



MSF REPORT

MISSING (FROM) THE UHC-TARGETS: LEAVING BEHIND THE MOST VULNERABLE

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1. WHY THIS REPORT?

On 21 September 2023, the UN High Level meeting (HLM) on Universal Health Coverage (UHC) will take place in New York, to “renew efforts and accelerate progress toward achieving health for all.” Universal Health Care means that all people receive the health services they need, of sufficient quality to be effective, while at the same time ensuring that the use of these services does not expose the user to financial hardship. This is the first high level meeting on UHC after the COVID-19 pandemic as the UN continues its push towards UHC by 2030. The political declaration on UHC prepared for the HLM acknowledges that significant progress still needs to be made and notes with concern the losses incurred during recent years as well as the insufficient pace towards improved UHC-targets. However, there are few propositions towards urgently needed measures to address the wide gaps, and few changes proposed to adapt strategies to past failures and to the current context.

In 2022 MSF intervened in 75 countries. Although MSF is most known for its health interventions in emergency settings (conflict, epidemic outbreaks, displacement and nutritional crises), MSF teams also support effective responses to improve access to and quality of health care where increased health needs and important service gaps exist, in particular for people and communities who face specific vulnerabilities or exclusion. In order to make health responses more effective and equitable, MSF also supports adapted strategies and delivery models of care, inclusive health and community systems, independent monitoring of patient-centred outputs, more equitable and affordable access to essential medicines and services.¹

Based on scientific evidence and its own experience, MSF provides essential care free-of-charge as a policy during all its interventions and invests in strategies that bring effective care closer to those who need it. Experience shows that a focus on the most vulnerable is key, as the major burden of ill health and of access to care problems lies within this group. Beyond taking its responsibility not to exclude or harm patients by requiring payments in MSF-supported services, MSF is concerned about access barriers elsewhere and will collaborate with others in innovative access strategies and advocacy against access barriers.

MSF also wants to stress the importance to health for the sake of people's health itself and is concerned about using health as a tool for political or development goals in various transformational agendas. Current international health frameworks focus predominantly on potential secondary effects of outbreaks with pandemic potential, those countries willing to deter migrants to move to safe(r) havens, support to those regimes willing to mitigate potential insecurity threats etcetera. 'Health for all' should not only apply for those that fit within certain agendas. For instance, the recent 'Health for Peace' initiative by WHO raises similar concerns, stepping away from championing the principle of 'health for people's health sake'.

Since the Sustainable Development Goals (SDG) replaced the Millennium Development Goals (MDG) initiative, MSF has called for sufficient focus on health and people's health needs, irrespective of where people are residing (a.o. the categorization of their country according to income) or their social or economic status.^{2,3} Moreover, the neglect of the health needs of the most vulnerable people is extremely concerning. We want the principle of 'Leave no one behind' to be more than a slogan.

On UHC in particular, MSF expressed deep concern in 2017 about the trend of the return of user fees despite of the UHC discourse in the report 'Taxing the ill: how user fees block UHC.'⁴ The UHC-agenda should tackle the real problems of real people, with at its core the people deprived from even the most basic of care because they cannot afford it or are excluded and neglected.⁵

Since, MSF has witnessed a diversity of initiatives around UHC in several countries. In some contexts MSF-teams have been invited to participate in the process together with other actors, in other countries there was limited or no meaningful involvement, reflecting the diversity in degree of participation of non-state or civil society stakeholders. In some countries UHC-exercises have focused more on mobilization of financial resources than on the need to improve access to care. Often UHC-priorities continue to fail those facing most and deepest gaps in responses to their needs and their precarity. Where possible we have raised issues of access to care for the country's UHC-agenda and shared positive experiences in better delivery and access to services to the UHC-roadmaps; we have tried to bring the reality of patients and the most vulnerable into scope, as well as the importance to respond to today's urgent needs of people.

MSF's experience shows that UHC plans cannot be missed as an opportunity to significantly improve access to health care and respond better to people's health needs in countries we work. The credibility and the accountability of the UHC-agenda depends on it. Without real change and tangible results in access to care for people in the reality of today, MSF will continue to challenge the UHC discourse.

METHODOLOGY

The information presented in this report is based on the country experiences of 20 separate contexts where MSF is operational: **Afghanistan, Burundi, Belgium, CAR, DRC, Guinea, Greece, Haiti, Italy, Kenya, Lebanon, Malaysia, Mali, Mexico, Mozambique, Poland, Sierra Leone, South Africa, South Sudan, Zimbabwe.** We compiled the report by using country-level information obtained from MSF field teams, Ministries of Health (MoH), Civil Society organisations (CSO), combined with available academic and grey literature.



2. BACKGROUND: THE UNIVERSAL HEALTH COVERAGE AGENDA IN CRISIS



Current indicators and health spending levels worldwide suggest that the world is dangerously off track towards achieving the world’s “Universal Health Coverage 2030” targets. In fact, there are real risks

that we are backsliding unless urgent steps are taken to maintain and increase the levels of global health spending on strategically important initiatives.

OVERVIEW KEY FIGURES FOR UHC WORLDWIDE⁶

The UHC target was to ensure health care without financial hardship for an additional 1 billion people by 2025. In 2019 this target was only achieved for 270 million people; the current pace of progress will not allow to reach the targets. Aggregated data mask inequalities between and within countries.

The UHC-target combines two elements:

 <p>1. Average Service Coverage:</p> <p>average of 14 tracer indicators for reproductive, maternal, child and newborn health; control of infectious diseases; treatment of NCD; medical service capacity & access</p> <ul style="list-style-type: none"> ● Overall UHC-index is 67 on 100 (target 80 by 2030); UHC-index for LIC is 42 ; for 14 countries it's below 40 (2019 data). ● Before COVID-19, the pace of progress overall was already too slow to reach the targets. The COVID-19 pandemic disrupted essential services in 92% of countries in 2021; in 2022, 84% still reported disruptions, with more people foregoing care. 	 <p>2. Financial hardship:</p> <p>proportion of the population that spends more than 10% of household expenditure on health or is pushed further in poverty by health spending</p> <ul style="list-style-type: none"> ● Worldwide about 2 billion people face catastrophic or impoverishing spending for health. ● Every year about 90 million people are pushed into “extreme poverty” (1,90 USD or less a day) because paying out-of-pocket for health care. ● Financial hardship indicators worsened between 2015 and 2019 and are expected to worsen further.
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Source: Tracking UHC 2021 Global Monitoring Report by WHO. <https://www.who.int/publications/i/item/9789240040618>

While governments increased spending in the health sector during the COVID-19 pandemic (mainly towards specific COVID-19-related interventions), the deteriorating macroeconomic conditions together with the consequences of the war in Ukraine and competing national priorities have significantly constrained public and donor spending on health.⁷ The combination of increasing external debt pressure and rising domestic inflation has driven further the gap between what is needed in health and what financial resources are available.⁸ Yet many countries where the health needs are greatest, are projected to see health spending drop or plateau, thus threatening the UHC 2030 project entirely. A World Bank report estimates that 41 governments will spend less on health between now and 2027 than they did in the pre-pandemic period; in 69 countries spending will remain on a par with pre-pandemic levels.⁹ This amounts to a fraction of

the required resources needed to sustain essential services, recover lost ground due to COVID-19-related disruptions, and adequately prepare for a potential future pandemic or other health crisis.

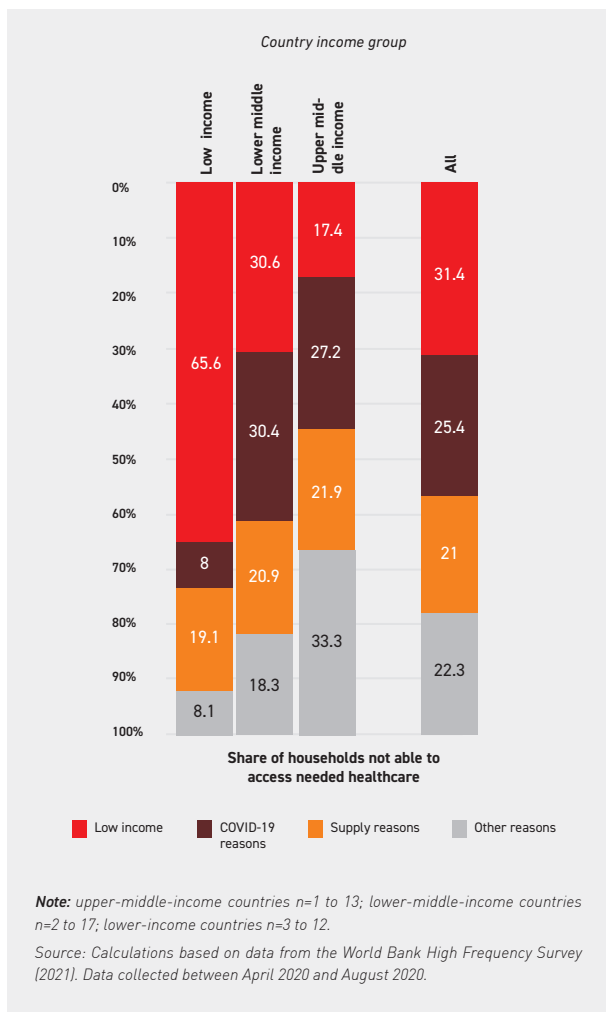
Amid the global economic downturn in L&MICs, aid budgets have been slashed. For example, the United Kingdom’s aid budget is set to be cut for the third time in three years, and the government’s contribution to the International Development Association (IDA), the World Bank’s concessional financing window and a major funder of health systems, was cut in half in 2021. Sweden recently announced cuts to its aid budget, falling below its previous target of 1% of gross national income.¹⁰ For some global health initiatives, the competition with the agendas of PPR, UHC and climate change is felt, as new initiatives rarely mean additional funds. The worsening macroeconomic conditions will

also impact on countries' abilities to meet co-financing requirements for HIV and immunization programs, among other health services.

Levels of excess mortality remain high across low-and-middle-income countries. In addition, the impact of foregone or postponed healthcare during COVID-19 have placed additional burdens on the health system requiring investment in health infrastructure as well for the health workforce.¹¹

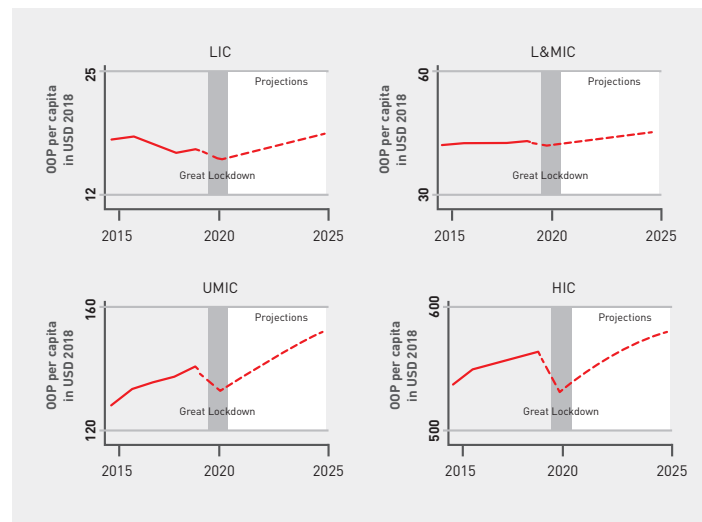
Even without systematic data collection on foregone care caused by financial barriers, it shows that even during the COVID-19 crisis the main reason for not accessing care remained financial in LIC and L&MIC. See figure 1 below.

Figure 1: Main reason reported by household for not accessing healthcare when needed, multi-country evidence ⁶



Considering that close to 100 million people worldwide were pushed into poverty during the COVID-19 pandemic, the impact of public funding cuts will be to further increase out of pocket spending and catastrophic health expenditure on the poorest populations in the world.¹² In worldwide projections, all countries are expected to face an increasing trend in OOP spending on health, although slower in LIC & L&MIC, where there is limited money to spend or limited health services to spend it on. See figure 2. Financial protection against the financial barriers and distress caused by OOP spending will be critical, more than ever.

Figure 2: Projected increases in out of pocket spending on health across the world (World Bank report) ⁹



For the populations MSF aims to serve, mounting financial crises and decreased external aid for health will further increase forgone care as medicines, hospital costs, and basic primary care become unaffordable to poor and vulnerable populations. Protection against the financial barriers and distress caused by OOP spending will be critical, more than ever. As our report shows, this is a time for urgent redoubling of efforts to resource health adequately, both from domestic AND external funding, with a priority to use this funding towards tangible benefits for the poorest and most vulnerable people.

See Appendix for table with overview of key indicators for selected countries.



3. UHC TARGETS NEGLECT KEY ACCESS TO CARE PROBLEMS AND FAIL TO 'LEAVE NO ONE BEHIND'

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MSF teams witness the barriers that some of the poorest and most discriminated communities face in accessing healthcare and we are concerned that the current UHC-agenda and most UHC country plans fall short of the 'Leave no one behind' principle. In this report we have collected illustrations of the real life problems to access care for the most vulnerable and for people in the most critical health situations, such as those in emergencies and crises; migrants, refugees and other marginalized people; and people forced to forego essential care because of financial barriers.

Without action on critical points for these people, the UHC agenda and country plans will miss their goal and might also diminish UHC's credibility.

Our concerns are not only about the delayed or slow pace of implementation of the UHC-agenda, but about the choices made to adopt - or neglect - particular priorities. Ensuring that individuals have access to basic healthcare should come before any considerations for return on investment, security or national interest. It's about saving lives and reducing the impact of diseases. Most proposed actions in the UHC agenda focus on medium to long term schemes, failing to include measures that focus on people's current health needs. Although access to health care is part & parcel of the definition of Universal Health Coverage, both in the international agenda and the country plans for UHC, objectives and selected indicators remain rather on a theoretical 'coverage' level, less on actual utilization of care. There is a need to aim at direct improvement of access to care, and measure tangible differences at patient level.



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3.1. UHC BUT NOT FOR THOSE UNABLE TO PAY

Specifically, financial access barriers leading to people foregoing care are neglected. This negative ‘coping mechanism’ of not seeking care when deemed unaffordable is most prevalent among poor households and among socially weaker or marginalized groups. Up to now, indicators focused on OOP expenses mainly as cause of catastrophic health expenditure, impoverishment and harmful financial coping mechanisms. However, there has been limited attention on the effects of OOPE on exclusion and delays in obtaining adequate care, as acknowledged in the WHO’s DG report (2023).¹³

Overall OOP-expenses have increased worldwide and although in some countries a reduction in OOP is reported, such improved indicators might be misleading and rather a consequence of higher forgone care, not a sign of better financial protection. Recent restrictions under COVID-19 have led to more patients forgoing care due to less physical and financial access. Evidence from a systematic review showed that even before the pandemic affordability was one of the most reported reasons keeping people from accessing health care.¹⁴ The increase of people affected by extreme poverty, combined with the consequences of the COVID-19 crisis and the current economic fallback, make it even harder for households to afford payment for health care and more urgent to take concrete, targeted measures to reduce financial barriers.

While negative effects of OOPE on household economy and as barriers to access health care are recognized, the specific contribution of user fees (direct patient payments for medicines, diagnostics or services at the point of care) remains fairly out-of-scope. Evidence has repeatedly shown that policies of wide user fee exemptions and/or (targeted) schemes supporting care free-of-charge for patients improve access to care, utilization rates and population impact.

