"27 things you need to do about UHC's most important challenges"

Gender equality

1. Name it. Speak explicitly of the disproportionate burden that women and girls shoulder around the world. Gender should be at the forefront and be an integral part of all UHC accessibility, quality and affordability discussions. Currently the word 'gender' is mentioned in merely one paragraph on page 69 of the declaration. Collect, analyze and report gender disaggregated data to underscore urgency. Prioritize.

2. Be inclusive. Gender is often associated with women but we should make a deliberate effort to also include the needs of trans-, non-binary and male people. Emphasize that gender is one important axis of inequality which often cannot be seen separate from other factors such as ability/disability, socio-economic class, race, age/widowhood, sexual orientation, etc. Make it intersectional and contextual.

3. Hear their voice. Invest in the training and mentoring of female young leaders in different fields (politics, health, advocacy). Fund grassroots women's organizations, and strive for meaningful representation at all levels.

4. Redress the workforce imbalance. There is little participation of women at higher levels of the healthcare workforce, while professions that are "feminized" are underpaid – such as nurses and community health workers. Redress. Invest in enabling work-family combinations. Recognize and value unpaid care work and the role it plays in health.

5. Share success stories. We need more champions to advocate for the importance of taking into account gender in UHC – female, male as well as from the LGBT+ community; sharing success stories, and creating linkages with others sectors (for example soccer, with USA player Megan Rapinoe).

Health financing

6. Improve planning and efficiency. Many governments – especially at subnational levels, face challenges in financial spending and planning. This leads to suboptimal allocation of resources, a failure to reach those populations in greatest need, and substantial amounts of health funding remaining unspent. Strengthen the financial planning capacity in LMICs, enhance budgetary transparency and make funding/spending horizons more flexible and longer-term.

7. Horizontalize. A large share of external funding is vertical, not aligned to national health plans, not coordinated and not harmonized with national systems. Horizontalize vertical funds and provide global funding for basic care.

8. Political will is key. Keep on calling for increased allocation to health in order to reach the minimum targets of 5% of GDP for public spending or an absolute level of 100 USD per person per year. UHC

success stories (including Costa Rica, Thailand, Rwanda, Mexico, Chile) were brought about by high-level political will in combination with evidence-based policy-making.

9. Power to the people. Support bottom-up, decentralized and community-based solutions. Increase the status of lower-level cadres that play a crucial role in public health, such as general practitioners and community nurses. Inform citizens of their rights so that they can demand what they are entitled to.

10. Go local and improve transparency. Encourage local business models that enhance transparency. Consider digital solutions such as mobile technologies and mobile money to increase efficiency, effectiveness, accessibility and quality of care.

11. Put your money where your mouth is. Donors are often quick to withdraw their development assistance in cases of abuse and corruption, but less willing to accept responsibility when it comes to illicit financial flows, tax evasion, tax avoidance and trade. Make real changes in international economic relations and refrain from trade relations with corrupt regimes.

Accountability and the role of communities

12. Invest in accountability mechanisms. Accountability is an essential element of Universal Health Coverage. This accountability should address and include representatives from all other stakeholder categories, such as civil society organizations, women's groups, youth groups, service providers, policy makers, private sector parties and many others. The diversity within (and beyond) these categories should be recognized and addressed.

13. Support the media. For citizens and communities to stand up for their right to health, the role of local and national media can be pivotal, for example to raise awareness or share relevant information. Support for their function towards an open and democratic society is therefore essential.

14. Use digital technology as a powerful driver of increased accountability. With so many mobile applications available to the public, the possibilities for sharing data and information, for making use of the 'wisdom of the crowds', and for mobilizing people and organizations, are almost endless. Smart and targeted use of such applications can greatly contribute to better accountability mechanisms.

