Guidance for national strategic planning (NSP)

Health sector response to HIV, viral hepatitis and sexually transmitted infections

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Foreword

Sound strategic planning provides the foundation for delivering high-quality services for population health and well-being. It reflects people's diverse needs, enables efficient use of health system resources and improves predictability, sustainability and transparency.

Countries worldwide have gathered vast and varied experience in developing health sector plans over the past decades. In a rapidly changing global health context, it is time to revisit traditional planning processes to respond effectively to today's complex health system challenges. COVID-19 and other health threats underscore the importance of aligned efforts to strengthen core health system functions for greater health security. Persistent inequities make it urgent to reorient disease responses with a primary health care approach. The full potential of community-led services should be deployed to reach those who are poorly served by regular delivery channels. The growing demand for health services, coupled with financial instability, require us to be smarter in our investment decisions. Fully inclusive dialogue is vital to ensure that affected populations are active stakeholders in decision-making. The health sector needs to take the lead in engaging other sectors in a holistic approach to health.

This guidance provides countries with the key elements of strategic planning for HIV, viral hepatitis and sexually transmitted infections in this dynamic health sector context. Presented in a single document, the guidance promotes greater integration across these related programme areas and calls on all countries to rethink their disease-specific planning and delivery with a primary health care approach. The guidance also encourages alignment with other health sector planning processes and emphasizes the importance of well-prioritized, costed and measurable strategic plans. The welfare of the populations to be served must be at the centre of our planning efforts, with the overarching resolve to protect and promote health as a human right.

As countries embark on their next planning cycles, we encourage all national partners, including health ministries, related ministries, civil society, affected communities and other stakeholders to use this guidance for participatory and evidence-informed planning processes. We also encourage all development partners, including bilateral and multilateral partners, to align their support around these national strategic plans. WHO stands ready to support countries in their planning efforts, and we are convinced that robust strategic plans will effectively steer HIV, viral hepatitis and sexually transmitted infection responses towards the goal of universal health coverage.

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Acronyms

ANC	Antenatal care
CCM	Country Coordinating Mechanism
GHSS	Global Health Sector Strategies on, respectively, HIV, viral hepatitis, and sexually transmitted infections
GUD	genital ulcer disease
HAV	Hepatitis A virus
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HDV	Hepatitis D virus
HEV	Hepatitis E virus
HIV	Human immunodeficiency virus
HPV	Human papillomavirus
HSV	Herpes simplex virus
JANS	Joint assessment of national strategies
M&E	Monitoring and evaluation
MNCH	Maternal, new-born and child health
NAC	National AIDS Council
NACP	National AIDS control programme
NCDs	Noncommunicable diseases
NSP	National strategic plan
NTDs	Neglected tropical diseases
PHC	Primary health care
PID	Pelvic inflammatory disease
SRH	Sexual and reproductive health
STIs	Sexually transmitted infections
TA	Technical assistance
TB	Tuberculosis
UD	Urethral discharge
UHC	Universal health coverage

Part 1.
Background and context

1. Introduction

HIV, viral hepatitis and sexually transmitted infections remain major interrelated global epidemics that collectively cause 2.3 million deaths and 1.2 million cases of cancer each year. More than 1 million people newly acquire sexually transmitted infections each day, and 4.5 million people acquire HIV, hepatitis B and hepatitis C each year *(1)*. Each of these epidemics disproportionately affect poor, marginalized and stigmatized populations.

There have been many achievements over the past decade in addressing these epidemics. The global HIV epidemic has been transformed with the large-scale expansion of antiretroviral therapy, reducing global HIV-related deaths by 47% between 2010 and 2020. The viral hepatitis response has gained significant momentum since 2015, with a 10-fold increase in the number of people receiving treatment for chronic hepatitis C virus infection between 2015 and 2020. Further, the proportion of children under five years of age chronically infected with hepatitis B virus dropped to just under 1% in 2019, from about 5% in the pre-vaccine era, ranging from the 1980s to the early 2000s *(2)*. The global response to sexually transmitted infections is slowly gathering pace after years of neglect.

However, the responses to HIV, viral hepatitis and sexually transmitted infection missed the global targets for 2020 and will require renewed efforts to get back on track towards the targets of the 2030 Agenda for Sustainable Development *(3)*. The COVID-19 pandemic has further hampered progress, placing an enormous strain on health systems worldwide and worsening the inequalities that make some populations more vulnerable to the diseases. The full benefits of available tools and technologies are not being realized, many populations are being left behind and structural and financial barriers persist. Accelerated action is needed to get back on track, by strengthening health and community systems, leveraging new knowledge and innovations and upholding human rights and evidence-informed practice *(1)*.

In 2022, WHO published the global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections (GHSS) 2022–2030 to guide the health sector to achieve the goals of ending these epidemics by 2030 *(4)*. HIV, viral hepatitis and sexually transmitted infections affect many overlapping population groups and interact synergistically, contributing to excess burden of disease in a population. They also share many common determinants, interventions and service delivery approaches. Recognizing the opportunities for harmonized approaches and programme linkages, the GHSS 2022–2030 consolidate the strategies for HIV, viral hepatitis and sexually transmitted infections into a single document for the first time with a primary health care approach. They promote the implementation of the strategies in ways that place people at the centre of the responses and underline the critical leading role of the health sector in achieving the goals of universal health coverage and the 2030 Agenda for Sustainable Development.

Purpose and scope of this guidance

This publication provides a resource for countries to develop their national strategic plans for HIV, viral hepatitis and sexually transmitted infections, guided by the GHSS 2022–2030 (Box 1). It presents the core elements of strategic plans for each of these diseases and provides considerations for shared approaches. The terms strategy and strategic plan are used interchangeably in this guidance, as is often the case in practice in country planning documents.

Countries worldwide are at different stages in their responses to HIV, viral hepatitis and sexually transmitted infections. To make progress towards ending these epidemics, each country needs to address HIV, viral hepatitis and sexually transmitted infections within the broader context of national health planning and budgeting for universal health coverage. This involves making evidence-informed decisions that respond to the local epidemiological and health system contexts and delivering services that leave no one behind. National strategic planning is a key step in this process.

Box 1. What is new in this guidance?

A single document for a people-centred approach to strategic planning for HIV, viral hepatitis and sexually transmitted infections. For the first time, guidance for national health sector strategic planning for HIV, viral hepatitis and sexually transmitted infections is presented in a single publication. The guidance thus enables countries to strategically integrate disease-specific and shared approaches for HIV, viral hepatitis and sexually transmitted infections and for other related programme areas as relevant (for example, tuberculosis (TB), sexual and reproductive health, maternal and child health, noncommunicable diseases or others) for a more effective people-centred response.

Alignment with global strategic shifts to end epidemics by 2030. The guidance aligns with global commitments to achieve universal health coverage and strengthen primary health care, leaving no one behind. It specifically aligns with the vision and priorities of the GHSS 2022–2030 on, respectively, HIV, viral hepatitis and sexually transmitted infections towards ending the epidemics of HIV, viral hepatitis and sexually transmitted infections as public health threats by 2030, as well as the Global AIDS Strategy 2021–2026 (see Chapter 2). Recognizing that each country will be at different stages of progress towards ending these epidemics, the guidance encourages all countries to set ambitious targets, as close to global targets as possible, in relation to the country situation and capacity.

Flexibility to adapt the guidance to various country planning contexts. The guidance is modular and enables countries to present the core components of HIV, viral hepatitis and sexually transmitted infection strategic plans in various formats depending on the country's planning context and conventions.

Target audience

The target audience for this guidance includes all stakeholders involved in national health sector strategic planning for HIV, viral hepatitis and sexually transmitted infections. This includes national disease programmes and other related programmes and departments within health ministries; other related ministries such as ministries of finance, education, justice, labour, social protection, agriculture, housing and the environment; national AIDS commissions and other multisectoral coordination bodies; civil society organizations and affected communities; bilateral and multilateral partners; donors; the private sector; and other relevant stakeholders in each country context. Although this guidance is primarily aimed at national level planning, the principles and processes described can also be used for planning at subnational levels.

How to use this guidance

This guide is presented in a modular format, so that countries can refer to and apply the content in different ways as relevant to their health sector planning situation and practice. The main features of the guide are described below.

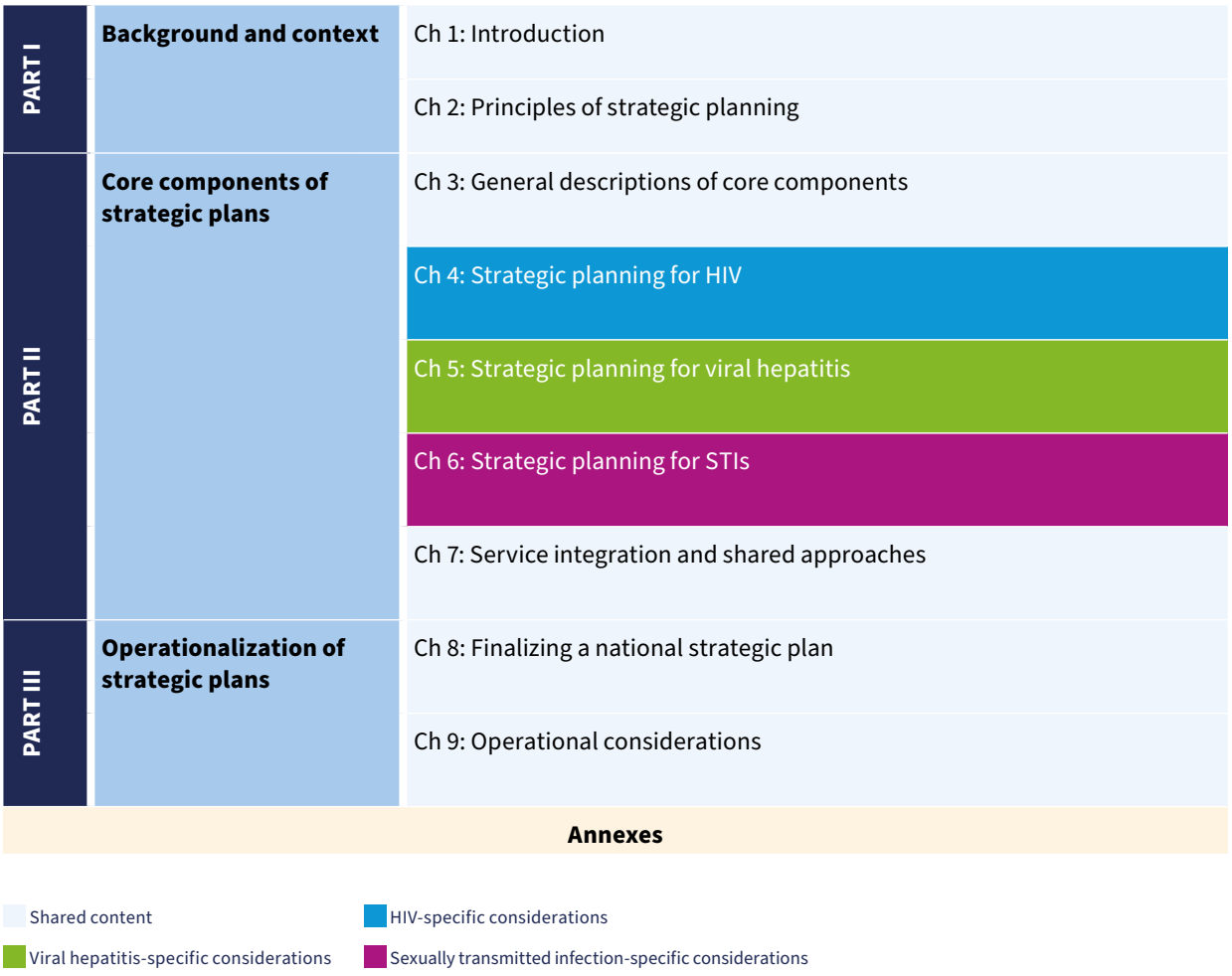
1) *A modular structure with shared and disease-specific content*. The guidance is presented in a modular structure (Fig. 1).

   Part 1 (Chapters 1 and 2) provides the overall background and context for strategic planning for all three disease areas.

   Part 2 describes core components (Chapter 3) and considerations for integration and shared approaches (Chapter 7) for all disease areas; supplemented by disease-specific content for HIV (Chapter 4), viral hepatitis (Chapter 5) and sexually transmitted infections (Chapter 6), respectively.

   Part 3 (Chapters 8 and 9) describe the various aspects of operationalization of strategic plans for all three disease areas.

Fig. 1. Structure of the document



2) *Flexibility to develop strategic plans in different formats.* The guidance enables countries to present the core components of HIV, viral hepatitis and sexually transmitted infection strategic plans in the most suitable format in relation to the country's situation and practice, for example:
   - as a stand-alone strategic plan for a single disease area;
   - as integrated within a national health sector strategic plan;
   - as combined strategic plans for more than one disease area, such as joint HIV, viral hepatitis and/or sexually transmitted infections strategic plans and/or joint plans with other related health areas such as TB, sexual and reproductive health, maternal, newborn and child health etc.; or
   - as the health sector component of multisectoral strategic plans (such as a HIV multisectoral plan).
   - The format selected should be guided by the critical shift to promote people-centred responses to these diseases, such that planning and implementation are organized to meet people's needs in a comprehensive manner rather than around individual disease programme areas.
3) *Practical tips, resources and tools.* The guidance uses figures, boxes and tables to help readers to navigate and apply the content. The annexes provide links to selected tools and resources that can provide additional guidance on the various aspects of strategic planning and a glossary of key terms that are useful in the planning process.

2. Principles of strategic planning

This chapter provides an overview of the health sector context and principles of national strategic planning for HIV, viral hepatitis and sexually transmitted infections (Box 2). It situates planning for HIV, viral hepatitis and sexually transmitted infections within the broader health and development context in a country, presents the guiding principles of robust strategic planning efforts and describes the strategic shifts that will be necessary in all national planning efforts to achieve the goal of ending these epidemics by 2030.

It is structured as follows:

- Section 2.1 presents the broader national context of health policies, strategies and plans.
- Section 2.2 describes the health sector context within which these are developed.
- Section 2.3 discusses a primary health care approach to disease responses.
- Section 2.4 discusses strategic planning in the context of health emergencies.
- Section 2.5 presents the principles of strategic planning and the directional shifts in this guidance.

Box 2. What is strategic planning?

Health sector strategic planning translates a country's health vision, objectives and priorities into a robust document that guides resource allocation and the implementation of activities to deliver on health outcomes for a population. WHO's handbook on strategizing national health in the 21st century (5) emphasizes that strategizing – defined as designing policies, strategies and plans to achieve a specific goal related to the health of a country – is critical to respond to an increasingly complex global health environment driven by social, demographic and epidemiological transformations. Strategic planning helps to guide and steer the pluralistic health sector and forms a key element for fiscal space and budget negotiations in government.

National health policies, strategies and plans must be well prioritized, reflect the needs and demand for health services and orient resource allocation towards universal health coverage objectives. They must be anchored in strong political agreements to improve consistency and predictability and developed through intersectoral (whole-of-government) and intrasectoral inclusive policy dialogue with all health stakeholders (whole of society). They must be translated into operational plans and budgets that will enable full implementation and be monitored and transparently evaluated for increased accountability and transparency.

2.1 National planning context

Strategic planning for HIV, viral hepatitis and sexually transmitted infections takes place within the country's broader health and development context, including the political, economic, demographic and sociocultural situation. These factors vary by country and within a country over time. Countries also face transformations and challenges on an ongoing basis, such as demographic shifts, urbanization, population mobility, climate change and insecurity, which influence the planning environment. National strategic planning for HIV, viral hepatitis and sexually transmitted infections should be aligned with and contribute to the country's overall development framework.

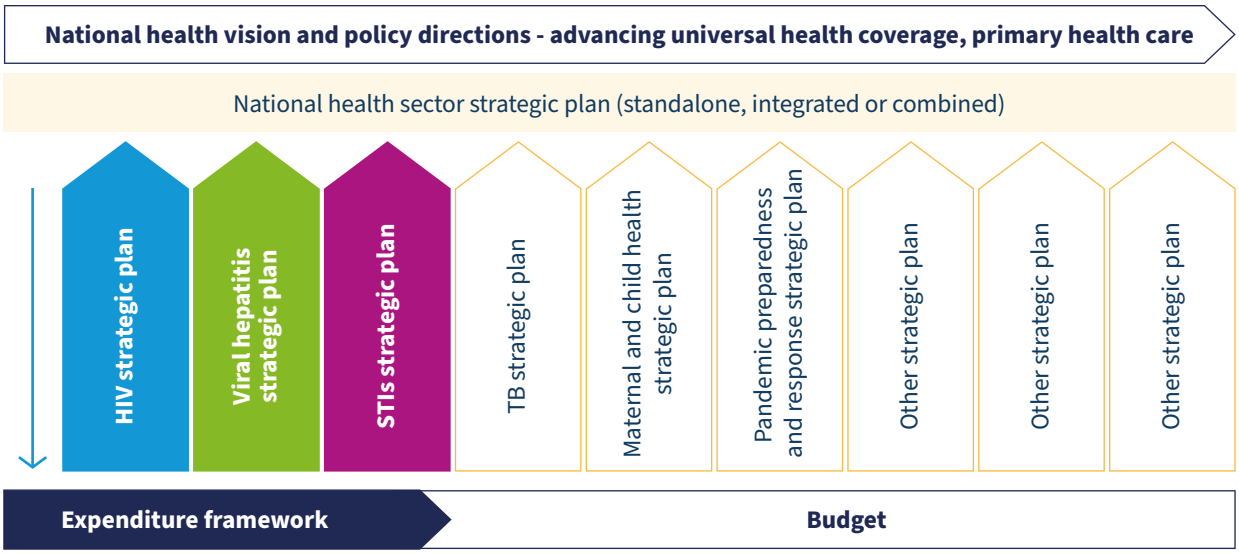
The health sector, which leads national responses to HIV, viral hepatitis and sexually transmitted infections, functions within this broader development context. A country's health system capacity, including its income level, past achievements and challenges and future priorities, will determine how a country plans and sets priorities to achieve universal health coverage for its population. Further, improved population health and well-being cannot be achieved by the health sector alone, making a multisectoral approach to health sector planning and policy dialogue essential. Strategic plans for HIV, viral hepatitis and sexually transmitted infections must therefore be developed in collaboration with all relevant government sectors (such as education, infrastructure, environment, labour and social protection), and through inclusive policy dialogue with key stakeholders (including civil society, communities, academia, media and the private sector). Section 2.2 provides further information on the health sector context.

The process of building comprehensive, coherent and well-balanced national health policies, strategies and plans is as much a political process as a technical one *(5)*. Specifically, many countries face large gaps in the resources needed to strengthen their health systems and achieve universal health coverage. Addressing these gaps and managing competing priorities requires strong political commitment, increased allocation of domestic resources to health and coherent planning and strategizing within the broader context to ensure greater efficiency and impact of available resources.

the following are key considerations for promoting coherence and alignment in planning.

1) Vision and priorities. Strategic plans for individual disease areas do not stand alone. They should be aligned with the overall vision and priorities for health and development in the country, with coherence among HIV, viral hepatitis, sexually transmitted infections and related disease areas such as TB, sexual and reproductive health, maternal and child health, noncommunicable diseases or others (Fig. 2). Achieving coherence requires that the priorities of each disease programme be reflected in the overarching national health plans and that individual disease programme plans be informed by realistic assessments of how they can draw on and contribute to shared resources and capacities within the health sector.

Fig. 2. Alignment of disease strategic plans with broader national health policies, strategies and plans



Source: adapted from Strategizing health in the 21st century: a handbook *(5)*.

2) *Planning cycles.* Strategic planning cycles for disease areas must be aligned with the broader health sector strategic planning cycle as well as the national fiscal cycles for domestic investments in health. When previous disease strategic plans may have different planning and implementation cycles from those of the national health sector and fiscal cycle, these can be brought into alignment by extending existing plans, developing interim plans to bridge the gap or ensuring that the targets are consistent across the different plans.

2.2 Heath sector context

A country's health sector context is determined by several factors, such as the demographics and population characteristics, the epidemiology of different diseases, the social determinants of health, national policies and priorities related to health, the capacity and organization of the health system and the health stakeholders and the availability of funding from domestic and external sources. These factors influence how strategic plans and priorities for HIV, viral hepatitis and sexually transmitted infections are developed and implemented and determine a country's pace towards achieving universal health coverage goals.

Further, the health sector is facing numerous and increasingly complex challenges linked to globalization, urbanization, ageing populations, growing burden of noncommunicable diseases, new or emerging pathogens and other threats such as climate change, population movements and displacement, economic insecurity, conflict and natural disasters. Strategic planning for HIV, viral hepatitis and sexually transmitted infections needs to evolve within this dynamic health sector context to effectively end these epidemics as public health threats. To achieve impact, disease strategic plans need to adopt people-centred approaches, promote equity, contribute to building resilient health systems and encompass action on the social determinants of health through pluralist and inclusive dialogue processes within each country.

Several global goals, strategies and commitments provide guiding frameworks for national strategic planning within this evolving health sector context. The key global strategies and commitments of relevance to HIV, viral hepatitis and sexually transmitted infection planning include:

- Transforming our world: the 2030 Agenda for Sustainable Development (3)
- Declaration of Astana (6)
- Political Declaration of the High-level Meeting on Universal Health Coverage (7)
- Political Declaration on HIV and AIDS 2021 (8)
- Global AIDS Strategy 2021–2026 (9)
- Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections 2022–2030 (4)

Specifically, the GHSS 2022–2030 (Box 3) guide all countries in their national planning efforts in the health sector, with a common vision to end these epidemics and advance universal health coverage, primary health care and health security through shared and disease-specific actions. Recognizing that each country will be at different stages of progress towards ending these epidemics, this guidance encourages all countries to set ambitious targets, as close to these global targets as possible, in relation to the country's resources and capacity.

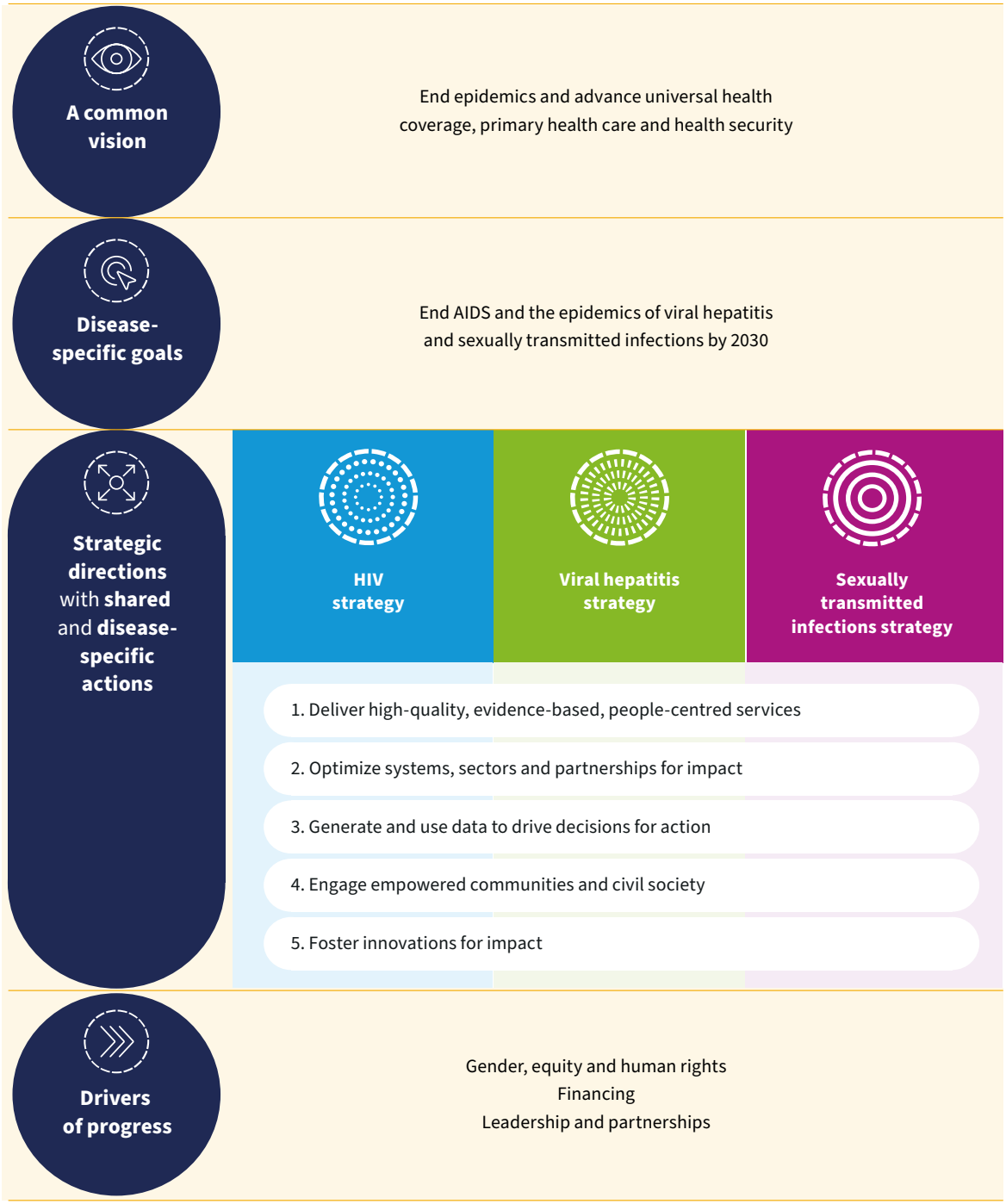
Box 3. The GHSS 2022–2030

The GHSS 2022–2030 (4) guide the health sector in implementing strategically focused responses to achieve the goals of ending AIDS, viral hepatitis B and C and sexually transmitted infections by 2030 (Fig. 3). Building on the achievements and lessons learned under the 2016–2021 global health sector strategies (10–12), the GHSS 2022–2030 consider the epidemiological, technological and contextual shifts of the past years, foster lessons across the disease areas and seek to leverage innovations and new knowledge for effective responses to HIV, viral hepatitis and sexually transmitted infections.

Vision, goals and strategic directions

The GHSS 2022–2030 share a common vision to end the epidemics, to advance universal health coverage, primary health care and health security and to achieve the goals of ending AIDS and the epidemics of viral hepatitis and sexually transmitted infections by 2030. Five strategic directions guide actions across all three strategies, reflecting synergy in the responses to HIV, viral hepatitis and sexually transmitted infections (Fig. 3).

Fig. 3. GHSS 2022–2030 – vision, goals and strategic directions



Strategic shifts towards ending epidemics

- The GHSS 2022–2030 recommend strategic and innovative shifts to protect the gains achieved in the response to HIV, viral hepatitis and sexually transmitted infections to date and to accelerate progress towards ending these epidemics by 2030:
- putting people at the centre: placing people at centre of health system responses by giving priority to services around people's needs rather than around diseases;
- addressing unique priorities for each disease area: addressing the unique gaps, challenges and priorities for HIV, viral hepatitis and sexually transmitted infections, respectively, to accelerate progress, and setting priorities for impact;
- taking a shared approach towards strengthening health and community systems: leveraging synergy in relation to service delivery and other health and community system functions such as governance, financing, health products and health information;
- responding to a swiftly changing health and development context: building resilience in response to the COVID-19 pandemic and other future emerging threats as well as other shifts such as the growing burden of noncommunicable diseases, climate change and increasing population displacement and insecurity; and
- eliminating stigma, discrimination and other structural barriers: taking a multisectoral approach to eliminate the inequalities, stigma and discrimination and criminalization that drive the epidemics and prevent many people from accessing needed services.

These global shifts guide national strategic planning efforts to end the epidemics and to advance universal health coverage, primary health care and health security for all.

2.3 Strengthening primary health care

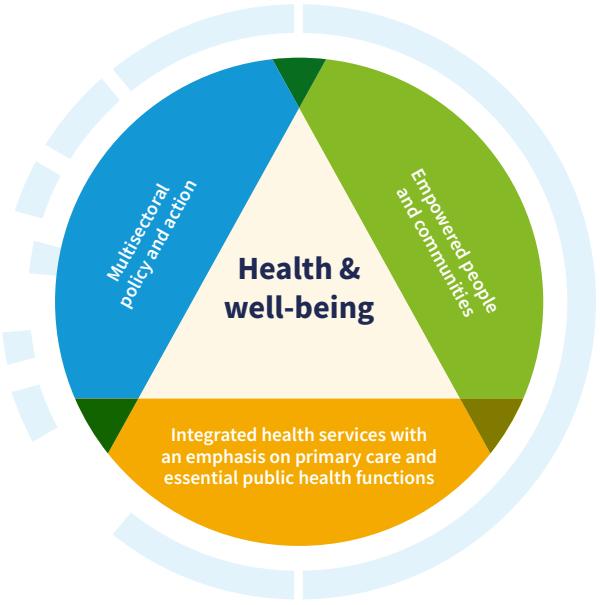
At the Global Conference on Primary Health Care in 2018, Member States adopted the Declaration of Astana *(6)* to reaffirm their commitment to primary health care as the cornerstone of sustainable health systems for universal health coverage and the health-related Sustainable Development Goals. Building on the principles of the Declaration of Alma-Ata in 1978 *(13)*, the Declaration of Astana centres around four commitments: making bold choices for health across all sectors, building sustainable primary health care adapted to each country's local context, empowering individuals and communities and aligning stakeholder support to national policies. The Seventy-second World Health Assembly in 2019 welcomed the Declaration of Astana *(14)* and urged Member States to take measures to share and implement its vision and commitments according to national contexts.

Ending the epidemics of HIV, viral hepatitis and sexually transmitted infections will require renewed commitments to promote the highest attainable standard of health and well-being for all within this primary health care approach, leaving no one behind. The WHO Operational Framework for Primary Health Care defines primary health care as a whole-of-government and whole-of-society approach to health that combines the following three components (Fig. 4) *(15)*:

- integrated health services emphasizing primary care and public health functions, including comprehensive promotive, protective, preventive, curative, rehabilitative and palliative care throughout the life-course;
- multisectoral policy and action to systematically address the broader determinants of health by involving stakeholders within and outside the health sector; and

empowering people and communities to optimize their health as advocates of policies that promote and protect health and well-being, as co-developers of health and social services and as self-carers and caregivers.

Fig. 4. Primary health care components



Source: adapted from Strategizing health in the 21st century: a handbook *(5)*.

In other words, primary health care is an approach to organize and deliver health services in ways that cover most of a person's health needs throughout their lives. Primary health care comprises primary care, a model of care that supports first-contact, accessible, continued, comprehensive and coordinated patient-focused care to optimize population health and reduce disparities in access to health services. It seeks to address the broader determinants of health by involving stakeholders within and outside the health sector and to empower individuals, families and communities to be more involved in their own health *(16)*.

Many HIV, viral hepatitis and sexually transmitted infection responses are already being delivered through primary health care approaches. For example, multisectoral action to address the social determinants of health has been a critical component of HIV responses worldwide and is an increasing part of efforts to address viral hepatitis and sexually transmitted infections. Many countries are already delivering HIV, viral hepatitis and sexually transmitted infection services emphasizing primary care, such as by providing differentiated service delivery to reach diverse populations in need, decentralizing service delivery, task sharing and expanding self-care approaches. Similarly, empowered communities of key populations and people living with HIV have been an integral part of the HIV response, playing a key role in advocacy, service delivery and accountability. A strengthened primary health care approach to HIV, viral hepatitis and sexually transmitted infections will require continued adaptations in how these services are designed, given priority, funded and delivered to meet people's comprehensive needs throughout the life-course.

The WHO Operational Framework for Primary Health Care proposes strategic and operational levers to translate global primary health care commitments into concrete actions and interventions. Strategic planning for HIV, viral hepatitis and sexually transmitted infection can define actions for each of these levers to orient planning and implementation towards strengthening a primary health care approach. Chapter 7 provides further information on concrete actions that can be taken by HIV, viral hepatitis and sexually transmitted infection programmes in relation to these levers.

In addition, the WHO UHC Compendium, a global repository of interventions across health areas, provides countries with a useful resource to plan integrated service delivery and promote linkage across health system levels towards universal health coverage *(17)*. The UHC Compendium spans the full spectrum of services across health areas, including HIV, viral hepatitis and sexually transmitted infections, and provides information on supporting evidence, associated human and material resource inputs and the cost impact for various interventions. Each country can use the UHC Compendium to inform assessments around which services to consider for providing within their system in relation to country capacity, resource availability and priorities; starting with a smaller guaranteed package and progressively expanding the number of services covered over time.

2.4 Addressing health emergencies

The world is facing an increasing number of threats to public health, linked to new or re-emerging infectious diseases with pandemic potential, natural disasters, environmental degradation, climate change, population displacements, chronic instability and armed conflict as well as other challenges such as gaps in the availability of health-care professionals and infrastructure. In the coming years, these threats are expected to continue to challenge health systems and cause widespread social and economic effects.

Since the start of 2020, the COVID-19 pandemic has affected all areas of society in unprecedented ways, destabilizing global economies, disrupting people's lives and livelihoods and setting back years of gains achieved in global health. Other recent outbreaks of public health concern, such as the Ebola virus disease outbreaks in western Africa in 2013–2016, in the Democratic Republic of the Congo in 2018–2022 and in Uganda in 2022 and the multicountry outbreaks of severe acute hepatitis of unknown cause among children in 2022 have created challenges for public health systems in many countries. The multicountry outbreaks of mpox in 2022 in countries that are not endemic for the disease show how re-emerging infectious diseases with pandemic potential can spread rapidly around the world. Further, other challenging situations of protracted conflict, major population displacements, natural disasters and food insecurity continue to cost lives and disrupt access to health services in many countries.