However, in the UHC-agenda this beneficial action is largely ignored. On the contrary, in many countries the contribution of user fees to exclusion, delays and inequity in access is neglected and action on patient payments & in particular user fees is largely missing.



Out-of-pocket expenses and User fees

‘User fees’ are direct payments by patients to get medical services and/or medicines at the point of health care utilization. Additional financial barriers to health care include costs for transport and food, as well as the costs linked to patients’ caretakers. Together, these costs constitute the ‘out-of-pocket’ or OOP expenses for health care.

Despite evidence that OOPE, including user fees, are an important barrier to access care and that user fees or co-payments are an inefficient and inequitable health financing mechanism, their (re)introduction is tolerated or even promoted. Countries that adopted policies to suspend user fees or provide wide exemptions face difficulties to ensure their application.

In many countries public health services charge patients for essential care and this creates exclusion from care and delays in obtaining needed care. User fees are burdening disproportionately people who are ill and at their most vulnerable moment; they reinforce the vicious circle between illness and poverty. The financial barrier of user fees reinforces other concurring access barriers such as social & cultural factors, distance, distrust in health providers, insecurity, stigma and discrimination etc. User fees are not a tool for improvement of health, instead they are increasing inequity by taxing the ill.

Lack of funding to compensate for the necessary exemptions makes health facilities reluctant to apply these policies where present. Domestic resources are falling short of supporting free care schemes and where international funding to health is reduced, patients feel the direct impact in the form of increased user fees and out-of-pocket expenses.

The costs of accessing medicines and medical product are the main contributors of OOP expenditure on health and directly linked to their availability and prices in the public sector. When health facilities run out of essential

medical items for diagnosis and/or treatment, patients are forced to purchase these from private outlets, at significantly higher, often unaffordable prices; additionally, quality concerns exist about certain of these sources. Recently shortfalls and stock outs of key medicines have been reported in many countries, including for infectious and non-communicable diseases. These gaps force patients to forego or delay care or run the risk of bad quality or incomplete care.

The other element linked to financial barriers concerns lack or insufficient remuneration of frontline health workers. Fiscal space restrictions on the health workers' pay roll do not only make it impossible to recruit sufficient staff, unpaid health providers tend to impose OOP payments on patients. Insufficient health worker remuneration undermines the implementation of free of charge or exemption policies.

As shown in the following country examples, patient payments imposed in public facilities contribute significantly to the financial barriers & burden for patients, making people forego or delay care; leading to financial hardship and abuse. And this in spite of the UHC discourse.

REASONS WHY USER FEES ARE NOT A GOOD IDEA

The reality is that, because of user fees:



- Patients are **excluded, deterred, and delayed** from seeking care, in particular, vulnerable groups or those with lower social status (such as women)
- Households are impoverished and forced into **financial distress** or harmful coping mechanisms
- Patients are more vulnerable to **abuse and misuse**, such as withholding care or holding them captive until they pay for the cost of treatment



- Health workers may **sacrifice** rational or qualitatively optimal care by opting for treatment options or unnecessary services that generate the most profit
- Health facilities are **underutilized** and service provision is rendered **less efficient**, both in terms of optimal use of health workers and avoiding expiry of drugs
- Frameworks for the detection of and **timely response** to outbreaks is weakened, as patients that cannot afford treatment tend to delay seeking care
- Health facilities with financial barriers are **ineffective at providing coverage** for preventive services (such as vaccination) and priority treatments (e.g. HIV, TB, and malaria)



- The main effect of user fees is **reduced demand** rather than mobilization of additional resources.
- Exemption systems based on individual means testing (i.e. indigent or not indigent eligibility criteria) are **ineffective in protecting vulnerable people** and imply transaction costs that may exceed revenue collection*.
- Without independent verification by civil society organizations or community monitoring for the implementation of free care policies, it is **unlikely that subsidies will translate into increased financial access** or utilization of care.

* Mathauer, I. Free health care' policies: Opportunities and risks for moving towards UHC (Health Financing Policy Brief No 2), WHO, Geneva, 2017.



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1. FREE HEALTHCARE INITIATIVES UNDER STRAIN

Countries that adopted policies to suspend user fees or provide wide exemptions face difficulties to ensure their application. With public health budgets shrinking under economic constraints and domestic funding expectations lowered, cuts in international funding have forced health services to charge patients (more) for essential care, worsening financial barriers and an increased financial burden on patients and households. In spite of the well-established benefits of providing care free-of-charge, public health facilities have started charging patients again or increased patient payments.

- In **Sierra Leone** sustained funding for the Free Health Care Initiative (FHCI) is at risk. Cuts in aid funding by the UK in 2021 led to significant reduction of critical funding for the purchase of medicines and medical items for the FHCI, putting this lifeline to the most vulnerable at risk. Even in 2020 funding was insufficient to meet needs (estimated at 20 to 24million USD annually).^{15 16} From about 200 essential medicines listed for provision to the health facilities under the FHCI, only 48 to 60-line items are being purchased because lack of resources.

In the MSF 2020 survey 38% of rural patients seeking delivery care in Tonkolili were told medicines were not available. In 2022 about half of patients referred to Hangha pediatric hospital ward from primary health care units in Kenema district reported having paid for services; one in five paid more than 100 Le (equivalent to 4,8 USD), which amounts to over 2,5 times the total income for people under the poverty line (over 40%). Many patients arrive late with severe complications.

Without access to free healthcare through the FHCI program, the most vulnerable people in Sierra Leone will be forced to forego care or to pay out-of-pocket for services and high user fees, which ultimately drives them further into poverty. Those unable to afford the cost of healthcare will stay home, forego care and face risks of complications and death; some will seek alternative means of care such as informal, unqualified, or traditional healers – consequently putting their health and lives at further risk. As shown in the health seeking behaviour survey in Gorama Mende and Wandor in 2020¹⁷, the main factor influencing people’s health-seeking behavior is financial and geographic access: *“Where my pocket can afford is where I will take my child”*.

- In **Burundi** the national policy has declared care free-of-charge for children under five and pregnant women (delivery, pre- & post-partum care) since 2006. This policy has allowed to increase access to care significantly and reduce mortality among these population groups. The budget to pay for this free care is ensured by a combination of government funds and international resources. However, for the period of 2019-2021 a financial gap of about 55 million USD was assessed and this shortfall creates tensions at the level of the health facilities, reluctant to apply the free care policy fully. The European Union financed about one quarter of the free care policy included in the performance-based financing, but this funding for health is coming to an end. The government and World Bank funding (previously about 45% and 25% respectively) will continue their funding but it’s uncertain if the EU’s leaving will be compensated; deeper gaps or delays in financing are likely as a consequence.

Outside the group that benefits targeted free care, out-of-pocket costs can be considerable, with user fees unaffordable for many. MSF paid instead of patients in three different districts in 2021-2022, with average hospitalisation fees at the public hospital cost between 12,000 and 21,000 Fbu (equivalent 4,5 USD to 8). In confessional hospitals fees for hospitalized patients went up to 48,000 Fbu (equivalent to 18 USD) in average and more. When patients without payment exemptions cannot pay their hospital bill, detention is applied. Recently the president has publicly denounced this practice and called to account the authorities in charge.¹⁸ Regularly there are cases reported in the press where patients are liberated thanks to the charity of VIPs.¹⁹



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- In **Mali** the benefits of the policy to provide care free-of-charge to children under five have been documented extensively, as well in terms of increased utilization of care – without excessive or unnecessary increases- and even positive effects on child mortality.^{20,21} Besides for children, care free-of-charge applies to pregnant women, delivery services and caesarean sections, diagnostics and treatment for HIV, TB and malaria. However, in reality a lack of resources blocks the implementation of the exemptions by the health facilities; without financial means to replace revenues from patients’ payments and the necessary medical supplies to respond to increased demand, health facilities are reluctant or unable to provide essential care free-of-charge as intended by the national policies. Financial gaps and service gaps ensue. In practice, the free-of-charge policy is only respected where international actors support health facilities. Reductions in international funding restrict the implementation of free care (even when temporary, for instance when Global Fund suspended its funding).

Besides these specific exemptions, a cost recovery system is applied for primary health care services, with costs shifted to users/patients. In a 2021 survey, almost half of people interviewed (46 %) said they did not seek care at the health centre because unaffordable costs.²² Out-of-pocket expenses represent 35 % of total health expenditure.



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- In **South Sudan**, the public health sector is almost entirely dependent on international donors. The 2 major programs, Health Pooled Fund (HPF) - covering 7 States since April 2022 - and the World Bank/UNICEF health funding - covering the 3 other States-, provide together support to around 790 out of 1,600 facilities reported as functional by WHO. While in 2016-2018 the HPF used to cover 1,200 facilities across 8 States, but this number went down to 807 facilities. Annual allocation to HPF (2018-2024) went from 72 million GBP/year down to 47 million USD now. In April 2022 these funding cuts to the HPF - mainly from the UK - resulted in the abrupt stop of support to 220 primary health care facilities, undermining essential basic primary health care services at community level, but also affecting 144 nutritional sites, the delivery of routine immunization services and the medical supplies of the boma (community) health workers. Hospitals were given a grace period of one year with a progressive handover to the Ministry of health of 9 hospitals until March 2023.

In Unity State health facilities were shifted to the World Bank/UNICEF program, but the number of supported health facilities reduced to 514 facilities and reduced again at the end of 2023; further reductions have been announced for next year.

After the HPF cuts in April 2022, user fees were officially increased in Northern Bahr el Ghazal in all medical facilities, except those with MSF support to ensure free of charge access for key services. The user fee increase did not compensate for reduced central financing nor avoid continued shortages of medical supplies. In many MSF projects, patients report having to pay user fees in the facility, including in supported ones where care is supposed to be provided free of charge.

In March 2023, MSF conducted a rapid assessment in 52 facilities in a 60km radius around Aweil town. Among the HPF supported facilities (40% of assessed facilities) more than 70% reported regular shortages of basic medical supplies; the quantity of supplies in the 3-month consignments were insufficient to cover the period. Community members interviewed by MSF reported they receive prescriptions to go and buy medicines in the market which is expensive.

Looking at the number of consultations reported by health facilities that have lost support in April 2022, there was a reduction of 50%. WHO mentioned a reduction of 68% of general consultation services, followed by EPI services (-60%) and SRH (-48% of ANC services).

Humanitarian funding is also shrinking, with South Sudan's health sector caught up into limbo between humanitarian and development aid.

- After previous similar assessments²³, MSF published a report in early 2023 on persistent barriers to accessing healthcare in **Afghanistan**²⁴, including interviews in Kabul, Kandahar, Khost, Helmand and Herat provinces. Its findings were disturbing, with unmet medical and humanitarian needs continuing to soar amid a deteriorating social, political and economic situation. Increased and widespread poverty and a further weakened public health system exacerbate people's health needs and vulnerability. Afghanistan's health services remain under-funded and under-resourced, lacking qualified personnel, equipment, medicines and medical supplies. Moreover, access to existing services is restricted by financial access barriers, distance to functional health facilities and lack of transport.

Costs are still the main obstacle to accessing healthcare according to 87.5% of respondents, an increase of 18% in comparison to 2021 survey's findings. Almost 58% highlighted direct medical costs as one of their main barriers. 88% of respondents delayed, suspended or decided not to seek medical care due to reported barriers, an increase of 14.3% compared to 2021. With the existing economic, banking and liquidity challenges, it's hardly surprising that for many the expenses linked to seeking care are

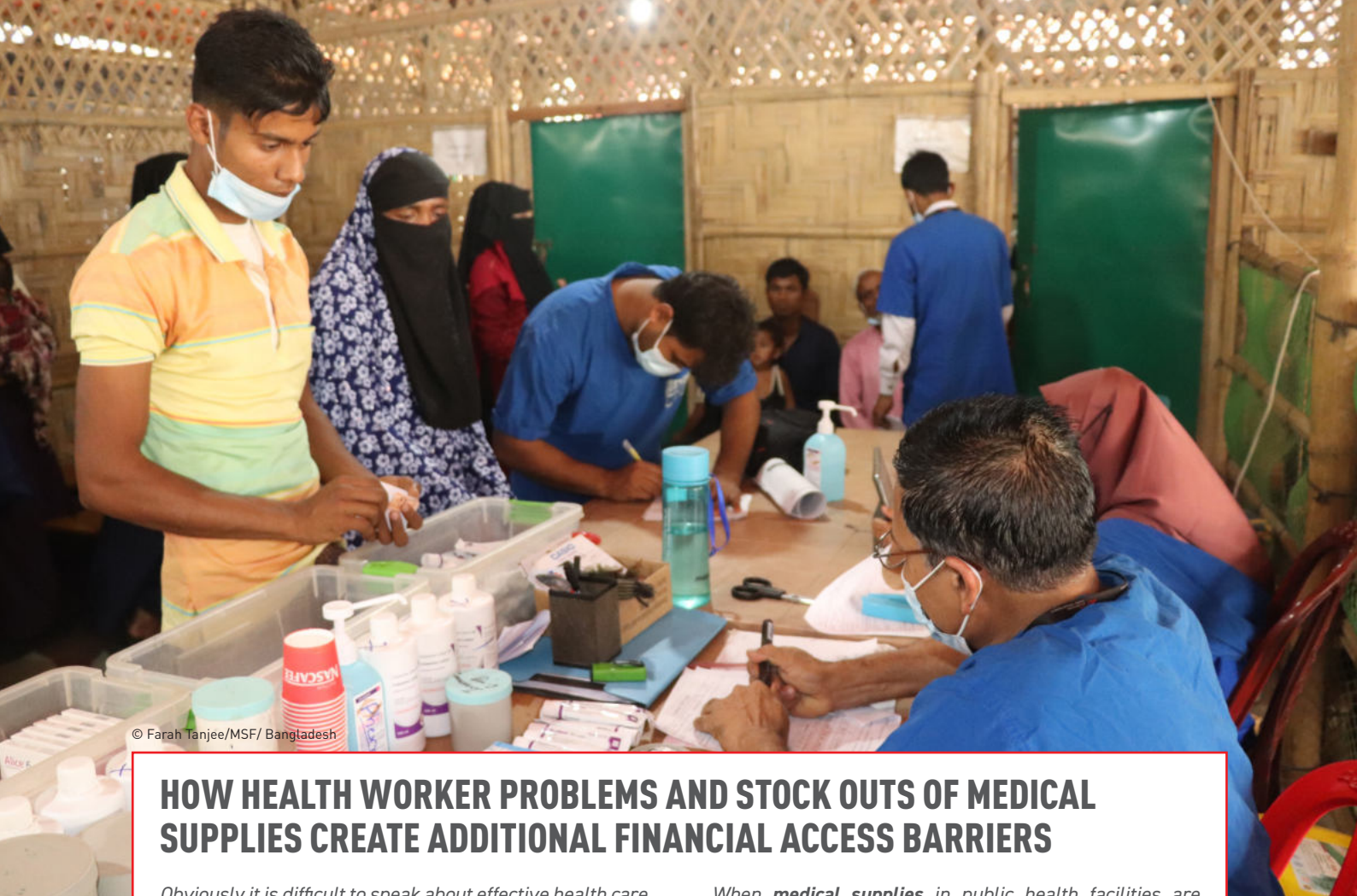
unaffordable and force people to forego essential healthcare. 52% of respondents believed their relative died due to lack of, or delayed, access to healthcare in the past 12 months. No fewer than 97.5% of respondents experienced financial difficulties due to spending money on healthcare, forced to borrow, dig into their savings, or sell household items or property; this is an increase of 20% compared to MSF's 2021 survey.

