



Regional action plans for ending AIDS and the epidemics of viral hepatitis and sexually transmitted infections 2022–2030

Regional action plans for ending AIDS and the epidemics of viral hepatitis and sexually transmitted infections 2022–2030



**World Health
Organization**

European Region

Abstract

HIV, viral hepatitis and sexually transmitted infections continue to pose a major public health burden in the WHO European Region, affecting millions of people and causing premature mortality. Despite some progress being made in achieving the targets outlined in the previous *Action plan for the health sector response to HIV in the WHO European Region* and the *Action plan for the health sector response to viral hepatitis in the WHO European Region*, challenges persist, particularly for countries in eastern Europe and central Asia.

The *Regional action plans for ending AIDS and the epidemics of viral hepatitis and sexually transmitted infections 2022–2030* outline the visions, goals and actions required to respond to these epidemics. Building on the progress made and the lessons learned from efforts to implement the previous action plans, the Regional action plans provide a framework to strategically combine disease-specific approaches, with people at the heart of the responses.

The Regional action plans will operationalize the *Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections, 2022–2030* through Region-specific actions and will align the responses with the *European Programme of Work, 2020–2025 – “United Action for Better Health”*. The Regional action plans will contribute to realizing the potential of primary health care by promoting multilevel care and delivery networks and moving the universal health coverage agenda forward by improving access to health services without financial hardship.

The Regional action plans were adopted at the 72nd session of the WHO Regional Committee for Europe, along with Regional Committee resolution EUR/RC72/R4.

Keywords

HIV, AIDS, VIRAL HEPATITIS, SEXUALLY TRANSMITTED INFECTIONS, PREVENTION, CARE, EUROPE

ISBN (PDF): 978-92-890-5895-7

© World Health Organization 2023

Some rights reserved. This work is available under the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 IGO licence (CC BY-NC-SA 3.0 IGO; <https://creativecommons.org/licenses/by-nc-sa/3.0/igo>).

Under the terms of this licence, you may copy, redistribute and adapt the work for non-commercial purposes, provided the work is appropriately cited, as indicated below. In any use of this work, there should be no suggestion that WHO endorses any specific organization, products or services. The use of the WHO logo is not permitted. If you adapt the work, then you must license your work under the same or equivalent Creative Commons licence. If you create a translation of this work, you should add the following disclaimer along with the suggested citation: “This translation was not created by the World Health Organization (WHO). WHO is not responsible for the content or accuracy of this translation. The original English edition shall be the binding and authentic edition: Regional action plans for ending AIDS and the epidemics of viral hepatitis and sexually transmitted infections 2022–2030.”

Any mediation relating to disputes arising under the licence shall be conducted in accordance with the mediation rules of the World Intellectual Property Organization (<http://www.wipo.int/amc/en/mediation/rules/>).

Suggested citation: Regional action plans for ending AIDS and the epidemics of viral hepatitis and sexually transmitted infections 2022–2030. Copenhagen: WHO Regional Office for Europe; 2023. Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at <http://apps.who.int/iris>.

Sales, rights and licensing. To purchase WHO publications, see <http://apps.who.int/bookorders>. To submit requests for commercial use and queries on rights and licensing, see <http://www.who.int/about/licensing>.

Third-party materials. If you wish to reuse material from this work that is attributed to a third party, such as tables, figures or images, it is your responsibility to determine whether permission is needed for that reuse and to obtain permission from the copyright holder. The risk of claims resulting from infringement of any third-party-owned component in the work rests solely with the user.

General disclaimers. The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement. The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by WHO in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters. All reasonable precautions have been taken by WHO to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall WHO be liable for damages arising from its use.

Contents

Preface	iv
Abbreviations	vi
Introduction to the Regional action plans	1
Epidemiology.....	1
Major epidemics with uneven progress	3
Vision and goals.....	5
Targets.....	6
Framing the Regional action plans	7
Rationale and approach.....	7
The Sustainable Development Goals.....	7
Alignment with WHO strategies and plans and the key global strategies of partners.....	7
Principles to be adopted by national health systems and models of service delivery	8
Target audiences for the Regional action plans (by strategic direction).....	9
Strategic Direction 1: A shared response to HIV, VH and STIs within UHC and a health systems approach.....	11
Targets.....	13
Priority actions for countries	14
Priority actions for WHO and partner organizations	18
Strategic Direction 2: Ending AIDS	23
Populations	24
HIV targets.....	24
Priority actions for countries	27
Priority actions for WHO and partner organizations	30
Strategic Direction 3: Ending the epidemics of viral hepatitis	33
Populations	34
Viral hepatitis targets	35
Priority actions for countries	38
Priority actions for WHO and partner organizations	41
Strategic Direction 4: Ending the epidemics of sexually transmitted infections.....	45
Populations	46
STI targets.....	46
Priority actions for countries	51
Priority actions for WHO and partner organizations	54
Partnerships, accountability and progress monitoring	56
Partnerships.....	56
Accountability, monitoring and reporting.....	56
References	58
Annex. Regional action plans for ending AIDS and the epidemics of viral hepatitis and sexually transmitted infections 2022–2030	62

Preface

HIV, viral hepatitis (VH) and sexually transmitted infections (STIs) represent a major public health burden in the WHO European Region. In the Region, as of 2019, an estimated 2.6 million people were living with HIV, approximately 14 million people were infected with the hepatitis B virus (HBV) and 13 million were chronically infected with the hepatitis C virus (HCV). In 2020, there were an estimated 23 million incident cases of four curable STIs: chlamydia, gonorrhoea, syphilis and trichomoniasis. HIV, VH and some STIs continue to cause premature mortality in the Region.

Despite the commitments to end AIDS as a public health threat, new infections are on the rise and AIDS-related deaths increased in 2020 in the European Region. Late HIV diagnosis and insufficient access to antiretroviral treatment remain challenges in achieving the 95–95–95 targets,¹ and these issues are driven by insufficient access to HIV prevention, testing and treatment services for key populations and their sexual partners. The Region continues to see a steady increase in liver cancer mortality and morbidity that is largely caused by VH. Although access to generic pan-genotypic direct-acting antivirals (DAA) has improved, only a fraction of those diagnosed with HCV infection have been treated. To date, the European Region has not had a dedicated action plan focused on STIs and not all countries have national guidelines on the diagnosis and treatment of such infections.

The full range of existing evidence, tools and strategies to address HIV, VH and STIs is not being used by all countries. Moreover, despite the commonality in the key populations and their behavioural risk factors for these diseases, service models are often centralized in their delivery and frequently lack common service delivery platforms. Stronger commitments to systemic changes to advance people-centred service models and the rapid deployment of innovations are needed to bring the Region closer to the goals of ending AIDS and the epidemics of VH and STIs.

The development of the *Regional action plans for ending AIDS and the epidemics of viral hepatitis and sexually transmitted infections 2022–2030* comes at a time of significant disruption and change in the Region. The coronavirus disease (COVID-19) pandemic has also derailed progress and temporarily deprioritized HIV, VH and STIs in the delivery of health care and programming. There are many important lessons that have been learned during the COVID-19 pandemic that will inform future responses to infectious diseases, including the contingencies and the approaches that have catalysed innovations in health and community systems, the need for a strong and well-supported health workforce to maintain service continuity and the vital role of communities in meeting people's needs during crises.

The war in Ukraine triggered an escalating humanitarian crisis that may have a serious impact on progress towards regional targets for HIV. The war has had a devastating impact on people's health and the functioning of the health system. The discontinuation of treatment and care due to disruption to health services and shortages of medical supplies poses a severe risk of increased mortality and morbidity from communicable diseases such as HIV and tuberculosis. This requires both immediate and long-term responses in Ukraine and across the Region. Furthermore, other challenges, such

¹ 95% of people estimated to be living with HIV know their HIV status; 95% of people who know their status are on treatment; and 95% of people on treatment have suppressed viral loads.

as demographic shifts, the growing burden of noncommunicable diseases, climate change, population displacement and economic insecurity, are also shaping the health and development context worldwide and call for strategic and operational shifts in the approach to ending epidemics in a new era.

The Regional action plans outline the vision, goals and actions required to respond to the epidemics of HIV, VH and STIs. Building on the progress made and the lessons learned from efforts to implement the previous action plans, the Regional action plans provide a framework to strategically combine disease-specific approaches, with people at the heart of the responses, contextualized to the Region and reflecting the input from Member States, the community and partners.

The Regional action plans will operationalize the *Global health sector strategies on, respectively, HIV, viral hepatitis, and sexually transmitted infections for the period 2022–2030* through Region-specific actions and will align with the European Programme of Work, 2020–2025 – “United Action for Better Health”. They will also contribute to realizing the potential of primary health care by promoting multilevel care and delivery networks and to moving the universal health coverage agenda forward by improving access to health services without financial hardship.

The WHO Regional Office for Europe developed the Regional action plans through a Region-wide participatory process, drawing on the feedback of a technical expert group. It formally sought feedback from all Member States, relevant United Nations agencies and programmes, nongovernmental organizations, international organizations and, most importantly, civil society organizations and the people in the Region living with the conditions. The Regional Office also held a web consultation on the plans that was open to the public. The Regional action plans were adopted at the 72nd session of the WHO Regional Committee for Europe, along with Regional Committee resolution EUR/RC72/R4.

Abbreviations

AMR	antimicrobial resistance
ANC	antenatal care
ART	antiretroviral therapy
COVID-19	coronavirus disease
DAA	direct-acting antivirals
ECDC	European Centre for Disease Prevention and Control
EEA	European Economic Area
EECA	eastern Europe and central Asia
EMTCT	elimination of mother-to-child transmission
EPW	European Programme of Work 2020–2025
EU	European Union
Euro-GASP	European Gonococcal Antimicrobial Surveillance Programme
GAM	Global AIDS Monitoring
GHSS	global health sector strategies
HBsAg	hepatitis B surface antigen
HBV	hepatitis B virus
HCV	hepatitis C virus
HDV	hepatitis D virus
HPV	human papillomavirus
MDR-TB	multidrug-resistant tuberculosis
OST	opioid-substitution therapy
PHC	primary health care
POCT	point-of-care testing
PrEP	pre-exposure prophylaxis
SDG	Sustainable Development Goal
STI	sexually transmitted infection
TB	tuberculosis
TRIPS	Agreement on Trade-Related Aspects of Intellectual Property Rights
UHC	universal health coverage
UNAIDS	Joint United Nations Programme on HIV/AIDS
VH	viral hepatitis

Introduction to the Regional action plans

Epidemiology

In the WHO European Region, the case numbers for HIV, viral hepatitis (VH) and sexually transmitted infections (STIs) are high (see Table 1). These conditions represent a significant burden of disease if they remain untreated and are not managed early and effectively. The European Region has the second highest number of new HIV infections globally, with the African Region having the highest number, and is second only to the Eastern Mediterranean Region for new hepatitis C virus (HCV) infections. These estimated infection numbers have been increasing over time for HIV, HCV, gonorrhoea and syphilis (1). Globally, HIV, VH and STIs are increasingly becoming regionalized epidemics that are concentrated in key and vulnerable populations, a pattern that is being replicated in the European Region (see Box 1).

Table 1. Incident cases of HIV, hepatitis B and C and selected STIs in the WHO European Region, 2019

HIV	190 000
Hepatitis B	19 000
Hepatitis C	300 000
Gonorrhoea	3 800 000
Syphilis	240 000

Source: WHO (1).

Nonetheless, since 2015 (the publication year of both the *Action plan for the health sector response to HIV in the WHO European Region* (2) and the *Action plan for the health sector response to viral hepatitis in the WHO European Region* (3)) progress has been made in the Region. This progress includes a steady increase in treatment coverage for both HIV and HCV. Vaccination activity has been significant, with high coverage rates achieved with the three-dose hepatitis B vaccine. In addition, there has been a sustained effort at achieving or maintaining the elimination of mother-to-child transmission (EMTCT) for syphilis, and two countries have successfully validated their elimination activities in this area.

Between 2010 and 2019, there was a 49% increase in new HIV diagnoses, and issues with high proportions of late diagnosis and undiagnosed HIV persist. In the European Region, 13 million people are estimated to be chronically infected with HCV and many of them are not aware of their infection (1). Each year, 64 000 people die due to hepatitis C-related liver disease. Many of these infections are insidious and individuals can be asymptomatic for many years, despite the clinical course progressing (4). Access to, and early initiation of, HIV and HCV treatment has remained problematic, particularly in the eastern part of the Region (5). Access to HIV and VH testing services, and treatment that is free from discrimination and is also affordable or cost-free for individuals, is not universal. Access to timely treatment for HIV/tuberculosis (TB) coinfection (including with multidrug-resistant TB (MDR-TB)) has also been challenging (6), leading to preventable deaths. There has been low coverage for preventive services and limited access to combination prevention services across all these diseases, including provision of condoms, detection and treatment of STIs, needle and syringe programmes, opioid-substitution therapy (OST) for people who inject drugs, and HIV pre-exposure prophylaxis (PrEP).² These issues are particularly pronounced in eastern European and central Asian countries.

² Such activities should be deployed consistent with the domestic context and legislation.

Box 1. Priority populations for HIV, VH and STIs

Many of the populations most affected by, and at risk of, HIV, VH and STIs overlap across these disease areas. Furthermore, many of these populations experience vulnerabilities, or are at risk, as a result of the social and structural determinants of health, including multiple forms of discrimination and the conditions of marginalization or exclusion in which they live. Shared priority populations across national HIV, VH and STI responses may include:

- people exposed through sexual transmission, including young people and adolescents; men who have sex with men; sex workers and their clients; transgender people; people in prisons and other closed settings; and people whose sexual behaviour is mediated by drug or alcohol use;
- people exposed through unsafe blood supplies and/or unsafe medical injections and procedures;
- people who inject and use drugs;
- children exposed through vertical (mother-to-child) transmission or early childhood infection;
- pregnant and breastfeeding women;
- women and girls, including adolescent girls and young women, who face risks associated with gender inequalities and exposure to violence, in conjunction with increased biological risks on the basis of sex;
- people of all ages, including men, who are less likely to use health services; migrants, mobile populations, and people affected by conflict and civil unrest; indigenous peoples;
- people with disabilities.³

Most notably, these epidemics disproportionately affect key populations and individuals who are most at risk of transmission. For HIV, 99% of the new HIV infections in most eastern European and central Asian countries, and 96% of those in western and central European countries, are found in key populations (7). The hepatitis C epidemic is likewise concentrated in individuals most at risk and key populations, including people who inject drugs and those living in closed settings, such as prisons. A substantial increase in the numbers of new syphilis cases has been observed recently among men who have sex with men (7). Lack of access to the necessary preventive, testing and treatment services is a chronic issue, which is exacerbated by various inhibitory country-level political, social and legal environments. Looking towards the future, it is clear that progress towards disease elimination cannot be achieved without a clear and sustained focus on prevention and care, especially in key populations and those most at risk, and a reorientation towards enabling environments in many countries.

³ These definitions are drawn from the *Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022–2030* (8).

Major epidemics with uneven progress

It has been over four decades since the first cases of HIV were identified in Europe and central Asia. The history of our understanding of STIs extends further, from when there was growing awareness of a sexually transmitted pathogen, later known as syphilis, in previous centuries (7). Despite the long histories of these diseases, and the significant public health efforts to end them, they persist as significant public health threats that warrant coordinated action.

To place people at the heart of the responses and to ensure full access to services, health systems must adapt. In acknowledgement of the similarities and differences between these diseases, it is necessary to strategically combine disease-specific approaches with health system responses. By delivering decentralized health care and people-centred primary health care (PHC) networks, the physical and mental health, and the social well-being, of key affected populations will be more thoroughly supported.

