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Civil Society Engagement Mechanism for UHC2030

uhc2030
International Health Partnership

From Commitments to Action:

Civil Society Perspectives on Reaching Universal Health Coverage

Findings from the 2022 Country Consultations

From Commitments to Action: Civil Society Perspectives on Reaching Universal Health Coverage (Findings from the 2022 Country Consultations) presents key findings from 18 country consultations on UHC with civil society and community participants.

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Civil society country consultations in 2022 were led by:

Argentina	Fundación Huésped
Botswana	Success Capital Organization
Cameroon	RAME
Dominica	NCD Alliance
Eswatini	Baphalali Eswatini Red Cross Society
Ethiopia	Consortium of Ethiopian NCD Associations
Ghana	Basic Needs Ghana
Italy	Fondazione Villa Maraini Onlus
Jordan	Jordan National Red Cross Society
Liberia	Cultivation for User's Hope
Malawi	Malawi NCD Alliance
Mali	RAME
Philippines	Healthy Philippines Alliances
Senegal	RAME
Singapore	School of Public Health, National University of Singapore
Sri Lanka	DSAT
Switzerland	Swiss Red Cross
Uruguay	Alianza ENT (NCD Alliance Uruguay)

CONTENTS

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

INTRODUCTION

Universal health coverage (UHC) is the global goal that all people can obtain the quality health services they need without suffering financial hardship. UHC policies and programs aim to make health care more accessible, equitable, and affordable.

At the United Nations High-Level Meeting (UN HLM) on UHC in 2019, member states set targets to progressively cover one billion additional people by 2023 with quality essential health services and safe, effective, affordable and essential medicines, vaccines, diagnostics and health technologies. The landmark 2019 Political Declaration on UHC included commitments to reach all people by 2030. To track these commitments, UHC2030 started the State of UHC Commitment (SoUHCC) review in 2020, which provides a multi-stakeholder overview of the status of UHC at country levels.

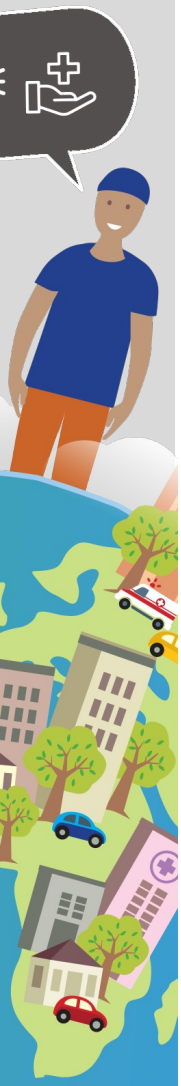
As a part of this process, the Civil Society Engagement Mechanism for UHC2030 (CSEM) – in partnership with civil society and community partners – conducted country-level consultations to highlight the perspectives of civil society and communities on progress made towards UHC.

From Commitments to Action: Civil Society Perspectives on Reaching Universal Health Coverage summarized results from 19 focus groups in 2021.[1] This 2022 summary report presents findings from focus groups conducted in 18 countries.

The consultations aimed to track progress of UHC Commitment at the country level by capturing the stories, experiences and perspectives of civil society and communities, understand which populations have been most left behind and the challenges they face in accessing quality health care, and engage stakeholders to build momentum for strong, comprehensive commitments at the UN HLM on UHC in 2023.

In 2021, there were civil society and community focus groups held in Bhutan, Burkina Faso, Cambodia, Colombia, Egypt, Georgia, India, Japan, Kazakhstan, Kenya, Lao PDR, Mexico, Nepal, Niger, Pakistan, South Africa, United States, and 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.

The consultations in 2022 were conducted in Argentina, Botswana, Cameroon, Dominica, Eswatini, Ethiopia, Ghana, Italy, Jordan, Liberia, Malawi, Mali, Philippines, Senegal, Singapore, Sri Lanka, Switzerland, and Uruguay.