The budget for Afghanistan's Humanitarian Response Plan (HRP) for 2023 was revised in May down from 4.6 billion to 3.2 billion USD; as of July it is only covered to 23%.²⁵ Cuts in humanitarian funding have also their effect on health services. Funding for ICRC's operations is under strain, which might hamper health service provision in many places in Afghanistan in the future. Their hospital relief programme will finish at the end of August 2023, severely undermining secondary care, but also will affect primary care.

WFP announced in April that it would reduce food distributions to millions of Afghans due to lack of funding, with further warnings in June. It has reduced food rations and cut 8 million people from assistance in Afghanistan so far this year and will potentially reduce further in the months to come.²⁶

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HOW HEALTH WORKER PROBLEMS AND STOCK OUTS OF MEDICAL SUPPLIES CREATE ADDITIONAL FINANCIAL ACCESS BARRIERS

Obviously it is difficult to speak about effective health care if there is shortage of qualified/trained health workers and/or unavailability of medical supplies; without them, the offer of care is absent or below standard, resulting in bad patient care and bad health outcomes. Moreover, there are important consequences that worsen the financial barriers for and burden on patients.

*In many countries the **lack of health workers** – that disproportionately affect people in rural areas and with less market potential - has recently become exponentially worse, with massive outflow to other countries or to professions in-country that pay better. Domestic budget shortfalls and restrictive economic policies limit recruitment of sufficient personnel and/or adequate remuneration of frontline health workers in the public sector. For instance in Sierra Leone and Guinea about half of staff in health facilities are not on the government's pay roll.*

This makes that health workers are tempted to ask patients for payment to make a living. They will also be reluctant to apply national policies of exemptions for certain patients, provide patients with drugs for longer periods or at community level, or even rational use of medicines, as this will reduce their revenue. This compromises access and quality of care for patients. Additionally, it will become tempting to sell the medical supplies that patients should receive free of charge.

*When **medical supplies** in public health facilities are interrupted or insufficient, patients are sent away without their treatment or they are referred to private pharmacies to purchase the necessary drugs, mostly at significant higher prices. For many patients these will remain out-of-reach and simply unaffordable; for others these extra OOP expenses will drive them into financial distress or poverty.*

In situations where drug shortages prevail, the supply of medicines and other items to community health workers (CHW) in particular is often disproportionately under pressure. This means community based services, more adapted and closer to patients, will be undermined and people forced to travel further to health facilities, with higher transport costs but also more costly user fees. When community workers are not paid adequately, they might have to rely on selling the medical items meant to be free-of-charge – including for prevention-, which again hampers access and coverage of essential services.

Patients face frequent stock outs of essential medicines and the medical consequences of this. In the current context of public budget gaps, these shortages in essential drugs seem to become more of a problem and take longer to resolve. Independent monitoring, preferably community based or by CSO, of availability of medicines free of charge at health facility and patient level, can play a key role in (early) gap detection and swift gapfilling, but also can pinpoint structural issues of repeated problems.



2. WOMEN'S HEALTH

Women in particular face additional challenges, with increased access barriers to preventive and curative care. In particular access to sexual and reproductive health services is promoting women's health, wellbeing and agency. Paying for health care is relatively more difficult for women as they face more poverty, lack access to cash and loans; often they cannot seek timely care as decisions to spend money lay with the male head of household. Exemption policies for pregnant women, including antenatal and postnatal care have allowed to increase significantly institutional deliveries and pregnancy related services in many countries. Additionally, schemes providing care free of charge have shown to improve women's access and agency (for themselves and for their children) in Burkina Faso, Uganda and Mali ^{27 28 29}, breaking the pervasive cycle of health exclusion and social discrimination.

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- In **Afghanistan** women struggle with constraints that limit their mobility and agency. They require male accompaniment to travel long distances, or in some areas even to leave the house, which impacts timely access to primary and secondary healthcare. The shortage of qualified women healthcare professionals further curtails the offer of key health services, including in Kabul³⁰. The 2021 & 2022 restrictions put in place by the government of Afghanistan (banning women from attending university, banning women from working for international and national non-government organisations, and closures of secondary schools to girls) will considerably reduce the availability of female medical staff and further restrict access to care for women, with increasing numbers of women forced to forego essential care. A study on perception of aid (June 2023)³¹ interviewed over 4,000 people cite financial constraints as the biggest access barriers, followed by distance to facilities, followed by lack of transport. Both women living in urban and rural settings mention being hindered by the need to have a *mahram* (chaperone) to travel with them. While urban women saw poverty as the main issue, in rural areas it's low availability of health services, greater distances to seek care and lack of transportation means. Women-headed households were found to face more barriers to accessing health services and to postpone medical treatment more than male-headed households (28 %).



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Many Afghans' only option is to adopt harmful coping mechanisms such as asking for loans, putting their children to work or arranging early marriages for their daughters. Women reported financial distress forcing them to sell their *mahr***.

** Mahr: the obligatory payment by the groom's family in the form of money or possessions to the bride, which should not be used by the man, remaining the property of the bride to ensure independent assets.

Taking out informal loans or selling belongings is less accepted as a coping mechanism for women, and there is the added barrier that many women lack the documentation and financial credit to take out formal loans through banks.

- In **Zimbabwe**, funding for reproductive, maternal, newborn, child and adolescent health (RMNCAH) has since 2019 been mostly dependent on donor funding sources and was supported with funding of 22 million USD in 2022 (up from 7 million USD in 2019), provided by the Health Development/Resilience Fund. There remain major funding gaps, however. As a result, maternal and neonatal mortality are high and have increased since 2020 with the impact of the COVID-19 pandemic, HRH challenges, and under-funding.

In contrast to MSF supported services, SRH services for adolescents are not provided for free at any level in Zimbabwe – at primary, secondary, or tertiary level. A typical primary care consultation fee costs 25 USD, an exorbitant sum for most Zimbabweans. At locally operated clinics there are some exceptions made, on a case-by-case basis, mostly at the discretion of the sister-in-charge, but their number remains limited. Even where consultations are free, medications are to be paid for, which can prove unaffordable for many patients.



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Diminished funding for local clinics by the central administration has facilities left with the task of raising their own funds, which they do by increasing the cost of care to patients. For instance in Epworth, a surrounding district within Harare province, consultation fees for primary care are 40 USD. In Epworth nurses report that these user fees have reportedly driven down the number of births in health facilities.

In one instance, MSF had to intervene to ensure the release of two adolescent patients who were detained until able to pay the required fees. Hospital detention of patients who cannot pay their medical bills is frequent in Zimbabwe, as reflected in press articles and other reports.

- In **Sierra Leone** a 2020 survey by MSF in Tonkolili³² showed that 48% of rural women and 31% of urban residents delivered outside health facilities. As main barriers for accessing timely care the distance to the health facility and costs of treatment was mentioned. Besides transport costs, the costs required to pay for health care prevented rural women to access care (48%) and caused delays in an additional 55%. Also in 15% of women living in an urban place, costs of health care delayed their access. In rural areas 38% of women and 7% in urban areas were told medicines were unavailable. A recent UNFPA assessment confirmed shortfalls in SRH-related medical supplies, such as contraceptives, oxytocin etc.
- In **South Sudan**, while the reported number of consultations overall was reduced with 50% in health facilities that lost support from the Health Pool Fund, WHO mentioned a reduction by 48% of antenatal care. Skilled birth attendance was estimated around 18% in 2019 and 15% end of 2021 with clear disparities between the States. According to the 2018 SARA assessment BEmONC services are offered only in 39% of health facilities and CEmONC services in only 3% of the facilities; C-Section was available in 5% of the facilities while blood transfusion only in 4%.
- In **Haiti**, despite the high maternal mortality (529 deaths per 100,000 births), in Port-au-Prince a patient will be charged up to 25,000 gourdes (equivalent of 190 USD) for a Caesarean section in a public health facility, with additional costs of certain medicines that need also be paid by the patient. In a private structure, a caesarean section can cost up to and above 150,000 gourdes (1094 USD), depending on the complication.



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3. MALARIA

As one of the main causes of mortality in children and pregnant women, malaria has a high disease burden in most of Sub-Saharan

Africa, with several episodes per person per year. Its toll is higher among malnourished children and people with other conditions that reduce their immunity. Changes in climate and environment are already altering its seasonality and geographical spread, making more people at risk of outbreaks. Early diagnosis and treatment of malaria at primary health care is needed to avoid complications such as severe (cerebral) malaria, anemia and death. Effective prevention includes insecticide impregnated bednets and indoor fumigation, when repeated timely & regularly.

Although international funding from the Global Fund, PMI and others pay for rapid diagnostic tests (RDT) and Artemisinin Combination Therapy (ACT) in most countries, access to timely care is hampered by gaps in product availability at health facility level and O.O.P. expenses required from patients for additional medical items and service fees. What remains to be paid by patients can be substantial and a significant financial barrier.

- In **Burundi**, although medical items for diagnosis and treatment of malaria are financed by international donors (mainly Global Fund and PMI), other elements of care beyond the Rapid Diagnostic test (RDT) and the Artesimine Combination Therapy (ACT) are not provided free of charge. Any other medicines, tests or services have to be paid out-of-pocket, such as anti-fever medicines or other needed drugs, the consultation fee, the hospital costs, a perfusion etc. The remaining costs to pay ('reste à payer') by patients can be substantial.

For the malaria project in Gitega and Ruyigi, MSF pays these OOP costs instead of patients. Outpatient treatment costs on average 2000 FBu (equivalent of 1 USD) per patient. Based on reimbursed costs by MSF (July to September 2023) in MSF supported facilities, in average hospital costs for patients would be between 30,000 to 50,000 FBu (equivalent 10 to 18 USD) per patient. These patient costs are required also during epidemic outbreaks, which delays seeking care.

- In **Guinea** people struggle with instability, recurrent epidemic outbreaks and economic problems, which affects people's health needs and ability to access care. In Kouroussa, in the North-Eastern part of the country, MSF has been supporting the Ministry of Health in tackling high rates of malaria (32% incidence rate and over 4 million cases nationwide in 2020), as well as associated health comorbidities in children under five through a community based program. Recurrent stock-outs of malaria rapid tests and treatment have been noted by MSF teams, often requiring reallocation of medical items from one health center to another, and for MSF to urgently and repeatedly fill gaps.

Despite the national policy declaring malaria care free of charge, the civil society health access watchdog OCASS (Observatoire Citoyen d'Accès aux Services de Santé) reported in 2022 that up to 28% malaria patients interviewed had been asked to pay for their treatment (5,7 USD or more), while 18% paid for their tests and lab exams (between 2,3 and 6,9 USD).³³ Additional costs to be paid by patients needing malaria treatment include paracetamol, ORS, perfusion liquids, syringes, needles, disinfectants, gloves, etc. in health centers and hospitals; none of these are included in external funding support for malaria and are charged to patients. These OOP expenses often deter patients from seeking care.

- In **Mali** malaria is among the major causes of mortality (24%) for children under five years of age. Also for pregnant women malaria is high among the indirect causes of mortality. Diagnosis by RDT and treatment of malaria (ACT) was declared free of charge since 2007 for children under five and pregnant women. However, several studies report that substantial costs remain as out-of-pocket expenses for the patients.^{34 35 36}

- In **South Sudan** only 50% of the Long Lasting Insecticidal Nets needed are confirmed (through the Global Fund), the remaining 50% are yet to have a confirmed donor. MSF spent around 500,000 Euros in gapfilling of malaria medical supplies in 2020; the annual budget planned in the new Global Fund cycle 2024-2026 is around 2,25 million USD. In 2022, MSF treated close to 268,000 cases of malaria (267,980); more than 14,500 (14,508) were complicated cases. From May to November 2022, 467 children received a blood transfusion following malaria complications among the 2,767 admitted (16.9%).

- In **Sierra Leone**, malaria is the main cause of mortality among children, with more than two million cases annually reported. The Global Fund (GFATM) and the US funded President's Malaria Initiative (PMI) are the main providers of medical items for malaria care and prevention. However, in practice, at the health facility level, there are often gaps and shortfall in malaria supplies. For instance, in Kenema district, MSF had to provide malaria treatment supplies for gapfilling in 6 health facilities for malaria from April to July 2023. During the last 7 months (since October 2022), the international order of malaria diagnostic & treatment supplies was blocked in customs procedures and health facilities did not receive the necessary supplies. Besides the RDT and the ACT that are funded and supplied by external donors, all other lab tests or additional medicines need to be paid. In rural areas this can amount to 200 Le (equivalent of 9,6 USD), in urban areas between 500-1000 Le (23 to 47 USD). Experience shows that the required amounts to be paid are for many unaffordable and the reason of foregoing care. One should remember that already before the poverty worsening by the COVID-19 pandemic, 43% of Sierra Leone's population lived below the poverty line. Moreover, non-pregnant patients and children above five are not exempted from payment under the FHCI and cannot access malaria treatment without payment

An assessment of patients arriving at emergency services in Gondamana hospital – from which 55% were seeking malaria care- almost all (96%) of patients arrived with a delay of over 24 hours since onset of symptoms; 58% of patients had to travel between 1 and 6 hours to reach the hospital, 21% even more than 3 hours; one in five had to travel more than 30 miles.³⁷



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4. HIV & TB

To ensure access to HIV & TB care is in line with UHC aspirations; this requires that financial barriers of direct payment must be removed, to avoid or mitigate negative effects on medical outcomes and on socio-economic strains on households. Retention in care of TB and HIV patients as well as timely initiation of treatment is critically affected by user fees. User fees also hamper the possibility to obtain a complete, quality treatment.

In many settings, patients continue to bear the brunt of the funding gaps, leading to catastrophic health expenditure and damaging coping mechanisms, including forced lending, pawning assets or foregoing other essential household expenditure. Significant OOP expenses are faced by patients with TB. Certainly when hospitalization or drugs for DR-TB are needed these are often a cause of catastrophic expenditure, including in middle income countries.³⁸ A recent systematic review reported catastrophic health expenses in 40% of sensitive TB affected households; this proportion increased to around 80% when it concerned DR-Tb or HIV-TB co-infection.³⁹ Even where TB care itself is provided free of care, additional costs are deterring timely and uninterrupted treatment.⁴⁰

Premature or overly optimistic transfer of responsibilities to purchase medical items with national budgets, particularly in challenging environments, creates additional or wider gaps in financial resources and shortfalls of essential medical supplies. In several countries, MSF observed how optimistic projections of domestic financing and co-financing have not materialized, resulting in additional gaps and key services ending up being cancelled, postponed or cut back.

