

# From Commitments to Action: Civil Society Perspectives on Reaching Universal Health Coverage



“Politicians call it UHC. I may not call it UHC, but I will call it one step towards UHC.”

– Civil society representative participating in a focus group in Pakistan

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## ACRONYMS

ART	Antiretroviral therapy
CSEM	Civil Society Engagement Mechanism for UHC2030
CSO	Civil Society Organization
LGBTQIA+	People who are lesbian, gay, bisexual, transgender and gender diverse, intersex, queer and questioning, asexual and aromantic, and other related identities
NCDs	Non-Communicable Diseases
NGO	Non-Governmental Organizations
STIs	Sexually Transmitted Infections
TB	Tuberculosis
UN HLM	United Nations High-Level Meeting
UHC	Universal Health Coverage
WHO	World Health Organization

## Summary of Country Perspectives

Insights from civil society and communities under each Key Ask of the global movement for UHC.

### ENSURE POLITICAL LEADERSHIP BEYOND HEALTH

#### FINDING 1

There remains a lack of clarity and leadership for cross-sectoral coordination on UHC, especially in policy planning. Governments must strengthen collaboration mechanisms with a specific aim of achieving UHC and include civil society as partners.



### LEAVE NO ONE BEHIND

#### FINDING 2

Despite progress made in expanding coverage, vulnerable communities face many barriers in accessing health care. The physical, financial, socio-cultural, and legal challenges faced by the most vulnerable must be prioritized and addressed as part of UHC programs.

#### FINDING 3

Stigma is a barrier to health care access across countries that leave many people behind. UHC cannot be achieved without systematic and intentional solutions to stigma and discrimination.



### REGULATE AND LEGISLATE

#### FINDING 4

Policies that aim to achieve UHC are often not implemented effectively because of restricted budgets, gaps in coordination, and limited accountability mechanisms. Effective legislation for UHC must be attached to adequate funding and include multi-stakeholder structures for implementation.



### UPHOLD QUALITY OF CARE

#### FINDING 5

The quality of health services is uneven within countries, across regions and communities. To uphold quality of care, governments should strengthen support to all health providers, especially community and frontline health workers, so that they are better able to deliver people-centered care to all.



### INVEST MORE, INVEST BETTER

#### FINDING 6

Increasing health spending is important but not enough. In order to achieve UHC goals, governments must prioritize investments in primary health care and the health care workforce especially at the community level.



### MOVE TOGETHER

#### FINDING 7

While most governments have committed to engaging civil society and communities in health policy, this engagement is often at a peripheral level. Countries must prioritize and create purposeful structures for civil society engagement in all health-related decision-making and civil society groups must likewise be prepared to participate.



### GENDER EQUALITY

#### FINDING 8

The impact of health vulnerabilities and gaps in health systems varies widely by gender identity across all settings. This inequity can only be addressed by gender-sensitive health policies and programs, which in turn requires diverse representation in leadership at the global, national and sub-national levels.



### EMERGENCY PREPAREDNESS

#### FINDING 9

While the full impact of the COVID-19 pandemic is yet to be seen, it is clear that the crisis has exacerbated existing barriers to access. To prevent further losses, governments must focus on the most vulnerable populations first in the pandemic response and recovery.



## INTRODUCTION

On 12 December 2012, the United Nations General Assembly unanimously endorsed a resolution on Universal Health Coverage (UHC), urging countries to accelerate the transition to universal access to quality and affordable health services for all. Governments reaffirmed their commitments to achieving UHC at the United Nations High-Level Meeting in September 2019 through a Political Declaration.<sup>1</sup> In the lead-up, UHC champions and advocates from across sectors mobilized high-level political attention and developed the [Key Asks from the UHC Movement](#), a set of core requests for leaders.

To monitor progress on these commitments, UHC2030 publishes a *State of Commitment to UHC* report that provides a multi-stakeholder review of the status of UHC. It includes country data profiles that present a snapshot of the key commitment areas in the 2019 Political Declaration on UHC and a global synthesis report with inputs from a range of stakeholders including civil society. The review is an important tool to support accountability processes within and across countries.

*From Commitments to Action: Civil Society Perspectives on Reaching Universal Health Coverage* summarizes results from 19 focus groups conducted alongside this multi-stakeholder review process.<sup>2</sup> They were planned and led by the Civil Society Engagement Mechanism for UHC2030 (CSEM) with APCASO, Global Health Council, International Federation of Red Cross and Red Crescent Societies (IFRC), Living Goods, NCD Alliance, People's Health Movement, the Joint United Nations Programme on HIV/AIDS (UNAIDS), and country partners.

The conversations highlighted important issues that governments and other decision-makers should address to ensure UHC policies are inclusive and equitable. Participants were mostly representatives of civil society organizations (CSOs) and networks, or communities often left behind. Their understanding of the progress made in each commitment area complements the multi-stakeholder review process with stories of lived experience, ground-level insights on the gaps in policy and practice, and recommendations for the road ahead.