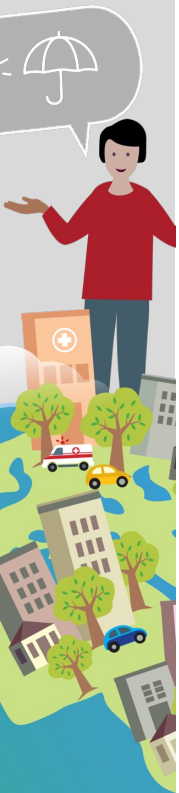
APPROACH

The global movement for UHC aligns with commitments to the Sustainable Development Goals (SDGs) and specifically contributes to SDG3 — good health and well-being for all. Implementation of the SDGs is assessed through the Voluntary National Reviews (VNR), a process through which countries share progress made toward each SDG and lessons learned along the way. However, there are few indicators on UHC used in this assessment. There is more work to be done to strengthen accountability mechanisms for UHC and critically, to include non-state actors such as civil society and communities in the process.

The 2022 SoUHCC review focuses on comprehensive reviews in 100 countries from the VNR lists of 2020, 2022, and 2023. The multi-stakeholder review on UHC thus aims to align with and contribute to the country-level VNR dialogues on SDGs, rather than creating a parallel accountability mechanism for UHC. The civil society consultations as part of the SoUHCC review prioritized countries submitting VNRs in 2022, followed by those from the 2020 and 2023 VNR lists. The consultations also serve as an initial step to build civil society and community support to include UHC commitments in future VNR and shadow report assessment processes.

METHODOLOGY

Consultations were in the form of focus group discussions, which are a qualitative research approach to gaining insight and in-depth understanding of social issues.



Invited participants included a broad range of civil society and community groups with focused outreach for vulnerable populations who are often left behind. Each focus group session was led and organized by one or more advocacy organizations in the country. These country partners were encouraged to share invitations widely, including to people who may not usually be engaged in UHC-specific work. Participants included civil society advocates, health care providers and program implementers, patients/persons with lived experience and family members, community members and leaders, researchers, and adolescents and young people (See Annex 1).

In each focus group, facilitator(s) used a set of global guiding questions to stimulate and direct the conversation. The questions were divided into nine categories, which included the UHC Commitment Areas and priorities for the next UN HLM in 2023. The global set of questions were further adapted by country partners to best suit their advocacy needs and contexts (See Annex 2).

The categories for the focus group questions (eight UHC Commitment Areas) are:

(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.

FINDINGS

This report summarizes the responses captured in the focus groups, per category. More detailed responses can be found in the country consultation summary reports compiled by implementing partners. While nuances from the different countries are highlighted, this report focuses primarily on the common themes that emerged from civil society and community actors across countries and distills key recommendations for decision-makers to achieve UHC.

ENSURE POLITICAL LEADERSHIP BEYOND HEALTH

Key Recommendations

- Build public support for UHC from the highest level.
- Clarify roles and responsibilities for UHC coordination and governance.
- Engage leadership across policy focus areas, including at the national and community levels.

Across countries, most participants found it difficult to identify a coordination mechanism that engaged across sectors to advance UHC. The primary barriers to political coordination for UHC were seen to be the lack of consistency in health policy, fragmentation of related decision-making, and a shortage of trained public officials.

In Cameroon, Eswatini, Ethiopia, Ghana, Italy, Mali, Philippines, and Singapore, participants were able to list primary agencies advancing UHC, including ministries of health, national councils, and technical groups. Some ranged even beyond health departments, such as those focused on social welfare and development in the Philippines and the Italian Medicines Agency in Italy. In Dominica, Liberia, and Sri Lanka, participants specifically noted that it was the responsibility of their ministries of health to carry out the multi-sectoral coordination required for UHC.

Participants in the focus group discussions in Botswana noted the role of the multi-stakeholder model championed by the Global Fund to Fight AIDS, Tuberculosis and Malaria in establishing partnerships with the National AIDS and Health Promoting Agency, Ministry of Health, and other civil society organizations for a broad coordinating mechanism. In Argentina, participants highlighted how the National Council on Social Policies of the Presidency of the Nation is responsible for coordinating and implementing policies to promote the fulfillment of SDGs; however, it does not have the power to directly implement or improve health policies.

Community and CSO stakeholders echoed the need for more political leaders beyond health-specific ministries and departments to be involved in advancing UHC. For their own work, most CSO representatives reported engaging with a range of government ministries or departments beyond health for health-related advocacy.

