



# From Left Behind to Front and Centre:

Key messages from **UHC** focus group  
discussions among vulnerable and  
marginalised groups in Bhutan,  
Cambodia, India, Japan, Lao PDR,  
Nepal, Pakistan and Vietnam.

In collaboration with:

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# Acronyms

<b>ART</b>	antiretroviral therapy
<b>CHW</b>	community health worker
<b>CSEM</b>	Civil Society Engagement Mechanism for UHC 2030
<b>CSO</b>	civil society organisation
<b>LGBTQI+</b>	lesbian, gay, bisexual, transgender, queer, intersex and other non-binary
<b>MSM</b>	men who have sex with men
<b>PLHIV</b>	people living with HIV
<b>PUD</b>	people who use drugs
<b>PWD</b>	people with disabilities
<b>SDG</b>	Sustainable Development Goals
<b>TB</b>	tuberculosis
<b>UHC</b>	Universal Health Coverage
<b>WHO</b>	World Health Organisation

# Foreword

Securing health care that is genuinely universal in terms of who and what it covers, is one of the greatest challenges facing the world today. According to the World Health Organisation (WHO), universal health coverage (UHC) “means that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course.”<sup>1</sup> This vision is important enough for it to be included as a Sustainable Development Goal (SDG) under Goal 3, “Ensure healthy lives and promote well-being for all at all ages,” as Target 3.8: “Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.”<sup>2</sup> Each of the countries that participated in the focus group discussions in the Asia Pacific – Bhutan, Cambodia, India, Japan, Lao PDR, Nepal, Pakistan and Vietnam – have committed to this goal, and will be judged by the proportion of the population that can access essential quality health services (SDG indicator 3.8.1), and the proportion of the population that spends a large amount of household income on health (SDG indicator 3.8.2). These are tall asks, but with sufficient commitment, engagement and investment, not impossible.

APCASO believes that the true measure of UHC will be to what extent a country’s most vulnerable and marginalised populations have access to, and are able to benefit from health care, without suffering financial hardship. That is, **we need to put those most likely to be left behind to be at the front and centre in all UHC planning, implementation, and monitoring.** It is for this reason that these discussions – with representatives of groups that are often excluded from many of the benefits their countries offer: the poor, gender minorities, those with identities, behaviours, or occupations that are considered outside the mainstream – are so important. UHC will only be realised when the most vulnerable and marginalised are able to enjoy good health and well-being outcomes. And as global targets are now less than ten years away, it is more urgent than ever that these voices be heard and elevated now.

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<sup>1</sup>WHO, “Universal Health Coverage”, April 2021, <https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage>

<sup>2</sup>United Nations, Department of Economic and Social Affairs, <https://sdgs.un.org/goals/goal3>

# Acknowledgements

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- **India:** National Coalition of People Living with HIV India (NCPI+)
- **Japan:** Global Health Program, Africa Japan Forum
- **Lao PDR:** Community Health & Inclusion Association (CHIAs)
- **Nepal:** Trisuli Plus
- **Pakistan:** Association of People Living with HIV & AIDS (APLHIV) – Pakistan
- **Vietnam:** Centre for Supporting Community Development Initiatives (SCDI)

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# The Scene

The Civil Society Engagement Mechanism for UHC2030 (CSEM) initiated a global series of universal health coverage (UHC) consultations to hear the voices of the most marginalised and vulnerable communities and their experiences with UHC across the world. These country consultations sought to capture civil society perspectives to be included in UHC2030's State of UHC Commitment 2021 report, a multi-stakeholder review on the state of progress being made towards UHC at country and global levels. APCASO served as the Asia Pacific coordinating organisation, and oversaw focus group discussions in eight countries in the region: Bhutan, Cambodia, India, Japan, Lao PDR, Nepal, Pakistan, and Vietnam. These discussions included a total of 213 individuals, representing diverse communities, including the most vulnerable and marginalised.

Participants included men, women, youth, elderly, transgender people, LGBTQI+, people living with HIV (PLHIV), people who use drugs (PUD), sex workers, migrants, urban poor, people with disabilities (PWD), and ethnic minorities. Some countries also engaged social workers and public health facility staff. Focus group discussions were facilitated by health and human rights civil society organisations (CSOs), using guiding questions provided by CSEM and UHC2030. The findings of these consultations will be integrated into a global advocacy report, however, APCASO has developed this regional overview to highlight the issues specific to the Asia Pacific, and to share the voices of the region's most marginalised and vulnerable communities – the voices that remind us that if we are to be successful in achieving UHC by 2030, no one must be left behind.



Figure 1: Countries that hosted focus group discussions, and the number of participants



This synthesis report shares the concerns and recommendations of the very people who often have the greatest need for health care and financial or

other assistance to access it – the people that UHC is designed to support, and the people who currently risk being left behind.