*Focus groups were held in:*  
Bhutan, Burkina Faso, Cambodia, Colombia, Egypt, Georgia, India, Japan, Kazakhstan, Kenya, Lao PDR, Mexico, Nepal, Niger, Pakistan, South Africa, United States (US), Vietnam

A separate focus group included participants from seven countries in the Caribbean region:  
Antigua & Barbuda, Bahamas, Barbados, Belize, Dominica, Haiti, St. Vincent & the Grenadines

We hope these reflections and recommendations from civil society serve as signposts on the road to the 2023 UN High Level Meeting on UHC, the next global opportunity to convene all stakeholders and recommit to achieving health for all.

<sup>1</sup> The [Political Declaration on UHC](#) adopted by UN Member States in 2019 includes the most comprehensive set of health commitments ever adopted at this level; countries will report their progress at the UN HLM in 2023.

<sup>2</sup> The State of the UHC Commitment review is focused on the 44 countries that submitted Voluntary National Reviews (VNR) in 2020. Of the focus group countries, those that participated in the VNR and are included in the State of the UHC Commitment review are Antigua & Barbuda, Bahamas, Bhutan, Colombia, Egypt, Japan, Lao PDR, and Niger.

## STRUCTURE OF CONSULTATIONS

Focus group discussions are a qualitative approach to gaining insight and in-depth understanding of social issues. The method is utilized to obtain data from a purposely selected sample of a population, who are theoretically representative of a broader group.

The focus group methodology was adapted by country partners to best suit their advocacy needs and align with ongoing activities. The discussion methodology was adapted to the local contexts, translated when necessary, and structured to suit the number of participants (*Annex I*).

Focus group discussions generally included a facilitator who posed a set of guiding questions (*Annex II*) to stimulate and direct the conversation, but also allowed stakeholders time and space to give their personal accounts related to UHC in their countries. Most occurred virtually given the COVID-19 context, but some country partners were able to hold in-person meetings with appropriate precautions.

*The focus groups addressed issues in health care access and equity.*

### *Discussions included:*

- What is working in terms of UHC policies/programs in your country?
- Which populations are most left behind by policies and programs?
- Who is not captured in UHC data and what are ways to include their voices in progressing toward UHC?
- What diseases have been left behind in terms of quality and coverage of care?
- What are some of the other critical UHC gaps in your country?
- What impact has COVID-19 had on UHC and access to quality health services?

## KEY FINDINGS

The nine key findings in this report are highlighted within the context of the *Key Asks of the UHC Movement*: (1) Ensure Political Leadership Beyond Health (2) Leave No One Behind (3) Regulate and Legislate (4) Uphold Quality of Care (5) Invest More, Invest Better (6) Move Together (7) Gender Equality (8) Emergency Preparedness.

### ENSURE POLITICAL LEADERSHIP BEYOND HEALTH

**Finding 1: There remains a lack of clarity and leadership for cross-sectoral coordination on UHC, especially in policy planning. Governments must strengthen collaboration mechanisms with a specific aim of achieving UHC and include civil society as partners.**

Community and CSO stakeholders across all countries felt that UHC is understood to be an important goal requiring collaboration from many sectors; however, coordination mechanisms that engage across sectors to improve health or advance UHC are not always well understood. Mechanisms highlighted by

stakeholders mostly include UHC as a potential focus within another focus area; specific UHC coordination platforms or working groups that cross-cut sectors and institutions were not common.

Participants in Bhutan, Colombia, Kenya, Pakistan, and Vietnam mentioned a few laws, initiatives or programs related to UHC, but noted there was no specific mechanism to facilitate multi-stakeholder engagement. Focus group participants in Georgia noted that the councils or committees that do exist are dominated by experts and professional associations, while communities represented by vulnerable groups are not invited to participate in a meaningful way.

*"If the government really had a commitment to UHC, it should implement a plan of inspection, control and surveillance over all the actors in the health system."*

*– Participant in Colombia*

This was echoed across the board. In the Caribbean regional focus group, stakeholders described a landscape ranging from minimal to high engagement; all agreed there is a lack of direct collaboration on regulation. In South Africa, stakeholders noted that consultation processes around the National Health Insurance (NHI), which is only a financial mechanism, were not sufficiently empowering for communities, with no coordination mechanism. In the US, there are stark differences in how health is coordinated in different states. Focus group participants shared that the fractured system and competing priorities prevent adequate planning, spending, and coordination for expanding coverage to quality health care.

Where there is coordination across sectors, it is not enough to be effective. In Niger, there are working group meetings on UHC, which were first held in 2014 and then in 2019; while stakeholders agreed that the meetings were constructive, they have not been regularly scheduled. This sentiment is unanimously echoed across all countries in the sample: there is a need to improve the scope and quality of multi-stakeholder engagement to achieve health for all as well as to ensure civil society and communities are included at all stages of decision-making including policy planning.

**LEAVE NO ONE BEHIND**

**Finding 2: Despite progress made in expanding coverage, vulnerable communities face many barriers in accessing health care. The physical, financial, socio-cultural, and legal challenges faced by the most vulnerable must be prioritized and addressed as part of UHC programs.**

All focus group discussions flagged groups of people who are struggling to gain access to health services due to physical, financial, socio-cultural, and legal challenges, including:

- People living with a disability
- People who use drugs or alcohol
- LGBTIQ+ communities
- Adolescent and young women who are pregnant or breastfeeding
- People living with HIV
- People living with non-communicable diseases (NCDs)
- Poor and vulnerable people, including the urban poor
- Sex workers
- Young people and children, including orphaned children

- People living in insecure or rural areas
- Internally displaced people, migrants, and refugees
- People who are elderly
- People with mental health needs
- People who have been incarcerated
- People experiencing homelessness
- Indigenous and ethnic minorities
- Coal miners

Even where there is progress made toward expanded coverage, some communities remain left behind. Focus group participants in Bhutan noted that barriers to accessing health services for vulnerable populations include stigma, high costs, and a shortage of service access points. Participants in Japan noted that the greater the vulnerability of an individual, the greater the time, cost, labor, and psychological burden for that person to access health care. Stakeholders in Pakistan suggested including a vulnerability index, which categorizes the risks among different populations in terms of their physical, socioeconomic, and financial access, as part of planning and evaluating UHC programs.