Such health emergencies can be very disruptive for ongoing disease control programmes. They can result in diversion of both attention and resources towards addressing the emergency. In contexts of mobility restrictions and distancing measures as in the case of COVID-19, they may cause disruptions in logistics and supplies and limit people's ability to access services. Armed conflicts and population displacements may increase the risk of sexually transmitted infections, including HIV, as a result of sexual violence. Emergencies may also overwhelm the health system by increasing demand for emergency health care, placing additional burden on the health workforce and infrastructure, and reducing the system's capacity to maintain routine interventions. Further, new or re-emerging infectious diseases may be more severe among individuals living with HIV or other sexually transmitted infections or may exacerbate these diseases.

Strategic planning for HIV, viral hepatitis and sexually transmitted infections should encompass contingency planning to ensure continuity of services for these diseases in the context of health emergencies or other crisis contexts. It should also contribute to building resilient health and community systems over the longer term to prevent and prepare for health threats and reduce the vulnerability of individuals and communities to these threats. Global responses to the COVID-19 pandemic catalysed many innovations in the health sector, such as the expanded role of communities in

service delivery, the rapid development and deployment of new vaccines and health products and the growing use of digital tools and self-care approaches for health. Building on these innovations will be critical to prevent disruptions in HIV, viral hepatitis and sexually transmitted infection services in ongoing and future health emergencies and to respond to the needs of the most vulnerable people. HIV, viral hepatitis and sexually transmitted infection strategic planning processes should engage with coordinated national efforts for pandemic preparedness and response, for example, by contributing to the development of a multiskilled health workforce that can adapt to emergency response needs, expanding community-led approaches, strengthening linkage to primary health care and providing social protection for the most vulnerable people during pandemics and health emergencies.

2.5 Guiding principles of strategic planning

In this evolving context, each country needs to revisit traditional planning processes to respond to the complex challenges faced by the health sector and to promote greater impact and equity. In 2021, WHO conducted a desk review of national strategic plans on HIV, viral hepatitis and sexually transmitted infection to inform the development of this guidance publication *(18)*. The review, which covered 179 current or recent national strategic plans for these disease areas from all WHO regions, found vast diversity in terms of the disease combination, types, structure, content and periodicity of the plans. Overall, the review found many opportunities to improve the content and quality of strategic plans, such as the need for more in-depth situation analysis, greater alignment with global and national efforts towards universal health coverage, addressing cross-cutting interventions and greater support for community-led and community-based services. Further, many strategic plans missed the opportunity to strategically promote integration and linkage with other types of health services, calling for more attention to ways to promote the most effective use of health system resources.

Although the specific approach to strategic planning depends on each country's situation (including the disease epidemiology, the planning conventions and practice and the organization of HIV, viral hepatitis and sexually transmitted infection services), this guidance document promotes the following core principles for HIV, viral hepatitis and sexually transmitted infection strategic planning across all disease areas and in all contexts:

- Country leadership and ownership. National strategic planning should be led by high-level government stewardship and national ownership to define, set priorities for and implement policies, strategies and interventions, supported by national coordination structures to steer partnerships for an effective response.
- Focus on impact and ensuring accountability. In a context of limited resources and growing needs, strategic planning efforts should rely on evidence-informed priority setting of the use of available resources to achieve clear and measurable results, maximize impact and promote accountability in programme implementation and resource use.
- Placing people at the centre. Effective strategic plans should be guided by a shift towards people-centred approaches, such that health services for HIV, viral hepatitis and sexually transmitted infections are planned, funded, managed and delivered around people's needs and expectations, including for the management of comorbidities, rather than around individual diseases.
- Partnerships. Successful planning and implementation relies on multistakeholder and multisectoral partnerships to address the broader determinants of health, with harmonization of partner actions around national strategies, plans and systems.
- Community engagement. The effective engagement of affected communities, including key populations and other priority populations, and civil society, including nongovernmental providers, with well-funded community-led responses are essential to ensure effective implementation of the strategies.
- Gender, equity and human rights. The protection and promotion of human rights and dignity of all, and promoting equity, including gender equity, are essential to reduce disparities and leave no one behind (Box 4).
- Sustainability. Health sector strategic planning for specific diseases must contribute towards building long-term health and community system capacity and promote financial sustainability as part of national health financing.

Box 4. What is meant by a rights-based approach to health?

The WHO Constitution envisages the highest attainable standard of health as a fundamental right of every human being. Human rights are universal and inalienable and apply equally to all people, everywhere, without distinction.National health policies, strategies and plans must be well prioritized, reflect the needs and demand for health services and orient resource allocation towards universal health coverage objectives. They must be anchored in strong political agreements to improve consistency and predictability and developed through intersectoral (whole-of-government) and intrasectoral inclusive policy dialogue with all health stakeholders (whole of society). They must be translated into operational plans and budgets that will enable full implementation and be monitored and transparently evaluated for increased accountability and transparency.

A rights-based approach to health is essential for an effective health sector response to HIV, viral hepatitis and sexually transmitted infections (19). It requires that health policy and programmes give priority to the needs of those furthest behind first towards greater equity, a principle that has been echoed in the 2030 Agenda for Sustainable Development, the United Nations Political Declaration of the High-level Meeting on Universal Health Coverage, the renewed commitment to primary health care in the 2018 Declaration of Astana and the Secretary-General's Call to Action for Human Rights (3,6,7,20). A rights-based approach is also central to the principles of gender equality and women's empowerment and to leaving no one behind.

A rights-based approach requires states to take steps to redress any discriminatory law, practice or policy. Another critical feature of rights-based approaches is the meaningful participation of all stakeholders in all phases of programming: assessment, analysis, planning, implementation, monitoring and evaluation.

Part 2. Core components of strategic plans

Part 2 (Chapters 3–7) presents the core components of strategic plans for HIV, viral hepatitis and sexually transmitted infections.

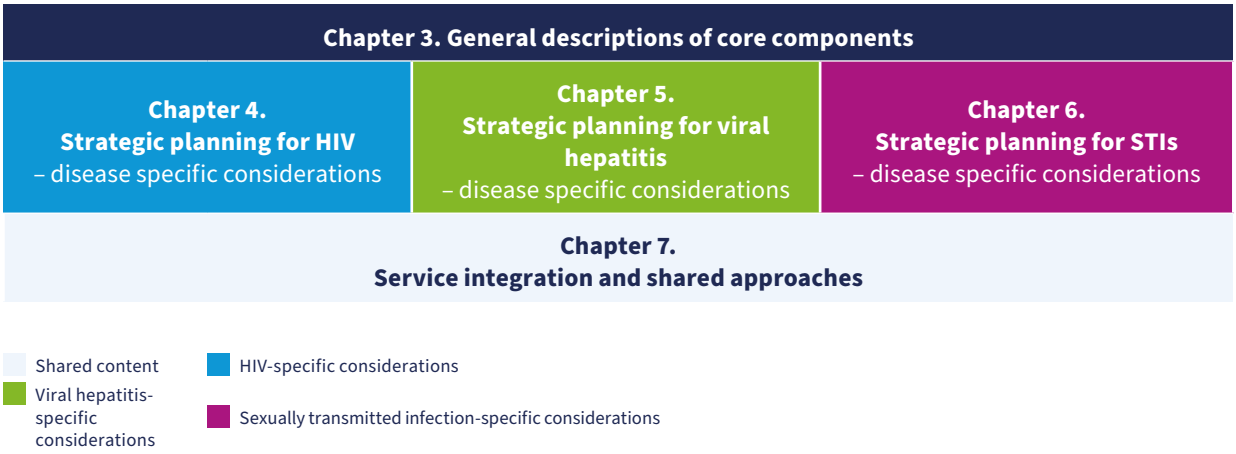
It is structured as follows (Fig. 5).

Chapter 3 presents general descriptions of the core components of a strategic plan, including the planning process, situation analysis, priority setting, service delivery, monitoring and evaluation, costing and budgeting and implementation arrangements, and is relevant for strategic planning for all three disease areas.

Chapter 4 (HIV), Chapter 5 (viral hepatitis) and Chapter 6 (sexually transmitted infections) supplement the general descriptions in Chapter 3 by presenting how the core components apply to each disease area respectively.

Chapter 7 discusses the commonalities across HIV, viral hepatitis and sexually transmitted infections. It presents considerations for integrating services and shared approaches across the disease areas in a primary health care approach and is also relevant for strategic planning for all three disease areas.

Fig. 5. Structure of Part II



Each national strategic plan should include all core components as described in the general descriptions. The content under each of these core components would cover either a single disease area, or multiple diseases, depending on whether the country chooses to develop standalone or combined strategic plans.

3. General descriptions of core components

The core components of a strategic plan constitute the content of the plan. They present the strategic vision of the plan, describe the current situation, outline priorities for the duration of the plan and define the means to achieve these. The core components are described in the following sections.

Section 3.1 describes the processes for strategic planning.

- Section 3.2 describes situation analysis.
- Section 3.3 describes priority setting and the presentation of the vision, goals and objectives of the strategic plan.
- Section 3.4 describes various aspects of service delivery, including service delivery models, health system strengthening, and enabling interventions.
- Section 3.5 describes monitoring and evaluation.
- Section 3.6 describes costing and budgeting
- Section 3.7 describes implementation arrangements.

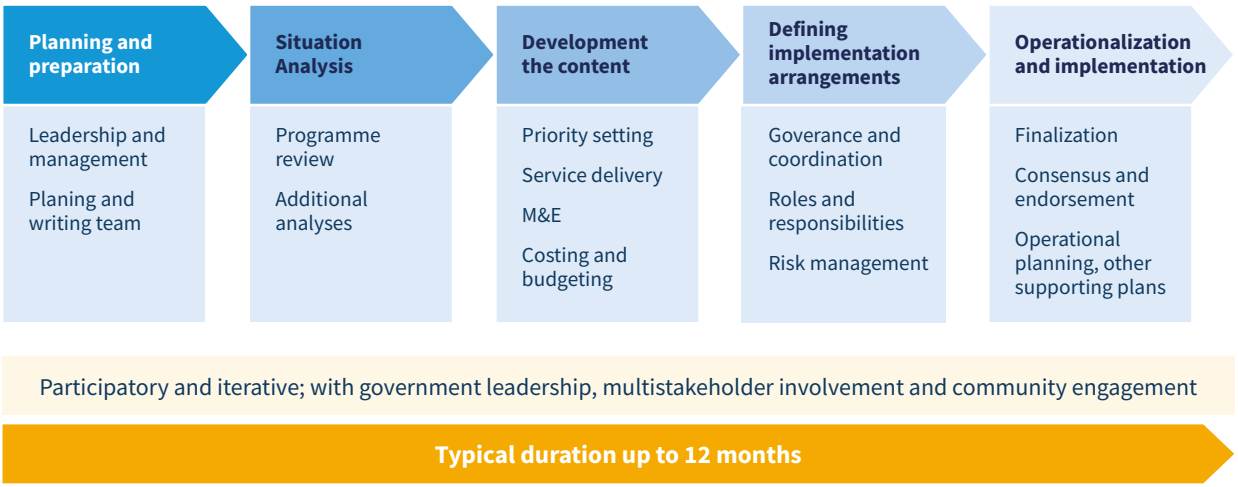
The terms countries use for these core components and presenting them in a national strategic plan may vary. The core components described in this chapter serve as a guide, and it is recommended to ensure alignment with other health sector plans in the country.

The following sections generally describe each of these core components. These general descriptions should be used along with the disease-specific considerations in Chapter 4 (HIV), Chapter 5 (viral hepatitis) and Chapter 6 (sexually transmitted infections) and the considerations for service integration and shared approaches (Chapter 7).

3.1 Planning process

Strategic planning is a complex process that involves a wide range of actors and requires leadership, coordination and various types of information and skill sets. The development of a new strategic plan can typically take up to 12 months, and developing a road map at the start is useful to guide the process (Fig. 6).

Fig. 6. Steps in developing a strategic plan



Source: adapted from Strategizing health in the 21st century: a handbook *(5)*.

The planning process for HIV, viral hepatitis and sexually transmitted infections should take the following elements into account.

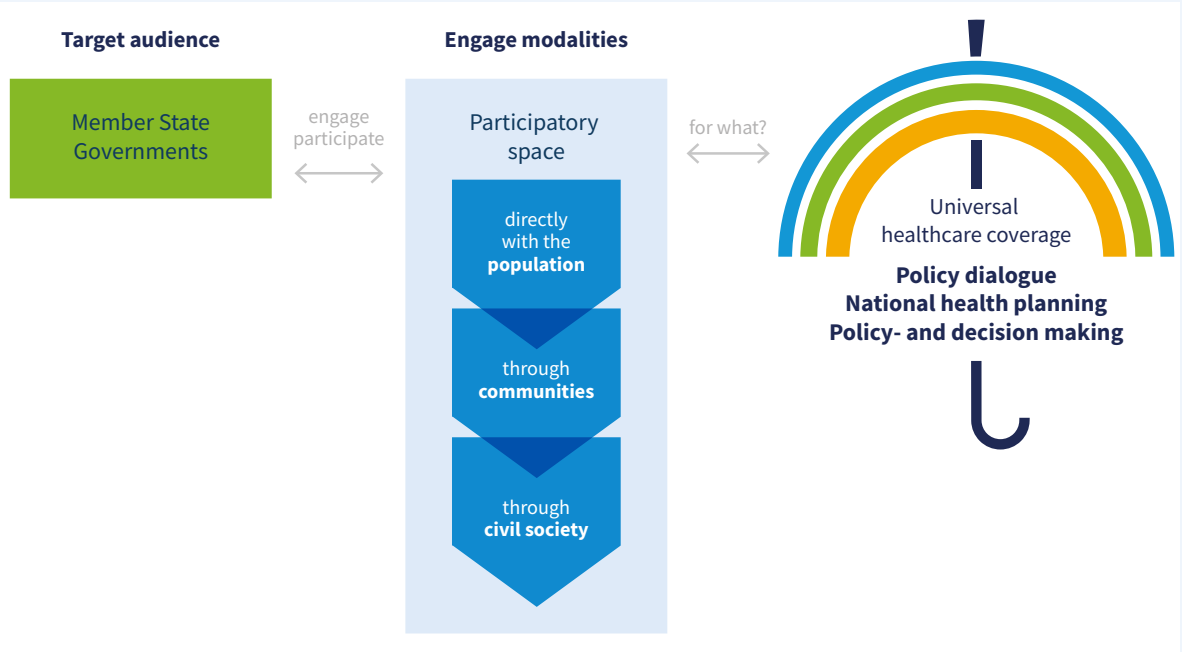
1) *Stakeholder involvement in the planning process.* As described in section 2.3, a primary health care approach to addressing HIV, viral hepatitis and sexually transmitted infections involves multisectoral policy and action to address the upstream wider determinants of health. Various stakeholders are involved in, influence and are affected by a health sector response to a disease. This makes it essential for the health sector to engage other sectors such as finance, education, justice, labour, social protection, agriculture, housing and the environment in planning efforts; including government leaders; policy-makers; technical programmes and agencies; service providers from the public, private and nongovernmental sectors; communities of people living with HIV, key populations and other priority populations; development partners; and other interested parties such as academia, professional associations and others.

Further, a primary health care approach also rests on empowered individuals, families and communities as advocates of policies that promote and protect health and well-being, as co-developers of health and social services and as self-carers and caregivers. Participatory approaches are critical to ensure that the perspectives of affected communities, including key populations and other priority populations, are incorporated in the planning process, and to promote broader ownership and accountability of the plan (Box 5) *(5)* To be effective, such inclusive processes should not be seen as a one-off exercise during the planning phase but rather sustained through planning, implementation and review.

Box 5. Engaging civil society, communities and beneficiaries in strategic planning

The WHO handbook on social participation for universal health coverage provides policy-makers with practical guidance on strengthening meaningful government engagement with the population, communities and civil society for national health policy-making (Fig. 7) (21). Civil society and communities should be meaningfully engaged in strategic planning processes, including as part of planning teams, technical working groups and writing teams. Strategic planning processes can also directly capture the population's demands, needs and expectations through various methods, including face-to-face dialogue, focus groups or surveys, to inform planning and priority setting and improve health outcomes (5).

Fig. 7. Bringing the voices of people and communities into policy-making for health



Source: Voice, agency, empowerment – handbook on social participation for universal health coverage (21).

2) *Timeline and planning cycle.* Strategic planning is part of the cycle of planning, implementation and review of a health sector response. The process of developing a new strategic plan can take up to one year, and the new plan should be in place before the current plan expires. Strategic plans for diseases should be aligned with the overall health sector planning cycle and the fiscal cycle in the country. If previous disease strategic plans may have different planning and implementation cycles, these can be aligned by extending existing plans, developing interim plans to bridge the gap or ensuring that the targets are consistent across the plans.

3) Leadership and management of the planning process. Well-prepared planning requires leadership and management structures to lead and manage the process and achieve legitimacy and ownership. The key structures are described below. Together these structures will ensure that all relevant stakeholders own the planning process, including civil society and community representatives, and that it is executed efficiently. The main roles and responsibilities include:

- a steering group or advisory group comprising senior officials from the health ministry and other national stakeholders, including civil society and community representatives, provides overall strategic direction and oversight of the planning process;
- a planning team generally led by the national disease programme is responsible for providing overall technical and operational guidance to the planning process;
- technical working groups with technical focal points, implementing partners and community representatives provide detailed inputs for specific technical components of the plan, such as the various programmatic areas and interventions, monitoring and evaluation and costing and budgeting;
- a writing team, with a lead writer and subject matter writers, is responsible for preparing the document drafts; and
- secretariat support, including administrative and logistics support to the process, usually provided by the health ministry and sometimes with contributions from partners.

4) *Resources*. The planning process requires a budget to cover the costs of the activities that need to be undertaken. Some of the cost elements include the costs of organizing meetings, conducting data collection and analysis and organizing field visits or technical assistance. Further, it also requires various types of technical expertise and information, including data from various sources to assess the status of the response and inform priority-setting scenarios, evidence on the effectiveness of interventions and information on costs and financing (see section 3.2). Resources for integrated and cross-disease approaches, including for service delivery and systems strengthening, should be considered.

3.2 Situation analysis

A robust situation analysis assesses the current health situation, including the drivers and determinants of infections, the progress to date and the barriers, challenges and gaps and is vital to a high-quality national strategic plan. It is a critical step in the strategic planning process since it helps to define priorities and set targets for disease impact in relation to the country context and capacity. It is also an important section in a national strategic plan document itself. Situation analysis must be participatory, inclusive and iterative, drawing on a wide range of expertise and capturing a broad range of stakeholder views.

The situation analysis builds on a programme review, which is usually carried out to assess the implementation of a national strategic plan at the mid-term and end of the implementation period of the strategic plan. Programme reviews take stock of how programme inputs, outputs and outcomes have translated into impact during the implementation period and draw the lessons learned. A robust programme review provides the key preparatory work for situation analysis and should be conducted before the planning process for a new strategic plan starts. The situation analysis supplements the programme review with additional information from various sources, forms the basis for identifying the needs and priorities of the new strategic plan. When no formal programme review has been conducted, the situation analysis should be based on a more thorough desk review of available data with the core elements described below. The various data sources are described in section 3.5 on monitoring and evaluation and in the disease-specific Chapters 4 (HIV), 5 (viral hepatitis) and 6 (sexually transmitted infections), respectively.

Situation analysis for HIV, viral hepatitis and sexually transmitted infections should include the following elements.

1) *Epidemiological analysis.* The availability and use of robust and granular data is a must for developing a sound strategic plan. Epidemiological analysis refers to analysis of the burden of disease and trends, transmission and risk factors, key and affected population groups and the needs and gaps for different services. The epidemiological analysis should identify the disease trends over time, the subpopulations and geographical areas that are most affected with an analysis of inequities, the main factors driving the epidemics, the gaps and priorities for increasing impact. Box 6 shows the key elements of epidemiological analysis.

Box 6. Epidemiological analysis

- Demographics (population size and distribution)
- Prevalence
- Incidence
- Morbidity
- Mortality, including causes of death
- Comorbidities and coinfections
- Modes of transmission
- Key and affected populations
- Determinants and risk factors

All of these should include disaggregation by age, sex, population groups, geography and other categories as relevant

2) *Programmatic response and gap analysis.* This includes analysing the disease response in the country, the extent to which the desired targets and results of the previous implementation period have been achieved, the key achievements and the remaining gaps that must be filled as a priority to achieve impact. The programmatic response analysis highlights the current need for services, the coverage of services against targets, major programme gaps such as populations or geographical regions left behind and gaps in coordination across health services to address people's needs comprehensively. It should also include bottleneck analysis of the various barriers faced by people to access services and factors affecting programme performance. Box 7 shows the key elements of programmatic response and gap analysis.

Box 7. Programmatic response and gap analysis

- Estimated need for various services
- Programme results
- Service availability
- Service coverage (progress towards targets)
- Service quality
- Programme gaps
- Integration and linkage across programme areas
- Root causes of barriers to access

All of these should include disaggregation by age, sex, population groups, geography and other categories as relevant

3) *Health and community system context.* This describes the overall health and community system context in the country within which disease programmes are implemented. It includes the overall vision for health in the country; its goals, such as those to achieve universal health coverage and primary health care for all; and an analysis of the overall organization, capacity, strengths and weaknesses of the country's health and community system (including in each of the health system areas of human resources, procurement and supply management, infrastructure, health information systems, community systems and financing). It also assesses the engagement of relevant non-health sector actors, such as from other ministries and sectors, in the response. Box 8 describes key information for the health and community system context.

Box 8. Health system context

- Health sector vision, policies and goals
- Health system governance
- Health system organization and service delivery models
- Levels of integration, linkage and shared approaches across disease programme areas
- Human resources
- Health commodities
- Laboratory services
- Health information systems
- Community systems and community-led responses
- Health financing mechanisms for universal health coverage and social protection mechanisms
- Pandemic preparedness and response
- Engagement of non-health sector actors
- Strengths and weaknesses

4) *Socioeconomic and political context:* This describes the social, cultural, economic, political and legal environments within which disease responses are implemented, which affect peoples' risks and vulnerabilities to infection and their access to services. Box 9 describes key information related to the socioeconomic and political context.

Box 9. Socioeconomic and political context

- Demographic context (such as social and humanitarian context and population movements and displacement)
- Political environment and political commitment to address the disease areas
- Macroeconomic context
- Funding landscape
- Income distribution and inequalities
- Education levels
- Social environment (such as social beliefs and practices, stigma, discrimination, gender-related norms and practices, violence, human rights violations and abuses that affect disease responses)
- Legal environment (such as punitive or discriminatory laws that affect disease responses)
- Policy environment (such as related to privacy, confidentiality, partner notification, age of consent for services etc. that affect disease responses)
- Humanitarian or other crisis context

5) *Stakeholder analysis:* This provides a strategic mapping of stakeholders of a disease response in the country, including their roles, contributions, comparative advantage and influence. These stakeholders include government, civil society organizations, communities, private sector, interest groups and development partners, among others. Box 10 describes key information for the stakeholder analysis.

Box 10. Stakeholder analysis

- Current and potential contribution of stakeholders, including financing
- Comparative advantage of stakeholders
- Influence and level of impact of stakeholders
- Potential conflicts or risks
- Engagement strategies

3.3 Setting priorities

Setting priorities is a critical component of strategic planning. It is about making choices and taking decisions in relation to what should be given priority, what not to do and how to allocate resources for maximum impact. Setting clear priorities is necessary to provide focus to a strategic plan while ensuring that it is feasible and context specific.

There are always many competing needs for finite national resources and implementation capacity between the health sector and other sectors, among disease programme areas within the health sector and among interventions within a disease programme. The primary focus of setting priorities should be to increase impact by identifying the population groups and locations that are most affected and who may face the largest gaps in service access, investing in the most effective interventions at the right scale and delivering with maximum efficiency.

Priorities are set based on the situation analysis (see section 3.2) and the process of costing and budgeting (see section 3.6). This is informed by evidence on needs, coverage and effectiveness of interventions; an analysis of gaps and inefficiency; the broader national health and development priorities; global level commitments; societal values; the availability of resources; and the country's health system capacity and organization. Commonly used criteria for setting priorities include considering where the country is on the trajectory of new infections, illness and deaths; where it should be over time; the scale of services required; the populations and geographies to give priority to achieve the desired impact; and considerations of fairness and acceptability. The specific criteria used for setting priorities may vary by country and by disease.

Priority setting can be incremental or ambitious. An incremental approach sustains past programme implementation and makes changes in small increments at conservative levels. Although there could be good reasons for doing so, such a business-as-usual approach typically does not drive impact and can prove more costly in both lives and resources in the long term. Ambitious priorities need to be set to achieve the greatest change in the shortest time. Realistic ambition sets priorities for what will produce the maximum desired results and is also within reach of the capacity and resources within the programme.

There are various approaches and methods for setting priorities. Statistical modelling can help to explore and examine different scenarios of cost–effectiveness and impact in relation to resources, to inform decision-making on priorities. The Integrated Health Tool for Planning and Costing (previously OneHealth Tool) is a resource to inform national strategic planning in low- and middle-income countries (see Box 21 in section 3.6 for further information) *(22)* In addition, a theory of change can illustrate how the selected priorities will lead to the desired impact.

Priority setting is inherently political, and choices need to be made that reflect a society's values and vision for the health system *(5)*. Priority-setting processes are often dynamic and iterative and can involve several rounds of analysis and discussion as various options are assessed in relation to the desired impact and capacity. Priority

setting must be participatory and inclusive to build broad consensus and ownership among all stakeholders of the defined priorities.

Once consensus has been achieved among stakeholders on the priorities, these need to be described in the strategic plan document. A wide range of other terms are used to describe the priorities, such as strategic priorities, strategic directions, results areas, priority areas, pillars or others. The priorities of a strategic plan are then translated into the vision, goals, objectives and interventions or services of the plan as well as the results framework with targets and milestones. These key elements are further described below.

1) *Vision.* National strategic plans should define their vision, which is an aspirational or political statement that articulates the desired future state of population health that is aspired towards in the medium and long-term. It should be motivating and challenging to stimulate good planning and implementation. Box 11 provides examples of vision statements in a strategic plan

Box 11. Examples of vision statements

- A country free from the burden of HIV, viral hepatitis and sexually transmitted infections.
- A country in which the epidemics of HIV, viral hepatitis and sexually transmitted infections have ended as public health threats, and everyone has access to health services free of stigma and discrimination.
- All people are able to access high-quality prevention, testing, treatment and care services to end the transmission and limit the impact of HIV, viral hepatitis and sexually transmitted infections through integrated and people-centred health systems.

2) *Goal.* The goal is a broad statement of a desired health impact during the period of the plan. It describes the anticipated change in the epidemic in the country and improvements in the quality of life. The national strategic plan must include goals that relate to disease-related effects in reducing new infections, mortality and improving quality of life. Goals could also address other health system and societal issues that are essential to the vision in the plan. Goals need to be quantifiable, to the extent possible, especially those that address impact on disease. Box 12 provides examples of goals in a strategic plan.

Box 12. Examples of goals

- Reducing new infections of HIV, viral hepatitis and sexually transmitted infections (number or percentage, by year).
- Reducing mortality and morbidity related to HIV, viral hepatitis and sexually transmitted infections (number or percentage, by year).
- Eliminating vertical transmission of HIV, syphilis and hepatitis B (percentage, by year).
- Reducing stigma, discrimination and other barriers to accessing services for HIV, viral hepatitis and sexually transmitted infections (indices or milestones, such as the People Living with HIV Stigma Index (23) and the National Commitments and Policy Instrument as part of Global AIDS Monitoring (24)).
- Improved health system capacity for high-quality people-centred services (critical milestones).
- Accelerated progress in research and innovation for HIV, viral hepatitis and sexually transmitted infections (critical milestones).

3) *Objectives.* The objectives define what needs to be done to achieve the goals of the plan. They are typically linked to the required outcomes or coverage of services and populations to achieve each of the goals of the plan. There may be multiple objectives contributing to a goal. Well-articulated objectives are SMART:
   - *Specific*. They reflect a precise or specific outcome linked to a rate, number, percentage, or frequency.
   - *Measurable*. They include targets that can be measured through a reliable information system.
   - *Achievable*. They indicate clear ways or methods for achieving the objective.
   - *Realistic*. They can be achieved with available or potential resources or efforts.
   - *Time-bound*. They have a clear start and finish date.

In order to be SMART, each objective should express the desired change, such as an increase in coverage of an intervention over the time period of the strategic plan. Some objectives may not be quantifiable in numerical targets. Such objectives can be described using qualitative measures or milestones that can assess what has been achieved. Box 13 provides examples of objectives in a strategic plan.

Box 13. Examples of objectives

- Increase the number of people who know their disease status (number or percentage, by year)
- Increase vaccination coverage (number or percentage, by year)
- Increase the coverage of tailored prevention packages for priority populations (number or percentage, by year)
- Increase the coverage of treatment services (number or percentage, by year)
- Improve adherence to treatment (number or percentage, by year)
- Improve service access for survivors of sexual and gender-based violence (number or percentage, by year)
- Reduce stigma and discrimination in health-care settings (composite indices or critical milestones)
- Improve the availability of disaggregated data and analysis (critical milestones)
- Sensitize the health workforce to deliver appropriate services for priority populations (critical milestones)
- Support the development and uptake of new technologies (critical milestones)
- Review and reform punitive laws, policies and practices (critical milestones)
- Strengthen multi-disease approaches and integrated service delivery (critical milestones)
- Strengthen collaboration across public and private stakeholders (critical milestones)

4) *Interventions.* Strategic plans present the interventions, or the products and services given priority for delivery along with the activities and sub-activities that need to be implemented to deliver them. Several interventions can be identified under an objective. The selection of interventions must be evidence informed such that they are appropriate, acceptable, effective, cost-effective and feasible in a given context for the problem being addressed; always keeping in mind the principles of human rights and equity. Interventions should be delivered on sufficient scale and quality to produce the required change.

Box 14 provides examples of interventions. WHO provides normative guidance related to interventions and the recommendations are updated on an ongoing basis. Further, the WHO UHC Compendium provides a database of health services and intersectoral interventions, with their supporting evidence, associated human and material resource inputs, and cost impact, to support countries in setting priorities for interventions within their health systems *(17)*. National guidelines related to the delivery of the interventions must also be kept up to date.

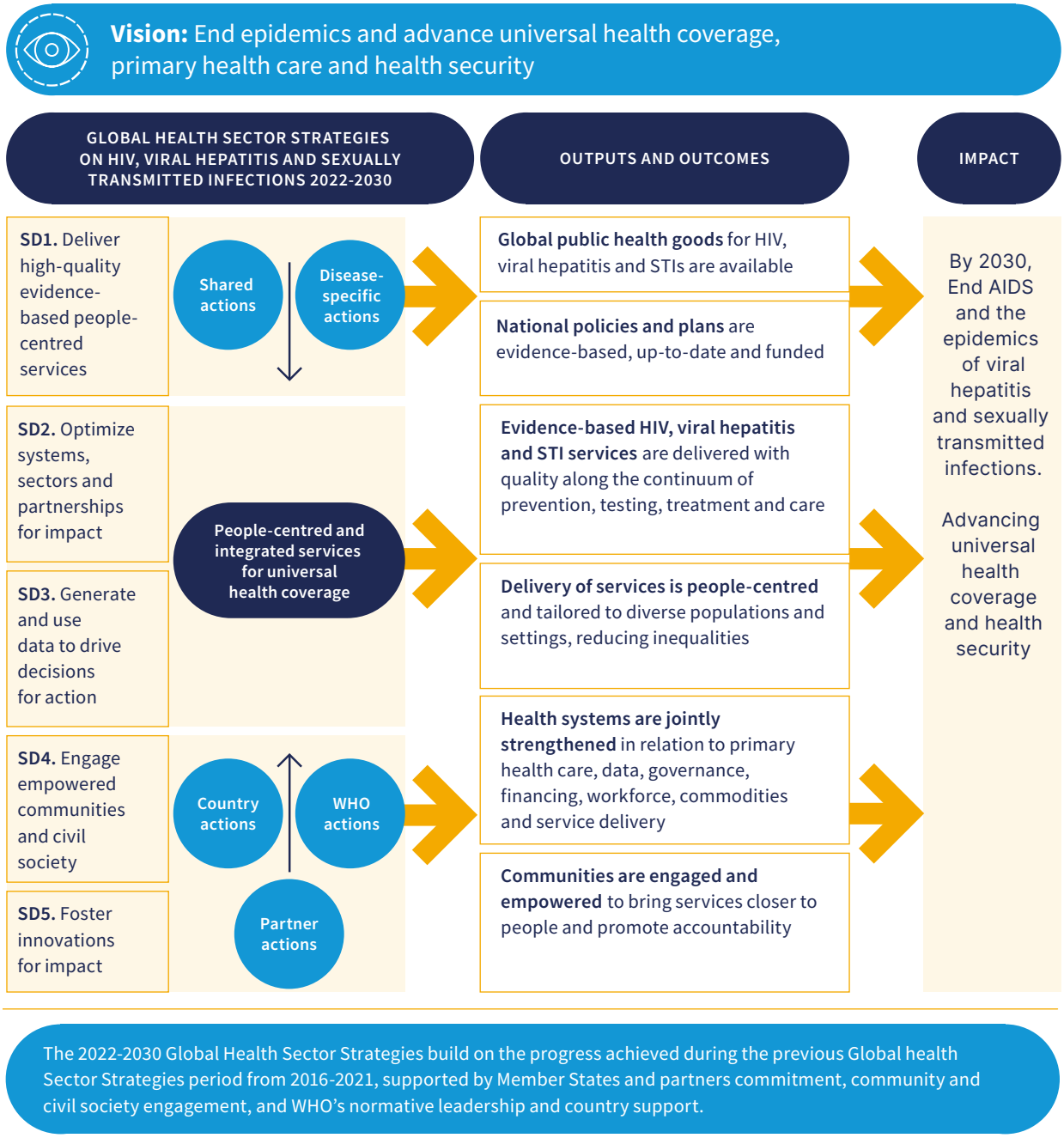
Box 14. Examples of interventions

- Comprehensive prevention services
- Vaccines and other prevention tools
- Screening, testing and diagnosis services
- Linkage to care
- Treatment services
- Targeted intervention packages for priority populations
- Review and reform of discriminatory policies and laws
- Social protection mechanisms
- Engagement of private-sector providers
- Quality assurance systems
- Person-centred monitoring
- Community-led responses, services and community-led monitoring
- Interventions for specific settings, such as humanitarian settings

5) *Theory of change.* The vision, goals, objectives and interventions of the strategic plan can be depicted as a theory of change, which is a framework to illustrate how the different components of priority setting link together to create the desired change. It is typically depicted along the results chain of inputs, outputs, outcomes and impact *(25)*. A theory of change can provide planning teams with a framework to think through the multiple determinants of a particular challenge, how these factors influence each other, the logical sequence of actions required to bring about change and the underlying assumptions and risks that are part of the change process.

