Protect the gains, push for progress
How to advocate for HIV services in universal health coverage, in the context of COVID-19
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Introduction

This advocacy guide is for country-level HIV advocates and community partners. It is designed to support them in developing advocacy strategies that integrate **rights-based, community-led, and inclusive approaches** into the universal health coverage (UHC) agenda in the context of COVID-19 to achieve #HealthforAll.

**Part One** sets out a brief introduction to UHC, why it is needed, and its key concepts and terminology. It explores the intersections between UHC and human rights, gender equality and HIV and concludes with discussion of the impact of COVID-19 on efforts to reach UHC and HIV global goals.

**Part Two** provides a set of tailored tools and guidance that country-level HIV advocates and community partners can employ as they prepare and advance their UHC advocacy strategies in the COVID-19 context. These are designed to be used in conjunction with standard advocacy strategy tools such as power mapping and stakeholder analysis.

**Part Three** provides key resources and advocacy materials that advocates can use to deepen their understanding of UHC, raise awareness of national commitments, and hold governments to account.

Wanja Ngure, Kenyan feminist and human rights activist: “Ideally UHC is a beautiful concept but when we have laws that criminalise some populations, how will these groups access services without stigma and discrimination? We will continue to lobby for the removal of structural barriers, without which health for all will remain a dream.”
Part One: Background

What is universal health coverage (UHC)?

Universal health coverage is a global goal

UHC is a global goal that all member states of the UN have committed to achieve by 2030 as part of the Sustainable Development Goals (SDGs). In 2019, this commitment was further strengthened with the Political Declaration of the High-Level Meeting on Universal Health Coverage setting out an ambitious agenda for the next 10 years. The Declaration has given impetus to countries to scale-up their implementation plans and strategies to deliver the necessary health reforms needed and set out what basic packages of health services and health financing mechanisms would look like if UHC were to become a reality.

According to WHO, UHC will have been achieved when all people and communities receive the health services they need without financial hardship. Although all the wealthiest countries in the world (except the USA) have some form of universal coverage, none actually cover 100% of the population for 100% of the health services, for 100% of the cost and with no waiting lists. Middle-income countries that have moved closer to UHC in recent years include Brazil, Mexico, Rwanda, South Africa and Thailand.

Universal health coverage is a national policy agenda

There is no ‘one size fits all’ approach to UHC. Embedded in the concept is the principle of national ownership, with lower- and middle-income countries setting and contributing financially to their own development targets and goals.

The key decision-making on how to achieve UHC is made at the national level and national health policies, strategies and plans (NHPSPs) are where countries answer key questions on how UHC will be financed and delivered. Domestic health reform can be a political hot topic, or even an election issue. Government commitment to UHC often becomes reduced by politicians to health insurance schemes. Civil society needs to actively participate in every stage of the national-level design, implementation and monitoring of UHC.

Universal health coverage is a concept founded in the right to health and health equity

The concept of UHC goes right back to the WHO Constitution of 1948 declaring health a fundamental human right. In 1978 the Declaration of Alma Ata identified primary health care as the means for attaining “health for all”. The core elements of UHC are embedded in international human rights conventions including the Convention on the Elimination of Discrimination Against Women, the Convention on the Rights of the Child and the Covenant on Economic, Social and Cultural Rights, as well as many national constitutions. According to WHO, UHC is by definition a practical expression of the concern for health equity and the right to health. Governments can no longer be guided purely by efficiency in terms of where to spend health budgets, as these may not be equitable. To ensure this, UHC indicators should be disaggregated by factors including income, gender and sexual identity, age, race, ethnicity, disability, location and migratory status.

“Progressive realisation of the right to health through UHC is primarily a national responsibility, assisted through regional and global solidarity, exchange and international cooperation. It can be best achieved through reforms that first prioritise meeting the needs of disadvantaged people”.

– The Global Compact for Progress towards UHC
Why do we need universal health coverage?

In 2017, less than half of the global population was covered by essential health services. Even in wealthy countries, the national health system provided by the state only covers part of the population, a limited range of services and only part of the total cost. Each year, an estimated 100 million people are pushed into extreme poverty because of health expenses.

Three dimensions of UHC

1. Leave no one behind, with specific attention to the poor, vulnerable and marginalised
2. Ensure progressive access to a wide range of high-quality services
3. Eliminate financial hardship among users of healthcare services

To achieve UHC, countries have to advance all three dimensions: include more people (who is covered), extend the range of services (what services are included) and reduce 'out of pocket' charges and fees (reduce costs). Governments need to increase domestic funding for health, and make critical choices around who to include first, which services to expand and how to move towards a system that shares the financial risk equally across society (often achieved via taxation or health insurance). Trade-offs have to be made in terms of how many services are provided and the proportion of the costs to be met from the public purse. In most countries, except for very low-income countries, UHC will be mostly funded through domestic resources, without or with very limited external donor support. Although this may seem ambitious, WHO estimates that in 65 low- and middle-income countries, 85% of the costs needed to achieve the SDG health targets could be met from domestic resources.

Countries that have made most progress towards UHC have prioritised spending on health from general taxation, rather than private or voluntary health insurance schemes. The most recent UHC Global Monitoring Report found that while health coverage has been improving, financial protection is heading in the wrong direction. Political will is required to avoid increasing pressure on health budgets and scarce resources being spread across a wide variety of health priorities.
# 1. Who is who in UHC?

## Global actors

### World Health Organization (WHO)

WHO is a driving force behind the UHC agenda and provides technical support to countries regarding implementation. It also contributes to the evidence base on how population engagement mechanisms can work, in which settings, and how. The upcoming WHO handbook on social participation for UHC will serve as a guidance document to member states to strengthen systematic and meaningful government engagement with populations, civil society and communities by drawing from best practice examples to establish, set up and institutionalise such mechanisms in national policy, planning and review processes. For more information, refer to WHO's webpage on UHC: [www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)](http://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc))

### World Bank

The World Bank and WHO work closely together to monitor and evaluate UHC progress globally. The report, Going Universal: How 24 countries are implementing universal health coverage reforms from the bottom up, describes how different countries are pursuing UHC, based on systematic data collection, to provide practical insights to policymakers. In 2018 and 2019, studies on an additional 17 countries were released. The World Bank page on UHC is: [www.worldbank.org/en/topic/universalhealthcoverage](http://www.worldbank.org/en/topic/universalhealthcoverage)

### UHC Partnership

The UHC Partnership brings together health experts and national Ministries of Health to promote UHC. Based at WHO, the aim is to build national capacity for the development, implementation, monitoring and evaluation of robust and comprehensive national health policies, strategies and plans and health financing policies, with a view to promoting UHC. The UHC Partnership’s [Handbook on Strategizing National Health in the 21st Century](http://www.who.int/healthpromotion/nh21/ueh/index.html) provides detailed guidance on national health planning and how civil society can be engaged at each step. A simpler version of this framework can be found in Tool 1 of this Guide.

### UHC2030

UHC2030 (formerly the International Health Partnership/IHP+) is the global movement to strengthen health systems for UHC. Its key areas of work are to: coordinate efforts to strengthen health systems; share learning and experience on health systems strengthening and UHC; advocate for policies and resources required to achieve UHC; and facilitate tracking of progress towards UHC and accountability. Everyone who promotes UHC, including countries, civil society organisations (CSOs), academia, the private sector and the media, is encouraged to become a partner by endorsing the [UHC2030 Global Compact](http://www.who.int/healthpromotion/nh21/ueh/index.html). UNAIDS and the Global Fund for AIDS, TB and Malaria are among the signatories. To engage with UHC2030 it is worth getting to know your three civil society representatives (grassroots, national and global) who sit on the Steering Committee. UHC2030 also publishes the annual [State of UHC Commitment Report](http://www.who.int/healthpromotion/nh21/ueh/index.html).

UHC2030 is the secretariat for Universal Health Coverage Day: 12 December and produces a campaign site each year with advocacy tools and resources: [universalhealthcoverageday.org/](http://universalhealthcoverageday.org/)

### The Civil Society Engagement Mechanism for UHC2030 (CSEM)

CSEM is the civil society section of UHC2030 working to ensure that UHC policies are inclusive and equitable, and that systematic attention is given to the most marginalised and vulnerable populations so that no one is left behind. The aims of CSEM are to: strengthen an inclusive and broad UHC/Health Systems Strengthening (HSS) movement at global, regional, and national levels; influence policy design and implementation of UHC/HSS; strengthen citizen-led and social accountability mechanisms at sub-national, national, regional, and global levels, following the principle of Leaving No One Behind; and ensure greater coordination and harmonisation between CSO platforms and networks working on health-related issues. CSEM produces a wide range of advocacy tools and resources, including the [UHC Advocacy Guide (2018)](http://www.who.int/healthpromotion/nh21/ueh/index.html).
2. Regional spotlight: Asian UHC frameworks and commitments

Outside of Africa there are few regional initiatives and frameworks for UHC.