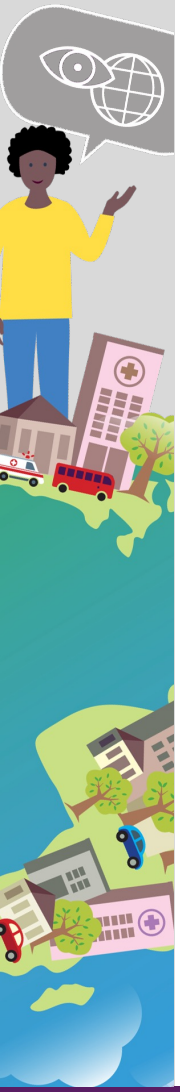
In multiple countries, civil society specifically noted engaging with the ministry of education in various health-related campaigns. Participants in Malawi highlighted how civil society organizations are at the forefront of engaging in multisectoral coordination.

In the focus group in Dominica, civil society stakeholders shared an example of collaborating with the ministries of health and education on a school nutrition policy. In the Philippines, participants recalled coordinating child and adolescent-related programs with the Department of Education. Other departments participating civil society and community members had worked with on health issues included the ministries of finance, social affairs, women, gender, family welfare, justice, agriculture, and foreign affairs.

LEAVE NO ONE BEHIND

Key Recommendations

- Strengthen policies to eliminate out-of-pocket expenditures, especially for marginalized communities and those facing multiple vulnerabilities.
- Develop inclusive health policies and programs that strongly address stigma and discrimination.
- Understand and prioritize the specific needs of those furthest left behind, including by institutionalizing their participation in health decision-making at all levels.



Country focus groups echoed that those from lower income social sectors and rural populations struggled to gain access to health services across the board. Health services are especially lacking for people living with disabilities, older adults, and individuals who need mental health services. People living with HIV, LGBTQIA+ communities, migrants and refugees, indigenous communities, women, children, and adolescents were also identified as vulnerable groups facing additional barriers to accessing physical and mental health care through the existing systems.

The most common challenge faced by the above communities in accessing a range of health services, as reported by the focus group participants, was stigma and discrimination, which forms a major barrier to access for both physical and mental health care and requires a strong government led response. Other systemic barriers included a shortage of trained health care professionals, lack of political will to address inequity, and ineffective policies to address out of pocket spending.

Transportation barriers to care were specifically reported by participants from countries such as Argentina, Cameroon, Dominica, Ghana, Liberia, Malawi, Philippines, Sri Lanka, Switzerland, and Uruguay, especially for rural populations and those living with physical disabilities.

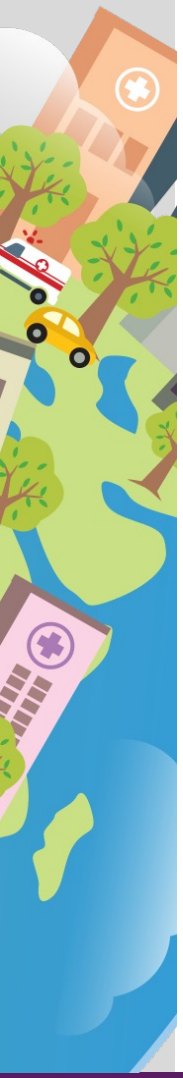
For people living with disabilities, migrants, and individuals who are transgender, legal hurdles such as identity document requirements and discriminatory regulations further keep them from accessing necessary care, as reported by participants in Uruguay.

"Most often it is the poor person who always finds it difficult to access these services. Those who can afford it, get services somehow – through influence or by paying money. We should address the rich-poor inequality to ensure equitable access to health for all."
– Participant in Sri Lanka

"Essentially, there is no UHC for anyone who doesn't fall within the 'normative group', which [only] include Singaporeans or permanent residents."
– Focus group participant in Singapore

Even where there has been progress in expanding coverage, some health services and populations remain underprioritized. NCDs, which often have the highest costs of treatments, are often left out of health benefit packages and UHC programs. Mental health and psychosocial services also stood out as difficult to access, especially for individuals facing multiple vulnerabilities. In the Philippines, for example, participants highlighted how patients seeking mental health care are often referred to specialized centers that are expensive and out of reach for many. Similarly, in Ghana, participants specifically called out how the National Health Insurance Scheme fails to cover mental health conditions.

Other services that were mentioned by participants as difficult to access included maternal care, substance abuse and addiction services, rehabilitation services, palliative care, HIV prevention and treatment, oral health, and sexual and reproductive health services. Participants in Cameroon, Malawi, Philippines, and Senegal also noted how services for non-communicable diseases at the level of both prevention and care have been neglected in their country.



