## Annex 1. Example of mapped baseline set of services and interventions for a country priority-setting exercise

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| **Services and interventions** | | **Systems, operational and enabling contexts** |
| Prevention of vertical transmission of HIV, hepatitis B and syphilis *(1–3)* | * Integrate testing into routine antenatal care contacts * Test all pregnant women as early as possible in pregnancy or during breastfeeding for HIV, hepatitis B surface antigen and syphilis * Provide partner testing of pregnant women diagnosed with HIV and syphilis and network-based testing for household members and partners of women diagnosed with chronic hepatitis B infection * PrEP options should be available for HIV serodiscordant couples * Use lower-cost, WHO-prequalified rapid diagnostics, including dual HIV and syphilis rapid tests and HIV self-testing * Immediate ART initiation or referral for initiation for all pregnant or breastfeeding women testing HIV positive * Prophylaxis with tenofovir disoproxil fumarate for all hepatitis B surface antigen–positive pregnant women with hepatitis B DNA >200 000 IU/mL or hepatitis B e antigen–positive (or to all hepatitis B surface antigen–positive pregnant women when hepatitis B DNA is not available) * Tenofovir disoproxil fumarate is recommended preferably from the second trimester of pregnancy until at least delivery or completion of the infant hepatitis B vaccination series. This should be accompanied by counselling and linkage to appropriate care and follow-up * For pregnant women with early syphilis, treat with single benzylpenicillin (penicillin G) injection given as one 2.4 million-unit injection or two 1.2 million-unit injections. For those with late or unknown stage of syphilis, treat with 2.4 million units of benzathine benzylpenicillin intramuscularly once weekly for three consecutive weeks. This can be given as one 2.4 million-unit injection or two 1.2 million-unit injections per dose. Penicillin G once weekly for three consecutive weeks * HIV retesting for pregnant women in the third trimester in settings with HIV prevalence ≥5% and for those with ongoing risk of infection * Tracing of pregnant women having positive results for HIV, hepatitis B and/or syphilis to ensure that they receive appropriate care and treatment * Infant antiretroviral drug prophylaxis for infants born to mothers living with HIV in accordance with the national protocol and co-trimoxazole prophylaxis from 4–6 weeks onwards until HIV infection is ruled out * Timely infant hepatitis B birth dose vaccination for all newborns within 24 hours of birth (regardless of maternal hepatitis B surface antigen status) followed by routine childhood vaccination series * After delivery, catch-up testing for mothers and early infant diagnosis for infants could be integrated into routine postpartum contacts * Early infant diagnosis for HIV-exposed infants at 4–6 weeks of life using nucleic acid amplification testing (DNA-polymerase chain reaction), with immediate ART initiation for all positive infants (see the section on treatment) * Immediate infant or child ART initiation for positive infants or young children with redrawing of laboratory sample for confirmatory testing * Routine follow-up and repeat HIV testing at nine months and the end of breastfeeding using an age-appropriate test for breastfeeding infants exposed to HIV * For infants with confirmed congenital syphilis or born to mothers with untreated or inadequately treated syphilis, treat with benzyl penicillin or procaine benzylpenicillin using weight-based dosing for 10–15 days * Offer PrEP to reduce the risk of acquiring HIV for pregnant and breastfeeding women at high risk (serodiscordance) | * Ensure that health-care personnel are equipped with the knowledge, skills and resources to provide services for preventing vertical transmission alongside routine maternal, newborn and immunization services * Align or integrate post-delivery follow-up contacts with routine postnatal and immunization schedules * Develop catch-up plans for mothers and newborns who miss follow-up visits, including HIV and syphilis testing, prophylaxis and treatment (such as infant antiretroviral drug prophylaxis). * If services are moved, relocated or co-located with related services, convene a multidisciplinary transition team and assess the related systems implications, opportunities including commodity supply chain coordination, health workforce training and roster planning, client information and any physical adjustments that may be required within facilities |
| Hepatitis B vaccination – infants *(4, 5)* | * Continue complete hepatitis B vaccine series through the Expanded Programme on Immunization: timely birth dose should be followed by 2–3 additional doses of hepatitis B vaccine, depending on the specific schedule used in the country; WHO recommends that all infants complete the full primary vaccination series by six months of age | * Coordinate hepatitis B vaccination with routine immunization schedules and maternal and newborn services to reduce missed opportunities and resource duplication |
| Hepatitis B vaccination – adults *(4, 5)* | * Hepatitis B vaccination of adults (especially key populations) according to the national protocol | * Pre-vaccination serological testing for adults is preferrable but not essential |
