AFRICA COALITION ON TUBERCULOSIS

COPPER
Communities in Pandemic Preparedness & Response

Integrating Pandemic Preparedness and Response (PPR) with Universal Health Coverage (UHC)

Communities and Civil Society guide on UHC and PPR

Definition of Key terminologies

Community Health Worker (CHW): Provide health education and referrals for a wide range of services, and provide support and assistance to communities, families and individuals with preventive health measures and gaining access to appropriate curative health and social services.

Community-led Monitoring (CLM): is an evidence-informed mechanism that can support health programme managers and service providers to identify and address local challenges in accessibility, acceptability, affordability and quality of prevention and treatment commodities, services and programmes.

Early Warning and Response (EWAR): Defined by the WHO as the organized mechanism to detect any abnormal occurrence or divergence from the usual or normally observed frequency of phenomenon (e.g. disease outbreaks, natural disasters, civil unrest, etc.) as early as possible.

Epidemic: an outbreak that occurs in a restricted geographical area.

Healthcare Infrastructure: this includes healthcare facility capacity, equipment, supplies, workforce training and readiness and referral systems.

Hyperendemic: refers to persistent, high levels of disease well above what is seen in other populations.

Incidence: is the rate at which new cases of a disease or condition occur in a population over a period of time.

International Health Regulations (IHR): agreement between all WHO Member States to work together for Global Health Security. Under the IHR all counties commit to report events of international public health importance.

Joint External Evaluation (JEE): is a voluntary, collaborative, multisectoral process to assess country capacities to prevent, detect and rapidly respond to public health risks whether occurring naturally or due to deliberate or accidental events.

Mortality: the estimated total number of deaths in a population of a given sex and /or age, divided by the total number of this population, expressed per 100,000 population, for a given year, in a given country, territory, or geographic area.

One Health: is an integrated, unifying approach that aims to sustainably balance and optimize the health of people, animals, and ecosystems. It recognized the health of humans, domestic and wild animals, plants, and the wider environment (including ecosystems) are closely linked and interdependent.

Out of pocket health spending: is any direct outlay by households, including gratuities and in-kind payments, to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services whose primary intent is to contribute to the restoration or enhancement of the health status of individuals or population groups.

Outbreak: a disease outbreak is the sudden occurrence of disease cases in excess of what would normally be expected in a defined population, geographical area, or season.

Pandemic Response Plans: National level plans developed by the government that include preventive measures testing and contact tracing, vaccination strategies.

Pandemic Preparedness and Response: An ongoing cycle of planning, training, organization, equipping, exercising, evaluation, and improvement activities to ensure effective coordination and enhance capacity to prevent, protect against, control, and provide a public health response to pandemics.

Pandemic: an outbreak that may extend over several countries it causes significant morbidity and mortality over a wide geographic area and can affect an exceptionally high proportion of the population.

Primary Health Care: essential health care made universally accessible to individuals and acceptable to them, through their full participation and at a cost the community and country can afford.

Response: any action triggered by the detection of a health risk.

Social Determinants of Health (SDH): non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.

Surveillance Systems: include early warning systems, data collection analysis and use and laboratory capacity.

Universal Health Coverage: means that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship. It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course

Overall UHC status and relevant policy frameworks

Universal Health Coverage(UHC) means that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship. It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course. The Sustainable Development Goals (SDGs) 3.8 commits to "Achieve universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all" by 2030.

Besides contributing to SDG 3 (Ensure healthy lives and promote well-being for all at all ages) and SDG1 (End poverty in all its forms, everywhere), UHC can make a significant contribution to many of the other SDGs. UHC promotes improved nutrition (SDG2)—nutrition-related interventions are a core part of comprehensive health benefit packages. Strong health systems support educational goals (SDG4) because more children are healthy enough to attend school and families can afford schooling and gender equality (SDG5), by ensuring women and girls receive the necessary services they need. UHC also can play an important role in economic growth (SDG8), and peaceful and inclusive societies (SDG16), as healthy populations help build effective, accountable and inclusive institutions at all levels.

According to WHO, at least half the world's population is not covered by essential health services. Communicable diseases, such as HIV, TB and malaria have the worst impact on the poorest and most marginalized communities. In all countries - whether low, middle or high income - wide health gaps remain between the rich and poor. Weak health systems account for many of these gaps, highlighted and made worse by the COVID-19 pandemic.

Looking at current state of UHC;

- The world is off track to make significant progress towards universal health coverage (Sustainable Development Goals [SDGs] target 3.8) by 2030. Improvements to health services coverage have stagnated since 2015, and the proportion of the population that faced catastrophic levels of out-of-pocket health spending increased continuously since 2000. This global pattern is consistent across all regions and the majority of countries.
- The UHC service coverage index increased from 45 to 68 between 2000 and 2021. However, recent progress in increasing coverage has slowed compared to pre-2015 gains, rising only 3 index points between 2015 and 2021 and showing no change since 2019.
- The proportion of the population not covered by essential health services decreased by about 15% between 2000 and 2021, with minimal progress made after 2015. This indicates that in 2021, about 4.5 billion people were not fully covered by essential health services.
- About 2 billion people are facing financial hardship including 1 billion people experiencing catastrophic out-of-pocket health spending (SDG indicator 3.8.2) or 344 million people going deeper into extreme poverty due to health costs.