The lessons learned in the implementation of the previous action plans have shown that effective disease responses are predicated on political commitment, systemic change and a need to invest in and deploy innovations. However, it has become apparent that not all countries are employing the full range of existing evidence, tools and strategies. Additionally, there are challenges with the organization of health systems, as many of the individual disease programmes for HIV, VH and STIs are centralized in their delivery and lack common service delivery platforms, despite the commonality in their key populations and their behaviours for each of the disease types. Strategic shifts are needed to bring the Region closer to the goals of ending AIDS, and the epidemics of VH and STIs.

Despite the commitment to end AIDS as a public health threat (9), the Member States of the Region – particularly in the eastern part – face persisting challenges in achieving the targets outlined in the *Action plan for the health sector response to HIV in the WHO European Region* (2). New infections are on the rise⁴ and AIDS-related deaths increased in 2020, as described in the final report of the previous HIV action plan (10). Despite the progress that has been made since 2015,⁵ the Region did not meet its 90-90-90 targets.⁶ Late HIV diagnosis remains a challenge in most countries, and delayed access to timely treatment of HIV/TB coinfection contributes to excess mortality (6). Success will require sustained commitments and flexible approaches to addressing a changing epidemic, with reinvigorated primary prevention efforts and differentiated service delivery to meet the diverse needs of specific populations and settings, and these services need to be resilient and adaptive to future threats.

Recent scientific advances in HIV treatment and technologies, and innovative service delivery methods, provide an unprecedented opportunity to end AIDS as a public health threat.

⁴ The previous action plan had the target to reduce new infections by 75%. The estimated number of new infections was 160 000 in 2016 and 170 000 in 2020.

⁵ By 2020, 77% of the people living with HIV in the Region were aware of their status, 83% of those diagnosed had initiated treatment, and 94% of those on treatment had achieved viral load suppression (compared with 69-69-91 in 2015). However, there is a pronounced geographical variation: the eastern part of the Region lagged behind considerably, with respective rates of 70%, 75% and 94%.

⁶ The Joint United Nations Programme on HIV/AIDS (UNAIDS) 90-90-90 targets are as follows: by 2020, 90% of all people living with HIV will know their HIV status; by 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy (ART); and by 2020, 90% of all people receiving ART will have viral suppression.

The Region has partially achieved the coverage targets for VH, which are given in the final report of the previous action plan (5). Over the time period covered by the previous action plan, there has been a genuine increase in the focus on hepatitis in many countries in the Region: in 2020, 33 countries had a national hepatitis plan and another 13 were in the process of developing one. However, the Region continues to see a steady increase in liver cancer mortality and morbidity that is largely due to VH. Despite improved access to generic pan-genotypic direct-acting antivirals (DAA) and a reduction in their cost, only a fraction of those diagnosed with hepatitis C have been treated. The availability of strategic information for hepatitis continues to be a challenge in the Region. Ending hepatitis will require a massive expansion in the availability of prevention, diagnostic and treatment services; integration of VH services into universal health care (UHC) packages; simplification and decentralization of service delivery; review and reform of legislation and policies that create barriers to appropriate evidence-based interventions and services; and improvement of coordination with other health services, such as those addressing cancer and maternal and child health – supported by greater public and political awareness and adequate funding.

In the WHO European Region, in 2020, there were an estimated 23 million incident cases of four curable STIs: chlamydia, gonorrhoea, syphilis and trichomoniasis (1). To date, the Region has not had a dedicated regional action plan focused on STIs, and not all countries have national guidelines on the diagnosis and treatment of STIs. There are large variations in investment, maturity and performance of STI surveillance systems between countries in the Region. The Region needs to intensify STI prevention, testing and treatment services, particularly among young people, people living with HIV and key populations in the context of expanded PrEP use for HIV prevention.

The development of the Regional action plans comes at a time of significant disruption and change in the Region. The coronavirus disease (COVID-19) pandemic has derailed progress and temporarily de-prioritized HIV, VH and STIs in public health programmes. However, the pandemic also showed that health systems can quickly adapt and accelerate uptake of innovations, including by embracing the benefits of the digital health revolution, decentralizing testing capacity and task shifting to service providers at lower levels of care. It is now urgent to accelerate the pace and scale of prevention, and increase the availability and accessibility of testing and treatment services in a new reality, building upon the contingencies and the approaches that emerged during the COVID-19 pandemic for people living with HIV, VH and STIs, and the key populations at risk of acquisition of these diseases.

The war in Ukraine triggered an escalating humanitarian crisis that may have a serious impact on progress towards regional targets for HIV. The war has had a devastating impact on people's health and the functioning of Ukraine's health system. The discontinuation of treatment and care due to disruption to health services and shortages of medical supplies poses a severe risk of increased mortality and morbidity from communicable diseases such as HIV and TB. Addressing immediate health challenges in Ukraine and ensuring continuity of HIV treatment and full service for refugees in Europe are short-term priorities. However, long-term efforts will also be needed to support the recovery in Ukraine and beyond, and the forecasted economic impact across the Region may affect the budgetary ability to fund the ambitious commitments needed to scale up the response to HIV, VH and STIs in many countries. Renewed political and financial commitments will be required to get back on track after the anticipated loss in progress towards ending AIDS and the epidemics of VH and STIs.

The European Region must pivot towards developing strategies that support the accessible, respectful, needs-driven range of services that are needed to combat the epidemics of HIV, VH and STIs, nested in strong and resilient health systems. The Regional action plans prioritize this reorientation and include the development of new goals for 2030 to drive the Region towards ending AIDS, VH and STIs as public health threats, with interim 2025 targets set to ensure the required momentum.

Vision and goals

The vision and goals of the Regional action plans are aligned with the global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022–2030 (GHSS)(8).

Table 2. Strategic directions, vision and goals for the Regional action plans

SD1: a shared response to HIV, VH and STIs within UHC and a health systems approach			
A common vision: to end AIDS and the epidemics of VH and STIs and to advance UHC, primary care and health security			
	SD2: ending AIDS	SD3: ending the epidemic of VH	SD4: ending the epidemics of STIs
Vision	Zero new HIV infections, zero HIV-related deaths and zero HIV-related discrimination in a world where people living with HIV are able to live long and healthy lives	A world where VH transmission is halted and everyone living with VH has access to safe, affordable and effective prevention, care and treatment services	Zero new infections, zero STI-related complications and deaths, and zero discrimination in a world where everyone has free and easy access to prevention and treatment services for STIs, thereby allowing people to live long and happy lives
Goal	End the AIDS epidemic as a public health threat	End VH as a major public health threat	End STI epidemics as major public health concerns

SD = strategic direction

Targets

The Regional action plans include overall targets and disease-specific targets. As soon as is practicable, countries should develop or update national plans with targets and goals, ideally informed by those in the GHSS (8) and the Regional action plans.

Countries are encouraged to select, set priorities for and adapt the proposed country actions in relation to local epidemiological and health system contexts, while upholding fundamental human rights, equitable access to health, and evidence-based practice.

While the effectiveness of the Regional action plans may be assessed as a whole in aggregate data, monitoring and evaluation must investigate impacts on each key population. Without an examination of progress among all key populations, the targets will not be achieved.

Framing the Regional action plans

Rationale and approach

The Regional action plans cover the health sector responses for a period of eight years; they are contextualized to the WHO European Region and reflect input from the Region's countries, key populations, communities and partner organizations.

For the first time, three individual regional action plans for ending AIDS and the epidemics of VH and STIs have been integrated into a single document. In addition, this is the first WHO regional action plan for STIs. The core of this document is the description of one health-system-focused strategic direction followed by three disease-specific strategic directions.

The Regional action plans serve as the implementation plans for the GHSS (8). The WHO Regional Office for Europe has developed the Regional action plans through a Region-wide participatory process, additionally drawing on the expertise of a technical expert group. The Regional Office formally sought feedback from all Member States, the relevant United Nations agencies and programmes, nongovernmental organizations, international organizations and, vitally, civil society organizations and people in the Region living with the conditions. The Regional Office also held a web consultation on the Regional action plans that was open to the public. The plans were finalized following guidance from the Twenty-ninth Standing Committee of the Regional Committee for Europe and were endorsed at the 72nd session of the WHO Regional Committee for Europe in September 2022, along with Regional Committee resolution EUR/RC72/R4.

The Sustainable Development Goals

The Regional action plans align with the 2030 Sustainable Development Goals (SDGs) (11). Various specific targets will guide the strategic directions of the Regional action plans in line with SDG 3: "Ensure healthy lives and promote well-being for all at all ages". The Regional action plans also contribute to other SDGs, such as those related to eradicating poverty, achieving gender equality, promoting inclusive societies, mobilizing resources and strengthening the implementation of the global development agenda.

Alignment with WHO strategies and plans and the key global strategies of partners

The Regional action plans are aligned with relevant WHO and partner agency HIV, VH and STI plans and strategies, and with WHO's Thirteenth General Programme of Work Triple Billion targets (12) and the European Programme of Work (EPW), 2020–2025 (13) and its three core priorities: 1) moving towards universal health coverage; 2) protecting against health emergencies; and 3) promoting health and well-being. The Regional action plans capitalize on the four flagship initiatives of the EPW: the Mental Health Coalition, Empowerment through Digital Health, the European Immunization

Agenda 2030, and Healthier behaviours: incorporating behavioural and cultural insights, as well as the United Action Against Cancer movement (14).

The Regional action plans have also been aligned with other regional plans and initiatives, including:

- Realizing the potential of primary care: lessons learned from the COVID-19 pandemic and implications for future directions in the WHO European Region (15);
- Tuberculosis action plan for the WHO European Region 2023–2030 (16);
- Action plan for the prevention and control of noncommunicable diseases in the WHO European Region 2016–2025 (17);
- European strategic action plan for antimicrobial resistance, 2011–2020 (18);
- WHO European framework for action on mental health 2021–2025 (19);
- European framework for action on integrated health services delivery (20);
- Action plan for sexual and reproductive health: towards achieving the 2030 Agenda for Sustainable Development in Europe – leaving no one behind (21);
- European Immunization Agenda 2030 (22);
- Roadmap to accelerate the elimination of cervical cancer as a public health problem in the WHO European Region, 2022–2030 (23);
- Europe’s Beating Cancer Plan (24);
- Regional digital health action plan for the WHO European Region 2023–2030 (25);
- European regional action framework for behavioural and cultural insights 2022–2027 (26).

The Regional action plans are also aligned with related commitments expressed in other global health strategies and plans, including the 2021 United Nations General Assembly *Political declaration on HIV and AIDS: ending inequalities and getting on track to end AIDS by 2030* (27), and build on the *Global AIDS Strategy 2021–2026* (28) and the priorities of the Global Fund to Fight AIDS, Tuberculosis and Malaria, UNAIDS and key bilateral partners.

In addition to these strategies, other key European strategies and plans have been taken into consideration in producing the Regional action plans. These include the *European Union Drugs Strategy 2021–2025* (29) and the *European Monitoring Centre for Drugs and Drug Addiction Strategy, 2025* (30).

Principles to be adopted by national health systems and models of service delivery

UHC is foundational to achieving all the SDGs, and will be essential in the achievement of the HIV, VH and STI goals as it ensures that all people have access to timely promotive, preventive, curative, rehabilitative and palliative health services, and essential, safe, affordable, effective and quality medicines and vaccines, while ensuring that the use of these services does not expose the users to financial hardship (31). In particular, the provision of UHC should have a special focus on key populations and those most at risk of HIV, VH and STIs.

PHC is the foundation on which UHC is built. Consistent with the 2018 Astana Declaration (on primary health care) (32), the Regional action plans contend that strengthening the role of PHC is critical to developing inclusive, effective and efficient HIV, VH and STI services. Thus, PHC also forms a crucial element of achieving UHC and the health-related SDGs.

People-centred health care explicitly adopts the perspectives of individuals, carers, families and communities as participants in, and beneficiaries of, trusted health systems that are organized around people's needs. People-centred care includes the provision of the full range of services including prevention, testing, linkage to care, treatment, chronic care and, where necessary, palliative care for all conditions. In this way, people-centred health services are an essential feature of PHC and expanded UHC.

Target audiences for the Regional action plans (by strategic direction)

The Regional action plans have been developed with two target audiences in mind, as listed below. It is important that both target audiences appreciate and respond to all the strategic directions to promote cross-collaboration and integrated programme design and delivery.

Strategic Direction 1 focuses on a shared response to HIV, VH and STIs within UHC and a health systems approach. This strategic direction, and the actions contained within it, is aimed at country-level decision-making bodies, including ministries of health, ministries of finance and other government policy-making entities. It relates to the strategic development of a health system that is supportive of universal access, PHC-based services, the minimization of out-of-pocket expenses, and discrimination-free, accessible HIV, VH and STI services.

Strategic directions 2 (HIV), 3 (VH) and 4 (STIs) are disease specific. These strategic directions, and the actions contained within them, are targeted towards country-level programme managers working on the portfolios of these diseases.

Strategic Direction 1



To promote integrated, person-centred care, it is essential that policy-makers appreciate, monitor and work towards the disease-specific strategic directions 2–4, as well as Strategic Direction 1

A shared response to HIV, VH and STIs within UHC and a health systems approach

HIV, VH and STIs share common modes of transmission and determinants, and many of the populations affected by these diseases overlap. Despite this, services for the full continuum of care for these conditions are often offered at different locations, making it more complicated for people to access the comprehensive services they need and impeding retention in care. The health and care workforce are not always trained or supported to meet these populations' needs (see Box 1 on priority populations).

Different populations have unique health needs and circumstances and require tailored responses that recognize and respond to the lived experiences of the people of these groups. The burden and distribution of HIV, VH and STIs vary across countries, and responses need to be adapted to local epidemiological and health system contexts, while upholding fundamental human rights, equitable access to health, and evidence-based practice.

The reorientation of health services towards integrated people-centred approaches via simplified and differentiated service delivery can be achieved in a variety of ways, depending on the country context and the epidemiological burden. A shift towards individuals, families, carers and communities that is coordinated both within and beyond the health sector is likely required. This change also incorporates a human rights approach, enshrining access to health care as a basic right, for everyone and for all communities. However, this right should not be compromised by discrimination based on age, gender, sex, sexual orientation and other population characteristics (8).

As governments move towards UHC, it is important that national governance structures for HIV, VH and STIs align with broader governance structures. These structures should include a range of actors, including researchers, health and workforce personnel and civil society actors, to ensure that strategies, policies and services are accessible to those who need them and are aligned with established and emerging evidence.

As the sophistication of the responses to HIV, VH and STIs have grown in the Region, numerous challenges relating to disease-specific responses have emerged in relation to their operation within broader health systems. The health systems of eastern European countries have undergone significant reforms to strengthen their PHC sectors; however, HIV, VH and STI services are not typically delivered in PHC settings in some countries.

The decentralization of health service delivery to primary and community health-care settings is an important strategic option for expanding access to services for HIV, VH and STIs, particularly in resource-limited settings and for marginalized populations.⁷ Together with the integration and simplification of service delivery, decentralization provides opportunities to deliver comprehensive services to people with non-complex needs at the PHC-level instead of at tertiary or specialized facilities. Decentralization

⁷ According to the World Health Report (2000) (33), decentralization has the main objective of improving responsiveness and incentive structures by transferring ownership, responsibility and accountability to lower levels of the public sector.

can optimize the use of health system resources; improve service acceptability, uptake and quality; optimize the scope of the health and care workforce to meet the demand for services and, subsequently, improve workforce retention; strengthen community engagement; and promote equity. This must be centred around the needs of people affected by HIV, VH and STIs, including key populations and those most at risk of infection, in a manner appropriate to the country's epidemiological context, health system architecture, legislation and jurisdictional responsibilities.

With a shift to more decentralized models of care, HIV, VH and STI services require an increasingly diverse cadre of human resources from multiple sectors. Countries in the Region should plan for this shift and, critically, include roles for well-trained personnel and well-resourced community-based services to ensure that people are retained in care and receive services in an equitable manner. Placing the person at the centre of the model of care also requires a wider range of services to be deployed by a broader range of health and non-health professionals, including psychologists, social workers, peers and community workers. Efforts to ensure training and ongoing capacity development for health and non-health professionals will be needed to ensure appropriate and sustainable decentralized care delivery that is accessible to key populations.