In Burkina Faso, Kenya, and Vietnam, stakeholders flagged that many health facilities lack access ramps, appropriate bathrooms, and equipment to meet the needs of people with disabilities, which prevents many from accessing care. Coverage for some services, such as mental health care, remain severely inadequate. Participants in Bhutan, for example, noted the difficulties people with mental health needs face in accessing necessary services due to the lack of appropriate prioritization of mental health within UHC plans and programs.

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*“Mental health is a core need in the current situation...Governments need to focus on this area more.”*

*– Participant in Nepal*

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Out-of-pocket payments for pharmaceuticals and laboratory tests are also a major barrier to health care access; individuals are pushed into high medical debt when needing to access essential medicines and services. The impact of out-of-pocket payments and catastrophic expenditure for health was especially highlighted in the experience of people living with NCDs and other chronic conditions. Participants in the Caribbean focus group noted inadequate access to cancer screenings and palliative care as well as insufficient coverage of NCD management. COVID-19 has further widened these gaps. Notably, cost barriers to accessing care extend beyond the direct expenses of health care services creating another challenge for achieving UHC. Stakeholders from Egypt, for example, pointed out that the cost of transportation to a health facility often creates inequities in access – a concern that was also raised by stakeholders in India, Kenya, South Africa, and the US.

It is no surprise that those who are below and closest to the poverty line were flagged to be the most impacted by out-of-pocket payments. In many countries (Cambodia, Egypt, Georgia, Japan, South Africa) it was highlighted that poorer populations tend to depend on public hospitals and are more likely to face long waiting lists for some types of care. These groups are most directly affected by health provider shortages and quality gaps.

Other barriers to care are the legal and regulatory frameworks in countries. In Colombia, stakeholders highlighted improper practices in the management of resources. Civil society emphasized that the most vulnerable communities are the ones most affected by non-compliance with health sector regulations, conflict between the interests of various health system agents, gaps in physical infrastructure availability, and the shortage of human resources, particularly in remote areas.

In Vietnam, transgender individuals may receive limited services because their identity documents do not match their appearance. In Kazakhstan, many people including those who were previously incarcerated or migrants do not have national identification or taxpayer numbers, which limits their access to health and social services. The participants added that it is also difficult for people living with HIV to gain citizenship or permanent residence in the country.

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*“It seems that the people who have access to health are the people who can buy access.”*

*– Participant in Mexico*

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This is an issue that was echoed in other countries, including Vietnam, Japan, South Africa and the US, where some immigrants are left out of basic safety net programs due to legal status. In Bhutan, it was noted that the legal status of sex work makes medical services inaccessible to them; notably, this means cases of sexual abuse often go unreported. In Pakistan, the Sehat Sahulat Program is intended to cover everyone without any discrimination; however, the program does not always cover immigrants, coal miners, persons currently experiencing homelessness, people living with HIV, displaced populations, those who were incarcerated, and people who use drugs.

Participants also highlighted the role of advocacy and practices that should be replicated to ensure vulnerable populations are prioritized. In India, stakeholders noted the impact of advocacy for key population groups: free antiretroviral therapy (ART) is now offered to people living with HIV under the Ayushman Bharat scheme. In Kenya, there is an ear-marked program to cover the health care costs for people living with disabilities.

A Free Health Care Policy was also adopted in Niger in 2006 to provide health care to children under five and pregnant women. In Burkina Faso, there are measures in place for the free provision of care to pregnant women and children under five, as well as for family planning, vaccinations, ART, and treatment for TB. In Japan, while welfare programs have been in existence, people were often reluctant to access these services due to stigma; during the COVID-19 pandemic, the government pushed for additional support for welfare assistance and facilitated access for more communities.

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*“People became more sympathetic toward the poor during the pandemic and media coverage of the poverty issue increased. A turning point was when the MHLW [Ministry of Health, Labour and Welfare of Japan] declared that welfare assistance is a right.”*

*– Participant in Japan*

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**Finding 3: Stigma is a barrier to health care access across countries that leave many people behind. UHC cannot be achieved without systematic and intentional solutions to stigma and discrimination.**

Participants across countries underlined that stigma and discrimination compounds the impact of other vulnerabilities. In Kenya, for example, adolescent girls who are already at higher risk of HIV and gender-based violence may not seek family planning services because of the fear of stigma or provider attitudes they may face. Survivors of gender-based violence face discrimination and may also avoid care. Members of the LGBTQI+ community, people living with disabilities, people living with NCDs such as mental health challenges, and sex workers are particularly impacted across countries by stigma, discrimination, and lapses in confidentiality policies.