## Key Messages



**Ensure UHC covers the specific health and well-being needs of marginalised and vulnerable populations, making them available when, where and how they are most accessible.**



**Include representatives of marginalised and vulnerable communities as equal and permanent partners in UHC oversight, decision-making, and evaluation mechanisms.**



**Invest in improving the integration and user-friendliness of UHC systems to reduce non-financial barriers to access.**



**Enable improved access to health care and better well-being outcomes by decreasing stigma and discrimination in the health sector.**



**Strengthen the health system's capacity to provide mental health support to all, particularly the most marginalised and vulnerable communities.**

## The Upshot

The countries in which focus group discussions took place are each at different stages in their journey towards UHC, giving us a broad perspective of the state of UHC across the region. UHC exists in some shape or form in all the countries that hosted discussions, and each government has made at least some commitment to providing free or subsidised health care to its citizens. Most countries have a policy, framework, or even the country's constitution outlining a commitment to UHC or national insurance coverage, and many have a functional coordination mechanism in place. However, despite commitments

and some progress, many gaps, quality issues, and barriers to access remain – particularly for the most vulnerable and those most in need of support. Many of the shortfalls are related to financing gaps that many countries are seeking to fill, but others are more systemic, and will require additional effort to ensure that UHC is genuinely universal. The following section outlines the key shortcomings identified in each of the countries, followed by examples of what works, the impact of the COVID-19 pandemic, and concluding with our key messages to governments, donors, and civil society.

# The Gaps



## 1. Coverage of conditions:

Discussion participants in many countries noted that even if “basic” health care is covered, many health issues facing vulnerable and marginalised groups are excluded. A Pakistan participant observed, “This does not offer the complete and comprehensive package of diagnostic, preventive, curative and promotive health services covering all in every corner of Pakistan... It is good for the fact that it will help avoid 90% out-of-pocket expenditure by individuals and families, yet only some priority diseases are covered.” Participants in countries such as Bhutan were concerned about the lack of support for addiction treatment and rehabilitation, particularly given a relatively high mortality rate linked to alcoholism in the country. Transgender individuals cannot access hormonal support in any of the countries despite UHC commitments. Growing segments of the population such as the elderly do not have access to long-term care in Vietnam – with significant gaps in mental health support. For some elderly, even physical access to health care remains a challenge, particularly if they are dependent on a caregiver.



## 2. Stigma and discrimination:

Without exception, participants in all countries raised stigma and discrimination as a key deterrent for many marginalised individuals from even seeking health care when they need it, as well as contributing to poorer services and ultimately, worse health outcomes. In some countries, certain activities (e.g., drug use) or occupations (e.g., sex work) are illegal, resulting in some individuals shunning seeking health care to avoid imprisonment or other legal action. As one discussion participant from Bhutan explained, “Key affected populations choose to remain hidden, also because there are criminalising laws against them. Such an environment is a threat to achieving UHC by 2030.” In other countries, PLHIV still face fear and discrimination in accessing services. One participant in Vietnam shared, “I was scheduled for an operation at the provincial hospital. When I filled in the form about my HIV status, they refused to do it. They told me that my condition does not need to be operated on. They told me if I want to operate, they can refer me to a specialised hospital. I went to the central hospital in Hanoi and the same thing happened again.”

“People either have to pay, or die.”

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(NEPAL)



### 3. Quality of care:

Participants in all countries reported a lack of quality in health care services available, particularly in the public sector, i.e., the services most likely to be covered by national insurance. Cambodia, India, Nepal and Pakistan highlighted the poor quality of the infrastructure and facilities, and participants in Lao PDR, and sex workers in Bhutan expressed concern about the quality of the drugs provided to them. One participant in Pakistan reported, “We often see more than one patient on one bed due to scarcity of resources and lack of compliance with the SOPs (standard operating protocols) of quality of care.” Even in Japan, which typically has high standards of care, quality could be variable depending on the attitudes of individual health care providers, and quality of mental health services was considered lacking.



### 5. Information:

Participants in Bhutan, Japan, Lao PDR and Nepal highlighted the fact that many citizens do not understand what services they have free access to, or how to access them. They will therefore not seek services since they don't understand their rights. The situation in Vietnam is also compounded by the lack of information available in ethnic languages, and the lack of translation services available. A participant from Bhutan mentioned that sometimes, “The government is trying but the general population is not cooperating”. This was specifically related to mask mandates, but it also reveals either a lack of trust in the government and/or inappropriate communication strategies. In other countries, information is needed to overcome traditional attitudes to encourage people to seek health care. For example, in Vietnam, one participant noted that, “In some localities, minority people still believe that they are poisoned if they get ill; and they go to worship instead of going to hospital for treatment.”



### 4. Physical access:

Participants in Nepal, Vietnam, and Lao PDR pointed to the limited physical access some populations have to health facilities – particularly those living in rural and remote areas. This can create barriers to accessing health care, particularly due to Nepal's challenging geography, or in Lao where access to provincial-level referral hospitals can be beyond the reach of rural populations. Visiting health facilities can require long trips, creating not only transportation but food and accommodation expenses – sometimes not only for the patient but also for a family member or caregiver, particularly in the case of children or the elderly – meaning that some delay seeking health care until a condition worsens, and all other options (e.g., self-treatment or ineffective treatment) have been exhausted.



### 6. Bureaucracy:

Many groups – particularly irregular migrants or the poor who may not have the necessary documentation – face particular challenges in accessing services. This is particularly challenging for those who have literacy limitations, or do not have the requisite identification forms, which can include the homeless in Vietnam. In many countries, such as India, trans-individuals face challenges when most of the forms only include binary gender options. In Vietnam, trans-people have been denied services when their appearance does not match the gender recorded on their identification, or if the spelling of an ethnic minority name has been transcribed inconsistently on different forms. Participants in Vietnam also noted that the procedure for being given access to insurance and health care is not user-friendly, requiring a lot of documentation, which can in itself pose a financial barrier.