The large expansion in services that is required to reach the 2030 HIV, VH and STI targets will not be achieved without addressing the inequalities that drive epidemics and prevent people from accessing health services and being active in improving their own health. Promoting equity and gender equality – and respecting, protecting and fulfilling the human rights and dignity of all – are critical enabling factors for success at the country level and are central to WHO's work in progressively incorporating and monitoring gender, equity and human rights across the Organization as part of its mission to serve the vulnerable and leave no one behind.

People living with HIV, and key populations who are most affected by HIV, continue to face stigma, discrimination and criminalization that exacerbate their risks and infringe on their rights to access the services they need. In many settings, people living with VH also face social exclusion, barriers to health care or workplace-related discrimination; and STIs continue to carry shame and remain hidden.

The health sector has a critical role to play in addressing stigma, discrimination and policy barriers within health-care settings, including by generating data and providing behavioural and cultural insights on how stigma and discrimination impact the populations most affected by HIV, VH and STIs. The health sector also plays an important convening role for multisectoral partnerships to address the broader determinants of health. The health sector must raise awareness about the importance of addressing these epidemics and overcoming taboos and discriminatory or stigmatizing behaviour, consistent with WHO's commitment to eliminating discrimination in health-care settings. The effective engagement and empowerment of individuals and communities, including those representing key populations and other beneficiaries, plays a key role in reducing these barriers.

Efficient and integrated financing and remuneration models are foundational to developing health services that support the 2030 HIV, VH and STI targets. Attention is required to reduce the fragmentation in funding through a re-alignment of resources to match strategic imperatives, and pooled, whole-of-health budgets that adequately cover services – along with task shifting, supporting the complete continua of care and minimizing out-of-pocket costs for people affected by these diseases.

Central to the uptake of new technologies, such as tests and treatment regimens, is the capacity of governments to ensure access to them and their affordability. Future efforts should improve access to affordable HIV, VH and STI medicines and diagnostics, through innovative drug-pricing mechanisms, access to international procurement platforms, faster registration, adequate regulatory capacity and quality, and the use of the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) regarding flexibilities to protect public health.

The lessons learned from the COVID-19 pandemic and health and humanitarian emergencies in the Region demonstrate that additional efforts are required to protect the gains achieved in the responses to HIV, VH and STIs. To get back on track to achieving the relevant targets, it is necessary to increase funding in the short term to support the recovery of the disease responses, which is a challenge in a regional landscape with numerous competing demands.

Targets⁸

The proposed targets are based on indicators monitored through the existing data collection tools. The translation of these targets to national settings should consider local epidemiological and health system contexts, while upholding fundamental human rights, equitable access to health and evidence-based practice.⁹ Table 3 presents the indicators and targets for Strategic Direction 1 for the 2025 interim period, and for 2030 at the cessation of the Regional action plans.

Table 3. Indicators and the 2025 and 2030 targets for Strategic Direction 1

Domain	Indicators ^a	Interim 2025 target	2030 target
Integration and differentiated service delivery of disease-specific approaches	Percentage of countries with coinfection policies in place for HIV, TB and hepatitis ^b	75%	95%
	Percentage of countries that have established mechanisms that include a role for meaningful community input into governance, planning and service implementation of health services ^c	75%	95%
	Percentage of countries that have national policies in place to promote service integration between HIV, VH and STIs and other significant comorbidities ^d	75%	95%

^a Additional details on the measurement framework, data definitions and data sources can be found in Annex 2 of the GHSS (8).

^b This indicator reflects service delivery for coinfections within countries' HIV, TB and VH services. It is measured through the Global AIDS Monitoring (GAM) National Commitments and Policy Instrument (NCPI) coinfection policies questions.

^c This indicator reflects the adoption of community leadership as measured through the GAM NCPI.

^d This indicator reflects the adoption of policies to promote service integration by countries. It is measured through the GAM NCPI.

⁸ Additional details on the measurement framework, data definitions and data sources can be found in Annex 2 of the GHSS (8).

⁹ "Each country should define the specific populations that are central to their epidemic and response, based on the local epidemiological context... noting that global epidemiological evidence demonstrates that key populations are more likely to be exposed to HIV or to transmit it." United Nations General Assembly Resolution 75/284. Political declaration on HIV and AIDS: Ending inequalities and getting on track to end AIDS by 2030 (34).

Priority actions for countries

Table 4 sets out the priority actions for countries for Strategic Direction 1. These priority actions are to be deployed by countries in a manner that is consistent with their epidemiological, social and legislative context.

Table 4. Priority actions for countries for Strategic Direction 1

Priority	Country priority actions
1.1. Ensure people are at the centre of a unified, partnership-based approach to service delivery with PHC, civil society, communities and public health agencies or institutions	<ul style="list-style-type: none"> ● Deliver HIV, VH and STI services using differentiated service delivery through a range of different providers including ● PHC clinicians, specialist service providers and civil society. Develop mechanisms to maximize the accessibility and efficiency of service delivery models. Ensure these services are adjusted to the country context, based on simplified patient pathways, and integrated where it makes sense. ● Decentralize and integrate services for HIV, VH and STIs into PHC settings where appropriate. This should include a careful consideration of the role of PHC in HIV, VH and STIs service provision tailored to national epidemiological contexts and the socioeconomic profile of the populations served. ● Provide and scale up a comprehensive package of combination prevention interventions tailored to the needs of all HIV, VH and STI-focused key populations (35–39).
1.2. Increase financial protection and reduce financial barriers to access	<ul style="list-style-type: none"> ● Plan and provide adequate financing of HIV, VH and STI services at all levels and implement payment mechanisms for multidisciplinary services, avoiding fragmented funding, especially in the delivery of services for key populations. ● Define, cost and fund the essential package of clinical and non-clinical services under UHC along the care continuum of HIV, VH and STI services.

Table 4. contd.

Priority	Country priority actions
1.3. Ensure that the health and community workforce provides quality care across the continuum of care	<ul style="list-style-type: none"> • Ensure the supply and maintenance of the required workforce through an understanding of: the available workforce (by number, full-time equivalent, demographics, skills); the skills required; the medium to long-term demand for the workforce; and the retention of the existing workforce. • Provide adequate regulation, remuneration, capacity-building and support for community-based members of the health workforce. • Provide continuing professional development to the health-care workforce on HIV, VH and STIs consistent with up-to-date clinical practice guidelines (including digitally enabled learning opportunities), and enhance supportive supervision systems.
1.4. Ensure reliable and affordable access to health technologies and novel products	<ul style="list-style-type: none"> • Accelerate uptake of new technologies, novel medicines and diagnostics, including capitalizing on the WHO prequalification scheme. • Pursue comprehensive strategies to reduce prices of HIV, VH and STI commodities – including through, where appropriate, the use of the provisions in the TRIPS flexibilities to protect public health and, where appropriate, voluntary licenses and generic competition. • Expand the use of telemedicine and video-based consultations in health care to improve the accessibility of care, and expand access to medicines using e-prescribing technologies.
1.5. Ensure accessible, decentralized diagnostic and laboratory services	<ul style="list-style-type: none"> • Develop strategic laboratory plans across disease programmes to clarify the role of reference laboratories, while decentralizing and integrating testing and optimizing the use of the available molecular diagnostic platforms including point-of-care testing (POCT) and rapid testing for HIV, TB, VH, STIs and other communicable diseases. • Ensure quality standards for decentralized testing strategies and appropriate professional competencies. • Implement laboratory information management systems that are linked to patient data systems to deliver timely results.

Table 4. contd.

Priority	Country priority actions
1.6. Ensure strategic information governance and health management information systems engineered for informed decision-making	<ul style="list-style-type: none"> ● Establish and use information systems to provide regular and timely surveillance data on HIV, VH and STIs, which are able to produce cascades of care, with incorporated data validation and quality assurance processes. The data should represent the whole population, though data also needs to be disaggregated by key population, sex and age. ● Align information systems related to specific diseases with broader health information systems and support the transition to digital information systems, with the appropriate attention given to data governance, security and interoperability. ● Include civil society in the monitoring and evaluation of HIV, VH and STI services to ensure they are responsive to the needs of key populations.
1.7. Ensure engaged and empowered communities and partners	<ul style="list-style-type: none"> ● Include or strengthen the role of civil society and community-based organizations as service providers to access populations that are not reached by the existing health services, through sustainable contracting and resourcing, capacity development, training and recognition, and integration into governance at all levels of the health system's operations. ● Provide domestic funding and support for sustainable community-led delivery and approaches to HIV, VH and STIs across the continuum of care for prevention, testing, treatment, linkage and retention in care, and to promote access and provide social support. ● 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 the most affected and at-risk populations, and create institutional and community environments, including in health-care settings, that make it safe for people to access services.

Table 4. contd.

Priority	Country priority actions
1.7. Ensure engaged and empowered communities and partners	<ul style="list-style-type: none"> ● Address stigma and discrimination in health services for those living with HIV, VH and STIs, as well as for key populations through the provision of the core stigma and discrimination interventions (stigma and discrimination reduction; gender equality and gender-sensitive programming; provision of legal services; monitoring and reporting laws, regulations and policies; legal literacy; sensitization of law makers and enforcers; capacity-building; and reducing gender-based discrimination and violence).
1.8. Ensure strong and inclusive governance and leadership	<ul style="list-style-type: none"> ● Ensure commitment to fair and equitable access to services for HIV, VH and STIs through legislative and financial support for national responses. ● Develop a forward-looking governance model of HIV, VH and STI responses that is relevant to the country context, resources and overall health system development strategy. ● Develop and implement clear plans for the transition and sustainability of services during the reform from disease-specific vertically specialized services to decentralized PHC systems. ● Integrate community-based monitoring mechanisms managed by consumers and local communities into national accountability mechanisms. ● Create inclusive and accessible health settings and social environments (in a manner that is appropriate to the country's situation and local context).
1.9. Ensure futureproofing for health emergencies and other epidemics	<ul style="list-style-type: none"> ● Informed by the learnings from the impact of COVID-19 on services, establish strategic approaches, policies and surge capacities to maintain focus on HIV, VH and STI goals and ensure the continuity of essential health services in the context of pandemics and during public health emergencies, and ensure rapid recovery following acute or prolonged emergencies. ● Establish programmes for antimicrobial stewardship to address, in particular, the inappropriate use of antibiotics, and establish or enhance disease surveillance systems to monitor HIV, VH and STI-related antimicrobial resistance (AMR), including working towards participation in the Central Asian and European Surveillance of Antimicrobial Resistance network (CAESAR).

Priority actions for WHO and partner organizations

Table 5 sets out the priority actions for WHO and partner agencies for Strategic Direction 1.

Table 5. Priority actions for WHO and partner agencies for Strategic Direction 1

Priority	WHO/partner priority actions
1.1. Ensure people are at the centre of a unified, partnership-based approach to service delivery with PHC, civil society, communities and public health agencies or institutions	<ul style="list-style-type: none"> ● Provide regional, and where requested, national advocacy and support to countries to adapt their HIV, VH and STI service planning approaches to context-specific service delivery models that aim to meet the needs of key populations in preventive and diagnostic services. This advice will take into account service mapping, factors to consider when deploying optimal service delivery platforms, various options for decentralization, differentiated care and service integration, and the critical roles of community and primary health care. ● Document and share best practices from countries on service delivery models aimed at better integrating communicable and noncommunicable disease services, sexual and reproductive health services, harm-reduction and treatment services for those who use drugs, and mental health services. ● Across partners, ensure support for integrated, decentralized delivery models for HIV, VH and STI services, drawing on evidence-based models with proven efficacy. ● Implement 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 (40,41), and for people who use stimulant drugs (42), in line with the domestic context, legislation and jurisdictional responsibilities.
1.2. Increase financial protection and reduce financial barriers to access	<ul style="list-style-type: none"> ● Provide support to countries to define, cost and include HIV, VH and STI service elements into service packages at the appropriate levels of care, and advise on optimal provider payment mechanisms. ● Leverage existing regional platforms to define common approaches to provider payment mechanism for HIV, VH and STI services as part of UHC.

Table 5. contd.

Priority	WHO/partner priority actions
1.3. Ensure that the health and community workforce provides quality care across the continuum of care	<ul style="list-style-type: none"> Support Member States to build the capacity of their health workforces to provide people-centred HIV, VH and STI services, ensuring thorough training programmes and e-learning opportunities, to ensure continuing medical education and appropriate oversight. Facilitate consensus building on ways to integrate the civil society workforce into government professional frameworks, and enable key population engagement and participation in all aspects of the workforce, including decision-making roles.
1.4. Ensure reliable and affordable access to health technologies and novel products	<ul style="list-style-type: none"> As part of HIV, VH or STI programme reviews, offer advice to countries on the procurement of affordable medicines and diagnostics, and on procurement mechanisms, including international or pooled procurement mechanisms; the WHO prequalification process; innovative drug-pricing mechanisms; accelerated registration; and the use of the provisions in the TRIPS flexibilities to protect public health. Capitalize on the new information technologies that provide opportunities to deliver effective prevention interventions and follow-up, such as eHealth, web- and app-based technologies.
1.5. Ensure accessible, decentralized diagnostic and laboratory services	<ul style="list-style-type: none"> Support countries to decentralize HIV, VH and STI testing to PHC and community-based organizations for key populations, including in closed settings. Provide guidance on the roles of national and regional reference laboratories and give examples of approaches to decentralized testing. Support the inclusion (and implementation) of the new testing modalities into the existing testing offerings, including self- testing, self-sampling and expanded molecular POCT options to complement current testing strategies.
1.6. Ensure strategic information governance and health management information systems engineered for informed decision-making	<ul style="list-style-type: none"> Support the integration or linkage of disease-specific patient information systems with broader national health management information services. In the absence of interoperability between such systems, support countries to undertake data linkage to create a patient-level picture of the entire continuum of care for patients with HIV, VH or STIs.

Table 5. contd.

Priority	WHO/partner priority actions
1.7. Ensure engaged and empowered communities and partners	<ul style="list-style-type: none"> ● In partnership with key agencies, support regional platforms and forums to create enabling legal environments by reviewing and reforming restrictive legal and policy frameworks, as needed, in order to enable equitable access to health services, especially for the most affected and at-risk populations, and create institutional and community environments, including in health-care settings, that make it safe for people to access services. This should be undertaken in a manner appropriate to the country context, legislation and health sector priorities. ● Actively contribute to reducing inequalities and ending stigma and discrimination, and to creating an enabling legal environment in order to facilitate equitable access to health services and create institutional and community environments, including in health-care settings, that make it safe for people to access services. This can be achieved through building on the regional partnerships with other multilateral agencies, communities and people living with, and affected by, HIV, VH and STIs. Attention should also be given to the intersectionality of stigma and discrimination for those living with, or at risk of acquiring, HIV, VH and STIs. ● Promote and further the rights of people living with HIV, VH and STIs in health settings by supporting equal treatment of those living with the conditions, undertaking programmes to advance social acceptance, and reducing and mitigating the impact of stigma and discrimination when it does occur. ● Support the meaningful engagement of civil society in the governance, planning and delivery of services for HIV, VH and STI in countries, documenting best practices and sharing case studies from countries in the Region.
1.8. Ensure strong and inclusive governance and leadership	<ul style="list-style-type: none"> ● Provide support to countries in selecting future governance models that are inclusive of civil society as countries advance towards ending HIV, VH and STIs.

Table 5. contd.

Priority	WHO/partner priority actions
1.9. Ensure futureproofing for health emergencies and other epidemics	<ul style="list-style-type: none"> ● Provide support to countries to establish contingency plans and strategic approaches, policies and surge capacities for the HIV, VH and STI response during public health emergencies, natural disasters and conflicts, and to enable rapid recovery following acute or prolonged emergencies. ● Promote the incorporation of service continuity for HIV, VH and STIs as part of health security plans.