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- In **DRC**, OOP payments of households for health represented 42% of total health expenditure in 2019.⁴¹ It is estimated that 17% of households face catastrophic health expenditure, spending more than 10% of their total household expenditure on health.⁴² Even if diagnostic and therapeutic tools for HIV are largely subsidized by the Global Fund and PEPFAR, user fees continue to constitute a significant barrier, with patients unable to afford prices asked for key elements of care, such as VL testing, laboratory services for HIV and TB diagnosis, detection and treatment of opportunistic infections, hospital admission and follow-up consultations. PLHIV, including those in need of urgent care, are facing exclusion, delayed initiation, retention barriers, substandard care and catastrophic health expenditure.⁴³

Diagnostic tests for HIV are rarely provided free of care; before testing a consultation fee needs to be paid; for instance in Nord Kivu this costs 2 to 3 USD. Despite of the policy instructions by the national program to provide PMTCT services free of charge, MSF teams observe that patients are required to pay for the consultation card, a consultation fee, antenatal care, delivery, a hospitalization or observation fee. Sometimes charges apply even for gloves or syringes for blood sampling for viral load, biochemistry tests.

The CSO observatory of UCOP+ confirms irregularities in certain provinces, with a wide range of fees required from patients for HIV and TB care; they also report stock-outs of key tests or drugs, making people dependent on private pharmacies or resulting in interrupted treatment when unaffordable.⁴⁴ In all five provinces monitored by UCOP+, most frequent shortfalls are reported for HIV-tests, Cotrimoxazol and ARV.

Patients that have interrupted their treatment or for who their ARV treatment no longer works, face a deterioration in their condition, with complications and risk of dying due to advanced HIV disease (AHD). Early detection of AHD signs at primary health care level is feasible and highly beneficial, but these patients are not diagnosed and their numbers are greatly underestimated. In MSF supported screening in 2021, 21% of newly diagnosed patients had AHD, with 73% diagnosed with TB and 21% a positive CrAg test (Cryptococcal infection screening test). For these AHD-patients costs are completely unaffordable and while time is of the essence, returning into care is a real challenge. Without financial support from MSF or the Global Fund (at present one facility in 4 provinces) drugs for opportunistic infections are unaffordable for patients. Without international support, these patients face death and/or ruin.

- In 2020, 71% of the population in **CAR** were living below the international poverty line.⁴⁵ Financial barriers faced by the population in CAR are recognized as important and multiple; average number of contacts is 0,5 per inhabitant per year, meaning people use health services in average less than once every two years. National decrees declare services free-of-charge for pregnant and breastfeeding women, children under five and victims of sexual and gender-based violence. Also services for HIV, TB, malaria and some neglected tropical diseases should be free of charge, as well as care in districts affected by conflict or violence. However, these policies exempting specific patients from payment remain mostly theoretical outside services supported internationally, such as by Global Fund and GAVI. PLHIV face costs for medicines, diagnostic tests and follow up exams, combined with payments for CD4 tests, medicines for opportunistic infections, administrative patient fees and cost linked to hospitalization.⁴⁶

MSF teams and other stakeholders interviewed patients that face user fees at almost every stage, such as a fee of about 3 USD charged in all facilities for initial HIV-testing (VCT, PICT, Index Testing, etc.); (mostly unnecessary) pre- initiation biological assessment costing from 45 to 90 USD per test. When PLHIV don't pay out-of-pocket, they are often relegated to a "non- priority" circuit, facing delays, incomplete care and neglect, risks of loss to follow up.



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Opportunistic Infections medicines needed for treatment of patients with AHD are missing in public health facilities or only at high prices. If patients cannot afford it, they have to do without. Similar obstacles of unavailability and unaffordability exist for TB patients. The burden of tuberculosis (TB) is high, with low detection rates and high co-infection of HIV & TB. TB-patients are expected to pay for initial consultation fees on admission, X-rays etcetera. Transport costs are expensive to the few health facilities with testing and treatment capacity.

- In **Guinea**, according to the national policy HIV-diagnosis and ARV-treatment is free of charge. However, in practice, any additional costs beyond what is international funded are to be paid out-of-pocket by patients. Required user fees in the general health system delay health seeking and the formal HIV-diagnosis that makes people eligible for free ART. In MSF supported health centres patients arrive often already with advanced HIV disease (AHD) (60% in 2022). As there is no international funding for AHD care, all costs of medicines for opportunistic infections, laboratory exams (up to 50 to 150 USD) and other AHD care fall on patients (except where MSF ensures that care is free of charge) and are unaffordable for most. These financial barriers have also implications for preventive activities; to get a diagnostic test people need first pay the consultation fee (about 4 USD) and also contraceptives are often charged to patients. PMTCT services are hampered because fees are asked for antenatal care and delivery; there has also been a shortfall of diagnostic tests to screen all pregnant women. Additionally, stock-outs for diagnostics for HIV & TB (rapid diagnostic tests, EID, Viral load) have been hampering progress. In 2022, there was a stock out of several months for Nevirapine. In the absence of a system of buffer stocks, MSF is regularly asked to provide gapfilling. Some of these gaps are the direct consequence of overoptimistic expectations of counter-financing by the government.

- In **Mozambique** ART coverage rates are widely different from province to province. Retention in care is problematic because of the distance to ART-sites, the cost of transport, unavailability of medical supplies or laboratory services and discriminatory attitudes of health workers. In Sofala province for instance, where MSF works, ART coverage is about 69% with a VL coverage of 64%. Recently an importation issue created a country-wide shortfall in condoms from the Ministry of Health channels. Also CRAG tests, necessary to ensure detection of complications among HIV patients, are often missing; MSF is asked to do gapfilling when facilities run out of these tests. A stock out survey in 10 health facilities identified stockouts of ARV and SRH commodities, due to lack of communication between health centers and provincial level, transport challenges and poor quality of pharmacy tools management.

The MoH's expansion plan for provision of care for patients with AHD in Sofala province includes 8 out of 184 ART sites. Currently the initial phase of this plan applies to only 4 health centers and Beira Central Hospital. Severe cases are referred by ambulance to Beira Central Hospital; patients have to reach at their own expenses those health centers to obtain access to specific tests for opportunistic infections for instance. To increase the access to care AHD MSF is supporting 7 additional health centers in Beira for early screening, diagnosis and treatment of advanced HIV disease and opportunistic diseases, training personnel and supplying laboratory commodities.

- In **South Sudan** countrywide figures indicate low coverage of HIV services, with about 29% of people knowing their HIV status, of whom 23% are on ART (even lower for children at 14%). Despite the need for an increased pace of roll out, because of funding shortfalls ART coverage targets for 2021-2023 have been flatlined at 48,720 patients. In health facilities in Bentiu, Lankien, Malakal and Ulang, MSF teams see many patients arrive late, with Advanced HIV Disease (AHD). In 2021, 81% of the 226 active HIV patients seen in MSF projects in Upper Nile presented with AHD, resulting in increased mortality risk. In Abyei hospital 43% of CD4-tested patients showed signs of AHD; 61% in Ulang and 38.2% in Malakal. In 2022 in the in-patient ward in Malakal, one third of the deaths were due to HIV/TB. Nevertheless, AHD remains outside the funding priorities.



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5. NON-COMMUNICABLE DISEASES (NCD)

For NCD patients that require regular follow up and uninterrupted treatment, OOP expenses are a particular financial barrier and burden on patients and households.⁴⁷ Retention in care is undermined when patients have to pay fees for services, medicines or lab tests; transport costs are also hampering access and retention. Without an international fund to ensure basic medical supplies for NCD, many people in L&MIC remain without access to lifesaving insulin and other NCD drugs.

- In **Kenya** primary care is supposed to be free of charge to patients, but NCD is deemed 'too costly' by the government to afford its inclusion in the care package at PHC level. Most NCD care is restricted to hospital level, where patient payments can be significant. For reasons of costs, insulin is included neither in the UHC package nor the NHIF.

In the aftermath of an MSF project in Embu, the continuation of providing NCD care at primary care level, closer to people and at lesser costs, was jeopardized by lack of medical supplies expected to be provided free of charge to patients by the public health system. The county budget (health is devolved function) to health facilities falls short, resulting in stock outs of essential medicines, including for NCD. A 2023 assessment by community based organisations (CBO) in Embu and Mbeere showed that none of the 11 previously supported health facilities had drugs available for diabetes or asthma, only one had epilepsy medication and 3 health facilities had none of the NCD drugs in stock. **Between 10 and 50% of NCD drugs ordered had not been supplied** and most orders were received after 3 months or longer. For diabetes, needles, syringes and swabs are not included in the standard order list.

Even in community-based revolving pharmacies in Embu, providing NCD-drugs at subsidized prices, **OOP- health expenses are unaffordable for many patients**, causing interruption of treatment. Additional transport costs increased the financial burden as only 2 CRP covered 11 health facilities in the county (since, 3 CRPs added). A 2021 assessment showed that only 50% of NCD people could obtain all needed drugs at the health facility, and an additional 29% only part of them. However, many did not recur to the CRP as alternative source for medicines, citing costs of transport (28%) or cost of drugs (24%) as reason for not attending the CRP. Some people said they could not afford to pay upfront the costs for the monthly quantity of drugs. The government explores such semi-private alternative of community pharmacies to provide essential drugs missing in the public health facilities, but the prices remain out of reach for most. Even if prices are much cheaper than in private pharmacy outlets, in absence of the government supplies free of charge, for many patients the medicines at lower price are still too expensive. As a dire consequence many patients with **diabetes and hypertension** cannot timely initiate or continue their treatment. Especially the cost of insulin is prohibitive (up to 5 USD per vial), generally only available at higher levels of health care and supplies are often irregular. Glucometers and test strips are expensive for patients to buy; in health centres there are often long waiting times for patients to have their glycemia tested and health centres face frequent stock-outs for test strips.



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6. REFERRAL SERVICES AND SECONDARY LEVEL SERVICES

- In Beirut, **Lebanon**, the worsening economic crisis (COVID-19, harbour explosion, inflation, currency crisis etc) has created additional financial barriers to access care, with the offer of public health services further restricted and the largely privatized health provision becoming unaffordable for most Lebanese. Where better off households turned pre-crisis to the private sector, costs have increased ten- to twentyfold and became unaffordable also for them; they increase demand on the semi-public health facilities, but these face multiple challenges for the cost and unavailability of resources including stock outs of essential medicines.

Health facilities without or with insufficient subsidy support have raised the patient fees. Also increased transport costs have increased financial barriers to access care timely. The costs of NCD-drugs has significantly increased as well because of the unfavorable USD exchange weighing on imported medical products.

MSF provides NCD care including management of diabetes and epilepsy care in the Beirut suburb and in northern Bekaa; contributing in the response to the increasing needs, the clinic has been enrolling patients in care with the plan to refer those who are stable to other health facilities once there is possibility to receive their long term management. However, referral options were much hampered by unavailability of insulin and other NCD-drugs. Besides other NGOs, MSF supports 2 clinics in NCD and mental health care, through capacity building and topping up NCD drugs for which frequent shortages occur.

In the UHC agenda, primary health care (PHC) is prioritized as the basis of progress. Besides ensuring geographic and financial access to those PHC services, in order to assure adequate care, effective referral and secondary services are necessary. Without the possibility for patients to obtain a complementary health care package, many will still die or suffer complications unnecessarily. Transport by ambulance of severely ill patients is often unavailable or expensive, unaffordable for most. People in rural and hard to reach areas are most confronted with the consequences of lack of transport, as are people living in areas with high insecurity. Secondary care is often financially and geographical inaccessible, with unavailable medicines or qualified staff, leading to delays, foregone care, substandard quality of care, unnecessary complications and deaths, financial distress and coping mechanisms, or abuse such as through hospital detention of patients unable to pay.

- In **Mali**, in absence of financial support from MSF or other NGOs, patients are charged for referral by ambulance. The cost of ambulance referral to the hospital or the Referral Health Centre can reach 20,000 FCFA (equivalent of 30 USD), which is unaffordable for many households, as 49% of the population lives under the extreme poverty threshold.⁴⁸ For women the financial barrier linked to transport is even more important. Out of-pocket payments are based on an average 6000 FG (equivalent 0,6 USD) per kilometer and as health facilities can be at 50 km distance or more, the required sums are often unaffordable. A solidarity fund exists in some health facilities, but people's contributions barely reach half of the expected, insufficient for the cost of fuel and maintenance of the ambulance.

- In **Sierra Leone** there is an important problem with referrals of patients to secondary care. In the MSF supported hospital in Hangha (Kenema district) 54% of patients reported having to pay for transport by bike or 'keke'; only 1% could use the government ambulance service. MSF supported ambulances provide this service free of charge and transported 25% of referred patients.
- In **Haiti's** capital, Port-au-Prince, patients admitted to the reference structure of Turgeau (supported by MSF) are receiving care free-of-charge in emergency and referred to other structures (private or public) with the costs paid for by MSF for the most vulnerable patients. Others have to pay out-of-pocket costs for drugs and medical material. It's also a major difficulty to obtain a transfusion for people suffering blood loss after violence/trauma or during delivery. The blood transfusion system in Haiti is highly centralized; any validation of testing blood donations across the country needs to pass through the capital, causing delays of 4 to 6 days. On an annual need of 80,000 bags of blood, only 30 to 40% are secured; there are too few promotion drives and/or mobile collections of donor blood. The current insecurity seriously blocks transport, making the centralized system quasi impossible and putting patients' lives at risk. Frequently reagents for testing are out-of-stock and there is no effective system to communicate the results from the capital to peripheral health facilities. In the South of the country, patients in need of transfusion have to go to Les Cayes, but often material is missing as supply from the capital is delayed or insufficient.
- In **Guinea**, patients arriving at public hospitals are asked to show they have the necessary money and often asked to pay upfront before they can be hospitalized and obtain the necessary care. For instance, in Donka Hospital, Conakry, people are asked to pay 70,000 GF (equivalent to 70 USD) as 'entry ticket'. At a rate of 50.000 GF per day for a hospitalized patient, bills can easily amount to 500,000 or 600,000 GF and lead to catastrophic health expenses for many households.
- In **Burundi**, MSF's experience in the Surgical Centre of Arche showed the importance of providing timely trauma care. MSF will continue to support technically the health authorities (Plateforme de la prevention des risques et gestion des catastrophes) in preparedness and response for mass casualties. However, we observe that required out-of-pocket costs for hospitalization, medicines and transport block access. Fortunately, the state ensures that care provided during the first 48 hours is free of charge to the surgical patient. However, continuity of care is at risk once that patients have to pay out-of-pocket after that period. According to the WB data base, costs for surgical care make 91% of patients at risk for catastrophic health expenditure in Burundi.⁴⁹
- In **Lebanon** health workers have been leaving the country in important numbers (an estimated 30-40% has left since 2019) and the impact on health service availability is felt. In some hospitals, there is insufficient medical staff to ensure night shifts for instance. Hospital beds in certain departments had to be decreased or remain unfunctional, despite equipment donations, because of the lack of nurses. Emergency rooms are understaffed or run by very junior doctors and nurses. Finding an available bed for referring women and newborn babies needing urgent obstetrical and neonatal is a challenge for teams at the MSF supported birth centre. Requests are turned away from maternity hospitals and in MSF a dedicated referral team has to try several attempts to get medical care, with risky delays.



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7. STRONG ACCESS BARRIERS FOR SPECIFIC VULNERABLE GROUPS

As the combined effect of financial barriers with socio-cultural obstacles have a strong effect on access to care for key populations and other extra vulnerable people; they need specific protection.