**Joint Ministers of Finance and Health Symposium on Universal Health Coverage in Asia and the Pacific: COVID-19 and Beyond (2020)** – More than 40 finance and health ministers from across Asia and the Pacific gathered to discuss accelerating progress toward UHC in the region in the new COVID-19 era, stressing the importance of UHC and the need for stronger collaboration to mobilise healthcare financing.

**South-East Asia Regional Strategy for Universal Health Coverage (2015)** – Endorsed at the sixty-fifth session of the WHO Regional Committee for South-East Asia, this regional strategy recommends four Strategic Directions for advancing UHC in the region.

**Universal Health Coverage: Moving Towards Better Health Action Framework for the Western Pacific Region (2016)** – Endorsed at the 66th session of the WHO Regional Committee for the Western Pacific, this action framework provides guidance for Member States to accelerate progress towards UHC and the SDGs.

Khuát Thị Hải Oanh, Executive Director SCDI in Vietnam: “We have to identify people that are being left behind by UHC but also ensure that these people can help to find the solutions and advocate for those solutions.”
3. Regional spotlight: African UHC frameworks and commitments

In addition to the UN Political Declaration and the World Health Assembly resolution from 2019 that all African countries have endorsed, there are a number of important regional-level commitments and policy instruments that are useful for UHC-related advocacy.

**Abuja Declaration (2001)** – African Union (AU) countries pledged to set a goal of allocating at least 15% of their annual budget to the health sector. Very few countries have met this target. The Abuja +12 Declaration in 2013 saw governments renew their pledges to end the epidemics of HIV, TB and malaria by 2030.

**Universal Health Coverage in Africa: From Concept to Action (2016)** – This call to action sets out five key areas for African states linking health to economic growth: financing, services, equity, preparedness and governance.

**African Health Strategy 2016-2030** – A strategic framework to strengthen health systems performance, increase investments in health, improve equity and address social determinants of health to reduce priority diseases burden by 2030.

**African Union Catalytic Framework to end AIDS, TB and Malaria in Africa by 2030** – A strategic framework setting out targets and milestones endorsed by the AU in 2016. A set of objectives are linked to each disease, with targets to be achieved if the diseases are to be eliminated by 2030. These objectives all have a set of interim targets (or ‘milestones’) to be met by 2020.

**67th WHO Regional Committee for Africa (2017)** – African Health Ministers agreed to implement six comprehensive framework actions in their countries that will contribute fundamentally to attainment of UHC.

**African Scorecard on Domestic Financing for Health 2019** – An annually updated health financing tool for AU member states to use in financial planning and expenditure tracking.
4. UHC terminology explained

Catastrophic health expenditure
Health expenditure is defined as being catastrophic if a household’s financial contributions to the health system exceed 10% of income after subsistence needs have been met. In 2015, the year the SDGs were adopted, about 930 million people incurred catastrophic health spending. For about 210 million people, out-of-pocket health spending exceeded 25% of the household budget.

Health benefit package
Also referred to as the essential health services package (EHSP) or minimum health benefit package, this is the core set of services that a government considers essential to meet the health needs of the population and for which they are willing to pay. These will vary from country to country but WHO provides guidance to governments on how to design health benefit packages.

The content of the health benefit package should be informed by three considerations:
• Equity – ensuring equal and fair access to services
• Disease burden profile – the main health needs of the population
• Cost-effectiveness analysis – aiming to achieve the greatest impact given the available resources.

Domestic health financing mechanisms/Domestic resource mobilisation
Health financing is one of the core components of UHC and refers to mechanisms by which countries raise funds to pay for health services so that people no longer have to pay ‘out-of-pocket’ (OOP). Domestic health financing mechanisms include:
• Revenue raising (sources of funds, including government budgets, compulsory or voluntary prepaid insurance schemes, direct out-of-pocket payments by users, and external aid)
• Pooling of funds (the accumulation of prepaid funds on behalf of some or all of the population, for example via health insurance), and
• Purchasing of services (the payment or allocation of resources to health service providers).

A more detailed explanation of health financing mechanisms for advocates is set out in the Frontline AIDS discussion paper: Universal health coverage: How to finance it.

National health policies, strategies and plans (NHPSPs)
This is a generic term for the range of national government health policies, strategies and health plans that set out policy on health reform and UHC. NHPSPs ensure that countries allocate domestic resources efficiently and fairly, and that domestic budgeting for health is consistent and predictable.

Out of pocket payments (OOPs)
These are the expenses that individuals have to pay to health care providers from their own pocket at the time they use the service. They can take the form of user fees, co-payments, prescriptions and other charges for health services. Many countries rely on these payments to finance health systems. Every year however these payments push over 100 million people a year into extreme poverty (defined as living on USD1.90 or less a day) because unexpected illness requires them to use up their life savings, sell assets, or borrow money. Key populations sometimes need to pay for services even if they are free because of the privacy and confidentiality they offer.

Anton Basenko, Global activist and Alliance for Public Health manager of programs on communities, rights and gender: “You cannot divide human rights, stigma and discrimination issues from the idea of UHC. These issues all have to be part of the UHC advocacy agenda.”
UHC and HIV: Risks and opportunities

The goals of achieving UHC and ending the AIDS epidemic are complementary and one cannot be achieved without the other. The underlying values and principles are the same: equity, non-discrimination, dignity, and social justice. In 2019, less than half of key populations were reached with combination HIV prevention services in more than half of the countries that reported to UNAIDS. New health funding from domestic sources for UHC could help close the HIV financing gap and improve sustainability.

The UNAIDS Strategy for 2016-2021 outlines three ways in which countries need to progressively address three UHC dimensions in planning HIV responses:

1. Define the essential, high-impact HIV interventions that should be integrated into the national health benefit package.
2. Ensure this package is adapted and equitably delivered to populations in need.
3. Ensure the national health financing system covers costs of HIV services to minimise OOP expenditure and risk of financial hardship.

There are four major concerns within the HIV community about the transition to UHC:

1. The shift in funding away from international donor support to domestic health financing will mean a significant shortfall in funding for HIV.
2. The transition from specific disease responses to a health systems approach will dilute the focus on tackling the structural drivers of HIV, especially measures to address stigma and discrimination, and people-centred approaches.
3. The value of community-led and human rights-based approaches that have been the driving force of the HIV response will be overlooked by national governments in favour of a focus on health facilities and generic health insurance schemes.

4. Key populations will be deemed ineligible or excluded from UHC implementation due to the criminalisation of sex work, sexuality, drug-use or on the basis of identity and residency, and there will be diminished support for tailored, stand-alone services and monitoring of service uptake for key and marginalised populations.

Each country will have to make important decisions on how HIV services will be funded and how the availability, affordability, and quality of HIV treatment is guaranteed. Different options include the inclusion of HIV treatment in national health insurance schemes, the use of specialised government funds, or a specific tax to cover HIV-related health costs.

Communities delivering HIV interventions

UHC is not just about treatment and medicines. Its success also depends on the delivery of all other interventions that are critical for good health, in particular prevention and other non-medical interventions, such as awareness-raising, advocacy, treatment adherence support or linking key populations to friendly health services. Many of these interventions are delivered outside of health systems by local civil society and community actors, which are mainly funded through external donors. Will governments be able or willing to support civil society or communities in the delivery of these critical activities?

"If universal health coverage is to be truly universal it must encompass everyone, especially those who have the most difficulty accessing health services, such as migrants, rural populations, people in prison, LGBT community, sex workers, drug users, poor people #Healthforall"

– Dr Tedros Adhanom Ghebreyesus, Director-General, WHO
Although UHC in theory is built on equitable implementation across society, how a government defines the vulnerable and marginalised will have a direct impact on who is included in the expansion of health services. It is extremely unlikely that in countries where HIV exposure and transmission, same-sex relationships, non-conforming gender identities and expressions, sex work, and drug use are criminalised, that key populations will be recognised as equally worthy of health services. For this reason, all national UHC legislation and health reform must be accompanied by a national debate on the need for a supportive policy and legal environment, with reform or repeal of discriminatory laws where necessary.

**Key message:**
UHC implementation that fails to take account of a comprehensive approach to HIV will entrench inequalities and make the goal of ending AIDS by 2030 impossible to reach.

**UHC and gender equality**

The term UHC and the rhetoric that surrounds it suggests that by definition UHC implementation will be equitable across society. However, the interpretation and implementation of UHC is all too often ‘gender-blind’.

Gender inequality and misogynistic social norms limit health outcomes for anyone whose gender identity, expression, sexual orientation or sex characteristics are perceived to be ‘different’. These perceived differences are used to decide who is more or less important in society and this leads to increased health risks, disease burden and health service needs among specific groups. For example, transgender people are 49 times more at risk of living with HIV compared to the general population. Women are 1.2 times more susceptible to HIV than men and this difference is even more marked in adolescence.

For women in general, UHC, and in particular the expansion of free primary health care, holds huge potential. There are examples around the world in countries such as Afghanistan, Mexico, Rwanda and Thailand of how commitment to UHC has been a powerful driver to improve health outcomes and equity for women.

