

Tracking Progress on Social Participation for Health

Preliminary Findings from a Civil Society–Led Multi-Stakeholder Assessment of Implementation of WHA77.2

1. Why social participation for health matters now

In May 2024, Member States unanimously endorsed WHA77.2, “Social participation for universal health coverage, health and well-being establishing social participation as a core health system function at the World Health Assembly (WHA)^{1,2}. The resolution defines social participation as *empowering people, communities and civil society to participate meaningfully in decision-making processes that affect health across the policy cycle and at all levels of the system*².

WHA77.2 builds on long-standing global commitments, including the Declarations of Alma-Ata and Astana, the Rio Political Declaration on Social Determinants of Health, and SDG 16.7 on inclusive decision-making^{3–6}. Crucially, it goes beyond previous commitments by placing explicit responsibilities on governments to institutionalise, resource, and monitor participation in practice, rather than treating participation solely as a normative principle¹. Early experience suggests that translation into routine, influential practice remains uneven, particularly where participation lacks formal mandates, sustained financing, or links to decision making authority⁷.

The period leading up to the third UN High-Level Meeting on Universal Health Coverage (UHC) in 2027 represents a critical window in which social participation will shape how UHC commitments are assessed, renewed, and transformed into actions. At the same time, ongoing debates on global health architecture reform underscore the importance of embedding civil society and community participation as a core and integral feature of governance processes, rather than as an ad hoc or optional add-on.

Two years into the implementation window of WHA77.2 (2024–2026), this moment represents a critical inflection point. Under the resolution, WHO is mandated to report to Member States on progress on a biennial basis; necessarily concise and focused on high-level global trends. In this context, there is a clear and complementary role for civil society. This civil society–led multistakeholder snapshot is undertaken in support of the Social Participation Core Group (SPCG) to provide more granular, experience-based insights into how WHA77.2 is being interpreted and implemented at country level, particularly from the perspective of communities and organisations directly engaged in participatory processes.

This assessment has been developed by a coalition of civil society organisations and stakeholders engaged in social participation for health, including the Global Health Council (GHC), Save the Children International (SCI), International Alliance of Patients’ Organizations (IAPO), the Civil Society Engagement Mechanism for UHC2030 (CSEM), Amref Health Africa, Action against Hunger and members of the WHO Social Participation Core Group. While the coalition reflects diverse constituencies and geographies, it does not claim to represent exhaustive views. Rather, it offers a structured, experience-based contribution intended to complement official reporting and elevate perspectives that are often under-represented in formal accountability processes.

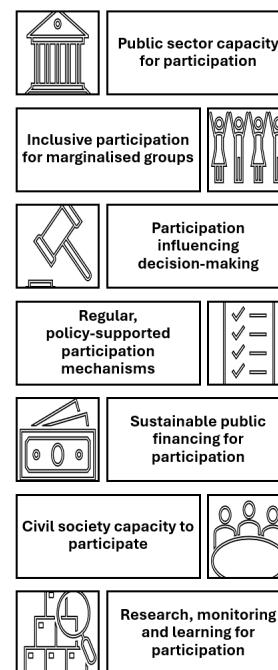
This preliminary report examines early progress in implementation of WHA77.2, drawing on perspectives from civil society, community organisations, patient groups, and selected institutional actors across WHO regions. Structured around the seven commitments to Member States set out in WHA77.2, it aims to contribute experience-based insights into how social participation is being interpreted and operationalised in practice.