A theory of change should be developed consultatively to reflect the understanding of all stakeholders. It should be grounded in robust evidence and should support continual learning and improvement in programme design and implementation. The theory of change of the GHSS 2022–2030 (Fig. 8) depicts the pathway through which implementing the five strategic directions through shared and disease-specific actions that place people at the centre will contribute to ending the epidemics and advancing universal health coverage and health security.

Fig. 8. Theory of change of the GHSS 2022–2030



Source: GHSS 2022–2030 *(4)*.

6) *Results framework.* Finally, the priorities of the strategic plan need to be translated into quantifiable and measurable indicators, baselines and targets that comprise the results framework of the strategic plan. The results framework is also referred to as the performance framework or results framework. It follows the same logical sequence as the theory of change. It may be included in the section on monitoring and evaluation or as an annex to the strategic plan. Section 3.5 provides additional information on the results framework.

3.4 Service delivery

Service delivery is about how the health sector will be organized to deliver on the priorities that have been defined. The strategic plan needs to define the approaches to organizing and delivering services and the actions that will be taken to strengthen service delivery. This includes defining the essential service packages, the models of service delivery and the health system functions and subfunctions that are needed to deliver services as well as the enabling factors that address the determinants beyond the health sector.

Service delivery approaches for HIV, viral hepatitis and sexually transmitted infections should address the following.

1) *Essential health benefit packages.* Most countries define their essential health service package: the set of evidence-informed priority health interventions they commit to provide, fund and track for all people as they advance progressively towards universal health coverage. Essential service packages should be defined through a transparent priority-setting process as outlined in section 3.3. Essential service packages vary across countries depending on the country's local context and disease burden, health system capacity, resource availability and priorities. Moreover, essential benefit packages are not static, and their definition and implementation will over time as new evidence and additional resources become available. Countries should strive to include key services for HIV, viral hepatitis and sexually transmitted infections in national essential health benefit packages, with a commitment to finance these through public and private channels, including health insurance.

2) *Service delivery models.* This is how health services will be organized (including the infrastructure, processes, management and roles and responsibilities) to deliver health interventions to populations in need. It includes the channels through which services will be delivered (such as through health facilities, mobile clinics and outreach), the service providers (the public sector, private sector, nongovernmental organizations, communities, religious organizations and others), the levels of service delivery (such as primary, secondary and tertiary levels) and the approaches to clinical or functional integration across service areas. It also includes differentiated channels to meet the needs of specific populations, such as key populations, young people and mobile and displaced populations.

The models of service delivery vary depending on the type of services being provided, the population groups for whom the services will be provided and the type of service delivery systems in the country (Box 15). High-quality health services provide the right care at the right time, responding to service users' needs and preferences, while minimizing harm and resource waste *(26)*. Service delivery models need to be tailored to local contexts, and different models of care should coexist to deliver the various required functions in a health system *(15)*. Integrated approaches to service delivery are important to address comorbidities and provide comprehensive people-centred care.

Box 15. Models of service delivery

The following are examples of service delivery models that are of particular importance to HIV, viral hepatitis and sexually transmitted infection responses.

Differentiated service delivery. Increasingly applied in the delivery of HIV services, differentiated service delivery (previously referred to as differentiated care) is a person-centred approach that simplifies and adapts service delivery in ways that serve the needs of people living with and vulnerable to HIV, reduces unnecessary burdens on the health system and improves service uptake and quality. The principles of differentiated service delivery can be applied across the continuum of services. Examples of such approaches include providing refills of antiretroviral therapy to individual clients; groups of clients managed by a health-care worker or self-managed groups of clients, with less frequent visits to a health facility or pharmacy; modifying service delivery hours to make them more accessible; or adapting the frequency of clinical visits in relation to the needs and health status of patients.

Decentralized service delivery. Service delivery can be decentralized to lower administrative levels as a means to expand geographical outreach and bring services closer to where people live and access them. Decentralization involves simplifying clinical protocols, task sharing with non-specialized personnel, training multidisciplinary teams, expanding service delivery to community-based, community-led or home-based services and engaging other providers, including the private sector.

Community-led delivery. Communities of key populations and other priority populations, including people living with the diseases, play a critical role in delivering people-centred health services by bringing services closer to where people live and access these services, adapting them to local needs and preferences and empowering individuals and communities with increased autonomy for self-care and decision-making for their health. Community-led service delivery, including with peer support, is an essential complement to facility-based services and an integral part of an effective health system. Self-care interventions for health – including medicines, diagnostics and other services that can be accessed fully or partly by individuals, families and communities outside formal health services, with or without the direct support of a health-care worker – provide additional choices and options to expand access to HIV, viral hepatitis and sexually transmitted infection services for people in need.

Special settings. Service delivery models need to be tailored to the needs of special settings, including prisons and other closed settings and settings of humanitarian concern. Health-care services in prisons are other closed settings should be equivalent to those available to the broader community, and the continuity of services should be ensured when people move within these settings and to the broader community. Mobile and displaced populations are often dislocated from their communities and may have inadequate access to local services. People's vulnerability to infections may increase further during emergencies and in humanitarian contexts in which health service delivery is disrupted.

Digital technologies. The use of digital technologies provides an expanding and powerful service delivery approach to enhance the coverage and quality of health interventions. Digital health technologies can be used to enhance targeted client communication, such as towards young people or individuals who may avoid in-person gatherings because of concerns about stigma and discrimination. They can also improve patient autonomy and agency by using wearable devices and mobile apps for personal health monitoring. Digitized health worker support tools can improve the quality of patient management and follow-up, and electronic health information systems can enhance the quality of data. Digital health interventions must be designed and implemented within the broader digital health architecture of a national health system, ensuring that risks related to confidentiality and privacy are adequately addressed. The use of digital technologies should not replace in-person services, create new inequalities or exacerbate existing inequalities faced by people who may not have access to digital technologies.

3) *Strengthening systems.* Programme implementation relies on critical health system functions and subfunctions that are necessary to deliver health services and meet the health needs of a population. These functions include governance, the health workforce, health commodities, financing and information systems (Box 16). Disease strategic plans need to consider their approach to engaging and strengthening each of these health system areas in a coherent and sustainable manner that engages communities, improves efficiency in the use of resources, enables the delivery of high-quality health services and builds capacity over the long term. Strategic planning for HIV, viral hepatitis and sexually transmitted infections should also engage in national efforts to protect people during pandemics and other health emergencies and build health system resilience.

Box 16. Strengthening health systems

The following are critical health system components for delivering HIV, viral hepatitis and sexually transmitted infection services.

Governance. Health system leadership and governance refer to the functions of providing the overall strategic vision for the health sector and its oversight, regulation, coalition building and coordination. Effective governance is inclusive and participatory, with meaningful engagement of communities. It promotes collaboration and coherence across sectors and stakeholders in the health sector and enhances transparency, accountability and responsiveness to public expectations. Disease-specific governance structures, where they exist, must be appropriately aligned with and linked to broader national health and development governance structures and plans.

Health workforce (including community health workers). This refers to the type, number and skills of the health workforce required to deliver the priorities of the plan. The human resource needs for a disease response must be addressed in ways that are synergistic with efforts to strengthen the overall workforce. Disease strategic plans should support ways to optimize the utilization of the existing workforce, such as through task sharing, the use of multidisciplinary teams and the engagement of peer and lay providers, with adequate investment for capacity building, training, supervision, adequate remuneration and retention of the health workforce.

Commodities. The long-term secure supply of medicines, devices and technologies that are accessible, affordable and acceptable is critical for an effective disease response. Disease strategic plans should promote equitable and reliable access to quality-assured and affordable health commodities by aligning to broader national efforts to strengthen national regulatory capacity: ensure timely in-country registration of new products; reduce prices; strengthen local development, manufacturing and distribution capacity; jointly strengthen logistics management information systems; and promote green procurement and waste disposal.

Laboratory services. Laboratory capacity is critical to expand testing and diagnostics services and provide appropriate linkage to care. Shared approaches to strengthening laboratory systems and networks, such as shared support for laboratory staff, quality assurance systems, referrals and sample transport and laboratory information systems, can improve flexibility and efficiency in the use of resources. Integrated diagnostics platforms can provide testing for multiple diseases.

Financing. In general, financing for disease responses should be addressed through national health financing systems, through joint efforts to raise funds through domestic sources, complemented by external sources and by avoiding fragmented funding streams and reducing costs. Well-costed national strategic plans and investment cases will be important to leverage available financing opportunities.

Health information systems. The availability of timely, accurate and granular health data is an essential component of health systems. Data are required for evidence-informed planning and setting priorities, resource allocation, performance monitoring, policy development and advocacy. Disease-specific information systems should be aligned with the broader national health information system to promote efficiency and reduce fragmentation. Community-led monitoring is a critical component of information systems (also see section 3.5 on monitoring and evaluation).

4) *Enabling interventions*. Disease strategic plans need to consider wider social determinants of health that lie outside the health sector (Box 17). For example, a supportive legal environment is critical to enable equitable access to services for all populations in need. Countries need to review and reform restrictive legal and policy frameworks where these persist and address the stigmatizing attitudes, discriminatory laws and practices and human rights violations and abuses that create barriers or reinforce stigma and discrimination. The health sector itself has an obligation to promote a safe and non-discriminatory environment within the health-care setting and to promote an enabling environment in other sectors to promote access to health services for all.

Box 17. Enabling interventions

The following are key enablers for effective HIV, viral hepatitis and sexually transmitted infection responses.

Community and civil society leadership and empowerment, including young people. A primary health care approach to addressing HIV, viral hepatitis and sexually transmitted infections means that the needs, rights and inclusion of vulnerable, marginalized and disadvantaged people – including key populations and other priority populations – must be given priority throughout the planning and implementation process. The engagement of individuals, communities and civil society is critical to strengthen programme design and delivery; to improve the reach, quality and effectiveness of services within an environment of trust; and to promote accountability, including through community-led monitoring. This can take many forms, such as fostering programmes and service delivery led by communities; meaningful participation of key populations and other priority populations in designing and operating services; peer education or navigation; task shifting to peers; self-care; implementation of legal literacy and service programmes; and ensuring civil space in which key populations can function without fear of reprisal. To be effective, community-led organizations require predictable funding and must be recognized by other stakeholders as key partners in disease response efforts.

Addressing stigma and discrimination, including in health-care settings. Many key populations and other priority populations continue to face stigma, discrimination, violence and human rights violations that increase their vulnerability and limit their access to services. Addressing stigma and discrimination includes interventions to eliminate these within the health sector-- such as training, awareness of patient rights and the rights of health-care workers and developing standards for health-care delivery-- to ensure that everyone can access services in an inclusive, non-discriminatory and supportive environment in all health-care settings.

Preventing and addressing violence. Violence can affect women, men, girls and boys or all ages and is a risk factor for disease transmission. It can take various forms – physical, sexual or psychological – and can be perpetrated by different people (27). Multiple structural factors influence vulnerability to violence, including power dynamics, discriminatory or harsh laws, policing practices and cultural and social norms that legitimize stigma and discrimination. The health sector has an important role to play in addressing violence, including gender-based violence and violence against key populations, by providing comprehensive health services, including for sexual and reproductive health; providing referrals to other support services; gathering evidence through data and research; fostering prevention policies in other sectors; and advocating for violence to be recognized as a public health problem and for resource allocation (28).

Legal, regulatory and policy reform. Efforts to review and reform restrictive legal and policy frameworks, including discriminatory laws and practices, that hamper access to health services, are an essential component of an effective disease response. Key populations face barriers to accessing HIV, viral hepatitis, sexually transmitted infection and other health services as a result of restrictive laws such as the criminalization of sex work, drug use and possession, gender identity or expression and sexual relations between people of the same sex. Numerous countries criminalize gender identity de facto by criminalizing cross-dressing or impersonation of the opposite sex (27). Migrants and mobile populations face obstacles in accessing services because of a lack of migrant-inclusive health policies. The health sector has a key role to play in reviewing such laws and policies and in developing supportive legislation including decriminalization, providing social protection for populations such as migrants and displaced populations; legal recognition of transgender and gender-diverse people; revising age-of-consent laws that may restrict service delivery to adolescents and young people; and eliminating HIV-related travel restrictions and mandatory testing.

Social protection. Many priority populations face common socioeconomic barriers related to poverty, inequality, exclusion and marginalization. Social protection approaches, such as insurance schemes, employment assistance, subsidies, vouchers, cash transfers and other social care interventions, are necessary to meet the multiple needs of these priority populations, including their health, education, economic, housing, food and nutrition, psychosocial and legal needs.

Multisectoral action. Many priority populations continue to face social and structural barriers that limit their access to interventions and exacerbate their risk of infection in many settings. Many of these barriers are influenced by policies and activities across multiple sectors such as finance, education, justice, labour, social protection, agriculture, housing and the environment. A comprehensive response to diseases must include multisectoral action across these sectors to improve the accessibility, acceptability, uptake and quality of interventions for all, and health-care actors must be empowered to build multisectoral partnerships and engage in policy processes in other sectors.

3.5 Monitoring and evaluation

Monitoring and evaluation are essential components of a strategic plan. They ensure that the priorities outlined in the plan are implemented as planned against stated objectives and desired results, demonstrate or interrogate the impact achieved and promote accountability to stakeholders and beneficiaries.

Monitoring involves bringing together all relevant data to inform decision-making and implementation. Evaluation builds upon monitoring and assesses whether the desired results of the strategic plan have been achieved. Based on evidence gathered through these processes, reviews are used to assess overall progress and performance, to identify challenges and take corrective actions. The monitoring and evaluation framework, also called the results framework, is a key component of the strategic plan and should be included in an annex to the plan.

The monitoring and evaluation framework for HIV, viral hepatitis and sexually transmitted infection strategic plans should consider the following elements.

1) *Indicators and target setting*. The monitoring and evaluation framework defines the priority core indicators that will be used to monitor progress towards the goals and objectives of the strategic plan. Typically, the framework follows the general principles of the results chain: defining indicators along the logical chain of inputs, outputs, coverage, outcomes and desired impact of the strategies. For each indicator, the monitoring and evaluation plan defines the corresponding baselines and expected targets over the time frame of the strategic plan. It also defines the sources of data and the approaches to their analysis and use for programme improvement. Targets describe the desired level of progress in interventions and programmes to achieve health goals, but they also need to be realistic and meaningful in relation to the country context and resource investment. A programme could identify core indicators that facilitate the overall monitoring of the programme (sometimes referred to as key performance indicators) in addition to detailed indicators for all programme areas.

2) *Methods and sources*. Data sources include routine health facility and community information systems; public health and disease surveillance; population censuses; civil registration and vital statistics systems; population-based surveys; research and evaluation studies; administrative data sources; as well as relevant data sources from other non-health sectors, such as those related to education, water and sanitation and the environment. Statistical modelling methods may also be used to generate estimates for certain core indicators such as disease burden and service needs using available data. Community-led monitoring brings the unique perspectives of communities and service users and contributes essential data related to health and human rights. The monitoring and evaluation plan should assess the quality of data sources and actions to improve data availability and use over time.

3) *Information systems.* The processes of monitoring, evaluation and review require an underlying health information system that enables the production, analysis, dissemination and use of high-quality health data by decision-makers (Box 18). A well-functioning health information system requires institutional capacity, human resource capacity, infrastructure and processes for data collection, analysis and, most importantly, data use to improve programmes. The use of digital technologies in health information systems is expanding rapidly, including the use of electronic patient and facility records, application of hand-held devices for data collection, data sharing and exchange through interoperable databases, web-based reporting of health events and data analytics and visualization. Countries should provide the overall legal and policy framework for these innovations in health information systems and promote a unified digital health information architecture.

4) *Data use for decision-making.* The data generated by the health information system provide the necessary information to inform the situation analysis and priority setting; track progress; identify gaps; and make adjustments as necessary. Data use is a critical part of evidence-informed strategic planning. It is also essential to ensure accountability of decision-making and transparent assessment and reporting, improve programme decisions and achieve impact. Regular programme reviews constitute an integral part of the programme cycle by assessing results in relation to strategic priorities and targets, identifying gap, and informing future planning and priority setting. Programme reviews can be undertaken as annual reviews for ongoing implementation, mid-term reviews around the mid-point of a strategic plan cycle or end-term reviews at the end of the strategic plan cycle. They should also be related to ongoing data use to improve programme management and implementation, often on a quarterly basis. Programmes may also undertake additional specific thematic reviews for priority topic areas. Ensuring harmonization and alignment in review efforts by the stakeholders and partners of a programme is important.

WHO has defined a technical package of the most effective interventions and tools to address critical data gaps and strengthen country health data for planning and monitoring (Box 18). Disease-specific investments in health information systems must align with and contribute to the broader vision and priorities for the health information in the country.

Box 18. Strengthening health information systems

The WHO SCORE for Health Data Technical Package compiles the best technical practices and the most effective interventions and tools to strengthen country capacity to generate, analyse and use health data (29). It comprises five key SCORE interventions.

Survey populations and health risks. Health information systems must generate regular, comprehensive, high-quality nationally representative statistics about population characteristics, population health status, health-related behaviour and risk factors and emerging threats to population health. This includes a system of regular population-based health surveys, public health surveillance and population and housing censuses.

Count births, deaths and causes of death. All countries must have a well-functioning civil registration and vital statistics for tracking public health trends, including fertility rates, mortality rates, cause-of-death distribution and life expectancy. These are essential for planning interventions to improve population health and evaluating policy effectiveness. This includes full birth and death registration and certification and reporting of causes of death.

Optimize health service data. Health service data are generated through several data subsystems, including routine facility and community reporting systems; health facility surveys or accreditation systems for monitoring service availability, quality and effectiveness; and various health resource data systems such as health workforce information systems, health financing information systems and logistics management information systems. The various subsystems should ideally be integrated or interoperable to facilitate comprehensive analysis of health services to support patient management, facility management, disease surveillance, sector planning, monitoring and management at all levels.

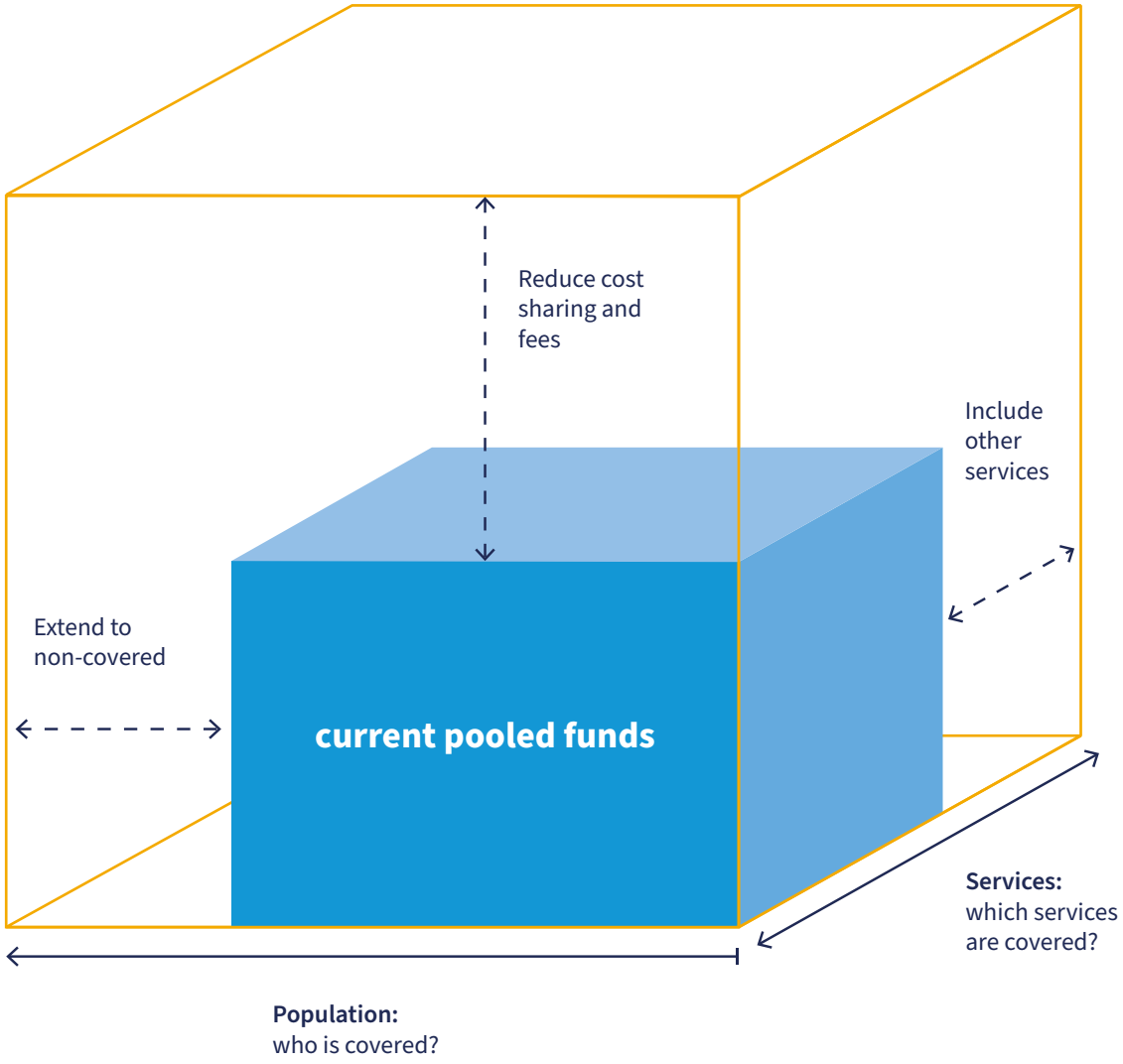
Review progress and performance. The use of data is critical to understanding what is working, support decision-making processes at all levels and guide resource allocation. This includes regular analytical reviews of progress and performance, including monitoring equity and building institutional capacity for analysis and learning.

Enable data use for policy and action. A well-functioning health information system requires a strong enabling environment, including structured processes for data analysis, evidence synthesis and expert review, accessibility and transparency of data for all data users, and a policy and institutional environment for strong country-led governance of data.

3.6 Costing and budgeting

Universal health coverage means that all people have access to the health services they need, when and where they need them, without financial hardship (Fig. 9). Universal health coverage emphasizes not only what services are covered, but also how they are funded, managed and delivered. Robust financing structures are key to achieving universal health coverage.

Fig. 9. Moving towards universal health coverage



Source: Strategizing health in the 21st century: a handbook *(5)*.

Every country has a different path to achieving universal health coverage and deciding what to cover based on the needs of their people and the resources at hand. In a context of limited resources, many countries define packages of essential health care services or the core set of services that will be made available to everyone from public funds. Essential services for HIV, viral hepatitis and sexually transmitted infections should be incorporated into such national priority essential packages, supported by adequate financing. The WHO UHC Compendium, a comprehensive menu of health interventions, can be a useful starting-point for countries to define or update their essential packages *(17)*.

There are many sources of funding for health, including domestic public revenue, private contributions (including voluntary prepaid contributions and out-of-pocket expenditure) and contributions from external partners. The funding landscape of HIV, viral hepatitis and sexually transmitted infections has varied significantly. HIV responses have benefitted from large-scale external funding and increasing domestic resources, whereas financing for viral hepatitis and sexually transmitted infections has lagged behind. Accelerating progress in all three disease areas will require strategic shifts in how these responses are funded. This includes incorporating essential HIV, viral hepatitis and sexually transmitted

infection services into national priority essential packages; raising additional funds through domestic sources; establishing mechanisms to pool funds to enable financial risk protection; identifying innovative financing mechanisms; and improving efficiency through integrated approaches and by reducing costs and fragmented funding streams.

Once the HIV, viral hepatitis and sexually transmitted infection priorities have been defined, the national strategic plans must include information on their costing (the resources required to deliver the plan) and budgeting (the allocation of resources to deliver the results of the plan given the level of resource availability). These components must be developed as an integral part of the planning process. Further, costing and budgeting are iterative processes and may require several rounds of analysis, discussion and fine-tuning to examine priorities and match them to the available resource envelope. These processes should be participatory and promote budget transparency.

1) *Costing*. This refers to the process of estimating the overall resource envelope that will be required to achieve the priorities and expected results of the plan, valuing this in monetary terms and determining how resources will be allocated. It involves strategic thinking around what resources would be required, along with detailed analysis of the inputs (such as staff time, health products and other materials) for the activities. Costing and priority setting (see section 3.3) go hand in hand. The costing process informs priority setting and technical efficiency and provides an important reality check for whether the planned activities are affordable. Costs should be compared with available financial resources, and if resources cannot be mobilized to cover the full set of planned activities, the plan ambition and related costing should be revised to correspond to fit within the available budget. The costing exercise should therefore include analysis of scenarios of the resource requirements for different investment strategies in the plan.

A plan that includes the above information is referred to as a costed plan. It provides the basis for resource allocation and resource mobilization from national and external funding sources. Costing should cover the entire strategic plan period, with more detailed estimates for the first 1–2 years and updates on an annual or rolling basis. Detailed cost estimates for near-term implementation should be linked to financing mechanisms (including funding sources and budget categories). Box 19 describes the key aspects of costing.

Box 19. Key aspects of costing

The following are key aspects of costing.

Unit costs. Unit costs represent the total direct and indirect costs of providing one unit of a given output or service over a given time period. Unit costs are normally identical to the average cost of delivering a service or intervention. Examples of unit costs may include the cost of providing antiretroviral therapy to one person for one year, the cost of procuring and distributing 1000 condoms to priority populations, the cost of testing one person for hepatitis B or C virus etc. Unit costs for some services (such as antiretroviral therapy) need to be expressed with a time frame since they are recurrent; others may be delivered only once (such as testing). Countries are encouraged to use existing data on programme costs and services delivered to calculate unit costs whenever possible.

Direct and indirect costs. In costing a plan, planners must take care to include all the costs associated with achieving a particular objective or implementing an activity. Some of these costs will be direct costs and others may be indirect costs. Direct costs are the obvious costs that can be attributed directly to providing a service or implementing an activity (for example, the cost of tests, medicines or staff time of a health-care worker). Indirect costs are the less obvious additional costs that cannot easily be attributed to providing a given service or activity (for example, a proportion of the operating costs of the infrastructure such as the rent, utilities, maintenance etc.)

Top-down versus bottom-up costing. Unit costs can be estimated using either a top-down or a bottom-up approach. Top-down costing involves evaluating resource use at a higher level and then separating it into smaller components. An example is taking full expenditure data from a hospital and then using allocation factors to identify a share of costs that can be attributed to HIV, viral hepatitis or sexually transmitted infections. Bottom-up costing, in contrast, involves detailed identification and measurement of all the resources used in producing a service. Costing developed using the two approaches may not always be consistent with one another, so iterations and reconciliation may be needed between costings at the strategic and operational levels.

Efficiency and effectiveness. Efficiency is described as the condition in which no productive resources are wasted in delivering a certain product or service. Effectiveness addresses the question of how well a given intervention delivers the desired result relative to the cost of the intervention. The results are usually described in terms of lives saved, life-years gained, infections averted or some other measure of the effect of a given intervention. An intervention is said to be cost-effective if it delivers the maximum effect at a given level of cost or if cost is minimized for a given effect.

2) *Budgeting*. This relates to the process of defining the allocation of available resources towards agreed strategic investments. When compared with the projected costs, the budget helps strategic planners to understand whether adequate resources are available to implement the plan, to identify gaps and areas where budget allocation is less than expected and to inform future resource mobilization efforts. Budgeting information also provides a basis for the relevant decision-makers to approve strategic plans and allocate funds.

Public finance processes are structured around the annual budget cycle in a country, which aims to ensure that public expenditure is well planned, executed and accounted for. A standard budget cycle incorporates four distinct stages – budget definition and formulation; budget negotiation and approval; budget execution; and budget reporting, auditing and evaluation *(5)*. A national health budget is a crucial and politically important text to orient health sector activities. Box 20 describes the key aspects of budgeting.

Box 20. Key aspects of budgeting

The following are key aspects of budgeting.

Estimating and allocating resources. Planners need to estimate what resources are available or will become available from all sources over the course of the strategic plan period. Once all the resources available have been estimated, the cost estimates are used to allocate the resources against the results framework of the plan to determine what funds are available for which priority areas and results. This may be referred to as the budget proposal process.

Financial gap analysis. Once the budget proposal is ready for review, planners need to compare the available resources to the projected estimated costs. Where there is an underestimate, stakeholders should engage in negotiations to propose budget adjustments. Funding may not be adequate to meet the full cost of the plan. A financial gap analysis represents the difference between the estimated cost of the strategic plan and the projected availability of funding. In this case, available resources must be optimized. Scenario analysis may be helpful to assess options for how the strategic vision of the plan may be realized in relation to projections of available funding. The gap analysis is important to allow planners to set priorities for interventions and objectives (for example, some areas my need to be scaled back or eliminated and others may be scaled up); to reallocate funding from areas that are overfunded to those that are underfunded; to adjust the scale and scope of a plan to make it financially feasible; and to focus resource mobilization efforts on the areas in most critical need of funding.

Various tools are available to support health sector costing and budgeting processes. The WHO Integrated Health Tool for Planning and Costing (previously OneHealth Tool) provides planners with a single framework for scenario analysis, costing, health impact analysis, budgeting and financing of strategies for all major diseases and health system components (Box 21)

Box 21. The Integrated Health Tool for Planning and Costing

The Integrated Health Tool for Planning and Costing (formally OneHealth Tool) is a resource for countries to assess costs and health impact associated with national strategic plans (22). The first version became available in 2012 and has since been used in a wide variety of settings in more than 60 countries.

The Tool includes modules devoted to specific health programmes such as TB, HIV and sexual and reproductive health as well as broader health system planning and costing frameworks. This approach ensures that disease- and programme-specific planning can be done not in isolation from the broader health planning strategy and budget but as part of an integrated health sector planning process.

The development of the Tool has been overseen by an interagency working group with representatives from WHO, UNAIDS, UNDP, UNFPA, UNICEF, World Bank and UN Women; taking into account country users' feedback to inform annual updates to ensure that the Tool responds to country needs for costing. Developed by Avenir Health, the Tool incorporates other tools such as the AIM, GOALS and Resource Needs Model tools frequently used for HIV costing. It includes interventions for preventing and treating hepatitis and sexually transmitted infections. The tool is pre-populated with defaults for disease prevalence and incidence, intervention protocols for promotive, preventive and curative care and prices of drugs, supplies and equipment – all of which can be changed by the user.

The Tool also includes a cost–effectiveness function that enables users to analyse the cost–effectiveness of selected interventions, calculating the healthy life-years gained per dollar spent and enabling comparison of value gained across interventions and packages of care. The cost–effectiveness calculations can therefore be run as an initial step to inform the priority-setting process before entering targets for a strategic plan and estimating the associated cost and projected health impact.

3.7 Implementation arrangements

The implementation of a strategic plan involves many entities and service providers, including from the public sector, private sector, nongovernmental organizations, communities and religious organizations and others. These entities operate at different levels, including at central level, subnational levels (such as state, province and district levels) and at the community level. They operate through different channels of service delivery, such as through the public health-care system, private health facilities, outreach services, digital services or service delivery channels that target specific population groups, such as key populations.

The strategic plan should define the leadership and governance structures for implementing the plan at the national and subnational levels, with the roles and responsibilities of each. Governance structures for individual disease areas will generally fall within the usual governance and oversight structures and mechanisms of the health sector. In some cases, these structures may need to be adapted to better address the specific programme areas. Although national HIV responses have evolved historically to have dedicated programme coordination units within health ministries, this has not been the case systematically for viral hepatitis and sexually transmitted infection responses. It is therefore particularly important to identify a coordinating structure, and a programme manager or a focal point, for each disease response and to outline how programme governance and coordination will take place within the broader health sector governance and oversight mechanisms existing in the country.

It is equally important to develop implementation mapping that lays out the roles and responsibilities of the implementing entities in the national disease response at the different levels of the health system; their respective contributions; the flows of funds, commodities and data among them; and the institutional arrangements and coordination mechanisms, to ensure the coherent and timely delivery of activities.

The capacity of the different institutions to deliver their respective roles and responsibilities and facilitate progress is an important aspect of implementation arrangements. Another important aspect of programme management is assessing and managing the risks that could adversely affect the implementation of the plan and planning for contingency measures in the event of emergencies that may disrupt health services. These risks may be internal (such as capacity issues not previously identified) or external (such as health emergencies, changes in donor funding landscape or instability). Risk management involves identifying potential risks that could arise, their likelihood and severity and possible strategies to mitigate them.

As mentioned in section 3.5, it is very important to include programme reviews, including annual, mid-term and end-term reviews, as part of the implementation and feedback process of a strategic plan. These reviews should be conducted jointly with all partners involved in programme implementation to assess performance, identify gaps and inform iterative programme improvements. These processes are also critical for accountability of the responses to these diseases.