REGULATE AND LEGISLATE

Key Recommendations

- Create transparent accountability structures that include civil society as partners in data generation, collection, and analysis.
- Promote health literacy and share relevant policy information, including how to ensure the implementation of existing policies.
- Develop and enact health legislations and policies that are rights-based, person-centric, and ensure accessibility of services to all.

Participants highlighted a knowledge gap around UHC regulations and legislations, signaling the need to build more public support for UHC and share the information needed to hold governments accountable. This recommendation was also echoed in the discussions on Category 1 questions. In countries like Argentina, Botswana, Dominica, Liberia, Philippines, Senegal, and Sri Lanka, civil society and community stakeholders reported that policies to ensure UHC either did not exist in their countries or they were not aware of them where they did.

In Ghana and Liberia, participants noted that regulation, legislation and policy around UHC

were not in line with international and regional human rights instruments and did not make health care accessible for all. As an example, in Ghana there was no provision for mental health and other conditions in the national health insurance scheme, precluding access to mental health and other essential health services as part of UHC.

Civil society and community actors in multiple countries highlighted the need for rights-based legislation and health policies that, importantly, involve all relevant stakeholders in their design.

Participants from Ethiopia, Italy, Jordan, Malawi, Singapore, and Uruguay felt that the existing policies relevant to UHC in their countries were inadequate in terms of accessibility and instead created further disparities and inequalities within their health care systems. As also recommended in the category above, participants raised the need for legislation that protects the right to health for all and includes specific provisions for the needs of stigmatized and marginalized populations.

Many participants were unaware of accountability mechanisms to ensure UHC in their country. This included participants in Botswana, Cameroon, Dominica, Italy, Liberia, Malawi, Singapore, Sri Lanka, and Uruguay. Participants in Ethiopia highlighted the National Health Account, which includes the health expenditure report for every five years, and participants in Jordan mentioned the Medical Accountability Act as accountability tools for UHC.

In the Philippines, CSO representatives identified performance monitoring and auditing mechanisms at the government level, but also highlighted that they lacked full information on these systems. The group reiterated the importance of citizens and CSOs in partnering with the government to better implement, monitor and improve existing policies. Similarly, the focus group in Italy highlighted that national surveillance systems and mechanisms exclude data collected by the private sector and civil society; therefore, a huge quantity of information, especially about marginalized populations' access to health services, is missing from official accountability tools. In country reports from Eswatini, participants noted how the Ministry of Health has policies that collect patient data within various health programs, but the data collected is fragmented and there is no system of feedback or accountability.

"Fraud and theft occurs at almost every level of the chain. This is a big hindrance to UHC."
– Focus group notes from Mali

"There are no laws for the protection of consumer information… leading to hesitation to ask for medical information. Doctors may charge for a medical report at an exorbitant cost."
– Participant in Dominica

UPHOLD QUALITY OF CARE

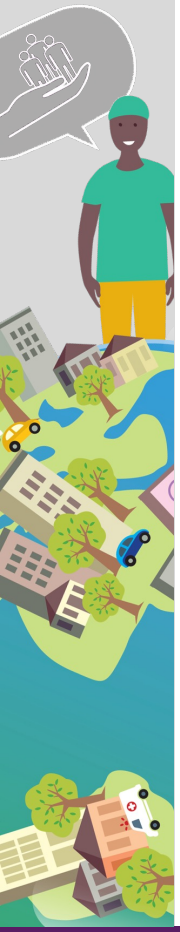
Key Recommendations

- Support the health care workforce, especially at the primary health care level, through additional investments in recruitment, retention, training, and protection.
- Expand community-led services, especially for marginalized groups.

Participants had mixed responses when asked about the quality of health services in their respective countries. Participants from countries like Dominica, Eswatini, Ethiopia, Liberia, Malawi, Mali, Senegal, and Uruguay were dissatisfied with the quality-of-care delivery. The common problems faced by those seeking health services in these countries were lack of trained staff, limited access to medical supplies, equipment and drugs, poor infrastructure of health facilities, and dehumanized care with poor satisfaction levels reported from patient groups.