- The COVID-19 pandemic further disrupted essential services in 92% of countries at the height of the pandemic in 2021. In 2022, 84% of countries still reported disruptions.
- To build back better, WHO's recommendation is to reorient health systems using a primary health care (PHC) approach. Most (90%) of essential UHC interventions can be delivered through a PHC approach, potentially saving 60 million lives and increasing average global life expectancy by 3.7 years by 2030.

The proportion of the world's population, which spent more than 10% of its household income on medical care, increased from 9.4% in 2000 to 12.7% in 2015, amounting to about US$927 million. The percentage of the population spending more than 25% of their family budget on health care also increased from 1.7% in 2000 to about 3% in 2015.

87% of the population that suffered huge out-of-pocket expenditures in 2015 were in middle-income countries. About 1 billion, or 12.9% of the population, were expected to spend at least 10% of their family budget on medical care by 2020.

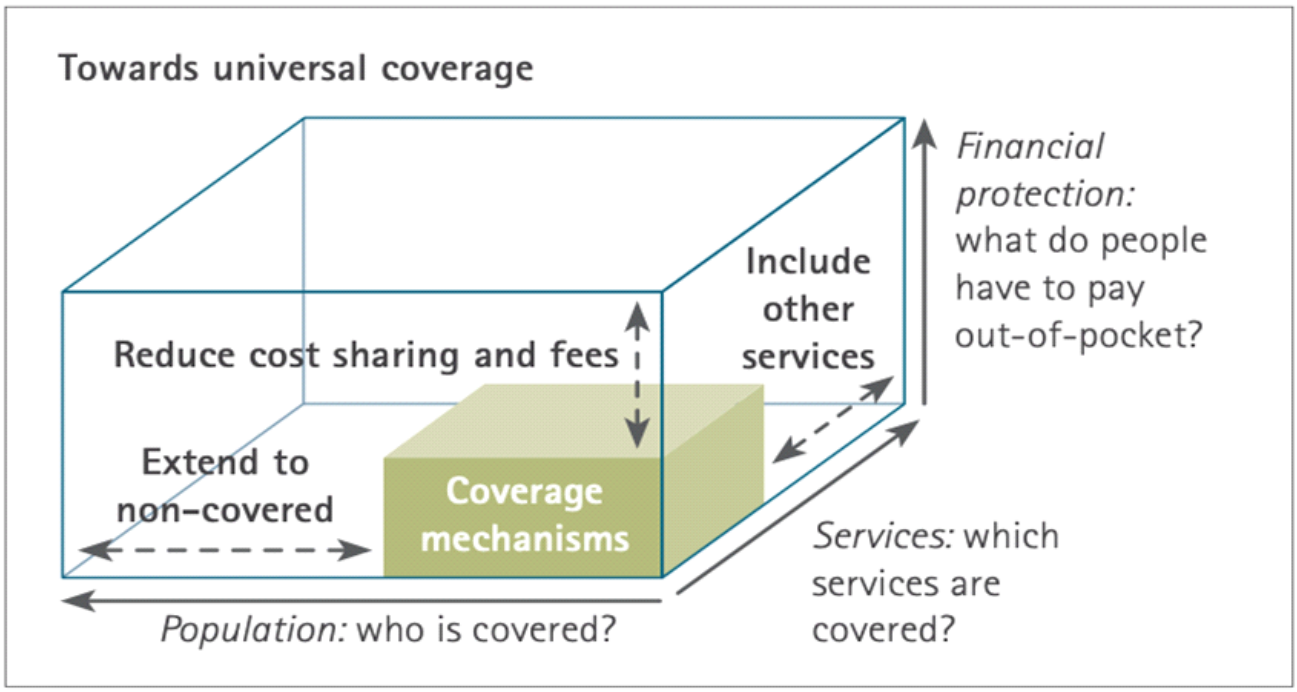
The Pandemic Accord recognizes UHC as “an essential foundation for effective pandemic prevention, preparedness, response and recovery”. This contribution was a reflection of critical lessons the world has learned from previous epidemics, such as the West Africa Ebola outbreak of 2014-2016. Communities and civil society have played a crucial role in UHC implementation and Pandemic Preparedness and Response (PPR), including holding governments accountable during pandemics. Now more than ever, communities and civil society need to actively participate; through advocacy, implementation, M&E, and provide their valuable expertise and knowledge, especially by strengthening accountability measures for UHC and PPR as they have;

- Understanding of community needs and priorities
- Knowledge of local context
- Knowledge of challenges to implementing public health actions
- Ability to reach marginalized communities.

Community engagement by nature is not a guaranteed tactic to advance equity. To actualize its full potential, community engagement must be designed with equity as its leading principle through engagement of diverse communities and accounting for power imbalances. By fostering trust and mutual respect, exposing unforeseen or unintended barriers to health, and improving program efficacy by accounting for the experiences of the people impacted by programs and policies, community engagement can promote equity.