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*“When you go to the maternity unit to give birth, the midwives will say: You are like that [disabled] so how come you get pregnant?...As if we don't have the right to children because of our disability.”*

*– Participant in Burkina Faso*

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In Bhutan and Burkina Faso, for example, the focus groups found that women with disabilities face discrimination, especially in terms of their sexual and reproductive health needs. In Vietnam, women, girls, and transgender people affected by HIV or TB reported discrimination when seeking health care.

Stakeholders in Bhutan, Cambodia and Mexico noted that people who use drugs or alcohol do not receive the same care and support as other patients, and are stigmatized by health care providers. Similarly in Vietnam, the national health insurance program does not cover addiction treatment. A known drug dependency is a plausible reason for an individual to be denied health services in Kazakhstan. Similarly in Japan, people who use drugs hesitate to access medical and welfare programs due to the fear of being reported; mental disorders caused by drug dependency are regarded as crimes and affected individuals are excluded from social safety net programs like disability pensions.

In Kazakhstan, people living with HIV noted that they pay high premiums for health insurance and even if they are covered, they are still often denied services due to provider attitudes and stigma. Nursing homes, boarding homes, and homes for people with disabilities discriminate against people living with HIV. Stigma and discrimination also prevent many sex workers from accessing necessary care. In Japan, for example, stakeholders highlighted that sex workers face discrimination, prejudice, and a lack of public understanding.

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*“I was scheduled for an operation at provincial hospital... [but after] I filled in the form about my HIV status, they refused to do it.”*

*– Participant in Vietnam*

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## REGULATE AND LEGISLATE

**Finding 4: Policies that aim to achieve UHC are often not implemented effectively because of restricted budgets, gaps in coordination, and limited accountability mechanisms. Effective legislation for UHC must be attached to adequate funding and include multi-stakeholder structures for implementation.**

Across Bhutan, Burkina Faso, Cambodia, India, Japan, Kenya, Lao PDR, Pakistan, South Africa, Vietnam and the Caribbean countries, there were laws, policies and strategies participants acknowledged as being critical for UHC, but there were caveats for each. Broadly community and CSO stakeholders noted that (1) coordination and collaboration among stakeholders is missing at the ground level, which in turn means implementation is unclear and not standardized; (2) UHC is not prioritized in budget and resource allocation, which limits the scope of policy implementation; and (3) awareness and understanding of UHC in the community is limited, which further hinders accountability activities.

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*“UHC [policies from other countries] may not all be relevant to the country context, however, the relevant ones may be translated into the country’s context or used as a reference document.”*

*– Participant in Bhutan*

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In Cambodia, for example, the Health Equity Fund, the National Social Protection Framework, and the National Social and Security Fund were mentioned as mechanisms in place to expand equitable coverage; however, the focus group emphasized that there were implementation gaps and the barriers to care described above remain for vulnerable communities. In Egypt, stakeholders noted that there are accountability mechanisms in place, such as a hotline for those facing discrimination in health care, but concluded that these must be strengthened for their full potential to be reached. In Vietnam, the national health insurance is meant to cover 100% of health care costs but stakeholders flagged that in reality, poor households need to pay around 20% of the costs, which is unaffordable to many.

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*“How can you read through a 50-page document and give feedback...all in a two-hour meeting?”*

*– Participant in Kenya*

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Limited data is a barrier to both implementation and to accountability efforts, particularly to assess equity. In India, stakeholders stated there is limited or no data on transgender or non-binary individuals, making it difficult to understand and relay their access issues. In Kazakhstan, some vulnerable populations, such as those who were incarcerated, are not captured in UHC data. Overall, the lack of data affects civil society’s capacity to advocate and hold governments to account.

Across countries, there were calls for greater understanding and awareness around UHC and the multidimensional nature of vulnerability. Many vulnerable communities do not have the necessary information about health care services and public assistance programs that exist. Stakeholders

called on governments to widely disseminate UHC strategies, develop more opportunities and platforms for community feedback, and prioritize multi-sectoral tracking and monitoring within its regulatory framework. UHC policies must include clear processes and structures for civil society and community engagement from their inception.

**UPHOLD QUALITY OF CARE**

**Finding 5: The quality of health services is uneven within countries, across regions and communities. To uphold quality of care, governments should strengthen support to all health providers, especially community and frontline health workers, so that they are better able to deliver people-centered care to all.**

*“We are a highly inequitable country. Some population groups, for example indigenous peoples, have a [quality] lag that is much greater...Geography is key; northern states have good health services and the southern and south-eastern states simply do not.”*

*– Participant in Mexico*

Poor quality of health services was highlighted by many stakeholders in Burkina Faso, Cambodia, Colombia, Georgia, Kenya, Pakistan, South Africa, and Niger. Where quality care exists, it is not accessible to all. In most focus groups, stakeholders stated that only those with the capacity to pay receive high quality and timely health services.

In the Caribbean countries, stakeholders noted that data gaps make it difficult to provide an evidence-based response on the quality of care. In countries where the poor quality of services was cited as a key concern, participants referred to the state of health facilities, availability of human resources, supply of medicines and other commodities, preparation for emergencies, and access to technical support as areas for improvement.

