Pre-launch global webinar:

WHO operational guidance for sustaining HIV, viral hepatitis and STI priority services in a changing funding landscape

Global HIV, Hepatitis and STIs Programmes

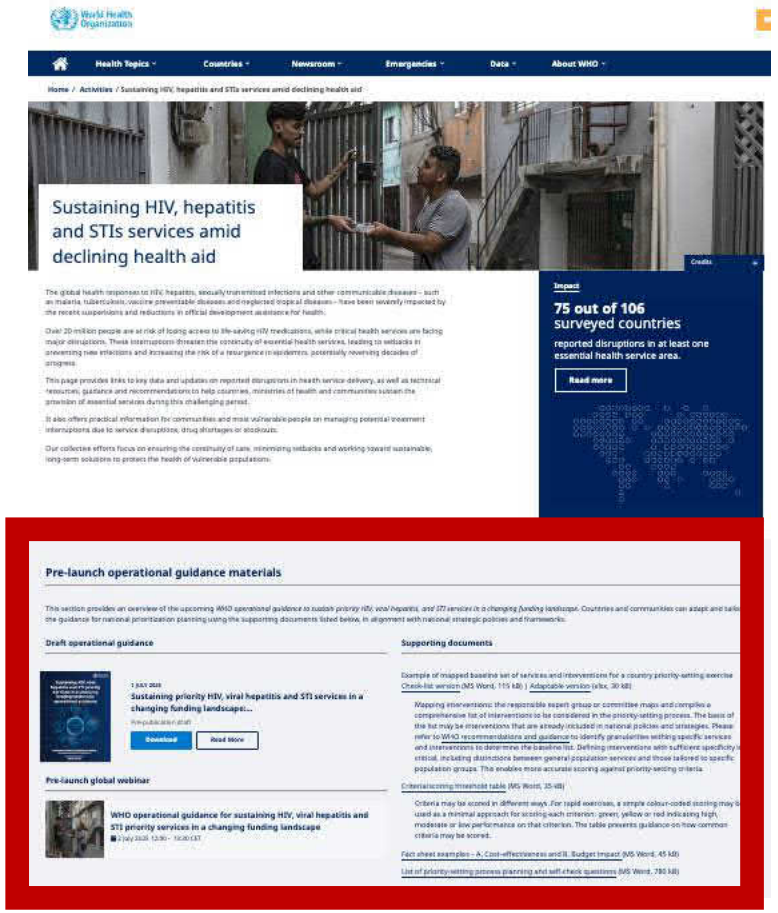
02 July 2025

World Health Organization

Go to WHO webpage:
Sustaining HIV, hepatitis and STIs services amid declining health aid

To access:

- Pre-publication draft operational guidance
- supporting documents
- webinar presentations,



https://www.who.int/activities/sustaining-hiv-hepatitis-and-stis-services-amid-declining-health-aid

World Health Organization

Meeting Agenda and Objectives

Moderator: Nirina Razakasoa (WHO HHS)		
12:00 - 12:10	Welcome remarks	Meg Doherty (WHO HHS) & Anna Vassal (WHO UHL/HFE)
12:10 – 12:35	Sustaining HIV, viral hepatitis and STI priority services in a changing funding landscape: Operational guidance	Clarice Pinto (WHO HHS) Susan Sparks and Altea Sitruk (WHO UHL/HFE)
12:35 – 13:05	Panel discussion: countries and communities share experiences of navigating aid cuts, their impact, and the process for prioritizing services.	Dr. Sivile Suilanji (Zambia MoH) Dr. Linda Kisaakye (Uganda MoH) Tariq EL Alaoui, (network of PLHIV in Middle East and North Africa)
13:05 – 13:25	Questions & Answers	Moderator: Cheryl Jonhson (WHO HHS)
13:25 – 13: 30	Key messages and closing remarks	Meg Doherty (WHO HHS)

Session objectives:

- Provide an overview of the upcoming WHO operational guidance to sustain HIV, viral hepatitis, and STI priority services in a changing funding landscape.
- Explore how countries and communities can contribute to adapting and tailoring the guidance for national prioritization planning.
- Discuss how the guidance can be applied across different stages of country progress, contextual and population needs.