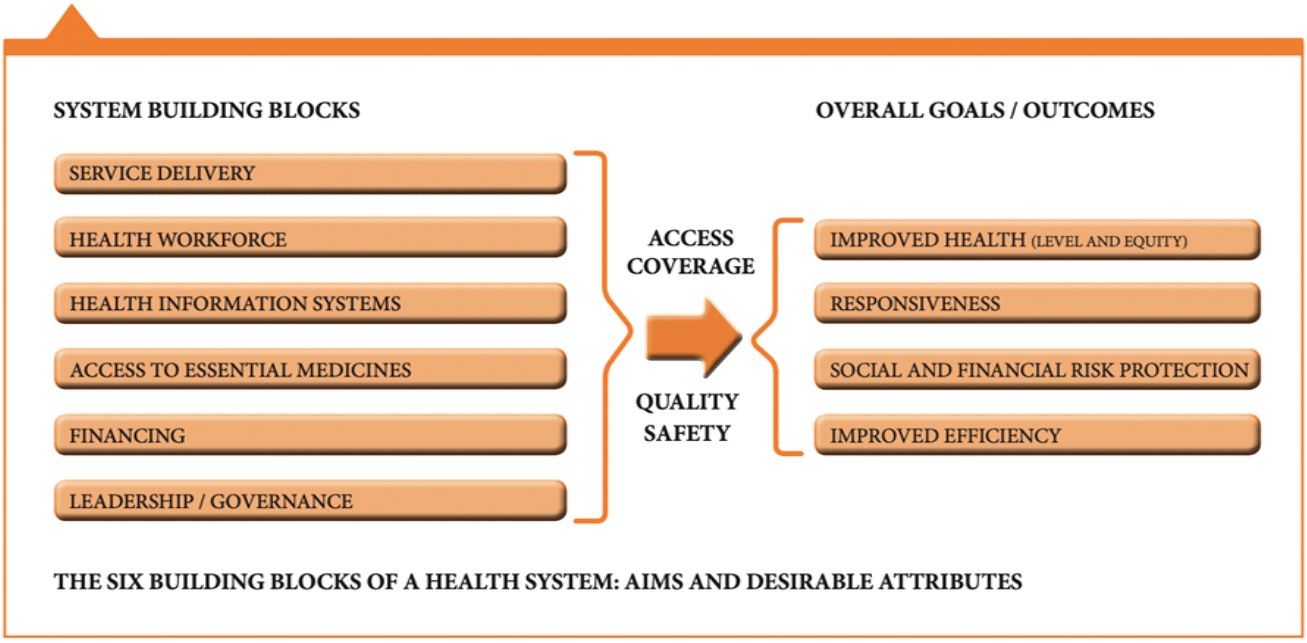
Communities and civil society have for long been calling for equitable access to health care irrespective of the ability to pay and without discrimination. Communities and civil society call for a just and equitable health services can be well captured by the UHC cube which proposes for an equilibrium to achieve UHC. The UHC cube encompasses three dimensions: coverage for everyone (breadth), type and number of needed health services covered (depth) and the proportion of total health service costs that are publicly funded and not subject to cost sharing (height), also referred to as financial risk protection.

In order to improve UHC and PPR, we need to understand health systems and how each programs interact. A health system consists of all the organizations, institutions, resources and people whose primary purpose is to improve health. This includes efforts to influence determinants of health as well as more direct health-improvement activities. The health system delivers preventive, promotive, curative and rehabilitative interventions through a combination of public health actions and the pyramid of health care facilities that deliver personal health care by both State and non-State actors. The actions of the health system should be responsive and financially fair, while treating people respectfully. A health system needs staff, funds, information, supplies, transport, communications and overall guidance and direction to function. Strengthening health systems thus means addressing key constraints in each of these areas. 9