4. Strategic planning for HIV

This chapter presents HIV-specific considerations for the core components of strategic planning. It supplements Chapter 3, which provides general descriptions of these core components, towards the global goal of ending AIDS as a public health threat by 2030.

Sound strategic planning has accompanied the vast scaling up of the public health response to HIV since the onset of the HIV epidemic in the 1980s. In affected countries across the world, HIV strategic plans have formed the basis of large increases in international funding and global partnerships in support of national HIV programmes and promoted inclusive and rights-based approaches that directly engage affected communities in all planning and priority-setting processes.

As a pioneer for multisectoral approaches to addressing the broader social and structural determinants of infectious diseases, the HIV response is also unique in its practice of having both multisectoral strategic plans (often led by coordinating bodies such as national AIDS councils) to oversee a harmonized response to HIV by all major stakeholders in society; with dedicated health sector strategic plans (often led by national AIDS control programmes within health ministries) to oversee the leading role of the health sector addressing the epidemic.

There have been tremendous achievements in the global HIV response in recent years (1,30). At the end of 2021, 85% of the people living with HIV knew their HIV status. About 75% of the people living with HIV were receiving antiretroviral therapy, more than triple the number in 2010, and helping to reduce AIDS-related deaths to their lowest point since 1994. Nevertheless, more than 1.5 million people acquire HIV each year, and the annual numbers of people acquiring HIV have increased over the past decade in eastern Europe and central Asia, the Middle East and North Africa and Latin America. Key populations and their sexual partners account for 70% of the people acquiring HIV globally. Expansion in HIV testing and treatment is stalling, and the resources available for HIV in low- and middle-income countries are declining. Access to services for children lags behind progress achieved for adults, and key populations continue to face many barriers in accessing services *(30)*.

The GHSS 2022–2030 defines global impact targets for 2025 and 2030 that must be achieved to end AIDS as a public health threat by 2030 (Table 1). These targets align with the global commitments of the 2021 United Nations General Assembly Political Declaration on HIV and AIDS *(8)*, which includes bold global targets to maximize equitable and equal access to HIV services and solutions, break down barriers to achieving HIV outcomes and fully resource and sustain efficient and integrated HIV responses. They also contribute to achieving the goals of the Global AIDS Strategy 2021–2026 *(9)*, which uses an inequalities lens to close the gaps preventing progress to end AIDS as a public health threat and sets out bold new targets and polices to be reached by 2025 (Fig. 10).

HIV is closely linked to other disease areas, including TB, which remains the leading cause of death among people living with HIV. Strategic planning for HIV must be linked to planning for TB, viral hepatitis, sexually transmitted infections, sexual and reproductive health, maternal newborn and child health, noncommunicable diseases, cancer, mental health and other related disease areas. Operational linkage should also be made among these areas along the whole programme cycle in a people-centred approach.

Table 1. Global HIV impact targets, 2025 and 2030

Indicator	Baseline – 2020	Targets – 2025	Targets – 2030
Number of people newly infected with HIV per year	1.5 million	370 000	335 000
Number of people newly infected with HIV per 1000 uninfected population per year (Sustainable Development Goal 3.3.1)	0.19	0.05	0.025
Number of children younger than 15 years newly infected with HIV per year	150 000	20 000	15 000
Number of people dying from HIV-related causes per year (including disaggregation by HIV cryptococcal meningitis, TB and severe bacterial infections)	680 000	250 000	<240 000
Reduced number of TB-, hepatitis B- and hepatitis C-related deaths among people living with HIV	210 000	110 000	55 000
Number of countries validated for the elimination of mother-to-child transmission of either HIV, hepatitis B or syphilis	15	50	100

Source: GHSS 2022–2030 *(4)*. The GHSS 2022–2030 provides a complete list of impact and coverage indicators and policy milestones.

Fig. 10. Global AIDS Strategy 2021–2026 – targets and commitments

Source: Global AIDS Strategy 2021–2026 *(9)*.

Although each country will advance towards these goals at a different pace, all countries must strive to set ambitious and feasible targets as close as possible to global targets in relation to the country context and capacity to advance towards ending AIDS as a public health threat. This will require health sector leadership in each country within the multisectoral HIV response to deliver evidence-informed priority actions for all communities. It will also require reinvigorated prevention efforts, innovative and differentiated service delivery to meet the diverse needs of key populations in different settings and ending the criminalization, stigma and discrimination that prevent many people from accessing services.

4.1 Planning process

In addition to the general considerations for the strategic planning process described in section 3.1, the planning process for HIV should consider the following HIV-specific aspects (Table 2).

Table 2. HIV strategic planning process

Key elements	Considerations for HIV strategic planning process
Stakeholder engagement	Include all key stakeholders for HIV, such as stakeholders within the health ministry and from other relevant ministries; stakeholders involved in implementation at various administrative levels; representatives of people living with HIV and common comorbidities; representatives of key populations and other community groups; nongovernmental organizations and civil society; key funders such as PEPFAR and the Global Fund to Fight AIDS, Tuberculosis and Malaria, when present in the country; bilateral and multilateral agencies; private sector providers; and academic and research institutions
Planning cycle	Ensure alignment of the HIV health sector strategic plan with the HIV multisectoral plan, where it exists, as well as alignment with the overall national health sector strategic plan
Leadership and management	Ensure that all the requirements for effective leadership and management of the planning process, including the functioning of the steering committee, writing committee and other entities in the HIV planning process, are in place The national AIDS control programme should work in close liaison with multisectoral national AIDS councils, where they exist
Technical resources	Refer to technical resources from WHO, UNAIDS and other Cosponsors as part of the planning process Ensure that all the required data and analyses are in place to make informed decisions regarding priority setting and resource allocation

4.2 Situation analysis

In addition to the general descriptions of situation analysis listed in section 3.2, the key elements of situation analysis for HIV are listed in Table 3.

Table 3. Situation analysis for HIV strategic planning

Key elements	Key information to include	Additional analyses
Epidemiological analysis	General population data and trends: • HIV prevalence • HIV incidence • AIDS-related mortality • HIV vertical (mother-to-child) transmission rate • Identification of population groups at highest risk of HIV, modes of transmission and key risk and vulnerability factors Data and trends for key populations and other priority populations: • HIV prevalence • HIV incidence • Size estimates Comorbidity data and trends: • TB-related deaths among people living with HIV • Incident TB cases in people living with HIV • AIDS-defining illnesses, including cancer and other noncommunicable diseases and mental health conditions • Sexually transmitted infections • Advanced HIV disease	Disaggregated by age, sex, geography and population groups, (including key populations and other priority population groups, such as adolescent girls and young women in settings with high HIV incidence), as relevant
Programmatic response and gap analysis	Primary prevention • Condom use at last high-risk sex • People receiving pre-exposure prophylaxis (PrEP) • People receiving post-exposure prophylaxis (PEP) • Prevalence of male circumcision • Knowledge about HIV prevention among young people (15–24 years old) • Harm reduction for people who inject drugs Progress towards 95–95–95 targets • People living with HIV who know their HIV status (%) • People living with HIV receiving antiretroviral therapy (%) • People living with HIV who have suppressed viral loads (%) • Late HIV diagnosis Elimination of vertical transmission • Coverage of treatment for pregnant women who receive antiretroviral therapy for preventing vertical (mother-to-child) transmission and their own health • HIV testing among pregnant women • Early HIV infant diagnosis and final outcome testing • Demand for family planning satisfied by modern methods	Achievements and performance against current strategic plan targets Major gaps in prevention, treatment and care, and coverage for underserved populations and geographies and analysis of whether the response is addressing the cause of new infections Disaggregated by age, sex, geography and population groups (including key populations and other priority population groups, such as adolescent girls and young women in settings with high HIV incidence), as relevant

Table 3 (cotinued). Situation analysis for HIV strategic planning

Key elements	Key information to include	Additional analyses
Programmatic response and gap analysis	Services for key populations • HIV testing and status awareness • Harm reduction • Antiretroviral therapy coverage • Condom use among sex workers • Coverage of HIV prevention programmes (including, PrEP and harm reduction for PWID) • Viral hepatitis screening, testing, treatment and vaccination • Screening for sexually transmitted infections – gonorrhoea, chlamydial infection and syphilis • Avoidance of health care because of stigma and discrimination Co-infections and co-morbidities • Proportion of people living with HIV receiving TB preventive therapy • People coinfected with HIV, hepatitis B virus and hepatitis C virus • Cervical cancer screening of women living with HIV • Screening for diabetes and hypertension, especially for people older than 50 years • Cryptococcal disease, severe bacterial infections and endemic fungal infections (such as histoplasmosis) • Mental health Social determinants • HIV-related discrimination in health-care settings (for example, using the People Living with HIV Stigma Index (23)) • Prevalence of sexual and gender-based violence, including intimate partner violence and other forms of discrimination • Structural inequalities and other determinants of health including education, occupation, income and other factors	
Health and community system context	• Availability and scope of national strategic plans, policies and guidelines related to HIV • Health systems capacity and organization in relation to human resources, commodities, laboratory services, information systems and policies as they relate to HIV • Service delivery packages and delivery models in place to reach key and affected populations • Community-led responses for implementing HIV prevention and care programmes with adequate resources, including for people living with HIV, key population networks, community-based organizations and faith-based organizations, when relevant • Funding landscape for HIV and financial sustainability	

Table 3 (cotinued). Situation analysis for HIV strategic planning

Key elements	Key information to include	Additional analyses
Socioeconomic and political context	Legal environment and sociocultural context that affect HIV responses and create barriers for key and affected populations to access essential HIV and other health services, including: • Presence of laws and policies that protect and uphold human rights • Presence of harmful laws, policies and practices (including laws that criminalize behaviour or restrict access to services) that hinder access to services • Levels of stigma and discrimination towards people living with HIV and key populations in the general community and in health-care settings • Human rights violations and responses • Multisectoral collaboration	
Stakeholder analysis	Analysis of roles, contributions, comparative advantage and influence, of key HIV stakeholders including: • Stakeholders within the health ministry (such as among units responsible for sexual and reproductive health, maternal and child health, occupational health, infectious diseases and noncommunicable diseases) • Stakeholders from other government sectors who need to be engaged for an effective multisectoral response (such as education, finance, justice, women and youth affairs and local government) • Representatives of people living with HIV and common comorbidities • Communities of key populations (gay men and other men who have sex with men, transgender and gender-diverse people, sex workers, people who inject drugs and people in prisons and other closed settings) and other priority populations • Representatives of other community groups (such as community leaders, traditional health practitioners and religious leaders) • Civil society organizations • Stakeholders involved in implementation from various levels, such as the regional and district levels • Key funders such as PEPFAR and Global Fund, when present in the country • Bilateral and multilateral agencies and other international donors and partners • Private sector • Academic and research institutions	

4.3 Setting priorities

Building on the general descriptions of priority setting in section 3.3, this section provides additional considerations for setting priorities for HIV that must consider the evidence base of the HIV epidemic and response in the country and focus resources and efforts on the population groups and interventions that are likely to bring about the greatest impact on the trajectory of the epidemic.

The GHSS 2022–2030 defines the global strategic and operational shifts that will be required to end AIDS as a public health threat by 2030 (Box 22). These shifts align with the priorities of the Global AIDS Strategy 2021–2026.

Informed by the situation analysis, each country should define the priorities that will be required in the national HIV response to achieve its goals in relation to the country context (Box 23). Many countries develop HIV investment cases or a proposal for optimized resource allocation that assesses gaps and opportunities in the national response and gives priority to interventions that are cost-effective, efficient and produce maximum impact in various resource scenarios *(31)*. Priority setting for HIV should be informed by the HIV investment case if it has been developed. There are many approaches to conducting such analysis, many of which rely on statistical modelling and cost–effectiveness analysis.

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Box 22. Global strategic and operational shifts for the HIV response

The GHSS 2022–2030 defines the following strategic and operational shifts for the HIV response:

- Renew the focus on primary prevention
- Address the major causes of HIV-related deaths, including TB, cryptococcal meningitis and severe bacterial infections
- Close gaps in service access for children and adolescents
- Ensure continued engagement of people living with HIV in HIV treatment and care services and addressing chronic care needs to improve the quality of life for an ageing cohort of people living with HIV and people with advanced HIV disease
- Address the barriers faced by key populations
- Apply differentiated approaches to service delivery to meet the specific needs of populations and settings
- Leverage innovations, including new treatment regimens, new prevention approaches, vaccines and effective cures, supported by research that includes the needs of resource-limited settings

Box 23. How to set priorities for HIV interventions in different country contexts

The UNAIDS guide on smart investments (32) describes the following investment approaches to allocate resources in ways that enhance the impact of national responses – averting new HIV infections, saving more lives and avoiding significant treatment costs over time.

- *Using a geographical approach to set priorities for investments.* Patterns of new HIV infections, HIV burden and availability and access to services vary considerably among and within countries. Services and resources should be focused in locations where the most people ac quire HIV and where the need is greatest.
- *Focused investments on populations with the greatest need.* In addition to geographical variation, the burden of HIV and access to services also differs between populations. All countries must strengthen evidence- and rights-based programming for populations whose needs have not been effectively addressed.
- *Reducing the costs of antiretroviral medicines* and *other essential HIV commodities.* Minimizing the costs associated with purchasing essential HIV commodities may require action in various domains including: optimizing tenders and purchasing processes for antiretroviral medicines; diversifying potential suppliers, including local producers; joint procurement, forecasting and other ways of using volume to reduce prices; and policy change, such as using available flexibilities under the World Trade Organization Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS).
- *Promoting efficiency gains through alternative service delivery models, including integrated approaches and community-led services.* New and innovative service delivery approaches, such as task sharing, multimonth dispensing of antiretroviral medicines, expanding partnerships with communities, faith-based organizations and the private sector and service integration and decentralization can improve the efficiency and effectiveness of services.
- *Eliminating parallel structures and reducing programme support costs to optimize investments.* Countries should also give priority to approaches to integrate HIV with other health services and improve programmatic linkage, to provide person-centred care and create health system efficiency by reducing costs.

Once HIV priorities have been agreed upon, these need to be expressed in terms of the vision, goals, objectives, targets, populations and interventions of the HIV strategic plan.

1) *HIV vision, goals, objectives and targets*. HIV national strategic plans should include the goals, objectives and targets specific to HIV. The GHSS 2022–2030 present the key targets for the global HIV response (Table 7), which provide a guiding framework for national HIV targets in relation to the country's baseline, national goals and capacity. The overall vision and direction for all countries should be towards ending AIDS as a public health threat by 2030. HIV goals could include the following, with targets defined for each country context:
   - reduced new HIV infections (number or percentage, by year);
   - reduced AIDS-related deaths (number or percentage, by year); and
   - reduced inequities in service coverage (number or percentage, by year, by population group).
2) *HIV populations.* Each country should define the priority population groups that are most affected in relation to the local epidemiological and health system context while upholding fundamental human rights, equitable access to health and evidence-informed practice. The GHSS 2022–2030 presents HIV priority populations (Box 24) that can be used as a reference for national strategic planning.

Box 24. Priority populations for HIV

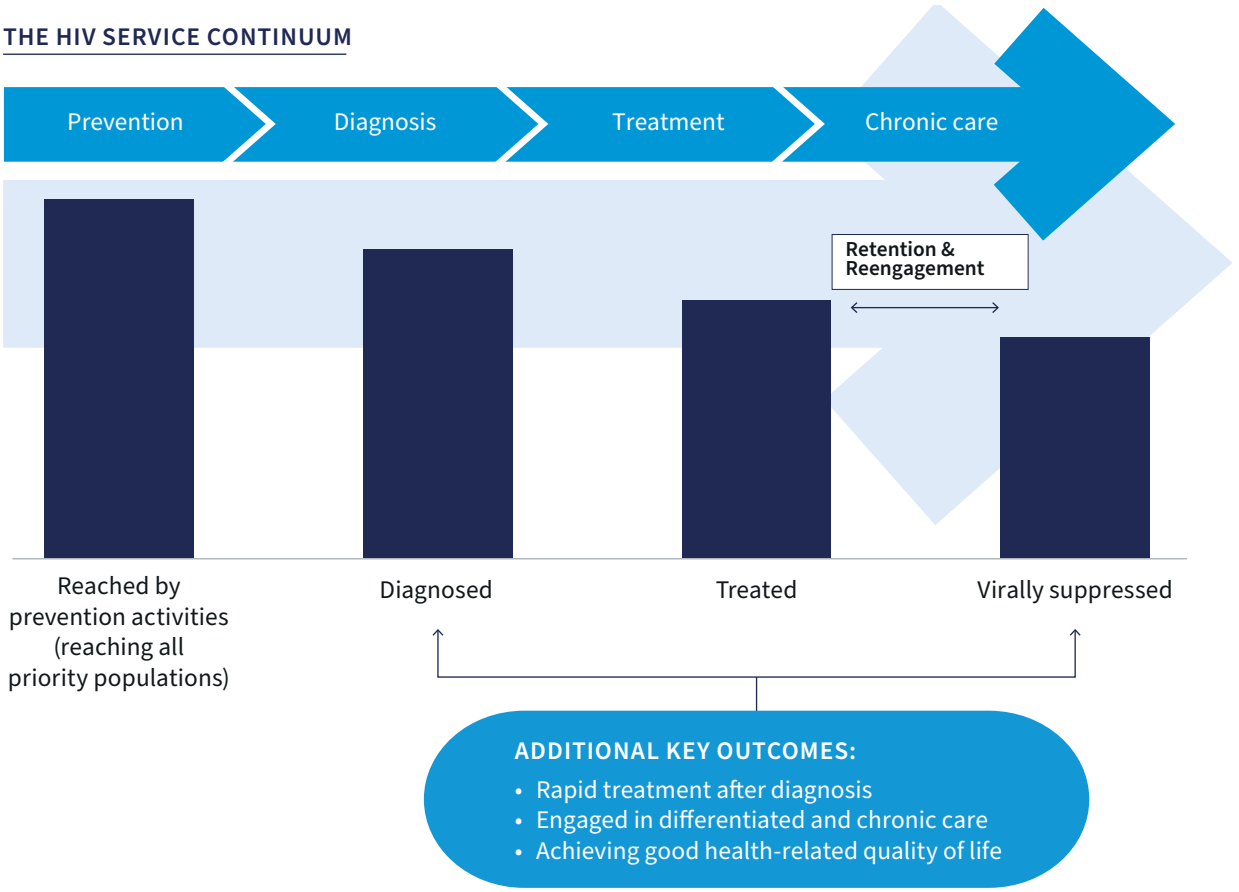
The GHSS 2022–2030 defines the following priority populations for HIV:

- people living with HIV;
- key populations for HIV: gay men and other men who have sex with men, people who inject drugs, sex workers, transgender and gender-diverse people and people in prisons and other closed settings;
- women, including pregnant and breastfeeding women, and adolescent girls;
- adolescents and young people, including young key populations in specific contexts;
- children;
- men and boys, who are less likely to use health services and experience poorer health outcomes in some settings; and
- other priority populations may include people with disabilities, indigenous peoples, migrants and mobile populations and people in settings of humanitarian concern.

Note that people can be members of more than one key population group and have more than one type of risk behaviour, and some people may engage in risk behaviour without identifying as members of a particular group, such as men who have sex with other men but do not identify as gay. People who inject drugs often stop using drugs, sex workers stop sex working and people move in and out of prison; recognizing the complexities and changes in people's lives is therefore important (27).

3) *HIV interventions.* Each country needs to define a package of essential HIV interventions along the continuum of HIV services, including combination prevention, early access to and engagement in care, continuity of treatment, re-engagement, monitoring and packages for advanced HIV disease. The interventions should be delivered along a service cascade that addresses people's needs across the continuum and ensures that they are able to remain engaged in care, to optimize outcomes at patient and population levels (Fig. 11).

Fig. 11. Moving towards universal health coverage



Source: GHSS 2022–2030 (4).

The GHSS 2022–2030 defines the priority intervention areas for the HIV response. Table 4 describes the key HIV interventions. Section 4.4 describes HIV-specific aspects of their service delivery, including service delivery models, systems strengthening functions and enablers.

Some HIV interventions, such as primary prevention, harm reduction and the triple elimination of vertical transmission of HIV, syphilis and hepatitis B virus, are shared interventions with other disease areas. These interventions offer opportunities for aligned approaches to service delivery and enhanced programme quality and efficiency.

When setting priorities for HIV interventions, national strategic plans should consider being involved in research and innovation and support the rapid uptake of new knowledge and innovations to maximize impact, including new HIV diagnostics technologies and testing approaches, new long-acting prevention and treatment products, new drug formulations that minimize toxicity and drug–drug interactions, innovations in developing HIV vaccines or a functional HIV cure as well as innovations in service delivery approaches, such as using digital technologies.

Table 4. HIV intervention areas

HIV interventions	Description	Priority populations	Opportunities for shared approaches
Prevention			
Primary prevention	Includes comprehensive education and information about sexual and reproductive health and HIV prevention noting WHO technical guidance; correct and consistent condom use; and addressing the harmful use of alcohol and drugs in the context of sexual behaviour	Key populations; other priority populations including young people, adolescents, men	Viral hepatitis, sexually transmitted infections, family planning, sexual and reproductive health
Antiretroviral drugs for HIV prevention	Includes strategic combination of pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) with other prevention interventions	Key populations; other priority populations including young people, adolescents, men	Sexually transmitted infections
Voluntary medical male circumcision	Includes voluntary medical male circumcision as part of comprehensive services to improve the health and well-being of adolescent boys and men	Boys and men 15 years and older	Viral hepatitis, sexually transmitted infections, TB, mental health, nervous system disorders and substance use Noncommunicable diseases
Harm reduction	Includes a comprehensive package of accessible harm-reduction and treatment services, where appropriate, as part of a comprehensive package of interventions for the prevention, treatment and care of HIV among people who inject drugs and for people who use stimulant drugs	People who inject drugs	Viral hepatitis, substance use treatment and management

Table 4 (continued). HIV intervention areas

HIV interventions	Description	Priority populations	Opportunities for shared approaches
Elimination of vertical transmission	Includes comprehensive and accessible prevention, testing, treatment and follow-up services for women, children and their families for triple elimination of vertical transmission of HIV, syphilis and hepatitis B virus, through an integrated approach with maternal and child health services	Pregnant and breastfeeding women, infants	Viral hepatitis, sexually transmitted infections, maternal and child health, sexual and reproductive health
Infection prevention and control	Includes interventions to prevent disease transmission in formal and informal health-care settings and other service settings	Key populations; other priority populations including pregnant women, young people, adolescents, men	Viral hepatitis, sexually transmitted infections
Voluntary partner notification and other partner and social network approaches	Includes human rights-based and gender-sensitive strategies for voluntary partner notification and other services for sexual partners of people diagnosed with HIV	Key populations; other priority populations including pregnant women, men	Viral hepatitis, sexually transmitted infections
Testing and diagnosis			
People-centred testing	Includes strategic approaches to expand people-centred testing through decentralized and differentiated service delivery with timely linkage to treatment and care	Key populations; other priority populations including adolescents, pregnant and breastfeeding women, men, children	Sexually transmitted infections
Early infant diagnosis	Includes early virological testing of infants for HIV at six weeks or as soon as possible thereafter to determine their HIV status and guide clinical decision-making at the earliest possible stage	Children born to mothers living with HIV	TB, viral hepatitis, sexually transmitted infection, emerging pathogens

Table 4 (continued). HIV intervention areas

HIV interventions	Description	Priority populations	Opportunities for shared approaches
Treatment (viral load) monitoring	Includes viral load testing as the preferred monitoring approach to detect and confirm the failure of antiretroviral therapy	People living with HIV on antiretroviral therapy, including children	
Treatment and care			
HIV treatment	Includes HIV treatment with WHO-recommended treatment regimens for all people living with HIV through differentiated service delivery models that provide people-centred care and monitoring, with support for adherence and for retention and re-engagement in care	People living with HIV who know their status, including children	TB, viral hepatitis
Advanced HIV disease	Includes a package of care for all people living with HIV with advanced HIV disease	People living with HIV who are newly diagnosed, re-engaging in care or on antiretroviral therapy, including children	TB, bacterial infections, cancer
TB preventive therapy	Includes providing TB preventive therapy for all adults and adolescents living with HIV who are unlikely to have active TB, as part of a comprehensive package of HIV care	People living with HIV	TB
HIV drug resistance	Includes coordinated action to prevent, monitor and respond to HIV drug resistance including support for continued research and development, transition to HIV therapies that have a higher barrier to resistance, ensuring uninterrupted drug supplies and strengthening monitoring and surveillance	People living with HIV receiving antiretroviral therapy	

Table 4 (continued). HIV intervention areas

HIV interventions	Description	Priority populations	Opportunities for shared approaches
Antiretroviral drug toxicity	Includes monitoring antiretroviral drug toxicity and promoting patient safety	People living with HIV receiving antiretroviral therapy	
Chronic care for people living with HIV	Includes comprehensive interventions to address the chronic care and quality of life needs of children, adolescents and adults living with HIV	People living with HIV receiving antiretroviral therapy	Noncommunicable diseases (diabetes, hypertension, chronic respiratory disease), cancer including cervical cancer; mental health, nefvous system disorders and substance use; disability
Enabling interventions			
Addressing structural barriers	Promoting community and civil society leadership, including young people Addressing stigma and discrimination, including in health-care settings Preventing and addressing violence Legal, regulatory and policy reform Multisectoral partnerships	Key populations; all other priority populations	Sector-wide

Source: GHSS 2022–2030 *(4)*. The GHSS 2022–2030 provides a complete list of impact and coverage indicators and policy milestones.

4.4 Service delivery

Once HIV priorities have been identified, the HIV strategic plan needs to define how the interventions will be delivered. Building on the general descriptions of the different aspects of service delivery in section 3.4, this section presents additional HIV-specific considerations related to essential benefit packages, service delivery models, health system strengthening and enabling factors.

1) *Essential benefit packages.* In addition to the general descriptions of essential benefit packages listed in section 3.4, essential packages for HIV should consider the following HIV-specific aspects (Table 5).

Table 5. Essential packages for HIV

Key elements	Considerations for HIV intervention packages
National essential benefit packages	Include key services for HIV in national essential benefit packages, including a commitment to finance these through public and private channels, including health insurance
Tailored packages for population groups	Define comprehensive packages of evidence-informed essential HIV interventions for specific population groups, including key population groups, that include biomedical, behavioural and structural interventions that address prevention, treatment and care needs Ensure that people can be provided with options and choices in relation to services and service delivery approaches to address their individual risks and needs that may change across a person's lifetime

2) *Service delivery models.* In addition to the general descriptions of service delivery models in section 3.4, service delivery for HIV should consider the following HIV-specific aspects (Table 6).

Table 6. Service delivery models for HIV

Key models and approaches	Considerations for HIV service delivery
Differentiated service delivery	Ensure that all populations established on antiretroviral therapy (including children, adolescents, key populations, pregnant and breastfeeding women and men) can benefit from differentiated service delivery models and their institutionalization into health system infrastructure, enabling HIV service provision to be maintained long term Expand differentiated approaches to HIV prevention and testing services
Decentralized service delivery	Ensure functioning linkage with primary care services, including task sharing, to deliver HIV services close to where people live, work and socialize
Community-led delivery	Leverage targeted community-led interventions to reach key populations and other priority populations that face gaps in service access Support and use data generated through community-led monitoring to understand barriers to access and the experiences, needs and expectations of communities
Special settings	Ensure that health-care services in prisons and other closed settings are equivalent to those available to the broader community and that the continuity of essential services such as antiretroviral therapy can be guaranteed when people move within these settings and to the broader community
Digital technologies	Offer online delivery of HIV services to key and affected populations, including online outreach, online case management and targeted health information, as an additional option while ensuring that data security and confidentiality are protected

3) *Strengthening systems.* Strategic planning for HIV must consider approaches to strengthen the critical health system functions that are necessary to deliver HIV services in ways that optimize the use of health system resources, reduce misalignment or duplications with other disease programme areas, reduce access barriers and contribute to advancing primary health and universal health coverage. In addition to the general descriptions of system-strengthening actions in section 3.4, strengthening systems for HIV should consider HIV-specific aspects (Table 7).

Table 7. HIV actions to strengthen health systems

Key health system functions	Considerations for HIV responses
Governance	Promote the meaningful engagement of affected communities, including people living with HIV, key populations and other priority populations
Health-care workforce (including community health workers)	Strengthen the role of community service providers, including lay providers, in delivering HIV services
Commodities	Ensure uninterrupted supply of quality-assured antiretroviral drugs, prevention commodities and diagnostics Ensure rational use of antiretroviral medicines and sound stock management, including when transitioning to newer regimens
Laboratory services	Increase capacity for HIV testing at peripheral levels, including self-testing and for HIV treatment (viral load) monitoring Consider diagnostic network integration to create synergy across disease programmes and integrate testing and diagnostics across diseases for more optimized and responsive networks
Financing	Ensure progressive increase in local resources allocated for HIV, such as through domestic resource mobilization, including from the private sector, within the context of increased health systems financing for universal health coverage Promote coordinated donor contributions to the HIV response

4) *Enabling interventions.* An effective response to HIV requires action to advance the key enablers that are essential to promote equity and overcome major barriers to service access. In addition to the general descriptions of enablers in section 3.4, HIV plans should consider HIV-specific aspects (Table 8).

Table 8. HIV actions on enabling interventions

Key enablers	Considerations for HIV responses
Community and civil society leadership	Include specific activities to engage and empower networks of people living with HIV, affected communities and civil society, such as: • Organizing meaningful engagement in inclusive planning, monitoring and representation • Supporting community leadership to represent and advocate for people-centred approaches in various health sector policy and coordination forums • Addressing stigma and discrimination • Advocating for legislative change, equitable access to treatments and commodities • Demanding transparency and accountability from institutions in positions of power and authority • Strengthening community-led monitoring, data generation and use
Addressing stigma and discrimination	Include specific activities to address HIV-related stigma and discrimination, such as: • Training health-care providers on non-discrimination, duty to treat, informed consent and confidentiality and violence prevention and treatment • Facilitating collaboration between health-care points and community organizations for patient support and quality control • Developing institutional policies and accountability mechanisms for health-care facilities • Community mobilization and sensitization on stigma and discrimination • Inclusion of anti-discrimination programmes and policies in work, health, social service and education settings • Addressing stigma and discrimination against health-care workers who may be affected by HIV themselves

4.5 Monitoring and evaluation

The WHO consolidated HIV strategic information guidelines *(33)* present the essential HIV indicators and guidance on choosing, collecting, setting priorities for and systematically analysing strategic information to manage, monitor and improve the national health sector response to HIV. In addition to the general descriptions of the various aspects of monitoring and evaluation in section 3.5, HIV strategic plans should consider the following HIV-specific aspects for monitoring and evaluation (Tables 9 and 10).

Table 9. Considerations for HIV monitoring and evaluation

Key elements	Considerations for HIV monitoring and evaluation
Indicators and targets	• Ensure that indicators included in the national monitoring and evaluation plan reflect the steps in the HIV services cascade and the extent and equity of services across geographical areas and population groups • Cover the three data use cases at country level: individual patient care and monitoring, programme management and programme monitoring
Methods and sources	HIV data are collected through many sources, and the main methods and sources include: • Routine patient-level and aggregate data • Community-based service data • Epidemiological surveillance • Biobehavioural surveillance • Modes-of-transmission studies • Population size estimates • Other population-based surveys • Assessments and reviews (such as health facility assessments) • Statistical modelling for HIV epidemic levels and trends • Community-led monitoring of health and human rights
Information systems	Move from aggregate to individual-level data in their HIV information systems as a critical component of patient care and programme monitoring, which requires unique identifiers to track and report individual access and outcomes along the cascade of HIV prevention, care and treatment services Strengthening information systems for HIV to generate granular data by location (such as by subnational administrative level), population characteristics (such as age, sex and presence of comorbidities and coinfections) and priority population group (such as key populations), including population size estimates, for tailored action and efficiently mobilizing and allocating resources Aligning HIV information systems with the broader health information system
Data use for decision-making	Conduct cascade analysis, anchored by the 95–95–95 targets for 2030, to assess performance across a set of related core HIV services to identify where the biggest gaps occur at all levels of the health system Conduct regular data reviews, including programme reviews and triangulation of data from multiple sources, to corroborate the interpretation of the core cascade analysis Ensure sufficient analytical capacity to use data to improve the HIV programme on an ongoing, quarterly or annual cycle

Table 10. Global HIV indicators

Impact indicators
Number of people newly infected with HIV per year
Number of people newly infected with HIV per 1000 uninfected population per year (Sustainable Development Goal 3.3.1)
Number of children younger than 15 years newly infected with HIV per year
Number of people dying from HIV-related causes per year (including disaggregation by HIV cryptococcal meningitis, TB, and severe bacterial infections)
Number of people living with HIV dying from causes related to TB, hepatitis B and hepatitis C
Number of countries validated for the elimination of the vertical transmission of either HIV, hepatitis B or syphilis
Coverage indicators
Percentage of people living with HIV who know their HIV status
Percentage of people who know their HIV status receiving antiretroviral therapy
Percentage of people living with HIV receiving treatment who have suppressed viral loads
Percentage of people at elevated risk of HIV who use combination prevention with a defined service package
Condom and lubricant use at last sex with a client or non-regular partner
Number of needles and syringes distributed per person who injects drugs (as part of a comprehensive harm reduction programme)
Percentage of people living with HIV who receive preventive therapy for TB
Percentage of people living with HIV and people at elevated risk of acquiring HIV who are linked to integrated health services, including sexually transmitted infections and viral hepatitis

Source: GHSS 2022–2030 *(4)*.