## 7. Fragmentation:

Access to services can be further complicated when systems are not aligned and information is not shared across facilities or departments. Efforts to improve this are underway in Lao PDR, but currently, personal data needs to be provided multiple times at different locations. The lack of continuous care within the system, between different services and locations, can make access more difficult – particularly for the less literate, posing another non-financial barrier to health-care, and contributing to loss to follow up. This is particularly complex at the moment in Nepal as the country shifts to a federal system, whereby national level policies are open to interpretation and varying implementation by 753 local governments.



## 9. Civil society engagement:

It was revealing that not all participants in all countries were aware of the bodies or mechanisms responsible for coordinating UHC. Many such mechanisms only coordinate across government line ministries, such as in Lao PDR and Vietnam, and few actively involve civil society and community. Other countries, such as India and Nepal did not discuss a coordination mechanism, but were aware of civil society advocacy efforts to influence government programmes. Pakistan participants, on the other hand, were aware of the coordination mechanism, but noted “its impact is yet to be seen”. In Bhutan and Japan, engagement of civil society in UHC coordination is usually by temporary invitation, and government receptiveness to civil society input is mixed. Discussions in Vietnam revealed how important it can be to have communities engaged in the design and implementation of UHC: “The MOH just issued great new policies but it takes a long time and requires a great effort to implement it in communities.” This is particularly relevant in countries such as Vietnam that have a relatively decentralised government authority. Nepal further emphasised the need for engagement not only of civil society, but of local leaders to ensure that UHC is effectively implemented and monitored at the community level.



## 8. Trust:

While only Bhutan participants explicitly mentioned this issue, it was implied in other countries that many citizens – particularly the most marginalised groups, do not trust services provided by governments, including the quality of drugs provided to them by public services. Countries with ethnic minorities also face trust issues, based on years of negative interactions with public services in the past. Participants in Nepal also demonstrated a distrust of the intentions and effectiveness of government bureaucrats and public health care providers.



## 10. Accountability:

Participants reported that most countries lack an accountability mechanism whereby patients are able to share feedback to public health care providers. As was shared during discussions in Pakistan, “Very often medicine is not available and during visits; programme managers, bureaucrats, politicians and other influential people either reprimand management of hospitals or they suspend or transfer them but the issues remain unresolved.” Participants in countries such as India mentioned the lack of transparency in the health system, and in how health budgets are spent. Participants in Japan also pointed to the lack of accountability of the government, as a result of paternalistic attitudes of those in charge.



## 11. Privacy and confidentiality:

While participants in many countries reported positive examples of health care provider professionalism, marginalised groups in Bhutan, India, Japan, Lao PDR and Pakistan, noted that some health care providers could be indiscreet about personal details – intentionally or otherwise – or publicly announce someone’s status as a welfare recipient. As one participant in Pakistan explained, “The majority of men who have sex with men and the trans-community feel great hindrance in accessing health facilities, as history-taking by healthcare providers is often intimidating and rather humiliating at public sector health facilities. In front of ten other people, healthcare providers ask questions related to sexuality from trans-genders.” Sex workers in Lao PDR also reported that their privacy is not respected, which could deter them from seeking the care they need.



## 12. Integration of mental health services:

While focus group participants acknowledged the many competing demands for health services and the limited resources available, all countries and across all groups participating in the discussions highlighted that support for growing mental health issues is inadequate. This came out particularly strongly in Bhutan, Cambodia, Lao PDR, Nepal, Pakistan and Vietnam. Mental health services have not been prioritised in general, resulting in a lack of services, poor quality of those available, compounded by inadequate adaptation to the needs of different groups, such as PLHIV, and increasingly, the elderly. In Nepal, for example, there are only 160 public psychiatric doctors for a country of nearly 30 million, and these specialists tend to be based in urban areas, with very few wanting to work in rural areas. Mental health continues to carry a stigma – including self-stigma – which has both deterred treatment-seeking, and limited investment in improving these services as it tends to be de-prioritised in favour of investing in treating physical illness. Participants in Nepal noted that this was indicative of perceived attitudes that patients are not treated holistically, but are rather defined by their disease.

## Case Study: Japan

Japan is often held up as a model of UHC, however, the focus group discussions revealed another side. Analysis of the discussions “found that **the greater the vulnerability of an individual, the greater the time, cost, labour, and patience required for that person to expend to access health and medical care.** This was mostly due to the complicated and bureaucratic architecture of social welfare and public assistance programs. While the majority of those with stable employment can access health services almost automatically, the minority and the more vulnerable populations often experience impediments caused by complex application procedures for social welfare subsidies and other public assistance programs. The community leaders also reported often encountering authoritarian and paternalistic responses when accessing medical services. Also, most of the communities we interviewed don’t have correct information on public medical insurance, social welfare and public assistance programs because they

have only limited opportunities to learn about these systems both through public educational institutions and everyday life experiences... Although Japan’s systems have long been believed to be universal in terms of coverage, they have left many vulnerable communities behind.”<sup>3</sup> The attitudes of some health staff themselves are creating a disincentive from seeking health care. As one focus group discussion participant shared, “At some hospitals and clinics, receptionists and other staff deliberately call out in a loud voice to patients receiving medical care under the welfare system, “welfare recipient”, so that other customers will know that they are public assistance recipients. Embarrassing experiences such as this easily become one of the reasons why women refuse to go to the hospital. The obstacle for welfare recipients is extremely high to reach medical services.”

