHC through government projects. Rural areas lack sufficient public health facilities, and in general service delivery in public health facilities discriminate against KVP. Despite the aforementioned progress, Morocco falls short of the Abuja declaration's target, currently allocating only 7.2% of its national budget to health. In addressing HIV/AIDS within UHC, Morocco also faces challenges in achieving the 95-95-95 targets, with only 58% of all HIV-infected individuals on ART. Discrimination and criminalisation of KVP, such as same-sex individuals, sex workers and drug users, further hinder progress in controlling HIV transmission.



8. Mozambique

8.1. Background

About two-thirds of Mozambique's estimated 33 million population (2022) people live and work in rural areas. The country is endowed with ample resources, including arable land, abundant water sources, energy and mineral resources, as well as newly discovered deposits of natural gas off its coast. After a modest recovery in 2021, growth gathered pace in 2022, reaching 4.2%, and is expected to accelerate to 6.0% in 2023, driven mainly by the recovery of services and the start of liquified natural gas production at the Coral South offshore facility. Total public debt declined in recent years, and it is assessed as sustainable. However, risks are tilted to the downside in the medium term.

In 2022 there were 97,000 new HIV infections among individuals of all ages, a reduction of 25% compared with 2017. Globally, Mozambique has the second-highest number of people living with HIV and of new HIV infections.[35] HIV prevalence among women is higher (15%) than among men (9.5%).

8.2. State of UHC

Mozambique scores 44 on the WHO UHC service coverage index. The MoH plays a key role in implementation of the right to health making health available to the majority of the population.[36] However, communicable diseases still spread, particularly HIV/AIDS, TB and malaria, due to social and structural barriers. Mozambique joined IHP+ (now UHC2030) in 2007. The Health Sector Strategic Plan 2014-2019 emphasises a "reform and decentralisation agenda" with particular attention to women, young people and the elderly.

8.3. Finance

Government health spending is 7.3% of the national budget (against the 15% Abuja target), with spending of 2.4% of GDP (against the 5% Chatham House recommendation) and an allocation of US$11.00 per capita (against the WHO HLTF recommendation of US$86.30). The government contribution to total health spending is 32%, household out-of-pocket spending is 10% (the World Bank characterises spending above 10% as catastrophic), the development partner contribution is 52%, other private health spending is 6% and voluntary pre-paid insurance spending is 0%. The percentage of government spending on health does not align with the Global Fund co-financing targets, but has achieved the target for adequate tax revenue to align with Global Fund tax-to-GDP ratio co-financing targets.

Since 2002, the Global Fund has signed over US$2.2 billion and disbursed over US$1.6 billion. Active grants total US$927 million for the 2021-2023 implementation period. PEPFAR has been funding Mozambique with US$400 million for the past few years. Together, PEPFAR and the Global Fund are the main sources of funds for the HIV response, contributing approximately 83% of HIV expenditures as of 2020.

8.4. HIV/AIDS within UHC

ARVs are covered by the national health system, but PrEP is not. The national policy allows the sharing of HIV data publicly, disaggregated by geographic region, age and gender; however, the data is shared less frequently than recommended. Mozambique's national policy allows for community ART distribution, reduced frequency of clinical visits and for multi-month dispensing, giving access to 6-month refills of ART. Self-testing is approved by the national policy, but the law does not prohibit compulsory testing, and national policy requires adolescents to obtain parental/guardian consent to access HIV testing and/or treatment.

As of 2023, among people living with HIV, 86% are aware of their HIV status; 81% of those who know their status are receiving ART; and 71% of those on ART have achieved viral-load suppression.

8.5. Access to services for key and vulnerable populations

According to the National Health Strategy, female sex workers, prisoners, people who use drugs, men who have sex with men, truck drivers, people living with HIV, adolescent girls and young women and people living with disabilities are identified as KVP. Although there is a general health service package for all citizens, there is no specific health service for KVP, but they may be referred to private health facilities. Service priority is given to men who have sex with men for PrEP, self-testing and lubricants, but there is no specific package of care for key populations. Most patients can access PHC and HIV services in public facilities without having to pay user fees. The national policy makes PHC and HIV services accessible for all migrants under the same condition as citizens.

The national law and HIV policy does not include harm reduction service packages for people who inject drugs, but national law avoids criminalising possession of syringes and associated paraphernalia. Condoms/lubricants and needles/syringes are prohibited in prisons as a matter of national policy.

Consensual same-sex sex is not criminalised under national law, and there are no reports of people being prosecuted in recent years. National law does not criminalise sex work; however, the management, organisation or facilitation of sex work is a crime and is sometimes used against sex workers. National law criminalises the use or possession of drugs for personal consumption, as well as HIV exposure/transmission, through laws that apply either to HIV specifically or other laws (including by imposing penalties if people living with HIV do not disclose their status to a partner). However, law-enforcement policy avoids arresting or prosecuting people for HIV transmission/exposure, and there are no reports of people such arrests or prosecutions in recent years. National law protects people from discrimination, including in employment, based on sexual orientation, gender identity/diversity and HIV status. Health is included as a right in the national constitution. Mozambique has an independent national human rights institution to which violations can be reported that is fully compliant with the Paris principles.

National policy does not encourage secondary-school retention among girls. Mozambique has domestic violence legislation with enforceable penalties. The country utilises unique IDs (or another method of de-duplicating data) that allows for continuity of care across multiple facilities. However national law does not include legally enforceable protections against disclosure of individually identifiable health data.

The health workforce has been increasing year by year and progress has been observed towards friendly services for KVP, but they still face stigma and discrimination when accessing services. (Moreover, there have been instances of sex workers being abused by law enforcers.) As a result, some key populations prefer to receive services after working hours, but this has been difficult to carry out because there are no resources to pay extra time for health workers. The resource limitation has also hindered distribution of some essential items (condoms and lubricants) to remote provinces and rural areas. Engagement mechanisms for CSOs and communities

