ESWATINI CIVIL SOCIETY ORGANIZATIONS (CSO) REPORT ON THE UNIVERSAL HEALTH COVERAGE CONSULTATION 28-29 JULY 2022, GEORGE HOTEL, MANZINI, ESWATINI

Number	ITEMS	DESCRIPTION	RESPONSIBLE PERSON
1	**Introduction**	Baphalali Eswatini Red Cross Society (BERCS) through the support of WACI Health Champions for Health and the International Federation of the Red Cross Crescent Societies (Pretoria Cluster Delegation and Geneva Headquarters) facilitated Consultations on Universal Health Coverage (UHC) the with Civil Society organizations (CSO) and community leaders. The consultation was guided by the 9 key asks on UHC. The first day (28th July 2022) was set aside for the CSO affiliated with Coordinating Organization of NonGovernmental Organizations (CANGO) and the second day (29th July 2022) was set aside for the communities. The idea to separate the consultations came from the Ministry of Health so that communities do not feel threatened as their level of understanding might be of varying levels and that the consultations were as civil society as much as possible. Other administrative/logistics items were also communicated with the informants as expected. Carthi Mannikarottu from WACI Health supported the consultation by giving an overview of UHC to both groups. Following the presentation, participants were given the opportunity to engage with the presenters. The participants appreciated the information and asked if the discussion could be considered when discussing the various questions in each of the 9 UHC key asks. Amalia Gatopoulou took notes of the consultations together with Linda Nene as the participants expressed their opinions regarding each of the 9 UHC key asks. On both day 1 and day 2, Carthi and Amalia participated, though Carthi had some other assignments to pursue on the second day and she had to leave the online connection earlier and participants on the second	**BERCS** Dr. EM. Jele **IFRC** • Mr. Linda Nene • Ms. Tshedi Sibande **IFRC (Geneva & India)** • Amalia Gatopoulou • Carthi Mannikarottu

		day were made aware of the movement. However, participants were extremely happy about the UHC overview presented to them. The duration of each focus group discussion for both days was approximately 2-3 hours starting from 10 am to 2.30 pm each day. The moderator explained the format, objectives, expected outcomes and the methodology for conducting the FGD and furthermore assured all participants that the discussions were anonymous and were asked if they were aware that most of the proceedings were being recorded and participants were asked not to identify themselves when proposing an idea or raising an issue. The audio clips from both days of consultations are available upon request.	
2	**DAY 1 & 2:**	On the first day, a total of fifteen participants participated (eleven were in physical attendance and four joined virtually). The CSOs representatives were of varying interests. Some were from the LGBTQ+ community, faith-based organizations and others had youth driven focus. A total of twelve participants attended the consultative session and the participants came all 4 regions of Eswatini (Hhohho, Manzini, Lubombo and Shiselweni). The community members selected came from a variety of public health services and organization including BERCS and rural health motivators.	**IFRC/BERCS**
3	**CATEGORY 1: ENSURE POLITICAL LEADERSHIP BEYOND HEALTH IN ESWATINI**		
		In terms of the existence of a coordination government agency/mechanism/department that engages across sectors for the specific purpose of improving health or advancing UHC, the CSO felt that in Eswatini the social platforms and the consortia within CANGO (Children, HIV/AIDS. Gender, Governance and Food Security) do pay a role to ensure advancing UHC is in place. However, resource limitations do not allow for consistency in the coordination of efforts and there is often fragmentation in the initiatives performed by the CSOs hence the overarching needs of the communities served are not met. The CSO pledged to ensure that existing organisations affiliated to CANGO are yet to successfully mobilize efforts in an effective single-minded fashion ensuring that there is geographic mapping of interventions and strengthening of coordination mechanisms with the view of getting more resources and pool together those resources in order to minimise duplication of efforts. Health advocacy on UHC with other agencies or Ministries, is ongoing and this is done by the CSO membership involved in health-related matter. CANGO through its membership (CSO) is involved in activities like budgeting. However, the existing consortia need to be driven further.	**Dr. E Jele**