In Sri Lanka, participants from the focus group discussion commented that generally the quality of services provided by doctors, nurses and other health staff is low due to a lack of sensitivity and empathy. This, coupled with the lack of coordination among multidisciplinary health services like HIV, NCDs, TB, nutrition, etc., negatively affects the quality of services provided.

All the focus groups highlighted that the most vulnerable and marginalized groups were also the ones most impacted by gaps in the quality of care; those with more financial means, for example, could travel to access better quality treatment options. With regards to health systems and services, some notable gaps that were mentioned by participants included inadequate and poorly resourced health care workforce and a shortage of medical equipment. A difference in quality was especially highlighted between public and private sectors, with public hospitals and rural health centers lacking investments in certain specialties. Participants in Eswatini called upon their Ministry of Health to invest in trainings that sensitize health care workers to the needs of vulnerable populations and to further investigate supply chain management of necessary health commodities.



In countries like Uruguay, participants highlighted that health systems are often centered on diseases rather than around people, which means necessary treatment and care remains incomplete and removed from the patient's life context and is not always in line with international and regional human rights instruments. This was re-emphasized in Dominica, Liberia, and Ghana where participants highlighted the poor integration of mental health in primary health care and health systems broadly, including in the diagnosis and treatment of comorbidities between mental and physical health as well as the prevention and treatment of communicable and non-communicable diseases.

"We are facing an organizational problem... services are carried out all within a hospital, but there is no [follow-up] service once the patient leaves the hospital."
– Participant in Uruguay

"Health services are clearly below expectations… incorrect diagnoses, unsanitary facilities, lack of ethics, frequent shortage of essential drugs. The shortcomings are too numerous to list them exhaustively."
– Participant in Mali

"Despite district nurses initiating a 'round -up' program for people with mental health conditions, these people encounter health personnel who do not want to deal with them or who just do not know how best to interact with them."
– Participant in Dominica

INVEST MORE, INVEST BETTER

Key Recommendations

- Invest in the health care workforce, especially at the primary health care level, including with remuneration, training, retention support, and protection.
- Work with civil society to identify key areas of investment needs, including in data and knowledge management, digital health, prevention and health promotion.
- Increase public financing for health, including through innovative mechanisms and taxation.

There was agreement among participants across all country groups that their government does not invest enough towards achieving UHC in their respective countries. The most common response for increased prioritization among all focus groups was for governments to spend more on salaries and incentives for health care workers along with increased recruitment and retention as well as training focused on addressing stigma and discrimination.

The global advocacy ask of not only investing more but also investing better was echoed by civil society and community stakeholders across countries. In Jordan, participants noted that financial spending need not be increased but rather health financing needs to be reorganized to effectively consolidate funds for major health services, reach remote regions, and operationalize existing high-priority programs.

Stakeholders in Sri Lanka also highlighted the role of civil society in ensuring investments are effective, with one participant adding: "The government spends a significant amount of money. But is that invested in the right place for the right people? We need to ensure that these investments are efficiently targeted at most needed communities."

Another key area in need of increased investment highlighted by participants across countries was public data, evidence, and information-based planning. Participants from Botswana, Singapore, and Sri Lanka emphasized the need to increase funding towards research and knowledge management, and to enhance dissemination of the acquired medical and scientific data to the public.

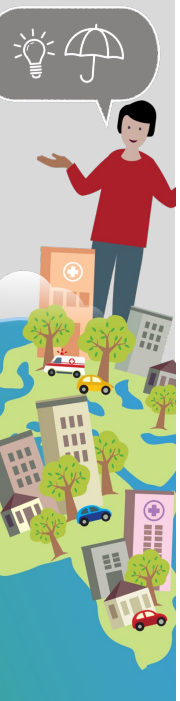
In Argentina, Italy, the Philippines, Sri Lanka, and Switzerland, participants added that their governments should shift more funds towards the digitalization of health services by improving electronic health records and telemedicine facilities in their respective countries.

To address the challenges associated with access and cost of drugs, equipment, and supplies, participants in country discussions held in Argentina recommended that governments increase funding towards public production of medicines. The focus group discussions in Botswana stressed that investments should be in localized intellectual property, operational research infrastructure, and manufacturing of commodities or generic medicines.