Health workforce

15. Put more emphasis on disease prevention. The burden on a country's health system (and thus: on its health workers) can be alleviated by investing more in primary prevention: vaccination, safe drinking water, sanitation, hygienic behavior, adequate housing, education and health literacy, quality nutrition, lifestyle changes.

16. Address health workforce shortages with context-specific solutions. Not all countries lack students, or training facilities, or jobs – but some do. (Further) task shifting is not in every context a sound solution when the end goal is quality care for all. Health worker mobility is not always a problem, and does not always have the same drivers. A thorough labor market analysis is needed to formulate realistic and context-specific solutions for actual problems.

17. Explore digital solutions but take care that no one is left behind. There is great scope for the implementation of digital solutions for self-management and telemedicine. Mobile technology and applications have enormous potential to support communication between patients and health workers in remote, inaccessible and underserved areas. However, experience shows that such

innovations tend to mainly benefit the better educated and more well-to-do sectors of society, thus increasing health inequities.

18. Pool donor funding. The health sector needs more resources, specifically for health worker salaries. Donors have a tendency to provide extensive and repeated in-service training for their own programmatic (shorter-term) purposes, and/or pay for staff salaries only for the duration of their programs. This does not contribute to sustainability. Longer-term financial commitments are needed to train, deploy and retain health workers. This can only be achieved through pooling of funds and investments in a joint & context-specific health workforce development plan.

Sexual and Reproductive Health and Rights

19. Build alliances. As various donors focus on different goals within the SRHR agenda, programs overlap or gaps will emerge. Moreover, financially this will result in inconsistent and fluctuating funding streams. Alliances are therefore essential to streamline efforts and build sustainable services and civil society networks.

20. Take into account the local context. Sexual and Reproductive Health and Rights sometimes tends to be a donor driven agenda from a global north perspective, whereby local uses and cultures are overlooked. Using the local context, stakeholders, actors and bottom up approaches might accelerate progress, instead of resistance.

21. Bring fields together. A silo'ed approach may lead to some areas of SRHR being well covered, especially reproductive health and some being neglected or missed out on, such as sexual health and rights, thereby risking incomplete service coverage. Within SRHR, national governments 'cherry-pick' issues that are comfortable for them to work with and avoid the more contentious areas.

22. Build on existing knowledge of integrating programs, such as HIV and Aids and TB to strengthen the linkage between SRHR and UHC. Some elements of the comprehensive sexual and reproductive health agenda will be linked more easily to UHC than others.

23. Safeguard that Universal Health Coverage is really about inclusiveness & equity. Ensure that really no one is left behind and those furthest left behind are reached first. Governments may focus on low hanging fruit and easy to reach targets, thereby leaving behind vulnerable groups that are denied access to services, such as young people and the LGBT+ community

Quality of Care

24. Support initiatives to hold health services to account in terms of quality of care. This accountability has two gradients: quality of care in the perception of the community, in order to ensure that services are responsive; and quality of care from a clinical perspective, in order to achieve that patients are treated correctly and according to the latest guidelines. Accountability should have consequences (incentives and sanctions) linked to their findings.

25. Invest in "social accountability" to improve quality of care. This includes, but is not limited to, patient satisfaction surveys and community participation (voice and vote!) in defining criteria for good quality services, and in formulating consequences of delivering poor quality health care.

26. Increase investments for long-term impact. More resources are needed for the structural and systemic elements of quality of care. This includes long-term financial commitments to create and sustain the minimal conditions for the delivery of quality care: suitable facilities with the necessary utilities, availability and maintenance of appropriate medical equipment, reliable and continued

supply of commodities, steady presence of fit-for-purpose and motivated health workers with the necessary skills and accreditations.

27. Involve the private sector and be clear about their expected contributions. The private sector (for profit and not for profit) can contribute substantially to a strong health sector. Their activities should complement the public sector and fit within a national UHC program with contracted services that meet the same standards for quality of care and for the required health (services) information. Not doing so will increase the risk of fragmentation and undesirable differences in quality of care.