Other challenges highlighted were those faced at the point of service delivery including ineffective communication, long waiting times, poor diagnostic arrangements, and a lack of accountability. Participants also mentioned the lack of respect for patients and lapses in ensuring privacy and confidentiality.

Perceptions of quality are especially concerning for communities who experience multiple vulnerabilities. In Bhutan, stakeholders noted that for population groups using drugs and alcohol as well as people dealing with mental illness, the quality of care is “pathetic”; when free medication is provided, it is not always trusted as high-quality medication. In Egypt and South Africa, it was noted that there is a significant gap between services provided at private hospitals versus public hospitals. Participants in South Africa noted the gross inequity between the care offered for health conditions, with NCDs being neglected when compared with HIV, TB, and STIs. In Mexico, stakeholders added that tertiary services are high quality, but primary health care services have long waiting times and lapses in ensuring a multidisciplinary approach.

Across countries, the shortage of health care workers was highlighted as a key barrier to upholding the quality of care. The existing workforce, particularly community health workers, are inadequately remunerated and trained; this barrier has been made worse by the COVID-19 pandemic. US stakeholders questioned if it is feasible to expect high quality in the wake of health provider shortages. The discussion in the Caribbean highlighted staff attrition, especially of nurses, and an undiversified staff mix as challenges for quality care. Stakeholders in Mexico noted that health providers do not work in the best conditions, with doctors receiving low wages and few incentives to stay in primary health care.

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*“[Community health workers] are critically important, especially in some communities ...However there needs to be increased education and training for these persons, to equip them with the skills to comfortably deliver [services]”*

*– Participant in the Caribbean Region*

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## INVEST MORE, INVEST BETTER

**Finding 6: Increasing health spending is important but not enough. In order to achieve UHC goals, governments must prioritize investments in primary health care and the health care workforce especially at the community level.**

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*“There is no question that PHC should be given the highest priority by the government. This is the greatest challenge for health system of Georgia to achieve UHC goals.”*

*– Participant in Georgia*

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Community and CSO stakeholders across countries shared perceptions on where governments should be investing to achieve UHC (Table 1), noting the importance of spending better through rigorous planning of health-related spending. Primary health care and the health workforce was the most common response for increased prioritization across all focus groups. Expanded spending on health systems strengthening must be inclusive of the organizations, people and actions that promote, restore or maintain health – including community-led and community-based systems for health.

In Cambodia, Egypt, Georgia, Kenya, Lao PDR, South Africa, and Nepal, the focus groups felt that health and health service delivery was not a priority compared to other sectors in terms of government spending. Notably, primary health care is not given as much attention as secondary and tertiary services. In Colombia and Kenya, stakeholders felt that investing in health providers and primary health care in rural areas would improve access and reduce the burden on referral hospitals.

Participants across countries noted that the success of UHC policies is based on having a strong primary health care system that would reach more people and reduce the need for more advanced treatment by addressing health issues earlier. This includes services for the prevention, treatment, care, and management of NCDs and HIV in primary care settings.

Countries with stronger primary health care systems were recognized to be responding better to the COVID-19 pandemic by the participants in the Caribbean region, signaling the potential impact of additional investments. Across focus groups, the budget for primary health care and health workforce shortages at this level were identified as the main barriers for improvement.

Civil society and communities in the focus groups noted that investments in health workers, especially in community health workers, are important to make sure the most vulnerable people and communities are reached, especially those in rural and hard to reach areas. Focus groups across countries highlighted the importance of formally recognizing community health workers and community systems for health as an integral part of health systems.

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*“You cannot have UHC without investing in PHC. It only leads to a backlog at the secondary and tertiary health care institutions.”*

*– Participant in Kenya*

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Many community health workers are volunteers and do not receive adequate remuneration or training, which negatively impacts both the quality and scope of care. Governments have a bigger role to play in building the health workforce and in protecting their service. Participants in Kenya highlighted the issue of ‘brain drain’ and suggested that the health workforce can only be retained through better protections and government prioritization.

Participants in Burkina Faso added that prevention and health promotion is important to encourage the adoption of healthier behaviors and reduce the demand on health centers. This work is also dependent on the availability of community health workers and community-led health systems.

## MOVE TOGETHER

**Finding 7: While most governments have committed to engaging civil society and communities in health policy, this engagement is often at a peripheral level. Countries must prioritize and create purposeful structures for civil society engagement in all health-related decision-making and civil society groups must likewise be prepared to participate.**

The focus groups identified many instances of CSO engagement in health policy at the national and community levels in many countries, but all raised concerns about how meaningful this participation is and how they must be improved. For example, stakeholders from various counties in Kenya noted that when there are calls for civil society and community involvement, the registration process is poor or hasty; some calls are too technical with no efforts made to educate and widen participation. This means channels for engagement are not inclusive and rarely adequately engage the community.

In Burkina Faso, civil society stakeholders similarly raised concerns that communications from the government on opportunities to engage are often ineffective and feedback processes are limited across the board. This sentiment was echoed in Cambodia, Egypt, Georgia, Kenya, Nepal, Pakistan, and South Africa: community members and CSOs have opportunities to engage in theory, but these

opportunities are not inclusive and their impact is perceived to be minimal. In the Caribbean region, participants acknowledged that while civil society has a vital role in planning, promoting, and evaluating health care services, even more collaboration is needed.