WHO UHC Cube diagram, 2010 World Health Report

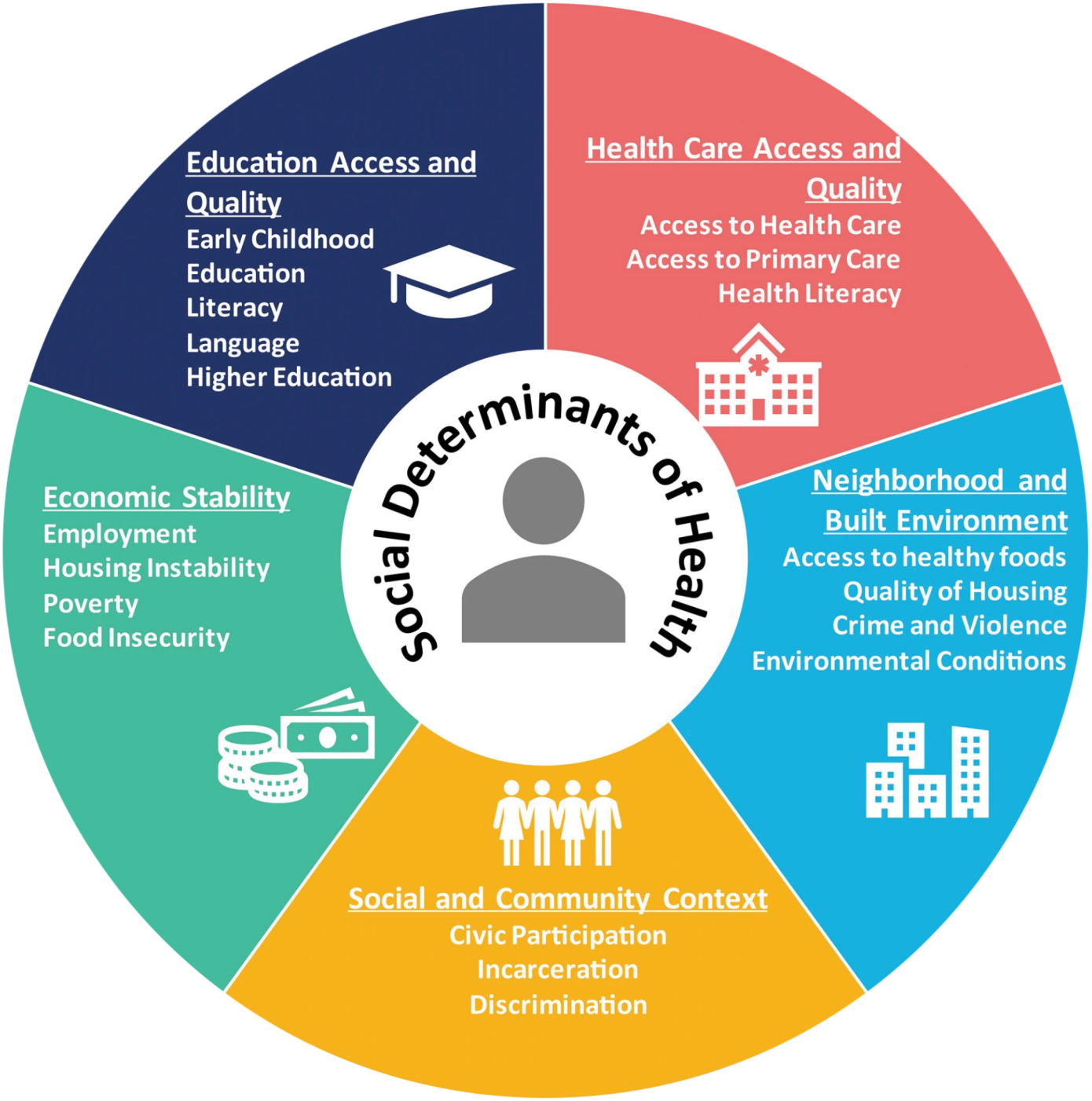
Health system itself is an important determinant of health. If it is designed appropriately and adequately resourced, it can help to remove wider inequities that affect health service coverage, financial protection, and outcomes. Nevertheless, even a robust, equitable health system cannot correct all the social determinants of health, which will require systematic examination of health in all public policies, for which the WHO action framework (health in all policies) seeks synergies and avoidance of harmful health impacts in order to improve population health and health equity. Thus, social determinants of health and "health in all policies" are integral to realizing the UHC goals, and budgetary resources for social determinants of health may be as crucial as those committed to overcome health inequities.



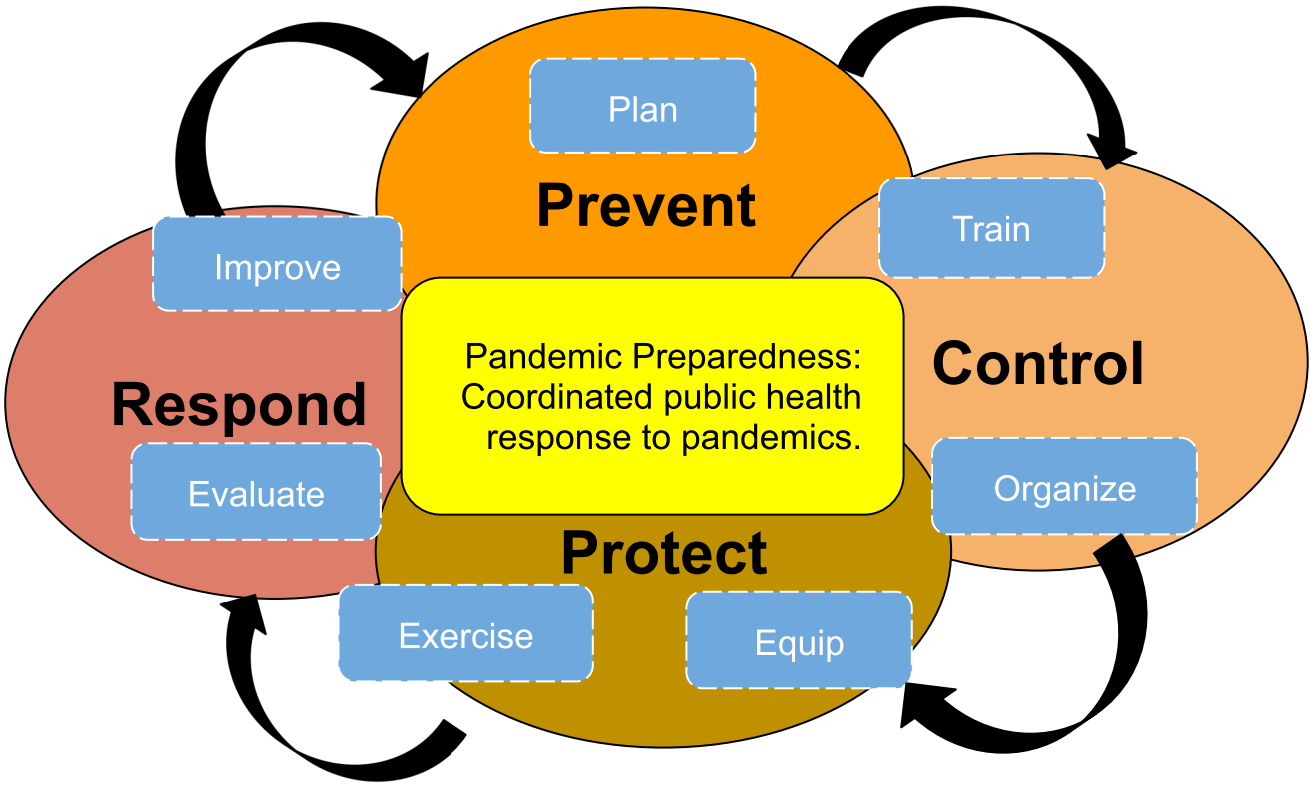
health systems thus means addressing key constraints in each of these areas. [9]