World Health Organization

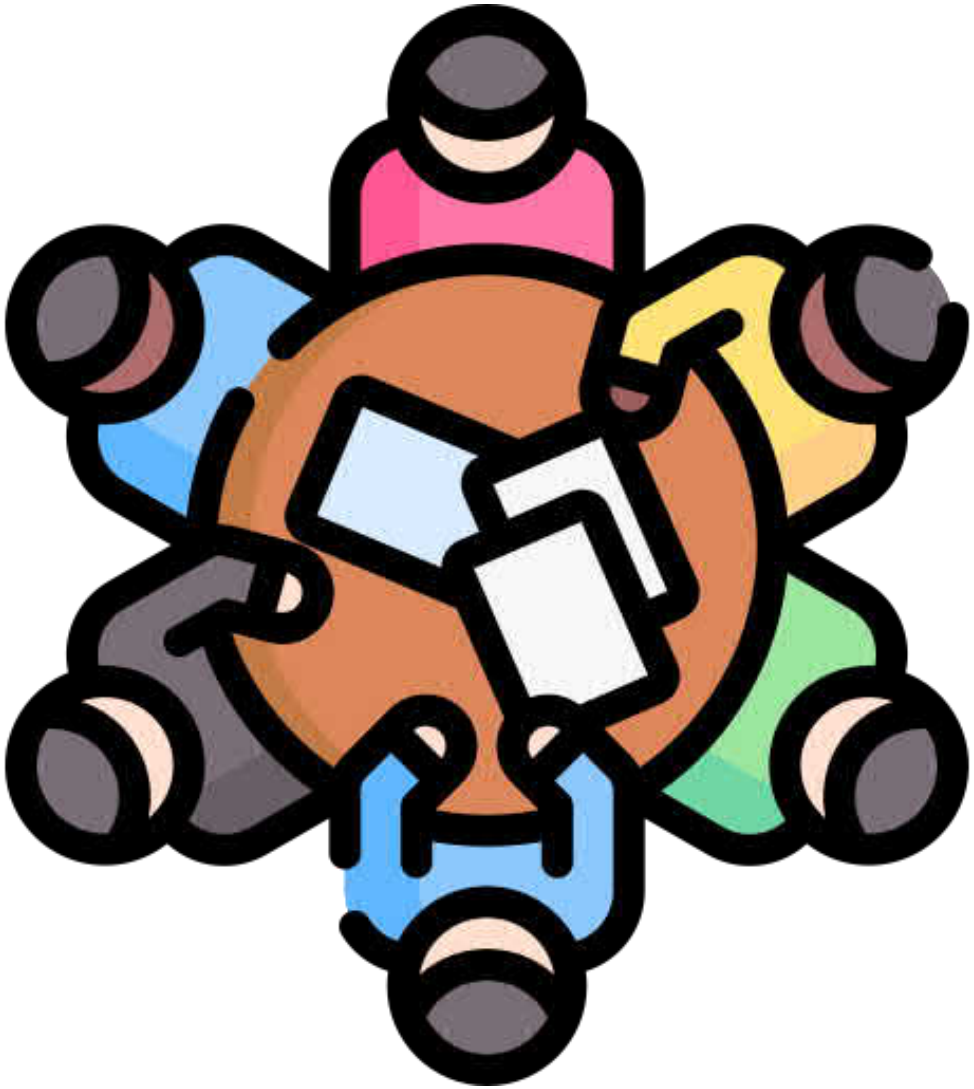
Welcome remarks

Meg Doherty,

Director, Department of Global HIV, Hepatitis and Sexually Transmitted Infections Programmes (WHO)

Anna Vassall,

Unit Head, Economic Evaluation and Analysis Unit, Department of Health Financing and Economics (WHO)



World Health Organization

Sustaining priority services for HIV, viral hepatitis and sexually transmitted infections in a changing funding landscape: Operational guidance

Clarice Pinto, Altea Sitruk, and Susan Sparkes

Department Health Financing and Economics

Department of HIV, viral Hepatitis, and STIs

World Health Organization

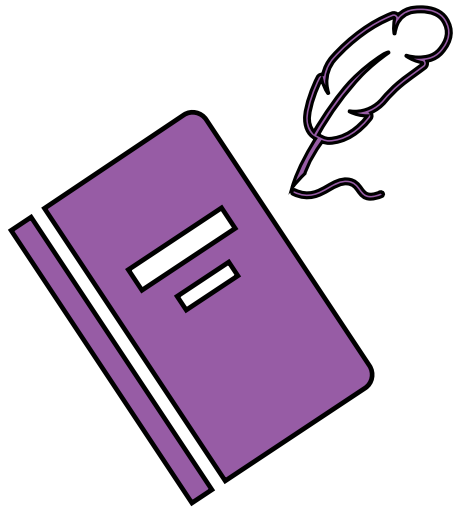
World Health Organization

Upcoming publications on priority setting

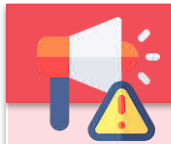
Final stages – *"Sustaining priority services for HIV, viral hepatitis and STI in a changing funding landscape: Operational guidance" – First Edition*

This is a ***'living document'*** and future editions are planned in 2025 to respond to feedback from countries, communities and partners

Under development – *Interim WHO Guidance for Evidence-Informed Priority-Setting in Health, including guidance on how to respond to shocks across disease areas* – HFE Q3 2025

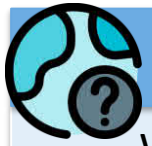


Sustaining priority services for HIV, viral hepatitis and STI in a changed funding landscape: An operational guidance



The Problem

Funding gaps for human resources and commodities for service delivery



The ASK

WHO guidance to support countries to identify, prioritize, and sustain essential HIV, viral hepatitis, and STI services in a changed funding landscape

Target audience

Ministries of Health, communities and civil society, donors, development and implementing partners

Operational Guidance provides two elements:

1. Prioritization Process Guidance

- Guidance to support countries in prioritizing HIV, viral hepatitis, and STI services to sustain under reduced funding.

2. Baseline Service Prioritization Exercise

- A structured 'starting point' list of prioritized services and interventions for countries to adapt based on global review.
- An example of an approach to rapid priority setting that can inform countries to set up their own procedures, until further guidance is issued.