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*“Just chatting to someone in a hut is not engagement. Is that person aware of their rights and policies? We must make sure there are clear, jointly produced plans and we must be jointly accountable for the process.”*

*– Participant in South Africa*

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Some stakeholders confirmed the existence of accountability or monitoring mechanisms for UHC but noted that the processes for feedback are not very clear. In Niger, while stakeholders highlighted the existence of citizen-led monitoring mechanisms, they raised questions on impact and called for more inclusive social dialogue at all levels of the health system. Cambodian stakeholders presented as good examples of participatory governance the implementation of the Social Accountability Framework and community feedback mechanisms to improve local health services as well as the National Committee for Sub-National Democratic Development, an inter-ministerial mechanism for promoting democratic development through decentralization.

Notably, stakeholders raised the importance of civil society engagement in decision-making rather than limiting it to consultations after decisions are made. Government leadership is needed to create environments to truly partner with civil society and communities to identify the issues and co-create solutions.

In many focus groups, stakeholders also mentioned that in addition to the governments’ role in creating better opportunities for participation, civil society and community groups should invest in improving their capacity to engage for UHC advocacy and accountability. They noted that there is often a lack of capacity for critical analysis of health policies and plans. Many civil society stakeholders may not be from the health sector and require more technical support. In addition, many are often volunteers with limited time and availability for sustained participation. There is also a lack of understanding around how CSOs can hold governments accountable to commitments once made.

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*“...Country Coordinating Committee of the Global Fund to fight AIDS, TB and Malaria has provided a platform for representatives of affected communities by HIV, TB and Malaria fully engage in the grant design, planning, budgeting, implementing and grant mentoring.”*

*–Participant in Cambodia*

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In Kenya, stakeholders noted that it is up to CSOs to ensure they are in the conversation and truly represent their constituencies, as well as to monitor the impact of their advocacy. In Nepal, it was stated that CSOs need to do more as the voice of the people and that religious leaders should also be playing a role as spokespeople. Stakeholders in the US also highlighted that there is an onus on the public to call on leaders, write to legislators, and raise awareness of issues in health care access.

This was flagged as a two-sided issue: governments need to invest in civil society, create enabling environments for participation, and fund civil society responses while civil society organizations must scale-up their health policy analysis, advocacy, and accountability capabilities.

## GENDER EQUALITY

**Finding 8: The impact of health vulnerabilities and gaps in health systems varies widely by gender identity across all settings. This inequity can only be addressed by gender-sensitive health policies and programs, which in turn requires diverse representation in leadership at the global, national and sub-national levels.**

Across all focus groups, participants noted that women and girls are disproportionately impacted by the gaps in health care systems, whether these are geographical barriers, financial barriers, or quality gaps. For example, transportation costs to health centers were often cited as a critical issue for women and girls in accessing care. In Japan, participants specifically mentioned that unstable employment and declining wages have had a notable impact on women and their ability to access health care.

Patriarchal attitudes as well as cultural factors and religious beliefs were raised as major barriers for women and girls in accessing health care; in many settings, they may not be able to go to a health clinic without permission or accompaniment by a husband. In Egypt, Colombia, Japan and South Africa, participants raised the issue of violence against women and girls as a critical public health problem that is not prioritized due to cultural factors. At the same time, attitudes and culture also affect men's access to care. Participants in the Caribbean noted men's reluctance to access health care at clinics and the importance of bringing services to them.

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*"Very few adolescent girls attend health centres because of their social isolation, their lack of knowledge and financial means, and their restricted freedom of movement."*

*– Participant in Niger*

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*"One of the transgender patients needed dialysis but there is no separate ward for the trans-community and when she was taken to hospital, both patients in both the males and female wards requested to shift her to another ward."*

*– Participant in Pakistan*

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Individuals who are non-binary or transgender face compounding vulnerabilities when accessing care. Stakeholders across the board agreed that few health systems plan services to be gender sensitive. In Kenya, Lao PDR, and Pakistan, for example, basic health forms often require patients to identify as male or female. In Cambodia, Colombia, and Lao PDR, health services for LGBTQIA+ groups were described as unfriendly and not responsive to their needs. In Bhutan, despite its strong national health program, stakeholders highlighted transgender individuals will not receive support for hormone replacement therapy and they have limited access to mental health care. In Georgia and

South Africa, participants concurred that transgender individuals often face abuse, violence, and discrimination. Stakeholders in the Caribbean noted that while LGBTQIA+ communities do face barriers of stigma and discrimination, there are also best practices in the region such as non-governmental organizations running clinics that are “safe spaces” and provide gender-sensitive care.

The inequity in health care access may be predicted by the starkly unequal gender representation in health decision-making and public policy. In the US, participants flagged that while health care workers in the country and across the globe are mostly women, decision-makers are predominantly men. Without representation in leadership, the challenges faced by women and gender minorities exist as a secondary problem with secondary solutions. Civil society stakeholders noted that diverse leadership is needed to overhaul the system and address the structural, socio-cultural, economic, and physical barriers that thwart gender equality in health care access.