8.6. Engagement mechanisms for CSOs and communities

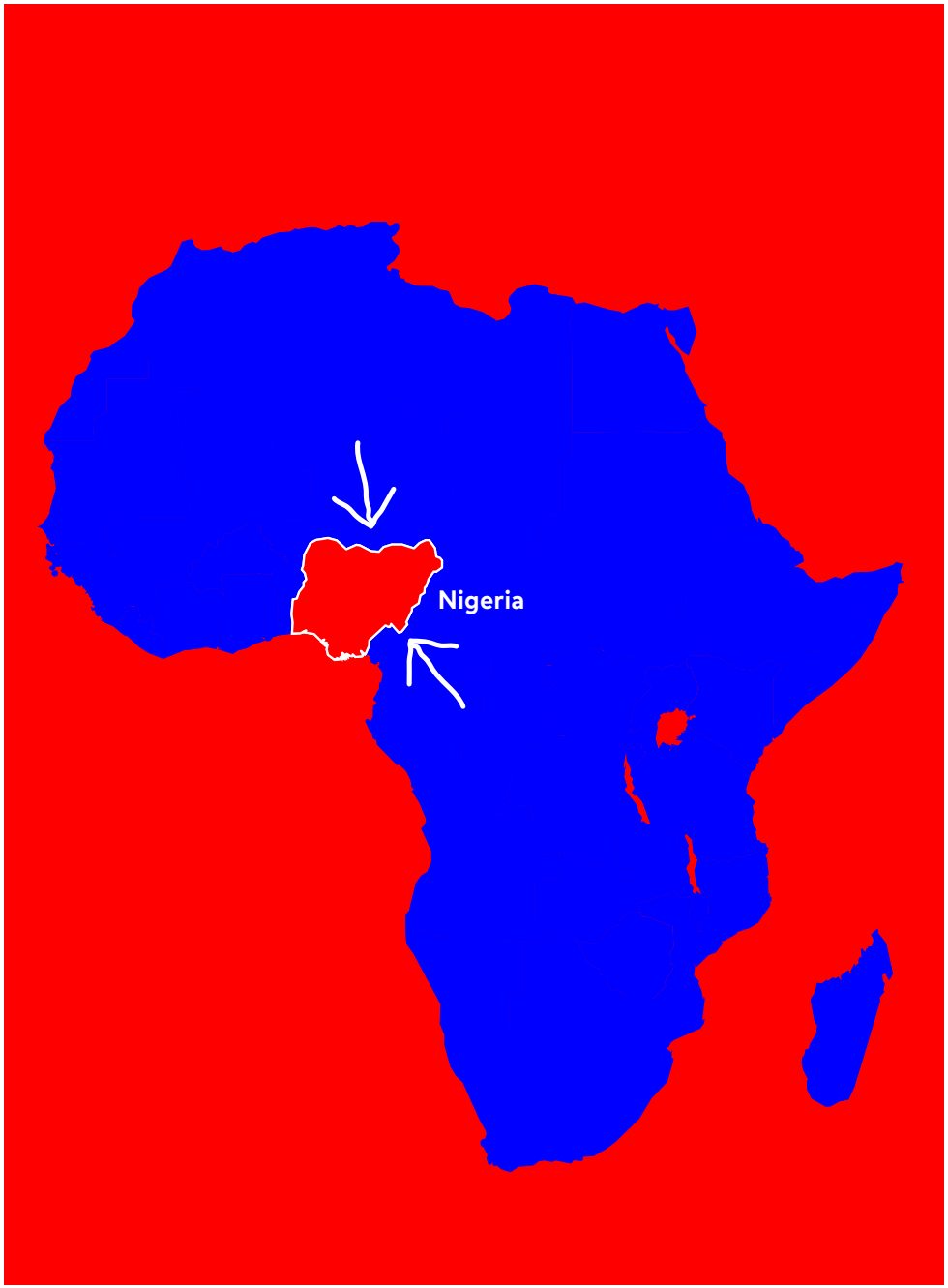
Despite growth over the last two decades, CSOs in Mozambique require stronger organisational capacity to fully participate in national dialogue and development. CSOs participate in the planning and validation of HIV activities, however due to inadequate capacity, they do not perceive that they have a significant impact, but feel that they participate more in the validation process rather than being involved from the start. There is room for improvement to institutionalise civil society contributions. Under national law/policy there are provisions for social contracting or other mechanisms by which the government finances CSOs to provide health services; but there are also legal barriers to the free operation of NGOs/CSOs, including those working with key populations.

CONCLUSION

Mozambique has made commendable progress in healthcare financing, with a budget allocation of 7.3% and reduced out-of-pocket payments, contributing to better accessibility of healthcare services. However, challenges in maternal mortality, service quality and spending efficiency persist, necessitating further efforts to reinforce UHC. There are several key obstacles which are impeding UHC in Mozambique. Notably, there is no specific health service tailored to KVP, and stigma and discrimination hinder their access to services. Furthermore, social and structural barriers impede the adoption of essential UHC policies, such as ending compulsory testing, PrEP, prisoners' HIV prevention policy, and drug use non-criminalisation.

Although the National Strategic Plan clearly opposes discrimination based on identity and sexual orientation, there are instances where professional, personal values and principles are not upheld. Recommendations have been made to the MoH to review curricula for health services providers, aiming to improve the current practice, because single initiatives are not sustainable to reach all health providers. There is also a need for regular health workforce training programmes which should be strengthened by a strategy and resources (both human and financial) for sustainability.

Recommendations have been made to the MoH to review healthcare provider curricula and implement regular training programmes for the health workforce. Ministries should work together to improve the legal environment, repealing punitive laws and creating a friendly regulatory environment towards KVP. Overall, Mozambique's efforts to enhance the healthcare system could be strengthened through greater investment and by fostering collaboration between stakeholders, the private sector and CSOs.



9. Nigeria

9.1. Background

Nigeria is a multi-ethnic and culturally diverse federation of 36 autonomous states and the Federal Capital Territory. Its population of 218.5 million makes it the most populous country in Africa.[37] Between 2000 and 2014, Nigeria's economy experienced broad-based and sustained growth of over 7% annually on average, benefitting from favourable global conditions, and macroeconomic and first-stage structural reforms. From 2015-2022, however, growth rates decreased and GDP per capita flattened, driven by monetary and exchange-rate policy distortions, increasing fiscal deficits due to lower oil production and a costly fuel subsidy programme, increased trade protectionism, and external shocks such as the COVID-19 pandemic. Weakened economic fundamentals led the country's persistent inflation to reach a 17-year high of 25.8% in August 2023, which, in combination with sluggish growth, is leaving millions of Nigerians in poverty. Nigeria has a GDP of US$477.38 billion, making the country the largest economy in Africa. The majority of the population live in extreme poverty.[38]

There were 74,000 new HIV infections in 2021 among individuals of all ages, a reduction of 33% compared with 2016.

9.2. State of UHC

Nigeria scores 38 on the WHO UHC service coverage index. In 2022, the Nigerian government instituted into law a National Health Insurance Act (NHIA) to promote, regulate and integrate health insurance schemes.[39] The NHIA makes health insurance mandatory for all residents of Nigeria, with the introduction of a Vulnerable Group Fund and implementation

of the Basic Health Care Provision Fund through the established State Health Insurance Schemes. This is a major step towards the achievement of UHC, as the NHIA aims to provide comprehensive, good quality care that covers basic health services for disease prevention, health promotion and health maintenance, including offering basic diagnostic tests and supplying safe, affordable medicines and vaccines.

9.3. Finance

Government health spending is 4.2% of the national budget (against the 15% Abuja target), with spending of 0.5% of GDP (against the 5% Chatham House recommendation) and allocation of $10.00 per capita (against the WHO HLTF recommendation of US$86.30). The government contribution to total health spending is 14%, household out-of-pocket spending is 75% (the World Bank characterises spending above 10% as catastrophic), the development partner contribution is 10%, other private health spending is 1% and voluntary pre-paid insurance spending is 1%. The proportion of government spending going towards health and the country's tax-to-GDP ratio do not align with the Global Fund co-financing target.

In 2022, PEPFAR disbursed over US$7.8 billion for comprehensive access to quality HIV prevention, care and treatment services for people living with HIV and had over 1.9 million Nigerians accessing ART.[40] The Global Fund allocated US$1.5 billion for the 2017-2019 and 2020-2022 funding cycles. The Global Fund has also allocated US$294 million to mitigate the impact of COVID-19. Nigeria pledged US$12 million for the Global Fund's sixth Replenishment and has so far contributed US$10.17 million, covering 2020-2022.

9.4. HIV/AIDS within UHC

Neither ARVs nor PrEP are covered by the national health system. Nigeria has adopted a national policy to publicly share HIV data disaggregated by geographic region, age and gender, on a quarterly basis. Nigeria's national policy allows for community ART distribution, and partially allows for reduced frequency of clinical visits (3-5 months for people established on ART) and for multi-month dispensing which gives access to 3-5-month refills of ART. Self-testing is approved by the national policy, which does not prohibit compulsory testing. The national policy requires adolescents to obtain parental/guardian consent to access HIV testing and/or treatment.