However, for this to happen, policies and programmes must pay particular attention to the design of the essential services package, women’s access to services, and financial and social barriers to gender equality. In particular, without specific attention to the impact of harmful social norms, gender imbalances in access to services and the national legal and policy environment, it is unlikely that secure sexual and reproductive health and rights (SRHR) will be achieved within UHC.

Conscious effort is needed to address existing gender imbalances in the health system and address the unique health needs of people in all their diversity, with an intersectional approach recognising that gender inequity also creates barriers for people of diverse sexual orientations, general identities and expressions, and sex characteristics. Embedded within the UN Political Declaration on UHC are several important commitments to ensure UHC is gender-responsive and to deliver gender equity in health (see Part Three: Key resources).
The COVID-19 crisis is therefore an opportunity to advocate for a more inclusive and rights-based UHC, politically and financially supported by donors and governments.

The impact of COVID-19 on UHC

The COVID-19 pandemic is having a devastating impact on social and economic development all over the world, with serious consequences for the delivery of the SDGs by 2030. Global human development is on course to decline this year for the first time since 199027. The financial impact of COVID-19 is expected to be worse than that experienced after the global financial crisis in 2008 and could trigger a global economic depression not seen since the 1930s28.

According to WHO, in less than a year the pandemic has already eroded the health gains achieved over the past 25 years29. COVID-19 has exposed and exacerbated existing weaknesses in health systems and their ability to deliver basic health services, as well as the extent to which national governments are dependent on international donors. It has severely disrupted the pace of national health reforms and at the same time illustrated perfectly why resilient and sustainable health systems are the first line of defence against the outbreak of disease. It threatens to wipe out decades of progress on HIV, an epidemic now in its fifth decade, with fears that AIDS-related deaths could double in the coming year.

COVID-19 is turning the clock back on HIV

People living with HIV are among those most severely affected by COVID-1930. The pandemic and measures being taken to mitigate against its impact are placing decades of progress on HIV at risk of being lost. Antiretroviral (ARV) stockouts, clinic closures and movement restrictions have led to huge challenges for people living with HIV being able to stay healthy. HIV prevention and sexual and reproductive health services have not been protected as essential, with HIV testing down by 50% in some places.

Women and girls in particular are facing high risks of HIV infection under lockdowns due to increased levels of gender-based violence31. Key populations and other marginalised groups have been particularly negatively impacted by harm reduction service closures, loss of income, increased risk of violence and police hostility leading to further exclusion32. Furthermore, funding at the national and international level is being channelled away from existing health programmes into the COVID-19 response33.

A window of opportunity

Notwithstanding the bleakness of this picture, there are some positives. Communities around the world have mobilised and innovated creative solutions to some of these challenges, demonstrating once again the value of community-led and rights-based approaches34. Among the policy breakthroughs that COVID-19 has catalysed or accelerated include the expansion of home-based harm reduction services and self-testing kits, longer ARV prescriptions and increased access to services for those under the age of 1835. The importance of a community-led and rights-based approach to health is being championed by the HIV community, with many opportunities to learn from this response.

Globally, the link between good health and strong economic development has never been clearer. In countries where health has never been high on the domestic budget, COVID-19 has helped push health up the political agenda, acting as an 'eye-opener' to the poor quality of domestic health systems. Strengthening health systems and protecting frontline health workers have risen to the forefront of the international debate around UHC and COVID-19.
The role of civil society and communities in UHC

We commit to engage all relevant stakeholders, including civil society, private sector and academia, as appropriate, through the establishment of participatory and transparent multi-stakeholder platforms and partnerships, to provide input to the development, implementation and evaluation of health- and social-related policies and reviewing progress for the achievement of national objectives for universal health coverage, while giving due regard to addressing and managing conflicts of interest and undue influence – UN Political Declaration on UHC, 2019

Civil society and communities have a critical role to play in UHC, especially in advocacy, research and service delivery. They need to be at the decision-making table at every stage of the design, implementation and monitoring of UHC, and hold governments to account, especially when it comes to the rights of the most marginalised people in society. Tool 1 of this Guide outlines the role of civil society in UHC policy development at national level in more detail, with key questions to ask at each stage of the process.

Four advocacy pillars

It may be helpful to think of your advocacy work on UHC and COVID-19 in terms of four pillars:

1. The right to health as central to the design and delivery of UHC
2. Community-led health services as central to the design and delivery of UHC
3. The voice and leadership of people living with HIV and key populations as critical to the UHC process
4. The scaling up of public investment in health and public services to meet the SDGs

These pillars align closely with those of other UHC movements, including the CSEM\(^3\) and the Alliance for Gender Equality and UHC\(^3\). The fourth one links to the wider global financial context, recognising that many developing countries are taking on large amounts of debt that is likely to put pressure on governments to pursue austerity measures rather than invest in health, potentially leading to another lost decade\(^3\). As you develop your advocacy strategies, these pillars will help you identify allies and build strong advocacy networks and coalitions.

Anton Basenko, Global activist and Alliance for Public Health manager of programs on communities, rights and gender: “From the HIV movement we know how important it is for civil society and communities to be organised. We also know how important it is for civil society and government to work in partnership together. The mobilised, organised movement that came out of the need to respond to HIV was incredibly done.”
Part Two: Advocacy tools

Introduction

There are many components to consider as you develop an advocacy strategy for the effective inclusion and integration of HIV services in UHC, in the context of COVID-19. Many of these are moving pieces on the chess board, as we deal with the unpredictability of the new pandemic, the fast-pace of socio-economic change it has triggered and countries moving in and out of stages of lockdown and recovery.

Tool 1 provides an overview of the UHC policy development process, outlining the role of civil society and key questions to ask at each stage. The relevant international UHC commitments that your government has signed up to are included for ease of reference.

Tool 2 is designed to help you set advocacy goals and priorities over the short, medium and long-term.

Tool 3 is a stakeholder mapping exercise that helps you identify the actors with the power to bring the change you are looking for, and who can influence them.

Tool 4 is a calendar of UHC events at the national, regional and global level to help you plan your advocacy strategy for the coming year.

Tool 5 provides guidance on how to use social media to get your message across.

Use Tool 4 in conjunction with the resources in Part Three to raise awareness of UHC and develop your own tailored tools and messages on the importance of rights-based, community-led and inclusive approaches for the UHC agenda.

Felicita Hikuam, Director ARASA: “In order to deal with HIV, you need to deal with the social determinants of health such as gender equality, the legal environment, stigma and discrimination – all the ‘fuzzy’ things that often times scientists and governments don’t want to deal with. I think the HIV movement has done really well to continually push that message, which is something that needs to be brought to debates on UHC as well.”
TOOL 1: Navigating the UHC policy maze

**Purpose:** This tool will help you do a number of things. It will help you identify where your government is in the UHC implementation process, the role you can play in decision-making and the key questions to ask at each stage. There are three main areas in the national UHC policy development process: priority-setting, planning and budgeting. These three areas are outlined in more detail in the grid below, with the relevant matching international government commitments to assist with advocacy messaging.

**How to use:** Having identified where your country is in terms of UHC implementation, you can focus in on the questions you need to ask. If you don’t yet have a seat on the national UHC Technical Working Groups, you will need to raise your concerns with Parliamentarians and policymakers via existing channels such as the National AIDS Councils, Country Coordinating Mechanisms of the Global Fund, SDG rapporteurs and parliamentary committees.