### EMERGENCY PREPAREDNESS

**Finding 9: While the full impact of the COVID-19 pandemic is yet to be seen, it is clear that the crisis has exacerbated existing barriers to access. To prevent further losses, governments must focus on the most vulnerable populations first in the pandemic response and recovery.**

Many civil society and community stakeholders noted that universal access to some health care has been made a priority during the COVID-19 pandemic, with governments swiftly acting in terms of education and awareness, case detections, screening, testing, treating and vaccine roll-out. However, the focus on COVID-19 often came at the cost of other health services, and participants raised concerns over setbacks in health gains made over the last decade.

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*“All vulnerable groups have become more invisible during the COVID-19 pandemic.”*

*– Participant in Georgia*

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Across countries, CSO and community stakeholders reported the disruption of primary health care services, as well as services for HIV and TB, NCDs, sexual and reproductive health during the pandemic and lockdown efforts. Overall, the most vulnerable populations were most impacted by these disruptions. In Bhutan, certain population groups seem to receive less focus and support, such as persons using drugs and alcohol. In the US, COVID-19 catalysed a shift towards telehealth, but stakeholders highlighted the challenges of a digital divide, both in terms of unequal internet access and digital literacy. This finding was echoed in the focus group in Colombia, where stakeholders pointed out that many could not access tele-consults.

The pandemic also exacerbated the shortage of health workers, and the existing workforce was often reassigned to COVID-19 at the detriment of ongoing health service delivery. Participants also noted that many health systems were ill-equipped for the high volume of COVID-19 patients. In addition, community-based activities for health promotion and prevention were hindered or completely paused during the height of the pandemic in many countries, including in Niger and Kenya.

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*"About three years ago, we were approaching universal coverage... between the contributory plan [employee-based] and the subsidized plan [informal or low-income workers], it reached 95%. But with the recent job losses, now there is a very high margin of population that does not have basic health services and they can only access them for serious emergencies."*

*– Participant in Colombia*

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The fact remains that the full impact of the pandemic is yet to be known but delays in preventive and continued care are expected to have long-term impacts on health systems, while the anxiety caused by lockdowns and the pandemic have heightened other challenges. Stakeholders in Burkina Faso mentioned that TB patients did not want to go to hospital for treatment due to the stigma associated with testing positive for COVID-19, leading to a break in their treatment. Likewise in Georgia, those needing treatment for NCDs have been hesitant to access health care due to fear of COVID-19 infection – a finding echoed in Kenya, Lao PDR, South Africa, and Mexico, where many patients with NCDs or HIV have missed appointments during the pandemic. In Vietnam, stakeholders also flagged that all health check-ups and treatment have become more complicated due to COVID-19 screening at health facilities.

The secondary impacts of the pandemic have increased vulnerabilities across all settings, contributing to rising rates of unemployment, poverty, gender-based violence, food insecurity, mental health concerns, unplanned pregnancies, substance abuse, and more. Even in countries that have made large strides in UHC, such as Colombia, the crisis has pushed more people into poverty and into greater risk of falling out of health coverage. Urgent prioritization is needed to prevent further increases in these threats to health and additional interruptions to life-saving health service delivery. In the recovery and response, these compounded vulnerabilities must be addressed in conjunction with delivering COVID-19 testing, treatment, and vaccines.

Lastly, stakeholders across countries noted that the pandemic caused fear among communities and misinformation was rampant. Participants in the US specifically discussed how misinformation has impacted trust in scientific research and the medical system more broadly. This too will have lasting impacts for years to come and further underlines the importance of civil society participation in health system decision-making to build trust and create impactful policies and programs.

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*"...a lot of patients [especially with NCDs are reluctant to access care] because the first thing is that if you cough or sneeze or have shortness of breath... you are going to be sent to the 'COVID hospital', so they are not coming, they don't want to go to the COVID hospital."*

*– Participant in the Caribbean Region*

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In some countries, CSOs have stepped up to bridge health service gaps caused by COVID-19. In Egypt, CSOs raised awareness in marginalized areas, as well as offered medical care, psychosocial support and guidance to PLHIV and other vulnerable groups. Similarly in the Caribbean region, stakeholders highlighted the work of CSOs and non-governmental organizations in filling the gaps, especially in

following up with patients through social media. In Georgia, CSOs took action throughout the pandemic for many types of health service delivery, but stakeholders noted that it was difficult to regain the ground that was lost for vulnerable communities. Stakeholders in Niger also highlighted how CSOs showed resilience in trying to maintain activities throughout the pandemic. However, these efforts rarely had institutional support. Participations called on leaders to invest in community-led responses and structures for both the pandemic response and strengthening the pathway to UHC.

## REACHING UHC: THE WAY FORWARD

The 19 focus groups held in 2021 brought together civil society and community stakeholders from the national and sub-national health space to discuss the state of UHC. In some groups, government representatives and implementers also joined the discussion. Both in countries that have made significant progress toward UHC through national health plans or coverage schemes and in countries that still have many more steps to take, the discussions unveiled that some communities face more barriers to accessing quality health care than others. **National leaders must intensify their focus on equity and prioritize communities facing additional vulnerabilities first.**

The implementation of UHC policies and plans remains uneven and, in many cases, uncoordinated. There is a need for structural changes to coordinate across sectors and across stakeholders to not only respond to and recover from the pandemic, but also build back better health systems. **Civil society and communities must be central to the planning, implementation, and monitoring of health policies and programs.** It is these groups who are best placed to identify challenges on the ground, provide evidence on implementation like on the ground, and support the alignment of often-lofty legislation to the lived realities of individuals, families, and communities.