Strategic Direction 2

“

To promote integrated, person-centred care, it is essential that HIV programmes work towards the disease-specific strategic directions, as well as Strategic Direction 1

Ending AIDS

A regional commitment to act decisively by scaling up effective HIV prevention, treatment and care interventions for everyone, leaving no one behind, can achieve the goal of ending the AIDS epidemic as a public health threat by 2030.

Key strategic and operational shifts required to end AIDS as a public health threat by 2030

- Refocus testing based on epidemiology and evidence; decentralize and use a full range of testing strategies to advance early and accurate confirmed diagnosis.
- Intensify focus on prevention by expanding access to comprehensive service packages tailored to the needs of key populations through a broader range of service delivery platforms.
- Address the major causes of HIV-related deaths by ensuring the best standards of care and focus on TB through urgent coverage and rapid treatment initiation for people living with HIV and accelerated access to TB prevention, screening and treatment.
- Address the needs of key populations and those most at risk by reducing social and structural barriers to services and by providing differentiated models of care. Provide communities living with and affected by the diseases, and civil society, with a stronger role and voice as part of UHC and integrated people-centered response.
- Ensure rapid uptake of innovations, including new treatment regimens and new prevention approaches supported by implementation research.
- Strengthen comprehensive surveillance and capacity to analyse data with population and geographical granularity to identify programmatic areas of focus.
- Ensure transition to sustainable, predictable and sufficient domestic revenue to fund the provision of accessible and affordable HIV services.

Action focused on key populations is essential to continued progress towards ending AIDS as a public health threat. Based on estimates from the Joint United Nations Programme on HIV/AIDS (UNAIDS) and WHO, almost all infections in the Region (99%) occur in key populations and their partners (6).

Between 2011 and 2019, the rate of newly diagnosed HIV infections in the WHO European Region increased by 5%, mainly driven by an upward trend in many countries in the east of the Region (43). However, this was followed by a sharp (24%) drop in newly diagnosed HIV cases between 2019 and 2020, that was probably due, in part, to a decrease in case detection as a result of the public health and social measures introduced by countries in response to the COVID-19 pandemic. More people have been estimated to be newly infected annually than have been diagnosed with HIV, suggesting that the number of people in the Region living with undiagnosed HIV is on the increase. Data from 2020 show that pronounced geographical discrepancies continue, whereby the rate of new diagnoses is nine times higher in the east of the Region than in the west (32.6 versus 3.7 per 100 000 population respectively); and is 14 times higher in the east of the Region than in the centre (2.3 per 100 000) (44).

TB is the leading cause of death for people living with HIV in the WHO European Region. Reduced access to TB services during the COVID-19 pandemic resulted in an increase in TB deaths, mainly due to an increase in TB/HIV-related deaths. The estimates for 2020 suggest there were 21 000 TB deaths among HIV-negative people (no change compared with 2019) and an additional 5400 among HIV-positive people (up from 4700 in 2019), with the combined total deaths showing an increase compared with 2019 (45). This is particularly concerning given that the Region observed the fastest decline in TB deaths prior to the pandemic.

The 90-90-90 targets for 2020 outlined in the GHSS (8) and previous action plans (10) were not met, though some progress has been made. Data from the WHO European Region from 2020 show that 77% of people living with HIV knew their HIV status; 83% of those who knew their HIV-positive status were receiving antiretroviral therapy (ART); and 94% of those on treatment had suppressed viral loads (10). This translates into 61% of all people living with HIV in the Region being virally suppressed. While countries in the west of the Region have already achieved increased success compared with the 2020 targets, countries in the centre and the east of the Region are still far from reaching these targets.

Late HIV diagnosis remains a challenge in most countries of the Region. The percentage of people newly diagnosed who were late presenters varied across transmission categories and age groups but was highest for people with reported heterosexual transmission (particularly men), injecting drug use, and for those in older age groups (44).

The “treat all” policy has been adopted in all countries in the Region. However, work is still required to scale up the number of people on ART and move to the most effective and simplified regimens recommended by the WHO guidelines (39). In particular, the transition to dolutegravir-containing regimens has been slow in many countries, largely due to the high costs of procurement in middle-income countries. Likewise, the scale-up of PrEP has been slow, with disparity in access, and must rapidly accelerate to prevent acquisition of HIV and save lives.

Populations

Key populations at higher risk for acquisition of HIV are defined as those groups of people most likely to be exposed to or to transmit HIV (27). According to WHO and UNAIDS, in the WHO European Region, key populations include people living with HIV and their partners, people who inject drugs, men who have sex with men, transgender people, sex workers, people in prisons and in other closed settings, and migrants.

HIV targets

Table 6 presents the HIV targets for the 2025 interim period, and for 2030, at the cessation of the Regional action plans.¹⁰ Targets should be monitored, assessed and met overall at the country level, as well as for each key population.

The translation of these targets to national settings should consider local epidemiological and health system contexts while upholding fundamental human rights, equitable access to health and evidence-based practice.

¹⁰ Additional details on the measurement framework, data definitions and data sources can be found in Annex 2 of the GHSS (8).

Table 6. Indicators, baseline, and 2025 and 2030 targets for Strategic Direction 2

	Indicator^a	Baseline 2020^b	Interim 2025 targets	2030 targets
Impact			32 000	13 000
	Number of new HIV infections (adult and child) per year	170 000 (130 000 in 2010)	(-75% compared with 2010)	(-90% compared with 2010)
	Number of new HIV infections per 1000 uninfected population per year (SDG 3.3.1)	0.18 (0.14 in 2010)	0.04	0.02
	Number of new HIV infections among children under 15 years of age per year	No data	-75%	-90%
	Number of HIV-related deaths ^c (including disaggregation by HIV-associated cryptococcal meningitis, TB and severe bacterial infections)	40 000 (2020) 32 000 (2010)	16 000 (-50%)	8000 (-75%)
	Percentage of people living with HIV who know their status ^d	77%	95%	95%
Coverage	Percentage of people diagnosed with HIV receiving antiretroviral therapy ^{d,e}	85%	95%	95%
	Percentage of people living with HIV, and who are on treatment, achieving viral load suppression ^{d,e,f}	94%	95%	95%
	Percentage of people at risk of HIV who use combination prevention with a defined service package	No data	95%	95%

Table 6. contd.

	Indicator ^a	Baseline 2020 ^b	Interim 2025 targets	2030 targets
Coverage	Condom/lubricant use at last sex with a client or non-regular partner	No data	90%	90%
	Number of needles/syringes distributed per year per person who injects drugs (as part of comprehensive harm-reduction programme)	No data	200	300
	Number of people who received PrEP at least once during the year	95 000 (2020)	500 000	1 100 000
	Percentage of eligible people living with HIV receiving preventive treatment for TB	80%	99%	99%
	Percentage of new HIV diagnoses which are diagnosed at a late stage of disease (CD4 < 350)	50	20%	10%
	Percentage of people living with HIV and people at risk who are linked to other integrated health services, including for STIs and VH	No data	95%	95%
Supporting environment	Percentage of people living with HIV and key populations experiencing stigma and discrimination	No data	< 10%	< 10%
	Percentage of countries with punitive laws and policies	Varied by populations	< 10%	< 10%

Table 6. contd.

	Indicator ^a	Baseline 2020 ^b	Interim 2025 targets	2030 targets
Supporting environment	Gender equality – prevalence of recent (last 12 months) intimate partner violence among women and girls 15–49 years old ^c	No data	11%	< 10%
	Differentiated service delivery – percentage of countries which have implemented 6-month refill of drugs	No data	75%	95%

^a Additional details on the measurement framework, data definitions and data sources can be found in Annex 2 of the GHSS (8).

^b Last available data as of end 2020. All data will be disaggregated by age, including adolescents, sex and, where relevant, focus on populations specific to the disease.

^c The mortality data will be further disaggregated to assess the urgent need to tackle the drivers and causes of deaths. For HIV, these include cryptococcal meningitis, TB and severe bacterial infections.

^d Achieved in all ages, sexes and key populations, including migrants.

^e Achieved in all ages, sexes and key populations.

^f Of those diagnosed who returned for sustained viral load testing.

^g SDG indicator 5.2.1: Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age (46).

Priority actions for countries

Table 7 sets out the priority actions for countries for Strategic Direction 2. These priority actions are to be deployed by countries in a manner that is consistent with the domestic context and legislation, and their epidemiological, social and legislative contexts.

Table 7. Priority actions for countries for Strategic Direction 2

Priority	Country priority actions
2.1 Collect and use strategic information for focused action and equity across the continuum of care	<ul style="list-style-type: none"> Strengthen comprehensive surveillance (including integrated bio-behavioural surveys) to monitor epidemiological trends in HIV and use the data to guide policy, strategy, decisions and responses. Strengthen capacity at the national and subnational levels to proactively interpret, analyse and triangulate surveillance data with sufficient population and geographical granularity to identify programmatic areas of need.

Table 7. contd.

Priority	Country priority actions
2.2 Prevent the transmission of HIV with a particular focus on key populations	<ul style="list-style-type: none"> • Expand the delivery of, and access to, comprehensive prevention programmes for key populations, including sexual health programmes, condom and lubricant programming and harm-reduction and treatment services. • Expand the delivery of, and access to, PrEP in a broader range of settings, including community-based environments, PHC, pharmacies or through online provision, and to all people at high risk of HIV acquisition. • In large cities, where it is epidemiologically indicated, adopt the Fast-Track Cities approach to accelerate the ending of AIDS as a public health threat.
2.3 Strategically increase testing and ensure early diagnosis of HIV infections	<ul style="list-style-type: none"> • Develop strategies to tackle the late diagnosis of HIV. These may include decentralized testing or peer-led partner/contact tracing; adding evidence-based approaches to self-testing/self-sampling to the existing complement of testing options; and expansion of indicator condition guided HIV testing in general health-care settings. • Align national policies with WHO guidance on early infant diagnosis. • Adopt or expand the use of rapid testing and POCT for HIV for early diagnosis and ensure prompt linkage to care and treatment initiation. Services should also integrate HIV and STI POCT in settings where PrEP is offered. • Initiate or scale up the use of reliable POCT for HIV diagnosis and patient monitoring, including for viral load measurement, in hard-to- access communities and geographies.

Table 7. contd.

Priority	Country priority actions
2.4 Provide early access to treatment and rapid linkage to effective care for HIV and common comorbidities	<ul style="list-style-type: none"> • Urgently scale up ART to treat all people living with HIV, including key populations and children, with earlier initiation of treatment with optimized WHO-recommended regimens (including fixed-dose formulations where feasible), and offer patients the option of multi-month dispensing or long-acting antivirals through a wider range of settings (PHC, community pharmacies and community-based organizations) to maximize retention on treatment and in care. Linkage to care and treatment initiation must be accelerated through easier access to services. • Ensure all people living with HIV have timely access to testing for TB infection and preventive treatment and, if necessary, to treatment. Likewise, all TB patients should have access to timely screening for HIV and ART as needed. • Stop the transmission of HIV in infants by expanding coverage with antenatal care (ANC) and testing (including in key populations), providing lifelong ART for women during pregnancy and after delivery, and ensuring early and integrated diagnosis and treatment of infants (as part of the EMTCT of HIV, congenital syphilis and hepatitis B virus (HBV)). • Develop routine screening and care pathways for people living with HIV into services for common coinfections, particularly VH, STIs and TB/MDR-TB, and common comorbidities, including mental health conditions, cardiovascular disease, diabetes, chronic lung disease and cancer (including cervical cancer screening) and address comprehensive needs of ageing people living with HIV. • Integrate surveillance for HIV drug resistance and the monitoring of early warning indicators and other quality-of-care indicators into national HIV diagnosis and treatment services.
2.5 Sustain the gains in financing and planning	<ul style="list-style-type: none"> • Ensure that HIV national service plans are accurately costed to support budgeting and resource mobilization efforts for prevention and treatment scale up. • Ensure the transition to sustainable, predictable and sufficient domestic revenue to fund the provision of accessible and affordable HIV services to limit or eliminate the out-of-pocket costs for key populations or those most at risk.

Priority actions for WHO and partner organizations

Table 8 sets out the priority actions for WHO and partner agencies for Strategic Direction 2.

Table 8. Priority actions for WHO and partner agencies for Strategic Direction 2

Priority	WHO/Partner priority actions
2.1 Collect and use strategic information for focused action and equity across the continuum of care	<ul style="list-style-type: none"> • Support countries to undertake case-based surveillance and report to WHO and the European Centre for Disease Prevention and Control (ECDC), and provide support for key population size estimation, bio-behavioural surveillance, and cascade monitoring for key populations, in collaboration with UNAIDS. • Support countries to regularly analyse and map barriers to access to health care, and to measure stigma and discrimination, and quality of life for people living with HIV and key populations.¹¹
2.2 Prevent the transmission of HIV with a particular focus on key populations	<ul style="list-style-type: none"> • Support countries to update guidelines on combination prevention for key populations. • Develop PrEP service delivery models for men who have sex with men and other key populations (including delivery via community-based organizations) and ensuring they are linked effectively to HIV and STI testing services. • Support countries to adopt innovations and emerging evidence-based practices, including the use of the new and long-acting formulations for PrEP.
2.3 Strategically increase testing and ensure early diagnosis of HIV infections	<ul style="list-style-type: none"> • Support the implementation of WHO guidance on HIV testing, including optimizing testing algorithms to ensure they are reliable, cost-effective and efficient. • Support countries to deploy new HIV testing technologies, including self-testing and self-sampling as guidance is updated, and integrate these technologies into the care pathway.

¹¹ Utilizing acceptable, evidence-based approaches including the STIGMA Index (47).

Table 8. contd.

Priority	WHO/Partner priority actions
2.4 Provide early access to treatment and rapid linkage to effective care for HIV and common comorbidities	<ul style="list-style-type: none"> • Support countries to implement or update guidelines on standardized and optimized ART regimens, and treatment of coinfections and comorbidities (including supporting a shift to fixed-dose formulations); and support the deployment of new formulations, including injectable long-acting ART and new paediatric formulations. • Strengthen countries' capacities to monitor progress towards EMTCT for HIV and support the validation of EMTCT through the Regional Validation Committee. • Support countries to conduct and report nationally representative surveys of pre-treatment and acquired drug resistance and use the data to inform national treatment policies.
2.5 Sustain the gains in financing and planning	<ul style="list-style-type: none"> • Support countries to update country-specific plans for HIV that promote alignment across disease areas, and with the UHC goals, and which explicitly identify strategies to reduce the stigma and discrimination for people living with, or at risk of acquiring, the condition.

Strategic Direction 3

“

To promote integrated, person-centred care, it is essential that viral hepatitis programmes work towards the disease-specific strategic directions, as well as Strategic Direction 1

Ending the epidemics of viral hepatitis

VH continues to be a significant challenge in the Region. In 2019, 14 million people were estimated to be infected with HBV, and 12 million to be chronically infected with HCV (1). In that year, there were an estimated 19 000 new chronic HBV infections and 300 000 HCV infections. Every year in the Region, it is estimated that of deaths due to cirrhosis or liver cancer, approximately 56 000 are related to HBV and 112 500 are related to HCV. Furthermore, hepatitis D virus (HDV) infection is related to more severe outcomes for HBV patients (1). While the prevalence of HDV is not well understood in the European Region, global prevalence estimates suggest anti-HDV prevalence is 4.5% among people who are hepatitis B surface antigen (HBsAg)-positive and attend hepatology clinics (48).