The six building blocks contribute to the strengthening of health systems in different ways. Some cross-cutting components, such as leadership/governance and health information systems, provide the basis for the overall policy and regulation of all the other health system blocks. Key input components to the health system include specifically, financing and the health workforce. A third group, namely medical products and technologies and service delivery, reflects the immediate outputs of the health system, i.e., the availability and distribution of care.

Social determinants of health (SDH) are the most successful means of enhancing all people's well-being and raising disparities. SDH are the conditions in which people are born, grow, live, work, and age. Their circumstances are shaped by the distribution of money, power and resources globally, nationally and locally. SDH are responsible for most health inequity – the unfair, avoidable differences in health status within and between countries. Inequity is seen, for example, in determinants such as safe, affordable housing; safe water; hygiene and sanitation; access to education; public safety; food security and nutrition; public health services; and pollution-free environment.


Education Access and Quality
Early Childhood Education
Literacy
Language
Higher Education
Health Care Access and Quality
Access to Health Care
Access to Primary Care
Health Literacy
Social Determinants of Health
Economic Stability
Employment
Housing Instability
Poverty
Food Insecurity
Neighborhood and Built Environment
Access to healthy foods
Quality of Housing
Crime and Violence
Environmental Conditions
Social and Community Context
Civic Participation
Incarceration
Discrimination

Pandemic Preparedness and Response: is a continuous process of planning, exercising, revising and translating into action national and sub-national pandemic preparedness and response plans. A pandemic plan is thus a living document which is reviewed regularly and revised if necessary.