As of 2022, among people living with HIV, 90% were aware of their HIV status; 90% of those who knew their status were receiving ART; and 86% of those on ART have achieved viral-load suppression.[41]

9.5. Access to services for key and vulnerable populations

KVP in Nigeria are identified as male and female sex workers, military men, adolescent girls and young women, prisoners, drug users and LGBTQI+ people. Some of the services provided for KVP are HIV testing and viral load testing, however there are funding constraints for HIV and palliative care. NGO-based healthcare providers have services for community-based treatment and self-test kits. Most patients are required to pay formal or informal user fees to access PHC and HIV services in public facilities. The national policy makes PHC and HIV services accessible for all migrants under the same condition as citizens.

National law and HIV policy includes a harm reduction service package for people who inject drugs and avoids criminalising possession of syringes and associated paraphernalia. Condoms/lubricant and needles/syringes are not available in prisons and are prohibited as a matter of national policy.

National law criminalises consensual same-sex sex acts, and there are reports of people being prosecuted in recent years. Sex work and the use or possession of drugs for personal consumption are also criminalised, as well as HIV exposure/transmission, through laws that apply either to HIV specifically or other laws (including by imposing penalties if people living with HIV do not disclose their status to a partner). However, law-enforcement policy avoids arresting or prosecuting people for HIV transmission/exposure, and there are

no reports of such arrests or prosecutions in recent years. National law does not have provisions to protect people from discrimination based on sexual orientation and gender identity/diversity, including in employment, but it does protect people from discrimination based on HIV status, including in employment. Nigeria has an independent national human rights institution to which violations can be reported that is fully compliant with the Paris principles. The national constitution does not include the right to health.

There is no provision to encourage secondary- school retention among girls. Nigeria has domestic violence legislation with enforceable penalties. The country utilises unique IDs and has legally enforceable data-privacy protections.

9.6. Engagement mechanisms for CSOs and communities

Under national law/policy there are provisions for social contracting or other mechanisms by which the government finances CSOs to provide health services; but there are also legal barriers to the free operation of NGOs/CSOs, including those working with key populations. There is currently no mechanism for CSOs to engage with the government on UHC or other health issues. Engagement with the government is often irregular and usually organised by partners such as Packard and AVAC.

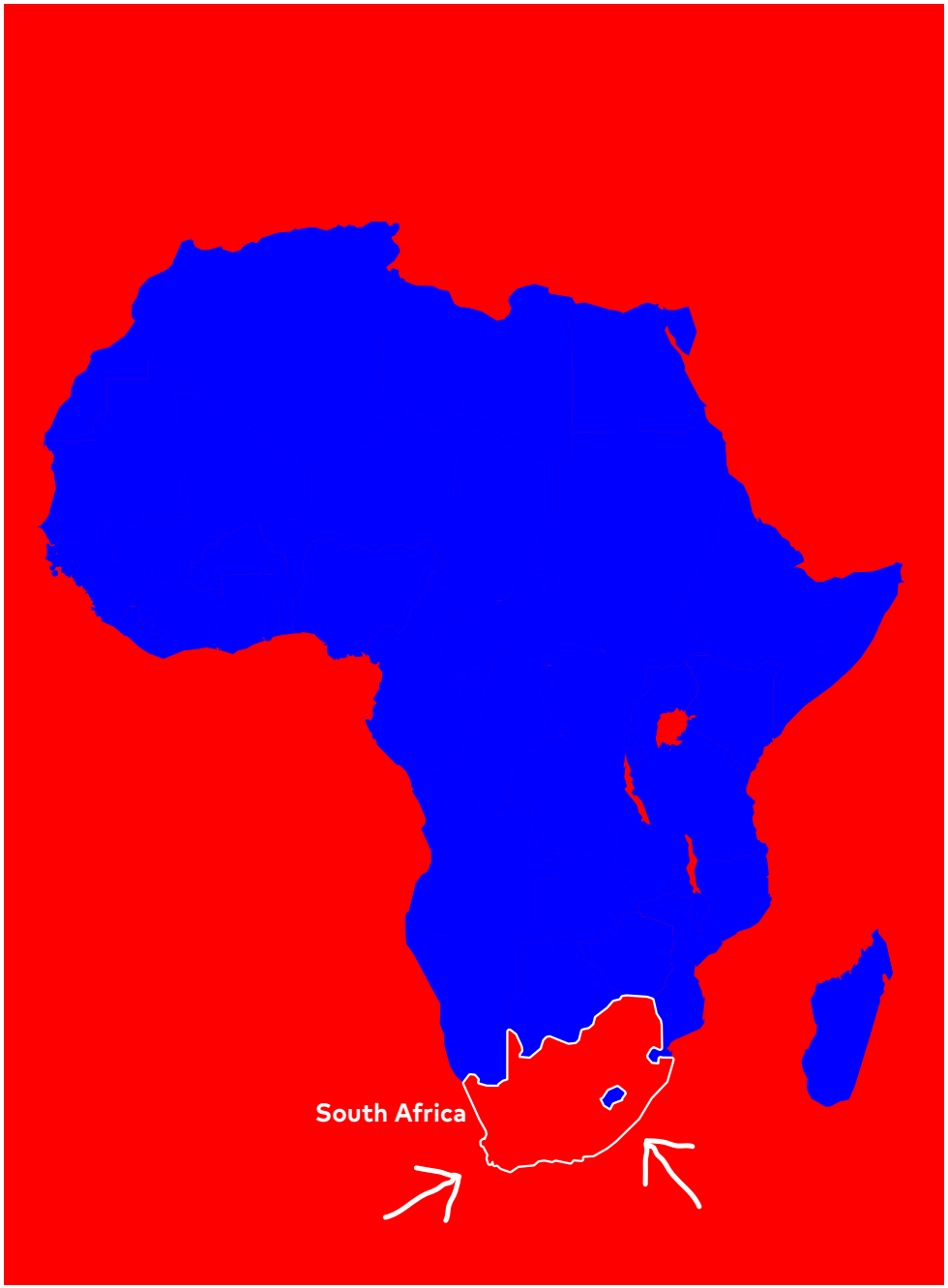
There is also a key population secretariat, the Nigeria Key Populations Health and Rights Network (NKPHRN), which is a group of minority representatives who serve as enforcers at the funding level to ensure communities get HIV services, and to help develop budgets. They also assist monitoring and evaluation to follow up whether funded activities have reached their intended targets.

CONCLUSION

There have been significant efforts to combat HIV/AIDS within the context of UHC. However, for UHC to be fully implemented, awareness about the needs of KVP is necessary, to reduce stigma and discrimination and to challenge laws that target sexual orientation. Challenges persist in reaching KVP. Discrimination against some of these groups within public health facilities hinders their access to essential services and care. Criminalisation of certain groups, such as drug users and sex workers, further hampers access to health services.

The UNAIDS Country Office has criticised the frequent arrest of key populations and violence, stigma and discrimination against them.[42] To improve services and to enable a friendly environment for KVP, there should be mass awareness campaigns for communities and health service providers. For instance, it should address the misconception that "HIV is no more; no need for protection". There is a need to address issues of "classism" (discrimination) based on sexual orientation and to address some of the legal support systems such as the Same Sex Marriage (Prohibition) Act of 2013, which encourages people to report others based on their sexual orientation. HIV and AIDS anti-discrimination law and mandatory policy legal coverage should also protect the rights and privileges of KVP.

Thus, while Nigeria has taken significant steps towards UHC, there remain considerable challenges to address, particularly in expanding coverage and accessibility for KVP. Moreover, there is a need for structured engagement mechanisms for CSOs and the government to discuss UHC and health issues, enabling better representation and collaboration for policy development and implementation.