2. How this Assessment was conducted

Approach and Analytical Frame: This assessment draws on a multistakeholder civil society-led global survey, conducted in March–April 2026, focused on early implementation of WHA77.2. The approach complements WHO reporting by capturing experiential and governance-level evidence alongside formal policy commitments. The analytical framework is structured around the seven commitments to Member States set out in WHA77.2, examining whether social participation in health systems is becoming regular and policy-supported, inclusive and equitable, influential across the policy cycle, and adequately resourced, monitored, and sustained (see figure 1 below)

Data Sources: The survey, led by the Global Health Council (GHC) and the Civil Society Engagement Mechanism (CSEM) for UHC2030, generated 138 responses from civil society organisations, community-based organisations, patient and rights-holder groups, academic institutions, and selected government and multilateral actors. Responses were received across all six WHO regions, with the largest share from the African Region (62), followed by the Region of the Americas (36), South-East Asia (22), Europe (12), the Eastern Mediterranean (4), and the Western Pacific (2). Findings were interpreted alongside WHO technical guidance, the UHC2030 ACT for UHC dashboard, documentation from the 2025 High-Level Political Forum, and selected peer-reviewed literature.

Limitations: As an early-stage, perception-based assessment, results are illustrative rather than exhaustive, reflecting uneven country coverage and limited participation by Member State officials.



3. What we are seeing: survey findings from early implementation of WHA77.2

Survey responses from civil society organisations, community-based organisations, patient groups, academic institutions, and selected institutional actors across all WHO regions provide insight into early experiences of social participation in health following the adoption of WHA77.2. Across respondent groups and regions, findings indicate that while participation mechanisms are increasingly recognised, meaningful implementation remains uneven, limited in scope, and constrained by structural barriers.

3.1. Public Sector Capacity to Design and Implement Meaningful Social Participation

Respondents consistently reported limited capacity particularly within government institutions to design, convene, and sustain meaningful participatory processes. Capacity-building was most often described as sporadic, project-based, or externally supported, rather than embedded within government systems. Few respondents reported the existence of permanent institutional units, formal mandates, or systematic training programmes dedicated to social participation in health. As some respondents noted:

“There is no dedicated, permanent institutional unit or formal national coordination body explicitly mandated to lead social participation in health.” (Cameroon)

“Offer consultation, but civil servants are not trained or resourced to implement it.” (Switzerland)

Several respondents noted that civil society actors often compensate for these gaps by leading or sustaining participatory processes but emphasised that this arrangement is fragile and unsustainable.

Public sector capacity to design and sustain participation remains weak in many settings, limiting effective implementation even where participation is formally encouraged.

3.2. Enabling Equitable, Diverse and Inclusive Participation

Inclusion emerged as the most consistently reported weakness across survey responses. More than two-thirds of respondents indicated that participation processes tend to prioritise established or well-resourced actors, with limited or tokenistic inclusion of marginalised and vulnerable populations. Groups most frequently cited as excluded include persons with disabilities, LGBTQ+ populations, migrants and displaced people, rural and remote communities, and people living with rare diseases, highlighting persistent barriers to equitable participation in practice.

Respondents highlighted both structural and practical barriers to inclusion, including lack of accessible formats, absence of safe spaces, financial constraints, and stigma. Many respondents illustrate these concerns:

“They are brought into meetings as tokenism (just for symbolism without their meaningful contribution).”
(Malawi)

“There is no safe space for inclusion events publicly for marginalized people.” (Myanmar)

“Rare disease patients and people with disabilities are not included.” (India)

Mechanisms intended to enable inclusive participation are widely perceived as limited or inconsistently applied in practice.

3.3. *Influence of Social Participation on Transparent Decision-Making*

Respondents overwhelmingly described participation as consultative rather than influential. Most reported that communities and civil society actors are invited to provide input but have little or no influence over policy priorities, budget allocations, or implementation decisions. Feedback on how contributions are used was often described as absent. For instance, many respondents noted:

“Most of their ideas are not taken into consideration.” (Malawi)

“Authorities listen but communities have no role in decision-making.” (Peru)

“We submit memorandums, but they don’t give feedback.” (Kenya)

A small number of respondents reported stronger influence in specific policy areas or contexts, often linked to formal advisory or decision-making bodies. However, these were exceptions rather than the norm.

Participation is predominantly consultative, with limited reported influence on final decisions.