- **People who use drugs (PWUD) in Kenya, an extremely vulnerable group**

In Kiambu hospital (level 4) MSF supports health care for people who use drugs (PWUD). As part of the project MSF ensures care free-of-charge, as most PWUD are unable to afford health care costs but don't get any exemptions from paying. MSF pays their subscription to the National Health Insurance (NHI) at 500 KSh (eq 4,2 USD) monthly per person (this membership fee is expected to increase to 1000 KSh). However, even under NHI additional out-of-pocket payments are required from patients. For instance, the toxicology test is supposed to happen quarterly and also in case of re-joining care after dropping out/interruption. This is a barrier at cost of 600 KSh per test. PWUD also suffer frequently of wounds, which care costs between 500 and 1000 KSh. Treating recurring urinary tract infections cost about 1000 KSh. Moreover, without MSF gapfilling shortages of drugs would be frequent at the hospital, with supplies twice per year but in insufficient quantities; often after one month stock outs already appear and patients have to be referred to private pharmacies for their drugs.

- **Key populations in Mozambique**

For key populations, such as sex workers and men having sex with men (MSM), access to care remains problematic. Although improved under mentoring by MSF to health workers in Beira, in a recent satisfaction survey almost one third of patients (sex workers and MSM) expressed dissatisfaction and in particular complained about the lack of privacy. Especially MSM feared stigma and discrimination. The lack of trust in health providers held people back in revealing their status. Stock outs of medicines were also frequently reported as problem to access care. Populations of sex workers in the region, like in neighboring Malawi, Zambia, Zimbabwe and the so-called Beira Corridor, are extremely vulnerable people, known to be exposed to high HIV infection risks and frequent violence.⁵⁰

- **Delayed care for victims of sexual and gender-based violence in Guinea**

Although care should be provided free of charge to victims of sexual violence, patients face significant financial barriers to obtain timely care. The objective to provide care as soon as possible (within 72 hours) is difficult to reach, in particular for minors that have no money to pay for the first medical exam and the certificate as is usual in the health facilities; laboratory tests can cost up to 50 USD, with additional costs for administrative-legal documents. Often patient arrive late and/or outdone of all their money in MSF-supported services.



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3.2. UHC BUT NOT FOR PEOPLE IN CRISIS?

It is well recognized that people in crisis situations are more vulnerable, facing additional health needs and additional barriers to access health care in a timely and effective way. This was shown during the COVID-19 pandemic but also during crisis situations linked to smaller scale epidemics, conflict and natural disasters. Previous vulnerability is often reinforced, with health care for vulnerable groups disproportionately hampered. Pre-crisis existing health service weaknesses and access barriers are often worsened. Measures to improve emergency preparedness and interventions that can improve people's protection against shocks linked to such crises are lacking in many places; timely measures to ensure access to essential care, for existing and new health needs, are missing in particular. Also community based and led interventions often still fail to be included, although their shown importance.

The interest to lift patient payments during crisis has been extensively documented. In addition to other obstacles, financial barriers block timely health care seeking for health problems directly linked to the emergency (such as the epidemic illness, wounds etc) but also affect negatively access to health care in general. Combined this leads to delayed reporting through health facility-based surveillance and reduced coverage for essential care.⁵¹ The risk of catastrophic health expenditure & long lasting impoverishing when trying to access care during outbreaks has also been documented.⁵²

The COVID-19 crisis created an important interruption and backlog in immunization services, with less protection coverage and increased risk of outbreaks. Even if recovery is noted in most countries, coverage remains below pre-COVID-19 coverage levels.⁵³ Currently many countries battle with vaccine preventable outbreaks, such as for measles, diphtheria etc. Access to other health services has also been interrupted, both because of lower service offer and more financial barriers among a population facing worsened economic precariousness.

Continuity of treatment is a specific challenge in times of crisis, in particular for people on treatment for HIV, TB and NCD. Because restoring access to those services does not always receive the necessary priority, delays in (re-)initiation of treatment cause deterioration of people's health and increase their public health burden.

Two billion people, or a quarter of the world's population now lives in conflict-affected areas.⁵⁴ Conflict brings specific challenges, with need for health care services for people affected by violence and displacement. Additionally, health interventions through the existing health system might not reach people among politically or socially marginalized groups or in areas of conflict.

Longer term effects of crisis on people's health needs and their vulnerability have been well documented. Crises are often not evolving in the expected linear improvement over time; regular fall backs into crisis are noted with deterioration of insecurity and vulnerability, or compounded by additional precarity.

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Even when a crisis is declared over, urgent health needs often continue to be prevalent, affecting mortality and morbidity. A need for a sufficiently long transition period is needed, determined by and with a strong focus on people's health needs, adapting strategies and making complementary interventions to ensure an effective response with impact on people's health.

While worldwide the current volume of emergency situations is at an unprecedented level, **humanitarian action faces huge gaps in funding and actors.** With the acute 2021 crisis in East Africa and the Sahel, malnutrition rates, already present in many conflict affected contexts before, have worsened; many countries are overwhelmed by food insecurity and raising malnutrition rates. Populations affected by malnutrition are more vulnerable for mortality and illnesses, such as malaria or measles. Further epidemiologic shifts or emergence of health problems are expected linked to climate and environmental challenges, such as for dengue, malaria etc.

Today's gaps during crisis situations in ensuring effective access to key health care show the need to include specific targets into the UHC agenda, as well as targeted strategies and approaches, adapted to the specific contexts and the most vulnerable groups. UHC-country plans should include specific adaptations of community and health systems support, such as suspension of user fee schemes and other patient patients, ensuring uninterrupted availability of medical supplies and adequate support to remuneration and working conditions of frontline health workers. In particular measures that lift specific access barriers for the most vulnerable and extremely precarious regions need increased focus.

● Violence and insecurity in Mali

Since 2012 the conflict caused around 375.000 people to flee.⁵⁵ The state of violence and insecurity has impacted an already fragile health system, in particular in the north of the country, with health facilities destroyed, closed or abandoned. Health staff have left and for the remaining health workers, motivation and qualification has dropped. With a shortfall in medical supplies and frequent interruptions, patients have no access to essential medicines. With functioning health facilities far and apart, insecurity, lack of public transport and high transport costs strongly limit access to care.

The importance of providing care free-of-charge has been recognized by the government and humanitarian actors like ECHO.⁵⁶ The government declared that care should be provided free of charge for people in the conflict ridden areas since 2012. However, in several regions these exemption schemes were stopped because lack of resources. Even if formally the 'free care' policy has not been lifted and the instability continues in the region, in practice health facilities charge patients where there is no international financial support. The level of required patient fees varies largely, even within the same health district.

● Violence and displacement in Cabo Delgado, Mozambique

Since 2017 the northern province of Cabo Delgado remains in the grip of conflict and humanitarian needs are immense, with more than 800,000 people displaced by the violence and living in extremely precarious conditions. While historically an under-resourced province, with lower development indexes and worse health indicators compared to other provinces, the health services have been severely disrupted by the conflict in the area. People are returning gradually to their homes where possible; however, health services are slow to start up again, with demand higher than available offer and quality often low because of lack of qualified staff.

In spite of Mozambique's high HIV prevalence, emergency aid in the conflict area has been slow to offer HIV & TB services. The massive displacement and the disruption of ART left many people lost to follow up and with limited possibility to re-start. Despite slow improvement over the last years, with re-opening of HIV sites and provision of HIV/TB diagnosis in mobile clinics, the overall situation in the North regarding the lack of HIV and TB care remains worrying.^{***}

- DR-TB continues to be among the leading cause of death in Cabo Delgado Province, and the primary cause of death and disability in HIV patients. Access to (DR-)TB diagnosis & treatment in most of districts of Cabo Delgado Province is still insufficient, with a lack of the recommended short regimens for DR-TB and for the prevention of tuberculosis (TPT); short regimens for drug-sensitive TB in children are also missing.

*** Cabo Delgado ranks lowest among all 11 provinces online with only 83% of PLHIV aware of their status; 10.2% of patients lost to follow up (15% among the paediatric population) against 3.8% at national level; only 42.5% (the lowest in the country) of viral load suppression among patients on treatment (compared to 80% in Gaza., 47% in Nampula, 51% in Sofala, 71% in Manica, 74% in Zambézia and 76% in Maputo Província for instance).



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HEALTH WORKERS IN CRISIS SITUATIONS

People providing care during crisis situations are under significant strain and face important risks. Especially in compounding and protracted emergencies, the toll on health workers is high. **How will UHC ensure protection and safety of health staff? How will UHC effectively support health workers in taking care of people?**

During a crisis situation, increased patient loads and urgent health needs created a high workload. At the same time, health facilities might be unable to function as expected, by a combination of factors such as physical damage of infrastructure, loss or looting of equipment, inaccessibility by natural disasters or insecurity. An overburdened health workforce is often the consequence. Living and working conditions might be deteriorated for staff too.

In conflict⁶⁷ settings in particular, the protection of health workers is difficult to ensure; recent alarming figures show eroded respect of international humanitarian law (IHL) protection to the wounded and sick, as well as to medical personnel and facilities. Domestic counterterrorism frameworks have been increasingly employed to criminalize impartial medical care to wounded and sick from non-State armed groups, labelling patients but sometimes also health care providers as criminals or suspects. It has also contributed to legitimize attacks and incidental damage on medical facilities in armed conflicts.

Also in outbreaks of infectious diseases, health staff is exposed to various hazards, in the first place transmission of dangerous pathogens, but also violence, harassment, stigma, discrimination, heavy workload and prolonged use of personal protective equipment (PPE).⁶⁸ Non-availability of vaccines, medicines or other medical countermeasures might disproportionately affect health workers during pandemic and other epidemic outbreaks. Adequate protection of health workers is often missing, exposing those trying to help others to life and health endangering illness.

- Mobile clinics see an important number of people with HIV & TB; many previously on ART had to interrupt their treatment. HIV testing of pediatric patients in March 2022 in the MSF-supported Mueda hospital showed over 30% positivity. In addition, many women in the maternity ward had no HIV-screening during their pregnancy.
- The reported treatment interruptions highlight the need to increase screening for AHD, with extra diagnostics and therapeutic tools to bring people back into care.
- Timely HIV & TB diagnosis and treatment is hampered because of lack of decentralized diagnostic tools (GenXpert, Viral Load, CD4 count) at district level and absence of an effective sample transport system; obtaining results can last up to 2 to 3 months. PCR for early infant diagnosis for HIV is centralized at Pemba only; initiation of ARV treatment of PMTCT among mothers is centralized, as well as the Nevirapine prophylaxis for exposed infants. The patient identification number confirmation needs to come from province or district level, creating additional administrative hurdles and delays in treatment initiation.
- Community services and support are missing in general, without a system to trace people and encourage re-starting treatment as soon as possible.

Additionally, functional mental health services are lacking, leading to lack of proper diagnosis and treatment of patients. The blood transfusion system in the region is not functioning, which is highly problematic for children with severe malaria and pregnant women. People have long distances to travel to reach health facilities and this is hampered by insecurity in certain areas. Because unavailability of ambulances, lack of fuel or vehicles not equipped adequately (e.g. no Oxygen), emergency referral is highly problematic.

- **Multiple crises and extreme violence in Haiti**

In the capital Port-au-Prince, patients speak about missing key medical appointments for post-hospital care because of insecurity. At the Traumatology project of MSF in Tabarre, 30% of patients admitted with trauma between November 2022 and January 2023, declared they had to interrupt their follow up because it was impossible for them to reach the hospital (road blocks, presence of armed groups) and 20% had to leave the capital fleeing violence in their quarter. Many patients return with post-operational infections after they missed appointments due to insecurity.

- **Multiple epidemic outbreaks in Sub-Saharan Africa**

Since February 2022, **South Sudan** has declared several measles outbreaks, with 6,429 cases reported between January 2022 and June 2023, with 86% of the counties affected. Over 75% of the children were unvaccinated. A nationwide measles vaccination campaign for children under five in April 2023 gave mitigated outcomes, with at least 15 out of 62 counties showing coverage below 80%. Most of the MSF supported health facilities continued to receive suspected cases of measles afterwards, several among returnees or among the refugee camps across the border.

After the violent episodes in recent years, many health facilities have been damaged additionally by the rains or the floods. For the last four years, South Sudan has been affected by historical floods, making roads unpassable during the rainy season. This requires earlier and higher volume transport of medical supplies, with increased storage at facility level; in particular supplies for prevention and treatment of malaria are critical to anticipate increased seasonal malaria outbreaks.

The population in **DRC** faces multiple crisis situations, such as epidemic outbreaks, humanitarian crises, displacements or natural disasters. In presence of major access issues, high mortality and morbidity, the practice of making people pay for care will have major consequences for health seeking behavior (not or delayed) and will lead to impoverishment. Especially during epidemics, such care delays have major effects on effective response and prevention of spread. Recent documentation showed the importance of offering general care free of charge during the Ebola epidemic in East Congo, allowing faster detection of and effective care for patient affected with Ebola, but also other life-saving services such as transfusions, surgical emergencies, deliveries etc.⁵⁹ ⁶⁰
⁶¹ However, the UHC-country plan fails to include an adapted chapter for UHC during crisis, in which a different approach to ensure access to care is needed; UHC plans should spell out specific measures that need to be applied asap from an early onset of crisis.





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DISPROPORTIONATE IMPACT ON THE POOR, THEIR HEALTH NEEDS AND ACCESS- WITHIN AND ACROSS COUNTRIES DURING COVID-19

As in past pandemics, including the recent influenza pandemic of 2009, pandemics and epidemics disproportionately affect the poorest populations, even in High Income Countries.⁶² The links between socioeconomic status (income, occupational background, educational attainment) and poorer health outcomes were magnified by COVID-19.⁶³ Lower socioeconomic status was associated with higher rates of comorbidities such as heart disease or diabetes and it was correlated with poorer clinical outcomes with COVID-19.⁶⁴ Inequities in access to healthcare were further exposed during COVID-19 as refugees, the poor, and people with disabilities could not access COVID-19 services and routine care. ⁶⁵ The exclusion of migrants and refugees from mainstream national health systems and public health measures risked jeopardizing the overall COVID-19 response effort, as it inhibited disease detection, contact-tracing, prompt linkage to treatment, and vaccination efforts.⁶⁶

A study of catastrophic spending in 194 countries found that in middle-income countries, there was a positive association between out-of-pocket spending and COVID-19 mortality – meaning that in countries where people had to spend more out of pocket there were higher deaths recorded.⁶⁷

Additional to restricted access to tools, countries in low resource contexts have insufficiently developed health systems that are organized to mount a unified pandemic response. Systemic challenges also hampered patients in low income countries (and within them those who were poorer) being accurately diagnosed and linked to care.⁶⁸ Diagnostic testing for COVID-19 led to a reduction in spending for necessities at varying levels by age across 83 countries analysed.⁶⁹

MSF teams witnessed in several contexts the financial barriers to access Oxygen and other care for COVID-19. In Haiti during the COVID-19 epidemic, access to care was unaffordable for many. One cylinder of Oxygen, able to provide lifesaving support during 6 hours, would cost upto 3,000 gourdes (31 USD). In Peru private providers similarly held out to get 15,000 USD per COVID-19 case.