10. South Africa

10.1. Background

South Africa's GDP per capita in 2021 was US$7,055, and the country is currently ranked 31st among the major economies. Approximately 55.5% (30.3 million) of the population live in poverty at the national upper poverty line (ZAR 992) while a total of 13.8 million people (25%) are experiencing food poverty.[43] South Africa remains a dual economy, with one of the highest and most persistent inequality rates in the world. High inequality is perpetuated by a legacy of exclusion and the nature of economic growth, which is not pro-poor and does not generate sufficient jobs. Inequality in wealth is even higher, and intergenerational mobility is low, meaning inequalities are passed down from generation to generation with little change over time.

In 2022 there were 160,000 new HIV infections among individuals of all ages, a reduction of 30% compared with 2017.

10.2. State of UHC

South Africa scores 71 on the WHO UHC service coverage index. In 2019, President Cyril Ramaphosa launched the Presidential Health Summit Compact to strengthen health systems. The compact laid out a five-year roadmap for health-systems strengthening reforms, with nine pillars for accelerating UHC, including: augmenting and better distributing human resources for health; improving supply-chain management to improve access to essential medicines, equipment and supplies; executing the health infrastructure plan; engaging the private sector; involving the community; improving the health system in terms of quality, safety and quantity; increasing efficiency in financial

management; developing national health information systems to guide policies, strategies and investment; and strengthening governance and leadership to ensure accountability.[44]

10.3. Finance

Government spending on health is 15.3% of the national budget (against the 15% Abuja target), with spending of 5.3% of GDP (against the 5% Chatham House recommendation) and an allocation of $304.00 per capita (against the WHO HLTF recommendation of US$86.30). The government contribution to total health spending is 62%, household out-of-pocket spending is 5% (well below the World Bank-recommended upper limit of 20%), the development partner contribution is 1%, other private health spending is 1% and voluntary pre-paid insurance spending is 31%. The percentage of government spending on health aligns with the Global Fund co-financing targets, and the country's tax-to-GDP ratio meets or exceeds the Global Fund co-financing target.

South Africa is both a donor and implementer of Global Fund-supported programmes. Since 2003, the Global Fund has disbursed US$1.3 billion to South Africa, and the government contributed to the Sixth Global Fund Replenishment with a pledge of US$10 million, which it has disbursed. PEPFAR contributed to the 2022-2023 budget a total of US$475.6 million to continue reducing HIV indicators in South Africa.

10.4. HIV/AIDS within UHC

Both ARVs and PrEP services are covered by the national health system/scheme, and there is a national policy to publicly share HIV data disaggregated by geographic region, age, and gender (at least), on a quarterly basis. South Africa's national policy allows for community ART distribution and reduced frequency of clinical visits, but the policy for multi-month dispensing has only been partially adopted, giving access to 3-5-month refills of ART. Self-testing is approved by national policy, which also prohibits compulsory testing. National policy does not require adolescents to obtain parental/guardian consent to access HIV testing and/or treatment. Achieving UHC in South Africa for people living with HIV and key populations still lags, in part because the government has not yet adopted HIV paediatric diagnosis and treatment.[45]

As of 2023, among people living with HIV, 94% are aware of their HIV status; 75% of those who know their status are receiving ART; and 69% of those on ART have achieved viral-load suppression.

10.5. Access to services for key and vulnerable population

KVP are identified as sex workers, people who use drugs, men who have sex with men, people living with HIV, prisoners, LGBTQI+ people, adolescent girls and young women. Government health facilities offer UHC services including HIV, TB and STI testing and treatment, pap smears for cervical cancer, abortion and family planning services. Most patients can access both PHC and HIV services in public facilities without having to pay user fees. The national laws and policy make PHC and HIV services accessible to all migrants under the same conditions as citizens.

Harm reduction services are included in national policy and service packages for people who inject drugs, and syringe possession is not criminalised. Condoms/lubricants are available in prisons, but needle/syringes are prohibited as a matter of national policy.

National law does not criminalise consensual same-sex sex acts, and there are no reports of people being prosecuted for such acts in recent years. The law does criminalise sex work and the use or possession of drugs for personal consumption. South Africa does not criminalise non-intentional HIV exposure or transmission, but there are reports of people being arrested or prosecuted for HIV exposure or transmission in recent years. National laws protect people from discrimination, including employment discrimination, based on sexual orientation, gender identity and HIV status. South Africa has an independent national human rights institution to which violations can be reported that is fully compliant with the Paris principles. Health is included as a right in the national constitution.

The national policy encourages secondary-school retention among girls. South Africa has domestic violence legislation with enforceable penalties. The country utilises unique IDs and has legally enforceable data-privacy protections.

South Africa's constitution guarantees everyone access to healthcare services, and vulnerable populations such as refugees and asylum seekers do not need a permit or South African identification documents to access free ART.[46] However, many health providers discriminate against key populations, especially sex workers and people who use drugs, making them ashamed to seek health services and reducing adherence to ART.

10.6. Engagement mechanisms for CSOs and communities

There is no official CSO engagement with the MoH, yet initiatives are being undertaken to strengthen the involvement of civil societies and communities. There is a social contracting policy for financing NGO/CSO-provided services, and NGOs/CSOs (including those that work with key populations) can register, seek funding and operate freely under national law.

CONCLUSION

In South Africa, achieving UHC has been impeded by the discrimination faced by KVP seeking services in government health facilities. This has resulted in reduced uptake of essential services among these marginalised populations. However, the engagement of CSOs has shown promising results in increasing service uptake among these groups. Yet there remains a pressing need to involve CSOs and communities in community-led monitoring and evaluation to ensure inclusive and effective health care. The government faces challenges in adopting policies that cater to the needs of sex workers and people who use drugs, hindering further progress in service uptake among these populations. This, combined with issues of affordability, has resulted in limited coverage for the South African population.