Across countries, civil society and community stakeholders recommended increased public spending on preventive and health promotion services, especially in primary care and community care contexts. Participants also added the need for improving health infrastructure by increasing bed capacity and upgrading hospital-based facilities. In Botswana, Ghana, and the Philippines, participants identified psychosocial services and mental health care as areas for increased financial investments, given the relative disparity in financing between physical and mental health.

> *"It is recommended that governments spend at least 5% of its GDP or at least 15% of its annual budget on health.*
>
> *But due to a lack of political will, the lack of implementation of decentralization policies, loopholes in government system, the misuse of funds, COVID-19 and the failure to tap in resources from private sectors, the commitment is far from being realized."*
> – Participant in Malawi

MOVE TOGETHER



Key Recommendations

- Strengthen sustained participation structures for civil society and communities in all stages from planning and budgeting to implementation and evaluation.
- Integrate mechanisms to include diverse and marginalized groups in health decision-making by investing in knowledge-sharing and capacity-building at the community level.

When discussing questions in this category around multistakeholder engagement, most participants identified opportunities for civil society and communities, especially people with lived experience, to engage in planning, budgeting, monitoring, and evaluating the health sector. However, across all focus groups, they raised concerns regarding how meaningful this engagement is and whether it is sustained throughout the policy decision-making process.

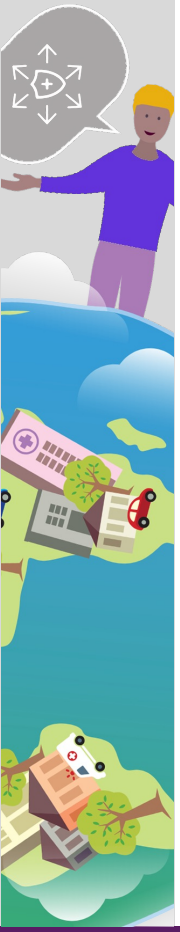
Stakeholders specifically noted that engagement is most limited at the budgeting stage. Additionally, opportunities are often uncoordinated and ad hoc, which leads to tokenistic multi-stakeholder engagement without real investments in inclusion.

Participants in Malawi highlighted District Executive Committees and District Health Management Committees at the district level as well as technical working groups in different government ministries at the national level, which facilitate civil society engagement. Similarly in Mali, focus group participants highlighted the National Federation of Community Health Associations as an important platform that supports broader multi-stakeholder engagement. In Senegal, participants highlighted how community members are involved in all health programs through the Community Health Division of the Ministry of Health and Social Action at the national level.

In Cameroon, participants cited multiple examples of CSO participation in strategic meetings in the implementation and management of UHC, especially through entry points in priority health programs like HIV, TB, and malaria. In Argentina, Botswana, Dominica, Italy, Liberia, and Uruguay, participants reported CSO participation in various program areas, including HIV, childhood obesity, post-disaster psychological support, water, sanitation, etc., but highlighted the exclusion of the most vulnerable and marginalized populations from these discussions, including people with disabilities and people living with mental health conditions.

In the regional discussions held in Uruguay, participants reported how decision-makers fail to take civil society into account, unless legal actions are initiated, or the press reports on the issue. The participation of civil society has been continuously requested; while there are regulations that establish areas of participation, many of those are ignored.

Community level engagement was highlighted across countries as being minimal and importantly, not adequately representative of marginalized populations. To note, participants highlighted that communities are not aware of opportunities to engage. There are inefficient processes and structures to enable them at the grassroots level. For example, in discussions from Malawi, participants reported that there are substructures like village development committees in respective communities, but they are challenged with insufficient funds and poor coordination in reaching policymakers. Participants recommended improving pathways to engage youth and adolescents, people with disabilities, and others often left behind.



"Civil society is most often considered as beneficiaries but not as equal partners in decision making related to health.

Hence advocacy by civil society on health-related matters is extremely difficult and most often met with a lot of resistance from the government agencies."
– Participant in Sri Lanka

GENDER EQUALITY

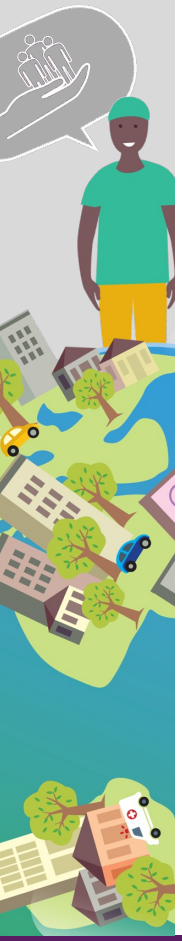
Key Recommendations

- Ensure gender perspectives are understood and integrated in health decision-making.
- Invest in gender-sensitive health workforce training at all levels, especially primary health care.