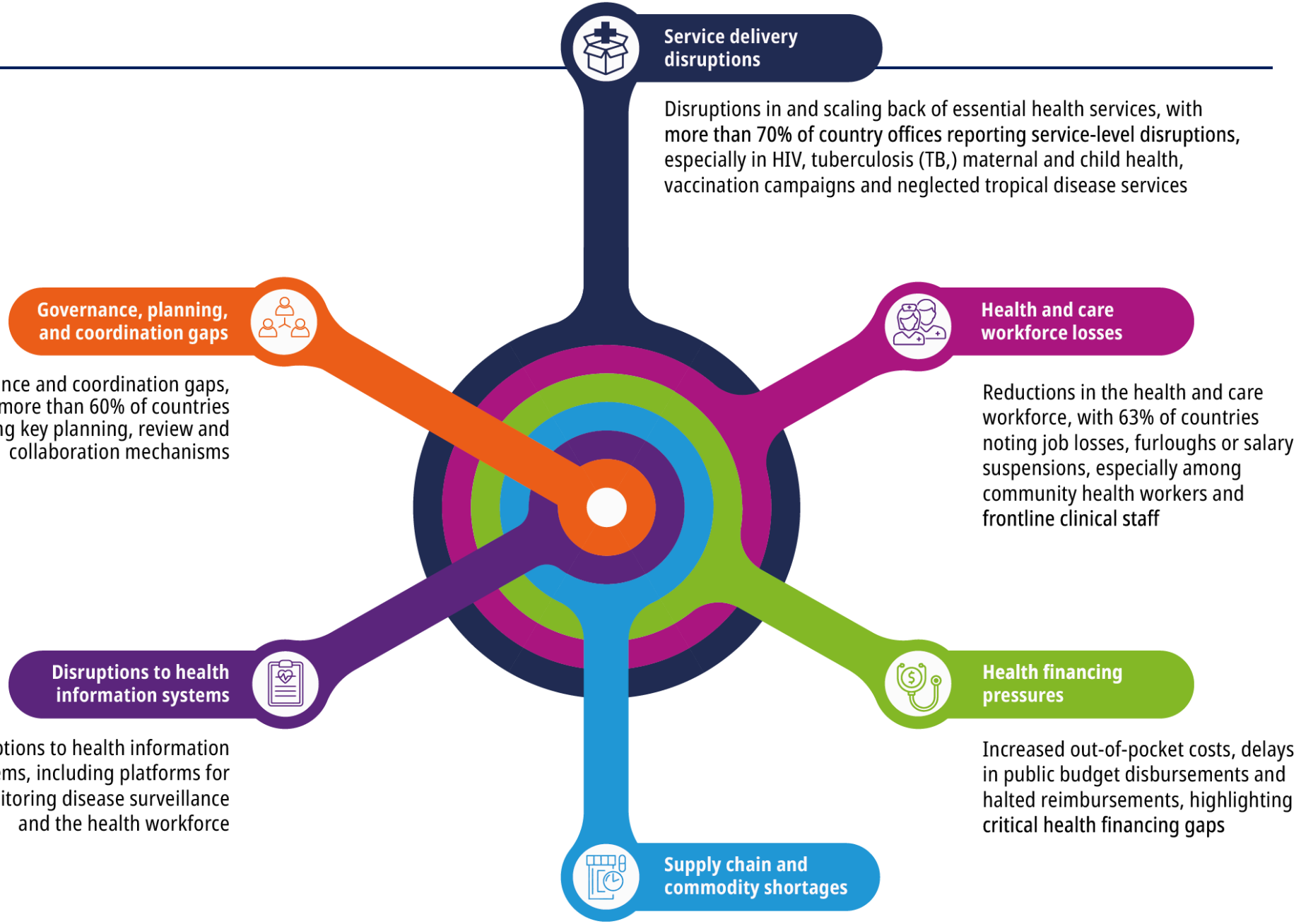
Users are encouraged:

- to adapt the content to their regional and country context and strategic priorities;
- to use the guidance in transition planning, policy dialogue and joint programme reviews
- Use it as a self-check questions for rapid assessments, planning and coordination with partners

The Problem

The impact of suspensions and reductions in health official development assistance on health systems provided a picture of temporary disruptions

(7March–2 April 2025)

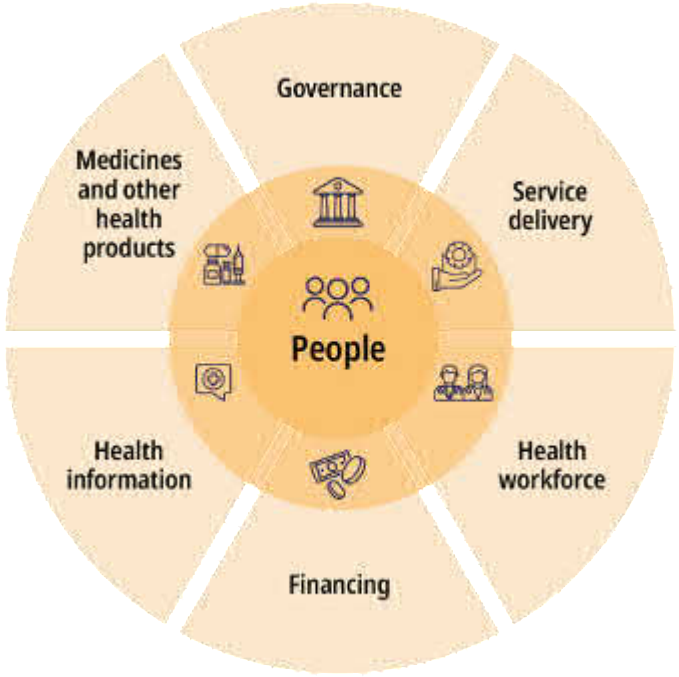


World Health Organization

3 Foundational Pillars

1. WHO Health System Framework Building Blocks

The guidance adopts a systems approach, recognizing that service delivery decisions occur within and affect broader health system functions.



World Health Organization

2. Priority-setting steps PRIORITE framework

- **P** Prepare the groundwork
- **R** Refine the scope
- **I** Implement the assessment
- **O** Organize the appraisal
- **R** Recommend actions
- **I** Implement decisions
- **T** Translate and uphold entitlements
- **E** Evaluate and sustain progress

3. Primary Health Care (PHC) strategic and operational levers

STRATEGIC LEVERS

1. Political commitment and leadership
2. Governance and policy frameworks
3. Funding and allocation of resources
4. Engagement of communities and other stakeholders

OPERATIONAL LEVERS

5. Models of care
6. Health and care workforce
7. Physical infrastructure
8. Medicines and other health products
9. Engagement with private sector providers
10. Purchasing and payment systems
11. Digital technologies for health
12. Systems for improving the quality of care
13. Primary health care-oriented research
14. Monitoring and evaluation

The ASK: WHO Prioritization Process Guidance

World Health Organization

- **R** Refine the scope
- **I** Implement the assessment
- **O** Organize the appraisal
- **R** Recommend actions

P Prepare the groundwork

I Implement decisions

T Translate and uphold entitlements

E Evaluate and sustain progress

Ethical Principles

Substantive principles:
- Efficiency,
- Equity,
- Social and economic impact,
- Feasibility

Procedural Principles:
- Transparency,
- Participation and inclusion,
- Evidence and responsiveness,
- Accountability

These form the moral and decision-making backbone of the guidance. They ensure that all prioritization decisions are fair, non-discriminatory, and based on values like equity, efficiency, and transparency.