### UHC national policy process

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<td><strong>Population consultation on needs and expectations</strong></td>
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<td>A national population consultation can be undertaken at any stage of the health planning cycle. Ideally, it should be one of the first steps, so the results can feed into the development of a new national health policy or strategy (NHPSP). It can also be done in the middle of the planning cycle to monitor progress or at the end of the policy development process, to get the public’s opinion on what has been done.</td>
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<td><strong>CSOs, NGOs, community leaders and community institutions from all sectors can all undertake or participate in citizen consultations to:</strong></td>
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<tr>
<td>• capture demands, opinions and expectations on health issues, to improve policy responses</td>
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<td>• increase ownership and engagement – especially of marginalised groups – to transform citizens into active stakeholders</td>
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<tr>
<td>• improve accountability and transparency</td>
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<tr>
<td><strong>How does your government define UHC and what steps have been taken so far?</strong></td>
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<tr>
<td><strong>Will there be a government-led population consultation? What form will it take?</strong></td>
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<td><strong>How will civil society and communities be engaged?</strong></td>
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<tr>
<td><strong>How will the results of consultations be fed into the UHC planning process?</strong></td>
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<tr>
<td><strong>UN Declaration on UHC, 2019 Paragraph 54. ‘Engage all relevant stakeholders, including civil society, the private sector and academia, as appropriate, through the establishment of participatory and transparent multi-stakeholder platforms and partnerships, to provide input to the development, implementation and evaluation of health- and social-related policies and reviewing progress for the achievement of national objectives for universal health coverage, while giving due regard for conflicts of interest and undue influence.’</strong></td>
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| **Situation analysis of the health sector** |
| A health sector situation analysis should aim to: |
| (a) realistically assess the current health situation, including root causes/effects; |
| (b) provide an evidence-informed basis for responding to health sector needs and expectations of the population; |
| **Health-specific CSOs and NGOs can play the following roles in situational analysis:** |
| • Contributing to the evidence base by providing disaggregated data on health indicators, case studies and conducting research on criminalised and marginalised populations |
| • Participate in analysis of the health situation to provide a community perspective |
| **How is UHC being measured? What indicators are being used?** |
| **Are the data on health indicators disaggregated by income, sex, age, race, ethnicity, disability, location and migratory status?** |
| **Does the analysis include community evidence and data?** |
| **UN Declaration on UHC, 2019 Paragraph 65. ‘Strengthen capacity on health intervention and technology assessment, data collection and analysis, while respecting patient privacy and promoting data protection, to achieve evidence-based decisions at all levels, acknowledging the role of digital health tools in empowering patients, giving them access to their own healthcare information, promoting health outcomes and making health systems better.’** |
provide an evidence-informed basis for formulating future strategic directions. A sound health sector situation analysis is one that is participatory and inclusive; analytical; relevant; comprehensive and evidence-based. A whole-of-sector situation analysis gives a voice and platform to all health sector stakeholders, increases accountability and transparency, and supports and strengthens monitoring and evaluation (M&E). Additionally, it contributes to concretising roles and responsibilities and helps to establish consensus on the status of health in the country.

- Raise concerns about gaps and weaknesses in service provision
- A health sector situation analysis typically brings together some or all of the following stakeholders:
  - Population/beneficiaries
  - Population and community representatives
  - Civil society, including NGOs/faith based organisations
  - Special interest groups
  - Community/non-profit health service providers

Civil society’s role is crucial, as these organisations are often closest to the relevant populations. A CSO representative can also be in the core team, and if not, should certainly actively participate and be transparent in providing relevant data and information.

Questions

- How does the government define who is ‘marginalised and vulnerable’?
- Are the health needs of criminalised and other marginalised populations included?
- Will migrants be included in national health plans?
- How will civil society and community stakeholders, including marginalised and criminalised communities, be consulted?
- Is HIV included in NHSPSPs/Health Reform Strategies? How does the National HIV Plan fit into the NHSPSP?

Government commitments

UN Declaration on UHC, 2019
Paragraph 12. ‘Reaffirm the importance of national ownership and the primary role and responsibility of governments at all levels to determine their own path towards achieving universal health coverage, in accordance with national contexts and priorities, and underscore the importance of political leadership for universal health coverage beyond the health sector in order to pursue whole-of-government and whole-of-society approaches, as well as health-in-all-policies approaches, equity-based approaches and life-course approaches’

UHC national policy process

<table>
<thead>
<tr>
<th>Priority-setting for national health policies, strategies and plans</th>
<th>Role of civil society</th>
<th>Questions to ask</th>
<th>Government commitments</th>
</tr>
</thead>
<tbody>
<tr>
<td>The process of priority-setting is inherently political: it is a process where societal values and goals are important, and resulting priorities reflect a compromise among stakeholders. The aim of the process is to select from different options how to address the most important health needs, as highlighted in the health sector situation analysis above, in the best way given limited resources (rationing). In health, priority-setting determines the key objectives for the health sector for a given period, thus directly feeding into the content of the national health plan.</td>
<td>CSOs, NGOs, community leaders and community institutions from all sectors can all participate in priority-setting processes</td>
<td>How will civil society and community stakeholders, including marginalised and criminalised populations, be consulted?</td>
<td>UN Declaration on UHC, 2019</td>
</tr>
<tr>
<td>Health-specific CSOs and NGOs in particular can advocate on behalf of marginalised and criminalised communities to ensure their voice is heard</td>
<td>In a decentralised environment, the policymakers are the local government. They must collaborate with service providers, civil society and the community (clients/citizens) for their insights and input.</td>
<td>Is HIV included in NHSPSPs/Health Reform Strategies? How does the National HIV Plan fit into the NHSPSP?</td>
<td>Paragraph 12. ‘Reaffirm the importance of national ownership and the primary role and responsibility of governments at all levels to determine their own path towards achieving universal health coverage, in accordance with national contexts and priorities, and underscore the importance of political leadership for universal health coverage beyond the health sector in order to pursue whole-of-government and whole-of-society approaches, as well as health-in-all-policies approaches, equity-based approaches and life-course approaches’</td>
</tr>
</tbody>
</table>
Citizens are the final decision-makers on priorities through their parliaments; they thus need to be involved at each step of a priority-setting exercise (see Boxes 4.2 and 4.3). The priorities which are set should ultimately be owned by citizens as part of the democratic process.

The 72nd World Health Assembly
1. Urges Member States:
   (4) to support better prioritization and decision-making, notably by strengthening institutional capacities and governance on health intervention and technology assessment, in order to achieve efficiencies and take evidence-based decisions... as a means of promoting equitable, affordable, and universal access to health and to inform policy decisions in support of universal health coverage.

<table>
<thead>
<tr>
<th>UHC national policy process</th>
<th>Role of civil society</th>
<th>Questions to ask</th>
<th>Government commitments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PLANNING</strong></td>
<td></td>
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<tr>
<td><strong>Strategic planning: transforming priorities into plans</strong></td>
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<tr>
<td>Health Sector Strategic Plans guide the activities and investments that are necessary for achieving medium-term outcomes and impact.</td>
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<tr>
<td>Decision-making should be based on a thorough analysis of the current situation, lessons learned from previous plans, expected available resources and chosen priorities.</td>
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<tr>
<td>To make the process effective, health sector stakeholders will need to come to a common understanding of the key issues and share institutional goals and expectations.</td>
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<tr>
<td>Such an inclusive approach is likely to be more potent, not only in terms of planning the right vision and activities, but also in ensuring that implementation of the strategic plan is jointly undertaken by all actor groups.</td>
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<tr>
<td>Strategising for health will be more effective if a wide range of stakeholders including civil society are involved, and both the process and the product are truly owned by the country.</td>
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</tr>
<tr>
<td>Are Health Sector Strategic Plans and NHPSPs public documents? If not, why not?</td>
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<tr>
<td>Do NHPSPs acknowledge and account for the social, economic and environmental determinants of health and health equity (structural drivers)?</td>
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<tr>
<td>What social protection measures are in place?</td>
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<tr>
<td>Is there a whole-of-government approach?</td>
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<tr>
<td><strong>UN Declaration on UHC, 2019</strong></td>
<td></td>
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<tr>
<td>Paragraph 10. ‘Recognize the need to tackle health inequities and inequalities within and among countries through political commitment, policies and international cooperation including those that address social, economic and environmental and other determinants of health’</td>
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<tr>
<td><strong>UN Declaration on UHC, 2019</strong></td>
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<tr>
<td>Paragraph 26. ‘Implement high impact policies to protect people’s health and comprehensively address social, economic and environmental and other determinants of health by working across all sectors through a whole-of-government and health-in-all-policies approach’</td>
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<tr>
<td><strong>UN Declaration on UHC, 2019</strong></td>
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</tbody>
</table>
| Paragraph 59. ‘Provide strategic leadership on universal health coverage at the highest political level and promote greater policy coherence and coordinated actions through whole-of-government and
Operational planning: transforming plans into action

Operational planning is the link between strategic objectives of the national health policy, strategy or plan (NHPSP) and the implementation of activities. Operational planning deals with day-to-day implementation, often has a one-year time horizon, and should be synchronised with the budgeting process.

The operational plan details the activities to be undertaken to provide the services included in the essential health services package, such as “training programme on nutrition for district hospital staff” or “support and supervision visits by district health management team”.

All CSOs, NGOs and CBOs responsible for health service provision or programmes should be involved in operational planning, either directly or through having their interests represented by someone involved in the formal planning process.

Health system end users are also key stakeholders and should therefore also be engaged in the development of operational plans.

For national HIV programmes, or national disease-specific programme, it might mean consulting CSOs that have a large stake in how the operational plan is implemented.

Planning is often made into something complicated, a mystery wrapped in jargon, process and politics. Planning is sometimes left to the professional planners or the managers to control and do. That is a mistake. The best operational plans, and certainly the ones most likely to be implemented, are those that are developed with the people who will carry them out (as well as other key stakeholders such as national and local health authorities, health service providers and health system end users.)

Are communities involved in the operational planning?

Are community-led responses included or taken into account?

Are health users engaged and consulted in operational planning?

Have action plans been developed with local and national health authorities, and with other service providers?

health-in-all policies approaches, and forge coordinated and integrated whole-of-society and multi-sectoral response, while recognizing the need to align support from all stakeholders to achieve national health goals.’