4.6 Costing and budgeting

The GHSS 2022–2030 projects the global costs for achieving HIV targets. Global costs peak at US$ 27.9 billion in 2025 and decline to US$ 26.3 billion by 2030. The health sector components of the multisectoral Global AIDS Strategy 2021–2026 account for 93% of the total costs of meeting global HIV targets by 2025. The largest cost components for the health sector include antiretroviral drugs for adults (US$ 4.7 billion per year), antiretroviral service delivery and laboratory services for adults (US$ 3.9 billion) and condoms (US$ 2.4 billion). In addition, significant resources support other priorities, including addressing stigma and discrimination (US$ 1.2 billion), addressing harmful laws and policies (US$ 1.2 billion) and ensuring services for key populations (US$ 6.2 billion).

As described in section 4.3, countries can develop strategic plan cost projections and investment cases as an instrument for strategic decision-making around funding and resource allocation for HIV. Investment cases assess gaps and opportunities in the national response and propose giving priority to interventions that are cost-effective and efficient and produce maximum impact in different resource scenarios. Many tools are available for countries to analyse cost and health impact scenarios for their own national context. The Integrated Health Tool for Planning and Costing includes an HIV and AIDS module that can be analysed as part of a broader health planning and costing process and is useful for integrated health sector costing and budgeting.

External funding has played a major role in financing HIV responses in many low- and middle-income countries since the start of the epidemic. Strategic planning for HIV must consider long-term financial sustainability, including to cover the costs of lifelong antiretroviral therapy and the cumulative costs of sustaining large-scale HIV responses. Ensuring long-term financial sustainability requires various approaches including promoting efficiency (for example by reducing costs, identifying efficiency in service delivery approaches and removing parallel HIV-specific health system functions and integrating HIV services where relevant and feasible), increasing domestic funding and developing innovative financing mechanisms (also see section 9.4).

4.7 Implementation arrangements

The HIV response worldwide has evolved historically to include a wide diversity of actors and approaches to service delivery at various levels of the system, making it critical to coordinate the contributions of the different stakeholders around the national strategic plan to ensure alignment and coherence. Ensuring that all the stakeholders are meaningfully engaged at all stages of the strategic planning and implementation process is equally important, supported by inclusive governance structures and accountability processes.

Typically, a national AIDS control programme, led by an HIV programme manager, is responsible for providing leadership for the health sector response to HIV within the health ministry. The national AIDS control programme works in close collaboration with a multisectoral national AIDS council to coordinate the multisectoral response to HIV and also directly with other government sectors. Civil society organizations and communities have played an extremely critical role in the response to HIV to date, including with innovative approaches during the COVID-19 pandemic. Leveraging their contributions, and supporting them in sustainable ways, are critical to ensure that national HIV responses meets the needs of the populations most affected.

Other coordination processes may also exist within the health sector, such as donor coordination processes for the health sector, or coordination structures related to external investments for HIV, such as the country coordinating mechanisms that oversee investments from the Global Fund in recipient countries. The health sector must play a leading role in all coordination structures to ensure evidence-informed and aligned programming for impact in all sectors.

5. Strategic planning for viral hepatitis

This chapter presents viral hepatitis–specific considerations for the core components of strategic planning. It supplements Chapter 3, which provides general descriptions of these core components, towards the global goal of eliminating viral hepatitis as a public health threat by 2030.

The development of the first global health sector strategy on viral hepatitis in 2016 was followed by the development of national strategic plans for viral hepatitis in more than 120 countries by 2022. These plans have provided the foundation to expand viral hepatitis diagnosis and treatment in these countries, especially where they have been supported by government commitment, domestic resources, simplified guidelines and reductions in the prices of viral hepatitis commodities. Further priority setting, costing and budgeting will be required to ensure that these plans drive maximum impact.

The WHO 2021 global progress report *(1)* noted the growing momentum to address viral hepatitis in recent years. The number of people receiving treatment for chronic hepatitis C virus infection increased almost 10-fold from a baseline of 1 million at the end of 2015 to 9.4 million people in 2020, reducing hepatitis C–related mortality. Nevertheless, nearly 80% of people with hepatitis B or C virus remain undiagnosed, affordable treatments are not available to all and hepatitis B and C together continue to cause an estimated 3 million new infections and 1.1 million deaths per year as a result of chronic liver disease and cancer.

The GHSS 2022–2030 defines global impact targets for 2025 and 2030 that must be achieved to eliminate viral hepatitis as a public health threat by 2030 (Table 11).

The response to viral hepatitis is also linked to other programme areas, such as HIV and other communicable diseases, immunization, noncommunicable diseases and cancer. Strategic planning for viral hepatitis must be linked to planning for these related areas, and operational linkage should be made along the whole programme cycle in a people-centred approach.

Table 11. Global viral hepatitis impact targets, 2025 and 2030

Indicator	Baseline – 2020	Targets – 2025	Targets – 2030
Prevalence of hepatitis B surface antigen among children younger than five years	0.94%	0.5%	0.1%
Number of new hepatitis B infections per year	1 500 000 20 per 100 000	850 000 11 per 100 000	170 000 2 per 100 000
Number of new hepatitis C infections per year	1 575 000 20 per 100 000	875 000 11 per 100 000	350 000 5 per 100 000
Number of new hepatitis C infections per year among people who inject drugs	8 per 100	3 per 100	2 per 100
Number of deaths per year from hepatitis B	820 000 10 per 100 000	530 000 7 per 100 000	310 000 4 per 100 000
Number of deaths per year from hepatitis C	290 000 5 per 100 000	240 000 3 per 100 000	140 000 2 per 100 000

Source: GHSS 2022–2030 *(4)*. The GHSS 2022–2030 provides a complete list of impact and coverage indicators and policy milestones.

Although each country will advance towards these goals at a different pace, each country must strive to set ambitious and feasible targets as close as possible to global targets in relation to the country context and capacity to advance towards eliminating viral hepatitis as a public health threat. In each country, progress will require health sector leadership and strong coordination to massively expand the availability of prevention, diagnostic and treatment services for viral hepatitis. This will involve expanding public and political awareness on viral hepatitis, integrating viral hepatitis services into universal health coverage packages, simplifying viral hepatitis testing and care, including by decentralizing services to lower levels of care and task sharing with primary care workers and other health practitioners and improving coordination with other related health areas.

5.1 Planning process

In addition to the general considerations for the strategic planning process described in section 3.1, the planning process for viral hepatitis should consider viral hepatitis–specific aspects (Table 12).

Table 12. Viral hepatitis strategic planning process

Key elements	Considerations for viral hepatitis strategic planning process
Stakeholder engagement	Include all key stakeholders for viral hepatitis, such as stakeholders within the health ministry (such as among units responsible for noncommunicable diseases, immunization, maternal and child health, water and sanitation, blood safety, infection and prevention control, occupational health, HIV, clinical care, infectious diseases and hepatology) and from other relevant government sectors; communities affected by viral hepatitis; professional associations; nongovernmental organizations and civil society; bilateral and multilateral agencies; private-sector providers; and academic and research institutions
Planning cycle	In some countries, viral hepatitis has been historically addressed within another disease-specific strategic plans, such as plans related to immunization, infectious diseases or cancer prevention; in such cases, the plan should adequately address all points relevant to hepatitis prevention, diagnosis and treatment Address the response to viral hepatitis A, B, C, D and E, focusing on viral hepatitis B and C at a minimum since these represent the most common cause of liver cirrhosis, liver cancer and viral hepatitis–related deaths
Leadership and management	Ensure that all the requirements for effective leadership and management of the planning process, including the functioning of the steering committee, writing committee and other entities in the viral hepatitis planning process, are in place Assign a person to take responsibility for the viral hepatitis planning process; some countries may not have a dedicated viral hepatitis management structure within the health ministry Mobilize resources for viral hepatitis
Technical resources	Ensure adequate availability of financial and technical resources Ensure that all the required data and analyses are in place to make informed decisions regarding priority setting and resource allocation

5.2 Situation analysis

In addition to the general descriptions of situation analysis listed in section 3.2, the key elements of situation analysis for viral hepatitis are listed in Table 13. In many countries where viral hepatitis programmes are nascent, a baseline evaluation with a detailed desk review of the relevant programmes and interventions may serve as an important first step for situation analysis and constituting a comprehensive hepatitis elimination programme.

Table 13. Situation analysis for viral hepatitis strategic planning

Key elements	Key information to include	Additional analysis
Epidemiological analysis	Core data and trends • New hepatitis B and C infections • Prevalence of hepatitis B surface antigen among children younger than five years old • Chronic infections, prevalence of hepatitis B surface antigen and hepatitis C virus viraemic infections • Mortality from viral hepatitis (acute liver failure, decompensated cirrhosis, liver cancer and other causes) Additional information • Modes of transmission (food and water for hepatitis A and E virus), percutaneous, parenteral, vertical transmission, close personal contacts and sexual transmission) • Population groups at highest risk of viral hepatitis and key risk and vulnerability factors • Outbreaks (hepatitis A and E virus) and high-prevalence settings (hepatitis B, C and D virus) • Sequalae of viral hepatitis (chronic hepatitis, liver cirrhosis, hepatocellular carcinoma and others) • Coinfections and comorbidities of viral hepatitis with other environmental risks (alcohol, aflatoxins, herb and drugs) and diseases (including HIV, noncommunicable diseases including cancer, etc.)	Disaggregation by specific hepatitis viruses (A, B, C, D and E) Disaggregation by age, sex, geographical location and other categories as relevant
Programmatic response and gap analysis	Progress towards core programme coverage targets • People living with hepatitis B virus who are diagnosed and treated • People living with hepatitis C virus who are diagnosed and treated • Coverage for timely hepatitis B vaccine birth dose • Coverage of other services to prevent the vertical transmission of hepatitis B virus (in addition to timely birth dose) • Blood units screened for bloodborne diseases in a quality-assured manner • Number of injections administered with safety-engineered devices in and outside health facilities • Coverage of harm-reduction services (needles and syringes distributed per person who injects drugs per year and coverage of opiate agonist therapy among opiate-dependent people) Continuum of viral hepatitis services • Providing comprehensive prevention services • Ensuring early initiation to care • Sustaining retention and optimizing adherence to treatment • Monitoring the service cascade for programme improvement	

Table 13 (continued). Situation analysis for viral hepatitis strategic planning

Key elements	Key information to include	Additional analysis
Programmatic response and gap analysis	Viral hepatitis intervention packages • Essential viral hepatitis interventions • Addressing the specific needs of priority populations and settings • Community-led services • Preventing the vertical transmission of hepatitis B and hepatitis C virus Viral hepatitis vaccines • Implementing a comprehensive hepatitis B virus immunization programme, including access to timely birth dose for hepatitis B virus Viral hepatitis testing • Strategic approach to testing in relation to the epidemiology of viral hepatitis and affected populations • Creating awareness related to hepatitis B and hepatitis C virus testing • Expanding access to testing using people-centred approach • Considering self-testing for hepatitis C virus • Linkage to diagnostics, treatment and care Chronic care for people with viral hepatitis • Providing treatment for viral hepatitis B, C and D to everyone who is eligible for treatment • Viral hepatitis prevention, treatment and care for children, adolescents and young adults • Early identification and monitoring of children at risk of progression to advanced liver disease and providing adequate follow-up and care • Support for children for a healthy transition into adolescence and adulthood, including providing adolescent-friendly psychosocial support and management of stigma in chronic hepatitis B infection as well as through linkage with adolescent-friendly harm-reduction services to prevent hepatitis C virus infection • Viral hepatitis and liver cancer management and surveillance among people infected with viral hepatitis Social determinants • Structural inequalities and other determinants of health, including education, occupation, income and other factors	Achievements and performance against current strategic plan targets Major gaps in prevention, screening and testing, linkage to care, treatment and coverage for underserved populations and geographies Disaggregation by age, sex, geographical location and other categories as relevant
Health and community system context	Availability and scope of national strategic plans, policies and guidelines related to viral hepatitis, including broader policies and strategies (such as blood safety, infection prevention and control, immunization and hospital waste management) Service delivery packages and delivery models in place to reach priority populations Health systems capacity and organization in relation to human resources, commodities, laboratory services, information systems and policies related to viral hepatitis Funding landscape for viral hepatitis and financial sustainability	

Table 13 (continued). Situation analysis for viral hepatitis strategic planning

Key elements	Key information to include	Additional analysis
Socioeconomic and political context	Structural determinants that affect viral hepatitis responses, such as populations and environments, harmful social beliefs and practices that promote unsafe injection, stigma and discrimination against people living with and affected by viral hepatitis in the areas of employment, education, housing and access to health care	
Stakeholder analysis	Analysis of roles, contributions, comparative advantage and influence, of key viral hepatitis stakeholders including: • Stakeholders within the health ministry (such as among units responsible for noncommunicable diseases, immunization, maternal and child health, water and sanitation, blood safety, infection and prevention control, occupational health, HIV, clinical care, infectious diseases and hepatology) • Stakeholders involved in implementation from various levels, such as the regional and district levels • Stakeholders from other government sectors that need to be engaged for an effective multisectoral response (such as finance and local government) • Patient groups and representatives of populations affected by viral hepatitis B and C • Professional associations (doctors, nurses etc.) • Civil society organizations • Private sector • Bilateral and multilateral agencies, and other international donors and partners • Academic and research institutions	

5.3 Setting priorities

Building on the general descriptions of priority setting in section 3.3, this section provides additional considerations for setting priorities for viral hepatitis that must take into account the evidence base of the viral hepatitis epidemics and response in the country and focus resources and efforts on the population groups and interventions that are likely to bring about the greatest impact on the trajectory of the epidemic.

The GHSS 2022–2030 defines the global strategic and operational shifts that will be required to eliminate viral hepatitis as a public health threat by 2030 (Box 25).

Box 25. Global strategic and operational shifts for the viral hepatitis response

The GHSS 2022–2030 defines the following strategic and operational shifts for the viral hepatitis response:

- Promote greater public and political awareness of the importance of viral hepatitis B and C prevention, testing and treatment
- Allocate increased financial resources to viral hepatitis B and C, which may include external catalytic funding and domestic funding by including viral hepatitis prevention, testing and treatment as part of essential national health benefit packages
- Scale up universal access to hepatitis B birth-dose vaccines and improved services for testing pregnant women for preventing the vertical (mother-to-child) transmission of hepatitis B
- Ensure continued investment in primary prevention, including improving the safety of medical injections and procedures, comprehensive prevention including harm reduction and other evidence-informed measures for people who inject drugs and hepatitis B vaccination for infants and priority populations
- Substantially increase access to hepatitis B and hepatitis C testing to reach people living with chronic hepatitis B virus and hepatitis C virus infection, of whom more than 80% and 90%, respectively, are currently undiagnosed
- Substantially increase treatment access by building on existing community and health facility–based services
- Promote simplified service delivery models that include decentralizing hepatitis B and C testing and treatment to lower-level health facilities including primary care; integrating with other services, such as at harm-reduction and HIV services; and task sharing, with delivery of care and treatment by nonspecialists and nurses
- Address the barriers faced by populations most affected
- Strengthen community and civil society engagement and innovative partnerships
- Advance the research agenda, focusing on developing curative treatment strategies for hepatitis B virus and a preventive vaccine for hepatitis C

Informed by the situation analysis, each country should define the priorities that will be required in the national viral hepatitis response to achieve its goals (Box 26).

Box 26. How to set priorities for viral hepatitis interventions in different country contexts

The relative composition and balance of viral hepatitis interventions will vary by country based on the country context and epidemic dynamics.

The epidemiology and drivers of hepatitis B and C infections vary markedly between countries and regions. In most settings, hepatitis B transmission is driven by unsafe injections and childhood transmission, especially where infant hepatitis B virus vaccination is suboptimal. For hepatitis C virus, epidemics in some settings are predominantly driven by sharing needles, syringes and drug paraphernalia among people who inject drugs and risk behaviour related to injecting drug use. Other settings have more generalized epidemics that affect general population and often older age groups in particular as a result of poor injection safety and infection control in both formal and informal health-care settings and in the community. The epidemic profiles of most countries show mixed hepatitis C virus transmission.

The essential package of viral hepatitis services should include all core viral hepatitis interventions, keeping in mind that priority setting should consider the variation in the burden of disease, epidemic dynamics and health system capacity in different contexts. For maximum impact, interventions should be strategically delivered to address the unique needs of each priority population and setting. Interventions targeting viral hepatitis B and C infection are critical, given their relative health burden, progression to chronicity and long-term morbidity and mortality caused by advanced liver disease and hepatocellular cancer. Important focus should also be given to viral hepatitis A and E infections that lead to outbreaks.

Countries are encouraged to pursue elimination of both viral hepatitis B and C together as a public health problem, but they may also choose to pursue a phased approach that is aligned with the certification options for disease validation recognized by WHO for eliminating the vertical transmission of hepatitis B virus or eliminating hepatitis B and/or hepatitis C virus as a public health problem *(34)*.

Once viral hepatitis priorities have been agreed on, these need to be expressed in terms of the vision, goals, objectives, targets, populations and interventions of the viral hepatitis strategic plan.

1) *Viral hepatitis vision, goals, objectives and targets.* Viral hepatitis national strategic plans should include the goals, objectives and targets specific to viral hepatitis. The GHSS 2022–2030 present the key targets for the global viral hepatitis response (Table 15), which provide a guiding framework for national viral hepatitis targets in relation to the country's baseline, national goals and capacity. The overall vision and direction for all countries should be towards eliminating viral hepatitis as a public health threat by 2030. The main goals could include the following, with targets defined for each country context:
   - Reduced incidence of hepatitis B and hepatitis C infections (number or percentage, by year)
   - Reduced hepatitis B surface antigen prevalence among children younger than five years old (number or percentage, by year)
   - Reduced hepatitis-related mortality (number or percentage, by year)
   - Reduced inequities in service coverage (number or percentage, by year, by priority population group)

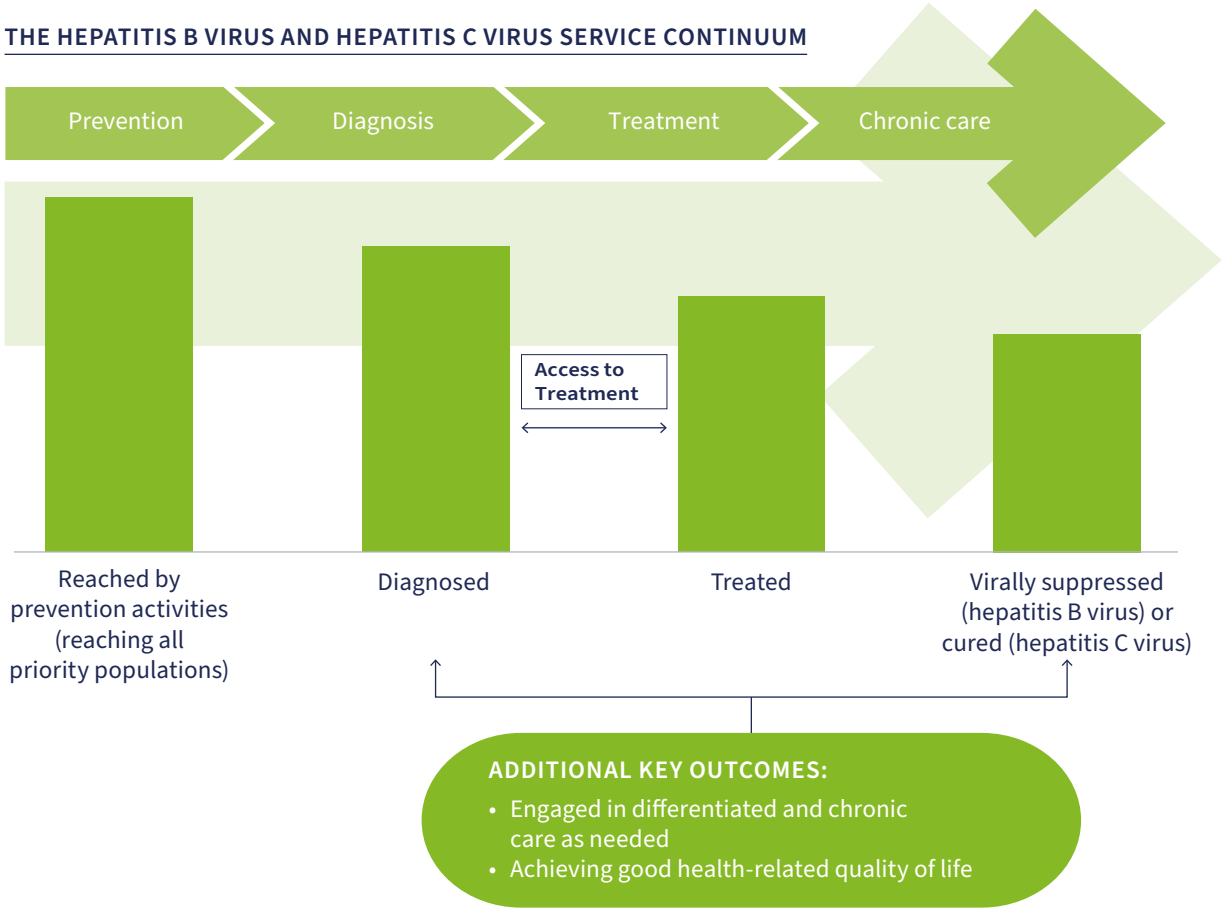
2) *Viral hepatitis populations*. Each country should define the specific populations that are most affected and at risk of viral hepatitis in relation to the local epidemiological and health system context while upholding fundamental human rights, equitable access to health and evidence-informed practice. Populations affected by viral hepatitis vary greatly worldwide and differ for viral hepatitis B and C. The GHSS 2022–2030 presents viral hepatitis priority populations (Box 27) that can be used at a reference for national strategic planning.

Box 27. Priority populations for viral hepatitis

- The GHSS 2022–2030 considers the following viral hepatitis priority populations:
- Populations from high endemic areas with generalized epidemics
- Certain mobile and migrant populations from high and intermediate endemic countries
- Some indigenous populations with a history of exposure
- Other affected populations, including people who inject drugs, people in prisons and other closed settings, gay men and other men who have sex with men, sex workers, people living with HIV and children of mothers with chronic hepatitis B or hepatitis C infection, especially if living with HIV
- Those at risk of exposure through unsafe blood supplies, unsafe medical injections or other health procedures
- Children in settings with high hepatitis B prevalence who have not been vaccinated
- People with advanced liver disease and with comorbidities such as TB, HIV or alcohol and drug use disorders
- People living in impoverished communities or humanitarian settings who face an increased risk of hepatitis A and E because of their living conditions and inability to access clean water and safe food

3) *Viral hepatitis interventions.* Each country needs to define a package of essential viral hepatitis interventions along the continuum of viral hepatitis services, including prevention, testing, care and treatment. The interventions should be delivered along a service cascade that comprehensively addresses people's needs and promotes early engagement in care, maximizes retention and maximizes treatment adherence (Fig. 12). The priorities should be set for the interventions, which should be organized in ways that promote early engagement in care, maximize retention and maximize treatment adherence. The retention cascade should be monitored to identify areas in which programmatic improvements are needed.

Fig.12. The service engagement cascade for hepatitis B virus and hepatitis C virus



Source: GHSS 2022–2030 (4).

The GHSS 2022–2030 defines the priority intervention areas for the viral hepatitis response. The key viral hepatitis interventions are described in Table 14. Section 5.4 describes the various aspects of their service delivery, including service delivery models, systems strengthening functions and enablers.

Some viral hepatitis interventions, such as primary prevention, harm reduction and the triple elimination of vertical transmission of HIV, syphilis and hepatitis B virus, are shared interventions with other disease areas. These interventions offer opportunities for aligning approaches to service delivery and enhancing programme quality and efficiency.

When setting priorities for interventions, national strategic plans should leverage the potential of new knowledge and innovations to maximize impact and overcome barriers to progress, including new viral hepatitis diagnostic technologies and testing approaches for simplified timely and accurate diagnosis of chronic hepatitis B and C virus; optimized antiviral agents for hepatitis B and C virus; new viral hepatitis vaccines; and research on a cure for hepatitis B virus. A crucial and recurrent research need related to viral hepatitis is generating high-quality epidemiological data on viral hepatitis, including through integration with surveys from other disease areas.

Table 14. Viral hepatitis intervention areas

Viral hepatitis interventions (Hepatitis B and hepatitis C virus)	Description	Priority populations	Opportunities for shared approaches
Prevention			
Primary prevention	Includes information about injection safety and infection control, sexual and reproductive health, and hepatitis prevention; correct and consistent condom use; and vaccination strategies	All endemic and priority populations	HIV, sexually transmitted infections, family planning, sexual and reproductive health, primary health care
Harm reduction	Includes a comprehensive package of accessible harm-reduction and viral hepatitis testing and treatment services, where appropriate, as part of a comprehensive package of interventions for the prevention, treatment and care of hepatitis C virus among people who inject drugs and people who use stimulant drugs	People who inject drugs and intersecting key populations such as sex workers and gay men and other men who have sex with men	HIV, TB
Viral hepatitis vaccines	Includes a universal hepatitis B virus infant vaccination programme as part of the national immunization programme and as catch-up for unvaccinated adolescents and targeted adult populations Effective vaccines also exist for preventing hepatitis A infections and use of hepatitis E vaccines in some settings	Infants and children; targeted adult populations, including the household contacts of people living with hepatitis B, health-care workers and frequent recipients of transfusion of blood and blood products	Immunization

Table 14 (continued). Viral hepatitis intervention areas

Viral hepatitis interventions (Hepatitis B and hepatitis C virus)	Description	Priority populations	Opportunities for shared approaches
Elimination of vertical transmission	Includes comprehensive and accessible prevention, testing, treatment and follow-up services for women, children and their families for triple elimination of vertical transmission of HIV, syphilis and hepatitis B virus through an integrated approach with maternal and child health services	Pregnant and breastfeeding women, infants	HIV, sexually transmitted infections, maternal and child health, sexual and reproductive health
Infection prevention and control	Includes interventions to prevent disease transmission in formal and informal health-care settings and other service settings	Health-care setting; all priority populations	HIV, sexually transmitted infections, TB
Voluntary partner notification and other social network approaches	Includes human rights–based and gender-sensitive strategies for voluntary partner notification and other services for sexual partners and family and household contacts of people diagnosed with hepatitis B and C	All priority populations	HIV, sexually transmitted infections, TB
Testing and diagnosis			
Viral hepatitis testing	Includes strategic approaches to testing for viral hepatitis B and C in relation to epidemiology, health system capacity and opportunities for integration	Individuals who are part of a population with high hepatitis B or hepatitis C virus prevalence	HIV, sexually transmitted infections, hospital care, primary health care
Diagnosis and clinical assessment	Includes improved diagnostics technologies and approaches for simplified, timely and accurate diagnosis of chronic hepatitis B and hepatitis C virus and strengthened patient monitoring	Individuals who are part of a population with high hepatitis B or hepatitis C virus prevalence	Shared diagnostic platforms, including molecular platforms for HIV and hepatitis B and hepatitis C virus
Treatment and care			
Viral hepatitis treatment	Includes treatment for chronic hepatitis B and C infection for all adults, adolescents and children who are eligible for treatment, especially those with more advanced disease, ensuring that the most effective treatment regimens are accessible and affordable to all populations	Adults and children with chronic hepatitis B or C infection or hepatitis D infection	

Table 14 (continued). Viral hepatitis intervention areas

Viral hepatitis interventions (Hepatitis B and hepatitis C virus)	Description	Priority populations	Opportunities for shared approaches
Chronic care for people with viral hepatitis	Includes interventions to address the chronic and long-term care and quality of life needs associated with viral hepatitis through people-centred approaches and using service delivery models that address comorbidities in an integrated manner	Adults and children with chronic hepatitis B or C infection	Noncommunicable diseases (diabetes, hypertension); cancer; mental health; nervous system disorders and substance use services; disability services
Chronic sequelae of hepatitis B and C virus, such as advanced liver disease and primary liver cancer	Includes strengthened integration and linkage between efforts to prevent and manage chronic viral hepatitis and primary liver cancer	Adults and children with chronic hepatitis B or C infection	
Enabling interventions			
Addressing structural barriers	Promotion of community and civil society leadership, including young people Addressing stigma and discrimination, including in health-care settings Preventing and addressing violence Legal, regulatory and policy reform Multisectoral partnerships	All endemic and priority populations	Sector-wide
Advocacy for viral hepatitis	Includes efforts to raise awareness of viral hepatitis among policy-makers and other government decision-makers combined with community engagement strategies	All endemic and priority populations	Sector-wide

5.4 Service delivery

Once viral hepatitis priorities have been identified, the viral hepatitis strategic plan needs to define how the priorities will be delivered. Building on the general descriptions of the different aspects of service delivery in section 3.4, this section presents additional viral hepatitis–specific considerations related to essential benefit packages, service delivery models, health system strengthening and enabling factors.

1) *Essential benefit packages*- In addition to the general descriptions of essential benefit packages listed in section 3.4, essential packages for viral hepatitis should consider viral hepatitis-specific aspects (Table 15).
2) *Service delivery models:* In addition to the general descriptions of service delivery models in section 3.4, service delivery for viral hepatitis should consider the following viral hepatitis-specific aspects (Table 16)

Table 15. Essential packages for viral hepatitis

Key elements	Considerations for viral hepatitis intervention packages
National essential benefit packages	Include key services for chronic viral hepatitis in national essential benefit packages, including a commitment to finance these through public and private channels, including health insurance Provide key services for preventing acute hepatitis with hepatitis A and E virus through collaboration with water and sanitation departments to ensure access to safe drinking-water and sanitation systems, especially in high-risk settings such as under-serviced neighbourhoods, and camps for internally displaced people or refugees.
Tailored packages for population groups	Implement a comprehensive package of services for pregnant women, including in the context of triple elimination of vertical transmission of HIV, syphilis and hepatitis B virus as well as a comprehensive package of services for all key populations, including harm-reduction services, where appropriate, based on the WHO package of evidence-informed harm-reduction interventions to prevent hepatitis C virus for people who inject drugs, considering the domestic context, legislation and jurisdictional responsibilities

Table 16. Service delivery models for viral hepatitis

Key models and approaches	Considerations for viral hepatitis service delivery
Differentiated service delivery	Consider differentiated service delivery approaches, for example, people without symptoms or those who are clinically stable may be served through primary health care and community-led services, whereas those with advanced liver disease may require more intensive clinical support and additional psychosocial and mental health services Use point-of-care hepatitis C virus RNA viral load and reflex RNA viral load testing as an alternative approach to laboratory-based RNA assays to diagnose viraemic infection, especially for urban populations and marginalized populations, such as people who inject drugs, and hard-to-reach communities with limited access to health care and high rates of loss to follow-up *(35)*
Decentralized service delivery	Expand viral hepatitis testing and treatment services, ideally at the same site, by decentralizing care to lower-level facilities; integration with existing services, such as in primary care, harm-reduction programmes, prisons and HIV services; and promoting task sharing by delivering hepatitis C virus testing, care and treatment by appropriately trained non-specialist doctors and nurses
Special settings	Ensure that viral hepatitis services in prisons and other closed settings are equivalent to those available to the broader community and that the continuity of services is assured when people move within these settings and to the broader community
Digital technologies	Offer online delivery of viral hepatitis services to priority populations, including online outreach, targeted health information, linkage to care of self-care innovations such as self-testing and online case management as an additional option while ensuring that data security and confidentiality are protected Leverage digital technologies for decentralized service delivery (such as through telementoring health-care providers) and data management and consolidation

3) *Strengthening systems*. Strategic planning for viral hepatitis must consider approaches to strengthen the critical health system functions that are necessary to deliver viral hepatitis services in ways that optimize the use of health system resources, reduce misalignment or duplications with other disease programme areas and contribute to advancing primary health and universal health coverage. In addition to the general descriptions of system-strengthening actions in section 3.4, system strengthening for viral hepatitis should consider viral hepatitis–specific aspects (Table 17).

Table 17. Viral hepatitis actions to strengthen health systems

Key health system functions	Considerations for viral hepatitis responses
Governance	Promote meaningful engagement of affected communities, including patient groups and professional associations (doctors, nurses etc.)
Health workforce (including community health workers)	Ensure that health-care workers in all settings are knowledgeable about viral hepatitis risk factors, prevention and management and have access to the training and supervision to deliver essential viral hepatitis interventions. Many essential viral hepatitis prevention interventions are integrated within broader health services, including programmes for childhood vaccination, blood and injection safety, food safety, water and sanitation and other targeted interventions such as harm reduction for people who inject drugs Given the risk of viral hepatitis transmission in formal and informal health-care settings, ensure that all health-care workers are covered by occupational health and safety programmes
Financing	Ensure that viral hepatitis services are part of national essential health benefit packages supported by adequate financing and coordinated action to optimize the use of resources, reduce costs and improve efficiency, including new opportunities for catalytic and innovative funding

4) *Enabling interventions.* An effective response to viral hepatitis requires action to advance the key enablers that are essential to promote equity and overcome major barriers to service access. In addition to the general descriptions of enablers in section 3.4, viral hepatitis plans should consider viral hepatitis–specific aspects (Table 18).

Table 18. Viral hepatitis actions on enabling interventions

Key enablers	Considerations for viral hepatitis responses
Community and civil society leadership	Promote the key role of communities in designing and providing culturally appropriate information about viral hepatitis to overcome the barriers caused by poor health literacy in some settings
Addressing stigma and discrimination	Ensure that anti-discrimination laws, public health policy, education and health systems work together with civil society and the affected communities to tackle stigma and discrimination related to viral hepatitis, including with the following interventions *(36)*: • Provide accurate and accessible information for those newly diagnosed including on transmission, health promotion, rights and responsibilities and long-term health plan • Ensure that all newly diagnosed individuals are linked appropriate services for ongoing monitoring and management • Ensure that all health-care professionals receive ongoing hepatitis education and are aware of stigma and how to address it • Ensure that anti-discrimination laws and policies are correctly implemented and adequate recourse is given to enable people experiencing discrimination
Legal, regulatory and policy reform	Ensure that programmes have the legal and administrative means to: • Promote access to prevention, diagnosis and treatment services and technologies, including harm-reduction services • Prevent and address stigma and discrimination against people living with and affected by viral hepatitis in the areas of employment, education, housing and access to health care

5.5 Monitoring and evaluation

The WHO consolidated strategic information guidelines for viral hepatitis *(37)* describe the key indicators and methods for surveillance of new hepatitis infections, chronic infections and sequalae that lead to morbidity and mortality. The guidelines also present the standardized indicators and programme data used to track progress. In addition to the general descriptions of the various aspects of monitoring and evaluation in section 3.5, viral hepatitis strategic plans should consider viral hepatitis–specific aspects for monitoring and evaluation (Table 19 and Box 28).