The final decisions should be made by the young women themselves. However, doctors and medical professionals tend to demand that the patients bring their parents or guardians.”

(JAPAN)



<sup>3</sup>Masaki Inaba, Chie Matsumoto, Naoko Tsuyama, Kaori Hirouchi, “Qualitative Research on access to health and medical services of people with vulnerability under COVID-19 pandemic in Japan”, Africa Japan Forum, 2021.

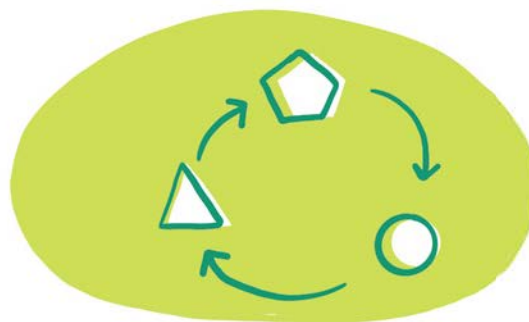
# The Positives

While this list of shortcomings is concerning, participants also pointed to some things that are going well in terms of improving access to health care services, and that others can learn from.



## 1. Integration:

India's health system includes provision of antiretroviral treatment (ART) for PLHIV, which is critical. It has also integrated the HIV program with some services for non-communicable diseases at wellness centres located at the district and state level, which makes them more accessible to the people who need them. Many called for more "one stop shop" models such as this, to increase physical access to care by locating services near the communities that need them. Furthermore, many vulnerable and marginalised groups report feeling more comfortable at local centres, which can help encourage treatment seeking behaviour. Having more services available in one location also reduces loss to follow-up.



## 2. Adaptation:

While the COVID-19 pandemic generally had a negative impact on the availability of health care (see next section), some countries took pragmatic approaches to maintaining access to services. One positive example was reported in Vietnam, where PLHIV who had good adherence track records were permitted to collect two months of ART instead of one. This reduced transportation costs and the need to move during the pandemic, which was a welcome change in policy, and one that will hopefully be continued after the pandemic.



### 3. Feedback:

Community feedback mechanisms are in place in Cambodia and Vietnam. In Cambodia, “There are several spaces for the community to engage and raise issues or needs, such as the commune investment plan and commune development plan. They are able to provide feedback through community feedback mechanisms through the social accountability framework mechanisms and complaint boxes of the government initiatives”. Other countries mentioned that having different types of feedback mechanisms would be useful to accommodate different types of accessibility, including a hotline for people with lower literacy.



### 4. Quality standards:

While most countries raised the issue of poor quality of health care, with some exceptions, Japan demonstrated high quality, with clear standards established, and largely followed. Bhutan also has a code of conduct for health staff, which contributes to quality and accountability. While monitoring and enforcement can be lacking, having clear standards in place is a necessary first step for ensuring consistent minimum standards across the health care system.



### 5. Enabling environment for civil society:

Different countries have included civil society to different degrees in informing UHC design. While civil society’s role in many countries is limited to advocacy and lobbying from the outside, participants in Bhutan noted that representatives of vulnerable and marginalised communities including PLHIV and LGBTQI+, were invited to participate in the design of the UHC monitoring and evaluation framework. What was particularly notable about this example was not only the fact that they were invited to participate, but that the representatives felt respected and heard throughout the discussions.



### 6. Power of political prioritisation:

While participants in many countries pointed to the lack of political commitment to improving health care, participants in Bhutan noted evidence of political will that increased access to health care. Free health care has been established as a basic right in the country, meaning that there are no out-of-pocket expenses for anyone. The government has also put effort into ensuring that people can access this care, for example with outreach workers who provide free support to patients to help them complete the necessary paperwork. While completely free health care for all services is beyond the reach of most countries, and while there are other weaknesses to overcome, Bhutan’s model demonstrates that it is possible for some countries to achieve more with sufficient commitment.



## Case Study: Indonesia

While Indonesia did not host focus group discussions under this CSEM initiative, civil society has been actively engaged in ensuring that the country's UHC approach is fully inclusive of the most vulnerable. Health has been included in Indonesia's national social security system since 2004; however, it took ten years for implementation to start. Health expenditure remains low in Indonesia. While those who can afford it pay for insurance, those who can't receive subsidised care. It remains challenging to remind people that paying tax and premiums for insurance is compulsory and for the good of the country, and more effective communication and education on this is needed, particularly since the two payments must be made separately.

The current system replaces private insurance, which was becoming increasingly expensive, and has resulted in an 11% reduction in out-of-pocket payments since 2012. An even more encouraging indicator is an observed increase of admissions in secondary and tertiary care for people from lower

socio-economic quintiles, implying improved access to more health care. As a result of these efforts, attitudes are gradually shifting in Indonesia from seeing health as a "want" to recognising it as a "need." However, not all needs are met and there is still room for improvement.