Key strategic and operational shifts required to end viral hepatitis as a public health threat by 2030

- Allocate increased domestic financial resources to hepatitis B and C through the inclusion of VH prevention, testing and treatment as part of UHC.
- Scale up testing to diagnose, using a range of evidence-based strategies, the large numbers of people living with hepatitis B and C who are unaware of their diagnosis, including key populations and those most at risk.
- Implement a test-and-treat strategy and significantly scale up treatment for hepatitis B, C and D to everyone who is eligible. Ensure that the most effective treatment regimens are accessible and affordable to all populations. Decentralize care for VH to primary and community settings, wherever possible, and develop these models of care in collaboration with civil society.
- Create an enabling legal environment for people affected by hepatitis and those most at risk including key populations by reviewing and reforming restrictive legal and policy frameworks in order to enable equitable access to health services.
- Prevent the transmission of VH, with a particular focus on key populations, through the integration of prevention services for HIV, VH and STIs, and intensify efforts to scale up comprehensive combination prevention services for people who inject drugs in all settings, including prisons.
- Ensure universal access to hepatitis B birth-dose vaccines and improve services for testing pregnant women to prevent vertical (mother-to-child) transmission of hepatitis B.

Over the course of the time period of the *Action plan for the health sector response to viral hepatitis in the WHO European Region* (2017–2021), there has been a genuine increase in disease-specific focus by many countries. In 2013, only 13 European Region countries had national hepatitis plans, though this increased to 33 in 2020, with a further 13 countries having plans under development (1).

There has been a small increase in prevention activities for both HBV and HCV, and a small number of countries have improved their blood safety and human blood products

practices. Likewise, a small number of countries have strengthened linkages between VH and harm-reduction services by providing OST for people who inject drugs. However, more broadly, VH prevention and testing requires significant scale up and integration with HIV and STI testing due to the high proportion of undiagnosed cases, the overlap between risk populations and the significant shortfall in harm-reduction services, in particular for people who inject drugs and those in prisons and other closed settings.

Progress has been made in other areas of VH control. Regional immunization coverage with the three-dose hepatitis B vaccination increased from 82% in 2016 to 92% in 2019 (49). In 2019, 35 countries achieved coverages of 90% with three doses of hepatitis B vaccine, and 19 (83%) out of 23 countries that provide universal newborn vaccination, achieved coverages of > 90% with the hepatitis B birth dose; 17 countries met both indicators. Three countries have successfully validated their achievement of the regional hepatitis B control targets. Despite these developments, 2019 data suggest only 19% of those living with hepatitis B knew about their condition, and 2% of those diagnosed had been successfully treated.

There has been some limited progress for those living with hepatitis C in the European Region. Access to treatment for people living with hepatitis C has improved over the past 5 years, helped in part by the development of, and access to, generic pan-genotypic DAAs; the cost reductions in the procurement of these drugs; and the removal of limits to accessing programmes that deliver these medicines. However, further progress must be made: an estimated 24% of people living with hepatitis C are aware of their condition, and 8% of those diagnosed have been treated.

The Region has seen a steady increase in liver cancer mortality and morbidity, due largely to the insufficient progress that has been made against VH (50). While WHO recognizes hepatitis as a preventable risk factor for cancer, further progress must be made to raise awareness and include hepatitis in cancer prevention services. By 2040, it is estimated that liver cancer deaths and cases will exceed 100 000 per year in the Region (51).

Strategic information continues to be a challenge in the Region, despite support from agencies including WHO, ECDC and other technical partners. The monitoring of acute infections, measuring the prevalence of chronic infections, and measuring the true burden of VH sequelae and mortality attributable to VH is still lacking. Several countries do not track antenatal screening for hepatitis B, hepatitis B birth dose and the three-dose vaccination in the infants of HBsAg-positive mothers. Strategic information is essential to track progress and identify gaps, and is the foundation on which effective public health efforts are established.

Populations

Prioritizing the populations most affected and at risk of VH should be based on each country's epidemiological and social context and should include micro-elimination strategies for key populations. These key populations may include: people who inject drugs and people who use drugs; sex workers; people in prisons and in other closed settings; people who have been exposed to hepatitis viruses through unsafe blood supplies and unsafe medical injections and procedures; men who have sex with men, and transgender people; infants born to HBsAg-positive mothers; foreign-born citizens

from high-burden countries; and migrants, mobile populations and people affected by conflict and civil unrest. People who require specific attention include those with coinfections such as: hepatitis B and C combined; VH and TB; and HIV and VH.

Viral hepatitis targets

Table 9 presents the VH targets for the 2025 interim period, and for 2030 at the cessation of the Regional action plans.¹²

Targets should be monitored, assessed and met overall at the country level, as well as for each key population. WHO validation of country VH elimination will be possible as per WHO interim guidance (52).

The translation of these targets to national settings should consider local epidemiological and health system contexts, while upholding fundamental human rights, equitable access to health and evidence-based practice.

Table 9. Indicators, baseline, and 2025 and 2030 targets for Strategic Direction 3

	Indicator ^a	Baseline 2020 ^b	Interim 2025 targets	2030 targets
	HBsAg prevalence in vaccinated cohorts ^c	No data	0.5%	0.1%
	Number of new HBV infections per year (incidence) ^d	19 000 (20 per 100 000)	10 500 (11 per 100 000)	2200 (2 per 100 000)
	Number of new HCV infections per year (incidence) ^e	300 000 (62 per 100 000)	65 000 (13 per 100 000)	25 000 (5 per 100 000)
Impact	Number of new HCV infections among people who inject drugs per year ^f	8 per 100	3 per 100	2 per 100
	Number of deaths due to HBV per year (number per 100 000)	43 000 (10 per 100 000)	28 000 (7 per 100 000)	16 000 (4 per 100 000)
	Number of deaths due to HCV per year (number per 100 000)	64 000 (5 per 100 000)	53 000 (3 per 100 000)	31 000 (2 per 100 000)

¹² Additional details on the measurement framework, data definitions and data sources can be found in Annex 2 of the GHSS (8).

Table 9. contd.

	Indicator ^a	Baseline 2020 ^b	Interim 2025 targets	2030 targets
Coverage	HBV – percentage of people living with HBV diagnosed/treated	19%/2% (2019)	60%/50%	90%/80%
	HCV – percentage of people living with HCV diagnosed/and cured	24%/8% (2019)	60%/50%	90%/80%
	Vaccination coverage (3rd dose) of childhood HBV vaccination	91% (2019)	95%	95%
	Percentage of pregnant women screened for HBsAg	No data	90%	95%
	Percentage of newborns who received timely (within 24 hours of birth) HBV birth-dose vaccination	> 90% (2019)	90%	95%
	Percentage of blood units screened for bloodborne diseases	95%	100%	100%
	Percentage of injections in health-care settings undertaken with safe injecting equipment ^g	No data	95%	100%
	Minimum sterile injection equipment kits distributed per person per year for people who inject drugs, as part of a comprehensive package of harm- reduction services(13) ^h	200	200	300
	Percentage of opioid-dependent people who inject drugs who receive OST	No data	40%	40%

Table 9. Contd.

	Indicator^a	Baseline 2020^b	Interim 2025 targets	2030 targets
Supporting environment	Number (%) of countries that have a costed plan to end hepatitis B and C with measurable targets and indicators	33 (62%) (2021)	42(80%)	53(100%)
	Number (%) of countries with: <ul style="list-style-type: none"> • burden of disease estimates • annual or every 2 years reporting of the cascade of care 	36 (70%)	40(75%)	48(90%)
	Integration – proportion of people living with HIV tested/and cured of HCV	No data	60%/50%	90%/80%

^a Additional details on the measurement framework, data definitions and data sources can be found in Annex 2 of the GHSS (8).

^b Last available data as of end of 2020.

^c For countries with high and intermediate endemicity, serosurveys will be conducted in vaccinated cohorts. For countries with low endemicity, seroprevalence in pregnant women can be used as a proxy.

^d Incidence of new, chronic HBV infections.

^e Viremic prevalence of successive surveys may be used together with key prevention, testing and treatment intervention coverage to estimate absolute incidence using mathematical modelling.

^f Based on those 20 out of 53 countries that reported (53).

^g Measured through a demographic health survey or other special survey.

^h Countries are encouraged to collect more precise data on coverage of needle and syringe exchange services through specific surveys among people who inject drugs.

Priority actions for countries

Table 10 sets out the priority actions for countries for Strategic Direction 3. These priority actions are to be deployed by countries in a manner that is consistent with their epidemiological, social and legislative context.

Table 10. Priority actions for countries for Strategic Direction 3

Priority	Country priority actions
3.1 Collect and use strategic information for focused action and equity across the continuum of care	<ul style="list-style-type: none">• Improve hepatitis B, C and D burden of disease estimations through population-based surveys, including using opportunities to piggyback on other surveys (i.e. COVID-19 surveys) to estimate baselines and measure progress towards elimination, and to estimate the proportion of deaths and liver cancer attributable to HBV and HCV.• Develop and strengthen health information systems (e.g. hepatitis patient registries, perinatal hepatitis registries) to monitor the cascade of care.• Integrate monitoring of quality-of-care indicators into national hepatitis diagnosis and treatment services.

Table 10. contd.

Priority	Country priority actions
<p>3.2 Prevent the transmission of VH, with a particular focus on key populations</p>	<ul style="list-style-type: none"> ● Define and deliver an essential package of VH interventions and services that includes all five core interventions: HBV vaccination (children and high-risk adults); injection, blood and surgical safety and universal precautions; prevention of vertical or mother-to-child transmission of HBV; harm-reduction and treatment services for people who use drugs; and testing and treatment for chronic HBV and HCV infection. ● Prevent the vertical transmission of HBV and HCV including through the screening of pregnant women and those intending to become pregnant; providing treatment, if indicated; the timely administration of HBV birth-dose vaccine to infants born in and outside of health facilities; and ensuring hepatitis B immunoglobulin is administered to exposed infants. ● Intensify efforts to scale up comprehensive combination services for people who inject drugs in all settings, including prisons and other closed settings. ● Strengthen infection prevention and control in and outside of health facilities and ensure that blood and other human products are routinely screened for bloodborne viruses, including HIV, VH and syphilis. ● Raise awareness of hepatitis as a preventable risk factor for cancer – with cancer prevention materials that provide information on hepatitis transmission risks, opportunities for testing, and treatment options. ● Introduce or expand efforts to end hepatitis in the design and implementation of national cancer prevention strategies.

Table 10. contd.

Priority	Country priority actions
3.3 Strategically increase testing and ensure early diagnosis of VH infections	<ul style="list-style-type: none"> • Deliver and scale up the full complement of WHO-recommended delivery options to increase access to HBV and HCV testing – including through offering affordable testing routinely for key populations and those most at risk, in PHC settings; using community-based organizations to conduct outreach testing outside of health settings; integrating testing options for common coinfections; and adopting POCT confirmation options for chronic HCV infection to improve the testing turnaround times and minimize loss to follow-up. Self-testing and self-sampling can also be provided in addition to the existing complement of reliable testing options to maximize access. • Introduce routine testing for hepatitis D for all people diagnosed with HBV infection. • Integrate routine hepatitis screening/testing into services for common coinfections, particularly STIs and TB/MDR-TB. • Invest in innovation including portable testing tools; fully integrated, automated sample-to-result molecular analyses; and platforms that can be used to drive forward the detection of hepatitis in both point-of-care and field settings.
3.4 Provide early access to treatment and rapid linkage to effective care for VH and common comorbidities	<ul style="list-style-type: none"> • Significantly scale up treatment for hepatitis B, C and D to everyone who is eligible, ensuring that the most effective treatment regimens are accessible and affordable to all populations. • Introduce or expand the delivery of decentralized, novel PHC and community-based approaches for differentiated service delivery, including for the prescription and distribution of hepatitis medicines by trained professionals in community settings to improve treatment adherence and retention in care.
3.5 Sustain the gains in financing and planning	<ul style="list-style-type: none"> • Fully fund national hepatitis programmes, which include harm-reduction and treatment interventions for people who inject drugs.

Priority actions for WHO and partner organizations

Table 11 sets out the priority actions for WHO and partner agencies for Strategic Direction 3.

Table 11. Priority actions for WHO and partner agencies for Strategic Direction 3

Priority	WHO/Partner priority actions
3.1 Collect and use strategic information for focused action and equity across the continuum of care	<ul style="list-style-type: none"> • Support countries to strengthen hepatitis surveillance and cascade monitoring, including (where necessary) key population size estimation, bio-behavioural surveillance and cascade monitoring for key populations, and the use of data for national programme planning. • Conduct hepatitis programme reviews and support comprehensive hepatitis national service package development, or revision, to work towards strategic targets. • Improve coordination between existing data registries across the Region to allow for greater comparability and informed action. • Support the process of validation of hepatitis elimination as a public health threat in specific countries, including the validation of EMTCT of HBV in countries that have achieved the elimination targets.
3.2 Prevent the transmission of VH, with a particular focus on key populations	<ul style="list-style-type: none"> • Support countries to update national HBV EMTCT strategies and practices to align them with the most recently available evidence and WHO guidance. • Support countries to fully implement WHO's injection safety policy and the global campaign to strengthen infection prevention and control, including the regular monitoring, prevention and treatment of people at high risk (e.g. health-care workers, haemodialysis patients). • Support campaigns and country-level efforts to increase awareness of VH, and anti-stigma and anti-discrimination activities. • Support provision of a comprehensive package for the prevention of VH in key populations, in particular for people who inject drugs.

Table 11. contd.

Priority	WHO/Partner priority actions
3.3 Strategically increase testing and ensure early diagnosis of VH infections	<ul style="list-style-type: none"> ● Support countries to update national hepatitis testing and diagnosis guidelines in line with the latest evidence and WHO guidelines. ● Support countries to improve diagnostic technologies, testing approaches and quality assurance processes for simplified, timely and accurate chronic HBV and HCV diagnosis and strengthened patient monitoring. ● Support and share emerging evidence on innovations for VH diagnostics, including findings from the pilots on HCV self- testing and postal self-sampling trials. ● Support the introduction of hepatitis D reflex testing for positive HBV cases in geographies with higher epidemiological risk.
3.4 Provide early access to treatment and rapid linkage to effective care for VH and common comorbidities	<ul style="list-style-type: none"> ● Provide policy and technical guidance aimed at building a competent and culturally safe workforce, with a particular focus on shifting care from vertical delivery models to PHC and community-led models. ● Build capacity of the health workforce through an online regional training curriculum for VH management, with a focus on PHC service delivery models. ● Support countries to diagnose and manage comorbidities, including with HIV and drug-susceptible TB (DS-TB)/drug-resistant TB (DR-TB); drug use and addiction; and mental health issues. ● Support regional research initiatives aimed at improving treatment success rates for DR-TB and coinfection management for HCV and DR-TB. ● Support improvements in point-of-care/rapid diagnostic tests for HCV and long-acting pan-genotypic DAAs, and evolutions in HDV treatments.

Table 11. contd.

Priority	WHO/Partner priority actions
3.5 Sustain the gains in financing and planning	<ul style="list-style-type: none"> ● Support the development of the investment case for hepatitis programmes in key high-burden countries, including developing a definition and investment case for an essential package of services for VH testing, treatment and management. ● Provide technical support to countries to develop fully funded national plans, forecast the demand for essential medicines and diagnostics, and implement national plans in a manner that meets the needs of key populations and those most at risk.

Strategic Direction 4



To promote integrated, people-centred care, it is essential that viral hepatitis programmes work towards the disease-specific strategic directions, as well as Strategic Direction 1

Ending the epidemics of sexually transmitted infections

To date, the European Region has not had a dedicated action plan focused on STIs, although EMTCT of syphilis was a critical element of the *Action plan for the health sector response to HIV in the WHO European Region (2)*, as was access to a range of STI services in the *Action plan for the health sector response to viral hepatitis in the WHO European Region (3)*, and actions to reduce STIs are included in the *Action plan for sexual and reproductive health (21)*.