Table 19. Considerations for viral hepatitis monitoring and evaluation

Key elements	Considerations for viral hepatitis monitoring and evaluation
Indicators and targets	Select viral hepatitis indicators for the national monitoring and evaluation plan based on the core interventions that need to be implemented to eliminate viral hepatitis as a public health threat by 2030 Include standardized hepatitis indicators into existing information systems (including electronic platforms) and ensure interlinkage
Methods and sources	Viral hepatitis data are collected through either routine (continuous) or periodic data collection mechanisms. The main methods and sources for viral hepatitis data include: Viral hepatitis surveillance, which includes surveillance of acute hepatitis, surveillance of chronic infections (such as through biomarker surveys) and surveillance of mortality from sequelae Programme data or health-care facility surveys such as the Service Availability and Readiness Assessment (SARA) to estimate service availability for viral hepatitis Routine data from the Expanded Programme on Immunization and programmes for preventing mother-to-child transmission, injection safety and harm reduction for prevention activities Data from patient registries or databases to monitor the cascade of diagnosis and treatment Community-led monitoring of health and human rights
Information systems	Integrate viral hepatitis information systems and promote data triangulation for analysis. Typically, the different components of viral hepatitis surveillance (surveillance for acute hepatitis that reflects new infections; surveillance for chronic prevalent hepatitis; and surveillance for sequalae) and the core programmatic indicators related to prevention, testing, treatment and care are captured by different actors within the health information system. Further, the gap between people being infected with hepatitis B or C and mortality can be 20–30 years Strengthen surveillance and monitoring for advanced liver disease and hepatocellular carcinoma to monitor progress and to enable WHO to validate the elimination of viral hepatitis Promote linkage to other related information systems, such as immunization, cancer registries and vital statistics Invest in strengthening health information systems for viral hepatitis with building institutional capacity, human resource capacity, infrastructure and processes for data collection, analysis and use
Data use for decision-making	Conduct regular data reviews, including programme reviews and triangulation of data from multiple sources, to assess programme performance at the different levels of the health system Ensure sufficient analytical capacity to use data to improve the viral hepatitis programme on an ongoing, quarterly or annual cycle

Box 28. Global viral hepatitis indicators

Impact indicators

Hepatitis B surface antigen prevalence among children younger than five years old

Number of new hepatitis B infections per year

Number of new hepatitis C infections per year

Number of new hepatitis C infections per year among people who inject drugs

Number of people dying from hepatitis B per year

Number of people dying from hepatitis C per year

Coverage indicators

Hepatitis B – percentage of people living with hepatitis B diagnosed and treated

Hepatitis C – percentage of people living with hepatitis C diagnosed and cured

Percentage of new-borns who have benefitted from a timely birth dose of hepatitis vaccine or from other interventions to prevent the mother-to-child transmission of hepatitis B virus

Number of needles and syringes distributed per person who injects drugs

Blood safety – proportion of blood units screened for bloodborne diseases

Safe injections – proportion of safe health-care injections

Source: GHSS 2022–2030 *(4)*.

5.6 Costing and budgeting

The GHSS 2022–2030 project the global costs of meeting global viral hepatitis targets. The costing projects major increases in the coverage of testing and treatment for hepatitis B and hepatitis C virus of 10% per year, so the global costs peak at US$ 8 billion in 2028, and then with impact and increased efficiency, decline by 15% to US$ 6.7 billion per year by 2030. Treatment costs decline and laboratory costs become an increasing proportion of total costs over time, largely because of hepatitis B virus, which requires life-long treatment and monitoring, showing the need for innovations in diagnosis and hepatitis B cure. Many of the mortality benefits accrue for several decades towards 2050.

Costing viral hepatitis strategic plans entails translating the broader goals of the plan into concrete costed activities (such as procuring commodities, delivering services, human resources and indirect costs), and provides an important reality check to refine the priorities and evaluate whether the planned activities are affordable. Strategies such as reducing the cost of hepatitis B and C diagnostics and treatment, making hepatitis C virus treatment affordable in all countries and improved community outreach can reduce the cost of elimination.

The external funding landscape for viral hepatitis has been severely limited, with few global donors. Some early-adopter countries have made tremendous progress by mobilizing both internal and donor funding and by successfully using investment cases and economic analysis with cost and impact modelling to gain political support and secure viral hepatitis elimination. Ensuring long-term financial sustainability requires various approaches, including promoting efficiency, developing country-specific strategic actions that can be included in the national essential benefit packages for universal health coverage and funded within national health insurance; increasing domestic funding; and developing innovative financing mechanisms.

In country-level costing and budgeting, current investments in viral hepatitis prevention, diagnosis and treatment will reduce future costs associated with morbidity and mortality from viral hepatitis as well as other bloodborne diseases. Tools such as the Integrated Health Tool for Planning and Costing can support the costing, budgeting and financing of viral hepatitis strategic plans as part of integrated health sector costing and budgeting. Cross-cutting actions across communicable diseases such as HIV, viral hepatitis, sexually transmitted infections, TB and noncommunicable diseases are essential to achieve the goals in the strategy.

5.7 Implementation arrangements

As countries scale up their viral hepatitis responses, it is critical to clearly define a coordinating unit or entity within the health ministry, along with a programme manager or a focal point, for the national viral hepatitis response. Historically, the viral hepatitis response has been coordinated in different ways in various countries depending on the country's context and practice. For example, viral hepatitis responses have been managed as part of units managing communicable diseases (including, in some cases, along with HIV) or in others, as part of units managing noncommunicable disease (such as those managing liver disease). In all cases, it is essential to clarify the roles and responsibilities and implementation arrangements for the viral hepatitis response to ensure the effective and timely implementation of activities.

6. Strategic planning for sexually transmitted infections

This chapter presents sexually transmitted infection–specific considerations for the core components of strategic planning. It supplements Chapter 3, which provides general descriptions of these core components, towards the global goal of ending sexually transmitted infection infections as public health threats by 2030 (Table 20).

Historically, few countries have developed stand-alone strategic plans for sexually transmitted infections. Instead, sexually transmitted infections have been typically addressed as part of HIV strategic plans or sexual and reproductive health strategic plans. Although integrating national sexually transmitted infection responses within other related public health strategies has several advantages, in practice the response to sexually transmitted infections has lagged behind because of inadequate funding and political commitment to address sexually transmitted infections specifically, lack of adequate service delivery infrastructure in resource-limited settings and stagnation in addressing the social and behavioural determinants of these infections.

The multiple epidemics of sexually transmitted infections continue to cause a significant burden of disease, and four curable sexually transmitted infections – syphilis (*Treponema pallidum*), gonorrhoea (*Neisseria gonorrhoeae*), chlamydia (*Chlamydia trachomatis*) and trichomoniasis (*Trichomonas vaginalis*) – are estimated to comprise more than 1 million infections each day globally. When left untreated, sexually transmitted infections can, depending on the nature of the specific infections, lead to long-term irreversible and potentially fatal outcomes, including chronic pelvic pain, cancers, ectopic pregnancies, infertility, adverse pregnancy outcomes, neonatal death and congenital abnormalities. Some sexually transmitted infections can also facilitate HIV acquisition.

The GHSS 2022–2030 defines global impact targets for 2025 and 2030 that must be achieved to end sexually transmitted infections as public health concerns by 2030 (Table 20).

The response to sexually transmitted infections is also linked to other programme areas, such as HIV and other communicable diseases, sexual and reproductive health, maternal, new-born and child health, immunization, noncommunicable diseases and cancer. Strategic planning for sexually transmitted infections must be linked to planning for these related areas, and operational linkage should be made along the whole programme cycle in a people-centred approach.

Table 20. Global sexually transmitted infection impact targets, 2025 and 2030

Indicator	Baseline – 2020	Targets – 2025	Targets – 2030
Number of new cases of four curable sexually transmitted infections among adults (15–49 years old) per year	374 million	<300 million	<150 million
Number of new cases of syphilis among adults (15–49 years old) per year	7.1 million	5.7 million	0.71 million
Number of new cases of gonorrhoea among adults (15–49 years old) per year	82.3 million	65.8 million	8.24 million
Congenital syphilis cases per 100 000 live births per year	425	< 200	< 50
Percentage of girls fully vaccinated with human papillomavirus vaccine by 15 years of age	14%	50%	90%
Number of new cases of four curable sexually transmitted infections among adults (15–49 years old) per year	374 million	<300 million	<150 million

Source: GHSS 2022–2030 *(4)*. The GHSS 2022–2030 provides the complete list of impact and coverage indicators and policy milestones.

Although each country will advance towards these goals at a different pace, each country must strive to set ambitious and feasible targets as close as possible to global targets in relation to the country context and capacity to advance towards ending sexually transmitted infection epidemics as public health threats. In each country, progress will require health sector leadership to reinvigorate national sexually transmitted infection responses to bring about a massive reduction in new infections, with efforts to vastly scale up primary prevention and access to screening for sexually transmitted infections and engaging public, private and nongovernmental service providers for sexually transmitted infection case management. Countries will need to further leverage synergy with sexual and reproductive health, family planning, adolescent health and HIV services through a primary health care approach and strengthen surveillance for sexually transmitted infections and antimicrobial resistance. Recommitting to addressing sexually transmitted infections will also mean addressing the individual, community and structural factors that contribute to the spread of sexually transmitted infections and ensuring that people have access to high-quality sexually transmitted infection services free from stigma and discrimination.

6.1 Planning process

In addition to the general considerations for the strategic planning process described in section 3.1, the planning process for sexually transmitted infections should consider sexually transmitted infection–specific aspects (Table 21).

Table 21. Strategic planning process for sexually transmitted infections

Key elements	Considerations for the strategic planning process for sexually transmitted infections
Stakeholder engagement	Include all key stakeholders for sexually transmitted infections, such as stakeholders within the health ministry (including HIV, sexual and reproductive health and primary health care) and other relevant government sectors (including health, planning and finance ministries); communities affected by sexually transmitted infections; professional associations; nongovernmental organizations and civil society; the private sector; bilateral and multilateral partners; and the general public, including community and religious leaders
Planning cycle	Align sexually transmitted infection strategic planning with strategic planning for HIV, sexual and reproductive health and the broader health sector strategy In some countries, sexually transmitted infections have been historically addressed within other strategic plans (such as HIV or sexual and reproductive health strategic plans). In such cases, all points relevant to sexually transmitted infection prevention, diagnosis and treatment should be adequately addressed in those plans
Leadership and management	Ensure that all the requirements for effective leadership and management of the planning process, including the functioning of the steering committee, writing committee and other entities in the sexually transmitted infection planning process, are in place Identify the technical capacity required on the core team for sexually transmitted infection strategic planning, appoint the team coordinator, ensure that all relevant sexually transmitted infection stakeholders are adequately represented on the core team and secure institutional support
Technical resources	Refer to technical resources from WHO, UNAIDS, UNICEF, UNFPA and other organizations as part of the planning process Ensure that all available data and analysis are in place to make informed decisions regarding priority setting and resource allocation

6.2 Situation analysis

In addition to the general descriptions of situation analysis listed in section 3.2, the key elements of situation analysis for sexually transmitted infections are listed in Table 22.

Table 22. Situation analysis for strategic planning for sexually transmitted infections

Key elements	Key information to include	Additional analyses
Epidemiological analysis	General population data and trends: • Sexually transmitted infection prevalence (such as syphilis, gonorrhoea, chlamydia, trichomoniasis, human papillomavirus and herpes simplex virus) • Reported cases – Syphilis (congenital syphilis, primary, secondary and tertiary syphilis), gonorrhoea, chlamydia, trichomoniasis, human papillomavirus and herpes simplex virus – Other sexually transmitted infections – Sexually transmitted infection syndromes – Sexually transmitted infection–related complications (such as pelvic inflammatory disease, ectopic pregnancies and ophthalmia neonatorum) – Key risk and vulnerability factors Data and trends for key populations: • Sexually transmitted infection prevalence • Reported cases • Size estimates Co-morbidities data and trends • Coinfection of HIV and sexually transmitted infections • Coinfection of Mpox and sexually transmitted infections Laboratory data • Causes of sexually transmitted infection syndromes • Patterns of sexually transmitted infection antimicrobial resistance – *N. gonorrhoeae* – *M. genitalium* – Other sexually transmitted infections Additional information • Health-seeking behaviour – where, when and why do different groups of the population seek sexually transmitted infection care?	Disaggregated by age, sex, geography and population groups and other categories as relevant Disaggregation by population groups can include key populations, migrant and displaced people, indigenous populations, adolescents including adolescent girls and young women and pregnant women Disaggregation by anatomic sites of infection can include urethral or cervical, anal and pharyngeal sites

Table 22 (continued). Situation analysis for strategic planning for sexually transmitted infections

Key elements	Key information to include	Additional analyses
Programmatic response and gap analysis	Primary prevention • Condom programming and condom use at last high-risk sex • Knowledge about preventing HIV and sexually transmitted infections among young people (15–24 years old) • Sexual behaviour trends • Human papillomavirus vaccination coverage • Linkage between HIV prevention (outreach) and sexually transmitted infection services Elimination of vertical transmission of syphilis • Syphilis testing among pregnant women • Syphilis treatment of pregnant women positive for syphilis Sexually transmitted infection case management • Guidelines for diagnosing and treating sexually transmitted infections • Locations providing sexually transmitted infection diagnosis and treatment (primary health care, family planning, antenatal care, maternal and child health, specialized sexually transmitted infection clinics, services for key populations and hospitals) • Providing partner services • Availability of drugs and diagnostics Targeted services for youth, key populations, people living with HIV and people using PrEP services • Treatment of symptomatic sexually transmitted infections • Screening for syphilis, gonorrhoea, chlamydial infection and other sexually transmitted infections • Linkage between HIV prevention (outreach) and sexually transmitted infection services Antimicrobial resistance monitoring Social determinants • Structural inequalities and other determinants of health, including education, occupation, income and other factors	Achievements and performance against current strategic plan targets Major gaps in prevention, screening and testing, linkage to care, treatment and coverage for underserved populations and geographies Disaggregation by age, sex, geographical location and other categories as relevant
Health and community system context	Availability and scope of national strategic plans, policies and guidelines related to sexually transmitted infections Sexually transmitted infection programme context (such as stand-alone programme or integrated with HIV or sexual and reproductive health) Sexually transmitted infection service delivery models (public and private) and service delivery packages in place to reach priority populations and linkage to outreach and community Supply of sexually transmitted infection treatment and laboratory tests Access to sexually transmitted infection services, including staffing levels and training of health-care providers, laboratory support and physical infrastructure Funding landscape for sexually transmitted infections and financial sustainability	

Table 22 (continued). Situation analysis for strategic planning for sexually transmitted infections

Key elements	Key information to include	Additional analyses
Socioeconomic and political context	Structural determinants that affect sexually transmitted infection responses and create barriers for certain populations to access essential sexually transmitted infection and other health services, such as harmful laws, policies and practices; stigma and discrimination; and violence	
Stakeholder analysis	Analysis of roles, contributions, comparative advantage and influence of key sexually transmitted infection stakeholders including: • Stakeholders within the health ministry (including HIV, sexual and reproductive health and primary health care) • Stakeholders involved in implementation from various levels, such as the regional and district levels • Stakeholders from other relevant government sectors that need to be engaged for an effective multisectoral response (such as education, finance, women and youth affairs and local government) • Priority populations for sexually transmitted infections, including key populations, youth and women • Patient groups and representatives of priority populations affected by sexually transmitted infections • Professional associations (doctors, nurses etc.) • Civil society organizations • Private sector • Bilateral and multilateral agencies and other international donors and partners • Academic and research institutions • General public, community leaders and religious leaders	

6.3 Setting priorities

Building on the general descriptions of priority setting in section 3.3, this section provides additional considerations for setting priorities for sexually transmitted infections that must take into account the evidence base of the sexually transmitted infection epidemic and response in the country and focus resources and efforts on the population groups and interventions that are likely to bring about the greatest impact on the trajectory of the epidemic.

The GHSS 2022–2030 defines the global strategic and operational shifts that will be required to end major sexually transmitted infection infections as public health threats by 2030 (Box 29).

Box 29. Global strategic and operational shifts for the sexually transmitted infection response

The GHSS 2022–2030 defines the following strategic and operational shifts for the sexually transmitted infection response:

- Create an environment that enables individuals to comfortably talk about their sexual health, adopt safer sexual practices and seek treatment for sexually transmitted infections
- Vastly scale up primary prevention and increase access to screening for sexually transmitted infections
- Increase access to high-quality, people-centred case management of sexually transmitted infections delivered by public, private and nongovernmental service providers
- Increase the integration of sexually transmitted infection services with primary health care, sexual and reproductive health, family planning, adolescent health and HIV services
- Ensure sufficient financing for sexually transmitted infection services as part of national health financing mechanisms
- Strengthen the capacity of national health information systems to ensure the timely collection and analysis of disaggregated data to inform health policies, treatment guidelines and resource allocation
- Support accelerated research and development on prevention technologies, diagnostics, treatments and vaccines for sexually transmitted infections

Informed by the situation analysis, each country should define the priorities that will be required in the national sexually transmitted infection response to achieve its goals, in relation to the country context (Box 30).

Box 30. How to set priorities for sexually transmitted infection interventions in different country contexts

To optimize the use of scarce resources, countries should give priority to interventions targeting groups most likely to be affected by sexually transmitted infections. Targeting groups such as people with sexually transmitted infection symptoms and key populations should have the highest priority. The factors that inform priority setting include the rates of sexually transmitted infection incidence or prevalence in the population, the extent to which individuals in the population contribute to further transmitting sexually transmitted infections, the size of the populations and the awareness and interest of the populations. Further, there are numerous sexually transmitted infections, and in setting programme priorities, it is important to focus on infections that have feasible and cost-effective tools, are amenable to cure, are associated with increased HIV transmission and have the highest burden. It is also essential to consider the feasibility of an intervention based on geographical accessibility, acceptability and availability of resources.

The following considerations can be kept in mind when setting priorities for sexually transmitted infection interventions in different contexts.

- *High rates of sexually transmitted infections in the general population*. Make sexually transmitted infection case management, screening and prevention, along with partner services, available at all health facilities; integrate prevention activities with HIV primary prevention programmes and within all health-care facilities, including primary health care, maternal and child health, adolescent health and reproductive health programmes; and strengthen the integration of curative services into the existing health-care delivery structure.
- *High rates of sexually transmitted infections concentrated within priority populations at increased risk of sexually transmitted infections (such as sex workers and gay men and other men who have sex with men)*. Provide targeted sexually transmitted infection interventions, including prevention, screening and management of sexually transmitted infections, in health-care facilities and settings accessed by the priority populations; and ensure linkage with PrEP and other HIV prevention and care services.
- *High rates of sexually transmitted infections in the general population and within priority populations at increased risk of sexually transmitted infections*. Integrate primary prevention with HIV prevention; integrate sexually transmitted infection services within all health care delivery structures; and provide targeted sexually transmitted infection interventions.

Once sexually transmitted infection priorities have been agreed on, these need to be expressed in terms of the vision, goals, objectives, targets, populations and interventions of the sexually transmitted infection strategic plan.

1) *Sexually transmitted infection vision, goals, objectives and targets*. National strategic plans for sexually transmitted infections should include the goals, objectives and targets specific to sexually transmitted infection epidemics in the country. The GHSS 2022–2030 present the key targets for the global sexually transmitted infection response (Table 24), which provide a guiding framework for national sexually transmitted infection targets in relation to the country's baseline, national goals and capacity. The overall vision and direction for all countries should be towards ending sexually transmitted infection epidemics as public health threats by 2030. The main goals could include the following, with targets defined for each country context:
   - reduced incidence of major sexually transmitted infections (syphilis, gonorrhoea, chlamydia and trichomoniasis) among people 15–49 years old (number or percentage, by year);
   - reduced congenital syphilis cases per 100 000 live births (number or percentage, by year); and
   - reduced inequities in service coverage (number or percentage, by year, by priority population group),
2) *Sexually transmitted infection populations*. Each country should define the specific populations that are most affected and at risk of sexually transmitted infections in relation to the local epidemiological and health system context while upholding fundamental human rights, equitable access to health and evidence-informed practice. Women and girls are disproportionately affected by sexually transmitted infections. Many sexually transmitted infections often do not cause symptoms or may have long asymptomatic periods and thus can be unknowingly transmitted during sexual intercourse or during pregnancy. The GHSS 2022–2030 present priority populations for sexually transmitted infections (Box 31) that can be used as a reference for national strategic planning.

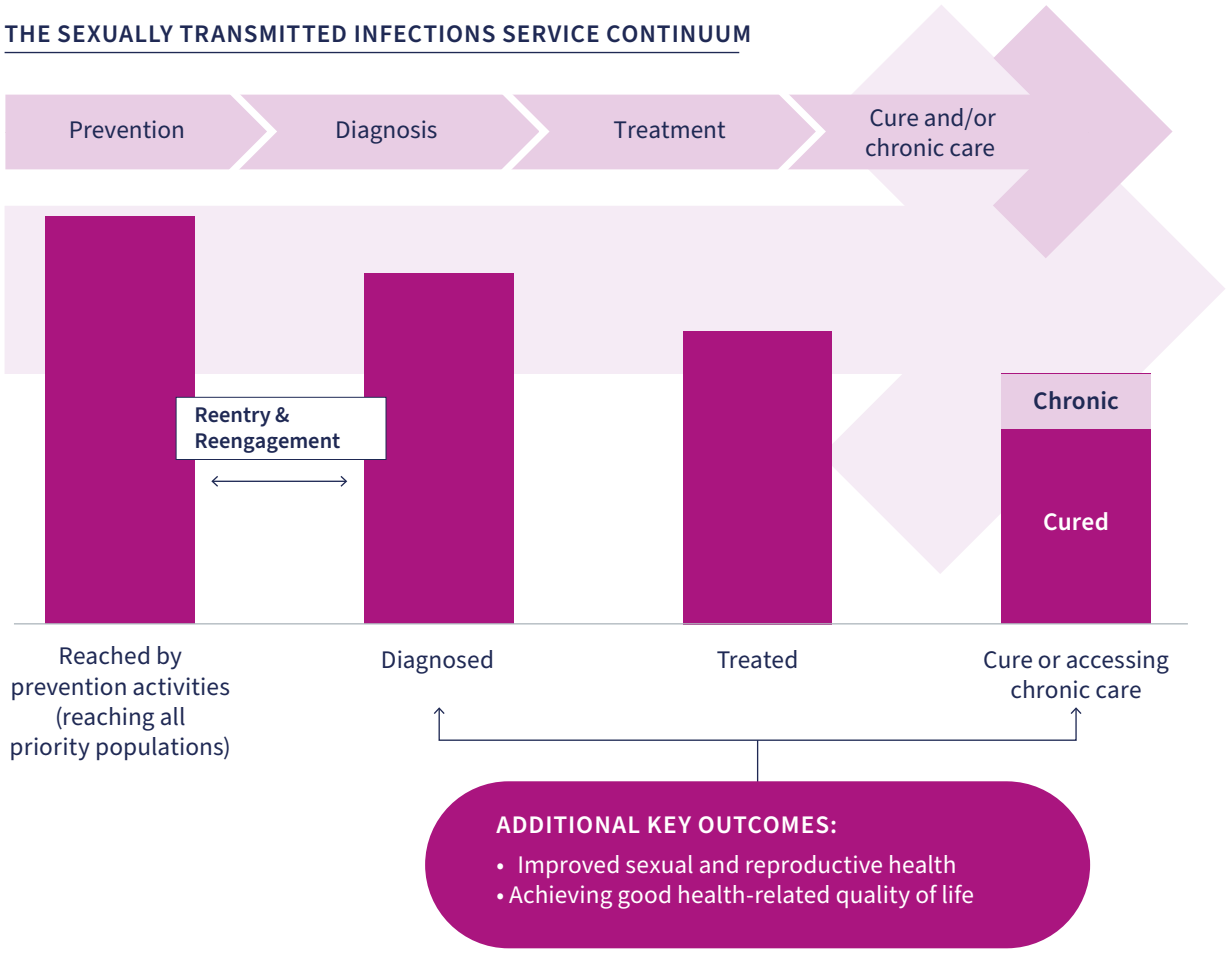
Box 31. Priority populations for sexually transmitted infections

The GHSS 2022–2030 consider the following priority populations for sexually transmitted infections:

- adolescent girls and boys
- young people
- sex workers and their clients
- gay men and other men who have sex with men
- transgender and gender-diverse people
- people living with HIV
- people who have other sexually transmitted infections
- pregnant women
- people who have experienced gender-based violence
- people in prisons and other closed settings
- people affected by conflict and civil unrest
- people with disabilities
- people with limited access to services, including indigenous populations

3) *Sexually transmitted infection interventions*. Each country needs to define a package of essential sexually transmitted infection interventions along the continuum of sexually transmitted infection prevention, testing, care and treatment services within the context of promoting sexual health and well-being. The interventions should be delivered along a service cascade that comprehensively addresses people's needs, such that individuals with curable sexually transmitted infections are diagnosed and treated on the same day and individuals with chronic infections are retained in long-term care (Fig. 13).

Fig. 13. The service engagement cascade for sexually transmitted infections



Source: GHSS 2022–2030 (4).

The GHSS 2022–2030 defines the priority interventions for the sexually transmitted infection response. The key sexually transmitted infection interventions are described below in Table 23. The various aspects of their service delivery, including service delivery models, systems strengthening functions and enablers are described in section 6.4.

Some sexually transmitted infection interventions, such as primary prevention, sexual partner services, and the triple elimination of vertical transmission of HIV, syphilis and hepatitis B virus, are shared interventions with other disease areas. These interventions offer opportunities for aligned approaches to service delivery and enhanced programme quality and efficiency.

When setting priorities for interventions, national strategic plans should leverage the potential of new knowledge and innovations to maximize impact and overcome barriers to progress, including new products and services (including the use of digital technologies) for sexually transmitted infection prevention, research in new vaccines, new diagnostics and testing strategies such as low-cost rapid point-of-care diagnostic tests and molecular tests to identify and characterize antimicrobial resistance and new treatments for sexually transmitted infections.

Table 23. Sexually transmitted infection intervention areas

Sexually transmitted infection interventions	Description	Priority populations	Opportunities for shared approaches
Prevention			
Primary prevention	Includes comprehensive education and information about sexual and reproductive health and sexually transmitted infection prevention noting WHO technical guidance; correct and consistent condom use; and addressing the harmful use of alcohol and drugs in the context of sexual behaviour	Priority populations, including key populations, adolescents (including adolescent girls and young women), boys and men	HIV, family planning, adolescent health, maternal health, sexual and reproductive health and primary health care
Voluntary medical male circumcision	Includes voluntary medical male circumcision as part of comprehensive services to improve the health and well-being of adolescent boys and men	Boys and men, 15 years and older	HIV, viral hepatitis, TB, mental health, nervous system disorders and substance use, noncommunicable diseases
Elimination of vertical transmission	Includes comprehensive and accessible prevention, testing, treatment and follow-up services for women, children and their families for triple elimination of vertical transmission of HIV, syphilis and hepatitis B virus through an integrated approach with maternal and child health services	Pregnant and breastfeeding women, infants	Viral hepatitis, HIV, maternal and child health, sexual and reproductive health
Vaccination – human papillomavirus	Includes a comprehensive human papillomavirus vaccination programme with strategies to promote vaccination coverage among priority populations	Adolescents, specifically adolescent girls and young women	Adolescent health, family planning, sexual and reproductive health, primary health care

Table 23 (continued). Sexually transmitted infection intervention areas

Sexually transmitted infection interventions	Description	Priority populations	Opportunities for shared approaches
Vaccination – hepatitis B	Includes hepatitis B vaccination of infants as soon as possible after birth, preferably within 24 hours, followed by two or three doses of hepatitis B vaccine at least four weeks apart to complete the vaccination series	Key populations, adolescent girls and young women, babies (birth dose)	Viral hepatitis
Vaccination – Mpox	Includes the provision of the Mpox vaccine for priority populations	Gay men and other men who have sex with men, people with multiple partners and exposed to Mpox cases	HIV, sexual and reproductive health, primary health care
Harm reduction for Mpox	Includes raising awareness of risk factors and educating people about the measures they can take to reduce exposure to the virus, including reduction of multiple sexual partners, condom use and case detection of Mpox	Gay men and other men who have sex with men, people with multiple partners and exposed to Mpox cases	HIV, sexual and reproductive health, primary health care
Sexual partner services for sexually transmitted infections	Includes human rights–based and gender-sensitive strategies for providing voluntary partner notification and accessible follow-up services for partners	Contacts of sexually transmitted infection patients	HIV, sexual and reproductive health, primary health care
Sexually transmitted infection awareness and treatment-seeking behaviour	Includes interventions to increase awareness of sexually transmitted infections and their symptoms and encourage individuals to seek early treatment, including through self-care approaches	Priority populations, including key populations, adolescents, men	HIV, family planning, adolescent health, maternal health, sexual and reproductive health, primary health care
Testing and diagnosis			
Screening priority populations for sexually transmitted infections	Includes sexually transmitted infection screening strategies for priority populations based on available epidemiological data	Priority populations, including key populations, adolescents, pregnant women, men, PrEP users, people living with HIV, adolescent girls and young women	HIV, family planning, adolescent health, maternal health, sexual and reproductive health, primary health care

Table 23 (continued). Sexually transmitted infection intervention areas

Sexually transmitted infection interventions	Description	Priority populations	Opportunities for shared approaches
Sexually transmitted infection testing of symptomatic patients	Includes expanding access to diagnostic tests for sexually transmitted infections, including point-of-care rapid tests and quality-assured laboratory testing	People with symptoms of sexually transmitted infections, including key populations and people living with HIV, adolescent girls and young women	HIV, family planning, adolescent health, maternal health, sexual and reproductive health, primary health care
Treatment and care			
Case management for symptomatic sexually transmitted infections	Includes effective and comprehensive case management for people with symptomatic sexually transmitted infections in an environment in which care is provided in a non-discriminatory and non-stigmatizing manner	People with sexually transmitted infections	HIV, family planning, adolescent health, maternal health, sexual and reproductive health, primary health care
Sexually transmitted infection treatment of partners of sexually transmitted infection patients	Includes voluntary provider-assisted referral of sexual partners of sexually transmitted infection patients and expedited partner treatment	Contacts of sexually transmitted infection patient	HIV, family planning, adolescent health, maternal health, sexual and reproductive health, primary health care
Identification and treatment of individuals with resistant infections	Includes monitoring of the patterns of antimicrobial resistance to inform treatment recommendations and policies, and increasing awareness of the correct use of antimicrobial agents among health-care providers and consumers, especially among priority populations	Patients with persistent sexually transmitted infection	Sector-wide antimicrobial resistance surveillance
Treatment for complications and sequelae of sexually transmitted infections	Includes providing appropriate prevention and management of sexually transmitted infection complications and their sequalae	People with sexually transmitted infections	HIV, family planning, adolescent health, maternal health, sexual and reproductive health, primary health

Table 23 (continued). Sexually transmitted infection intervention areas

Sexually transmitted infection interventions	Description	Priority populations	Opportunities for shared approaches
Enabling interventions			
Addressing structural barriers	Promotion of community and civil society leadership, including young people Addressing stigma and discrimination, including in health-care settings Preventing and addressing violence Legal, regulatory and policy reform Multisectoral partnerships	All priority populations	Sector-wide

6.4 Service delivery

Once sexually transmitted infection priorities have been identified, the strategic plan for sexually transmitted infections needs to define how the priorities will be delivered. Building on the general descriptions of the different aspects of service delivery in section 3.4, this section presents additional sexually transmitted infection–specific considerations related to essential benefit packages, service delivery models, health system strengthening and enabling factors.

1) *Essential benefit packages.* In addition to the general descriptions of essential benefit packages listed in section 3.4, essential packages for sexually transmitted infection should consider sexually transmitted infection–specific aspects (Table 24).

Table 24. Essential packages for sexually transmitted infections

Key elements	Considerations for sexually transmitted infection intervention packages
National essential benefit packages	Include key services for sexually transmitted infections in national essential benefit packages, including a commitment to finance these through public and private channels, including health insurance
Tailored packages for population groups	Define comprehensive packages of evidence-informed essential sexually transmitted infection interventions for specific population groups, including different key population groups. These packages include biomedical, behavioural and structural interventions that address prevention, treatment and care needs Ensure that people can be provided with options and choices in relation to services and service delivery approaches to address their individual risks and needs that may change across a person's lifetime

2) *Service delivery models*. In addition to the general descriptions of service delivery models in section 3.4, service delivery for sexually transmitted infections should consider sexually transmitted infection–specific aspects (Table 25).