Photo: Cynthia R Matonhodze

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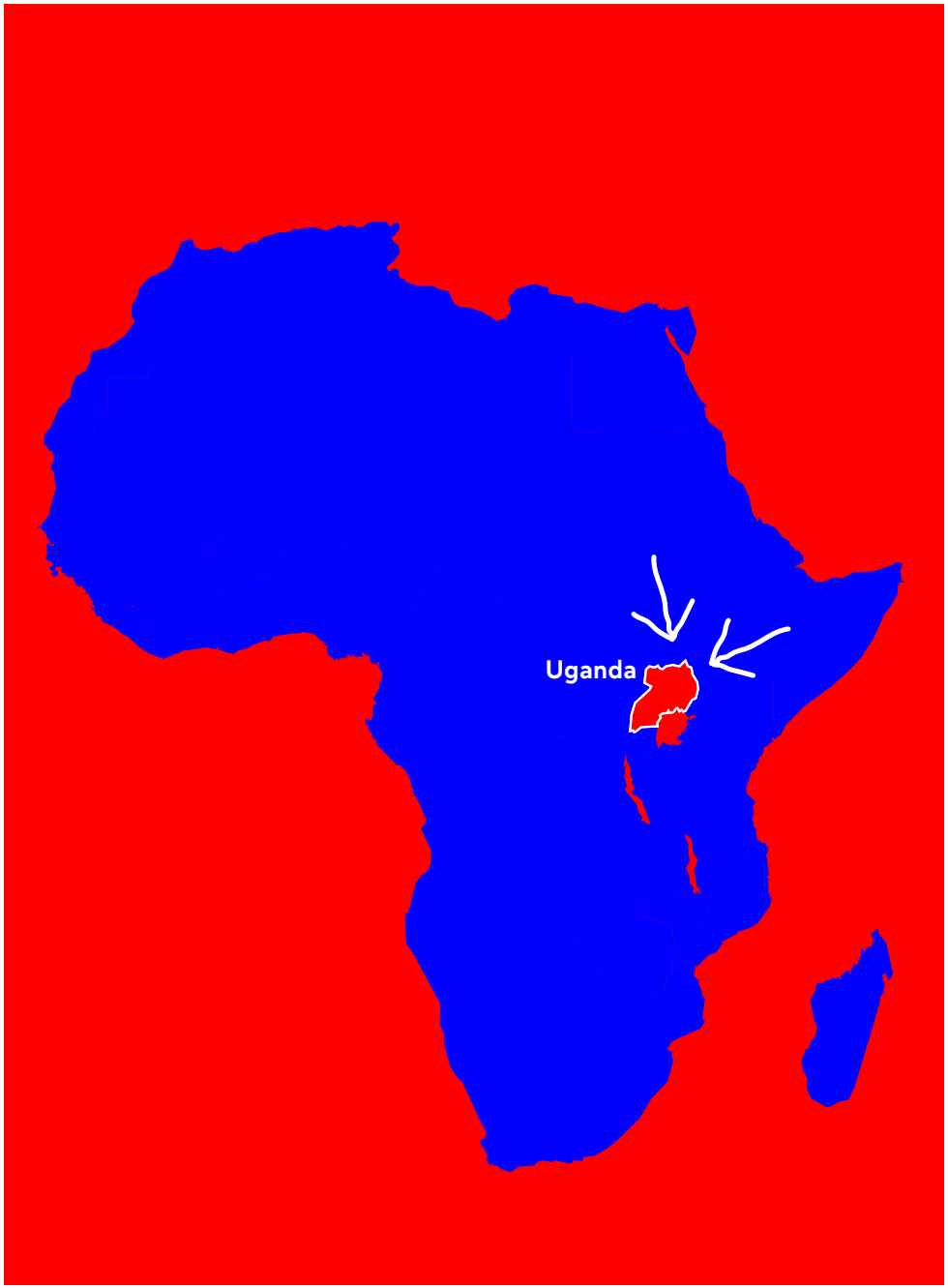


11. Uganda

11.1. Background

Uganda has a population of 48.5 million. The country's GDP is expected to reach US$55.30 billion by the end of 2023,[47] with 20.3% of the population living below the national poverty line.[48] GDP per capita at Purchasing Power Parity(PPP) stands at US$2694, which is 158th place in the Worldometer rankings.[49] Uganda's economy has rebounded strongly, with all three sectors (agriculture, industry and services) weathering recent shocks to push growth in GDP to 5.3% during FY23, compared with 4.7% the year before. Private consumption increased, while public investment was scaled back as fiscal space narrowed and private investment retracted in response to a tight monetary stance through the fiscal year. With higher capital imports, due primarily to investments related to the country's crude oil development project, the current account deficit widened to 8.7% of GDP in FY23, up from 7.9% in FY2022.

In 2022 there were 52,000 new HIV infections among individuals of all ages, a reduction of 15% compared with 2017.

11.2. State of UHC

Uganda scores 48 on the WHO UHC service coverage index. The country's national insurance scheme, which has not yet come into force, is intended to allow recipients to receive health services in both the public and private sectors, increasing accountability for providers to offer competitive and high-quality services.[50]

11.3. Finance

Government spending on health is 3.1% of the national budget (against the 15% Abuja target), with spending of 0.7% of GDP (against the 5% Chatham House recommendation) and an allocation of US$6.00 per capita (against the WHO HLTF recommendation of US$86.30). The government contribution to total health spending is 17%, household out-of-pocket spending is 37% (the World Bank characterises spending above 10% as catastrophic), the development partner contribution is 41%, other private health spending is 1% and voluntary pre-paid insurance is at 4%. The proportion of government spending going towards health does not align with the Global Fund co-financing target, and Uganda has not achieved the target for adequate tax revenue to align with Global Fund tax-to-GDP ratio co-financing targets.

Uganda pledged US$2 million for the Sixth Global Fund Replenishment (2020-2022), and has contributed US$1.08 million. The Global Fund has five core grants active in Uganda, with funding totalling US$602 million assigned for 2021-2023. This includes a combined HIV and TB grant of US$33 million and US$263 million for malaria. PEPFAR contributed to the 2022-2023 budget a total of US$400.2 million.

11.4. HIV/AIDS within UHC

ARVs are covered by the national health system, but PrEP is not. Uganda has adopted a national policy to publicly share HIV data disaggregated by geographic region, age and gender (at least), on a quarterly basis. Uganda's national policies include multiple options for differentiated service delivery, including community ART distribution and maximum flexibility for clinic visit and multi-month dispensing. Self-testing is approved by the national policy, but the law does not prohibit compulsory testing; however, national policy does not require adolescents to obtain parental/guardian consent to access HIV testing and/or treatment. PEPFAR Uganda is playing a key role in improving UHC indicators. As of December 2021, PEPFAR Uganda supported 1.27 million people living with HIV on treatment.

As of 2023, among people living with HIV, 90% are aware of their HIV status; 84% of those who know their status are receiving ART; and 79% of those on ART have achieved viral-load suppression.

11.5. Access to services for key and vulnerable populations

According to the government of Uganda, WHO and UNAIDS, key populations are identified as sex workers, men who have sex with men, people in prison, and people who use drugs. Vulnerable or priority populations are adolescent girls and young women, truck drivers and fishermen. The Uganda key population consortium (UKPC) identifies KVP as LGBTQI+ people, sex workers, and people who use and inject drugs.

Services provided for KVP within the public sector are provided under the most-at-risk-initiative special clinic for key populations in regional hospitals; these services include HIV services, ART, PrEP, services for STIs, specialised operations and HPV vaccine. At drop-in centres, community-led health services focus on malaria, mental health, prevention commodities like condom and lubricants, PrEP services and providing a safe space. Most patients can access both PHC and HIV services in public facilities without having to pay user fees. The national law makes PHC accessible to all migrants under the same conditions as citizens, but restricts access to HIV services for some or all migrants.

Harm reduction services are included in national policy, with service packages for people who inject drugs, and syringe possession is not criminalised. Needles/syringes are available in prisons, but condoms/lubricants are prohibited as a matter of national policy.

Consensual same-sex relations are criminalised by law, and there are reports of people being prosecuted in recent years. National law also criminalises sex work and the use or possession of drugs for personal consumption. Uganda criminalises non-intentional HIV exposure or transmission, and there are reports of people being arrested/prosecuted for this. The law does not offer provisions to protect people from discrimination based on sexual orientation and gender identity/

diversity, including in employment; however, it does protect people from discrimination based on their HIV status, including in employment. Uganda has an independent national human rights institution to which violations can be reported that is fully compliant with the Paris principles. Health is not included as a right in the national constitution.

National policies take limited steps to encourage secondary-school retention among girls. Uganda has domestic violence legislation with enforceable penalties. National law includes legally enforceable protections against disclosure of individually identifiable health data, including HIV status, but does not utilise unique IDs (or another method of de-duplicating data) that allows for continuity of care across multiple facilities.