3.4. *Institutionalisation of Participation Mechanisms through Policy and Law*

A majority of respondents described social participation mechanisms as not yet institutionalised¹. Approximately 70–80% of respondents characterised existing mechanisms as *“early-stage,” “partially established,”* or *“ad hoc.”* Fully institutionalised mechanisms described as regular, sustained, legally anchored, and embedded within health decision-making structures were reported by only a minority of respondents. Several respondents indicated that participation structures exist nominally but lack effectiveness or authority. For instance, respondents mentioned:

“Committees exist only to justify the process, but they are ineffective.” (Kenya)

“Participation remains ad hoc or consultative rather than fully integrated into decision-making processes.” (Mauritius)

“Health decision-making processes are often centralized, technocratic, and poorly communicated.”
(Cameroon)

However, respondents from Brazil and Thailand more frequently described participation as regular and sustained, while respondents from Malawi, Cameroon, Costa Rica, and several other countries reported that structures exist on paper but lack continuity, reach, or enforceable mandates.

Institutionalised and continuous participation mechanisms are uncommon, and most participation is reported as informal or partial.

¹ Here, institutionalisation refers specifically to the existence of regular and sustained participation mechanisms supported by public policy or legislation, as set out in WHA77.2

3.5. Financing of Social Participation

Lack of dedicated financing was identified as a major systemic constraint. Approximately 80% of respondents reported no or minimal government funding for social participation.

Participation-related costs are frequently borne by civil society organisations or individuals:

“Work is unpaid. Patient organisations don’t receive public funding.” (Switzerland)

“Government does not fund CSOs to participate at national or subnational levels.” (Malawi)

Even where participation is recognised in policy or law, respondents indicated that financial allocations rarely follow.

Without predictable public financing, participation relies on unpaid labour and remains inequitable and unsustainable.

3.6. Capacity of Civil Society to Participate Meaningfully

Respondents consistently highlighted that civil society organisations, community-based organisations, and patient groups play a central role in sustaining participatory processes, often compensating for gaps in public sector capacity. However, their ability to participate meaningfully and consistently is widely constrained by limited institutional support, unpaid labour, and lack of predictable resourcing.

Several respondents described participation as dependent on volunteer time and organisational goodwill rather than structured support:

“Work is unpaid. Patient organisations don’t receive public funding.” (Switzerland)

“Government does not fund CSOs to participate at national or subnational levels.”
(Malawi)

In contexts where public sector leadership on participation is weak or fragmented, respondents noted that civil society actors are often expected to organise, convene, or sustain participatory processes without commensurate investment, raising concerns about sustainability and equity across organisations of differing size and resources.

Civil society engagement is essential but remains fragile; without systematic capacity-strengthening and support, participation risks depending on unpaid labour and excluding less-resourced actors.

3.7. *Monitoring, Evaluation and Learning*

Monitoring and evaluation of social participation were described as limited or absent in most settings. Few respondents reported national-level mechanisms to assess the quality, inclusiveness, or influence of participation. Where monitoring occurs, it is often informal or project-specific:

“If no social participation, what is the work of M&E?” (Tanzania)
“There are no standardized, system-wide processes to assess effectiveness.” (Kenya)

Weak monitoring limits learning, transparency, and accountability.

Without systematic monitoring and feedback, participation risks becoming symbolic and disconnected from policy improvement.

4. **What this means for the World Health Assembly: priority implications and actions**

The survey findings point to a common conclusion: the challenge facing WHA77.2 is no longer normative consensus, but implementation design. Social participation is widely recognised in principle, yet remains weakly embedded in decision-making authority, public financing, and accountability systems. For the World Health Assembly, the priority is therefore to signal *how* the resolution should be operationalised, drawing on both the survey evidence and established global experience on participatory governance.