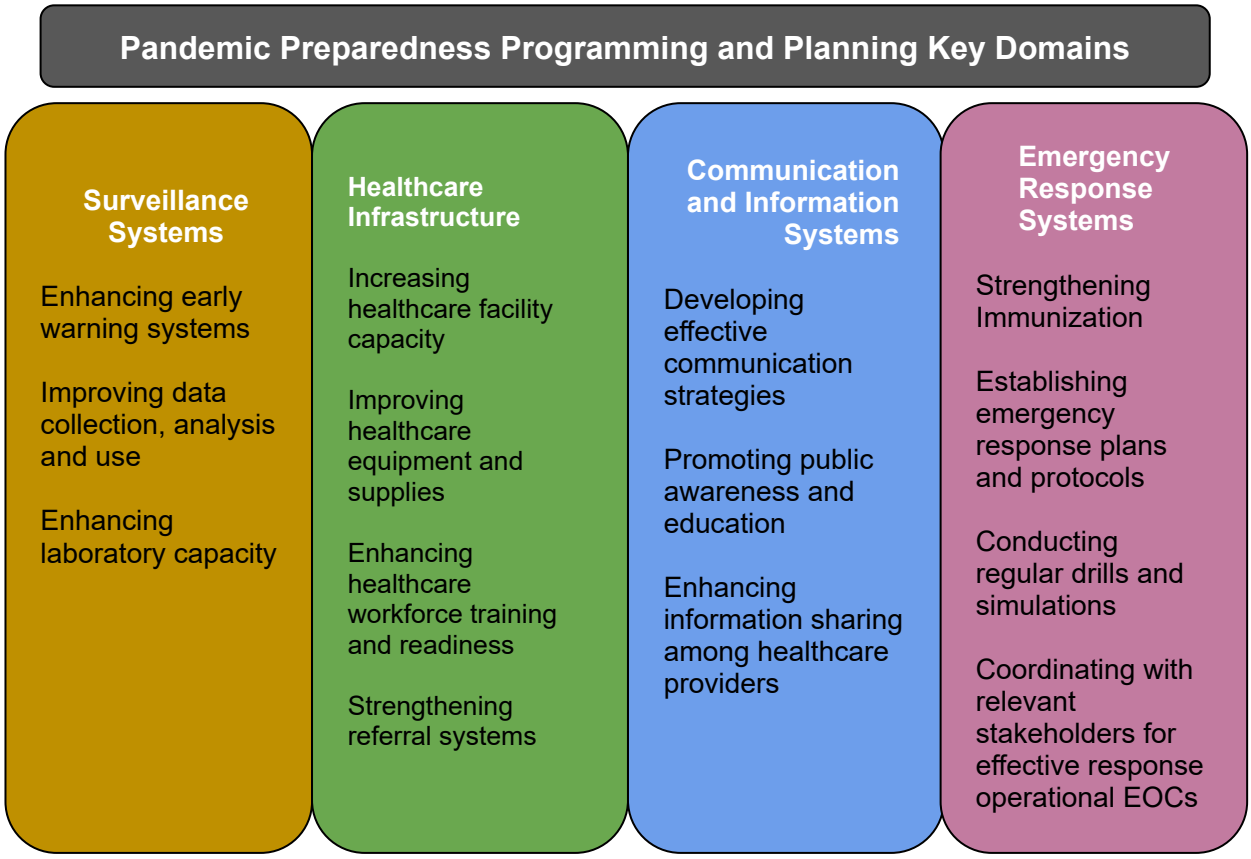


Global Health Advocacy Incubator: What is Pandemic Preparedness?"

PPR is the ability of countries to act quickly when responding to outbreaks. Countries must act quickly when responding to outbreak: infectious disease threats can travel the world in just 36 hours

WHY:

- Reduce the effect that a pandemic might have on communities.
- A core element of national and international security.
- Preparation is a key determinant of response capacity.
- Maintains existing health, social services (HIV, TB and malaria) and medication for vulnerable populations.
- Ensures continued delivery of health services, such as immunization and screening.



"Global Health Advocacy Incubator: Pandemic Preparedness Programming and Planning Key Domains

Existing policies / strategies / commitments on UHC and PPR

UN HLM on PPPR: The UN High-Level Meeting (HLM) on Pandemic Prevention, Preparedness and Response (PPPR) was convened on 20 September 2023. The overall theme of the HLM was "Making the world safer: Creating and maintaining political momentum and solidarity for Pandemic Prevention, Preparedness and Response". This HLM is an opportunity for Member States to prevent and prepare for pandemics and their consequences, using an approach that involves all government sectors. The outcome of the HLM is a political declaration that aims at "mobilizing political will at the national, regional and international levels for pandemic prevention, preparedness and response". The political declaration has 4 paragraphs that calls for increased and strengthened commitment for achieving UHC for PPR to be effective.

UN HLM on UHC: In September 2019, Heads of State and Government endorsed an ambitious and comprehensive political declaration at the UN General Assembly high-level meeting on UHC, reaffirming the right of every human being, without distinction of any kind, to the enjoyment of the highest attainable standard of physical and mental health and recommitting to achieve universal health coverage by 2030. The declaration was adopted through resolution A/RES/74/2, with a decision to convene another HLM on universal health coverage in 2027 in New York.

Intergovernmental Negotiating Body (INB) Negotiation on the Pandemic Agreement: In 2021, the World Health Assembly established the INB to negotiate a "WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response" and submit the outcome for the assembly's consideration in May 2024. The global COVID-19 disaster prompted proposals for creating a treaty to transform how governments deal with pandemics. Nine negotiating rounds did not produce consensus by that deadline, so the assembly extended the INB's mandate for one year. The INB faced serious challenges. The negotiators had to sort through proposals from WHO member states about what a pandemic agreement should include. The INB also had to operate alongside negotiations on amending the International Health Regulations (IHR). The Twelfth meeting of the INB was held in hybrid format from 4-15 November 2024. The opening and closing plenary sessions of the INB are open to WHO Member States, Associate Members, Observers and regional economic integration organizations, as well all relevant stakeholders. The latest draft of the pandemic agreement is awash with green highlights – an indication that countries have reached consensus on much of the text.

UN HLM on AMR: On September 26, 2024; the UN General Assembly convened a High-Level Meeting on Antimicrobial Resistance (AMR) for the second time during its 79th session (UNGA 79) in New York, and approved a political declaration committing to a clear set of targets and actions, including reducing the estimated 4.95 million human deaths associated with bacterial antimicrobial resistance (AMR) annually by 10% by 2030. The declaration also calls for sustainable national financing and US$100 million in catalytic funding, to help achieve a target of at least 60% of countries having funded national action plans on AMR by 2030. This goal is to be reached through, for example, diversifying funding sources and securing more contributors to the Antimicrobial Resistance Multi-Partner Trust Fund. The intersectoral challenge of AMR demands a One Health systems approach that unites human, animal, plant, and environmental health, backed by robust and accountable global AMR governance. Sustainable, consistent and diversified financing is essential to support the clear priorities and measurable targets for decisive action, while recognizing local, national and regional contexts.

Resource allocation modalities and matching political commitment

Global Fund: Provides 28% of all international financing for HIV programs, 76% of all international financing for TB programs and 62% of all international financing for malaria programs. Over the past two decades, the Global Fund partnership has helped save 65 million lives, reducing the combined death rate from AIDS, TB and malaria by 61%. By investing in treatment, countries' overall health systems have been strengthened, quality of care has been boosted, data tracking has been enhanced, accountability, governance and service delivery has been improved. And by reducing the burden on HIV, TB and malaria, Global Fund has freed up the capacity of health systems for other important health priorities such as for PPR.