Governance
(Strategic and Operational Enablers for Prioritization)

- Institutionalizing priority-setting within national governance mechanisms.
- Establishing leadership and coordination led by health authorities.
- Engaging multisectoral and community stakeholders from the outset.
- Aligning prioritization with national strategies, budgets, and planning cycles.
- Building ownership and accountability through transparent, participatory processes.

Services Prioritization
(Scoping, Assessment, Appraisal and Recommendations)

Refining the Scope
- Mapping and tailoring services to pop needs

Assessment Methods and Results
- Defining Prioritization Criteria
- Scoring Process

Organization of Appraisal
- Stepwise Prioritization Approach
- Ensure all population groups (Common barriers to maintaining engagement)

Formulating and Finalizing Decisions
- Engaging in Follow-up Stakeholder Consultation
- Ensure Accountability and Integration of Appraisal Results

Systems, Strategic and Operational considerations

Integrating priority-setting into broader health systems resilience strategies.

Integration of service delivery within PHC person-centered models of care

Health Workforce and Systems Resilience
- **Sustaining Community Health Workforce**

Medicines and other health products

Health Financing Considerations:
- **Urgent, Medium to longer term actions**

Communicate Decisions

Document and Disclose Decisions

Communicate clearly and Strategically

Use multiple channels and trusted messengers

Ensure accessibility and Clarity

Support Health Providers

Enable Feedback and Accountability

Evaluate and Sustain Progress

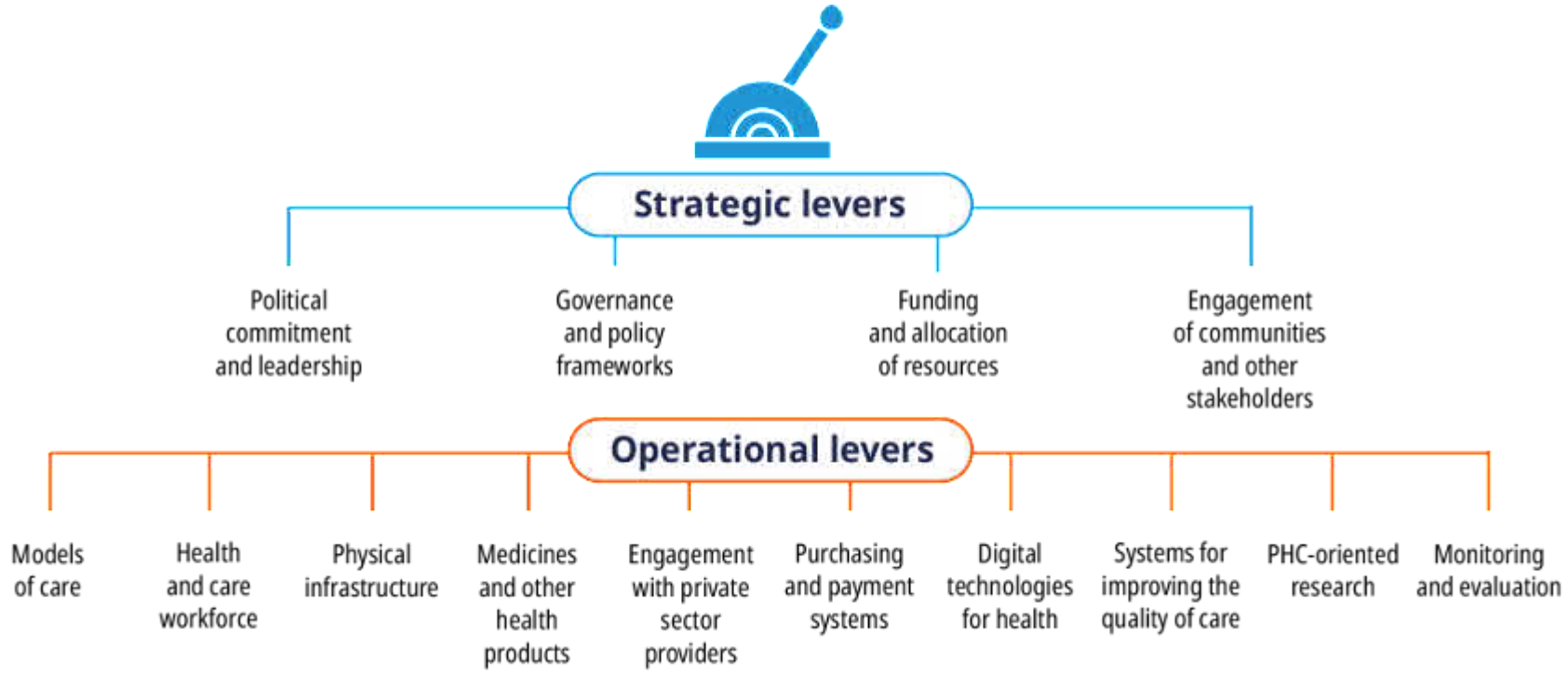
Data and Monitoring Systems Support:
- Monitoring implementation progress using simple, actionable indicators.
- Evaluating priority-setting outcomes and system performance.
- Using disaggregated, integrated data systems to guide adaptive decisions.

Documenting and sharing lessons, tools, and good practices for learning

Continuing to work toward a sustainable response

PHC and HIV, viral hepatitis and STIs – Shared Principles, Common Challenges, Convergent Actions

Fourteen levers that support PHC implementation



https://www.who.int/publications/i/item/9789240077065

- Scaling up high-quality, people-centred services through a **PHC approach is critical** to achieving both health and disease-specific goals.
- Integration should be guided by **strategic and operational levers**, tailored to each context.
- Sustained progress depends on equitable, stigma-free access to health services for **all populations**.
- Collaboration across the health system is key to advancing shared priorities.