| HIV PEP *(6)* | * Maintain availability of HIV PEP in care settings for occupational exposure * Expanded availability of HIV PEP, including for non-occupational exposure * Use rapid diagnostic testing and HIV self-testing for PEP initiation and follow-up | * Distribute PEP through task sharing in primary care settings and pharmacies * Use simplified protocols and job aids to enable non-specialist health workers to initiate PEP |
| HIV PrEP *(1, 7)* | * Uninterrupted access to HIV PrEP to reduce the risk of acquiring HIV, notably for key populations * Use oral PrEP over long-acting (long-acting cabotegravir and dapavirine vaginal ring) * Use rapid diagnostic testing and self-testing for HIV testing before initiating PrEP and for continuation. | * When possible, organize stocks and systems to facilitate multimonth dispensing of oral PrEP (3–6 months), including for clients initiating PrEP, depending on stock availability * Waiting for kidney function or hepatitis test results should not delay PrEP initiation or continuation. In addition, lack of available kidney function or hepatitis testing should not be a barrier to initiating or using PrEP |
| Blood product safety and health care infection control *(8)* | * Mandatory screening of all blood donations for HIV, hepatitis B, hepatitis C and syphilis before use in clinical care in accordance with WHO’s recommended essential in vitro diagnostics * Use sterile, single-use needles and syringes and properly dispose of sharps in puncture-proof containers; consider using safety-engineered injection devices where feasible | * Ensure linkage to care for people with positive screening results * Eliminate unnecessary injections, favouring oral medications when possible |
| Harm-reduction services, including opioid agonist maintenance therapy, needle and syringe programmes and naloxone provision for opioid overdose management *(4, 9)* | * Distribution of sterile needles, syringes and other harm-reduction supplies through facility-based and community-based services * Using alternative distribution routes, including public or private pharmacies, secondary distribution through peers and vending machines * Offering facility-based opioid agonist maintenance therapy services to people with opioid dependence, ideally including psychosocial support * Offering take-home dosages of opioid agonist maintenance therapy for stable clients * Facility-based and community-based distribution (through opioid agonist maintenance therapy and needle and syringe programmes) of naloxone kits for overdose management and prevention to clients, families and peers * Medical withdrawal management when requested by clients, when opioid agonist maintenance therapy continuation is not possible or in other specific circumstances | * When setting priorities for harm-reduction interventions, consider that continuing opioid agonist maintenance therapy services for clients who are already in the programme and providing naloxone for overdose management should be given priority as lifesaving in the short term * Direct collaboration with communities and key population networks since they are essential to identify and provide safe, effective service delivery channels with greater reach * Engaging peer workers may mitigate stigma towards clients of harm-reduction services and improve the acceptability and uptake of services |
| Provision of condoms and lubricants *(1)* | * Availability and distribution of condoms and lubricants at health-care facilities and, when feasible, at communities, giving priority to key populations and young people | * Integrate condom and lubricant distribution with other health services (such as family planning) |
| Voluntary medical male circumcision *(10)* | * Give priority to voluntary medical male circumcision services in settings and districts with high HIV prevalence and lower circumcision coverage for adolescents aged 15 years and older and adult men * Ensure that adequate information is provided and informed consent and assent are obtained before each procedure and other preoperative necessities in accordance with the WHO manual for male circumcision under local anaesthesia. * Continue follow-up services for clients recently circumcised (such as post-operative checks) * A minimum package of services, including education on safer sex, condom promotion, offer of HIV testing services and management of STIs, must be delivered along with the surgical procedure * Transition to sustainable voluntary medical male circumcision services and integrate with other health services for men | * Voluntary medical male circumcision services should be provided based on the principles of sustainability as described in WHO voluntary medical male circumcision sustainability guidance *(10)* with a focus on men aged 15 years and older. * Client safety, infection prevention and control remain critical operational considerations in accordance with the WHO manual for male circumcision under local anaesthesia and HIV prevention services for adolescent boys and men |