Pandemic Fund: The Pandemic Fund is the first and only multilateral, pooled financing mechanism dedicated to providing long-term funding for PPPR to low and middle-income countries and in its 15 months has raised over USD 2 billion in seed capital from 27 contributors. The Pandemic Fund is specifically designed to support and reinforce capacity building and implementation of pandemic prevention, preparedness and response under the International Health Regulations, and any amendments/ enhancements thereof, as well as other internationally endorsed legal frameworks, including the Pandemic Agreement currently being negotiated by the member states of WHO.

Domestic Financing: Sustainability of health care can only be ensured when only there is a predictable and sustainable domestic resource for health. Both Global Fund, Pandemic Fund and other Global Health Institutions (GHI's) are important financing mechanisms to strengthen health systems; however, do not guarantee a long-term solution for sustainable health care. There is a need for countries to come up with strategies for a progressive and sustainable Domestic Resource Mobilization, this can be achieved by increasing the tax: GDP ratio by expanding the tax base, maximizing efficiency, and promoting innovative approaches, i.e., public, private and communities partnership.

The Lusaka Agenda: In 2022-2023, the Future of Global Health Initiatives engaged in a series of multi-stakeholder dialogues to capture consensus around the long-term evolution of Global Health Initiatives (GHIs) – and the wider health ecosystem – towards a joint long-term vision of domestically financed health systems and UHC that leaves no one behind.

The Lusaka Agenda recommends five key shifts for the long-term evolution of the GHI ecosystem:

- Make a stronger contribution to primary health care by effectively strengthening health systems.
- Play a catalytic role towards sustainable, domestically financed health services and public health functions
- Strengthen joint approaches for achieving equity in health outcomes
- Achieve strategic and operational coherence
- Coordinate approaches to products, research and development, and regional manufacturing to address market and policy failures in global health.

Integration of PPR into UHC

Integrating PPR in UHC would make it an innovative international agreement that, at this most pressing time of need, seizes the opportunity to deliver on health for all. Individually and collectively, countries need to do better on both health security and UHC. These two goals for protecting the health of everyone have been called "two sides of the same coin". World leaders and the global health community have a crucial second chance to secure a safer and healthier future for everyone. The Pandemic Treaty is also a high-level international political, legal and accountability instrument that can help them do so.

The treaty could acknowledge three important aspects of UHC in pandemics:

- Pandemics harm progress towards UHC, especially as they affect the most vulnerable and disrupt other essential health services.
- UHC principles are crucial for a successful response to health crises – including, for example, to ensure universal access to vaccines and treatments and remove financial barriers and disincentives to seeking care.
- UHC should include a full spectrum of public health services and functions. This includes prevention and promotion, surveillance and testing for infectious diseases, and provision of services to promote good health and prevent and manage underlying health conditions. It thereby contributes to crucial protection from, including preparedness for, pandemics.
- https://www.graduateinstitute.ch/sites/internet/files/2022-02/PB-no8.pdf)

Communities and civil society engagement mechanisms in UHC and PPR essential decision-making processes

Civil society and communities play important roles in the health service delivery, which cuts across the planning, demand creation, service delivery, advocacy, and holding service providers accountable, identification and resolution of bottlenecks which adversely affect access to and the quality of health services at various levels. Similarly, civil society organizations have the capacity to play a significant part in facilitating the realization of the health commitments made by governments through the SDGs and the UN HLM Political Declarations on UHC, HIV/AIDS, TB and AMR. The potential of civil society and communities is recognized at various levels and by many including the Global Fund amongst others, which recognizes the important roles of CS and communities and have underscored the importance of involving them in decision making from the onset.

Engagement from civil society and other stakeholders can accelerate UHC rollout and implementation and strengthen PPR. But, as consistently underscored across all nations, for civil society and communities to actively participate they must be represented and empowered and must have a decision-making role in the overall process – design, implementation, M&E and reporting. This could be through a national technical working group on UHC, where communities and civil society are represented. An alternative is a community-led observatory, as it is important to have open access to public data on key issue areas. In any case, progress-based timelines, adequate funding and formalised platforms should be a requirement. civil society and communities should benefit from legal and financial support to help them participate in all stages of UHC, while retaining their independence.

Advocacy, campaigning and participation in accountability

- Participation in decision-making and monitoring mechanisms, including monitoring the development, enforcement and impact of laws.
- Securing accountability and fulfilling a watchdog role.
- Advocacy and campaigning for health issues.
- Advocacy and campaigning on broader human rights, including law reform.
- Campaigning across society.

Community-based service delivery

- Prevention, including HIV.
- Confidential and voluntary testing and counselling, particularly for HIV.
- Treatment, including HIV.
- Demand creation and service uptake.
- Care and support.
- Rights and legal services.
- Task shifting and task sharing.
- Training and sensitization of service providers, including health-care personnel, lawmakers and law enforcement officials.