The 72nd World Health Assembly

1. Urges Member States:
   (13) to continue to strengthen disease prevention and health promotion by addressing the determinants of health and health equity through multisectoral approaches involving the whole of government and the whole of society, as well as the private sector.
## BUDGETING

### Estimating cost implications of a national health policy, strategy or plan

The process of estimating costs is a crucial step which allows decision-makers to consider the extent to which health objectives are feasible and affordable.

A costing team can form the liaison between the broader planning discussions and the cost estimation process. The team is often headed by specialists in the ministry of health (MoH) planning department, along with cadres from the MoH department of finance, but works closely with a range of stakeholders (e.g. various technical agencies and departments including the Ministry of Finance (MoF), district managers, development partners) to promote participatory processes and gain buy-in.

The estimated costs should be compared with the projected available financial resources, to assess affordability and potential resource gaps.

### Budgeting for health

The way public budgets are formed, allocated and used in the health sector is at the core of the UHC agenda. To make progress towards UHC, a predominant reliance on public, compulsory, prepaid funds is necessary.

Ministries of budget/finance and related entities are the leading agents for budget development.

Ministries of health play a critical role to prepare, present and negotiate credible, priority-oriented budget proposals for the sector.

<table>
<thead>
<tr>
<th>UHC national policy process</th>
<th>Role of civil society</th>
<th>Questions to ask</th>
<th>Government commitments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Civil society</strong></td>
<td>The role of civil society is crucial when it comes to providing input data, ensuring consistency with government policies and plans put forth in other sectors, validating the final estimates in terms of targets, costs and related projected outcomes such as accessibility to care and overall population health impact. A well-costed plan allows a range of stakeholders – including civil society, private sector, parliamentarians and the media – to have insight into the rationale for resource allocation decisions, and to hold policy implementers accountable to the same.</td>
<td>Who decides what will be covered and what will not be covered? Will the cost of ARVs and prevention commodities (needles/condoms etc) be fixed, or commercially determined? Will the cost of addressing other socio-economic determinants of health (through comprehensive sexuality education CSE, HIV information and education etc) be covered through the health budget? Can the national health budget cover the total cost of ARVs or does this need to be shared with development partners?</td>
<td><strong>UN Declaration on UHC, 2019</strong> Paragraph 39. ‘Pursue efficient health financing policies, including through close collaboration among relevant authorities, including finance and health authorities, to respond to unmet needs and to eliminate financial barriers to access to quality, safe, effective, affordable and essential health services, medicines, vaccines, diagnostics and health technologies, reduce out of pocket expenditures leading to financial hardship and ensure financial risk protection for all throughout the life course, especially for the poor and those who are vulnerable or in vulnerable situations, through better allocation and use of resources, with adequate financing for primary health care, in accordance with national contexts and priorities’ Paragraph 40. ‘Scale up efforts to ensure there are nationally appropriate spending targets for quality investments in public health services, consistent with national sustainable development strategies, in accordance with the Addis Ababa Action Agenda, and transition towards sustainable financing through domestic public resource mobilization’ Paragraph 41. ‘Ensure sufficient domestic public spending on health, where appropriate, expand pooling of resources allocated to health, maximize efficiency and ensure equitable allocation of health spending, to deliver cost-effective, essential, affordable, timely and quality health services, improve service coverage, reduce service gaps, and improve population health outcomes’</td>
</tr>
</tbody>
</table>

| **Civil society** | Civil society can influence health budget definition by engaging with government and Parliament at the right time. For those who seek to influence resource allocation in country, a good understanding of the guiding principles of budgeting as well as the political dynamics that enable the budget elaboration and approval process is essential. Good understanding of the budget process and engagement by MoH and other health sector stakeholders at the right time during the | How will healthcare be financed domestically? How much will people have to pay and how will that be decided? What proportion of costs will the health budget cover and what impact might this have on end user fees? Does the national health budget include funding for HIV prevention services and ARVs? | |
budget cycle will increase the chances that the final resource allocation matches planned health sector needs.

The Parliamentary health committee will study the health sections of the overall budget and prepare an analysis and response, often in the form of amendments. It is here that the MoH has the vital opportunity to liaise with the legislature and support the technical analyses and cross-verification with the costed health plan. During this stage of the budget cycle, media attention to the country’s budget is high and this forum can be used to bring attention to specific issues, in partnership with advocacy organisations and civil society.

impoverishment from health expenditure and ensure financial risk protection, while noting the role of private sector investment, as appropriate’

43. ‘Optimize budgetary allocations on health, sufficiently broaden fiscal space, and prioritize health in public spending, with the focus on universal health coverage, while ensuring the fiscal sustainability, and in this regard encourage countries to review whether public health expenditure is adequate to ensure sufficiency and efficiency of public spending on health and, based on such review, to adequately increase public spending, as necessary, with a special emphasis on primary health care, where appropriate, in accordance with national contexts and priorities, while noting the WHO’s recommended target of an additional 1% of GDP or more’

The 72nd World Health Assembly
1. Urges Member States:
(3) to continue to mobilize adequate and sustainable resources for universal health coverage, as well as ensuring efficient, equitable and transparent resource allocation through good governance of health systems; and to ensure collaboration across sectors, as appropriate, with a special focus on reducing health inequities and inequalities;
<table>
<thead>
<tr>
<th>UHC national policy process</th>
<th>Role of civil society</th>
<th>Questions to ask</th>
<th>Government commitments</th>
</tr>
</thead>
<tbody>
<tr>
<td>MONITORING AND EVALUATION</td>
<td>Civil society and community have a strong role to play in monitoring UHC implementation and supplementing the evidence base that can feed into the cycle of planning again from the top.</td>
<td>What Parliamentary accountability mechanisms are in place to hold local and national decision makers to account? Are community-led accountability mechanisms included in UHC implementation plans?</td>
<td>UN Declaration on UHC, 2019 Paragraph 83. 'Decide to convene a high-level meeting on UHC in 2023 in New York, aimed to undertake a comprehensive review on the implementation of the present declaration to identify gaps and solutions to accelerate progress towards the achievement of universal health coverage by 2030, the scope and modalities of which shall be decided no later than the seventy-fifth session of the General Assembly, taking into consideration the outcomes of other existing health-related processes and the revitalization of the work of the General Assembly.'</td>
</tr>
</tbody>
</table>

Baby Rivona, Co-founder of Indonesian Positive Women Network: “When you are talking about criminalisation, about justice, about healthcare services, about UHC – they are crosscutting each other. You cannot look at one in isolation without looking and thinking about the others.”
**TOOL 2: Advocacy prioritisation**

**Purpose:** This tool will help you identify critical gaps and highlight areas of concern to inform your advocacy goals and objectives. Some of these key issues will translate into short-term asks, while others will require medium or longer-term advocacy effort.

**How:** Ideally, this exercise will be carried out collectively at the national level by key population and HIV community organisations and networks. This is where you can capture national commitments on HIV, compare them against UHC implementation to date, and bring in the impact - good and bad - of COVID-19 to these agendas. Start by listing your national HIV targets and commitments in the far-left column. We have used the global commitments as an example. Then consider for each target or commitment what role UHC implementation can play in delivering on these targets, and on the COVID-19 impact.

**Outcome:** Having completed the grid, you should be in a position to focus in on your top three advocacy asks. Once you have completed the next stages, circle back to Tool 2 to help you frame your messages and validate them with community partners.