| Facility-based HIV testing services *(11)* | * Give priority to testing based on HIV burden, latest epidemiology and ART coverage and information on viral suppression at the subnational level * Give priority to maintaining routine testing access and coverage to the facilities with the greatest number of HIV-positive diagnoses and ART initiations * Give priority to testing for specific populations based on public health impact and the ability to identify the greatest number of HIV cases and the potential to prevent new infections. HIV testing priorities should include:   + sexually active adults and adolescents (15+): with HIV-related signs, symptoms or risk factors (including key populations) attending any clinic or hospital;   + individuals with TB, hepatitis C or STI coinfections: testing should be tailored to the localburden;   + children: those who are sick in high-HIV-burden settings (≥5% prevalence), HIV-exposed infants (optimally at six weeks) and any biological children of newly diagnosed people with HIV at any clinic or hospital;   + pregnant women: first antenatal care (12) contact or as early as possible if missed (aligned with guidance on preventing vertical transmission); and   + Partners of newly diagnosed people living with HIV and those in risk networks: at minimum, offering client referral with option of a self-test for all sexual and drug-injecting contacts as well as close contacts and associates identified to have substantial HIV risk. * Give priority to services to facilitate rapid ART initiation (or re-engagement) for all people following an HIV-positive diagnosis * Give priority to approaches that support low-cost rapid initiation and continuation of HIV prevention wherever available or offered for PEP and PrEP. | * Simplify testing delivery and discontinue all non-essential retesting: biannual testing for key populations and annual testing for other groups with ongoing risk, one targeted retest exclusively for pregnant women from key populations or in high-HIV-burden settings (≥5% prevalence) during third trimester or labour and delivery and one retest for HIV-exposed infants at the 6- to 9-month visit if breastfeeding * Discontinue all recency testing, Western blotting, use of other line immunoassays for routine HIV diagnosis and only use nucleic acid amplification for infant diagnosis <18 months. * Use lower-cost rapid tests and self-tests such as those prequalified by WHO: rapid diagnostic testing, dual HIV and syphilis tests and HIV self-testing * Use WHO-recommended flexible three-test rapid diagnostic testing strategy and simplified quality tools to ensure accuracy and prevent misdiagnosis and unnecessary ART initiation * Consider integrated testing and multiplexing (such as dual HIV and syphilis rapid diagnostic testing) based on epidemiology and resources * Task shift testing and test for triage using lay providers and self-tests across delivery |
| Facility-based testing for syphilis *(12)* | * Ensure that syphilis testing is available for pregnant women and key populations * Manage all positive cases with same-day treatment provided whenever possible. * Deliver prevention messages through community-based or remote channels. * Follow up with pregnant women and key populations who missed testing * Continue clinic-based syphilis screening for pregnant women and key populations * Offer catch-up testing and treatment for key populations and pregnant women who were affected by service interruptions | * Use network-based testing when community testing is no longer feasible to reach key populations and individuals at high risk of HIV infection outside facilities |
| Facility-based testing for viral hepatitis *(4, 5, 13)* | * Facility-based testing for hepatitis B and C, hepatitis B surface antigen and anti-hepatitis C serological testing in all settings for:   + adults and adolescents living with HIV, TB or STIs;   + key and high-risk populations, including migrant and indigenous populations, as well as populations from areas of high endemicity;   + adults, adolescents and children with a clinical suspicion of chronic viral hepatitis (symptoms, signs and laboratory markers); and   + blood donors. * All pregnant women should be tested for HIV, syphilis and hepatitis B surface antigen at least once and as early as possible during pregnancy (information aligned with the section on preventing vertical transmission) | * Use low-cost, WHO-prequalified rapid diagnostic testing or immunoassays * Ensure linkage to care for people with positive test results * Consider task shifting and hepatitis C self-testing approaches to reduce the burden on the health workforce |
| Community-based testing for HIV, viral hepatitis and syphilis *(11, 14)* | * Focus community-based testing for high-risk populations, with attention to the needs of key populations * Collaborate with community stakeholders to plan periodic (1–3 years) outreach testing activities based on the latest epidemiology and across disease areas * Workplace testing for men in high-risk industries through financing and partnerships with the private sector * Virtual service delivery and expand HIV self-testing access, including through pharmacies and user-paid delivery options * Consider options for hepatitis C self-testing distribution * When traditional community testing is no longer feasible, leverage facility network-based approaches to reach key populations and individuals at high risk of HIV infection | * Establish referral and follow-up systems that remain functional even when community-based services are temporarily disrupted * Integrate hepatitis and syphilis testing with HIV testing in community outreach to maximize efficiency |