Key strategic and operational shifts required to end STIs as a public health threat by 2030

- Develop surveillance systems in all countries to effectively monitor key indicators and increase the geographical coverage of the European Gonococcal Antimicrobial Surveillance Programme.
- Prevent the transmission of STIs, with a focus on key populations, through the integration of services for HIV, VH and STIs, and intensifying efforts to scale up comprehensive combination approaches across all service platforms, including PHC, sexual and reproductive health, family planning, adolescent health and HIV services.
- Increase access to testing and early diagnosis by expanding the use of high-quality STI POCT technologies and evidence-based screening and testing innovations.
- Provide early access to treatment and rapid links to effective care for STIs and case management delivered by public, private and nongovernmental service providers.
- Fund STI plans through national health financing mechanisms to deliver an essential package of high-impact, evidence-based STI interventions relevant to the country context and tailored to the needs of key populations and settings.
- Accelerate research and development on prevention technologies, diagnostics, treatments and vaccines for STIs.

In 2020 in the WHO European Region, there were an estimated 23 million incident cases of four curable STIs: chlamydia, gonorrhoea, syphilis and trichomoniasis (1).

From 2015 to 2019, the reported number of cases of bacterial STIs (chlamydia, gonorrhoea and syphilis) increased in the European Union/European Economic Area (EU/EEA) and the United Kingdom. As documented in several studies, STI prevalence is increasing among users of PrEP for HIV (54). In the EU/EEA, syphilis, gonorrhoea and chlamydia notifications have also been increasing among HIV-negative men who have sex with men in the last few years (55). Data on the prevalence of syphilis among key populations collected through integrated bio-behavioural surveillance are available for some countries in eastern Europe and central Asia and vary considerably (56). Recent data from the European Region highlights the concerning and evolving

situation with AMR of *Neisseria gonorrhoea*, although this is less dire than in some other Regions (57).

However, the conclusions that can be drawn from epidemiological surveillance are limited due to large variations in investment, maturity and performance of STI surveillance systems across the countries of the Region. Key strategies for the Region will be the development of surveillance systems (sentinel or comprehensive) in all countries to effectively monitor the key indicators of the Regional action plans, and the increase of the geographical coverage of Euro-GASP.

Based on a survey conducted in 2019 (1), some countries in the Region do not have a national STI strategy, nor do they have national guidelines on the diagnosis and treatment of STIs. Additionally, not all countries have policies or guidelines on cervical cancer prevention, screening and control, and some do not have the human papillomavirus (HPV) vaccine included in the national immunization schedule.

The countries of the Region need to intensify STI prevention, testing and treatment services, particularly among young people, people living with HIV and key populations in the context of expanded PrEP use for HIV prevention.

All individuals should be able to access safe, high-quality and people-centred services for the prevention, testing and treatment of STIs, using the latest highly sensitive diagnostic and treatment capacities.

Populations

Key populations, and those most at risk of STIs, should be defined based on each country's epidemiological and social context (27). These populations may include pregnant women and women of reproductive age, young people aged 15–25 years old, sex workers and their clients, men who have sex with men (including those enrolled in PrEP programmes), transgender people, people who use drugs, people with a prior STI, and people living with HIV. In some contexts, migrants and displaced people may also be considered a key population for STIs.

STI targets

Table 12 presents the STI targets. The STI targets are presented below for the 2025 interim period, and for 2030 at the cessation of the Regional action plans.¹³

Targets should be monitored, assessed and met overall at the country level, as well as for each key population.

The translation of these targets to the national context should consider the nature and dynamics of the country's epidemics, the populations affected, and the structure and capacity of the health-care and community systems.

¹³ Additional details on the measurement framework, data definitions and data sources can be found in Annex 2 of the GHSS (8).

Table 12. Indicators, baseline, and 2025 and 2030 targets for Strategic Direction 4

	Indicator^a	Baseline 2020^b	Interim 2025 targets	2030 targets
Impact	Number of new cases of syphilis, gonorrhoea, chlamydia and trichomoniasis ^c in adults (aged 15–49 years) per year	23 million (2020)	18.4 million -20%	9.9 million -90% for gonorrhoea and syphilis -50% for chlamydia and trichomoniasis
	Number of new cases of syphilis in adults (age 15–49) per year	240 000 (2020)	192 000 -20%	24 000 -90%
	Number of new cases of gonorrhoea in adults (age 15–49) per year	3.8 million (2020)	3.04 million -20%	380 000 -90%
	Congenital syphilis cases per 100 000 live births	19 ^d	≤ 10	≤ 1
	Syphilis prevalence in women attending antenatal care	0.10% ^d	< 0.05%	< 0.01%

Table 12. contd.

	Indicator ^a	Baseline 2020 ^b	Interim 2025 targets	2030 targets
Impact	Syphilis and gonorrhoea prevalence among men who have sex with men, and female sex workers	Syphilis median prevalence in EECA: 3.8% in men who have sex with men; 5.7% in female sex workers (56)	< 2% syphilis	< 0.5% syphilis
			< 3% gonorrhoea	< 0.5% gonorrhoea
		No data on gonorrhoea		
Coverage	Percentage of pregnant women attending antenatal care who were screened for syphilis / percentage treated if positive	94%/94% ^d	> 95%/> 95%	> 95%/> 95%
	Percentage of priority populations screened for syphilis/ percentage treated if positive	No data/no data	> 80%/> 90%	> 90%/> 95%
	Percentage of priority populations ^e screened for gonorrhoea/ percentage treated if positive	No data/no data	> 20% /> 90%	> 90% /> 95%

Table 12. contd.

	Indicator ^a	Baseline 2020 ^b	Interim 2025 targets	2030 targets
Coverage	Percentage of girls fully vaccinated for HPV by the age of 15 years ^f	25% (2019 and 2020)	35%	90%
	Percentage of women screened for cervical cancer using a high-performance test, by the age of 35 years and again by 45 years ^f	No data	> 40% /> 40%	> 70% /> 90%
	Percentage of women screened and identified as having pre-cancer treated or invasive cancer managed ^f	No data	> 40%	> 90%
Supporting environment	Number of countries with national STI plans updated and funded within last 5 years	38% ^g	> 70%	> 90%
	Number of countries with national STI case management guidelines updated within last 3 years	79% ^g	> 90%	> 95%

Table 12. contd.

Indicator ^a	Baseline 2020 ^b	Interim 2025 targets	2030 targets
Number of countries with strong STI surveillance systems that allow monitoring of STI burden and progress towards elimination ^h	Not available	75%	90%
Number of countries reporting AMR in <i>Neisseria gonorrhoeae</i> to Euro-GASP	82% ^g	>90%	>95%

EECA: eastern Europe and central Asia.

^a Additional details on the measurement framework, data definitions and data sources can be found in Annex 2 of the GHSS (8).

^b Latest data for end of 2020. All data will be disaggregated by age, including adolescents where available, sex and, where relevant, focus on populations specific to the disease. Incidence estimates are based on prevalence.

^c Curable STIs. 2025 targets reflect a 20% reduction in incidence of all four diseases (2020 baseline), while the 2030 targets reflect the target of 90% reduction in the number of new cases of syphilis and gonorrhoea, as well as a 50% reduction in the number of new cases of chlamydia and trichomoniasis by 2030. These targets are aspirational.

^d 2016 estimates (58).

^e Priority populations are defined by individual countries.

^f The European Union's: Europe's Beating Cancer Plan includes HPV vaccination for boys and girls. Member States may choose to include boys in their national plans depending on their local context.

^g Indicator collected by sexual and reproductive health programmes.

^h WHO headquarters survey conducted in 2020: 27 out of 52 countries responded.

Priority actions for countries

Table 13 sets out the priority actions for countries for Strategic Direction 4. These priority actions are to be deployed by countries in a manner that is consistent with their epidemiological, social and legislative context.

Table 13. Priority actions for countries for Strategic Direction 4

Priority	Country priority actions
4.1 Collect and use strategic information for focused action and equity across the continuum of care	<ul style="list-style-type: none"> • Strengthen STI surveillance systems for gonorrhoea, chlamydia, syphilis (including congenital syphilis) and trichomoniasis to measure progress against targets with a particular focus on key populations. This may take the form of prevalence surveys and may involve an expansion of existing surveillance systems, such as those established for HIV, to collect comprehensive STI pathogen-specific notifications. This should cover and document the full cascade of care. • Ensure regular surveillance of AMR in gonorrhoea (Euro-GASP) and consider surveillance of other sexually transmitted pathogens, such as shigellosis and hepatitis, to inform treatment protocols.
4.2 Prevent the transmission of STIs, with a focus on key populations	<ul style="list-style-type: none"> • Engage community-based organizations, key populations and those most at risk in the development and delivery of prevention and testing programmes for STIs, including outreach and delivery and distribution of prevention materials, such as condoms, post-exposure prophylaxis and PrEP for HIV. • Expand access to, and effectiveness of, partner services, including voluntary partner notifications and contact tracing, integration of partner case management with the presenting patient, and patient-delivered partner therapies for appropriate STIs.

Table 13. contd.

Priority	Country priority actions
<p>4.2 Prevent the transmission of STIs, with a focus on key populations</p>	<ul style="list-style-type: none"> • Accelerate the elimination of congenital syphilis in infants by: expanding coverage of testing within ANC (including in key populations); routinely screening for syphilis during pregnancy (universal offer of syphilis testing during early pregnancy and targeted re-testing during the last trimester and at delivery for women from risk groups); providing treatment where indicated; and ensuring early diagnosis and treatment of infants. This should be executed within the broader framework of the EMTCT of HIV, congenital syphilis and HBV. • Deliver evidence-based comprehensive sexual health programmes for young people and ensure this is complemented by low-cost, easily accessible barrier methods, including condom provision. • Ensure that the HPV vaccine is included in the national immunization plan for all genders, where possible, and ensure that HIV and STI prevention programmes are linked to these national immunization plans.
<p>4.3 Strategically increase testing and ensure early diagnosis of STIs</p>	<ul style="list-style-type: none"> • Expand the use of high-quality STI POCT technologies at sites where HIV, VH or sexual and reproductive health services are delivered, as well as in appropriate PHC settings with the goal of reducing the testing turnaround time and minimizing loss to follow-up. • Scale up the use of contextually appropriate evidence-based screening and testing innovations to complement existing options, including high-quality rapid tests, self-testing and self-sampling, postal testing, point-of-care molecular diagnostics and app-based technologies (e.g. medication scheduling, health professional capacity development tools) to enable a greater reach of key populations. • Strengthen national laboratory capacity through quality assurance, increased capacity for high-volume testing, and the introduction of POCT to ensure routine monitoring of STIs and AMR in <i>N. gonorrhoeae</i>.

Table 13. contd.

Priority	Country priority actions
4.3 Strategically increase testing and ensure early diagnosis of STIs	<ul style="list-style-type: none"> • Increase awareness of the need for STI testing among key populations and use flexible outreach testing models for hard-to-reach groups, including sex workers and those attending sex-on-premises venues, and maximize routine testing for young people and men who have sex with men, in sexual health clinics. • Detect and control outbreaks of emerging and re-emerging STIs (e.g. lymphogranuloma venereum) and other infections that are associated with sexual activity (e.g. shigellosis, monkeypox) in specific populations. • Ensure that screening, treatment and care for cervical cancer is routinely included in all sexual and reproductive health services for all women, including women living with HIV.
4.4 Provide early access to treatment and rapid linkage to effective care for STIs and common coinfections and comorbidities	<ul style="list-style-type: none"> • Provide STI services or links to such services in PHC, HIV, sexual and reproductive health, youth health, family planning, perinatal care and immunization programmes. • Ensure the availability of effective STI treatments and commodities, and medicines, with a particular focus on quality-assured drugs and diagnostics, and ensure they are offered to consumers with no co-payments.
4.5 Sustain the gains in financing and planning	<ul style="list-style-type: none"> • Develop an up-to-date national plan and establish targets and milestones for ending the STIs of public health concern and regularly evaluate and report on progress. The national plan should define and deliver an essential package of high-impact, evidence-based STI interventions relevant to the country context and tailored to the needs of key populations and settings. This should include, at a minimum: the delivery of health information and education, condom programming, evidence-based clinical guidelines, partner notification standards, the use of perinatal care settings for routine screening and care, greater use of social marketing programmes, and ensuring access to HPV and hepatitis B vaccination. • Ensure that the national STI plans are funded, and consider the inclusion of STI control activities for HIV prevention in funding requests to the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Priority actions for WHO and partner organizations

Table 14 sets out the priority actions for WHO and partner agencies for Strategic Direction 4.

Table 14. Priority actions for WHO and partner agencies for Strategic Direction 4

Priority	WHO/partner organization actions
4.1 Collect and use strategic information for focused action and equity across the continuum of care	<ul style="list-style-type: none"> • Support countries to finance STI surveillance and improve the availability and quality of surveillance data, and report STI trends in the Region together with ECDC. This includes supporting the development of strategic information systems, case reporting, prevalence assessments, aetiological assessment and AMR monitoring. • Provide regular reporting of the Region's progress and areas for focus, in collaboration with ECDC.
4.2 Prevent the transmission of STIs, with a focus on key populations	<ul style="list-style-type: none"> • Identify, evaluate, disseminate and scale up best practices in STI prevention and treatment, including through translational, implementation and communication science research. • Build the capability of the health workforce (including the PHC workforce) through ongoing capacity development and training curricula focused on STI prevention, treatment and screening. • Support countries to develop service delivery models that adopt additional, evidence-based, quality-assured STI testing technologies, including self-sampling, self-testing and the use of point-of-care platforms to improve the accessibility of testing. • Support the development and dissemination of consolidated STI management guidelines that include clinical, operational and programmatic guidance on screening, testing, treatment, partner notification and counselling.

Table 14. contd.

Priority	WHO/partner organization actions
4.3 Strategically increase testing and ensure early diagnosis of STIs	<ul style="list-style-type: none"> • Develop and disseminate guidance and tools to strengthen STI service integration within health systems, including integrated testing and decentralized, PHC-based and outreach models of care, delivered in partnership with civil society and community-based organizations. • Provide support to identify and address AMR of sexually transmitted pathogens. This includes identifying AMR in <i>N. gonorrhoeae</i> and <i>Mycoplasma genitalium</i> under Euro-GASP and other efforts to monitor AMR and contain the spread of untreatable gonorrhoea.
4.4 Provide early access to treatment and rapid linkage to effective care for STIs and common coinfections and comorbidities	<ul style="list-style-type: none"> • Develop novel models of providing accessible care, including increasing the capacity of PHC to test, treat and manage STIs; task shifting; and the delivery of community-based services to reach key populations.
4.5 Sustain the gains in financing and planning	<ul style="list-style-type: none"> • Promote affordability, efficiency and reliability in the country-level procurement of, and supply chains for, STI medicines, diagnostics and commodities through regional pooled procurement platforms (including to prevent shortages of long-acting penicillin and spectinomycin and other antimicrobials prescribed/indicated by treatment guidelines). • Support countries to establish and build a business case for STI surveillance programmes at the country level. • Support the development of regionalized and country-specific research agendas and facilitate development and trialling of new biomedical and public health interventions.