Indonesia's decentralised system gives local governments a certain amount of autonomy, which also increases civil society's opportunity to be influential in decision-making spaces at lower levels. However, decentralisation also results in regional disparities as no national standards exist. This is compounded by the fact that populations in some provinces face greater geographic or communication barriers than others. Quality healthcare can be harder to access outside big cities. A community-based monitoring feedback system is in place at the district level, but it needs to be operational at more levels to ensure greater accountability.<sup>4</sup>



<sup>4</sup>Information provided during a conversation with representatives of Jaringan Indonesia Positif (JIP) – the Indonesian Positive People's Network on 19 October, 2021.

# The Impact of Covid-19

The COVID-19 pandemic has had three direct impacts on people's access to health care. Firstly, it resulted in the diversion of resources away from some health services towards COVID-19 testing and treatment, and more recently, vaccinations. In all countries, health staff were removed from their usual posts, including primary health care facilities, to work in COVID-19 centres. Secondly, due to travel restrictions, reduced services, or orders not to seek care for non-COVID related issues, many people's treatment was interrupted, including antenatal care, kidney dialysis, ART, and testing services, including for HIV. Methadone treatment was suspended and many non-emergency medical issues were delayed in Vietnam, and Japan temporarily closed HIV testing in public health facilities. Japan also closed its comprehensive care centres, which provide critical social relationships for the elderly – the loss of which resulted in a deterioration of mental health. Finally, the fear of COVID-19 resulted in many patients choosing not to seek care for fear of infection at health care centres, which allowed health conditions to worsen and go untreated, or be treated at home, with unknown outcomes.

Some vulnerable and marginalised communities observed that they were not always prioritised for COVID-19 resources (testing and vaccinations), but in countries such as Cambodia, the reasons for this were understood, in terms of prioritising healthcare workers, the elderly, the immunocompromised, or those living in urban areas with higher transmission.

Similarly, while some participants in Cambodia complained that the potential side-effects of COVID-19 treatments or their interaction with other medications were not well explained, it was also recognised that little was known even by health workers in early stages of the pandemic. Cambodia also reported interruptions of services provided by community health workers (CHW) who were not authorised to administer COVID-19 tests. As access to services was not possible without a COVID-19 test first, this restriction limited the work of the CHWs, such as conducting HIV testing.

**“As the number of tests declined, the number of infected people plunged. People who learn of their HIV infection by the onset of AIDS are on the rise.”**

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(JAPAN)

The indirect impact of COVID-19 was just as serious for many individuals. The loss of work or usual sources of income – particularly for the urban poor and those dependent on daily labour – resulted in decreased living standards. Some people were forced to choose between rent and food, which has created negative health outcomes – particularly when good nutrition is critical to support many health conditions. Others could no longer afford medical care. The additional stress, uncertainty, isolation or loneliness, also contributed to deteriorating mental health. In many countries, rates of domestic violence and abuse also increased, compounded by confinement with aggressors, and decreased access to health care and support.

Bhutan may be an outlier since the Government provided a stipend to individuals working in some professions whose businesses were shut down, and civil society was able to provide material relief to still more people. Travel restrictions made this harder, however, particularly in hard-to-reach areas. Unlike other countries, Bhutan's economy bounced back quite quickly, vaccines were rolled out efficiently, and some felt that the crisis actually brought the community closer together, creating the opportunity to improve communications and networks. This meant that many individuals in Bhutan did not experience the same deterioration in mental health as reported elsewhere. In every other country, participants reported that the pandemic contributed to deteriorating mental health due to stress, anxiety, loneliness and sometimes depression resulting from

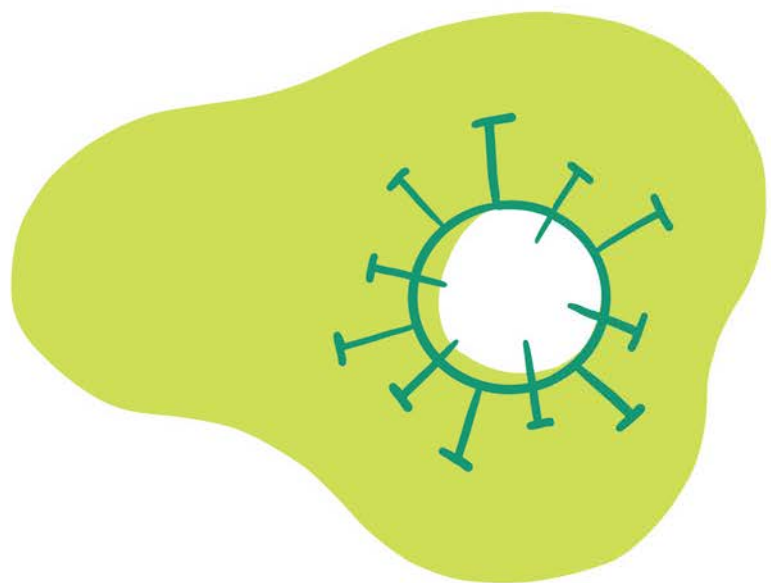
the uncertainty, loss of income, reduced service access, or confinement. Participants in Nepal shared that they had been informed that there were suicides among PLHIV during lockdown.