Participatory-based research

- Evaluation of programmes and services.
- Research on human rights, stigma and discrimination.
- Improving "know your epidemic" and "know your response".
- Research on new treatment and prevention technologies.
- Research to reach key populations with community and rights-based policies and programmes

Community financing

- On-granting (forward granting).
- Resource mobilization.
- Community financing initiatives

The Global Fund Strategy 2023-2028 prioritizes investments in long-term, tailored capacity building of community-led and community-based organizations, networks and groups, in order to strengthen links and improve service continuity between community-led activities and formal health care provision. Community-led monitoring (CLM) is an approach to ensure communities and civil society hold governments accountable based on the different policy instruments including the UN HLM Political Declarations on UHC and PPPR of 2023; even though both declarations have significant shortcomings in adhering to the principles of equity especially for key and vulnerable populations. To address the observed limitation of the Political Declarations, there is a need for contextualization; which CLM can facilitate through systematic monitoring and reporting on how services, programmes and policies are implemented and experienced at the level of communities of care to translate policies into action. Here, it is important to refer to the wealth of knowledge, experience and know-how of communities and civil society in HIV/AIDS, TB, malaria and Ebola response.

Furthermore, CLM can strengthen UHC and PPR commitments by;

- Reaching and protecting the most vulnerable groups in society, including women and girls, in line with SDG commitment to leave no one behind, and noting that pandemics widen inequalities.
- Scale up efforts and strengthen cooperation to promote training, development, recruitment, and retention of competent, skilled and motivated health workers, including community health workers, and mental health professionals.
- HIV/AIDS, TB, and malaria responses have taught us much about the need to center community-led responses and meaningfully engage civil society to achieve success and meet people where they are to prevent spread.

Conclusion / Recommendation

Whilst communities and civil society have a significant role to play in facilitating the realization of UHC and PPR commitments, it is important for them to be knowledgeable of the various spaces where they can be most effective. For communities and civil society to effectively participate in UHC and PPR decision making and implementation processes, they must:

- Be empowered with knowledge and understanding of the global context leading to the SDGs, UHC, and PPR. This can be realized through phased in person and online orientation sessions. This knowledge will enable them to engage from an empowered perspective and help demystify UHC and PPR commitments at community level.
- Undertake widespread sensitization of the community and the public on the importance of ensuring UHC and PPR commitments are implemented. The increased understanding will facilitate increased demand and strengthen accountability measures.
- Understand their respective country context with respect to the overall approaches of UHC and PPR including domestic health spending, domestic resource mobilization initiatives, accountability, and governance frameworks to gain understanding on the extent to which their respective governments are fulfilling their commitments, challenges, and bottlenecks to enable them provide constructive inputs.
- Knowledge of calendar of events, operational committees and or working groups, and their respective representatives at all levels. This will enable them to identify and effectively prepare for all key moments and events.
- Mobilize and capacitate professional champions from all sectors including community leaders, media, legal and human rights, parliamentarians, politicians amongst others. A critical mass of diverse champions will be instrumental when undertaking advocacy.
- Invest in research and community-led monitoring (CLM) to both inform advocacy and to provide a factual basis for holding decision makers, duty bearers and governments at all levels accountable
- Align their respective programming to UHC and PPR Commitments.
- Call for independent panel of Communities and civil society for the purposes of reviewing progress and provide critique on what?

Countries should accelerate and intensify the roll out of health, education schemes, impact mitigation and social protection packages under the umbrella of UHC; and, communities and civil society have a significant role to play in guiding implementation and ensuring accountability for improved health outcomes. Strengthening the health system will enable reliable delivery of a robust Environment Health and Safety (EHS) package in a way that addresses the needs of people and not diseases. Governments must invest in strong national and sub-national primary health care systems to be better equipped to deliver family and community oriented EHS packages.

As countries draw upon select, evidence-based, people-centered, integrated essential health services to design their EHS packages, they must ensure mechanisms for active participation and accountability. Countries must also uphold the fundamental right to equitable access for all, including the most vulnerable and disadvantaged populations. While considering cost-effectiveness with the potential health benefits of each service, it is important to recognize that a single, homogenous approach will not meet the needs of the entire population.

Ensure that health care is available to KVP by addressing barriers that hinder access to health services. The first crucial step is repealing legislation that criminalises and stigmatises KVP, which can be improved by promoting the active engagement of communities and civil society in all stages of UHC and PPR program rollout. A multi-stakeholder and multi-sectoral approach to monitoring should be adopted to enable non-state actors to hold governments to account on policy implementation, and to assess the quality of health services accessible to communities and KVP. Several countries exhibit piecemeal engagement from civil society, lacking a formal mechanism that consolidates that role of communities.

The attainment of the highest possible standard of health for populations continues to be a significant challenge. This challenge has been exacerbated by COVID-19 pandemic. SDGs, UN HLM Political Declaration on UHC, PPPR, TB, and AMR provide a blueprint to address challenges, promote domestic financing for health and work towards attainment of equitable access to healthcare. For this to happen, communities and civil society need to be properly informed and engaged with the processes that led national, regional, and global health decision-making processes as well as the status of working towards attaining the commitments. This guide serves as a reference for communities and civil society to ingrain their knowledge and engagement with the process to become champions of the various health commitments and advocate for governments to fulfil their obligations.

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