Table 25. Service delivery models for sexually transmitted infections

Key models and approaches	Considerations for sexually transmitted infection service delivery
Differentiated service delivery	Consider tailored approaches that can make high-quality non-stigmatizing services easily accessible to priority populations, including through approaches such as community-led service delivery, targeted prevention for adolescents, promoting regular sexually transmitted infection check-ups among populations such as sex workers and gay men and other men who have sex with men, and using self-care strategies that empower individuals to become active participants in promoting their own health. Focused efforts are also needed to engage men and boys in sexually transmitted infection services through interventions that speak to their specific needs
Decentralized service delivery	Expand the use of simplified service delivery models for sexually transmitted infection services, including through task sharing with primary health care and community-led services, and integrate these more widely with other health services, including primary health care, HIV, antenatal care and sexual and reproductive health Engage private-sector providers and nongovernmental organizations in national efforts to improve services for sexually transmitted infections, such as health franchising, public–private partnerships and training on sexually transmitted infections for private-sector health-care workers
Community-led delivery	Leverage targeted community-led interventions to reach priority populations that face gaps in service access Support and use data generated through community-led monitoring to understand barriers to access and the experiences, needs and expectations of communities
Special settings	Ensure that health-care services in prisons and other closed settings are equivalent to those available to the broader community and that the continuity of essential services can be guaranteed when people move within these settings and to the broader community
Digital technologies	Offer online delivery of sexually transmitted infection services to priority populations, including online outreach, self-care and linkage to online case management and targeted health information as additional options, while ensuring that data security and confidentiality are protected

3) *Strengthening systems.* Strategic planning for sexually transmitted infections must consider approaches to strengthen the critical health system functions that are necessary to deliver sexually transmitted infection services in ways that optimize the use of health system resources, reduce misalignment or duplications with other disease programme areas and contribute to advancing primary health and universal health coverage. In addition to the general descriptions of system-strengthening actions in section 3.4, systems strengthening for sexually transmitted infections should consider sexually transmitted infection–specific aspects (Table 26).

Enabling interventions. An effective response to sexually transmitted infections requires action to advance the key enablers that are essential to promote equity and overcome major barriers to service access. In addition to the general descriptions of enablers in section 3.4, sexually transmitted infection plans should consider sexually transmitted infection–specific aspects (Table 27).

Table 26. Sexually transmitted infection actions to strengthen health systems

Key health system functions	Considerations for sexually transmitted infection responses
Governance	Promote meaningful engagement of affected communities, including patient groups and professional associations (doctors, nurses etc.) Improve coordination of sexually transmitted infection services with primary health care, sexual and reproductive health, family planning, adolescent health and HIV services
Health workforce (including community health workers)	Expand the sexual health education and training of frontline health-care workers to strengthen their clinical competence to detect and treat sexually transmitted infections and to ensure that individuals who seek sexual health services can do so in an environment free from stigma and discrimination
Commodities	Incorporate sexually transmitted infection prevention, diagnostic and treatment commodities in national health procurement and supply management systems to ensure that the right products are selected, purchased at a reasonable price and efficiently delivered Strengthen critical laboratory capacity to screen and diagnose sexually transmitted infections, with referral systems to ensure that specimens are transported appropriately and results returned in a timely manner
Financing	Identify opportunities to mobilize funding for sexual health and to incorporate the prevention and treatment of sexually transmitted infections into broader health benefit packages Expand the availability of affordable sexually transmitted infection tools, including low-cost point-of-care diagnostic tests and drugs

Table 27. Sexually transmitted infection actions on enabling interventions

Key enablers	Considerations for sexually transmitted infection responses
Community and civil society leadership	Engage priority populations at increased risk of sexually transmitted infections in providing sexually transmitted infection–friendly services, including community-led monitoring of the quality of services Mobilize peers to promote sexually transmitted infection services and regular sexually transmitted infection screening Promote the key role of communities in designing and providing culturally appropriate information about sexually transmitted infections
Addressing stigma and discrimination	Create an environment that enables individuals to comfortably talk about their sexual health, adopt safer sexual practices and seek treatment for sexually transmitted infections Train health-care workers to provide sexually transmitted infection services free of stigma and discrimination
Preventing gender-based and sexual violence and promoting gender equity	Include post-exposure prophylaxis for sexually transmitted infections in managing sexual and gender-based violence, which increases the risk of sexually transmitted infections Provide partner services and promote gender equity for improved access to sexually transmitted infection services
Legal, regulatory and policy reform	Address policies that restrict access to clinical and preventive services, especially for women and young people Address policies that restrict the provision of health services, such as by enabling decentralized delivery of services by nurses and midwives (such as benzathine benzylpenicillin injections)
Multisectoral action	Coordinate the provision of sexuality education with other sectors such as culture, education, labour, security, finance, tourism and transport

6.5 Monitoring and evaluation

National routine health information systems are the primary source of data on sexually transmitted infections. Information systems for sexually transmitted infections are well developed in some countries while still being developed in others. Modelling tools, such as Spectrum-STI and the WHO Congenital Syphilis Estimation Tool, can also be used to complement data collection and to estimate national trends in the prevalence and incidence of sexually transmitted infections *(38)*. In addition to the general descriptions of the various aspects of monitoring and evaluation in section 3.5, strategic plans for sexually transmitted infections should consider sexually transmitted infection–specific aspects for monitoring and evaluation (Table 28 and Box 32).

Table 28. Considerations for sexually transmitted infection monitoring and evaluation

Key elements	Considerations for sexually transmitted infection monitoring and evaluation
Indicators and targets	Ensure that indicators included in the national monitoring and evaluation plan reflect steps in the sexually transmitted infection services cascade and the extent and equity of services across geographical areas and population groups Cover the three data use cases at country level: individual patient care and monitoring, programme management and programme monitoring
Methods and sources	Sexually transmitted infection data are collected through many different sources. The main methods and sources for sexually transmitted infection data include: • Routine patient-level and aggregate data • Community-based service data • Epidemiological surveillance • Biobehavioural surveillance • Household surveys • Population size estimates • Other population-based surveys • Assessments and reviews (such as health facility assessments) • Modelling tools, such as Spectrum-STI and the WHO Congenital Syphilis Estimation Tool • Community-led monitoring of health and human rights
Information systems	Build off data collected as part of the expanded person-centred monitoring and case surveillance using unique identifiers to track and report individual access and outcomes along the cascade of HIV prevention, care and treatment services Generate granular data by location (such as by subnational administrative level), population characteristics (such as age, sex and presence of comorbidities and coinfections) and priority population group (such as key populations), including population size estimates, for tailored action and efficiently mobilizing and allocating resources Align sexually transmitted infection information systems with the broader health information system
Data use for decision-making	Build capacity to develop cascade analyses for specific sexually transmitted infections to identify where the biggest gaps occur at all levels of the health system Conduct regular data reviews, including programme reviews and triangulation of data from multiple sources, to corroborate the interpretation of the core cascade analysis

Box 32. Global sexually transmitted infection indicators

Impact indicators

- Number of new cases of syphilis, gonorrhoea, chlamydia and trichomoniasis among people 15–49 years old per year
- Number of new cases of syphilis among people 15-49 years old per year
- Number of new cases of gonorrhoea among people 15–49 years old per year
- Congenital syphilis cases per 100 000 live births per year
- Percentage of girls fully vaccinated with human papillomavirus vaccine by 15 years of age

Coverage indicators

- Percentage of pregnant women attending antenatal care who were screened for syphilis/ percentage treated if positive
- Percentage of priority populations screened for gonorrhoea and percentage treated if positive
- Percentage of women screened for cervical cancer using a high-performance test, by the age of 35 years and again by 45 years and percentage screened and identified as having precancer treated or invasive cancer managed
- Number of countries reporting antimicrobial resistance in Neisseria gonorrhoeae to the WHO Gonococcal Antimicrobial Surveillance Programme

Source: GHSS 2022–2030 (4).

6.6 Costing and budgeting

The GHSS 2022–2030 project the global costs of meeting global sexually transmitted infection targets. The overall costs peak at US$ 6.3 billion per year in 2026. The costing includes increased costs for primary prevention reaching US$ 344 million per year by 2030 (in addition to HIV costs, to boost outcomes for both sexually transmitted infection and HIV), and outreach to and screening for focus populations and tackling treatment failures and antibiotic resistance threats reaches US$ 1.9 billion per year by 2030. Progressively, as rates of sexually transmitted infections fall, outreach screening and diagnostics cover a larger share of total costs, highlighting the importance of innovations and efficiency in implementing new approaches in diagnostics for sexually transmitted infections by 2025.

Financing for sexually transmitted infections has been very limited in most countries so far, and national governments and external development agencies have not given priority to funding public health responses to sexually transmitted infections. Countries need to identify opportunities to mobilize funding for sexual health and to incorporate the prevention and treatment of sexually transmitted infections into broader efforts to increase overall investments in health.

6.7 Implementation arrangements

Historically, the sexually transmitted infection response has been coordinated in different ways in various countries, depending on the country's context and practice. For example, sexually transmitted infection responses have been managed as part of HIV units, sexual and reproductive health units or broader communicable diseases units. As countries strive to renew and strengthen their sexually transmitted infection responses, it is critical to clearly define a coordinating unit or entity within the health ministry along with a designated focal person for the national sexually transmitted infection response. It is also important to define the roles and responsibilities and implementation arrangements, including how these links with HIV and other related programme areas.

7. Service integration and shared approaches

Integrated people-centred health services put people and communities, not diseases, at the centre of health systems. Historically, national strategic plans for many disease areas have been developed as stand-alone plans for several reasons, including historical practice, the use of specialized providers and service delivery models and external funding streams for priority programme areas. This not only prevents people from receiving comprehensive patient-focused health services but can also lead to fragmentation, duplication or inefficiency in the use of health system resources *(39)*. Integrated approaches reduce health system fragmentation and foster greater coordination and collaboration among providers and stakeholders across care settings *(40)*. By doing so, they enable people-centred care, improve programme efficiency and quality and maximize impact.

7.1 Shared approaches across HIV, viral hepatitis and sexually transmitted infections

HIV, viral hepatitis and sexually transmitted infections form a cluster of interlinked communicable diseases and share several commonalities that provide opportunities for integration (Table 29). These diseases have common modes of transmission, affect many common priority populations and are linked to common social and structural risk factors such as criminalization stigma, discrimination, poverty and inequities. Further, people can be members of more than one key population group and have more than one risk behaviour, and some people may engage in risk behaviour without identifying as members of a particular group; for example, men who have sex with other men but do not identify as gay. People who inject drugs often stop using drugs, sex workers stop sex working and people move in and out of prison. Integrated approaches are essential to recognize the complexities and changes in people's lives, address syndemics (defined as two or more infections interacting synergistically, contributing to excess burden of disease in a population) and meet their needs in a comprehensive manner.

In addition, HIV, viral hepatitis and sexually transmitted infections also cause a range of coinfections and comorbidities that need to be addressed through close collaboration across related programme areas. These commonalities across HIV, viral hepatitis and sexually transmitted infections provide opportunities for integrated or shared interventions and service delivery models, and coordinated use of health system resources, with a primary health care approach.

Table 29. Examples of commonalities across HIV, viral hepatitis and sexually transmitted infections

Common domains	Specific areas	Related programmes
Modes of transmission	Sexual transmission	HIV, sexually transmitted infections, hepatitis A, hepatitis B, hepatitis C, human papillomavirus, family planning
	Injecting drug use	HIV, hepatitis B, hepatitis C, syphilis
	Vertical transmission	HIV, hepatitis B, sexually transmitted infections, hepatitis C virus (in rare cases)
	Blood contamination	HIV, hepatitis C, hepatitis B
Priority populations	Sex workers	HIV, sexually transmitted infections, hepatitis B, sexual and reproductive health, family planning, mental health
	Gay men and other men who have sex with men	HIV, sexually transmitted infections, hepatitis B, hepatitis C, mental health
	People who inject drugs	HIV, hepatitis B, hepatitis C, syphilis, mental health
	Transgender and gender-diverse people	HIV, sexually transmitted infections, hepatitis B, hepatitis C, mental health
	Adolescents and young people	HIV, sexually transmitted infections, sexual and reproductive health, family planning
	Pregnant women	Triple elimination of HIV, syphilis and hepatitis B virus, sexual and reproductive health, family planning
	Children	HIV, hepatitis, sexually transmitted infections, maternal, newborn and child health, immunizations
	People in prisons	HIV, hepatitis, sexually transmitted infections, TB, mental health
	Underserved (rural and migrants etc.)	All

Table 29 (continued). Examples of commonalities across HIV, viral hepatitis and sexually transmitted infections

Common domains	Specific areas	Related programmes
Coinfections and comorbidities	HIV, sexually transmitted infections and hepatitis	HIV, sexually transmitted infections, hepatitis
	HIV and hepatitis	HIV, hepatitis
	TB and HIV	HIV, TB
	Mental health	HIV, hepatitis, sexually transmitted infections, mental health and all others
	Cervical cancer	HIV, sexually transmitted infections, sexual and reproductive health
	Neglected tropical diseases	HIV, hepatitis, sexually transmitted infections, neglected tropical diseases
	Noncommunicable diseases	HIV, hepatitis, sexually transmitted infections, noncommunicable diseases
Service delivery platforms and interventions	Antenatal care	HIV, hepatitis, sexually transmitted infections, maternal, newborn and child health
	Condoms	HIV, sexually transmitted infections, family planning, hepatitis B
	Harm reduction	HIV, hepatitis C
	Community services	All
	Sexual and reproductive health	HIV, sexually transmitted infections, sexual and reproductive health
	Infection prevention and control	All
Technology and resources	Digital technologies for health management information systems	All
	Biobehavioural surveys	HIV, sexually transmitted infections, cervical cancer
	Diagnostics	HIV, sexually transmitted infections, hepatitis, TB
	Procurement and supply chains	All
	Community health workers	All
	Training and supervision	All
	Other (physical facilities, transport etc.)	All
Social determinants	Stigma and discrimination	All
	Human rights violations and responses	All
	Legal environment	All
	Social protection	All
	Gender-based violence	All

7.2 Integration across health programmes

In practice, integration is highly context specific, and the scope and extent of integration will vary in different country contexts. Integration can be thought of in various ways. For example, integration may be clinical (such as coordinating patient care across the system's different functions, activities and operating units) or functional (such as coordinating functions such as human resources, financing and strategic planning across disease programmes). It may also be horizontal (such as coordinating functions, activities or operating units at the same level of care) or vertical (such as coordinating functions, activities or operating units across different levels of services such as links between hospitals, outpatient surgery centres and home-based care agencies).

Integration should focus on specific populations, service delivery platforms, health system resources and social determinants that provide opportunities for synergy and efficiency through consolidation or coordination. Planners should ensure that integration does not lead to any unintended negative consequences and that the progress achieved by disease-specific responses is sustained, especially for key and affected populations.

A shift towards integrated approaches requires enhanced coordination across planners, decision-makers, service providers and service delivery locations and sectors, with efforts to strategically align, link or integrate elements in new ways. The WHO Operational Framework for Primary Health Care proposes 14 strategic and operational levers that are needed to translate the global commitments to primary health care into concrete actions and interventions *(15)*. Within each of these levers, it provides examples of national and subnational actions that could be taken by health programme areas to strengthen primary health care–oriented health systems.

Table 30 provides some specific actions for HIV, viral hepatitis and sexually transmitted infections based on the GHSS 2022–2030 that can be applied across the primary health care levers to strengthen people-centred health services. Countries will need to assess, set priorities for, optimize and sequence their respective actions in relation to their context and capacity informed by a robust evidence base and agreed through inclusive planning processes with the participation of all stakeholders, including communities and health-care workers.

Table 30. Examples of HIV, viral hepatitis and sexually transmitted infection actions related to primary health care levers

Primary health care levers	Selected HIV, viral hepatitis and sexually transmitted infection actions[a]
Political commitment and leadership	Promote political commitment and leadership for inclusion and integration of HIV, viral hepatitis and sexually transmitted infections as an important component of universal health coverage Create an enabling legal environment by reviewing and reforming restrictive legal and policy frameworks, as needed, to enable equitable access to health services, especially for most affected and at-risk populations, and create institutional and community environments, including in health-care settings, that make accessing services safe for people
Governance and policy frameworks	Strengthen national governance structures and costed strategic plans to guide national responses to HIV, viral hepatitis and sexually transmitted infections, with meaningful engagement of communities and promoting synergy with broader health governance structures and plans, aligned with international human rights principles and standards
Funding and resource allocation	Address the financing of HIV, viral hepatitis and sexually transmitted infection responses through national health financing systems, avoiding fragmented funding, maximize the efficient use of resources and minimize overall catastrophic health expenditure Ensure the inclusion of HIV, viral hepatitis and sexually transmitted infections in national health benefit packages for universal health coverage Progressively increase the proportion of domestic expenditure on HIV, viral hepatitis and sexually transmitted infections
Engagement of communities and other stakeholders	Establish, catalyse and coordinate multisectoral and community partnerships to address social and structural barriers hindering effective responses to HIV, viral hepatitis and sexually transmitted infections Engage and support communities and civil society to enhance their pivotal contributions to advocacy, service delivery, policy-making, monitoring and evaluation and initiatives to address social and structural barriers

Table 30 (continued). Examples of HIV, viral hepatitis and sexually transmitted infection actions related to primary health care levers

Primary health care levers	Selected HIV, viral hepatitis and sexually transmitted infection actions[a]
Models of care	Organize health service delivery to address people's needs across the full continuum of HIV services by providing comprehensive prevention services, ensuring early access to and engagement in care, continuity of treatment, re-engagement and monitoring the service cascade for improving programmes Promote the integration of HIV, viral hepatitis and sexually transmitted infection services and their key coinfections and comorbidities into primary health care platforms where feasible and appropriate, including through decentralized and community-based service delivery, and contribute to jointly strengthening these platforms for sustainable progress towards universal health coverage Strategically leverage health systems to deliver essential HIV, viral hepatitis and sexually transmitted infection services as part of universal health coverage by aligning disease-specific and health system efforts at the policy, programme and service levels. Identify and optimize opportunities to use differentiated service delivery models for HIV, viral hepatitis and sexually transmitted infection services, guided by strategic information to understand the diverse needs and preferences of beneficiary populations in various settings, as a means to expand access to comprehensive people-centred services. Identify and optimize opportunities to decentralize the delivery of HIV, viral hepatitis and sexually transmitted infection services when appropriate, by diversifying their provision to include lower administrative levels and non-specialized personnel and simplifying protocols where appropriate, as a means to expand access to comprehensive people-centred services. Provide equitable access to services in special settings, including prisons and other closed settings, and settings of humanitarian concern. Eliminate stigma and discrimination in health care settings and strengthen accountability for discrimination-free health care. Protect the gains achieved in the responses to HIV, viral hepatitis and sexually transmitted infections and ensure the continuity of essential health services in the context of pandemics and other emerging health threats by building health and community system resilience
Primary health care workforce	Address immediate and future health workforce needs in relation to HIV, viral hepatitis and sexually transmitted infections in ways that are synergistic with efforts to strengthen the overall health workforce Provide adequate regulation, training, supervision and support for community-based members of the health workforce
Physical infrastructure	
Medicines and other health products	Ensure equitable and reliable access to quality-assured and affordable medicines, diagnostics and other health products for HIV, viral hepatitis and sexually transmitted infections by accelerating their development, quality assurance and in-country registration; reducing prices; strengthening local development, manufacturing and distribution capacity; and aligning efforts with broader health commodity plans and budgets
Engagement with private sector providers	Optimize the potential for innovation through market analysis and strengthening research and development–based partnerships, including strengthening engagement with the private sector Promote partnerships between public and private sectors for delivering integrated health services for HIV, viral hepatitis and sexually transmitted infections, especially where health care is mostly funded through out-of-pocket expenditure

Table 30 (continued). Examples of HIV, viral hepatitis and sexually transmitted infection actions related to primary health care levers

Primary health care levers	Selected HIV, viral hepatitis and sexually transmitted infection actions[a]
Digital technologies for health	Harness the growing power of digital technologies to enhance the coverage and quality of health interventions
Systems for improving the quality of care	Strengthen systems at the local, subnational and national levels to continuously assess and improve the quality of integrated health services for HIV, viral hepatitis and sexually transmitted infections
Primary health care-oriented research	Promote research and knowledge management, including dissemination of lessons learned in implementing integrated services and the use of knowledge to accelerate the scale-up of successful strategies to strengthen integrated systems
Monitoring and evaluation	Generate high-quality data and use data analysis to drive action, including at decentralized levels Expand person-centred monitoring to support people-centred services by placing the individual at the centre of health information systems and by increasing the granularity of data appropriately disaggregated by sex, disability, age and other relevant population characteristics, supplemented by information from community-led monitoring Align information systems related to specific diseases or infections with broader health information systems to strengthen universal health coverage and support the transition to digital information systems with appropriate attention to data governance, security and interoperability

[a]Based on the WHO Operational Framework for Primary Health Care and the GHSS 2022–2030

Part 3.
Operationalizing strategic plans

Part 3 presents the practical elements related to finalizing and operationalizing strategic plans for HIV, viral hepatitis and sexually transmitted infections. It is structured as follows.

- Chapter 8 presents a draft structure of a plan and discusses processes for reviewing, finalizing and endorsing the plan.
- Chapter 9 discusses how strategic plans can be used, including for detailed operational planning, harmonized partner programming and informing resource mobilization efforts.

8. Finalizing a national strategic plan

This chapter presents a proposed structure of a national strategic plan that can be adapted as relevant to different country contexts. It also discusses the key steps in finalizing the plan, including assessments or peer reviews, followed by endorsement and dissemination of the plan.

8.1 Structure of a strategic plan

This section presents a proposed structure of a national strategic plan document with some example templates. This structure is not prescriptive and can be adapted as relevant to the country context. In all formats, it is important to ensure a logical structure and flow in the document and to maintain coherence and consistency across the different sections.

1) Title

2) Preliminaries

A strategic plan begins with the core front matter of the document, such as the following elements:

- foreword
- acknowledgements
- acronyms
- table of contents.

3) Executive summary

The executive summary provides a high-level overview of the key elements of the strategic plan, such as the vision, goals, objectives, strategic priorities, key targets and costing of the plan. An executive summary is useful if the main document is long.

Indicative length: 1–4 pages

4) Introduction

The introduction presents the country situation, describes the history of the epidemics and response and provides background to the development of the strategic plan. It can include the following elements:

- country profile, including demographics and socioeconomic and political context
- history of the epidemics in the country, including trends, populations affected and response
- key policy and directional shifts in the response to the epidemics
- strategic plan development process, including methods and timelines.

5) Situation analysis (see sections 3.2, 4.2, 5.2 and 6.2 for details)

The situation analysis provides an assessment of the health situation, achievements, challenges and gaps in the response to the diseases. It is good practice to use tables, figures and maps to present the key information. The situation analysis can include the following elements:

- epidemiological analysis
- programmatic response analysis
- health and community system context
- socioeconomic and political context
- stakeholder analysis.

6) Strategic priorities (see sections 3.3, 4.3, 5.3 and 6.3 for details)

This section presents the overarching vision of the strategic plan and the key goals and objectives. It includes the following elements:

- considerations in priority setting
- vision, goals and objectives of the strategic plan.

7) Interventions (see sections 3.3, 4.3, 5.3 and 6.3 for details)

This section presents the strategic priorities of the plan, with the rationale for priority setting. Various other terms may also be used to describe these, such as the pillars, strategic directions, priority areas or key priorities. This section can include the following elements:

- priority populations and geographical locations
- priority interventions, with current status, challenges and expected impact
- a theory of change
- priority indicators and targets (detailed monitoring and evaluation framework can be presented below).

Table 31 provides an example of a template to summarize the priority setting of the plan.

Table 31. Template for priority setting and targeting

Intervention	Target population	Target geographical location	Target coverage

8) Service delivery (see sections 3.4, 4.4, 5.4 and 6.4 and Chapter 7 for details)

This section presents how the priorities of the strategic plan will be delivered, including the service delivery models to reach the priority populations, ways to integrate service delivery in a person-centred approach, using and strengthening health system resources and action on enabling interventions. It includes the following elements:

- service delivery models and approaches to reaching priority populations
- service integration in a person-centred approach
- health system strengthening, including pandemic preparedness and response
- enabling interventions.

9) Monitoring and evaluation (see sections 3.5, 4.5, 5.5 and 6.5 for details)

This section presents the monitoring and evaluation framework or performance framework of the plan and describes the health information system, the indicators and targets, methods and sources, and data analysis and use for decision-making. Table 32 provides an example of a monitoring and evaluation framework.

Table 32. Monitoring and evaluation framework

	Indicator type	Baseline	Year 1 target	Year 2 target	…	Disaggregation	Measurement method and definitions	Data source
Goal 1:								
Objective 1.1								
Indicator number	Such as impact, outcome, coverage	*n* or %				Such as age, sex, population group	Such as programme data, survey, statistical modelling	Such as DHS survey 2023
Indicator number								
Indicator number								

Table 32 (continued). Monitoring and evaluation framework

	Indicator type	Baseline	Year 1 target	Year 2 target	…	Disaggregation	Measurement method and definitions	Data source
Objective 1.2	…							
Indicator number								
…								
Goal 2:								
…								

10) Costing and budgeting
(see sections 3.6, 4.6, 5.6 and 6.6 for details)

This section provides information on the cost of the strategic plan and the projected resource availability and allocation. Tables 33 and 34 provide examples of templates for a total budget and a financial gap analysis, respectively.

Table 33. Template for a total budget

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Goal 1						
Objective 1.1						
Intervention 1.1.1						
Intervention 1.1.2						
Intervention 1.1.3						
Objective 1.2						
Intervention 1.2.1						

Table 34. Template for a financial gap analysis

Planning element	Year 1			Year 2			…			Total		
	Cost	Available	Gap	Cost	Available	Gap		Cost	Available	Gap		
Goal 1												
Objective 1.1												
Intervention 1.1.1												
Intervention 1.1.2												
Intervention 1.1.3												

Table 34 (continued). Template for a financial gap analysis

Planning element	Year 1			Year 2			…			Total		
	Cost	Available	Gap	Cost	Available	Gap		Cost	Available	Gap		
Objective 1.2												
Intervention 1.2.1												
…												
Goal 2												
…												

11) Implementation arrangements (see sections 3.7, 4.7, 5.7 and 6.7 for details)

This section describes how key actors will manage and coordinate the implementation of the strategic plan, including the organizational structure and approaches to risk management. It is useful to include an organogram of the management and coordination structure and an implementation mapping of the implementing entities and service providers. Table 35 provides an example template for a risk assessment.

Table 35. Template for a risk assessment matrix

Potential risks	Likelihood High, medium or low	Impact High, medium or low	Mitigation strategies
Such as inability to raise required resources			
Such as disease outbreak that disrupts service provision			

12) Annexes

The annexes to a strategic plan can include:

- monitoring and evaluation framework
- detailed budget
- other supporting annexes.

As mentioned in Chapter 1, countries can present their strategic plans for HIV, viral hepatitis and sexually transmitted infections as stand-alone or combined in various ways, depending on the country's situation and practice. Each of the sections listed in the structure above can thus also be included in various ways depending on the format chosen by a country chooses to present its strategic plan (Box 33).

Box 33. Example of a section outline in a combined HIV, viral hepatitis and sexually transmitted infection strategic plan

Such as Section 1: Situation analysis

1.1	**Epidemiological analysis**	*> For example, general description of population demographics and health status, social determinants of health and risk factors, comorbidities and coinfections and common priority populations affected by HIV, viral hepatitis and sexually transmitted infections*
1.1.1	**Overview**	
1.1.2	**HIV**	*> Disease-specific*
1.1.3	**Viral hepatitis**	*> Disease-specific*
1.1.4	**Sexually transmitted infections**	*> Disease-specific*
1.2	**Programmatic response analysis**	*> For example, combined analysis of common health interventions and enabling interventions across HIV, viral hepatitis and sexually transmitted infections*
1.2.1	**Overview**	
1.2.2	**HIV**	*> Disease-specific*
1.2.3	**Viral hepatitis**	*> Disease-specific*
1.2.4	**Sexually transmitted infections**	*> Disease-specific*
1.3	**Health and community system context**	*> For example, general description of the health and community system in the country, service delivery models being used to reach priority populations and enablers; and analysis of current levels of integration (common service delivery channels, shared health system resources) across HIV, viral hepatitis and sexually transmitted infections*
1.3.1	**Overview**	
1.3.2	**HIV**	*> Disease-specific*
1.3.3	**Viral hepatitis**	*> Disease-specific*
1.3.4	**Sexually transmitted infections**	*> Disease-specific*
1.4	**Stakeholder analysis**	*> For example, the overall landscape of stakeholders in the health sector*
1.4.1	**Overview**	
1.4.2	**HIV**	*> Disease-specific*
1.4.3	**Viral hepatitis**	*> Disease-specific*
1.4.4	**Sexually transmitted infections**	*> Disease-specific*
1.5	**Socioeconomic and political context**	*> For example, the shared social, cultural, economic, political and legal environment within which HIV, viral hepatitis and sexually transmitted infection strategies are implemented*
1.5.1	**Overview**	
1.5.2	**HIV**	*> Disease-specific*
1.53	**Viral hepatitis**	*> Disease-specific*
1.5.4	**Sexually transmitted infections**	*> Disease-specific*

8.2 Joint assessment of national strategies

Once a strategic plan has been drafted, a country may wish to undertake an assessment or a peer review of the quality of the draft plan. The purpose of such a process is to assess the strengths and weaknesses of the plan and to enhance its quality and stakeholder confidence that forms the basis for implementing a sound programme and domestic and international investments. There are various approaches to conducting such assessments, including internal assessments undertaken by the parties directly involved in developing the plan or joint external assessments involving both internal and other interested external parties in assessing the plan.

The International Health Partnership for UHC 2030 (formerly IHP+), a global compact of partners supporting health system strengthening for universal health coverage, has developed a tool for joint assessment of national strategies that is a shared approach to assessing the strengths or weaknesses of a national health strategy or plan *(41)*. It has three main purposes – enhancing the quality and relevance of the strategy, increasing confidence in the strategy and ensuring that funding decisions are closely aligned to the strategy and reducing transaction costs at country level by avoiding multiple assessments and review processes by different stakeholders.

The joint assessment of national strategies tool and guidelines provide the method to conduct these assessments *(42)*. They outline the essential elements of any sound national health strategy and provide a framework to examine the strengths and weaknesses of five sets of attributes considered the foundation of a sound and comprehensive national health strategy:

- situation analysis and programming: clarity and relevance of strategies, based on sound situation analysis;
- the process through which national plans and strategies have been developed;
- costs and budgetary framework for the strategy;
- implementation and management arrangements; and
- monitoring, evaluation and review mechanisms.

Given the diversity of country circumstances, the approach is generic such that it discusses the essential elements that would ideally be present for a strategy to be considered technically sound and to enable a funding decision based on the strategy. The joint assessment of national strategies tool and guidelines do not prescribe what the strategy must contain; rather they define the attributes that must be present. It is not assumed that the strategy or plan document itself will detail all the attributes; rather some aspects may be covered in other policy, strategy and operational documents. The joint assessment of national strategies therefore requires reviewing a portfolio of documents and not the strategy alone.

The way to conduct a joint assessment of national strategies may differ from one country to another, but the assessment process must adhere to four key principles: it should be driven and led by the country, it should build on existing in-country processes and experiences, it should have a strong independent element and it should be inclusive, involving civil society and other stakeholders in the health sector. The findings of the joint assessment of national strategies are presented in terms of feedback and recommendations, which can be discussed by national stakeholders and used to refine the strategy.

8.3 Endorsement and dissemination of the plan

The national strategic plan, once finalized by bringing all the different components together in a single document, must be validated by all stakeholders involved. Continuous engagement of stakeholders throughout the various steps of the strategic planning process will ensure that their views have been captured and facilitate consensus around the content and presentation of the plan. To facilitate this process, the final draft of the plan may be widely circulated to all key stakeholders for review and feedback, accompanied by a consensus meeting of stakeholders. The joint assessment of national strategies tool facilitates the process of validation (see section 8.2).

Once consensus is achieved and the plan has been finalized, the relevant national authorities need to formally endorse it. Endorsement typically involves official approval and signing off on the strategic plan by authorities such as the parliament, the health ministry or others, thereby adopting the plan as a formal element in the country's overall health sector strategy. A plan without endorsement may be perceived as lacking legitimacy.

After official endorsement, the plan needs to be promoted and disseminated widely to all stakeholders and implementing partners internally within the health ministry and externally to stakeholders from other sectors to provide the strategic framework to guide the contributions of all partners and inform the implementation of their activities. Dissemination plans should include all administrative levels of planning and implementation: both national and subnational levels (such as provinces, districts and local authorities).

9. Operational considerations

This chapter presents practical elements related to operationalizing strategic plans and the various ways strategic plans can be used. It covers the following.

Section 9.1 discusses the supporting plans and documents that supplement strategic plans.

Section 9.2 discusses operational planning at national and higher subnational levels.

Section 9.3 discusses microplanning at lower levels of programme implementation.

Section 9.4 discusses programme management, including the managing risks.

Section 9.5 discusses harmonization and alignment across stakeholders involved in implementing the plan.