4.1. *Shift the Emphasis from Voice to Decision-Making Authority*

The survey highlights that participation without decision-making influence remains the dominant model. This gap is captured by one respondent’s observation: *“Your opinion doesn’t matter, however good it is”* (Kenya). Global governance literature shows that participation shapes outcomes only when it is connected to clearly defined decision points and response obligations, rather than confined to consultation or information-gathering^{14,15}. The UHC2030 ACT for UHC dashboard similarly demonstrates that progress on UHC commitments is associated with stronger accountability and participatory governance, not consultation alone.

The Assembly should emphasise that meaningful participation under WHA77.2 requires shared influence over priorities, budgets, implementation, and review, and encourage Member States to demonstrate how participatory inputs are formally considered and acted upon.

4.2. *Treat Institutionalisation as a Governance Reform, Not a Programme Activity*

Survey findings indicate that many participation mechanisms remain contingent, project-based, or donor-driven. Respondents described participation as episodic and uneven: “*Participation depends on the territory, the theme, and whether NGOs are active - there is no system*” (Brazil). Evidence from health system governance shows that participation becomes durable and influential only when institutionalised through law, regulation, and core administrative functions, rather than through temporary initiatives^{16–18}.

The Assembly should frame institutionalisation of social participation as a governance reform requiring formal mandates, continuity across political cycles, and integration into health system structures rather than as a series of pilot or engagement activities.

4.3. *Make Inclusion a Design Requirement, Not an Aspirational Outcome*

The survey underscores that inclusion does not emerge organically. A respondent noted that “*most national health councils do not represent marginalized populations*” (Brazil). Peer-reviewed evidence consistently shows that participatory spaces reproduce existing power asymmetries unless inclusion is intentionally designed, resourced, and safeguarded, particularly for populations facing stigma, poverty, or structural exclusion^{7,18–20}.

The Assembly should reinforce inclusion as a minimum design standard under WHA77.2, promoting expectations related to accessibility, representation, safe participation spaces, and targeted outreach, rather than relying on voluntary or symbolic inclusion.

4.4. *Resource Social Participation as a Core Health System Function*

Survey findings demonstrate widespread reliance on unpaid or self-funded participation. Comparative evidence shows that unfunded participation undermines equity, sustainability, and legitimacy, and limits engagement to already-resourced actors^{7,15}. UHC2030 accountability analysis likewise indicates that commitments without dedicated financing are among the least likely to be realised in practice.

The Assembly should encourage Member States to treat participation as a budgeted system function, including reporting on dedicated financial allocations, not only on policies or mechanisms.

4.5. *Embed Participation in Monitoring, Accountability, and Learning*

The survey points to weak monitoring of participation quality and influence. Governance research shows that participation without feedback and monitoring risks becoming symbolic and eroding trust ^{14,21}. Current gaps in participation indicators within UHC monitoring frameworks further reinforce this risk (UHC2030).

The Assembly should support the integration of participation indicators into UHC and health-system monitoring, aligned with WHO reporting ahead of the 2026 review cycle.

5. Conclusion and way forward

Social participation has crossed an important threshold in global health governance. With the adoption of WHA77.2, Member States have moved beyond recognising participation as a principle and have committed to institutionalising, resourcing, and monitoring it as a core health system function.

Two years into the implementation window (2024–2026), early evidence suggests that progress is fragile. While social participation is increasingly referenced in laws, policies, and strategies, it is rarely embedded in decision-making authority, public budgets, or accountability systems. Participation remains predominantly consultative and under-resourced, particularly for marginalised and vulnerable populations.

The period leading to WHO's first biennial report to the World Health Assembly in 2026 is therefore decisive. Member States, WHO, and civil society face a narrow but critical opportunity to translate normative commitments into governance reform, ensure that participation influences policy priorities, budgets, and implementation, and embed social participation within UHC monitoring and accountability frameworks. Social participation is no longer a discretionary addition to health policy; it is a requirement for legitimate, people-centred, and equitable health systems.

The question for the next WHA cycle is not whether participation matters, but whether it will be implemented with the power, resources, and accountability envisaged in WHA77.2.

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