The pandemic highlighted many of the weaknesses and inequities of health systems, from the lack of preparedness, inefficiency of the supply chain to provide adequate personal protective equipment for health workers, to the way that testing has been provided and vaccines are being rolled out. The poorest, the most marginalised, are the least likely to be able to easily access these essential services for the same reasons they are vulnerable in the first place. The pandemic also demonstrated, however, the potential for the community and civil society to step up and self-organise support to fill some critical gaps in services that should be covered by the government.

**“This is a problem caused by the government that is only committed to efficiency.”**

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(JAPAN)



## Case Study: The Philippines

The Philippines is another country that was not represented in the CSEM initiative, but where civil society has played an active role in advocating for improved UHC, particularly for vulnerable, marginalised, and other neglected groups. This vision was achieved when the country passed an ambitious UHC law in 2019, which aims to ensure that every Filipino's health care is covered. Notably, this also includes Filipinos working outside the country, and their dependents who remain in the country. This approach recognises that many migrant workers have difficulty accessing health care when working abroad, and even in countries that require employers to cover migrant worker health insurance, short cuts can leave migrant workers exposed. Health coverage is also being extended from the current in-patient support currently provided to out-patient services as well, including not only curative services, but also promotion, prevention, mental health, and health literacy. This will represent a significant improvement for a country where 45-50% of health costs are still covered by out-of-pocket payments.

The Government of the Philippines has set itself a ten-year time frame to achieve its ambitious goal. Health literacy is a particular priority in order to encourage those who can afford it to pay their health premiums to ensure the health of everyone in society – a conversation that civil society is working with the government to encourage. The plan was also dealt a blow by COVID-19, which reduced its funding sources as the economy suffered, and revenue received from “sin taxes,” which are earmarked for health, diminished as a result of alcohol sale bans during lockdown. Civil society is continuing to work with the government on a new AIDS law, which will expand coverage to not just HIV treatment, but also to opportunistic infections. There is still a lot to be done: quality of care needs to be improved, the health system needs to be overhauled to reduce administrative constraints, costing and other studies are still underway, and physical access to health care by remote communities needs to be addressed. However, the Philippines' ambitious plan is to be lauded and supported.<sup>5</sup>

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<sup>5</sup>Information provided during an interview with Executive Director of Action for Health Initiatives on 25 October, 2021.

# The Asks

The litmus test of UHC must be to what extent the most marginalised and vulnerable members of society have access to the care they need without undue financial, or any other type of burden or distress. Currently, in many countries in the region, UHC is inadequate in terms of its universality, its health outcomes, and its coverage – particularly for those who need its support most. In other words, those that usually come last, must be put first. We echo the recommendations of global civil society in movement for UHC, and have specific asks for three key stakeholders in our region: governments, donors, and ourselves – civil society, particularly those representing the most marginalised and vulnerable communities. We ask the following:

**The recommendations from the Asia Pacific focus group discussions reinforce the same messages that CSEM advocates globally:**

- **Leave no one behind**
- **Increase public financing for health**
- **Improve involvement of CSOs, citizens, transparency and accountability.**
- **Invest in health workers.**







## 1. Ensure UHC covers the specific health and well-being needs of marginalised and vulnerable populations, making them available when, where and how they are most accessible:

All countries must ensure that critical health needs of marginalised and vulnerable groups are covered by UHC. These include access to ART, sexual and reproductive health products and services, diagnosis and treatment of HIV-opportunistic infections, hormonal support for transgender people, and support for addiction treatment and rehabilitation. This requires increasing the number of health staff and health facilities available to the public, particularly to reach the urban poor and areas that are currently considered hard to reach. One-stop facilities at the community level have been found to be most effective, particularly when staffed by well-trained and supported health workers who are incentivised and inspired to continually improve the quality of care available to all, also improving staff retention rates.

**“Since addiction is declared as a disease by WHO, governments should invest in patient’s rehabilitation treatment fees.”**

(BHUTAN)



### Role of governments:

Increase domestic financing for UHC and prioritise additional funding for the health services needed by marginalised and vulnerable populations. This includes not only supporting more services, but ensuring that they are available in a location and manner that are accessible for those who need them, and respectful of their dignity. This will include ensuring that public, private, and community-based services and facilities can be covered by UHC.



### Role of donors:

Provide direct financial support to governments to fill gaps in UHC, and technical assistance to ensure the quality of services provided. Support civil society directly to carry out necessary assessments among marginalised populations, and encourage governments to involve civil society in service design.



### Role of civil society:

Gather and present evidence on the needs of different marginalised and vulnerable groups to inform government programs on the extent of the scale and nature of the needs, and work with government to identify or co-design appropriate services, particularly at the community level.



## 2. Include representatives of marginalised and vulnerable communities as equal and permanent partners in UHC oversight, decision-making, and evaluation mechanisms:

To ensure the transparency, accountability, acceptability, and appropriateness of UHC, marginalised and vulnerable communities must be represented at all stages of UHC, from design, to implementation, monitoring and evaluation. All countries must include civil society as permanent members in coordination and oversight mechanisms. User-friendly feedback mechanisms for community members to share their grievances without fear of retaliation also need to be created and promoted where they do not yet exist. These should be supported by local leaders or civil society organisations, but with clear governmental procedures to ensure that feedback is responded to and learned from.