The WHO/UNICEF PHC Operational Framework offers a coherent pathway to select, implement and then learn from PHC and HIV convergent actions https://www.who.int/publications/i/item/9789240017832

World Health Organization

Navigating the health financing emergency

Susan Sparkes,

Department Health Financing and Economics (WHO)

World Health Organization

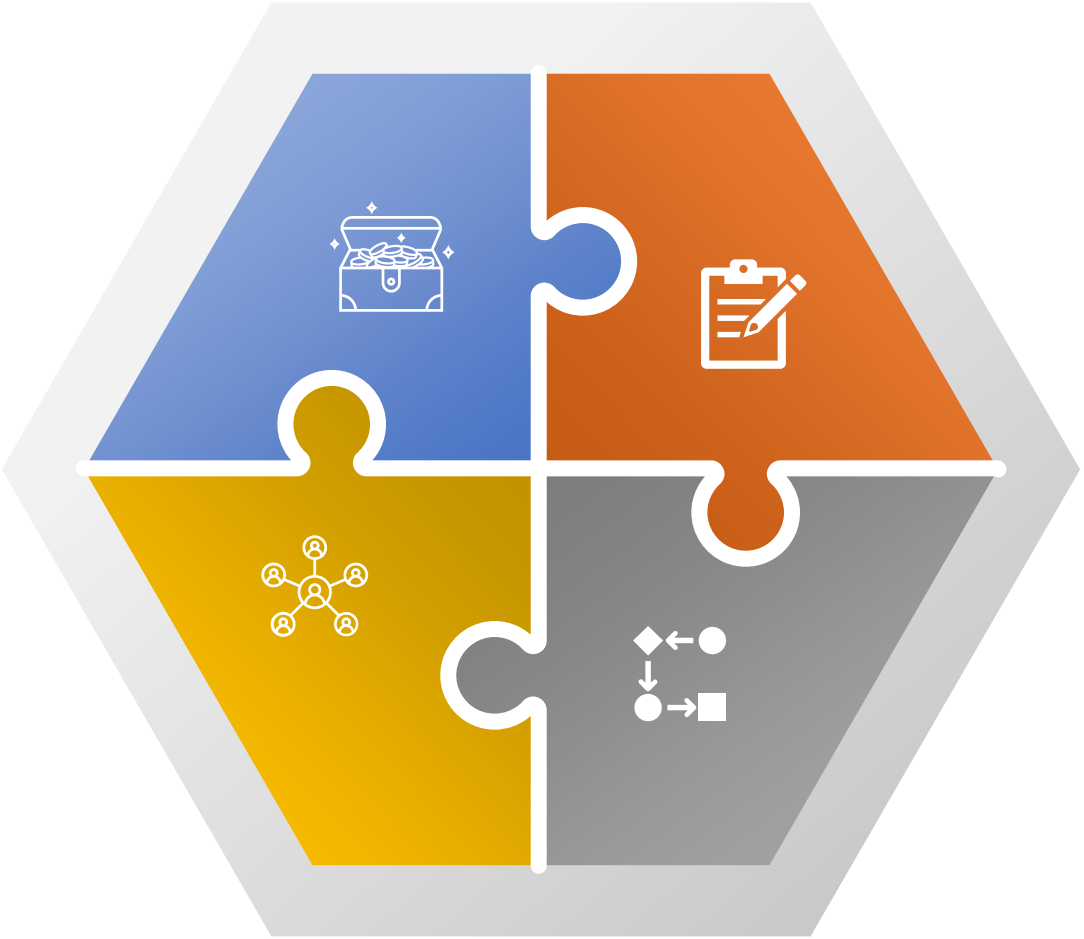
Navigating the health financing emergency

1. Fiscal capacity

Engage with finance and parliament to address underlying revenue generation

2. Efficiency and priority setting

Improve public financial management (PFM) systems, reducing duplications, improving alignment, strategic integration, deliberately setting priorities within boundaries



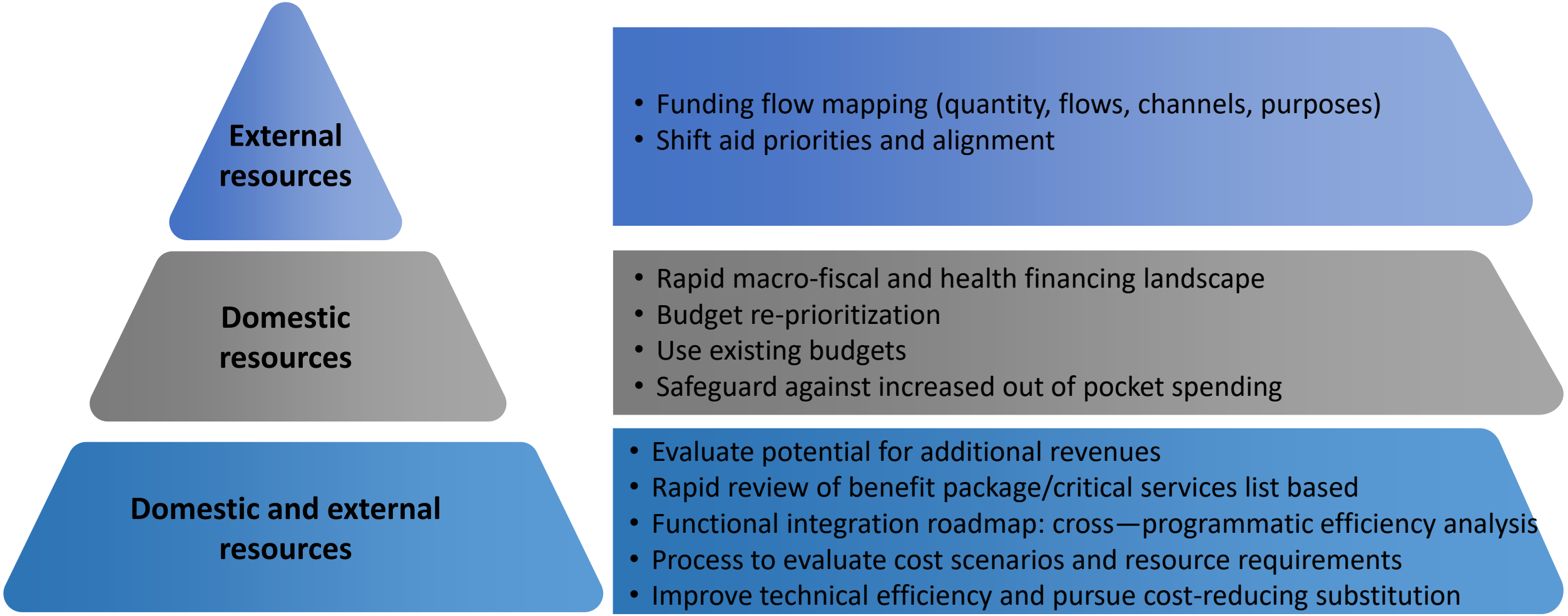
3. Political advocacy domestically and globally for health