Violence and discrimination against LGBTQI+ people is prevalent in Uganda. After the government passed the now-scrapped 2014 Anti-Homosexuality Act, Human Rights Watch research found that people faced a notable increase in arbitrary arrests, police abuse, extortion, loss of employment, discriminatory evictions by landlords, and reduced access to health services because of their perceived sexual orientation or gender identity.[51] Over the years, Ugandan police have carried out mass arrests at LGBT pride events, at LGBT-friendly bars, and at homeless shelters on spurious grounds, and forced some detainees to undergo anal examinations, a form of cruel, degrading, and inhuman treatment that can, in some instances, constitute torture.[52,53,54,55]

Not all health facilities provide friendly services for KVP, but some are friendly as a result of training and capacity-building, as well as formal policies on sexual and gender-based violence to guide health workers on how to provide services to diverse key populations. These policies were developed with the support of the Global Fund. There is also a mechanism to ensure a proper transition of health workers from one facility to the other, so that services for KPs are not interrupted and confidence and trust built over time continue. Private clinics are more key population-friendly than government health service providers, but are not accessible to all key population communities due to the small number of the facilities and the cost.

One of the main challenges for the uptake of services for KVP is the limited understanding of health providers on the needs of key populations, and the limited number of health providers. As a result, key populations are not comfortable going to health facilities because of the negative reactions they may receive. Another problem is the recent anti-LGBT legislation passed by parliament, which will create problems to access services, since criminalisation will not only increase stigma and discrimination but also make it harder for LGBTQI+ people to disclose medical or other issues, thus putting their health and that of their communities at risk.

A further challenge is the poor funding landscape, which is evident with stockouts of essential medicines and a poor doctor-to-patient ratio. The funding gap has also created a "brain drain", with doctors migrating, which exacerbates the shortage of clinicians. These factors affect accessibility, as is seen in the long lines, lack of medicines, and dilapidated infrastructure, as well as the long distances that many people must cover to get services, coupled with resource constraints for transport to the nearest health facilities.

11.6. Engagement mechanisms for CSOs and communities

There have been some platforms organised by the government and WHO to guide conversations around UHC, but the government has not dedicated resources to continuing the engagements. The agenda is there but a coordination mechanism is needed whereby government, development partners and CSOs can engage in a sustainable manner. There is also a technical working group of key populations under the MoH where there is the opportunity to push for UHC in general and for key populations, and another forum under the Uganda AIDS Commission – the National Steering Committee for Key and Priority Populations, co-chaired by USAID and the UKPC – where there is a push for general health agendas and UHC.

Under national law/policy there are provisions for social contracting or other mechanisms by which the government finances CSOs to provide health services; but there are also legal barriers to the free operation of NGOs/CSOs, including those working with key populations.

CONCLUSION

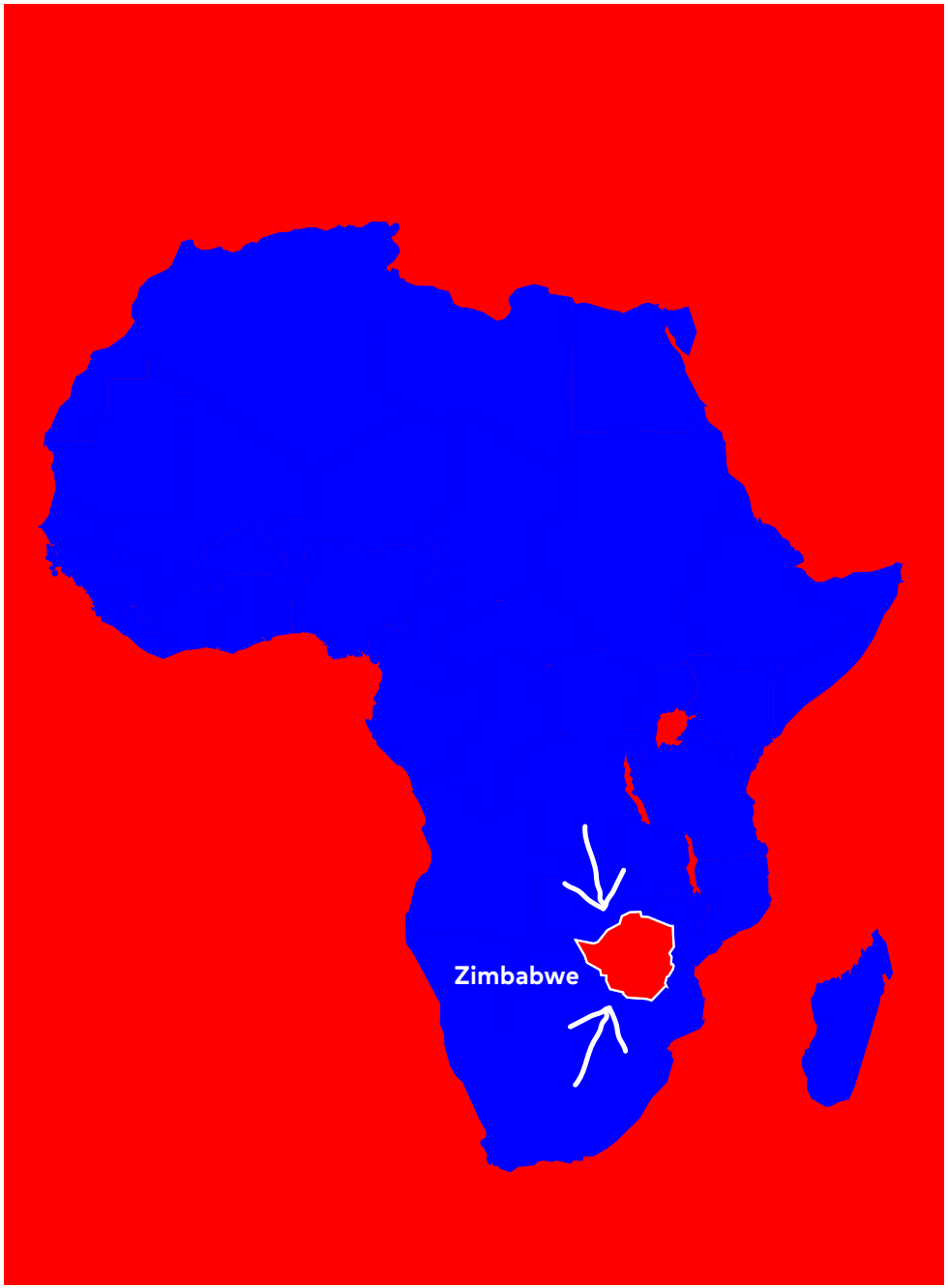
Although the National Health Insurance Scheme was passed in 2021 to increase health coverage, Uganda's current health insurance options only cover a small fraction of the population, estimated at less than 2%. The scheme is yet to come into force, but its implementation is expected to improve accountability and service quality in both the public and private sectors.

However, there are notable policy gaps in removing barriers to health services, and out-of-pocket health expenditures account for a significant portion of health spending, indicating financial barriers for many individuals. Notwithstanding these barriers, foreign aid has played a crucial role in supporting HIV/AIDS initiatives in Uganda and improving UHC indicators.

Despite progress in addressing HIV/AIDS, challenges persist in reaching KVP in Uganda. Identified groups, including sex workers, men who have sex with men, prisoners and drug users, face barriers in accessing friendly and accepting health services. Limited understanding of their specific needs, insufficient healthcare providers, and inadequate funding for essential medicines contribute to their difficulties in accessing services. Additionally, the recent legislation criminalising LGBTQ+ people creates further stigma and discrimination, impeding their ability to express their health needs openly and exacerbating access problems.

Although CSOs have been actively involved in advocating for UHC and engaging in various platforms, the government's commitment and dedicated resources to drive UHC initiatives have been limited.