<table>
<thead>
<tr>
<th>National HIV commitments</th>
<th>How can UHC address gaps and help to deliver on HIV targets?</th>
<th>Impact of COVID-19, what are the challenges and opportunities?</th>
<th>Conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>90-90-90</td>
<td>e.g. -Inclusion of ARVs, CD4 and viral load testing covered under health insurance schemes, health benefit packages, essential health services packages - Integration of ARV and SRHR services into existing health services -Fixed prices for ARVs</td>
<td>Use the boxes below to list the impact of COVID-19 on progress towards HIV targets</td>
<td>Use the boxes below to highlight critical areas of concern, reflecting on national progress against HIV commitments, UHC implementation and the impact of COVID-19.</td>
</tr>
<tr>
<td>Ensure key populations and adolescent girls and young women (AGYW) have access to combination prevention options and services, including harm reduction</td>
<td>e.g. Designation of HIV prevention services as essential services (therefore open during lockdowns) e.g. Inclusion of HIV prevention commodities and services in health insurance schemes, health benefit packages etc</td>
<td>e.g. Closure of primary care facilities and community- and NGO-based HIV service providers risks interrupting access to regular HIV testing and antiretroviral prevention (PrEP) and treatment. Undiagnosed and uncontrolled HIV increases risk of severe symptoms and adverse outcomes from COVID-19.</td>
<td>e.g. In 2018, an Indonesian Presidential Decree stated that conditions arising from drug or alcohol dependence, personal accident or a “hobby” that is harmful to the individual will not be covered by the National Health Insurance (JKN) e.g. In Uganda, condoms are not included in the national health budget</td>
</tr>
<tr>
<td><strong>Eliminate barriers, including stigma and discrimination, in health-care settings</strong></td>
<td>e.g. - Health workforce training - Inclusion of key populations in UHC monitoring</td>
<td>e.g. Disinformation based on stigmatising attitudes and beliefs about LGBT drawn from the HIV epidemic may be used to scapegoat LGBTIQ as vectors and carriers of COVID-19</td>
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</tr>
<tr>
<td><strong>Ensure 75% of people living with, at risk of and affected by HIV have HIV-sensitive social protection</strong></td>
<td>e.g. Inclusion of key populations in social protection measures such as health insurance schemes</td>
<td>e.g. In Indonesia, access to the National Health Insurance Scheme requires a family-based ID card e.g. In Vietnam, key populations are not eligible for health insurance</td>
<td></td>
</tr>
<tr>
<td><strong>Eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and key populations</strong></td>
<td>e.g. National UHC legislation addresses violence as a public health issue - Repeal or reform of laws that criminalise people living with HIV and key populations</td>
<td>e.g. Uganda’s HIV and AIDS Prevention and Control Act of 2014 includes two HIV criminalisation provisions e.g. Indonesia has proposed legislation criminalising all sex outside of marriage</td>
<td></td>
</tr>
<tr>
<td><strong>Increase funding for HIV prevention and social enablers (advocacy, community and political mobilisation, community monitoring, outreach programmes and public communication)</strong></td>
<td>e.g. National health budgets have earmarked/ designated funding for community-led services, outreach and UHC monitoring - UHC legislation endorses the role of civil society and communities in delivering UHC</td>
<td>e.g. in Kenya, communities are not invited to participate in UHC policy dialogue e.g. in Myanmar, many PLHIV-led and key population-led CBOs are not legally registered and therefore ineligible as UHC service providers</td>
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</tbody>
</table>

Once you have completed the rows above, what are your top three advocacy asks? What can be addressed in short, medium and long-term?

**Useful resources:**


Report not yet launched at time of publication, please look at aidsfonds.org to download report. Civil society review of implementation of African Union’s catalytic framework to End AIDS, TB and Eliminate Malaria when published


TOOL 3: Stakeholder/target mapping (at national level)

**Purpose:** This tool will help you identify and map the stakeholders and targets that you will need to engage at national level.

**How:** First enter your existing and potential supporters and champions in the appropriate sections of the grid. Your allies will be those who believe UHC implementation should be equitable and inclusive. Secondly enter your targets, both in terms of raising awareness and changing policy. This may require additional research.

**Outcome:** Having completed the mapping, you will have the basis of an advocacy coalition and where to focus your strategy. You are now ready to identify the key moments that will be hooks or entry points for your advocacy and the start of an advocacy roadmap.

### Allies
Those who believe UHC implementation should be equitable and inclusive and want to see increased public investment in health

- Health NGOs
- Human rights NGOs
- Members of CSEM
- Patient groups
- Medical associations
- Trade unions
- Academia
- Social/tax justice movements

### Civil Society/Community

#### Government
National AIDS Councils
Parliamentary champions on HIV

#### UN/Development Partners
Global Fund CCMs
PEPFAR
WHO
UNAIDS
UNDP
World Bank
Bilateral donors in country

#### Private Sector
Healthcare providers

### Targets
Who is unaware of the implications of UHC for the HIV response?
Who do you need to influence policymakers and what role can they play?

- Where does the power lie at national level?
  - e.g. President & First Lady
  - Ministry of Health (especially finance & planning departments)
  - Technical Working Groups
  - Parliamentary Health Committee
  - Ministry of Finance
  - Ministry of Social Affairs/ Welfare
  - District Authorities
  - Health Commission

#### UN/Development Partners
Which of these sit on the UHC technical working groups and can bring you into the conversation?
Who do you need to influence policymakers and what role can they play?

- e.g. Pharmaceuticals
- Pharmacy associations
- Industry lobbies

#### Private Sector
How is the private sector engaged with UHC implementation? Do you share any common ground?

- e.g. Pharmaceuticals
TOOL 4: UHC advocacy calendar 2021

Purpose: This tool will help you identify key advocacy moments and opportunities and to develop an advocacy workplan. Although we have provided the dates for 2021, many of these events occur at the same time each year.

How: In the right-hand column, enter in key national dates such as national elections, national health summits, conferences and national days. Also consider the relevant regional events and conferences. Once you have conducted policy research, you can also add in the dates of national legislative, policy and budgeting processes you will need to influence or engage with, for example public consultations, National Health Summits, budget readings in Parliament or preparation of National Health Plans.

<table>
<thead>
<tr>
<th>Code</th>
<th>Global Events: Use international days to raise public awareness, call for action and hold governments to account for their commitments</th>
</tr>
</thead>
<tbody>
<tr>
<td>UN Conferences: Ask your government delegations to include CSO perspectives, and where appropriate publish shadow reports on UHC implementation</td>
<td></td>
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<tr>
<td>Regional Conferences: Push for UHC and HIV on the agenda and ask government delegations to include civil society perspectives</td>
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</tr>
<tr>
<td>National Events: Campaign for greater focus on UHC and HIV among politicians and policymakers</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>January</th>
<th>African Union Summit (11-15 January)</th>
<th>PEPFAR COP Process (until 21 April)</th>
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</thead>
<tbody>
<tr>
<td>February</td>
<td></td>
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<tr>
<td>March</td>
<td>International Women's Day (8 March)</td>
<td>UN Human Rights Council (TBC) (22 February - 19 March)</td>
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<td>African Health Agenda International Conference (8-10 March)</td>
</tr>
<tr>
<td>April</td>
<td>World Health Day (7 April)</td>
<td>ECOSOC Forum on Financing for Development (TBC) (12-15 April)</td>
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<td>ASEAN Summit (TBC)</td>
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<tr>
<td>May</td>
<td>World Health Assembly (24 May- 1 June)</td>
<td>Vietnam General Election</td>
</tr>
<tr>
<td>June</td>
<td>UN Human Rights Council (TBC)</td>
<td>Commonwealth Heads of Government Meeting, Rwanda (21 June)</td>
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<tr>
<td>July</td>
<td>WHO Regional Committees: Europe, Americas, South East Asia (TBC)</td>
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<tr>
<td>August</td>
<td>WHO Africa Regional Committee (TBC)</td>
<td>Southern African Regional Development Summit (TBC)</td>
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<td></td>
<td></td>
<td>Zambia General Election</td>
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<tr>
<td>September</td>
<td>WHO Regional Committees: Europe, Americas, South East Asia (TBC)</td>
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<tr>
<td></td>
<td>UN Human Rights Council (TBC)</td>
<td></td>
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<tr>
<td>October</td>
<td>World Health Summit, Berlin (25-27 October)</td>
<td>WHO Regional Committees: Eastern Mediterranean, W. Pacific (TBC)</td>
</tr>
<tr>
<td>November</td>
<td>East African Community Summit (TBC)</td>
<td></td>
</tr>
<tr>
<td>December</td>
<td>ICASA, Uganda (6-11 December)</td>
<td>UHC Day (12 December)</td>
</tr>
</tbody>
</table>
TOOL 5: How to use social media to get your message across

COVID-19 has had a dramatic impact on how advocacy is conducted, especially in contexts where in-person face-to-face interaction is considered essential to relationship building and reaching common ground. Our traditional methods of in-person face-to-face meetings with policymakers and others are no longer the best option. The timing of Parliamentary and Ministry schedules and legislative processes have become less predictable. Key UHC legislative and policy processes have been put on hold and/or delayed into 2021. In some places, civil servants and Parliamentarians have struggled to make the technological and cultural shift to working online and it has proven hard to get their attention. On the other hand, virtual meeting options have increased opportunities for dialogue and opened up participation to a larger number of participants. Social media and video platforms have become more important than ever as an effective way to communicate our message to the world, especially in a fast-moving political environment.

Social media channels
Social media are essential in delivering your advocacy strategy. Many organisations deliver around 70% of their digital communications through their own online media (website and social media). Of course there are good reasons for this: your own media is available, familiar, safe, and free. However, there is a problem with this: your own media only reaches the people who already support your cause.

If you want to reach other audiences, like people who are not yet engaged in your cause but could be persuaded; your opponents who you want to neutralise; the decision makers who you want to influence; and all the people who you want to mobilise you need to expand your social media reach.

There are two main strategies you can look at to do this:
1. Use your own channels to attract attention
2. Use channels where your target audiences are already present

Strategy 1: Using your own channels to attract attention
In January 2020, 500 million tweets were sent each day globally. In a world where everyone has a message and the capacity and opportunity to share it, it’s not easy to break through the “noise”. Attracting audiences to your cause is a vast science in itself, that feeds countless publications, studies, manuals, online courses and consultancies. Tagging decision-makers and their staff is one way to ensure that your message is seen, and thanking them for positive actions they have taken can encourage them to do more.