Health care spending should be increased. As the COVID-19 pandemic has made apparent, strong health systems and population health are necessary precursors to the effective functioning of all aspects of society and government, including national economic systems. It is therefore clear that adequate investments in health cannot be eschewed. Civil society and communities note that it is not enough to just increase spending on health. Rather, **the focus of increased public spending on health must be on strengthening primary health care, including prevention and health promotion services.** Primary health care is fundamental to achieving UHC so that all people can access the health services they need at the earliest possible moment in the settings where they are located.

The health worker shortage must be urgently addressed. This includes institutionalizing the role of community health workers, ensuring adequate remuneration, providing training and protections, and developing plans for retention. **Governments must prioritize health care workers at all levels so that they are available to deliver people-centered health care to all.** Achieving UHC is not possible without the people who can deliver care.

Specific recommendations for national political leaders highlighted by the civil society and community focus group participants in these four key areas of action are presented here. As the UN High Level Meeting in 2023 approaches and countries gear up to assess the progress made thus far, these insights from people on the ground are critical guideposts for action.

**Table 1: Priority Areas to Increase Government Spending on Health**

COUNTRY	PRIORITY AREAS IDENTIFIED IN THE FOCUS GROUPS
<i>Bhutan</i>	Research Medical services and facilities for alcohol addiction
<i>Burkina Faso</i>	Prevention and health promotion for tobacco and alcohol use Water, sanitation and hygiene (WASH) Community health, including health promotion Care for people living with disabilities and the elderly, including palliative and rehabilitation care
<i>Cambodia</i>	Health provider workforce in primary health care settings NCDs at primary health care settings Supply chains Health insurance and social protection schemes
<i>Colombia</i>	Health promotion and disease prevention Improving hospital infrastructure Rural health Mental health services
<i>Egypt</i>	Mental health services Geriatric programs Organ transplantation
<i>Georgia</i>	Primary health care Health promotion and disease prevention
<i>India</i>	Emergency preparedness
<i>Japan</i>	Public health and infectious disease control Disaster response Education and health communications

<i>Kazakhstan</i>	Programs for prisoners, refugees and their families
<i>Kenya</i>	Preventive and promotive services Primary health care Community Health Workers Developing health facilities in rural and remote areas
<i>Lao PDR</i>	Expanding health services including laboratory services Social protection programs Community mobilization
<i>Nepal</i>	Health facilities in rural areas
<i>Niger</i>	Reducing the cost of care at the point of services
<i>Pakistan</i>	Human resources, equipment, new technology, and tele-health Emergency preparedness Primary health care
<i>South Africa</i>	Medical infrastructure and equipment, human resources Health literacy and education for communities Accountability measures and independent monitoring systems Health responses during political and economic instability
<i>United States</i>	Education Health providers including mental health practitioners, school nurses, community health workers and home caregivers
<i>Vietnam</i>	Long-term health care services for the elderly Addiction treatment, family planning services, services for LGBTQIA+ Support mechanisms for prisoners and people living with disabilities
<i>Caribbean Region</i>	Strategic human resource planning, including training and retention of nurses Education on wellness, nutrition, physical activity Timely access to medicines Primary health care

# Key Recommendations to Political Leaders



## Leave no one behind

Populations and communities facing additional vulnerabilities must be prioritized in UHC programs and plans.

- Invest in effective analysis and research to fully understand the challenges communities face in accessing health care, especially in settings where UHC plans exist, and engage those communities in interpreting those findings and designing solutions.
- Promote the inclusion of vulnerable individuals and households for social programs, even if they do not have formal identification.
- Recognize stigma and discrimination as human rights violations; sensitize health care providers; monitor and address cases of rights violations in people's experiences accessing health care.
- Prioritize education and awareness on available health care services and welfare programs, including with translations and accessible formats, and create mechanisms to ensure people have access to these programs.

## Increase public financing for health

Governments must increase spending on health, especially on primary health care and health promotion.

- Strengthen primary health care services, including preventive and promotive health.
- Invest in and strengthen community systems for health.
- Reduce and regulate costs of health care services and commodities, especially for NCDs.
- Address prolonged stock-outs of drugs and commodities.
- Invest in funding for emergency preparedness.



## Support health workers

Investments in the health workforce must be increased to attract and retain more workers, formalize community health workers, and provide adequate remuneration and training.

- Address health provider shortages and develop plans for recruitment and retention.
- Formalize the role of community health workers, who are essential to delivering quality health care services.
- Ensure adequate remuneration and training for all health care workers, including community health workers.
- Protect health providers, including developing and implementing health personnel management policies and supporting trainings during health crises.



## Improve involvement of CSOs, citizens, transparency and accountability

Civil society must be partners in creating strong health systems that are responsive to the needs of people.

- Include civil society in all stages of UHC policy development, implementation and monitoring.
- Standardize feedback mechanisms and formalize monitoring and evaluation processes for health policies including from health system users, including support the development of community-led monitoring systems.
- Institutionalize inter-agency, inter-department, or inter-ministry collaboration for UHC.
- Support civil society and communities including with funding for capacity building and mobilizations that can facilitate ground-up, community-led advocacy and engagement.



**Civil Society Engagement Mechanism for UHC2030 (CSEM)**

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