With public health services overwhelmed, governments sought to harness private capacity for care, with mixed results. Some countries, such as South Africa, Kenya, Thailand, Malaysia, the Philippines, Indonesia and some states in India, took measures to limit the financial burden on patients, in particular imposing regulation of patient payments in the private health facilities.

In **Burundi**, during MSF's intervention for an outbreak of ulcerating wounds in Muyinga (2019 to 2022) 13,900 children with wounds on feet and legs were treated, about 6,250 annually in 2021. Among them 10% were children under five and 90% above (most 5-15 years of age). Before MSF's support, children above five years of age had to pay for disinfection and wound dressing. This simple care at primary health care centres was unaffordable for most (average cost 10,000 FBu (equivalent to 3,5 USD). As a consequence, wound care was delayed; most presented late, with severe or complicated wounds, in particular diagnosed among poor households. Many households could not even afford simple primary prevention with soap, nor disinfection care once wounds were infected. With a simple wound dressing protocol and care free-of-charge supported by MSF, 90% of patients were cured. MSF has advocated to ensure integration of such wound care into the 'small surgery' category of the performance-based financing and to apply free care also above the age limit of 5 years.



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3.3 . UHC BUT NOT FOR ALL MIGRANTS AND REFUGEES

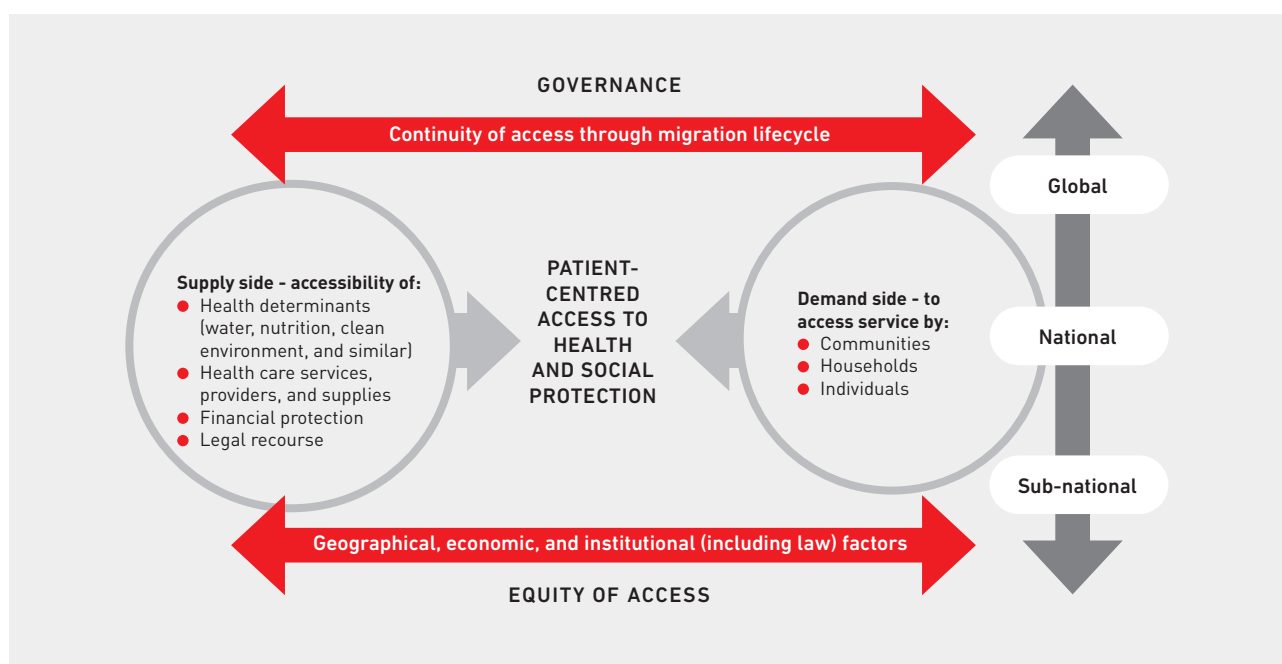
Safeguarding and improving the health of migrants and refugees is increasingly recognized as a global health priority. The recently adopted Rabat Declaration, as well as the WHO Global Action for Migrants and Refugee Health⁷⁰ emphasize that the health of refugees, migrants and host communities is an integral part of the overall population health, and that UHC is only truly universal if it includes refugees and migrants⁷¹. Despite this, **migrants, including refugees, often have poorer health outcomes and face multiple barriers in accessing health care**⁷².

One in eight people today is either a migrant or is forcibly displaced, of which 281 million are considered international migrants and more than 100 million are forcibly displaced either across international borders or in their own countries. Almost 90% of forcibly displaced people remain in low- and middle-income countries⁷³, and many other migrants in vulnerable situations remain trapped along migration routes, or living and working in sub-standard conditions exposing them to adverse health detriments. Added to these global trends are the inherent challenges in effectively addressing the health needs of migrants, which are multi-factorial and complex.

Whilst refugees and migrants are not inherently less healthy than populations in the host country, poor health amongst migrants is often shaped by exclusion from national health and social protection systems, precarious legal status, poor living and sanitation conditions and exposure to violence, exploitation and racism, as well as the negative impact of an increasingly restrictive policy environment, for example the use of immigration detention, across all stages of the migration journey. These vulnerabilities were exacerbated during the COVID-19 pandemic.

MSF experiences, providing medical care in displacement and migration settings globally, have demonstrated that health responses should consider peoples' mobility as well as the political and social determinates of health during transit and at countries of destination. Health systems must ensure that there are proper legal channels for migrants to access health and to ensure migrant-sensitive health services, which are appropriate, inclusive, and offered in a timely manner; this implies also adaptation of existing social security and payment mechanisms and reducing language barriers and providing support in navigating health systems. Such responses remain elusive in most countries where MSF responds to the needs of migrants.

Figure 3: Health Systems Framework for Migrants Access to Health and Social Protection (Source: UCL-Lancet Commission on Migration and Health, Abubaker et al. 2018.)



At each stage of the migration journey, the needs facing migrants are complex and may require a range of health services, including mental health services which is often the most lacking. In countries of origin and transit, common health needs include trauma and acute health problems linked to dangerised journeys, violence and ill-treatment such as hypothermia, dehydration, burns, and injuries. In detention settings, MSF responds to the health needs born of undignified living and detention conditions, including skin diseases, malnutrition, tuberculosis, and the psychological impact of trauma, while in destination countries, consequences of multiple and compounding barriers to accessing health services can have a long term impact on health outcomes. Many migrants often have preventable and treatable health conditions which become more long term and acute if left untreated, this includes, mental health conditions, infection of wounds, lack of treatment of chronic conditions such as diabetes, hypertension, hepatitis or HIV and lack of appropriate reproductive health care. Equity of access contributes to mitigating these adverse health effects.

UHC can only be achieved if migrants have access to essential health services and effective, high-quality medicines and vaccines, without any barriers. Whilst

several commitments have been made at national and global levels, there is little evidence in UHC national strategies. Accommodation should be made available to ensure migrants have timely access healthcare, as well as disease prevention programs. If anything, most migrants face both practical and legal barriers to access. UHC targets ought to include specific provisions made to absorb migrants into health systems, as without doing so, both individual and community health is adversely affected.

Migrants continue to face a multitude of barriers to access health care

Migrants, refugees and other displaced people face a multitude of overlapping barriers which limit their access to care. Common barriers to care reported by patients attending MSF projects across the world, in Europe, Asia, Africa and South and North America are **fees and financial barriers**, both of health service and of transport to health services, **administrative** barriers, lack of **knowledge** or information on their rights to health care, linguistic and cultural barriers, **discrimination** and racism from health workers, and importantly, **fear of criminalization**, border enforcement, detention and deportation.

In some countries, there are restrictions or differentiated provision of health care to some migrants (i.e., asylum seekers, undocumented migrants, labor migrants and migrants without health insurance), and those countries that do provide health care often limit it to emergency care rather than ongoing, community-based, preventive health care such as infection screening or vaccination, or restrict availability of services, which result in higher severity of morbidities related to preventable or manageable NCDs. Such an approach does not represent universal health coverage.

● Out of Pocket Fees and Financial Barriers

Many migrants, including refugees and asylum seekers face out-of-pocket expenses for most health services across their journeys. Even when migrants and refugees are legally entitled to health services, there are often hidden costs (e.g. transportation or hiring translators), services or medicines outside the package covered or required co-payments that hinder access to health. Where migrants are supposed to access care through the existing service provision, there are many reported instances where access to healthcare is limited not only to migrants and refugees but also to host populations who cannot afford care.

In **Lebanon** the various economic and health crises, including COVID-19, have affected the health system, leading to a significant emigration of medical staff, drug shortages and supplies, and decreases in hospital bed capacity down to 50%. Affordable healthcare has become unattainable for many, given the impact of inflation and barriers to care have been intensified for Lebanese, but also for migrants and refugees. Displaced Syrians and other refugees registered with UNHCR receive subsidies to cover health care cost. In 2023, due to funding concerns, the percentage of health cost covered by UNHCR has been cut; previously UNHCR paid 75% of costs of care, leaving 25% as OOP expenses for patients, now they only pay 50% of costs.

For decades, migrant workers in **Lebanon** have been struggling for basic rights, dignity, and survival. Migrant domestic workers are especially vulnerable to exploitation. There have been several reported incidents of employers hinder access to care through refusing to pay for health insurance or withholding identification documents. Although employers should provide health insurance, in practice coverage is limited to hospitalization for work-related accidents. The health insurance does not cover mental health, physiotherapy, medication, and laboratory tests, even

for emergency cases. Migrant workers and often the employers themselves are not aware of this health insurance, or the duration of its validity. According to an IOM survey more than 2 in 5 migrant households in Lebanon reported having at least one member with a health problem in need of care and one person per household was unable to access care. Treatment costs (68%), consultation costs (50%) and transport (16%) costs were some of the most common barriers cited in migrants lacking access to healthcare. 41% of migrants could not afford to buy medication. Two thirds of migrants in Beirut and Mount Lebanon reported that medicine was too expensive. Over half (60%) of migrant households (versus 40% of Lebanese households) reported that they did not seek healthcare because they could not overcome the barriers, they faced⁷⁴.



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MSF projects target migrant domestic workers to access essential care since 2020 in Beirut. In 2022, our teams in Lebanon provided 7,686 medical consultations to migrant workers, mostly for patients suffering from musculoskeletal conditions, gastrointestinal disorders, respiratory diseases, and non-communicable diseases such as diabetes and hypertension. In case migrant workers need health care, an emergency assessment is provided by MSF and support for their referral to primary health clinics and/or hospital. Many patients return without care or medicines to MSF. Patients delay seeking care, in fear because no documents and of violent reactions by their employers. They lack money to access care and face other obstacles, such as language and cultural barriers; even with money, many experience discrimination and mistreatment.



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In **South Africa**, while legally migrants are eligible for access to health, regardless of status, the reality is more complex. Individual provinces have attempted to restrict this access through introduction of new policies: requiring documentation for all services, including emergency services, and assigning migrants to be charged as 'private' patients requiring them to pay upfront fees prior to care. MSF has documented several incidents related to the denial of care or request to pay upfront payments; this includes for migrant mothers who were unable to access maternal and/or child health services, as well as people seeking care after physical and sexual assault. A joint study with MSF and the African Center for Migration Studies which surveyed 1,375 migrants found that a third of the interviewees who looked for medical care after being physically assaulted were asked to pay in order to be treated, and the average price for the service was 78 USD. The perception of difficulty in accessing medical assistance varied across cities. For instance, a greater number of people reported experiencing barriers to care in Pretoria and Johannesburg, where 25% and 16.6% of migrants respectively said that medical assistance was either difficult or almost impossible to get⁷⁵.

A recent court decision of the Johannesburg High Court ordered that the National Department of Health must provide free health care to pregnant migrant women and their children. The case was brought after the death of a 6 year old Zimbabwean child who died because he could not access timely emergency care due to being unable to present valid papers and because his parents could not afford the R5,000 upfront payment required to access health services⁷⁶. Although the provincial policy has been struck down by the courts, the country is currently deliberating eligibility conditions under a new National Health Insurance policy; while aimed at expanding universal health coverage, this will in fact reduce migrant access to health services to emergency services only.



- **Administrative barriers and lack of health information**

Effective access to healthcare for migrants is frustrated by a range of administrative barriers, as well as a lack of awareness of often complex procedures related to national health systems. Médecins du Monde's Observatory on Health found that 78% of migrants treated across ten European countries did not have access to health care due to administrative barriers or lack of knowledge of health entitlements, where they did have legal access⁷⁷. As a result, and despite the much broader legal entitlements being afforded to many categories of migrants, emergency services remain the main entryway for undocumented migrants, asylum seekers, and refugees to access health services across many countries⁷⁸.

In **Italy**, for example, MSF found that due to administrative barriers, migrants and refugees especially those living in informal settlements, regardless of their legal status, have less opportunities to access medical treatment. Since September 2016, MSF has been working together with local volunteer groups to promote migrant access to local public healthcare services through information desk at gathering places about regulations and administrative procedures concerning access to the National Health Service and local health services, as well as accompanying vulnerable people through the registration process. MSF also includes staff and volunteers from diverse communities to support as linguistic facilitators and cultural mediators in information and accompaniment sessions. Often

people supported by the service are not registered to the National Health Service due to complicated procedures, lack of knowledge of procedures or lack of permanent address; this included migrants who had been in the country of several years⁷⁹.

Moreover, due to the bureaucratic complexities of obtaining legal status and/or social insurance, for example through asylum procedures, many individuals who in principle should be able to access healthcare find themselves outside the system. For example, in **Greece**, newly registered asylum seekers are given a 'Foreigner's Temporary Insurance and Health Coverage Number' - conditional upon their right to remain in the country- which grants them access to social services until the outcome of their asylum procedures. However, they face significant challenges in converting this temporary insurance into a permanent social security number upon recognition of their refugee status. This often results in protracted periods without insurance, and therefore without access to care. Meanwhile, those rejected from the restrictive asylum procedures find themselves automatically barred from health coverage⁸⁰.

- **Restrictive migration governance and immigration controls limiting the right to health**

Migrants in irregular situations are often reluctant to seek needed medical care out of fear of repercussion on their migratory situation. According to patients seen by MSF in **Mexico**, MSF's data shows that 59% of people on the move affected by violence did not seek any assistance during their transit through Mexico,

largely due to concerns for their personal safety, a fear of retaliation or deportation⁸¹. MSF teams observe that fear of arrest frequently leads undocumented patients either to delay seeking healthcare or to not seek care at all. In **Poland**, MSF treats patients having crossed the Belarusian border, who, out of fear of being pushed back and/or face prolonged detention periods, delay needed medical treatment and are often reluctant to be referred to hospital. These barriers put the health and lives of patients at risk. In **Malaysia**, healthcare providers are required to report undocumented migrants, which may include refugees and asylum seekers, to the police or immigration services. As such, refugees who lack UNHCR documentation risk threats of arrest and detention when seeking treatment at public medical care facilities, especially when they are unable to pay medical fees, resulting in fear and distrust of public healthcare staff⁸².