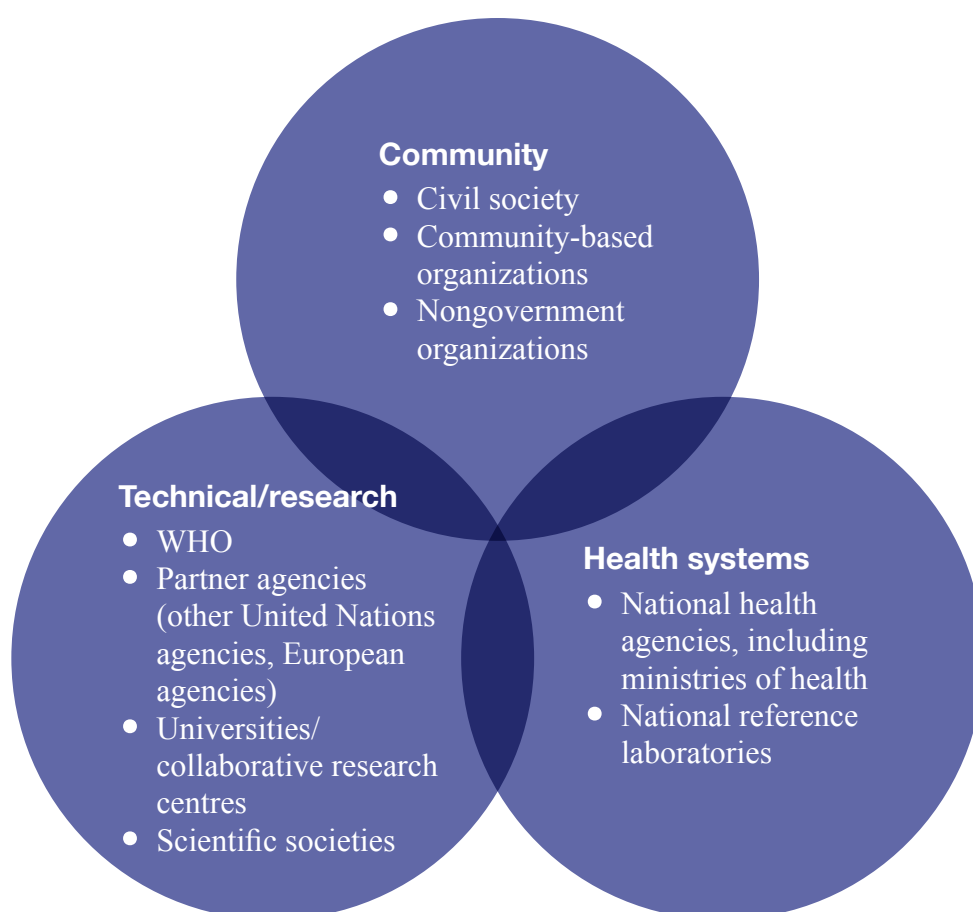
Partnerships, accountability and progress monitoring

Partnerships

Implementing the Regional action plans, as well as sustaining previous gains and advancing in each of the disease-specific areas, can only be accomplished by the countries of the Region through effective partnerships.

At the core of any country response should be a three-way collaboration of: 1) health systems; 2) civil society organizations, with their knowledge and experience about key populations and those most at risk; and 3) disease-specific technical expertise, which can be offered by WHO and partner agencies, including national and regional research agencies and universities (see Fig. 1).

Fig. 1. Collaborative partnership model for the implementation of the Regional action plans

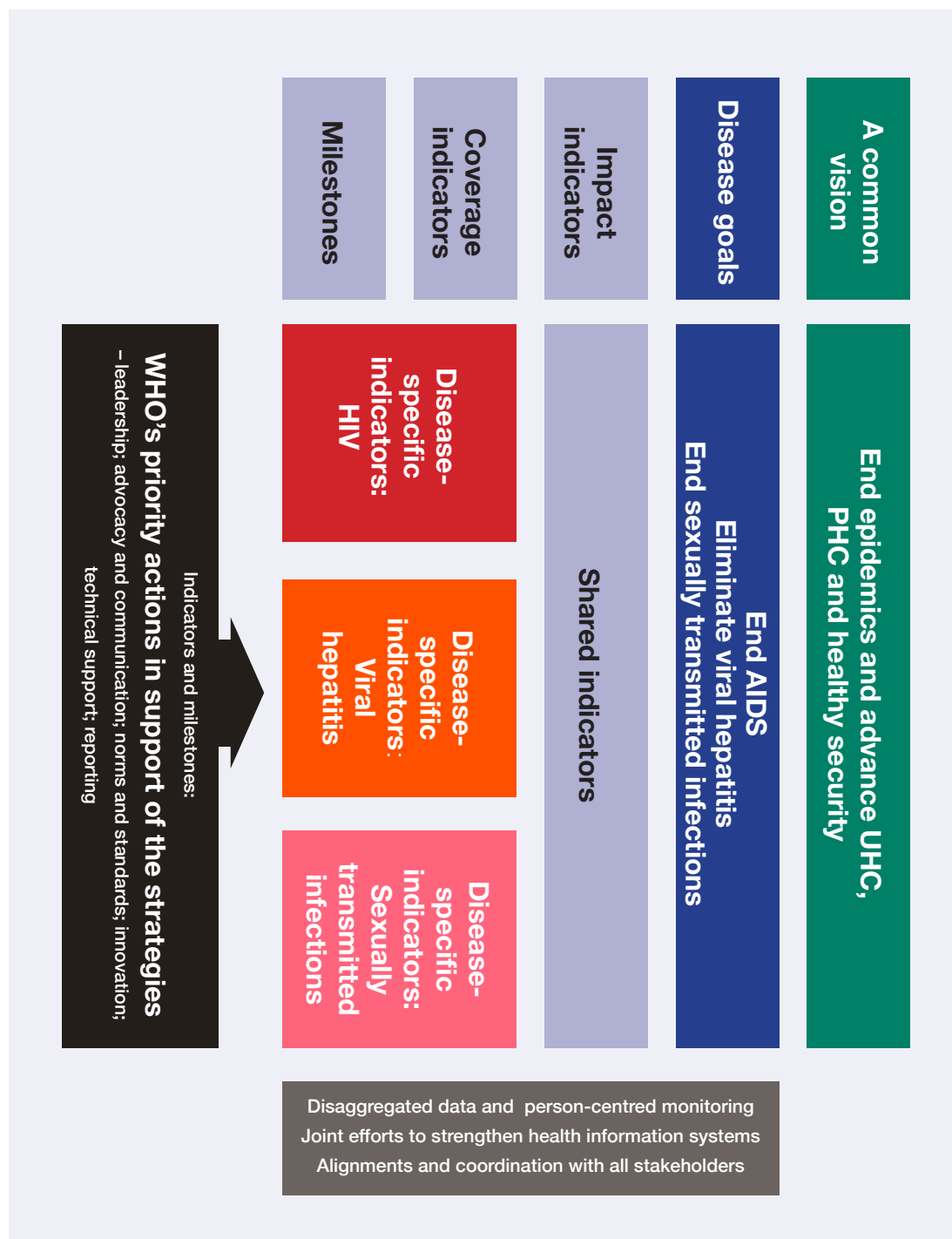


Accountability, monitoring and reporting

Driving continued progress towards ending AIDS and the epidemics of VH and STIs will require regular and transparent monitoring, accountability frameworks and reporting mechanisms. This will enable periodic monitoring and reviewing of priorities and realigning of resources.

The Regional action plans will draw on the reporting framework, information systems and mechanisms identified in the GHSS for HIV, VH and STIs (8) to minimize the administrative burden for countries in the Region (Fig. 2).

Fig. 2. Reporting framework for the GHSS for HIV, VH and STIs



Note: Interim targets for 2025 have been outlined in the GHSS and include two targets from the EPW. An interim review of the progress in the Region will be conducted in 2026, which will allow the countries of the Region to identify emerging issues and review the strategic priorities. Special attention will be given to the implementation of STI-specific strategies, given their novelty in these Regional action plans.

References

1. Global progress report on HIV, viral hepatitis and sexually transmitted infections. Accountability for the global health sector strategies 2016–2021: actions for impact. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/341412>, accessed 29 November 2022).
2. Action plan for the health sector response to HIV in the WHO European Region. Copenhagen: WHO Regional Office for Europe; 2017 (<https://apps.who.int/iris/handle/10665/329423>, accessed 29 November 2022).
3. Action plan for the health sector response to viral hepatitis in the WHO European Region. Copenhagen: WHO Regional Office for Europe; 2017 (<https://apps.who.int/iris/handle/10665/344154>, accessed 29 November 2022).
4. Hepatitis C – key facts [online factsheet]. Geneva: World Health Organization; 2022 (<https://www.who.int/news-room/fact-sheets/detail/hepatitis-c#:~:tex- t=Overview,of%20infection%20without%20any%20treatment>, accessed 29 November 2022).
5. Implementation of the Action Plan for Health Sector Response to Viral Hepatitis in the WHO European Region. Final progress report. Copenhagen: WHO Regional Office for Europe; 2022 (EUR/RC72/17(A); <https://apps.who.int/iris/handle/10665/360902>, accessed 29 November 2022).
6. Global AIDS Update 2020. Seizing the moment. Tackling entrenched inequalities to end epidemics. Geneva: Joint United Nations Programme on HIV and AIDS (UNAIDS); 2020 (<https://www.unaids.org/en/resources/documents/2020/global-aids-report>, accessed 5 January 2023).
7. Beale MA, Marks M, Cole MJ, Lee M-K, Pitt R, Ruis C et al. Contemporary syphilis is characterized by rapid global spread of pandemic *Treponema pallidum* lineages. medRxiv. 2021. doi: 10.1101/2021.03.25.21250180.
8. Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022–2030. Geneva: World Health Organization; 2022 (<https://apps.who.int/iris/handle/10665/360348>, accessed 29 November 2022).
9. Political declaration on HIV and AIDS: On the fast track to accelerating the fight against HIV and to ending the AIDS epidemic by 2030. Resolution adopted by the General Assembly. New York: United Nations General Assembly; 2016 (<https://digitallibrary.un.org/record/833243?ln=en>, accessed 29 November 2022).
10. Action plan for the health sector response to HIV in the WHO European Region. Final progress report. Copenhagen: WHO Regional Office for Europe; 2022 (EUR/RC72/17(B); <https://apps.who.int/iris/handle/10665/360910>, accessed 29 November 2022).
11. SDG 3. Good health and well-being. Ensure healthy lives and promote well-being for all at all ages – Overview [online factsheet]. Geneva: United Nations; 2022 (<https://sdgs.un.org/goals/goal3>, accessed 30 November 2022).
12. The Triple Billion targets [webpage]. Geneva: World Health Organization; 2022 (<https://www.who.int/news-room/q-a-detail/the-triple-billion-targets>, accessed 30 November 2022).
13. European Programme of Work (2020–2025) – “United Action for Better Health”. Copenhagen: WHO Regional Office for Europe; 2021 (<https://apps.who.int/iris/handle/10665/339209>, accessed 30 November 2022).
14. United Action Against Cancer [factsheet]. Copenhagen: WHO Regional Office for Europe; 2021 (<https://who.canto.global/b/GLLE3>, accessed 30 November 2022).
15. Realizing the potential of primary health care: lessons learned from the COVID-19 pandemic and implications for future directions in the WHO European Region.

- Copenhagen: WHO Regional Office for Europe; 2021 (EUR/RC71/9; <https://apps.who.int/iris/handle/10665/343168>, accessed 30 November 2022).
16. Background document: Tuberculosis Action Plan for the WHO European Region 2023–2030. Copenhagen: WHO Regional Office for Europe; 2022 (EUR/RC72/BG/6; <https://apps.who.int/iris/handle/10665/361921>, accessed 30 November 2022).
 17. Action plan for the prevention and control of noncommunicable diseases in the WHO European Region. Copenhagen: WHO Regional Office for Europe; 2016 (<https://apps.who.int/iris/handle/10665/341522>, accessed 30 November 2022).
 18. European strategic action plan for antibiotic resistance. Copenhagen: WHO Regional Office for Europe; 2011 EUR/RC61/14; <https://apps.who.int/iris/handle/10665/335840>, accessed 30 November 2022).
 19. WHO European framework for action on mental health 2021–2025. Copenhagen: WHO Regional Office for Europe; 2021 (<https://apps.who.int/iris/handle/10665/352549>, accessed 30 November 2022).
 20. European framework for action on integrated health services delivery: an overview. Copenhagen: WHO Regional Office for Europe; 2016 (https://www.euro.who.int/_data/assets/pdf_file/0010/317377/FFA-IHS-service-delivery-overview.pdf, accessed 30 November 2022).
 21. Action plan for sexual and reproductive health: towards achieving the 2030 Agenda for Sustainable Development in Europe – leaving no one behind. Copenhagen: WHO Regional Office for Europe; 2016 EUR/RC66/13; <https://apps.who.int/iris/handle/10665/338130>, accessed 30 November 2022).
 22. European Immunization Agenda 2030. Copenhagen: WHO Regional Office for Europe; 2021 (<https://apps.who.int/iris/handle/10665/348002>, accessed 30 November 2022).
 23. Roadmap to accelerate the elimination of cervical cancer as a public health problem in the WHO European Region, 2022–2030. Copenhagen: WHO Regional Office for Europe; 2021 (EUR/RC72/BG17; <https://apps.who.int/iris/handle/10665/362396>, accessed 30 November 2022).
 24. Europe’s Beating Cancer Plan. Brussels: European Commission; 2021 (https://health.ec.europa.eu/system/files/2022-02/eu_cancer-plan_en_0.pdf, accessed 30 November 2022).
 25. Regional digital health action plan for the WHO European Region 2023–2030. Copenhagen: WHO Regional Office for Europe; 2022 (EUR/RC72/5; <https://apps.who.int/iris/handle/10665/360950>, accessed 30 November 2022).
 26. European regional action framework for behavioural and cultural insights for health, 2022–2027 [video]. Copenhagen: WHO Regional Office for Europe; 2022 (<https://www.who.int/europe/multi-media/item/european-regional-action-framework-for-behavioural-and-cultural-insights-for-health--2022-2027>, accessed 30 November 2022).
 27. Political declaration on HIV and AIDS: ending inequalities and getting on track to end AIDS by 2030. New York: United Nations; 2021 (https://www.unaids.org/en/resources/documents/2021/2021_political-declaration-on-hiv-and-aids, accessed 30 November 2022).
 28. Global AIDS Strategy 2021–2026 – End inequalities. End AIDS. Geneva: UNAIDS; 2016 (<https://www.unaids.org/en/resources/documents/2021/2021-2026-global-AIDS-strategy>, accessed 30 November 2022).
 29. Council of the European Union, General Secretariat. European Union Drugs Strategy 2021–2025. Luxembourg: Publication Office of the European Union; 2021 (<https://www.consilium.europa.eu/media/49194/eu-drugs-strategy-booklet.pdf>, accessed 30 November 2022).
 30. European Monitoring Centre for Drugs and Drug Addiction. EMCDDA Strategy, 2025. Luxembourg: Publications Office of the European Union; 2017 (<https://www.emcdda>.

europa.eu/system/files/publications/4273/2017.1998_EMCCDDA_STRATEGY_2025_web-1.pdf, accessed 30 November 2022).