**“Communities and CSOs can engage in country planning, budgeting, monitoring and evaluation... However, the voices of communities and CSOs seem to be less impactful in term of contributions, comments and feedback given to improving country budget implementation.”**

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(CAMBODIA)



## Role of governments:

Demonstrate political will by being willing to include and listen to civil society. Ensure that all UHC coordination and oversight mechanisms include permanent civil society representation, who are given an equal role in participation and decision-making. Work with civil society and local leaders to co-design an appropriate community feedback mechanism (or different mechanisms at different levels) to maximise opportunities for access.



## Role of donors:

Advocate and facilitate as necessary, an active role for civil society to participate in UHC oversight. Where required, contribute to strengthening the capacity or functioning of these mechanisms or supporting the individuals involved to participate effectively, including by sharing best practices and providing technical and/or financial assistance to promote inclusion and accessibility.



## Role of civil society:

Invest in our own capacity to represent our marginalised and vulnerable constituents effectively and bring their issues to the table. Ensure that our advocacy skills are effective and that we are equipped with the necessary evidence to drive data-driven decisions, and creative solutions to ensure that our participation in decision-making bodies is valuable. And with our seat at the table, ensure that we are bringing back information to our communities. This includes ensuring that our constituents are aware of feedback mechanisms available to them, that they contribute to designing in a way that ensures their accessibility, confidentiality and accountability.



### 3. Invest in improving communication and access to information, and integration and user-friendliness of UHC systems to reduce non-financial barriers to access:

Bring together the multiple departments and institutions involved in the provision of UHC to work together to integrate and simplify all systems to ensure that access is user-friendly and accessible to all members of the public through one process or entry-point. This includes minimising and harmonising the forms and bureaucratic processes across facilities and services, minimising the documents necessary to access care (particularly for the transgender community and mobile or migrant populations), and ensuring that services and paperwork are available in all necessary languages. It also requires partnering with civil society to improve communication to the public – particularly vulnerable and marginalised communities – on what services are available to them, where, and how they can access them. Finally, provide public services or engage civil society partners to provide direct support to any

individual in need, to understand his/her/their rights, how to navigate the system, and to assist them in completing any necessary paperwork – all in their preferred language.

**“What is the use of having the services if people don’t want to use them?”**

(BHUTAN)



#### Role of governments:

Facilitate a simplification and/or integration of the health information system to ensure it is simple for users to access, preferably through one entry point. This may also include adjusting information systems to update identification requirements for transgender people, and being able to share information across systems while protecting patient privacy. Co-develop with civil society a public information campaign to ensure that all citizens and migrants are aware of UHC, what it covers, and how to access it. Provide support to individuals to ensure they are able to complete paperwork and access services, or engage civil society to provide this service.



#### Role of donors:

Provide technical assistance to governments to develop simple and effective systems for accessing and managing complex UHC arrangements, from data sharing (while ensuring privacy and confidentiality), and providing training to government officials as required. Provide financial assistance to support system integration and upgrading, and programs to disseminate information and support access, such as funding civil society groups to assist individuals with completing paperwork, accessing translation services, or accompanying those to appointments who need assistance.



#### Role of civil society:

Coordinate with the government to advise them on what “user friendly” means for marginalised and vulnerable communities. Co-design strategies to improve access, including and dissemination developing materials and information campaigns at the community level, ensuring that even the most remote and marginalised individuals have access to the knowledge they need on how and where they can access what health service, and where they can seek additional support.



#### 4. Enable improved access to health care and better well-being outcomes by decreasing stigma and discrimination in the health sector:

Health care facilities must be places that all individuals feel safe, welcome, respected, and cared for. Currently, stigma and discrimination towards different marginalised and vulnerable communities and/or specific behaviours or personal attributes are creating a fear that deters people from seeking the care they need. Governments should work with civil society to develop policies, sensitisation campaigns, training, and policy enforcement mechanisms to reduce stigma and discrimination by all health sector staff towards all vulnerable and marginalised individuals: women and girls, LGBTQI+, PLHIV, PUD, sex workers, PWD, migrants, the poor, the elderly, and people from different ethnic groups. This includes respecting and enforcing policies of privacy and confidentiality. All staff should be trained on empathy and to be sensitive to the needs of different marginalised and vulnerable communities, with incentives built in to promote dignity and sensitivity as a key aspect of performance management.

Client satisfaction should be a metric considered as part of eligibility for UHC funding.

**“Young women lose motivation to go to the hospital because they don’t want doctors interrogating them about their personal life.”**

(JAPAN)



##### Role of governments:

Work with civil society to develop sensitisation training, and policies regarding stigma and discrimination in health care settings. Review the incentive and performance management structure to consider client satisfaction as a key metric. In some countries, additional work is necessary to either decriminalise some work or activities (e.g., sex work or drug use), which is deterring vulnerable individuals from seeking health care – or at least make it safe for them to do so, without fear of arrest.



##### Role of donors:

Where necessary, provide additional funding to support efforts to combat stigma and discrimination, and provide technical assistance on successful efforts elsewhere. Share lessons learned and best practices between countries.



##### Role of civil society:

Work with the government to develop sensitisation training, and policies regarding stigma and discrimination in health care settings. Ideally, our work should extend into the community to ensure that stigma and discrimination also diminish in the wider community, including in some instances, self-stigmatisation among our constituents.