Here are some useful tips on digital engagement:

1. Make it urgent: Responding to a sense of urgency seems to be written into our DNA. But this obviously only works for certain types of communications and an over-use of urgency will soon lose its credibility.

2. Make it personal: No message is as effective as one coming from a person and directly addressed to another. Think of it this way: every good digital communication is like eye contact.

3. Make it emotional: People are “powered” by emotions. There is simply no energy without them. Think of it as fuel for a car: your car can be perfect with the best design but without fuel it won’t go anywhere. Every good campaign video is loaded with emotions.

4. Confront stereotypes: Stereotypes and assumptions, which are often unconscious, need to be first made visible before they can be confronted. This tactic attracts audiences by directly talking to their unconscious biases.
5. Make it fun: There are many ways to use humour for your cause. There are obviously also caveats and humour is not universal. Some serious issues don’t mix well with humour. But when used well it can become a fantastic way to attract audiences who mainly seek distraction. The impact of humour is often incomparably better than a serious message.

6. Come out of hiding: For some issues, it is not strategic to tell your audience the key message too early, because this could raise their defences, or purely switch them off. It can be more strategic to only tell your audience at the very end what the communication was about, and to use this “surprise effect” to drive home the message.

Remember above all to produce high quality material. With so much happening online, bad quality content has virtually no chance to make it beyond your most dedicated supporters.

**Strategy 2: Using channels where your target audiences are already present**

Even if you employ the previous strategy you might be disappointed, as your carefully crafted messages, infographics, memes, calls for action or videos might gain little visibility. Why, and what do you do now?

The next step is to identify your audiences more clearly and meet them in their own spaces.

Let’s say you have identified that young urban women are likely to support one of your particular advocacy objectives. After some careful social research, you have developed a moving video message from a young woman living with HIV who shares her powerful story of struggle, resilience, and eventual success in turning her life around.

You post the video on your social media channels and get some shares. After a couple of weeks, the video has 2,000 views, but then the views stop increasing. You know that you’ve exhausted the capacity of members, allies and supporters to disseminate and share. So you now need to investigate audiences in other spaces.

To identify where your target group is interacting digitally, you need to have a deep understanding of them and carefully study their behaviours online. Once you have identified where your target group is interacting online, your next job is how to define how you will engage with them.

**The social engagement ladder**

A good lesson in communications for advocacy, is that it’s always better to listen to your audience before you do the talking, and you must find the common ground between you and your audience.

The decision on what social media channel to use and what messages would have the biggest impact comes down to your knowledge and how you approach each of your audiences.

The key to engaging with your audiences is to understand that there are different stages of engagement. Working with the social engagement ladder below will help you devise precise strategies to determine where your audiences are on the ladder and what you need to do to increase their engagement with you and your cause.
Aware/observing
Supporters are interested in the cause and might be aware of your organisation. They are not yet connected with you. They get information about your cause or your organisation via other channels and other groups which they are part of (for example they see a post from your page on a friend’s timeline).

Interested/following
Supporters have connected with you. They agree to receive information from you. They provide their contact information or subscribe to your newsletter.

Interacted/endorsing
Supporters take a single-step or straightforward action with low risk or investment. For example they share your content, sign petitions or make a one-time/ small donation.

Engaged/contributing
Supporters take multi-step assignments or actions, representing significant contribution of time, money and/or social capital. They join groups, attend events, or make large donations.

Evangelised or owning/committing
Supporters take on-going and collaborative actions, representing major investments of time, money and social capital. They publish about your cause and speak in public. They are the core volunteers you can rely on.
UHC social media toolkits and resources

WHO and UHC2030 have produced social media advocacy toolkits to support the promotion of UHC, highlight key issues and draw attention to UHC Day on the 12 December each year. Many of the resources on these pages are compatible with HIV advocacy messaging and can inspire your own versions. You can find links to more resources in Part Three of this Guide.


universalhealthcoverageday.org/

Video conferencing platforms

If you cannot hold face-to-face events and meetings to bring together communities, civil society and policymakers, it’s worth considering online video conferencing tools. The most popular platforms are Zoom, Microsoft Teams and GoToMeeting. The benefit of using these is that you can invite more people than you can normally have in a physical meeting space. With careful planning, the space can also be more ‘democratic’ as you have more control over how much time you allocate for discussion and who can present. Be aware that organising a successful online meeting can require as much preparation as organising a traditional one.

With online platforms such as Facebook Live, other types of advocacy engagement are also possible, for example livestreaming of actions, webinars, discussion spaces and even vigils.

Further reading

Take a look at the online Communications for Advocacy course created by PITCH and Sogicampaigns. This course is especially designed for advocates, with activities that use communications, including digital communications and storytelling, as effective ways to reach your advocacy objectives: http://course.sogicampaigns.org/comms4advocacy/

Khuất Thị Hải Oanh, Executive Director SCDI in Vietnam: “I want to tell the story of the HIV response. How we managed to reach people who are hidden, who are ignored, who are invisible and engage them – not in a charitable manner but for them to be agents for change.”
Part Three: Key resources

Advocacy guides and toolkits

UHC Day, 12th December
universalhealthcoverageday.org/toolkit/

Universal Health Coverage Advocacy Guide. UHC2030, 2018


Communications & Advocacy Strategy, Civil Society Engagement Mechanism for UHC2030, 2019

Videos

WHO: Universal Health Coverage - what does it mean? (1.5 minutes)
www.youtube.com/watch?v=pZHiiiGFLN8Y&feature=youtu.be

WHO: Universal health coverage - the best investment for a safer, fairer and healthier world (2.5 minutes)
www.youtube.com/watch?v=C1bljI5MI1o

WHO: Health care for all: let’s make it a reality (2.5 minutes)
youtu.be/azbaxrg75A4

WHO: Universal health coverage: Launch of pilot programmes in Kenya (3 minutes)
www.youtube.com/watch?v=5plA6EiTW4k&feature=youtu.be

WHO: Universal Health Coverage - how are we doing? (3.5 minutes)
youtu.be/gCqZT2gOpIc

Universal Health Coverage: Right. Smart. Overdue. (2.5 minutes)
healthforall.org/why-health/

UHC e-learning courses

World Bank
olc.worldbank.org/content/advocacy-universal-health-coverage

WHO
www.who.int/health_financing/training/e-learning-course-on-health-financing-policy-for-uhc/en/
www.who.int/news-room/events/detail/2021/04/01/default-calendar/seventh-advanced-course-on-health-financing-for-universal-coverage-for-low--and-middle-income-countries

The Joint Learning Network for UHC (JLN)
This is a community of 34 member countries committed to achieving universal health coverage. The members’ pages are particularly useful as they provide country profiles on UHC implementation to date. www.jointlearningnetwork.org/members/
Selected community publications on UHC

Ready for Universal Health Coverage: Youth advocacy on UHC. Frontline AIDS, 2020
frontlineaids.org/ready-for-universal-health-coverage/

Towards the universal health coverage we want: Inclusive, person-centred and equitable. Enhancing inclusion of key and vulnerable populations in the UHC agenda: An African civil society call to action, November 2012
www.arasa.info/blog-news-details/call-to-action-universal-health-coverage-day-2019

World Health Assembly agrees to protect the most vulnerable but who are they?
frontlineaids.org/world-health-assembly-agrees-to-protect-the-most-vulnerable-but-who-are-they/

Briefing Note: Universal health coverage. The Global Network of Sex Worker Projects, 2019

What does UHC mean for people who use drugs? A Technical Brief. INPUD, 2019
www.inpud.net/sites/default/files/Universal%20Health%20Coverage.pdf

Universal health coverage: Putting the last mile first: Position Statement on UHC. GNP+, 2019

GNP+ calls for a strong accountability mechanism for UHC. GNP+, 2019
www.gnpplus.net/gnp-calls-for-a-strong-accountability-mechanism-for-uhc/

Shattering the myths around ‘universal’ health coverage. Frontline AIDS, 2019
frontlineaids.org/shattering-the-myths-around-universal-health-coverage/

Factsheet: UHC and HIV. STOPAIDS, 2019

UHC simplified: Universal health coverage (UHC) in Kenya. KESWA, June 2019
keswa-kenya.org/publications/

aidsfonds.org/assets/resource/file/PITCH_Global-Report_UHC_WEB.pdf

A human rights perspective on UHC: Stories from Indonesia, Kenya, Southern and Eastern Africa, Ukraine and Vietnam. PITCH, 2019
aidsfonds.org/assets/work/file/Pitch%20handout%20UHC%20stories%20A4_V2_online.pdf

www.poz.com/article/hiv-high-level-meeting-universal-health-coverage?fbclid=IwAR2aLnlEoo82okuQoqfHEKMiniM2MOTCmBzmcE-21l1Q_dialGz1p5HTDZazzlBq

Does the UN’s Universal Health Coverage Declaration fail the most vulnerable people? Frontline AIDS, September 2019
frontlineaids.org/does-the-uns-universal-health-coverage-declaration-fail-the-most-vulnerable-people/