Continue to make the case for prioritization of health in budgets

4. Different approach to donor funding

Align with domestic PFM systems, supporting institutional development (not replacing), avoiding recurrent costs, aligning to country priorities

System-wide actions to navigate the health financing emergency



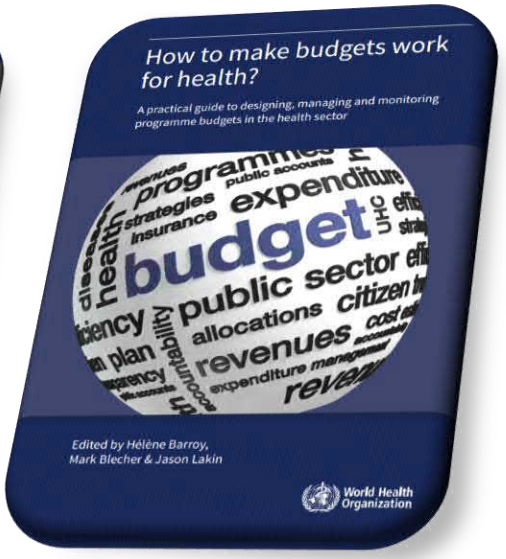
Sector-wide decision-making, analytics, prioritization, and reforms
Donor- and programme-specific considerations need to plug into sector-wide, domestic health budget dialogue
Focus on efficiency/cost reductions and sustaining coverage wherever possible

WHO Resources:

Precipitated aid transition in health – priority actions for low-and-middle income-countries

Hélène Barroy, Susan Sparkes, Kalipso Chalkidou (WHO/HQ)

With contributions from Christabel Abewe (WHO/Uganda), Kingsley Addai Frimpong (WHO/Ethiopia), Georgina Bonet (WHO/AFRO), Riku Elovainio (WHO/Democratic Republic of Congo), Sophie Faye (WHO/AFRO), Jayendra Sharma (WHO/SEARO), Tsolmongerel Tsilaajav (WHO/Vietnam), Anna Vassall (WHO/HQ), Ding Wang (WHO/Cambodia), MyMai Yungrattanachai (WHO/HQ).



https://www.pfm4health.net/blog/precipitated-aid-transition-in-health-priority-actions-for-lowandmiddle-incomecountries

https://openknowledge.worldbank.org/entities/publication/8878fbd9-879d-43d4-ab1f-ecaed1a4576a

https://www.who.int/publications/i/item/9789240044982

https://www.who.int/publications/i/item/9789240049666

Contact: healthfinancing@who.int

Priority-setting process

Altea Sitruk,

Department Health Financing and Economics (WHO)

World Health Organization

Resources to support global and country-led priority-setting

Interim guidance on priority-setting processes

Evidence-informed

Participatory

Aligned with ethical principles

Methodological support

Synthesizing and using economic data for priority-setting

Real-world examples

Practical application on global prioritization of HHS interventions

Upcoming country sector-wide applications

South-south exchange

Exchange of knowledge, experience and data

Contact: whochoice@who.int

Ethical Principles

World Health Organization

Substantive principles to guide priority-setting decisions

- Efficiency
- Equity
- Social and economic impact
- Feasibility

Procedural principles to guide the decision-making process

- Transparency
- Participation and inclusion
- Evidence and responsiveness
- Accountability

Priority-setting steps – PRIORITE framework

P Prepare the groundwork	Identify the guiding committee and secretariat, technical support where required and overarching policy framework for setting priorities. This typically requires high-level policy support and reflects core health policy context and goals, considers existing institutionalization of priority-setting processes and may require a situation analysis of core capacity.
R Refine the scope	Determine the scope in terms of services and interventions to be considered and define criteria and methods for assessment. Identify the relevant technical expert communities to assess and appraise the scope of services.
I Implement the assessment	Collect and analyse evidence on services and interventions using agreed criteria and methods (such as the burden of disease, cost–effectiveness, budget impact and equity). Assess the extent to which each service or intervention achieves the criteria.
O Organize the appraisal	Facilitate the deliberation of options through a transparent and inclusive appraisal process. Arrive at a list of services with priorities set to present to decision-makers and payers.
R Recommend actions	Develop evidence-informed recommendations on priority-setting that are legitimate, aligned with values and policy relevant. Relevant authorities decide and communicate decisions to those affected, including the health workforce and populations and allow for the decisions to be appealed.
I Implement decisions	Operationalize decisions through revised guidance, essential medicines and product lists where relevant, implementation plans for service delivery and integration into financing instruments, public financial management and procurement.
T Translate and uphold entitlements	Clearly communicate guidance, plans and conditions of access to users and providers and establish mechanisms for accountability.
E Evaluate and sustain progress	Monitor delivery and spending against plans, generate insight to inform revision and ensure long-term financial and programmatic sustainability and improvement.

World Health Organization

Refining the scope: Criteria for consideration

- Health impact
- Cost effectiveness
- Financial sustainability and budget impact
- Equity
- Feasibility
- Social and economic impact
- Financial risk protection
- Acceptability

- Criteria should be:
  - explicit
  - locally-defined and relevant to context
- They are primarily derived from two pairs of health system objectives:
  - to improve population health and access to services
  - to distribute health and health services fairly

Implementing the assessment

Approach:

- Evidence-informed but deliberative.
- Involves expert judgment and dialogue.
- Rapid evidence synthesis.