Photo: Cynthia R Matonhodze



12. Zimbabwe

12.1. Background

Zimbabwe has strong foundations for accelerating future economic growth and improving living standards. The economy has excellent human capital, comparable to that of upper-middle-income economies in sub-Saharan Africa, although skill shortages are emerging in some sectors. Moreover, Zimbabwe possesses abundant mineral and natural resources that, if well managed, can support the country's development objectives. Nevertheless, Zimbabwe's economic development continues to be hampered by several challenges. Real GDP growth remained high at 6.5% in 2022, from 8.5% in 2021, driven by a continued growth in agricultural production. Mineral exporters benefited from rising high global prices and together with tourism contributed to overall economic growth. However, triple-digit inflation constrained private sector demand.

In 2022 there were 17,000 new HIV infections among individuals of all ages, a reduction of 50% compared with 2017. HIV prevalence is almost twice for as high for men who have sex with men as it is for other population groups.

12.2. State of UHC

Zimbabwe scores 55 on the 2021 WHO UHC service coverage index. Zimbabwe joined the UHC Partnership (UHC-P) in 2018, which supports capacity-building for human resources for health and strengthening health-information systems. Zimbabwe, like many other African countries, is still struggling to adopt policies that support increased access to health facilities among KVP.

12.3. Finance

Government spending on health is 5.2% of the national budget (against the 15% Abuja target), with spending of 0.8% of GDP (against the 5% Chatham House recommendation) and an allocation of US$11.00 per-capita (against the WHO HLTF recommendation of US$86.30). The government contribution to total health spending is 22%, household out-of-pocket spending is 10% (below the World Bank-recommended upper limit of 20%), the development partner contribution is 56%, other private health spending is 4% and voluntary pre-paid insurance spending is 7%. The proportion of government spending going towards health aligns with the Global Fund co-financing target, but the country's tax-to-GDP ratio does not.

Zimbabwe participated in contributions to the Sixth Global Fund Replenishment (2020-2022), and pledged and successfully contributed US$1 million. Additionally, PEPFAR contributed a total of US$203.8 million to the 2022-2023 budget.

12.4. HIV/AIDS within UHC

ARVs are covered by the national health system, but PrEP is not. Zimbabwe has adopted a national policy to publicly share HIV data on a quarterly basis; however, data are not disaggregated by geographic region, age or gender. Self-testing is approved by the national policy, but the law does not prohibit compulsory testing. Zimbabwe's national policy allows for community ART distribution, reduced frequency of clinical visits and for multi-month dispensing, which gives access to 6-month refills of ART. The national policy requires adolescents to obtain parental/guardian consent to access HIV testing and/or treatment.

Zimbabwe offers HIV, TB and malaria prevention and treatment services in public health facilities for all populations, but not categorically targeting KVP. The UHC service package includes HIV testing and screening, cervical and breast cancer screening, and STI treatment and management.

As of 2023, among people living with HIV, 95% are aware of their HIV status; 94% of those who know their status are receiving ART; and 89% of those on ART have achieved viral-load suppression.

12.5. Access to services for key and vulnerable populations

According to the HIV National Strategic plan, KVP in Zimbabwe are identified as sex workers, men who have sex with men, people who use drugs, people with disabilities, fishermen, truck drivers, young and adolescent women, youth and transgender people. Most patients can access PHC and HIV services at public facilities without having to pay user fees. National law and policy makes PHC and HIV services accessible to all migrants under the same conditions as citizens. The law does not criminalise possession of syringes and associated drug-injecting paraphernalia, but harm reduction services are not included in national policy and service packages for people who inject drugs. Neither condoms/lubricants nor syringe access/exchange programmes are available to prisoners.

National law criminalises consensual same-sex sex acts, and there are reports of people being prosecuted in recent years. The law also criminalises sex work and the use or possession of drugs for personal consumption. Zimbabwe does not criminalise non-intentional HIV exposure or transmission, but there are reports of people being arrested or prosecuted for HIV exposure or transmission in recent years. The law protects people from discrimination based on sexual orientation and gender identity/diversity, including in employment, but it does not protect people from discrimination based on their HIV status, including in employment. Zimbabwe has an independent national human rights institution to which violations can be reported that is fully compliant with the Paris principles. Health is included as a right in the national constitution.

The national policy encourages secondary school-retention among girls. Zimbabwe has domestic violence legislation with enforceable penalties. The country utilises unique IDs and has legally enforceable data privacy protections.

In terms of services provided to KVP, private or NGO-run facilities are more friendly than government facilities. In addition, services in NGO facilities are free and are delivered by a well-trained, adequately staffed and well-paid health workforce. By contrast, government health facilities are overwhelmed and do not provide adequate services as a result of health workforce migration and drug stockouts, and services for KVP in particular are below average. The main reasons for the observed gaps in government health facilities is that health workers are not trained on KVP-friendly service delivery, and limited access of services for KVP due to stigma, discrimination and for those living in rural areas.

12.6. Engagement mechanisms for CSOs and communities

There is no formal engagement mechanism of CSOs with the MoH on issues related to health or UHC, although there have been a few attempts by CSOs, but these did not take off due to lack of funding. As much as the government has shown interest and a good approach for UHC rollout, there is a coordination gap between government and CSOs in addition to the resource constraints.

National law/policy does not provide for social contracting or other mechanisms by which the government finances CSOs to provide health services, and imposes legal barriers to the free operation of NGOs/ CSOs, including those working with key populations.

CONCLUSION

Zimbabwe has made important steps the UNAIDS 95-95-95 targets, with a high percentage of people living with HIV diagnosed and on ART.

Despite these steps, there is room for improvement, especially in making services accessible to all parts of the population. Access to health services for KVP in Zimbabwe remains limited, with the government criminalising same-sex sex, drug users, sex workers and prisoners. Private and NGO facilities are observed to offer more friendly and adequate services compared with overwhelmed government health facilities. Limited training on friendly service delivery and stigma-related issues are among the reasons for the gaps in government health care for key populations.

KVP and CSOs are not formally engaged in meetings with the government to improve UHC service delivery. These populations experience difficulties in accessing health services in public hospitals due to unfavourable laws. Poor access to services is also exacerbated by having few and inadequately equipped public health facilities.

Photo: Cynthia R Matonhodze

13. Recommendations

13.1. State of UHC

Across the countries, there is notable movement towards UHC. However, the provision of inclusive, quality services to KVP remains a major concern. One of the major recommendations to governments is to address the health needs of KVP as a priority – and therefore to provide essential and adequate services to all, to properly ensure that no one is left behind.

Taking measures to deeply understand the local context is crucial to implement UHC effectively and efficiently. This involves determining and defining the minimum package of services to be offered for KVP, understanding how to generate and cater to the demand, ensuring active community participation and integrating emerging health concerns such as non-communicable diseases. Subsequently, to address how it will be affordable and accessible to all, how to apply community-led monitoring and finally to ensure continuous improvement based on documentation of experiences, especially from KVP. All of this will help to establish sustainable and strengthened health coverage.

13.2. Finance

Regionally, improving financing is a crucial area to ensure UHC. This necessitates commitments and advocacy towards the Abuja Declaration. While South Africa has achieved the 15% target, further action is required to fund UHC services and alleviate financial burdens on patients. To achieve this, health insurance must become universally accessible, encompassing all segments of the population through partial payments by the government.

Even in countries like South Africa, where the Abuja target has been met, the majority of the population still lack medical insurance. Moreover, in countries with fragmented financing sources, such as in Burundi, gaps in subsidies and health coverage are created, leaving patients to bear out-of-pocket costs. Political will from governments is needed to prioritise and invest in funding for UHC services. This includes bolstering NHI programmes such as the Régime d'Assurance Maladie Universelle in Burkina Faso. Moreover, clarity on how financing programmes will be resourced, and clear steps to achieve them, are necessary.