| Routine ART for all children, adolescents and adults, including pregnant, breastfeeding women and key populations *(14)* | * Uninterrupted treatment to all individuals receiving ART, all populations (including pregnant, breastfeeding women and key populations) and regimens * Rapid ART initiation for all people diagnosed with HIV, including same-day ART initiation, including for individuals starting treatment outside a facility (such as during outreach or when attending mobile services) * Routine ART for children:   + uninterrupted dolutegravir-containing treatment to all children who are already receiving ART; and   + dispense three months of ART refills for children aged >2 years. | * In situations of severe antiretroviral drug stock-out or limited access, consider giving priority to people living with HIV with symptomatic disease and/or with CD4 <350 calls/mL * In situation of forced ART interruption because of stock-outs, all drug components of the regimen should be stopped at the same time and reinitiated together as soon as possible * Ensure the stability of the supply chain for paediatric formulations: redistribution, confirm antiretroviral drugs in the pipeline and plan for future orders * On-site capacity-building and tools for non-trained government health workers for paediatric formulations and dosing, adherence support and referral for advanced HIV disease management for children |
| Routine screening for people living with HIV initiating (and reinitiating) ART *(1)* | * CD4 testing:   + for individuals newly initiating ART; and   + for those returning to care after a period of disengagement. | * Establishing a stock threshold that triggers an alert when reached may help to prevent stock-outs and ensure the continuity of activities by enabling timely supply, response and coordination * Requires supply chain support to ensure the availability of reagents, maintain functional laboratory equipment and the presence of trained staff to support uninterrupted CD4 testing across all service delivery points |
| Advanced HIV disease management *(1)* | * Advanced disease package of care, including for those returning after having disengaged from treatment:   + screening and prophylaxis for common opportunistic infections (such as TB, cryptococcal meningitis and histoplasmosis);   + rapid ART initiation;   + treatment of identified opportunistic infections; and   + adherence support. * Use of device-free, point-of-care tests can facilitate continued implementation of the advanced HIV disease package of care – CD4 and lateral flow urine lipoarabinomannan assay can be conducted device-free, while cryptococcal antigen and GeneXpert can be conducted at the point of care * Preserve preventive prophylaxis with co-trimoxazole and fluconazole, repeat CD4 testing not required for stopping co-trimoxazole; can be discontinued after the individual is established on ART * Clinical screening to rule out signs and symptoms of meningitis * Referral and linkage reporting system for people transitioning in care (such as inpatient to outpatient) to minimize individuals lost to care * Offer TB preventive treatment | * Consult WHO guidelines on bacterial meningitis and the WHO AWARE antibiotic book for management of severe bacterial infections and WHO policy brief on caring for seriously ill people living with HIV |
| TB screening, diagnosis, treatment and prevention for people living with HIV *(1)* | * Screening, diagnosis, treatment and prevention for TB * Provision of adequate stocks of TB prevention medicines to all clients to support treatment completion * Give priority to using shorter WHO-approved TB preventive treatment regimens in certain populations | * Decentralize TB screening and TB preventive treatment provision to primary care, avoiding reliance on TB specialists in low-resource settings * Optimize sample transport |
| ART (viral load) monitoring *(1, 15)* | * Routine annual viral load monitoring testing (unless clinically indicated) * Testing after unsuppressed viral load: viral load testing three months after a previously elevated result (>1000 copies/mL) * Pregnancy:   + viral load at 34–36 weeks for all pregnant women;   + viral load at first antenatal care contact if ART started pre-conception; and   + viral load at three months if ART started during pregnancy. * Breastfeeding: viral load at three months postpartum, then every six months | * Develop catch-up testing for clients who missed a routine viral load test or had a previously unsuppressed result |
| Management of mpox (essential for outbreak control) *(16, 17)* | * Management of clients with suspected or confirmed mpox, following clinical and infection prevention guidelines * Clinical management of severe cases, especially among individuals with advanced HIV disease * Referral of severe cases to specialized care | * Develop referral pathways for severe cases for specialized care |
| Multimonth dispensing of 3–6 months of ART (reduced frequency of ART pick-up) *(14)* | * Minimum of 3 multimonth dispensing for all clients, unless clinically unwell, with 6 multimonth dispensing preferred (if feasible) * Enrolment of eligible clients in less-intensive differentiated service delivery models * Alternative antiretroviral drug distribution routes, including public or private pharmacies, secondary distribution through peers, vending machines, faith-based groups or centres, community posts and community models led by trained clients (such as community ART groups) | * Assess antiretroviral drug stock levels to guide the optimal refill and supply planning that ensures equitable distribution of antiretroviral drugs * Transition from groups led by health-care workers to client-led groups when necessary * Use of early-warning indicators to monitor and manage stock levels of antiretroviral, antituberculosis and antimalaria medicines |