Count of Traffic score	Column Labels			
Row Labels	High	Moderate	Low	#N/A
Adherence and Mental health support for HIV treatment and care		2	2	
ARV adherence interventions: Intervention comprised of elimination of ART copayments, Provision of free OI medications, increased training of healthcare workers, reimbursment of trans		1		
ARV adherence interventions: Link4Health intervention			1	
ARV adherence interventions: Two types of interventions: (1) risk reduction, (2) outreach: re-link			1	
ARV adherence interventions: Weekly interactive SMS interventions		1		
Advanced HIV disease (AHD) management		1		
Advanced HIV disease (AHD) management		1		
Cervical cancer screening and treatment				8
Cervical cancer screening and treatment				2
One-off vaccination and treatment				2
PAP, every 3 years from age 20 until age 65+ vaccination + treatment				1
PAP, every 5 years from age 20 until age 65+ vaccination + treatment				1
screening by visual inspection with acid+ vaccination + treatment				2
Community-based testing for HIV	6	7		
Community-based HIV self-testing Adult men		1		
Community-based HIV self-testing WTS	1			
Community-based HIV self-testing Young		1		
Community-led HIV self-testing		1		
HIV self-testing/Community-based self-test followed by confirmatory testing and counseling - Adult men, (25–49 years)		2		
HIV self-testing/Community-based self-test followed by confirmatory testing and counseling - Women having transactional sex	2			

Goal: Guide—not dictate—prioritization decisions.

Basis: Ethical principles + health technology assessment norms

Key Considerations:

- Rapid yet structured
- Inclusive of local context and expert insight
- Supports fair, transparent, and evidence-based decision-making

Implementing the assessment: Scoring system

- Simple color-coded for each criterion indicating high, moderate, or low performance on that criterion.
  - High
  - Moderate
  - Low
- Cutoffs defined for each criterion.
- Factsheets and instructions provided to assist in the assessment of the criteria and deliberation.
- Use scoring sheets & pilot tests
- Individual scoring → group consensus
- Document reasoning for transparency

Score	What it means	Criteria*
High	Strong value for money	Consistent evidence suggesting an incremental cost per DALY averted < 0.5x GDP per capita or cost-saving
Moderate	Acceptable value	Consistent evidence suggesting an incremental cost per DALY averted between 0.5 and 1x GDP per capita
Low	Weak value for money	Limited evidence of an incremental cost per DALY averted < 1x GDP per capita or dominated

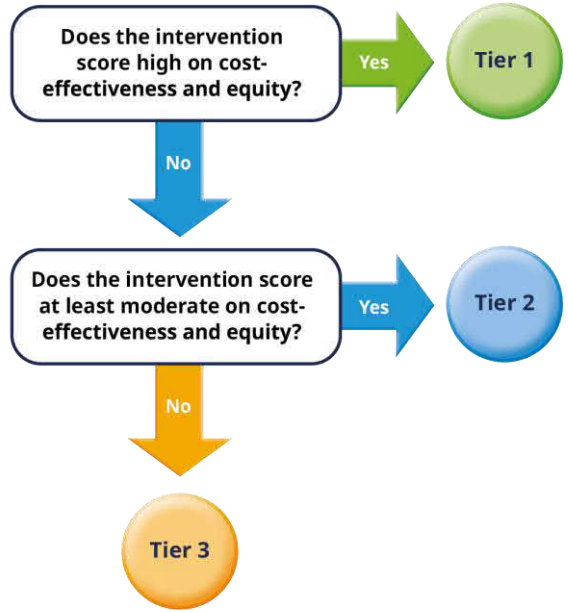
Services and Interventions	Criteria						Comments
	Health impact & effectiveness	Cost-Effectiveness	Feasibility & Health System Capacity	Equity & Vulnerability	Budget impact	Social and Economic Impact	
Prevention of mother-to-child transmission of HIV, hepatitis B and syphilis	[select]	[select]	[select]	[select]	[select]	[select]	
Vaccination for HBV	[select]	[select]	[select]	[select]	[select]	[select]	
HIV Post-exposure prophylaxis (PEP)	[select]	[select]	[select]	[select]	[select]	[select]	
HIV Pre-exposure prophylaxis (PrEP)	[select]	[select]	[select]	[select]	[select]	[select]	
Blood product safety and health care infection control	[select]	[select]	[select]	[select]	[select]	[select]	
Prevention and Harm reduction services for people who use drugs	[select]	[select]	[select]	[select]	[select]	[select]	
Provision of condoms and lubricants	[select]	[select]	[select]	[select]	[select]	[select]	
Voluntary Medical Male Circumcision (VMMC)	[select]	[select]	[select]	[select]	[select]	[select]	
Differentiated HIV Testing Services (HTS)	[select]	[select]	[select]	[select]	[select]	[select]	
Facility-based testing for syphilis	[select]	[select]	[select]	[select]	[select]	[select]	
Differentiated testing for viral hepatitis	[select]	[select]	[select]	[select]	[select]	[select]	

Criteria	Summary of scores				Overall score
	Green	Yellow	Red	Cannot score	
Health impact & effectiveness	14	0	0	0	
Cost-Effectiveness	10	2	0	2	
Feasibility & Health System Capacity	6	8	0	0	
Equity & Vulnerability	11	3	0	0	
Budget impact	7	6	1	0	
Social and Economic Impact	13	1	0	0	

Organizing the appraisal

Approach

- Uses consensus scoring to inform—not replace—dialogue on formulation of recommendations.
- Deliberation via consultative meetings.
- Scores highlight strengths/weaknesses; qualitative nuances considered.
- Decision rules may also be established.
- Documentation of decisions, stakeholder views, and disagreements is critical.