While UHC must be politically championed, it should not be exploited for political gains or presidential campaigns. A clear distinction needs to be made between UHC and entities like the NHIF in Kenya, which is simply a means of achieving UHC. Ultimately, UHC is a collective responsibility owned by the people, and funded for them.

13.3. HIV/AIDS within UHC

Remarkable progress has been made in the fight against HIV/AIDs in certain countries. For instance, Kenya and Zimbabwe are close to achieving the UNAIDS 95-95-95 targets. Additionally, countries like South Africa and Uganda show promise in meeting the UNAIDS targets.

On the other hand, several countries face greater challenges in dealing with HIV/AIDS. For example, Morocco is still far from achieving the 95-95-95 targets, and in Egypt, while UHC is in its preliminary stages, there has been no national rollout of HIV treatment services. Across all 10 countries, KVP continue to face significant disadvantages in accessing HIV services. Even in countries where progress has been made in offering HIV/AIDS health care, social, structural and legal barriers persist. Nigeria, for instance, is close to epidemic control but needs to improve case-finding in specific demographics and locations. In Burkina Faso social stigmatisation and criminalisation of KVP have slowed progress toward achieving the 95-95-95 target.

Additionally, barriers to the adoption of HIV testing and prevention policies remain, including age restrictions on testing and treatment, lack of comprehensive sexuality education, and inadequate prevention measures for prisoners. Particularly concerning Zimbabwe, the prevalence of HIV among men who have sex with men is significantly higher than that of the rest of the population. Yet this group systematically struggles to access HIV services and testing.

While there are a few examples of enabling policies, such as the Presidential Health Summit Compact in South Africa, legislation in Burkina Faso which supports HIV treatment and Burundi's resource allocation to end HIV/AIDS, these efforts must be bolstered by more comprehensive policies that aim to extend UHC to all. In addition to the aforementioned policies, it is necessary to implement TB diagnosis in line with WHO recommendations, particularly in Burundi and Burkina Faso. Some governments need to prioritise greater inclusion of marginalised groups and community-led efforts to improve their HIV/AIDS response, e.g. in Kenya and Burundi.

13.4. Access to services for key and vulnerable populations

To ensure that UHC services are available to KVP, countries need to identify and overcome several obstacles. The first crucial step is repealing legislation that criminalises and stigmatises KVP. Example of such legal barriers include the criminalisation of homosexuality, drug use and sex work in countries like Kenya, Mozambique, Egypt, Nigeria, Zimbabwe, Morocco and Uganda.

Uganda's Anti-Homosexuality Act of 2023 discriminates against people with disabilities, contrary to the country's constitution, by making the offence of homosexuality aggravated if the "victim" has a disability, thereby denying persons with disabilities the capacity to consent to sex. Anyone advocating for the rights of LGBT people, including representatives of human rights organisations or those providing financial support to organisations that do so, could face up to 20 years' imprisonment for the "promotion of homosexuality." There is a chance that the law might reverse gains achieved so far in the fight against HIV/AIDS.

Beyond punitive laws, a lack of enabling policies also hinders progress towards UHC. For instance, Egypt is currently working on launching a CSO initiative with organisations led by people living with HIV and KVP, but without supportive legislation this health platform cannot move forward. Across all countries, there is a lack of needed UHC policies, such as on compulsory testing, prisoners' HIV prevention, and non-criminalisation of same-sex sex , sex work and drug use.

Barriers to essential services are not only legal, but structural, such as barriers to access public health facilities in rural areas; or social, as in several countries where KVP feel unsafe accessing health services because of stigmatisation and discrimination from health providers. Stigmatisation is in part the result of gaps in knowledge and awareness. Health workforce capacity-building, training, and public campaigns can help educate and shrink the awareness gap. Indeed, in countries where the population are hostile to or disregard the needs of KVP, such campaigns are imperative to change the narrative about the healthcare needs of the most vulnerable. In Nigeria, for example, campaigns would have to address the prevalent and damaging idea that "HIV is no more there, so no need for protection".

13.5. Engagement mechanisms for CSOs and communities

Beyond addressing the needs of KVP, the engagement of CSOs in all stages of UHC rollout must be strengthened. A multi-stakeholder and multi-sectoral approach to monitoring should be adopted to enable non-state actors to hold governments to account on policy implementation, and to assess the quality of universal public health services accessible to communities and KVP. Several countries exhibit piecemeal engagement from CSOs, lacking a formal mechanism that consolidates that role of communities; this is particularly an issue in Burkina Faso, Nigeria and Mozambique, where there is ad hoc engagement from CSOs on resource mobilisation, proposal writing and capacity-building, but which overlooks organisations that represent KVP.

There is evidence of positive formal engagement between CSOs and government which can act as a blueprint for other countries in the region. Significantly, Morocco's constitution has granted CSOs direct influence in the enactment, implementation and evaluation of the government's decisions and initiatives. This kind of positive collaboration is only made possible by an improved legal framework for civil society and public participation in health. Indeed, in Burundi, national health councils may bring together multi-sectoral organisations, but without laws, policies or regulations that give guidelines for CSOs to be funded or supported.

Frequent engagement from CSOs and other stakeholders can accelerate UHC rollout and implementation, as seen in Morocco and to an extent Egypt and Mozambique. But, as consistently underscored across all nations, for CSOs and communities to actively participate they must be represented and empowered by having a decision-making role in the overall process – design, implementation, M&E and reporting. This could be via a national technical working group on UHC, where CSOs are represented on the steering committee. An alternative is a community-led observatory, as it is important to have open access to public data on key issue areas. In any case, progress-based timelines, adequate funding and formalised platforms should be a requirement. CSOs and communities should benefit from legal and financial support to help them participate in all stages of UHC, while retaining their independence.

SOURCES

The table below presents information on sources for data and other information in each country profile.

Background		
Economic data	World Bank	www.worldbank.org/en/where-we-work
State of UHC		
WHO UHC service coverage index	WHO UHC service coverage index	data.who.int/indicators/i/9A706FD The score is the geometric mean of 14 tracer indicators measuring coverage of four essential health-service areas: 1. Reproductive, maternal, newborn and child health 2. Infectious diseases 3. Noncommunicable diseases 4. Service capacity and access.
Domestic health financing	2023 Africa Scorecard on Domestic Financing for Health	score-card.africa/ The World Bank characterizes out-of-pocket spending on health above 10% of household income as catastrophic: blogs.worldbank.org/opendata/catastrophic-expenditure-health-antiquity-today
Global Fund contributions	Global Fund country profiles	www.theglobalfund.org/en/government/profiles/
PEPFAR contribution	PEPFAR Country Operational Plans	www.state.gov/where-we-work-pepfar/
Global Fund co-financing targets	HIV Policy Lab; Global Fund Guidance Note on Sustainability, Transition and Co-financing	www.hivpolicylab.org/ www.theglobalfund.org/media/5648/core_sustainabilityandtransition_guidancenote_en.pdf A portion of a country's Global Fund allocation is dependent on the country meeting its co-financing targets: the country receives that portion if it meets the targets, which are a specified level of domestic health funding, and a tax-to-GDP ratio.
HIV/AIDS within UHC		
Progress towards 95-95-95	WHO HIV Country Intelligence	cfs.hivci.org/index.html
Access to services for key and vulnerable populations		
Legal status of key populations	HIV Policy Lab	www.hivpolicylab.org/
Legal status of HIV exposure/transmission		
Protection from discrimination		
National human rights institution		
Secondary-school retention		
Social contracting and free operation of NGOs/CSOs		
Domestic violence legislation		
Unique IDs		

END NOTES

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