9.1 Supporting plans

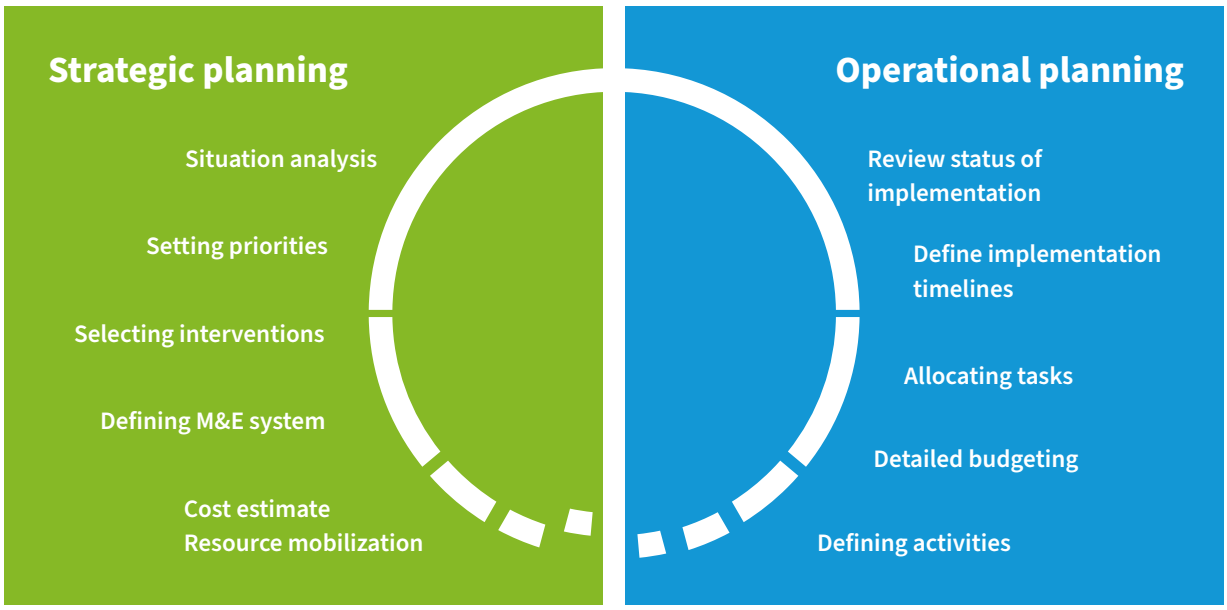
National strategic plans are accompanied by several supporting plans and other documents that provide additional detail regarding the implementation of the plans. The key plans include:

1) Monitoring and evaluation plan. The monitoring and evaluation plan is based on the results framework (or monitoring and evaluation framework) of the strategic plan. As described in section 3.5, the results framework lists the objectives of the plan, the expected results and targets and the key indicators and data sources that will be used to monitor performance, undertake equity-focused analysis across relevant stratifications and promote the accountability of all stakeholders. In addition to the results framework, the monitoring and evaluation plan also describes the data collection processes, the measurement methods and the analysis of the data. It also describes the required monitoring and evaluation capacity, the processes for data quality assurance, the plans for data reviews, evaluations, surveys and research, the dissemination of results and monitoring and evaluation coordination mechanisms. The monitoring and evaluation plan also describes the periodic programme reviews and evaluations to assess programme performance and results, draw lessons learned, provide an opportunity to course correct and promote transparency and accountability. The main reviews include annual reviews, mid-term reviews, end-term reviews and special studies and reviews to explore specific aspects of programmes in detail. Programme reviews conducted at the end of a planning cycle provide key input to the situation analysis for the following implementation period.
2) Procurement and supply management plan. This provides information on the goods and services that will be purchased during the implementation period and on the procurement and supply management processes. These processes cover the various steps of the procurement and supply management cycle, including product selection, forecasting of needs, procurement planning, distribution, logistics information management systems and quality assurance systems. It also describes the required procurement and supply management capacity.
3) Resource mobilization plan. Accompanied by an investment case, the resource mobilization plan outlines the resources needed to achieve the goals of the strategic plan and the approaches to mobilize additional resources during the implementation of the plan from domestic and external sources. This plan forms the basis of budget negotiations with the finance ministry and other decision-makers in the public sector as well as in discussions with external partners.
4) Capacity-building or human resource development plan. This plan assesses the needs and gaps in core capacity, including human resource capacity, for implementing the strategic plan. It is often based on capacity assessment and outlines the activities that will be undertaken to address the capacity gaps identified through this assessment. Such activities could include training, supportive supervision and the additional resources, materials or technologies that may be required. It is linked to the technical assistance plan.
5) Technical assistance plan. This plan lists the technical support needed for implementing the strategic plan, with the key objectives and expected outcomes of the technical assistance, the profile or expertise required, the duration of the technical assistance, the process for selecting and contracting the expertise and the estimated budget.

9.2 Operational planning

As countries move from the strategic planning stage to implementation, the strategic plans for HIV, viral hepatitis and sexually transmitted infections need to be translated into operational plans to guide activities and the management of resources. Strategic planning provides the overall vision, goals, objectives and priorities of the plan, typically over 5–10 years, the operational plans provide a practical framework for implementation: the “how” or the actions that should be undertaken to deliver the desired results – typically over a shorter period of 1–2 years or on a rolling basis (Fig. 14).

Fig. 14. Strategic and operational planning



Source: GHSS 2022–2030 (4).

Operational planning defines what is required to deliver the national strategic plan: the activities, their timing, location, roles and responsibilities, the inputs and resource needs and the source of funding. The operational plan usually refers to detailed planning at the national level and higher subnational levels such as states, provinces and regions. It can involve translating the national strategic plan into a shorter-term implementation plan, translating it into subnational (such as state, provincial or regional level) plans or translating it into a subset for a particular implementing entity or partner. National strategic plans are often costed using a top-down approach: estimating costs at the level of goals and objectives; operational plans are costed using a bottom-up approach: providing detailed cost information at the level of main and sub-activities.

To be effective, operational plans should be closely linked to the strategic plan and to its goals, objectives and targets and define indicators and milestones to track progress. The extent of linkage often depends on the level of detail in the national strategic plan and on the degree of autonomy for implementation at decentralized levels in the country. Many countries link the national strategic plan with operational plans through rolling medium-term plans and expenditure frameworks.

Operational plans that are linked to the strategic plan help to align the contributions of all stakeholders to national goals, ensure coordination and efficiency in implementation efforts and rationalize the allocation of resources. Operational plans must also be informed by past implementation experience, the successes and challenges and the lessons learned. Accompanied by regular review processes, operational planning also ensures that programme implementation is dynamic and responsive to the changing dynamics of the epidemic and response.

Table 36 provides an example of a template for an operational plan

Table 36. Template for an operational plan

Year 1: 20xx–20xx									
Goal 1:									
Objective 1.1:									
Intervention 1.1.1:									
	Unit	**Quantity**	**Date**	**Location**	**Implementer**	**Cost**	**Funding source**	**Indicator**	**Other**
Activity 1.1.1.1									
Activity 1.1.1.2									
…									
	Unit	**Quantity**	**Date**	**Location**	**Implementer**	**Cost**	**Funding source**	**Indicator**	**Other**
Intervention 1.1.2:									
…									

9.3 Microplanning

Within the context of the operational plan, each implementing entity involved in programme implementation may develop its own detailed subplans, or microplans, to define the activities each entity will implement to deliver on the results and targets it has been assigned in the national operational plan. These microplans are defined at lower levels of programme implementation, such as districts, wards, health facilities, villages or townships.

Microplanning is an important step in promoting integrated people-centred service delivery for HIV, viral hepatitis and sexually transmitted infections through a primary health care approach. Microplans seek specifically to address the challenges in reaching populations that are underserved at local levels by making implementation more responsive to the contexts of local communities and helping to close gaps in the coverage of essential services. Microplanning has a strong community component, since it strives to promote social participation in decision-making processes and engage communities and local stakeholders to find solutions.

The process of microplanning involves four key steps:

- diagnosis, which includes identifying the affected populations and target groups, their barriers to service access, the underlying causes and the issues to be addressed;
- analysis, which includes setting priorities for the actions to be taken, such as defining the services that are needed and the targets that will be pursued;
- planning implementation, which includes planning the detailed structures, systems and resources required to meet the needs of affected populations, redesigning model(s) of care where needed and ensuring appropriate entry points for service integration and improved service quality; and
- implementation, monitoring and learning, which include tracking implementation and impact.

9.5 Support from external partners

As the number of stakeholders involved in HIV, viral hepatitis and sexually transmitted infection programmes grows, harmonizing and aligning the efforts of all partners engaged in national responses becomes ever more essential. It is vital that national programmes fully understand who the key actors are, what they do, what activities, resources and added value they offer and how the stakeholders will work together within the framework of national priorities, plans and systems to deliver on national goals.

1) *Harmonization and alignment.* External partners, including funding partners, play a critical role in disease responses in many low-income settings. All external partners should be aligned around the priorities of the national strategic plan and provide their support within the framework of the plan to ensure programmatic and operational coherence, reduce fragmentation and duplication and improve the effectiveness of aid (Box 34). National strategic plans that have been developed and validated through multistakeholder engagement processes and that reflect the needs and priorities of affected communities are more likely to be used as the basis for all partner programming efforts.

Box 34. Paris Declaration on Aid Effectiveness

The Paris Declaration on Aid Effectiveness lays out five fundamental principles to improve the quality of aid and its impact on development:

- Ownership: developing countries set their own strategies for poverty reduction, improve their institutions and tackle corruption.
- Alignment: donor countries and organizations align behind these objectives and use local systems.
- Harmonization: donor countries coordinate, simplify procedures and share information to avoid duplication.
- Results: developing countries and donors shift focus to development results and results get measured.
- Mutual accountability: donors and partners are accountable for development results.

2) *Coordination mechanisms.* Various coordinating mechanisms and processes exist within the health sector to facilitate such harmonization and alignment in partner efforts throughout the planning and implementation cycle, such as high-level health sector coordinating bodies led by the health ministry; disease-specific bodies such as national AIDS councils for the HIV response; or coordination mechanisms related to international investments, such as the country coordinating mechanisms that plan and oversee Global Fund investments in a country. Existing structures should be leveraged for HIV, viral hepatitis and sexually transmitted infection responses, under the leadership of the health ministry.

3) *Funding applications.* Well-costed strategic plans, with a good analysis of resource needs and funding gaps, also form the basis for resource mobilization, including in dialogue with the finance ministry to secure domestic funding and for donor coordination and funding applications to national and external funding partners. Funding partners such as the Global Fund encourage countries to develop robust strategic plans through participatory processes, and where such plans exist, they have supported the direct use of these plans in funding applications. Such approaches improve the alignment of donor financing with country priorities and planning cycles and reduce transaction costs for countries compared with dedicated efforts to develop funding proposals for individual funding partners.

   If national strategic plans also include sound monitoring and evaluation frameworks, they have formed the basis of new and innovative results-based financing models that shift the focus of donor grant management and reporting away from inputs and outputs towards health outcomes and quality. Such funding models rely on national health information systems to gather, and report results and ensure data quality and remove duplicative donor-specific reporting requirements. Such approaches help countries to establish and strengthen national systems, promote national ownership and enhance mutual accountability.

9.4 Programme management

Programme implementation should be supported by structures and processes that can successfully provide real-time direction for day-to-day management along with strategic decision-making to steer the programme towards its longer-term goals.

National programmes on HIV, viral hepatitis and sexually transmitted infections are becoming increasingly complex over time. To be successful, these programmes need management structures that can coordinate across a range of stakeholders and sectors, including beyond the health sector. They need to balance competing priorities and interests and take complex resource allocation decisions in contexts of growing needs and limited resources. They need to keep up with advances in science and knowledge, engage communities and address the social and cultural sensitivities related to the broader determinants of HIV, viral hepatitis and sexually transmitted infections. They need to be agile in a rapidly evolving global health environment and ensure the sustainability of their achievements.

Skilled and well-equipped programme managers who have strong leadership skills and are goal-oriented, inclusive and participatory are crucial to successful responses to HIV, viral hepatitis and sexually transmitted infections. Programme managers themselves require higher-level stewardship and support from senior government officials, community leaders and partners to ensure that the programme has the commitment and buy-in of all the major stakeholders necessary for its success.

Programmes are strengthened by good governance or the presence of sound structures and processes by which the health system is regulated, directed and controlled to achieve national health goals. Some of the key elements of good governance include inclusiveness, consensus building, transparency, equity, accountability and efficiency. The capacity of governance and management structures should be strengthened not only at the national level but also at subnational or decentralized levels to ensure that they can exercise their governance role to advance local priorities and engage effectively with stakeholders, including communities.

Programme management also involves supervising implementing entities at lower administrative levels and coordination and collaboration to oversee and manage the contributions of the stakeholders in a disease response. This is especially important as the number of stakeholders increases, often accompanied by an increase in the funding available from various sources. Coordination is necessary to align all efforts around the national plan and priorities, ensure synergy of activities and reduce overlaps and duplication. Inclusive processes, regular consultations and joint monitoring and accountability frameworks are critical to support coordination efforts.

An important aspect of programme management is assessing and managing risks that could adversely affect the implementation of the plan and planning for contingency measures in the event of emergencies that may disrupt health services. These risks may be internal (such as capacity issues not previously identified) or external (such as health emergencies, changes in donor funding landscape or instability). Risk management involves identifying potential risks that could arise, their likelihood and severity and possible strategies to mitigate them. In an evolving global health context, including in the face of pandemics and health emergencies, HIV, viral hepatitis and sexually transmitted infection programmes need to prevent and manage disease outbreaks, protect the gains achieved and build health and community system resilience over time.

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Annex 1. Useful resources and tools

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General resources and tools related to planning

Strategizing national health in the 21st century: a handbook. Geneva: World Health Organization; 2016 (https://apps.who.int/iris/handle/10665/250221).

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Participatory approaches to planning

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Beyond consultations and surveys: enhancing participatory governance in health systems. Geneva: World Health Organization; 2022 (https://apps.who.int/iris/handle/10665/351077).

Situation analysis

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Data collection and analysis tools [online database]. Geneva: World Health Organization; 2023 (https://www.who.int/data/data-collection-tools).

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One Health Tool. Geneva: World Health Organization; 2023 (https://www.who.int/tools/onehealth).

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Building the primary health care workforce of the 21st century. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/handle/10665/328072).

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Joint assessment of national health strategies and plans – tools and guidelines [website]. Geneva: UHC2030 (https://www.uhc2030.org/what-we-do/improving-collaboration/health-systems-strengthening/jans-tool-and-guidelines).

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Checklist and reference list for developing and reviewing a national strategic plan for HIV. Geneva: UNAIDS; 2020 (https://www.unaids.org/en/resources/documents/2020/checklist-developing-national-strategic-plan-hiv).

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Viral hepatitis–specific resources and tools

Manual for the development and assessment of national viral hepatitis plans: a provisional document. Geneva: World Health Organization; 2015 (https://apps.who.int/iris/handle/10665/183726).

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Assessment of country implementation of the WHO global health sector strategy for sexually transmitted infections (2016–2021): results of a national survey. Geneva: World Health Organization; 2021 (https://apps.who.int/iris/handle/10665/345086).

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Annex 2. Glossary

Accountability: The obligation to report or give account of one's actions, for example, to a governing authority through scrutiny, contract, management and regulation or to an electorate.

(Source: WHO, UNICEF. Operational Framework for Primary Health Care: transforming vision into action. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/handle/10665/337641).)

Budgeting: the process of elaborating a detailed plan for the future showing how resources will be acquired and used during a specific time period, expressed in formal, measurable terms.

(Source: WHO health systems strengthening glossary. Geneva: World Health Organization; 2011 (https://cdn.who.int/media/docs/default-source/documents/health-systems-strengthening-glossary.pdf).)

Coherence (of a national health policy, strategy or plan): (a) The extent to which proposed strategies are aligned with the priorities identified in the situation analysis; (b) the extent to which programme plans are aligned with the national health strategy and plan; (c) the extent to which the different programmatic strategies in the national health policy, strategy or plan are coherent with each other; or (d) the extent to which the budget, monitoring and evaluation framework and action plan introduce the proposed strategies.

(Source: WHO, UNICEF. Operational Framework for Primary Health Care: transforming vision into action. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/handle/10665/337641).)

Community: A unit of population, defined by a shared characteristic (for example, geography, interest, belief or social characteristic), that is the locus of basic political and social responsibility and in which every day social interactions involving all or most of the spectrum of life activities of the people within it takes place.

(Source: WHO, UNICEF. Operational Framework for Primary Health Care: transforming vision into action. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/handle/10665/337641).)

Community engagement: The process of involving people and communities in the design, planning and delivery of health services, thereby enabling them to make choices about care and treatment options or to participate in strategic decision-making on how health resources should be spent.

(Source: WHO, UNICEF. Operational Framework for Primary Health Care: transforming vision into action. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/handle/10665/337641).)

Costing: (i) the estimation of a specific strategy or intervention, or of an overall national policy, strategy or plan. (ii) the estimation of the cost of different scenarios, corresponding to different priorities or strategies, in the short, medium or long term.

(Source: WHO health systems strengthening glossary. Geneva: World Health Organization; 2011 (https://cdn.who.int/media/docs/default-source/documents/health-systems-strengthening-glossary.pdf).)

Decentralization: Political reform designed to promote local autonomy, decentralization entails changes in authority and financial responsibility for health services. Hence, decentralization can have a large impact on health service performance. There are several forms of decentralization affecting the health sector in different ways: (i) deconcentration, which transfers authority and responsibility from the central level of the health ministry to its field offices; (ii) delegation, which transfers authority and responsibility from the central level of the health ministry to organizations not directly under its control; (iii) devolution, which transfers authority and responsibility from the central level of the health ministry to lower level autonomous units of government; (iv) privatization, which involves the transfer of ownership and government functions from public to private bodies, which may consist of voluntary organizations and for-profit and not-for-profit private organizations, with varying degree of government regulation.

(Source: WHO health systems strengthening glossary. Geneva: World Health Organization; 2011 (https://cdn.who.int/media/docs/default-source/documents/health-systems-strengthening-glossary.pdf).)

Differentiated service delivery: Differentiated service delivery, previously referred to as differentiated care, is a person-centred approach that simplifies and adapts HIV, viral hepatitis and sexually transmitted infection services across the cascade in ways that both serve the needs of people living with and vulnerable to HIV and optimize the available resources in health systems. The principles of differentiated service delivery can be applied to prevention, testing, treatment and care.

(Source: Updated recommendations on service delivery for the treatment and care of people living with HIV. Geneva: World Health Organization; 2021 (https://apps.who.int/iris/handle/10665/341052).)

Ending epidemics: The goal of Sustainable Development Goal 3.3 is by 2030, end the epidemics of AIDS, TB, malaria and neglected tropical diseases and combat hepatitis, waterborne diseases and other communicable diseases. The targets for the GHSS 2022–2030 are linked to this goal.

Endorsement (of a national policy, strategy or plan): The approval and signing off on the national policy, strategy or plan by relevant authorities (parliament, health ministry or others).

(Source: WHO health systems strengthening glossary. Geneva: World Health Organization; 2011 (https://cdn.who.int/media/docs/default-source/documents/health-systems-strengthening-glossary.pdf).)

Evaluation: A process that systematically and objectively assesses the relevance, effectiveness and impact of activities in the light of their objectives and the resources deployed. Several varieties of evaluation can be distinguished, such as evaluation of structure, process and outcome.

(Source: WHO, UNICEF. Operational Framework for Primary Health Care: transforming vision into action. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/handle/10665/337641).)

Fragmentation (of health services): (a) Coexistence of units, facilities or programmes that are not integrated into the health network; (b) the lack of service coverage of the entire range of promotion, prevention, diagnosis, treatment, rehabilitation and palliative care services; (c) the lack of coordination among services in different platforms of care; or (d) the lack of continuity of services over time.

(Source: WHO, UNICEF. Operational Framework for Primary Health Care: transforming vision into action. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/handle/10665/337641).)

Gender: Gender refers to the socially constructed characteristics of women and men – such as norms, roles and relationships of and between groups of women and men. It varies from society to society and can be changed.

(Source: Gender mainstreaming for health managers: a practical approach. Geneva: World Health Organization; 2011 (https://apps.who.int/iris/handle/10665/44516).).

Harmonization: The coordination of donor contributions and activities, the transparent sharing of information and the attempt to be collectively effective and avoid duplication in alignment with national health policies, strategies and plans.

(Source: WHO, UNICEF. Operational Framework for Primary Health Care: transforming vision into action. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/handle/10665/337641).)

Health equity: The absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically.

(Source: Social determinants of health. Geneva: World Health Organization; 2022 (https://www.who.int/health-topics/social-determinants-of-health#tab=tab_3).)

Health security: Health security has two separate dimensions – individual and collective. Improving individual health security aims at reducing individual vulnerability to health risks through trusted access to safe and effective health services, products, and technologies. Collective health security at the global level involves reducing the vulnerability of societies to health threats that spread across national borders.

(Source: Strategizing national health in the 21st century: a handbook. Geneva: World Health Organization; 2016 (https://apps.who.int/iris/handle/10665/250221, accessed 20 February 2023).)

Health service: Any service (not limited to medical or clinical services) aimed at contributing to improved health or to the diagnosis, treatment and rehabilitation of individuals and populations.

(Source: WHO, UNICEF. Operational Framework for Primary Health Care: transforming vision into action. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/handle/10665/337641).)

Health system: A health system is the aggregate of all public and private organizations, institutions, and resources mandated to improve, maintain or restore health. This includes both personal and population services, as well as activities to influence the policies and actions of other sectors to address the political, social, environmental and economic determinants of health.

(Source: Strategizing national health in the 21st century: a handbook. Geneva: World Health Organization; 2016 (https://apps.who.int/iris/handle/10665/250221, accessed 20 February 2023).)

Health information system: A system used to manage data to inform decisions on the design or management of health services; the system encompasses data collection, compilation, analysis, synthesis and use.

(Source: Consolidated HIV strategic information guidelines: driving impact through programme monitoring and management. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/handle/10665/331697).

Health system strengthening: Health system strengthening is the significant and purposeful efforts to improve the performance of existing health systems.

(Source: Strategizing national health in the 21st century: a handbook. Geneva: World Health Organization; 2016 (https://apps.who.int/iris/handle/10665/250221, accessed 20 February 2023).)

Inputs: Inputs constitute the elements required to produce results, such as money, human resources, equipment, infrastructure and knowledge. (also see results chain)

(Source: Planning guide for the health sector response to HIV/AIDS. Geneva: World Health Organization; 2016 (https://apps.who.int/iris/handle/10665/44747).)

Integrated service delivery: Integrated health services are health services that are managed and delivered in a way that ensures that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services at the different levels and sites of care within the health system and according to their needs throughout the life-course.

(Source: Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach, 2021 update. Geneva: World Health Organization; 2021 (https://apps.who.int/iris/handle/10665/342899).)

Impact: Impact refers to change in health status, such as changes in disease incidence, prevalence, morbidity, mortality and quality of life. Impact is often a result of a complex set of factors and combination of diverse efforts and not attributable to a single intervention or programme. (also see definition of results chain)

(Source: Planning guide for the health sector response to HIV/AIDS. Geneva: World Health Organization; 2016 (https://apps.who.int/iris/handle/10665/44747).)

Indicator: A quantitative or qualitative measure that provides a valid and reliable way to assess performance or reflect changes connected to an activity, project or programme. Indicators should be SMART – that is, specific, measurable, attainable, relevant and time-bound – and be associated with clear sources of data.

(Source: Consolidated HIV strategic information guidelines: driving impact through programme monitoring and management. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/handle/10665/331697).

Intervention: A health intervention is an act performed for, with or on behalf of a person or a population whose purpose is to assess, improve, maintain, promote or modify health, functioning or health conditions. (https://icd.who.int/icdapi/docs/ContentModelGuide.pdf)

Key populations: Key populations are defined groups who, due to specific higher-risk behaviour, are at increased risk of HIV irrespective of the epidemic type or local context. Also, they often have legal and social issues related to their behaviour that increase their vulnerability to HIV. This guidance focuses on five key populations: *(1)* gay men and other men who have sex with men, *(2)* people who inject drugs, *(3)* people in prisons and other closed settings, *(4)* sex workers and *(5)* transgender and gender-diverse people. People in prisons and other closed settings are included in these guidelines also because of the often-high levels of incarceration of the other groups and the increased risk behaviour and lack of HIV, viral hepatitis and sexually transmitted infection services in these settings. The key populations are important to the dynamics of the transmission of HIV, viral hepatitis and sexually transmitted infection. They also are essential partners in an effective response to the epidemic.

(Source: Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. Geneva: World Health Organization; 2014 (https://apps.who.int/iris/handle/10665/128048).)

Model of care: A conceptualization of how services should be delivered, including the processes of care, organization of providers and management of services. The model of care evolves to meet the health aims and priorities of the population and to improve the performance of the health system.

(Source: WHO, UNICEF. Operational Framework for Primary Health Care: transforming vision into action. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/handle/10665/337641).)

Monitoring: Ongoing, routine reporting of priority information about a programme, its inputs and intended outputs, outcomes and impacts in order to track progress.

(Source: Consolidated HIV strategic information guidelines: driving impact through programme monitoring and management. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/handle/10665/331697).

Multisectoral action on health: Policy design, policy implementation and other actions related to health and other sectors (for example, social protection, housing, education, agriculture, finance and industry) carried out collaboratively or alone, that address social, economic and environmental determinants of health and associated commercial factors or improve health and well-being.

(Source: WHO, UNICEF. Operational Framework for Primary Health Care: transforming vision into action. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/handle/10665/337641).)

Operational plan: Operational plans focus on effective management of resources with a short time framework, converting objectives into targets and activities, and arrangements for monitoring implementation and resource usage. Specific meanings include: (i) translation of the national strategic plan within a one-year time frame; (ii) translation of the national strategic plan into a subnational plan, such as a district plan, usually with a shorter time frame than the national strategic plan; (iii) a subset of a national strategic plan, limited to a particular programme.

(Source: WHO health systems strengthening glossary. Geneva: World Health Organization; 2011 (https://cdn.who.int/media/docs/default-source/documents/health-systems-strengthening-glossary.pdf).)

Outputs: Outputs refer to products and services that are delivered by a programme, such as interventions for disease prevention testing, treatment and care. (also see definition of results chain)

(Source: Planning guide for the health sector response to HIV/AIDS. Geneva: World Health Organization; 2016 (https://apps.who.int/iris/handle/10665/44747).)

Outcomes: Outcomes relate to changes in behaviour resulting from utilizing the services, such as increased knowledge, service uptake or adoption of preventive behaviours. (also see definition of results chain)

(Source: Planning guide for the health sector response to HIV/AIDS. Geneva: World Health Organization; 2016 (https://apps.who.int/iris/handle/10665/44747).)

People-centred care: an approach to care that consciously adopts individuals', carers', families' and communities' perspectives as participants in, and beneficiaries of, trusted health systems that are organized around the comprehensive needs of people rather than individual diseases and respects social preferences. People-centred care also requires that patients have the education and support they need to make decisions and participate in their own care and that carers are able to attain maximal function within a supportive working environment. People-centred care is broader than patient and person-centred care, encompassing not only clinical encounters, but also including attention to the health of people in their communities and their crucial role in shaping health policy and health services.

Source: Framework on integrated, people-centred health services: report by the Secretariat. Geneva: World Health Organization; 2016 (https://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_39-en.pdf).

Person-centred monitoring: Monitoring that places the person at the centre of accessing and measuring a sequence of health services. In the context of this document, it refers to a shift from measuring services (for example, the number of HIV tests) to supporting patients, cases and people receiving HIV health services (for example, number of people tested or who know their HIV status).

(Source: Consolidated HIV strategic information guidelines: driving impact through programme monitoring and management. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/handle/10665/331697).

Primary care: A key process in the health system that supports first-contact, accessible, continued, comprehensive and coordinated patient-focused care.

(Source: WHO, UNICEF. Operational Framework for Primary Health Care: transforming vision into action. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/handle/10665/337641).)

Primary health care: Primary health care is a whole-of society approach to health that aims to ensure the highest possible level of health and well-being and their equitable distribution by focusing on people's needs and preferences (as individuals, families and communities) as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment.

(Source: WHO, UNICEF. A vision for primary health care in the 21st century: towards universal health coverage and the Sustainable Development Goals. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/handle/10665/328065).)

Priority setting: The identification, balancing and ranking of priorities by stakeholders.

(Source: WHO health systems strengthening glossary. Geneva: World Health Organization; 2011 (https://cdn.who.int/media/docs/default-source/documents/health-systems-strengthening-glossary.pdf).)

Priority populations: In the context of this guide, priority populations refer to all population groups that are most affected, vulnerable or at higher risk of HIV, viral hepatitis and sexually transmitted infections. Their needs require special consideration in programming, and a focus on these populations is necessary to achieve equity and impact.

Programme management: Real-time direction and decision-making of multifaceted health programme services and resources made on the basis of health information on programme inputs, outputs, outcomes and impact.

(Source: Consolidated HIV strategic information guidelines: driving impact through programme monitoring and management. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/handle/10665/331697).

Quality care: Care that is safe, effective, people-centred, timely, efficient, equitable and integrated.

(Source: WHO, UNICEF. Operational Framework for Primary Health Care: transforming vision into action. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/handle/10665/337641).)

Referral: The direction of an individual to the appropriate facility or specialist in a health system or network of service providers to address the relevant health needs. Counterreferral may occur when an individual is referred back to primary care for follow-up care following a procedure in secondary or tertiary care.

(Source: WHO, UNICEF. Operational Framework for Primary Health Care: transforming vision into action. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/handle/10665/337641).)

Results chain: The results chain describes the relationship between the different levels of results, or the end-state that follows an intervention in a cause-and-effect relationship. Results can be defined as inputs and processes, outputs, outcomes and impact, depending on the level at which change occurs.

(Source: Planning guide for the health sector response to HIV/AIDS. Geneva: World Health Organization; 2016 (https://apps.who.int/iris/handle/10665/44747).)

Rights-based: A rights-based approach to health requires that health policy and programmes prioritize the needs of those furthest behind first towards greater equity, a principle that has been echoed in the 2030 Agenda for Sustainable Development and universal health coverage. The right to health must be enjoyed without discrimination on the grounds of race, age, ethnicity or any other factor. Non-discrimination and equality require states to take steps to redress any discriminatory law, practice or policy. Another feature of rights-based approaches is meaningful participation. Participation means ensuring that national stakeholders – including non-state actors such as nongovernmental organizations – are meaningfully involved in all phases of programming: assessment, analysis, planning, implementation, monitoring and evaluation.

(Source: Human rights and health. Geneva: World Health Organization; 2022 (https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health).)

Service delivery platforms: Modes or channels of health service delivery. Examples include public and private health facilities (for example, health posts, clinics, health centres, mobile clinics, emergency care units, district hospitals and pharmacies), other entities (for example, home-based care, schools, community centres and long-term care facilities) and outreach services, campaigns or digital platforms. These can be classified in a variety of ways. Examples are family-oriented community-led services; population-oriented schedulable services; and individual-oriented clinical services at different levels (primary level, first referral level and second referral level).

(Source: WHO, UNICEF. Operational Framework for Primary Health Care: transforming vision into action. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/handle/10665/337641).)

Sexual health: Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

Source: WHO, UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction. Sexual health and its linkages to reproductive health: an operational approach. Geneva: World Health Organization; 2017 (https://apps.who.int/iris/handle/10665/258738).)

Shared approaches: In the context of this guide, shared approaches refers to coherent and aligned approaches to planning and implementation of HIV, viral hepatitis and sexually transmitted infection responses to address the commonalities across these disease areas, promote linkage and integration where relevant and maximize efficiency and impact. Shared approaches can be considered at different levels, including shared approaches to reaching common priority populations with a range of services, or the functional level as well as shared approaches to service delivery and health system functions. The exact nature of shared approaches depends on what makes sense in a particular country context.

Social determinants of health: The social determinants of health are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live and age and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems. The social determinants of health have an important influence on health inequities – the unfair and avoidable differences in health status seen within and between countries. In countries at all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health. The following list provides examples of the social determinants of health, which can influence health equity in positive and negative ways: income and social protection; education; unemployment and job insecurity; working life conditions; food insecurity; housing, basic amenities and the environment; early childhood development; social inclusion and non-discrimination; structural conflict; and access to affordable health services of decent quality.

(Source: Social determinants of health. Geneva: World Health Organization; 2023 (https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1).)

Strategy: Strategizing means designing plans and policies to achieve a particular goal related to the health of a country.

(Source: Strategizing national health in the 21st century: a handbook. Geneva: World Health Organization; 2016 (https://apps.who.int/iris/handle/10665/250221, accessed 20 February 2023).)

Strategic information: Information that is interpreted and used for planning and decision-making to improve the direction and results of a programme. Relevant data may be derived from a wide variety of sources (for example, monitoring systems, evaluations, programme reviews, surveys, models and case studies) and should be analysed holistically and strategically to improve the programme.

(Source: Consolidated HIV strategic information guidelines: driving impact through programme monitoring and management. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/handle/10665/331697).

Triple elimination: The global community has committed to the triple elimination of mother-to-child transmission, also referred to as vertical transmission, of HIV, syphilis and hepatitis B virus (hepatitis B virus) as a public health priority. The purpose of the elimination goal is to ensure the availability of quality reproductive and maternal and child health services to reduce and control the transmission of HIV, syphilis and hepatitis B virus between mothers and their offspring and to provide the best available treatment to the mother, such that incidence is reduced to a very low level and ceases to be a public health concern. (also see definition for vertical transmission)

(Source: Global guidance on criteria and processes for validation: elimination of mother-to-child transmission of HIV, syphilis and hepatitis B virus. Geneva: World Health Organization; 2021 (https://apps.who.int/iris/handle/10665/349550).)

Universal health coverage: Universal health coverage means that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship. It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the life-course. The delivery of these services requires health and care workers with an optimal skills mix at all levels of the health system, who are equitably distributed, adequately supported with access to quality assured products, and enjoying decent work.

(Source: Universal health coverage. Geneva: World Health Organization; 2022 (https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc).)

Vertical transmission: Women living with HIV and their advocates have promoted use of the phrase vertical transmission as an alternative to mother-to-child transmission in an effort to avoid language that places mothers at the centre of HIV transmission. To reduce stigma felt by women living with HIV, vertical transmission is considered neutral and is consistent with other disease elimination language. There are ongoing consultations about mainstreaming the phrase vertical transmission in HIV programmes, while recognizing previous discussions on the topic and views from a broad network of civil society members and technical partners.

(Source: Global guidance on criteria and processes for validation: elimination of mother-to-child transmission of HIV, syphilis and hepatitis B virus. Geneva: World Health Organization; 2021 (https://apps.who.int/iris/handle/10665/349550).)

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