31. Political declaration of the high-level meeting on universal health coverage. New York: United Nations General Assembly; 2019 (<https://undocs.org/en/A/RES/74/2>, accessed 30 November 2022).
32. Declaration of Astana. Astana: Global Conference on Primary Health Care. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF); 2018 (<https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf>, accessed 28 June 2022).
33. The world health report 2000. Health systems: improving performance. Geneva: World Health Organization; 2000 (<https://apps.who.int/iris/handle/>, accessed 27 March 2023).
34. United Nations General Assembly Resolution 75/284. Political declaration on HIV and AIDS: ending inequalities and getting on track to end AIDS by 2030. New York: United Nations; 2021 (https://www.unaids.org/en/resources/documents/2021/2021_political-declaration-on-hiv-and-aids, accessed 30 November 2022).
35. Prevention of mother-to-child transmission of hepatitis B virus: Guidelines on antiviral prophylaxis in pregnancy. Geneva: World Health Organization; 2020 (<https://apps.who.int/iris/handle/10665/333391>, accessed 30 November 2022).
36. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, 2016 update. Geneva: World Health Organization; 2016 (<https://apps.who.int/iris/handle/10665/246200>, accessed 30 November 2022).
37. WHO position paper on hepatitis E vaccines. Geneva: World Health Organization; 2015 (<https://apps.who.int/iris/handle/10665/242352>, accessed 30 November 2022).
38. Policy brief: guidelines for the prevention, care and treatment of persons with chronic hepatitis B infection. Geneva: World Health Organization; 2015 (<https://apps.who.int/iris/handle/10665/155081>, accessed 30 November 2022).
39. Guidance on prevention of viral hepatitis B and C among people who inject drugs. Geneva: World Health Organization; 2012 (WHA67/2014/REC/1; <https://apps.who.int/iris/handle/10665/260211>, accessed 20 March 2023).
40. Resolution WHA67.6. Viral hepatitis. Geneva: World Health Organization; 2014 (https://apps.who.int/gb/ebwha/pdf_files/WHA67/A67_R6-en.pdf, accessed 5 January 2023).
41. WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment, and care for injecting drug users. Geneva: World Health Organization; 2009 (https://www.unaids.org/sites/default/files/sub_landing/idu_target_setting_guide_en.pdf, accessed 5 January 2023).
42. HIV prevention, treatment, care and support for people who use stimulant drugs. Technical guide. Vienna: United Nations Office on Drugs and Crime; 2019 (https://www.unodc.org/documents/hiv-aids/publications/People_who_use_drugs/19-04568_HIV_Prevention_Guide_ebook.pdf, accessed 5 January 2023).
43. WHO Regional Office for Europe/European Centre for Disease Prevention and Control. HIV/AIDS surveillance in Europe 2020 (2019 data). Copenhagen: WHO Regional Office for Europe; 2020 (<https://apps.who.int/iris/handle/10665/337037>, accessed 6 January 2023).
44. European Centre for Disease Prevention and Control/WHO Regional Office for Europe. HIV/AIDS surveillance in Europe 2021 (2020 data). Stockholm: European Centre for Disease Prevention and Control; 2021 (<https://www.ecdc.europa.eu/en/publications-data/hiv-aids-surveillance-europe-2021-2020-data>, accessed 1 December 2022).
45. Global tuberculosis report 2021. Geneva: World Health Organization; 2021 (<https://www.who.int/publications/i/item/9789240037021>, accessed 1 December 2022).

46. SDG indicators: metadata repository [online database]. New York: United Nations; 2022 (<https://unstats.un.org/sdgs/metadata/?Text=&Goal=5&Target=>, accessed 1 December 2022).
47. Stigma Index [website] (<https://www.stigmaindex.org/about-the-stigma-index/>, accessed 27 March 2023).
48. Stockdale AJ, Kreuels B, Henrion MYR, Giorgi E, Kyomuhangi I, de Martel C et al. The global prevalence of hepatitis D virus infection: systematic review and meta-analysis. *J Hepatol.* 2020;73:523–32. doi: 10.1016/j.jhep.2020.04.008.
49. Global AIDS Monitoring 2019: indicators for monitoring the 2016 United Nations Political Declaration on Ending AIDS. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS); 2018 (<https://www.aidsdatahub.org/sites/default/files/resource/un aids-global-aids-monitoring-2019.pdf>, accessed 2 December 2022).
50. Pimpin L, Cortez-Pinto H, Negro F, Corbould E, Lazarus JV, Webber L et al. Burden of liver disease in Europe: epidemiology and analysis of risk factors to identify prevention policies. *J Hepatol.* 2018;69:718–35. doi: 10.1016/j.jhep.2018.05.011.
51. Sung H, Ferlay J, Siegel RL, Laversanne M, Soerjomataram I, Jemal A et al. Global cancer statistics 2020: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries. *CA Cancer J Clin.* 2021;71:209–49. doi: 10.3322/caac.21660.
52. Interim guidance for country validation of viral hepatitis elimination. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/341652>, accessed 2 December 2022).
53. Khetsuriani N, Mosina L, Van Damme P, Mozalevskis A, Datta S, Tohme RA. Progress toward hepatitis B control – World Health Organization European Region, 2016–2019. *MMWR Morb Mortal Wkly Rep.* 2021;70:1029–35. doi: 10.15585/mmwr.mm7030a1.
54. Traeger MW, Schroeder SE, Wright EJ, Hellard ME, Cornelisse VJ, Doyle JS et al. Effects of pre-exposure prophylaxis for the prevention of human immunodeficiency virus infection on sexual risk behavior in men who have sex with men: a systematic review and meta-analysis. *Clin Infect Dis.* 2018;67:676–86. doi: 10.1093/cid/ciy182.
55. Surveillance atlas of infectious diseases [online database]. Stockholm: European Centre for Disease Prevention and Control; 2022 (<https://atlas.ecdc.europa.eu/public/index.aspx>, accessed 6 December 2022).
56. Barbaric J, Kuchukhidze G, Seguy N, Vovc E, Babovic MJT, Wi TE et al. Surveillance and epidemiology of syphilis, gonorrhoea and chlamydia in the non-European Union countries of the World Health Organization European Region, 2015 to 2020. *Euro Surveill.* 2022;27(8):2100197. doi: 10.2807/1560-7917.ES.2022.27.8.2100197.
57. Unemo M, Lahra MM, Escher M, Eremin S, Cole MJ, Galarza P et al. WHO global antimicrobial resistance surveillance for *Neisseria gonorrhoeae* 2017–18: a retrospective observational study. *Lancet Microbe.* 2021;2:e627–e36. doi: 10.1016/s2666-5247(21)00171-3.
58. Korenromp EL, Rowley J, Alonso M, Mello MB, Wijesooriya NS, Mahiané SG et al. Global burden of maternal and congenital syphilis and associated adverse birth outcomes – Estimates for 2016 and progress since 2012. *PLoS One.* 2019;14:e0211720. doi: 10.1371/journal.pone.0211720.

Annex. Regional action plans for ending AIDS and the epidemics of viral hepatitis and sexually transmitted infections 2022–2030*

Resolution

The Regional Committee,

Having considered the draft Regional action plans for ending AIDS and the epidemics of viral hepatitis and sexually transmitted infections 2022–2030, which were developed based on consultations with Member States and civil society organizations;¹

Concerned that HIV, viral hepatitis and sexually transmitted infections (STIs) continue to pose a major public health burden in the WHO European Region, affecting millions of people with long-term complications, affecting quality of life and causing premature mortality, especially in key populations;²

Concerned that stigmatization and discrimination still pose a major challenge to diagnosis and treatment of STIs, and especially HIV/AIDS, in the Region;

Recognizing (i) the need for an integrated response to and management of HIV, viral hepatitis and STIs, with a focus on nationally defined, people-centred, differentiated, decentralized, adequately financed, sustainable and resilient service delivery (according to the national capacity), (ii) that service delivery should be undertaken in a way that promotes gender equity and human rights, and through united action of primary health care, civil society and communities, and public health institutions, as well as through universal access to health care and commodities, and (iii) the benefits that the above can bring to minimize the impacts of pandemics and other health emergencies;

Considering the 2030 Agenda for Sustainable Development and the Sustainable Development Goals, in particular Sustainable Development Goal target 3.3;

Recognizing the progress made in the Region through implementation of the Action Plan for the Health Sector Response to HIV in the WHO European Region (resolution EUR/RC66/R9) and the Action Plan for the Health Sector Response to Viral Hepatitis in the WHO European Region (resolution EUR/RC66/R10), while acknowledging that many of the 2020 targets of both action plans have not been met, as presented in the final progress reports;³

*Seventy-second Regional Committee for Europe: Tel Aviv, 12–14 September 2022: Regional action plans for ending AIDS and the epidemics of viral hepatitis and sexually transmitted infections 2022–2030: resolution. Copenhagen: WHO Regional Office for Europe; 2022 (<https://apps.who.int/iris/handle/10665/363080>).

¹ Working document EUR/RC72/9.

² For HIV, key populations are people who inject drugs, men who have sex with men, transgender people, sex workers, people in prisons and correctional facilities, and migrants, as well as their sexual partners. For hepatitis, additional groups include people who use drugs, people who have been exposed to the hepatitis virus through unsafe blood supplies and unsafe medical injections and procedures, people with thalassemia who are at increased risk of transfusion-related hepatitis infection, and infants born to hepatitis B surface antigen-positive mothers. For STIs, additional groups include young people, pregnant women and women of childbearing age.

³ EUR/RC72/17(A); EUR/RC72/17(B).

Recognizing the importance of committing to the promotion, protection and fulfilment of all human rights and to the full and effective implementation of the Beijing Platform for Action and the Programme of Action of the International Conference on Population and Development (ICPD) and the outcomes of their review conferences, and of remaining committed to sexual and reproductive health and rights (SRHR), in this context, to commit to the promotion, protection and fulfilment of the right of every individual to have full control over, and decide freely and responsibly on matters related to their sexuality and sexual and reproductive health, free from discrimination, coercion and violence and to further stress the need for universal access to quality and affordable comprehensive sexual and reproductive health information, education, including comprehensive sexuality education and health-care services;

Recognizing further the benefits that the above can also bring to minimizing the impacts of pandemics and other health emergencies;

Recognizing the importance of responding to HIV, viral hepatitis and STIs within the framework of the Thirteenth General Programme of Work, 2019–2025, and the European Programme of Work, 2020–2025 – “United Action for Better Health in Europe”, adopted through resolution EUR/RC70/R3;

Recalling the United Nations General Assembly’s 2021 Political declaration on HIV and AIDS: ending inequalities and getting on track to end AIDS by 2030;⁴

Recalling World Health Assembly resolution WHA75.20, in 2022, taking note with appreciation of the Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections, for the period 2022–2030;

Recognizing the health and economic consequences of the ongoing COVID-19 pandemic and of any future pandemics or emergencies, military conflicts and natural disasters, particularly for those in marginalized and vulnerable situations, and noting the need to regain lost ground and increase resilience to future crises;

Recognizing the need to strengthen prevention of new HIV infections and STIs and to end AIDS as a public health threat by 2030;

Acknowledging the need for political commitment, country ownership and collective actions from all relevant stakeholders to achieve the goals of ending AIDS and the epidemics of viral hepatitis and STIs;

1. ADOPTS the Regional action plans for ending AIDS and the epidemics of viral hepatitis and sexually transmitted infections 2022–2030 and their vision, goals, strategic directions, targets and priority actions;
2. URGES Member States:⁵
 - a. to commit to the promotion, protection and fulfilment of all human rights and to the full and effective implementation of the Beijing Platform for Action and the Programme of Action of the International Conference on Population and

⁴The political declaration was adopted by vote, with 165 Member States voting in favour of and four voting against the adoption.

⁵And, where applicable, regional economic integration organizations.

Development (ICPD) and the outcomes of their review conferences, and to remain committed to sexual and reproductive health and rights (SRHR), in this context, to commit to the promotion, protection and fulfilment of the right of every individual to have full control over, and decide freely and responsibly on matters related to their sexuality and sexual and reproductive health, free from discrimination, coercion and violence, and to further stress the need for universal access to quality and affordable comprehensive sexual and reproductive health information education, including comprehensive sexuality education and health-care services;

- b. to enhance commitment, invest adequate resources and scale up evidence-based interventions to end AIDS and the epidemics of viral hepatitis and STIs, in particular by strengthening prevention of new HIV infections and STIs;
- c. to align, as appropriate, their national HIV, viral hepatitis and STI strategies and action plans and targets with the Regional action plans for ending AIDS and the epidemics of viral hepatitis and sexually transmitted infections 2022–2030;
- d. to ensure that the needs of people affected by HIV, viral hepatitis and STIs, and the needs of key populations at risk of acquiring these diseases, are addressed through nationally defined, people-centred, decentralized, gender-responsive and sustainably financed service delivery, according to the national capacity, through a partnership-based approach with civil society, communities, primary health care, social services and public health institutions, and to ensure that services are delivered in a way that promotes human rights;
- e. to ensure that prevention, treatment and care programmes are sustainably financed to end AIDS and the epidemics of viral hepatitis and STIs, moving towards achievement of the universal health coverage goals;
- f. to prioritize data-driven decision-making, to foster operational research, to instill appropriate governance mechanisms of health information systems and telemedicine, to expand the use of digital health solutions, and to use data to address inequalities;
- g. to regain lost progress in HIV, viral hepatitis and STI coverage, outcome and impact targets due to the COVID-19 pandemic and due to humanitarian, health and other emergencies, and to improve the resilience of programmes to prevent similar impact due to emergencies;
- h. to urgently increase access to health services, including comprehensive HIV prevention programmes in key populations, a full range of testing strategies to achieve early diagnosis, and universal HIV treatment coverage with optimized antiretroviral regimens, as well as multidisciplinary services for the long-term holistic care of people ageing with HIV;
- i. to prioritize access of people living with HIV to appropriate services linked to prevention, screening and treatment for tuberculosis and hepatitis coinfections;
- j. in line with national priorities and epidemiologic context, to (i) allocate increased financial resources to expand comprehensive viral hepatitis interventions for people affected by viral hepatitis, including preventive interventions for key populations and for pregnant women, mothers and newborns, (ii) expand testing and early diagnosis of

viral hepatitis infections, as well as simplified, affordable and decentralized treatment of hepatitis B and C, and (iii) strengthen surveillance and monitoring;

- k. to plan for comprehensive STI prevention, testing and treatment interventions, including integrating STI-related services into all services for key populations and people living with HIV and expanding the use of quality-assured testing technologies, human papillomavirus vaccination, and cervical cancer screening and treatment for women living with HIV, and to strengthen STI surveillance and monitoring of the antimicrobial resistance of STIs;
- l. to formulate appropriate national regulations and policies to reduce discrimination, to ensure an enabling environment for people living with HIV and affected by viral hepatitis and STIs, key populations, and those at risk of acquiring HIV, viral hepatitis and STIs in accessing services linked to HIV, viral hepatitis and STIs, and to plan targeted communication strategies reaching the general public, health professionals, people living with HIV and affected by viral hepatitis and STIs, and key populations, aiming to improve care and treatment as well as to reduce stigmatization and discrimination;
- m. to report on the monitoring indicators in the Regional action plans for ending AIDS and the epidemics of viral hepatitis and sexually transmitted infections 2022–2030;

3. REQUESTS the Regional Director:

- a. to support the Member States by advocating for demonstrable political commitment and adequate investment in ending AIDS and the epidemics of viral hepatitis and STIs, in partnership with international, regional and national partners, including civil society and communities;
- b. to strengthen subregional collaboration to implement the strategic priorities outlined in the Regional action plans for ending AIDS and the epidemics of viral hepatitis and sexually transmitted infections 2022–2030, and to facilitate the peer-to-peer exchange of country experiences, with a focus on overcoming implementation barriers;
- c. to support operational research, including with engagement of communities, and accelerate and scale up innovative strategies based on locally tailored knowledge and evidence-informed approaches;
- d. to foster collaboration between regional and national public health institutions, as well as national and subnational stakeholders and partners, and to provide strategic direction towards implementation of national action plans;
- e. to report on the progress made in the implementation of the action plans by submitting a midterm progress report to the Regional Committee at its 76th session and a final report on the 2030 goals at its 81st session.

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

Member States

Albania	Germany	Poland
Andorra	Greece	Portugal
Armenia	Hungary	Republic of Moldova
Austria	Iceland	Romania
Azerbaijan	Ireland	Russian Federation
Belarus	Israel	San Marino
Belgium	Italy	Serbia
Bosnia and Herzegovina	Kazakhstan	Slovakia
Bulgaria	Kyrgyzstan	Slovenia
Croatia	Latvia	Spain
Cyprus	Lithuania	Sweden
Czechia	Luxembourg	Switzerland
Denmark	Malta	Tajikistan
Estonia	Monaco	Türkiye
Finland	Montenegro	Turkmenistan
France	Netherlands	Ukraine
Georgia	(Kingdom of the)	United Kingdom
	North Macedonia	Uzbekistan
	Norway	



**World Health Organization
Regional Office for Europe**

UN City, Marmorvej 51,
DK-2100 Copenhagen Ø, Denmark
Tel.: +45 45 33 70 00
Fax: +45 45 33 70 01
Email: eurocontact@who.int
Website: www.who.int/europe