Stigma and discrimination emerged again as the most mentioned barrier to accessing health services for women and gender minorities across the included countries. This was especially highlighted as a barrier for sexual and reproductive health services in Botswana, Dominica, Eswatini, the Philippines, Senegal, and Sri Lanka. Women and girls living in poverty and those affected by HIV, disabilities, or mental health conditions face the most stigma and discrimination in accessing necessary physical and mental health care.

Participants also highlighted harmful gender norms and cultural practices, including child marriage in some communities and reduced decision-making power. In most countries, it was noted that women and girls are often dependent on men while accessing care. Many women are reluctant to seek care from male health care providers, which further limits their access. Participants also noted a shortage of midwives and community health workers compared to the demand for their services.

> *"In some remote areas, it is the men who decide whether the woman needs to see a doctor or a midwife. These are cultures that still exist, so it will be necessary to pass through the husbands to reach the wives."*
> – Participant in Senegal



Community and CSO stakeholders across countries highlighted that the societal stigmatization and discrimination against non-binary individuals is a major barrier to access health services, including preventive services, with specific examples cited in Liberia, Cameroon, Sri Lanka, the Philippines, Eswatini, and Uruguay.

Other systemic issues include limited funds and health insurance for sexual and reproductive health services. Participants also noted that there are inconsistent policy frameworks and infrastructure gaps for these services, including pre- and post-natal care, and maternal mental health care. The focus group discussions in Liberia called out the lack of trained midwives and birth attendants as challenges faced by health care service providers.

Women who are victims of gender-based violence find it challenging to secure justice and access comprehensive care, a concern echoed by participants in Botswana, Dominica, Liberia, and the Philippines. Policies that aim to protect the right to health for all must include specific provisions for women and gender minorities that consider threats to their health and well-being. Participants also noted the important of integrating gender perspectives for health in stages of implementation and supporting health education,

including age-appropriate sex education.

Notably, even in a health system that has made progress in improving the quality of care, there are gaps seen in gender equity. Participants in Singapore highlighted negative attitudes towards women in the health system, including the feeling of being unwelcomed and underheard with little emphasis on patient autonomy or dignity. They also shared examples of policy discrimination and health workers' discrimination against individuals who are transgender. The lack of patient confidentiality and privacy were also identified as major challenges across multiple focus groups.

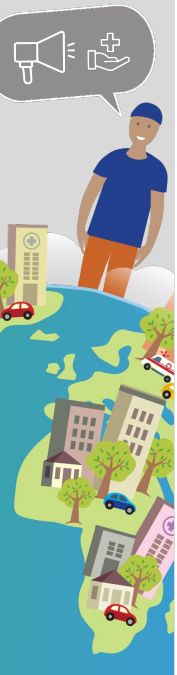
"Cervical cancer screening is given by male provider in one health facility in eastern part of the country which inhibits the mothers to go to the health facility and get screened."
– Civil society participant in Ethiopia

"Doctors are not trained in [LGBTQI+] care even when there are decades of scientific research. The quality is inconsistent and doctor-dependent, when [all patients should be] treated in a way that is affirming, respectful and suitable."
– Student advocate in Singapore

EMERGENCY PREPAREDNESS

Key Recommendations

- Increase public investments in health facilities and workforce, especially at the primary health care level.
- Improve digital health services and technology access.
- Integrate community engagement and knowledge sharing within and across countries.



All focus group discussions noted that health systems have been affected negatively by the COVID-19 pandemic in their respective countries. The disruption of clinical services during the pandemic affected service delivery for mental health, sexual and reproductive care, NCDs, TB, HIV, immunization, and palliative care, among others. Civil society participants were not formally engaged in planning during the pandemic, although many provided examples of bridging service delivery gaps through community networks.

Across country groups, civil society and communities recommended strengthening primary health care systems to deal with the aftermath of the pandemic and to face future pandemics. A recurring theme was the need to invest more in health facilities and better integrated community health systems through workforce strengthening and community engagement.