		During COVID-19, the government shifted the focus from the other key important UHC matters and invested heavily on the pandemic. COVID-19 had negative impact on access, quality, and cost of UHC in that during the initial stage of the pandemic the government established very restrictive policies like identification checkpoints on public roads, restrictions on movement and curfews. There was also a limit on the number of people that could be admitted into health facilities/hospitals due to COVID-19 safety protocols which were a major restriction that hampered health seeking behaviours of the public. In a positive way, the Authorities learned later that not all organizations were supposed to be barred from offering services, such as the Red CROSS which was then given clearance to respond to emergencies and provide support without restriction from the security forces. The community group share almost the same sentiments when it comes to the impact COVID-19 and its accepting regulations/laws. The participants felt government had done very well when responding to the COVID-19 pandemic, overall. Community members felt the whole health system is ailing and it is not clearly coordinated within the community frameworks and structures. Establishing a very good coordination structure for communities where all other service provision ministries account is needed. This is the structure that can continuously provide regular update regarding health issues and more resources should be injected into such infrastructure. This includes the re-evaluation of the current communication structures such as the *Tinkhundla*.	
4	**CATEGORY 2: LEAVE NO ONE BEHIND**		
		Both the CSO and the community groups share the same understanding regarding the key populations that are most prone to high-risk behaviours continue to face stigma, which limits their access to care. These groups are the elderly as they have difficulty accessing health care due to distance and the younger population adolescents are often stigmatized or not taken seriously when attempting to access health care services such as sexual reproductive health (SRH). Affordability of services is also an existing issue because some clinics run out of medications which forces people to go to private pharmacies/clinics and gender-non confirming populations also face difficulties in public health facilities. There was also a discussion regarding reports that there is generally apathy from health care providers struggling to ensure access, quality, and affordable services to the needs of vulnerable populations like adolescents and queer populations. Extreme religious practices are also a factor that has created vulnerability within some communities as these individuals can no longer access care.	**Dr. E Jele**

		In response to some of these challenges, the CSO have stretched themselves and provided onsite clinical services which made a difference for hard-to-reach communities and individuals who struggle with reaching health facilities such as the people with disabilities and older populations with limited mobility. However, they commend government for providing expert services even though the queues at facilities are too long for someone who is very ill and needs urgent attention. CSO also noted that the Eswatini abortion laws that only make provision for abortion under exceptional circumstances which is a limitation for women seeking care. Some policies currently in existence are not always clear on the objectives that should be met and can create issues on the ground for implementation. The CSO recommend that greater advocacy is needed for a variety of policy related issues that limit access to care and CANGO has established the SRH network to support in its advocacy efforts	
		Eswatini is doing well when it comes to the subsidies which stop out-of-pocket spending, and the government has in place a way of controlling the fees. At health facilities, fees are subsidized, and the facilities only charge clients' operation related levies. These subsidized services include immunizations, family planning and SRH. This is done through the existing schemes which are considerably efficient at ensuring that people save money. However, there are gaps which need to be addressed and these include the following: Patients who need more specialized care (e.g., cancer, psychiatric conditions and etc) and who in most cases suffer the most when it comes to out-of-pocket spending should be assisted. Drug stock outs occur, which forces people to access care from private healthcare providers. There is a lack of capacity in soft skills and even complex issues in mental health and psychosocial support because the care provided currently is not comprehensive (i.e., technical skills are required). Burdened specialized care facilities often run short of meeting all the needs of their clients. In most cases these groups of patients suffer direct costs (e.g.., paying care provider) and indirect costs (e.g., fuel, accommodation, time taken off work and etc)	**Dr. E Jele**
5	**CATEGORY 3: REGULATE AND LEGISLATE**		

		The MoH has accountability and monitoring systems and policies such as the (Health Management Information Management System (HMIS) which collects data on daily basis and within this framework, there are modules for various health programmes) in place which are enshrined in the Ministry five-year Strategic Plan. However, the system is not giving feedback to the public especially to those who generate the data, and it is on many occasions fragmented. There are limitations presented by the budgets approved	**Dr. E Jele**

		for the healthcare portfolio and the amounts committed in public addresses are not what is translated into the resources on the ground. CSO recommend for more rigorous ways to ensure stronger feedback mechanisms are introduced and implemented. This can be encouraged at unit level of the MoH. What was noted was that typically, the CSOs felt the Ministry of Health needs a "story" before providing support to specific area of need. Often waiting on CSOs and other entities to provide operational models for specific activities. The Community group, especially the health workers felt like they are being ignored (not involved and cannot participate in major planning/budgeting and other process that affect the way they do the work) and at times not regularly supported though do so much work by collecting data on behalf of their communities whom they want to see free from ailments or have their problems attended to timely.	
6	**CATEGORY 4: UPHOLD QUALITY OF CARE**		
		Both the CSO and community members felt the quality of care is wanting. All groups felt elderly and those previously mentioned under category 2 are the most impacted by shocks. The MoH needs to improve on sensitizing all healthcare workers on the plight of these key populations and this should be institutionalised in training institutions such as curricular level. MoH should also look into supply chain management particularly the health care commodities, for example drugs, highly specialised care and medical devices and keep staff motivated in order to perform at the expected level However, in general terms of the provision of quality health care, the MoH has competent and well-trained staff and in terms of infrastructure, though limited, is of good quality. This includes the mission institutions as well, who are also key players in health care service delivery. Community health care workers do also contribute immensely and the MoH has a running roster. Community health care workers are included in health rosters and are said to be fairly remunerated.	**Dr. E Jele**