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- **Fragmented and parallel health access a risk for individual and communal health**

In many countries, migrants including refugees, asylum seekers and other categories of migrants have differentiated and fragmented access to the public health system depending on legal status and administrative issues. The multiple barriers to accessing health care have given rise to fragmented health systems, with alternative, often non-governmental, health structures forced to exist in parallel to national and public health systems to respond to the most pressing needs of migrants.

For example, **in Belgium**, health insurance and coverage are differentiated depending if some is a national, an EU citizen or, a non-EU citizen residing in Belgium, asylum seeker or undocumented. For undocumented migrants, there is an option to apply for the Aide Médicale Urgente (AMU) which is limited to emergency health services, if they have a medical need, financial hardship and an address in Belgium. Asylum seekers' access to health services is contingent upon their admission to the reception system. The chronic exclusion of large numbers of asylum seekers from the reception system since 2022 has de facto also barred individuals from accessing care beyond emergency medical care. With very cumbersome procedures to access emergency care, NGOs in Belgium have effectively become the only accessible health service provider, especially for preventative, primary and secondary care; for asylum seekers excluded from reception, in addition to undocumented migrants.

In 2022, as a result of rising and unmet needs, MSF opened a temporary medical clinic in front of the Immigration Office registration centre on Boulevard Pachéco, in which almost 90% of those seeking care were found to be asylum seekers who should have had access to health care. During this process, MSF detected an epidemic of cutaneous diphtheria, prompting a major vaccination drive by MSF, also highlighting the lack of access to preventative care for asylum-seekers. According to the European Center of Disease Control, the majority of diphtheria cases identified in Europe had lived in a migrant facility upon arrival in Europe⁸⁶. This means that several opportunities were neglected (or denied) to provide vaccines and boosters to prevent further outbreak as well as mitigate vaccine preventable disease. While the MSF clinic has since been taken over by the Belgian Red Cross with Belgian state funding, the lack of a long-term, sustainable, and structural solutions enabling the meaningful integration of migrants into national health systems, including preventative care, signals continued fragmentation in health service provision.

Pregnant women from refugee communities are among those at risk as barriers prevent many pregnant refugee women from seeking maternal healthcare, until late in the term or not at all. According to a study by the UNHCR in 2019, the maternal mortality rate among refugees in Malaysia was estimated to be 62 per 100,000 live births, which is significantly higher than the national average of 36 per 100,000 live births⁸³.

The provision of healthcare should never be subjected to the implementation of immigration control and health actors – public and non-governmental – should never be expected to play any part in the work of immigration enforcement, a practice that eradicates trust between patients and health care professionals. To achieve UHC clear firewalls between health care, as well as other social services and immigration enforcement should be put in place.

While restrictive migration policies, such as those predicated on containment, are themselves an exacerbating factor to peoples' health and wellbeing, containment settings, like those implemented on the **Greek** Aegean islands, often preclude access to needed healthcare. In Refugee Identification Centers (RICs) and Closed Control Access Centers (CCAC) on the Aegean Islands, where asylum seekers are confined for the duration of their asylum procedures, there is chronic understaffing of medical personnel and unsatisfactory facilities within state-managed reception centers, which have been reported as main obstacles for ensuring effective access to care. This is further exacerbated by the restrictions individuals face in obtaining services outside the RICs/CCACs.⁸⁴ The location of state-run centers, which are often in remote areas isolated from the host community, is reported as one of the main barriers to accessing secondary health facilities, even when individuals have a legal entitlement to do so⁸⁵.

MSF experience in **Poland** demonstrates that through inclusion of displaced Ukrainians, health systems can quickly adapt to needs of migrants, even during large and sudden influxes. Due to the Temporary Protection Directive, Ukrainians in Poland and other parts of the EU could have the same level of access to the health care as the local community. This has opened opportunities to integrate new models for continuation of care – for Ukrainian refugees and host populations alike. In close collaboration with the TB institute of Poland and the World Health Organisation (WHO), MSF has worked towards ensuring availability and accessibility of ambulatory and patient-centered tuberculosis treatment⁸⁷. Ukraine has a higher TB burden than Poland, as such, although Ukrainians benefitting from temporary protection have access to social security and national health care in Poland, treatment for tuberculosis and in particular for Drug Resistant tuberculosis (DR-TB) in the country was ill-adapted to patient-centered models of ambulatory care. Indeed, free tuberculosis treatment in Poland was contingent upon the hospitalization of patients for the duration of their treatment. Patients seeking out-of-hospital care for drug resistant tuberculosis, for example, were required to pay out-of-pocket for expensive drugs that are not covered by insurance and received limited patient support, while individuals with drug sensitive tuberculosis without national ID numbers faced administrative barriers in accessing online platforms required for prescriptions.

MSF has supported the shift to ambulatory care by donating the drugs for which patients were required to pay out-of-pocket and, through its operations on the ground, has engaged in active case finding, linguistically appropriate health information, medical case management in ambulatory care, and linking patients to existing TB services. This has since prompted a nation-wide introduction of full oral treatment in July 2022, the introduction of new national guidelines, and the piloting of a two-year Ministry of Health-led pilot project for drug resistant TB ambulatory treatment. This positive example shows how inclusive and innovative approaches to continuity of care for migrants are possible and can, indeed, be a catalyst for change in benefiting health systems as a whole.

Further action can be taken to ensure this inclusive access to health care for all. For instance, people without social security - which could include Ukrainians not benefitting from temporary protection and other groups of undocumented migrants – who do not have easy access to a GP, where early diagnosis can happen. They only have access to 'emergency care', typically at the point where TB is already very advanced. If the patient is admitted to hospital, treatment is usually free, however medicines and additional care needed to treat the side effects of tuberculosis represent costs that are not covered for those without social security.

.....moving towards inclusive and migrant-sensitive health systems

Access to care for migrants, is more than about the barriers, it is about creating equitable, inclusive and sensitive healthcare. there is a need to strengthen both service delivery and the system. To overcome the barriers highlighted above, a proper migrant-sensitive system should provide free of charge services, with availability of interpretation and language-appropriate written materials. To reduce discrimination, health care workers must be trained to be culturally sensitive and clear firewalls should be put in place – this will support efforts to build trust in the providers. The model of care should also account for the nature of risk factors and health determinants, together with health outcomes connected with social disadvantages this includes preventative, primary health and mental health care. Finally, at the center active and effective community participation and engagement in strengthening of health services may prove crucial.



4. LIMITATIONS OF HEALTH INSURANCE SCHEMES TO IMPROVE ACCESS BARRIERS AND UHC FOR VULNERABLE PEOPLE

In many of the universal health care (UHC) country plans, the option of health insurance scheme is put forward as the way to make progress in financial protection and improved access to care, possibly combined with various other subsidy schemes for specific health issues or people. Often the historic example of the so-called UHC-champion countries, such as Japan, certain European member states and other OECD countries are put forward. Although there are several health insurance schemes, evidence on these has shown limitations in health insurance coverage and difficulties in the attempt to increase it, especially in low-income contexts where both governments and populations have scarce financial resources. A recent estimation placed health insurance coverage at 7.9% in the low-income countries (LIC) and 12% in average across Africa. The enthusiasm for health insurance system as part of UHC road maps is often promoted by international technical assistance, adopting the models used in the high-income countries (HICs), while many low-and middle-income countries (L&MIC) are not equipped with many of the factors needed for success of such approaches.^{88 89}

These include current health expenditure per capita, quality care service which supports people's motivation to join health insurance system, and even demographics to include the whole population into the system. For example, the large informal sectors in L&MIC pose particular challenges to enacting social health insurance mechanisms. In these situations, alternative schemes or adapted phase-based approaches are crucial for no one to be left behind and to get access to essential healthcare.

In fact, the international community has sought different schemes from the ones which HICs use. For example, community-based health insurance (CBHI) is one of these. However, according to WHO, despite much previous hope in this scheme, the evidence^{90 91} suggests the impact of CBHI on financial protection and access to needed healthcare is moderate for those enrolled; it has low participation levels and the poorest people tend to remain excluded; theory and practice show that CBHIs play only a limited role in helping countries move towards UHC.⁹²

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In many UHC country road maps, the plans on health insurance schemes are dominated by their potential perspectives to raise additional revenues for health. However, there is also limited evidence on whether the schemes generate increased revenues to the health sector.

MSF has also witnessed the struggles of countries and populations on the way to develop their health insurance systems.

- In **Kenya** an estimated **19.9%** of the population has access to health insurance coverage, but this varies throughout the country. The monthly premium for National Health Insurance Fund (NHIF) is 1200 KSH (equivalent to 10 USD) per family and care can be obtained at an empaneled hospital where people have to register (at a cost equivalent of +/-10 USD). The NHIF covers in-patient and out-patient care at hospital level, but is limited for daily drug needs. For repeated or expensive care, insurance cover can be depleted after 3 to 4 days as a monthly capitation is applied; hospitals are reluctant to provide care when costs exceed the lump sum that the hospital gets reimbursed per patient cared for. The care package covered is limited as well, in particular in terms of medicines and laboratory exams provided free of charge. For instance, the high costs make Insulin not eligible for reimbursement. This makes that additional OOP expenses apply even for people with NHIF.

- In **Burundi** patients can buy a type of health insurance card, the Carte d'Assurance Mutuelle or CAM at the local health centre, giving payment reductions. Purchasing such card was until recently in average 3,000 FBu (equivalent of 1 USD) per person, but now might be increased tenfold, i.e. 30,000 FBu (equivalent to 10 USD). When MSF checked among admitted malaria patients, about half (**49%**) did not hold such a CAM card. With difficulties and delays in reimbursement, health facilities are reluctant to provide CAM-cards, as this basically means a loss of revenues for the facility. The package of care that can be accessed at a reduced price by CAM-holders is not very complete; patients need still to pay out-of-pocket (OOP) for certain medicines and services. Based on MSF experience, CAM card holders paid about **60%** of the initial cost, still a substantive cost (equivalent 3 and 5 USD). Other insurance schemes, such as for civil servants, the national health insurance fund or private insurances are not very much spread. Depending of the type of insurance, patients have to pay OOP one fifth or one third of initial costs.

Targeted enrollment can be obtained, including by international funding, like the initiative in **Rwanda** where membership fees for households with people living with HIV (PLHIV) are paid for by the Global Fund⁹³. The recent experience in **Senegal** of promoting health insurance among PLHIV and particular key populations such as men having sex with men (MSM) did not lead to the expected benefits. The number of PLHIV with coverage is low and the system showed limited effectiveness. In particular it proved ineffective in implementing free healthcare, as recommended. Patients would pay 11 USD for a routine consultation and consultation costs for MSM was almost threefold (eq to 32,5 USD)⁹⁴

An important concern is how health insurance schemes are perceived as complementary or rather as being in opposition to subsidy schemes that ensure care free-of-charge to targeted population groups. A combination should be, and is possible, but we have noted in several contexts that the health insurance scheme is perceived as THE dominant and sometimes the only option, seen as opposed to providing free care.



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In **DRC** for instance, the UHC plan includes a health insurance model with pre-payment of membership fee as a condition to access health care at a reduced cost. The community health insurance experiences have shown that most people cannot afford –even considered low- membership fees and coverage remains very low (below 10% mostly). Even for those with membership, care is not free of charge and the package of care offered is limited. The UHC-plan expresses the intention to end existing free-of-charge care and this creates a reluctance towards non-governmental actors like MSF to allow them to offer care free of charge, as this is perceived to ‘discourage’ people to pay for enrollment. The intention to raise future coverage could risk to sacrifice effective access to care for the health problems of today. Clear and reasonable eligibility guidelines for effective combination of the schemes are critical.

Another trial for UHC is the combinations of public and private-for-profit schemes. However, there are additional risks of increased OOP spending. This includes governments’ subsidies to health insurance schemes that include services from private care providers. For these schemes, there is poor regulation of the private actors, who face the potentially contradictory goals of profit maximisation and enhancing public health objectives. There is little evidence that for-profit healthcare schemes improve healthcare outcomes, and strong evidence that they increase costs and reduce efficiency.⁹⁵ They are often associated with denial of care, double charging, upselling unnecessary procedures by private-for-profit providers. Public financing of private healthcare brings many contradictions and political tensions that are difficult to navigate. The intention of involving the private sector in UHC country plans need to be accompanied with some specific caution towards private-for-profit health care schemes^{96 97 98}, including by international aid support.^{99 100}

Last but not least, a point of UHC to be raised is about **displaced populations or populations on the move**. Enrollment into health insurance schemes is problematic for refugees, migrants and people



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without the right papers or administrative status. In many countries the national health insurance schemes legally do not allow non-residents to join or has no state subsidized enrollment available for those unable to pay. This makes access to care disproportionately more difficult and more expensive for these vulnerable groups.

UNHCR and other international agencies might pay for enrollment of refugees, displaced or migrants into existing schemes, but the funding channel might not be as effective as expected to ensure access and financial protection, compromising people’s health needs. These arrangements also critically depend on the ability of the existing health system to provide timely quality care. In many countries, patients face a lack of eligibility or even availability of the medical items they need, forcing them to purchase higher priced medicines in the private sector.

As such, there are considerable evidences of limited financial protection as well as inequality and fragmentation on the way to seek for possible but needed financial protection measures. Although health insurance schemes intend to mitigate households’ OOP spending, protective effects against OOP expenses have been limited in practice in many L&MICs and populations in unstable settings. Moreover, the current indicator of OOP expenditure underestimates the financial burden on households as it excludes spending on health insurance premiums, which can cost a substantial portion of people’s income and in itself could contribute to catastrophic health expenditure¹⁰¹.

In these conditions, health insurance schemes probably will not protect people most in need; they continued to be deprived of access to essential care and face serious risks to be left behind.

5. CONCLUSIONS

Several reports have highlighted the failure to reach UHC according to plan, with important losses in coverage and financial protection. At the current pace of progress, the UHC-objectives for 2030 cannot be reached. Moreover, we see increased gaps and a higher burden placed on patients and communities.

Much of the lack of progress can be linked to the effects of the COVID-19 crisis on health systems and economics, but a critical review of the strategies in use is necessary, as already before, progress was insufficient and unequal, in particular for certain contexts and among certain population groups. Adapting the existing strategies to the new post-COVID-19 situation, based on lessons learned on what works and what less, is urgent to improve access to care and to leave no one behind. Also a revision of the current UHC-indicators and their disaggregation for specific groups at risk is needed to better focus on the key issues at stake and measure effectiveness of the responses.

When the objectives of UHC were set within the broader SDG framework, the resources were projected to come mainly from domestic financing, but this seems now an unrealistic scenario in many countries. The importance of international solidarity for better health - beyond health security and other transformational agenda's - is critical. In order to make tangible progress within the ambitious timeframe of UHC, the burden cannot be left to countries most affected by ill health and precarity. Without consistent international support, the burden risks to be shifted to communities and individuals.

The reality of today's economic crisis hits many L&MIC, creating higher poverty rates and precarity, leading to austerity measures and public health budget cuts, hampering people's timely access to effective health care responses. In order to reach the UHC-targets within a reasonable timeframe in most L&MIC (and in several countries even to counter the losses endured), there is a need for additional international resources, at least for a certain period. It is of concern that international funding for health shows a stagnating or even downward trend. In many countries the direct consequences of cuts in international aid are felt already in health service provision and access, as illustrated in this report.