## 5. Strengthen the health system's capacity to provide mental health support to all, particularly the most marginalised and vulnerable communities:

COVID-19 saw an increase in mental strain on many individuals, which compounded existing mental health issues faced by many marginalised and vulnerable communities. "Health" needs to be viewed in a more holistic sense that also includes both physical and mental well-being. It is necessary to build the quantity and quality of mental health services available to the general public, including trained practitioners sensitive to the needs, concerns, and lives of individuals with special needs, including PLHIV, LGBTQI+, PUD, sex workers, PWD, youth, and the elderly. The government needs to influence public thinking to remove the stigma attached to seeking support for mental health and give it the same priority as physical health.

**"Emotional distress, depression, exhaustion, trauma, and grief/sadness are among the psychosocial illnesses which were most prevalent among people in low socio-economic strata."**

(PAKISTAN)



### Role of governments:

Invest in building a cadre of well-trained and well-supported mental health specialists, and embed them in different health facilities where they can be easily accessible to those who need the support. Work with civil society to develop a communication campaign to contribute to the de-stigmatisation of mental health issues and seeking care.



### Role of donors:

Encourage governments to prioritise mental health support, and offer opportunities to train or strengthen the capacity of psychiatrists and psychologists – particularly those specialised in working with PLHIV and other marginalised and vulnerable individuals. Fund research and pilot projects to demonstrate how such programs could work in different countries and its impact on health outcomes, and build government confidence to manage them.



### Role of civil society:

Gather evidence and stories to demonstrate the mental health needs of marginalised and vulnerable communities, and share this evidence with the government and donors to inform the development of pilot projects, and advise on appropriate services for different communities.

# Closing Thoughts

The Universal in UHC entails removing all barriers to health care – financial, as well as physical, social, legal and administrative. Health is a human right, not an entitlement of the privileged, and one that is not indivisible from other rights. The inequities, barriers and stigma faced by marginalised communities in health mirror the same inequities they confront in other aspects of life: education, housing, employment, protection, basic dignity... and we will not achieve equitable access to health without addressing other inequities.

APCASO recognises UHC as a priority for our region, and we have been working consistently on this issue in recent years, including by leading “The UHC that we want” campaign in 2017,<sup>6</sup> which we updated in 2021 with “The UHC that we want: before, during, and post-pandemics”.<sup>7</sup> We enshrined UHC in our ten-year strategy, under objective 2: “Contribute to the UHC that we want: Strengthen political will and financial commitment by governments and donors towards rights-based, gender-transformative and people-centred UHC.”

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

(PAKISTAN)

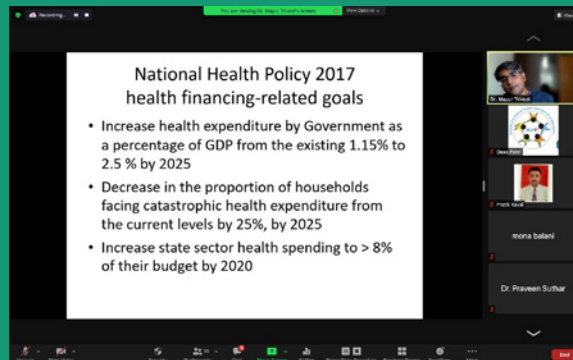
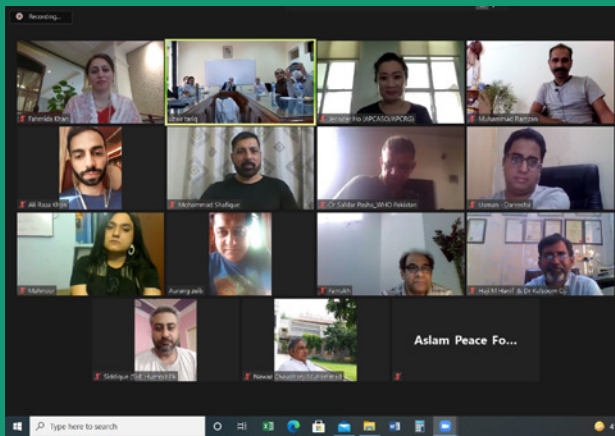
## We will do this by:

- 1. Leading civil society advocacy efforts on UHC from grassroots to high-level forums;**
- 2. Monitoring financing commitments to ensure greater inclusion of civil society, respect for the needs of vulnerable and marginalised populations, and effective use of funds; and**
- 3. Ensuring the inclusion and integration of mental healthcare in UHC.**

We call on our partners in and outside the region – donors, technical agencies, academia, policy makers and decision-makers – to work with APCASO and our country civil society and community partners in achieving people-centred, rights-based, gender-transformative, sustainably resourced UHC that values and supports community agency and engagement – the UHC that we want, and the UHC that those that everyone – including those who otherwise risk being left behind, deserve.

<sup>6</sup><https://apcaso.org/wp-content/uploads/2017/12/v1-Final-UHC-AP-Statement-for-UHC-Forum-2017.pdf>

<sup>7</sup><https://apcaso.org/the-uhc-that-we-want-and-need-before-during-and-post-pandemics/>



Photos from focus group discussions in India, Bhutan, Laos, Pakistan and Cambodia.

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