How do we get the UHC we want? Frontline AIDS, December 2019
frontlineaids.org/how-do-we-get-the-uhc-we-want/
Wanja Ngure, Kenyan feminist and human rights activist: “For me advocacy is all about the push, it’s about getting yourself into the spaces you’ve not even been invited to. Are key population issues on the UHC agenda? No, not yet, but we are seeing people from key populations asking really pertinent questions. To me this journey has been about creating this awareness, in creating this force, and now people are able to speak out about UHC.”
United Nations Political Declaration on Universal Health Coverage

We, Heads of State and Government and representatives of States and Governments, assembled at the United Nations on 23 September 2019, with a dedicated focus for the first time on universal health coverage, reaffirm that health is a precondition for and an outcome and indicator of the social, economic and environmental dimensions of sustainable development and the implementation of the 2030 Agenda for Sustainable Development, and strongly recommit to achieve universal health coverage by 2030, with a view to scaling up the global effort to build a healthier world for all, and in this regard we:

9. Recognize that universal health coverage implies that all people have access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative, rehabilitative and palliative essential health services, and essential, safe, affordable, effective and quality medicines and vaccines, while ensuring that the use of these services does not expose the users to financial hardship, with a special emphasis on the poor, vulnerable and marginalized segments of the population;

14. Recognize the fundamental importance of equity, social justice and social protection mechanisms as well as the elimination of the root causes of discrimination and stigma in health-care settings to ensure universal and equitable access to quality health services without financial hardship for all people, particularly for those who are vulnerable or in vulnerable situations;

We therefore commit to scale up our efforts and further implement the following actions:

32. Strengthen efforts to address communicable diseases, including HIV/AIDS, tuberculosis, malaria and hepatitis, as part of universal health coverage and to ensure that the fragile gains are sustained and expanded by advancing comprehensive approaches and integrated service delivery and ensuring that no one is left behind;

54. Engage all relevant stakeholders, including civil society, the private sector and academia, as appropriate, through the establishment of participatory and transparent multi-stakeholder platforms and partnerships, to provide input to the development, implementation and evaluation of health- and social-related policies and reviewing progress for the achievement of national objectives for universal health coverage, while giving due regard to addressing and managing conflicts of interest and undue influence;

70. Ensure that no one is left behind, with an endeavour to reach the furthest behind first, founded on the dignity of the human person and reflecting the principles of equality and non-discrimination, as well as to empower those who are vulnerable or in vulnerable situations and address their physical and mental health needs which are reflected in the 2030 Agenda for Sustainable Development, including all children, youth, persons with disabilities, people living with HIV/AIDS, older persons, indigenous peoples, refugees and internally displaced persons and migrants;

Gender Commitments in the United Nations Political Declaration on Universal Health Coverage (UHC)

8. (We) recognize that universal health coverage implies that all people have access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative, rehabilitative and palliative essential health services, and essential, safe, affordable, effective and quality medicines and vaccines, while ensuring that the use of these services does not expose the users to financial hardship, with a special emphasis on the poor, vulnerable, and marginalized segments of the population;

14. Recognize the fundamental importance of equity, social justice and social protection mechanisms as well as the elimination of the root causes of discrimination and stigma in health-care settings to ensure universal and equitable access to quality health services without financial hardship for all people, particularly for those who are vulnerable or in vulnerable situations;

We therefore commit to scale up our efforts and further implement the following actions:

24. Accelerate efforts towards the achievement of universal health coverage by 2030 to ensure healthy lives and promote well-being for all throughout the life course, and in this regard reemphasize our resolve to:

   a. progressively cover one billion additional people by 2023 with quality essential health services and quality, safe, effective, affordable and essential medicines, vaccines, diagnostics and health technologies, with a view to cover all people by 2030;

   b. stop the rise and reverse the trend of catastrophic out-of-pocket health expenditure by providing measures to assure financial risk protection and eliminate impoverishment due to health-related expenses by 2030, with special emphasis on the poor as well as those who are vulnerable or in vulnerable situations;

25. Implement most effective, high impact, quality-assured, people-centred, gender- and disability responsive, and evidence-based interventions to meet the health needs of all throughout the life course, and in particular those who are vulnerable or in vulnerable situations, ensuring universal access to nationally determined sets of integrated quality health services at all levels of care for the prevention, diagnosis, treatment and care in a timely manner;

61. Develop, improve, and make available evidence-based training that is sensitive to different cultures and the specific needs of women, children and persons with disabilities, skills enhancement and education of health workers, including midwives and community health workers, as well as promote a continued education and life-long learning agenda and expand community-based health education and training in order to provide quality care for people throughout the life course;

63. Provide better opportunities and working environment for women to ensure their role and leadership in the health sector, with a view to increasing the meaningful representation, engagement, participation and empowerment of all women in the workforce, addressing inequalities and eliminating biases against women, including unequal remuneration while noting that women, who currently form 70% of the health and social workforce, still often face significant barriers in taking leadership and decision making roles;

69. Mainstream a gender perspective on a systems-wide basis when designing, implementing and monitoring health policies, taking into account the specific needs of all women and girls, with a view to achieving gender equality and the empowerment of women in health policies and health systems delivery and the realization of their human rights, consistent with national legislations and in conformity with universally recognized international human rights, acknowledging that the human rights of women include their right to have control over and decide freely and responsibly on all matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence;

World Health Assembly Resolutions 2019

WHA72.3 Community health workers delivering primary health care: opportunities and challenges
The Seventy-second World Health Assembly,
2. URGES all Member States, as appropriate to local and national contexts and with the objective of the success of primary health care and the achievement of universal health coverage:
(4) to allocate, as part of broader health workforce strategies and financing, adequate resources from domestic budgets and from a variety of sources, as appropriate, to the capital and recurrent costs required for the successful implementation of community health worker programmes and for the integration of community health workers into the health workforce in the context of investments in primary health care, health systems and job creation strategies, as appropriate;

WHA72.4 Preparation for the high-level meeting of the United Nations General Assembly on universal health coverage
The Seventy-second World Health Assembly,
1. URGES Member States:
(1) to accelerate progress towards achieving Sustainable Development Goal target 3.8 on universal health coverage by 2030, leaving no one behind, especially the poor, the vulnerable and marginalized populations;
(3) to continue to mobilize adequate and sustainable resources for universal health coverage, as well as ensuring efficient, equitable and transparent resource allocation through good governance of health systems; and to ensure collaboration across sectors, as appropriate, with a special focus on reducing health inequities and inequalities;
(4) to support better prioritization and decision-making, notably by strengthening institutional capacities and governance on health intervention and technology assessment, in order to achieve efficiencies and take evidence-based decisions, while respecting patient privacy and promoting data security; and to encourage

the greater and systematic utilization of new technologies and approaches, including digital technologies and integrated health information systems as a means of promoting equitable, affordable, and universal access to health and to inform policy decisions in support of universal health coverage;
(5) to continue investing in and strengthening primary health care as a cornerstone of a sustainable health system, to achieve universal health coverage and targets of the health-related Sustainable Development Goals, with a view to providing a comprehensive range of services and care that are people-centred, of high quality, safe, integrated, accessible, available and affordable, as well as providing public health functions as envisioned in the Declaration of Astana from the Global Conference on Primary Health Care (Astana, Kazakhstan, 25 and 26 October 2018) and implementing the commitments of that Declaration;
(6) to continue investing in and strengthening gender-sensitive health care services that address gender-related barriers to health and secure women and girls’ equitable access to health, in order to realize the right to the enjoyment of the highest attainable standard of health for all and achieve gender equality and the empowerment of women and girls;

apps.who.int/gb/ebwha/pdf_files/WHA72-REC1/A72_2019_REC1-en.pdf#page=25
SDG3: Good Health and Well-Being

Ensure healthy lives and promote well-being for all at all ages

**Target 3.3:** By 2030, end the epidemics of AIDS, Tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases

**Target 3.8:** Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
End notes

1 Defined as health promotion, prevention, treatment, cure, rehabilitation and palliative care services.
2 World Health Report 2010
4 www.who.int/iris/bitstream/handle/10665/112671/9789241507158_eng.pdf?sequence=1
9 policy-practice.oxfam.org.uk/publications/universal-health-coverage-why-health-insurance-schemes-are-leaving-the-poor-behind-302973
13 www.ncbi.nlm.nih.gov/pmc/articles/PMC5886176/
22 www.ncbi.nlm.nih.gov/pmc/articles/PMC23790226/
23 www.unaids.org/sites/default/files/media_asset/2020/rights-in-a-pandemic
25 www.ncbi.nlm.nih.gov/pmc/articles/PMC3882205/
26 pubmed.ncbi.nlm.nih.gov/24315063/
28 unctad.org/webflyer/world-investment-report-2020
31 www.gnpplus.net/assets/wbb_file_updown/8170/BeyondLIVING_COVID-19_Updated.pdf
36 www.unaids.org/sites/default/files/media_asset/2020/rights-in-a-pandemic
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