7	**CATEGORY 5: INVEST MORE. INVEST BETTER**		
		Both CSO and the community group recommended that Eswatini Government should spend more resources on ensuring the country is able to provide comprehensive care, improve on risk communication and community engagement, which is becoming more prominent as a result of the recent disease outbreaks (e.g., COVID-19 and Monkeypox). So, to prevent any future outbreaks, health promotion to protect resources from future related costs is needed, as well as localised and specialized health care services	**Dr. E Jele**

		Challenges noted are that budgets committed by government hardly materialize into resources on the ground. There is generally lack of transparency in expenditure and the suggested 15% health expenditure can only be achieved if the Ministry of Defence retreats so that a political decision is made by the Ministry of Finance to reallocate to health. In order to improve budgeting and allocation, it is recommended that bloated ministerial budgets should be reduced. CSO also noted that due to the sensitivity surrounding the topic of government spending, any criticisms or recommendations levelled tend to be associated with prodemocracy movements within the country	
8	**CATEGORY 6: MOVE TOGETHER**		

		CSOs and the private sector do get some opportunities to participate in budgeting even though they are not well coordinated and are too fragmented. The community group felt the opportunities are acceptable. However, the community group was quick to note that there are no community forum groups which can enhance communication and worse, at present, feedback from community members is construed as prodemocratic if they raise an issue with the authorities. The MoH requests the participation of stakeholders such as the private and CSO in planning. For example, the MoH engaged the organizations when the 5-year strategic plan of the MoH was developed. The Ministry is also very instrumental in consolidating reports and accounting in Parliament, which is commendable however, the public/people has very limited contribution – it is right to say there is no clear-cut process by which the CSO is involved hence transparency on budgeting and expenditure is deficient CSO also noted that, "They expect reports from CSOs but hardly ever account back to them on what is done regarding the information provided to the ministry and their activities and Ministry of Health takes credit for data generated by CSOs but do not speak much on their own activities openly."	**Dr. E Jele**
9	**CATEGORY 7: GENDER EQUALITY**		
		Both CSO and the communities shared similar views on issues of gender equality. Adolescent girls and young women are the most vulnerable populations, particularly because of the stigma surrounding SRH service programming and the environment in Eswatini is still strongly anti-queer. This is because of a lack of legislation that can integrate the othered members of society. The justice system has a bearing on the way the cases are handled.	**Dr. E Jele**

		There is need for rigorous advocacy and education of the communities with regard to the marginalized groups in the societies. Community resilience needs to be prioritized for future public health emergencies, especially at the level of providing the youth with livelihood initiatives	
10	**CATEGORY 8: EMERGENCY PREPAREDNESS**		

	The Eswatini	healthcare system was extremely overwhelmed as there was a noticeable capacity issues in terms of labour and skills. The Ministry worked under extreme pressure to open up space where nobody would think the place would be used as a COVID-19 management care site for those who fell ill to COVID-19 and its complications. This caused a lot of shifting resources earmarked for other programmes to COVID-19. The Eswatini government can prevent or mitigate the effects of a similar outbreaks by ensuring that surveillance equipment, systems and people using the system are always in place. COVID-19 did not only create opportunities, but it was a requirement in every facility for all patients to get COVID-19 screening and that gave health workers an opportunity to screen other diseases hence COVID-19 also assisted with increasing intake for other clinical services since it is not screened in isolation. Government has deprioritised the care for the healthcare providers since the pandemic started.	
11	**CATEGORY 9: LOOKING TO 2023**		
		Additional thematic areas under UHC: Human rights advocacy, resources, collapse of the health care system, taxation, global crises, making UHC must be for everyone whether foreign, queer etc. Hence UHC should be globalized. A hunger crisis is looming in Eswatini, and this may affect the 58.9% people who are poor especially in rural communities Access to services needs to be improved by working on issues such as identification, language barriers for foreign nationals. Migration in the region also require consideration when assessing UHC Consider traditional medicines, regulate, and integrate the alternative therapies since so many are still reliant on them and worse when the poverty line and unemployment shift the course of livelihood. **Key ASK:** • Increase budgets for Ministry of Health • Put in place monitoring system for the funds	**Dr. E Jele**

		• ‘Prioritise the healthcare system, so it can deliver and be accounted for’ • ‘There should be community engagement’ • ‘Hire more health workers’ **ONE Message to share with world leaders:** • Developing countries should be treated fairly and needs more support • Standardize the quality of care across countries.	