Such critical rebalancing of prospects in domestic and international financing will need to be accompanied by revised priority setting and strategies adapted to today's situation. We would argue that a renewed focus on the most acute health needs, the vital access gaps and the most vulnerable people is needed, certainly to live up to the intended SDG principle of 'leaving no one behind'. A return to basics as it were, but with ambitious objectives to turn around the major access problems faced today by the most vulnerable.

Access to care is an enormous problem today, which requires urgent attention and action, also as part of the UHC agenda. To make a significant difference for people facing access barriers on a reasonable short term is not only important, but also would raise credibility of UHC-plans.

In this report we highlighted the access problems witnessed by MSF teams at patient, community and health facility level, that get insufficient attention and sometimes are ruefully neglected.

- There are few concrete actions proposed to mitigate financial barriers that cause patients to forego care. In contrast with measures on financial distress, monitoring indicators of the health consequences of these financial barriers -such as forced to go without the required care- are currently not tracked. Most UHC country plans fail to set objectives to reduce OOP and their effect on exclusion and delayed care. It's also concerning that insufficient attention goes to user fee reduction or exemptions in public health services, which are an important part of out-of-pocket expenses required from patients. Several countries have very important government policy initiatives that exempt certain patients and services from payments but now these are at risk of being undone because of lack of financial support; the documented benefits in access and impact on people's health and mortality risk to disappear with them.
- Access to health care is in particular under strain in crisis situations, such as in conflict, epidemic outbreaks, forced displacement, natural disasters etc; there are immediate short terms gaps in the response to people's health needs but often access to care is hampered over longer time. In most UHC country plans the health issues linked to crisis situations are neglected, often absent even. Even in countries that frequently face emergency situations, adapted scenarios are missing. When crisis hits, long term paths to UHC described in the countries' UHC-roadmaps are mostly unfeasible and need a change in orientation or even suspension in order to ensure timely access to care.
- People on the move face huge barriers in accessing timely, adequate and continued care. Currently most policies are restrictive and deterring towards migration, completely neglecting people's specific needs to access care and rather causing discrimination and exclusion. Even if disproportionately vulnerable, we see that access to care for migrants and refugees is simply not taken into account in country plans for UHC.

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6. RECOMMENDATIONS

As a medical humanitarian organization, our expertise is not necessarily in health systems financing or in enabling greater fiscal space for health, but rather in providing or supporting healthcare itself. We focus on options that can make a direct difference for patients to access the necessary essential care and in particular for vulnerable people in precarious situations. Our recommendations therefore derive from practical experiences from the delivery of healthcare – often in difficult settings.

RECOMMENDATION 1:

During and in immediate follow up of the upcoming UHC High Level meeting, we ask all participants to heighten the focus on urgent action to tangible improvements of people's access to essential care and in particular for the most vulnerable.

This implies clear, strong and specific objectives on:

- reducing existing financial barriers that make people forego care
- improve access to care during crisis situations
- improved responses to health needs and access to care for migrants and refugees

Measuring progress towards such objectives includes an adequate choice of selected indicators within the framework of assessing UHC progress. As reported by WHO, forgone care may not be picked up in current UHC indices and metrics. It is important that we explicitly record this – and challenge it. We need specifically and explicitly to measure forgone care, with disaggregated data on disaggregated data, especially among poorer and vulnerable people, including during crisis periods. To measure real impact of access barriers it's necessary to organize independent verification and reporting by CSO on OOP expenses and patient payments at facility level. We recommend also a systematic critical review of country plans to evaluate their inclusivity and adaptation to migrant & displaced populations. Additionally, it's recommended to install a reporting mechanism on patient abuse, such as refusal of access to care or detention by the health facility when unable to pay.

RECOMMENDATION 2:

Ensure priority support to initiatives providing subsidized health services under exemptions of patient payments for broad population groups, specific vulnerable people and key health services with important public health impact.

Following the COVID-19-crisis and current economic problems worldwide, already important gaps in the public health budget undermine the offer and access of health services. Patients face increased OOP expenses, both in public services and in private alternatives. Poverty is expected to further increase, leading to widening unaffordability of health care for more households. All this makes it more urgent even to take concrete, targeted measures to reduce financial barriers and burdens on patients. It's highly concerning that user fees are planned to increase in many L&MIC and national exemption policies are at risk of being turned back or restricted.

When medical supplies are already funded, extra subsidies to suspend patient fees for services or additional payments are critical to ensure their optimal use.

Free of charge essential health services have shown to bring substantive gains in accessing care overall and on time, in reducing mortality and impacting positively people's health; UHC-plans should include its continued support, with funding explicitly directed at purchasing care provision under such free-of-charge conditions.



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RECOMMENDATION 3:

All countries are encouraged to update their UHC country plan with a specific chapter that includes principles and practical modalities for effective and timely service delivery for urgent health needs during crisis and emergency situations.

Currently many countries face multiple crises. Such crisis affects people’s ability to pay for healthcare as well as public health service capacity and resourcing. Frontline health workers are under significant strain and face important risks, especially in compounding and protracted emergencies; in conflict in particular, the protection of health workers as well as of the wounded and sick is important.

In order to respond effectively and rapidly to additional and pre-existing health needs, specific adaptations to health service delivery and health systems support are necessary. Some of the priorities include suspension of user fees, ensuring uninterrupted availability of medical supplies and adequate support to remuneration and working conditions of frontline health workers. Community based and led approaches have also proven to be critical during crisis. Some financial schemes are unsuited to crisis situations and will need to be put on hold. The development of such strategic approaches for crisis should be developed by inclusive collaboration with all relevant stakeholders and experts.

RECOMMENDATION 4:

UHC country plans should ensure systematic, pro-active and effective inclusion of migrants, refugees and displaced, asylum seekers, undocumented people and other marginalized groups.

The issue of migration and health is a defining issue for global public health and UHC, as well as an area of humanitarian concern. It is urgent to better acknowledge and respond to the health needs of migrants and their precarity in accessing health care; access barriers are shaped by social and political inequity, including by increasingly restrictive migration policies, aimed at deterring and detaining people. Health systems must allow for the legal and effective access of health for all, regardless of documentation status. Country plans to implement UHC must eradicate the bureaucratic, financial, linguistic, discrimination and other barriers to accessing healthcare at all levels, including preventative care for migrants. The models of care offered should also account for the risk factors from political and social determinants of health faced by migrants and beyond emergency care, they should incorporate preventive, primary, and mental healthcare.

As part of the UHC reporting, disaggregated data on specific access indicators for these population groups have to be included to measure the extent to which access is effective; an international specific monitoring & reporting mechanism should be developed and implemented in and across countries, allowing to document challenges in access for migrants and other displaced people.

Engagement with migrant communities on countries’ UHC- roadmaps is critical to include and achieve solutions to migrant health challenges.

RECOMMENDATION 5:

Revise the balance of domestic and international funding for UHC plans, based on realistic assessments of post-COVID-19 prospects. International funding initiatives should support the basics of access to care to avoid further gaps and losses, focusing on the most vulnerable first.

Following the COVID-19-crisis and current economic problems worldwide, the expectations of domestic resource mobilization levels from public sources have to be reviewed downward in many countries. Moreover, goals of mobilization of domestic financing cannot lead to increased OOP expenditure. With restricted fiscal space, already important gaps in the public health budget undermine service delivery and access to essential care. Without a (temporary) injection of international funding to boost health in L&MIC, there is a real risk that the UHC-targets will become even more off track and that people already facing access barriers will face even more difficulties. This aid must also prioritise vulnerable populations such as migrants, those fleeing conflict or living in crisis situations.

RECOMMENDATION 6:

Improve the quality of meaningful involvement of patients, communities and civil society in the processes to develop and evaluate UHC-country plans.

The quality of UHC country plans depends on the level of involvement of all stakeholders in health. Unfortunately, in many countries participation of patients, communities and civil society organisations in the process has been too limited.

In order for the UHC targets to act upon the slogan 'Leave no one behind', it's critical to include more attention and action for those people that currently face the strongest access barriers. A strong priority focus is required on the needs of the most vulnerable first: those now forced to forego care, those in crisis situations and those with vulnerability linked to migration.



ANNEXE: KEY COUNTRY INFORMATION

	Afghanistan	Belgium	Burundi	CAR	DRC	Greece	Guinea	Haiti	Italy	Kenya	Lebanon	Mali	Mexico	Mozambique	Poland	Sierra Leone	South Africa	South Sudan	Zimbabwe
Population (millions) 2022 ¹⁰²	41	12	13	6	99	11	14	12	59	54	5	23	126	33	38	9	60	11	16
GDP per capita PPP ¹⁰³	1,674	65,024	836	967	1,337	36,834	3,187	3,305	51,865	5,764	14,330	2,517	19,547	1,468	43,268	1,931	15,905	1,182	2531
Category LIC; LMIC; UMIC; HIC ¹⁰⁴ , 2022 & 2023	LIC	HIC	LIC	LIC	LIC	HIC	LIC	LIC	HIC	LMIC	UMIC	LIC	UMIC	LIC	HIC	LIC	UMIC	LIC	LMIC
Human Capital Index (HCI) (scale 0-1), 2020 ¹⁰⁵	0.4	0.8	0.4	0.3	0.4	0.7	0.4	0.4	0.73	0.5	0.5	0.3	0.6	0.4	0.8	0.4	0.4	0.3	0.5
UHC service coverage index 2021 (1-100) ¹⁰⁶	41	86	41	32	42	77	40	54	84	53	73	41	75	44	82	41	71	34	55
UHC service coverage MNCH, 2021 (1-100) ¹⁰⁷	46	>80	58	38	40	>80	44	49	86	73	75	47	85	60	>80	72	76	29	72
UHC service coverage Infectious diseases, 2021 (1-100) ¹⁰⁷	32	>80	55	39	44	>80	51	57	90	53	>80	55	72	56	>80	39	68	28	52
UHC service coverage Noncommunicable diseases, 2021 (1-100) ¹⁰⁷	57	67	71	54	70	62	67	64	71	72	49	72	67	66	48	63	50	72	64
UHC service coverage Service capacity and access, 2021 (1-100) ¹⁰⁷	23	>80	17	14	18	83	13	27	90	35	>80	16	78	22	>80	13	>80	18	37
Current health expenditure (% of GDP) ¹⁰⁷	16.8	11.1	6.5	9,4	4,1	9,5	4	3,2	9,45	4,3	8	4,3	6,2	7,6	6,6	8,8	8,6	5,3	3,4
Current health exp.per capita, PPP (current international \$) ¹⁰⁸	322.5	5,883	46.2	84,1	44,6	2653	110,5	100,6	3351,5	203,2	1058,5	96,5	630,6	99,1	2528,5	146,5	1156,7	54	118,1
Out-of-pocket expenditure (% of health expenditure) ¹⁰⁸	77.2	16	30.2	51,9	39,7	33,4	47,3	46,9	21,28	24,1	44	28,7	38,8	10	20	55,7	5,4	32,2	10,4
Out-of-pocket expenditure per capita, PPP (current international \$) ¹⁰⁹	241.3	943.7	14	43,7	17,7	887,1	52;3	47,2	956,68	48,9	468,3	27,7	462,3	9,9	494,6	81,7	62	12,5	12,3
Catastrophic health expenditure ¹¹⁰ [%]	26	11	5	7	5	17	2	12	9,29	5	27	2	4	4	16	16	1	12	12
External health expenditure [% of current health expenditure], ¹¹¹	19.4	0	31	34,4	37,5	0,2	22,5	30,6	0	17,9	0,8	35,6	0	52,1	0,1	28	1,3	63,6	55,7

ABBREVIATION LIST

ACT	artemisinin combination therapy (malaria)	MIC	Middle Income Country/ies
AHD	advanced HIV disease	MoH	Ministry of Health
AMU	aide médicale urgente (urgent medical help)	MSF	Médecins Sans Frontières
ART	anti-retroviral therapy (for HIV)	MSM	men having sex with men
ARV	anti-retroviral(s)	NCD	non-communicable disease(s)
BEmONC	basic emergency obstetric and neonatal care	NGO	non-governmental organisation
CAM	Carte d'Assurance Maladie	NHI	National Health Insurance
CAR	Central African Republic	NHIF	National Health Insurance Fund
CBHI	community based health insurance	OCASS	Observatoire Citoyen d'Accès aux Services de Santé (Guinea)
CBO	community based organization	OECD	Organisation for economic cooperation and development
CCAC	closed control access centers	OOP	out of pocket
CD4-count	laboratory test that estimates immunity levels	OOPE	out of pocket expenses
CEmONC	comprehensive emergency obstetric and neonatal care	PEPFAR	the President's Emergency Plan For AIDS Relief (USA)
C-section	caesarean section	PHC	primary health care
COVID-19	Corona Virus Disease 2019 (infectious disease caused by the SARS-CoV-2 virus)	PICT	provider induced counselling & testing (HIV)
CrAg	lab test to detect cryptococcal antigen in body fluids	PLHIV	people living with HIV
CRP	community revolving pharmacy	PMI	the President's Malaria Initiative (USA)
CSO	civil society organization	PMTCT	prevention of mother-to-child transmission
DRC	Democratic Republic of Congo	PPE	personal protective equipment
DR-TB	Drug Resistant Tuberculosis	PPR	pandemic preparedness & response
ECHO	European Commission humanitarian aid & civil protection	PWUD	people who use drugs
EPI	Enlarged Program of Immunisation	RDT	rapid diagnostic test
EU	European Union	RIC	refugee identification centers
FBu	Franc(s) Burundais (currency of Burundi)	SDG	Sustainable Development Goals
FG or GF	Guinean Francs (currency of Guinea)	SRH	sexual & reproductive health
FHCI	Free Health Care Initiative (Sierra Leone)	SW	sex workers
GAVI	the Vaccine Alliance	TB	tuberculosis
GBP	Great Britain Pound (currency in UK)	THE	total health expenditure
GF or GFATM	the Global Fund for AIDS, TB & Malaria	UCOP+	l'Union Congolaise des Organisations des Personnes Vivants avec le VIH
Gourde(s)	currency in Haiti	UHC	Universal Health Coverage
GP	general practitioner (family doctor)	UK	United Kingdom
HIV	Human Immunodeficiency Virus	UMIC	Upper Middle Income Country/ies
HLM	High Level Meeting	UNAIDS	United Nations program for AIDS
HPF	Health Pool Fund (South Sudan)	USA	United States of America
HRH	Human Resources for Health	USD	US Dollar
HRP	Humanitarian Response Plan	UNFPA	United Nations Population Fund (UNs sexual and reproductive health agency)
ID	identity card	UNHCR	United nations High Commission for Refugees
IHL	International Humanitarian Law	VCT	voluntary counselling & testing (HIV)
IOM	International Organisation for Migration	VIP	very important person(s)
Le	Sierra Leones (currency of Sierra Leone)	VL	viral load
LIC	Low income Country/ies	WB	World Bank
L&MIC	Lower Middle Income Country/ies	WFP	World Food Program
KSh	Kenyan Shilling (currency of Kenya)	WHO	World Health Organization
LLIN	Long lasting insecticide treated nets		

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**Missing (from) the UHC-Targets:
Leaving behind the most vulnerable
September 2023**

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