The health worker shortage was highlighted as an important area to address. During the COVID-19 response, health care providers were overworked, often unsupported or under-supported, with inadequate compensation and protections. Stakeholders noted that this

was primarily due to the lack of financial investments in the health workforce. The mental health challenges faced by the health workforce during the COVID-19 pandemic underlined the importance of integrating mental health into response and recovery plans.

In Botswana, participants noted that during the pandemic, dispensing of essential medicine was taken up by private pharmaceutical shops which resulted in increased out of pocket expenditures. Participants from Ethiopia and Liberia also reported decreased availability of drugs and decreased adherence to antiretroviral therapy in their countries.

While alternate strategies like telemedicine were introduced in countries like Argentina and Uruguay, participants noted that inequalities in health access still worsened. In Argentina, telemedicine was largely employed to resolve scheduled consultations or slightly mitigate the interruption of scheduled clinical care; in Uruguay, telephone consultations were used to mitigate some disruptions to primary health care.

Civil society actors added recommendations to improve digital health services and equip health teams with technological tools to improve surveillance and monitoring. Additionally, the pandemic highlighted the importance of community-based and community-led physical and mental health care services. Multiple country reports noted that this cannot remain a missed opportunity for further investments.

"The government should work towards creating a resilient health care system that can withstand any type of challenges."
– Civil society participant in Ethiopia

"COVID-19 was an extremely difficult period for many. Those who were going to government clinics found themselves stranded. They didn't have money to buy drugs privately. For many, it was like a death sentence."
– Participant in Sri Lanka

LOOKING AHEAD TO 2023

Civil society and community participants highlighted recommendations for policy and advocacy action in each of the UHC Commitment Areas above through the focus groups.

They shared insights, stories, and recommendations for health care systems in over 40 countries in 2021 and 2022. The consultations presented a set of these challenges, including the effects of stigma and discrimination, deficits in the health workforce, gaps in data availability and quality, the uneven impact of health emergencies, and the deprioritization of certain health conditions. They also highlighted vulnerable and marginalized communities most likely to be left behind, even in settings where there has been progress on expanding coverage to quality health services, and the barriers they face in accessing care.

In 2022, participants also discussed what they see as the main priorities for the UN HLM on UHC in 2023, the next global opportunity for leaders to reflect and renew their

commitments to achieving UHC in their countries. What areas need more commitments? Where should the global community increase advocacy action? The health care system users, care providers, advocates, families, and communities represented in these consultations raised one ask above all: equity.

KEY AREAS FOR AMPLIFIED ATTENTION AND ACTION

- Legislation, regulations, and policies with a redoubled focus on **reducing inequalities and upholding rights** in health care access. The needs of people living with disabilities, young people and adolescents, migrants and refugees, indigenous populations, women and gender minorities, LGBTQ+ communities, and others facing multiple vulnerabilities must be addressed with targeted solutions.
- Increased **public funds for the health sector**, especially allocated to strengthening primary health care, supporting community-based health care, expanding promotion and prevention approaches, and strengthening the health workforce.
- Quality **data generation and sharing** to support evidence-based planning, including in partnership with and through investments in civil society and community groups.

Other areas recommended for more specific commitments from global decision-makers in 2023 included: protecting **patient rights**, confidentiality and safety; addressing health needs in **emergency settings**; promoting incentives to **retain health workforce** in low- and middle-income countries; building strong multisectoral and international **cooperation**; creating pathways for **better infrastructure and resources** (e.g., medical equipment, supplies); and addressing the health effects of **climate change**.

"Involving civil societies in care and increasing public investment in primary health care is one of the best ways to ensure equity, availability, accessibility, quality, and effectiveness of health services."
– Country report from Senegal

The recommendations presented above add to our collective understanding of the priorities the end-users of health systems observe on the ground in order to achieve health for all. Achieving UHC is a question of political will. We all have a role to play in building public support for UHC and driving targeted actions for UHC policies and investments.

In a consultation in 2021, a civil society representative opined on the state of their country's health system: "Politicians call it UHC. I may not call it UHC, but I will call it one step towards [it]." As we look ahead to world leaders gathering again for the UN HLM on UHC in 2023, we acknowledge the ambition of the 2019 Political Declaration and the progress made so far. But we have many more steps to take, together, with partners across sectors and geographies, to ensure that all people can obtain the quality health services they need.

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