| Viral hepatitis B treatment and monitoring *(4, 5, 13)* | * Uninterrupted treatment to all individuals already receiving hepatitis B treatment * Confirm eligibility for hepatitis B treatment for people with positive serology and assess level of liver disease and liver fibrosis and assess coinfections and comorbidities when indicated * Extended medicine supply at treatment initiation (with adherence support) to 3–6 months for hepatitis B treatment * Monitoring and follow-up: annual viral load monitoring for hepatitis B * Additionally, when enrolment into viral hepatitis treatment is continued:   + Provide hepatitis B treatment to all adults and adolescents aged ≥12 years with chronic hepatitis B infection (including pregnant women and girls and women of reproductive age) meeting the eligibility criteria | * Consider integration, decentralization and task-shifting approaches, notably for clients without advanced liver disease, to reduce the health workforce burden in specialized settings   + Consider using point-of-care solutions as well as reflex testing for hepatitis B DNA |
| Viral hepatitis C treatment and monitoring *(4, 5, 14)* | * Uninterrupted treatment for all individuals already receiving hepatitis C treatment * Confirm chronic hepatitis C diagnosis and assess the level of liver disease and liver fibrosis and assess coinfections and comorbidities when indicated * Provide full treatment course (8, 12 or 24 weeks) for hepatitis C * Scheduling of hepatitis C confirmation of cure at 12 weeks post-treatment * Additionally, when enrolment into viral hepatitis treatment is continued: provide hepatitis C treatment to all adults, adolescents and children aged ≥3 years with chronic hepatitis C infection, regardless of stage of disease | * Consider decentralization and task-shifting approaches, notably for clients without advanced liver disease, to reduce the health workforce burden in specialized settings * Consider using point-of-care solutions as well as reflex testing for hepatitis C RNA |
| Syndromic management of STIs (genital discharge; ulcer disease) *(12)* | * Continue to provide syndromic management of STIs * Provide partner treatment, with a strong preference for same-day treatment whenever feasible | * On-the-job capacity building of health-care providers on the syndromic management of STIs * Steady supply of STI syndromic management medications and diagnostic at all primary care facilities * Collect and report STI data through existing health information systems, digitally if possible * Conduct integrated regular quality and compliance with syndromic management guidelines * Integrate awareness of syndromic management services through health outreach * Strengthen the referral system for clients requiring specialized care * Develop clear pathways for partner notification and testing |
| Prevention and continuing care for common comorbidities among people living with HIV *(1)* | * Prevention and continuity of care for people living with HIV who have common noncommunicable diseases, such as hypertension, cardiovascular disease and diabetes * In case of chronic diseases preceding the HIV diagnosis, it is essential to assure continuity of treatment and care of the respective chronic condition | * Use combined client visits (for example, ART + noncommunicable diseases refill) to reduce client burden and clinic congestion |
| Cervical cancer screening and treatment *(18)* | * Screening for human papillomavirus for women living with HIV who have never been screened before in their lifetime * Treatment for all women screening positive * Management for all women diagnosed with invasive cervical cancer disease | * On-the-job capacity-building of nurses and midwives to perform screening and basic treatment to maintain coverage under human resources constraints |
| Adherence support for HIV treatment and care *(1)* | * Provision of basic adherence assessment, support and follow-up to clients who self-report non-adherence or adherence barriers | * Support can be provided by trained nurses, pharmacists and other non-specialist health-care workers |
| Mental health support for HIV treatment and care *(1)* | * Screen for mental health concerns (such as depression and anxiety) by nurses and non-specialist health-care workers using simplified or multi-disorder tools | * Train nurses and other non-specialist health-care workers to screen for mental health concerns (such as depression and anxiety) and refer to available specialized services * Develop referral pathways to specialized mental health services |
| Tracing and re-engagement support *(19)* | * Tracing clients with abnormal lab results, including viral loads >1000 copies/mL * Tracing for clients who missed scheduled appointment by more than 28 days, especially those with active opportunistic infections, presenting with advanced HIV disease, pregnant and breastfeeding women and children * Re-engagement pathways that include clinical assessment upon return to care * Same-day ART reinitiation for all clients returning to care after disengagement unless clinical guidelines recommend deferral * Same-day ART reinitiation for all clients transferring from another facility, including those without formal transfer documentation | * Review criteria for phone and home tracing * Provide tracing teams with simplified on-the-job guidance rather than formal training * Ensure that returning clients are not penalized or judged * Empower providers with simple scripts or guidance to encourage the reinitiation of care without delay |

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