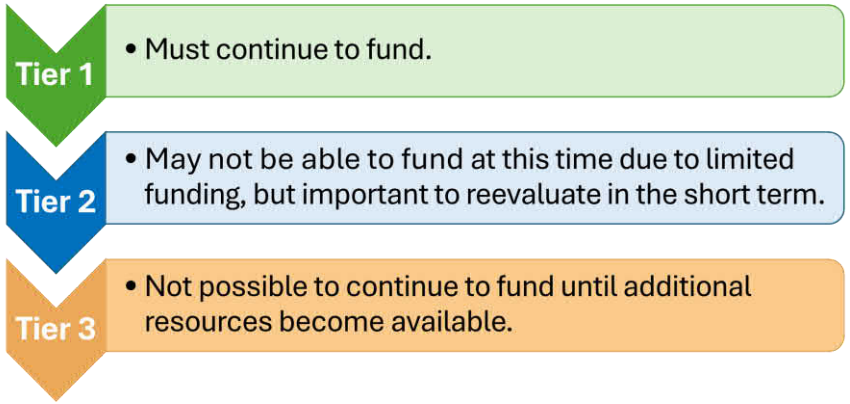


Key Considerations

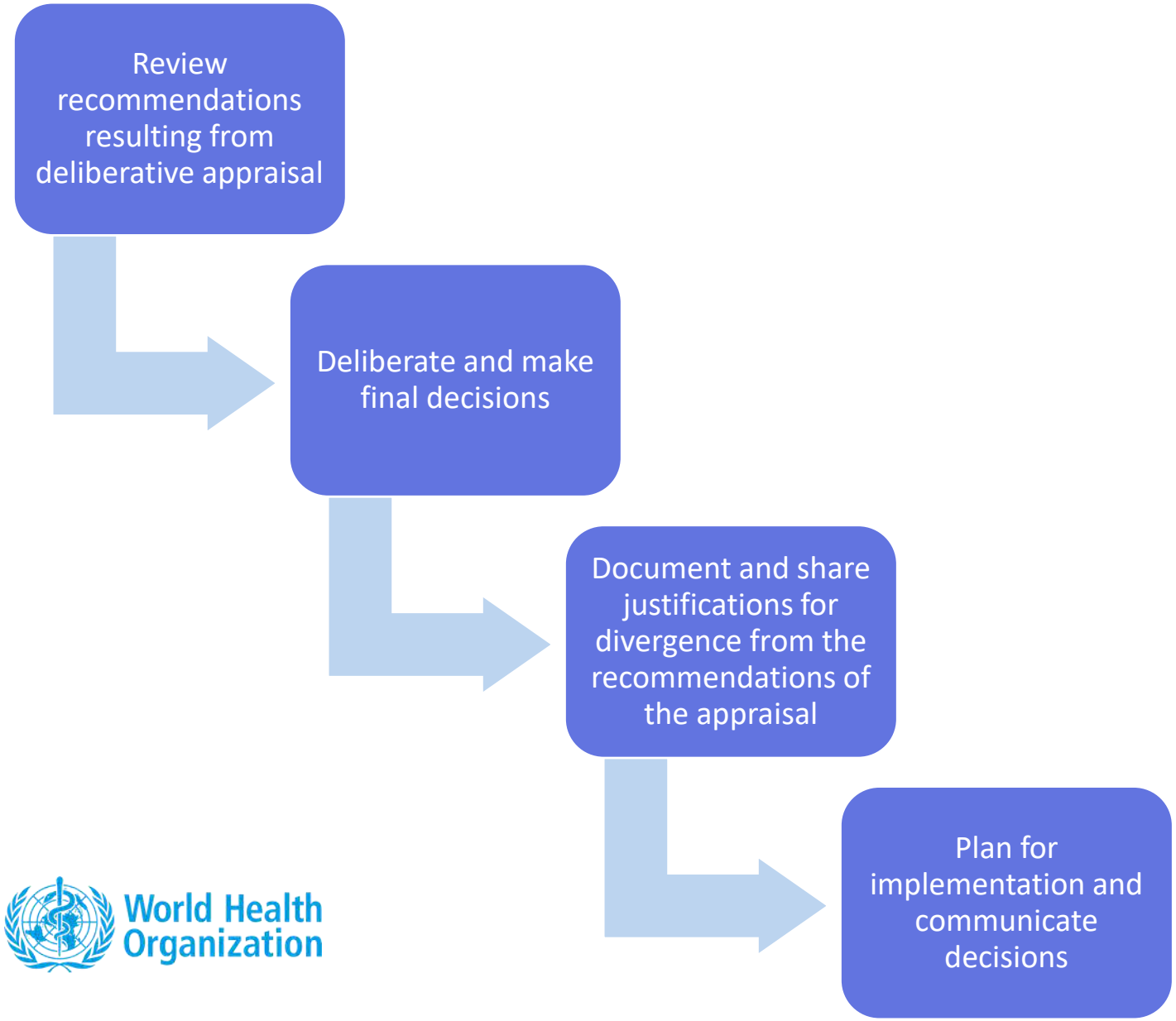
- Focus on maintaining equity—avoid widening disparities.
- Time-bound deliberations to avoid delays in planning.
- Adaptable to country-specific contexts and evolving needs.

Stepwise Prioritization

- Structured approach aligned with national priorities and context.
- E.g. Three-tier model based on funding necessity.

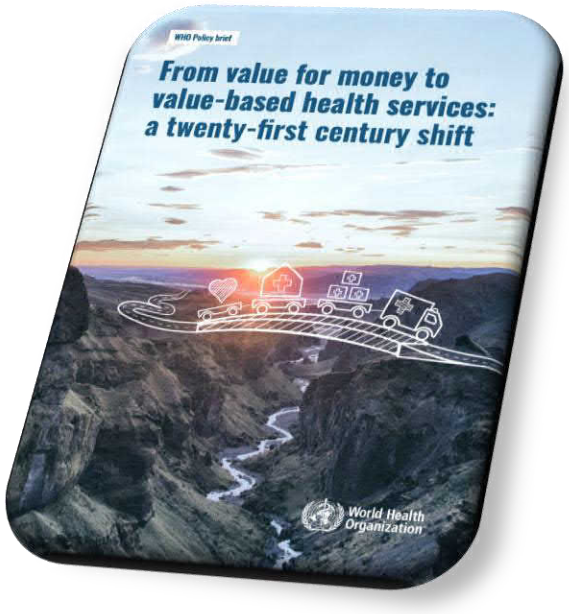


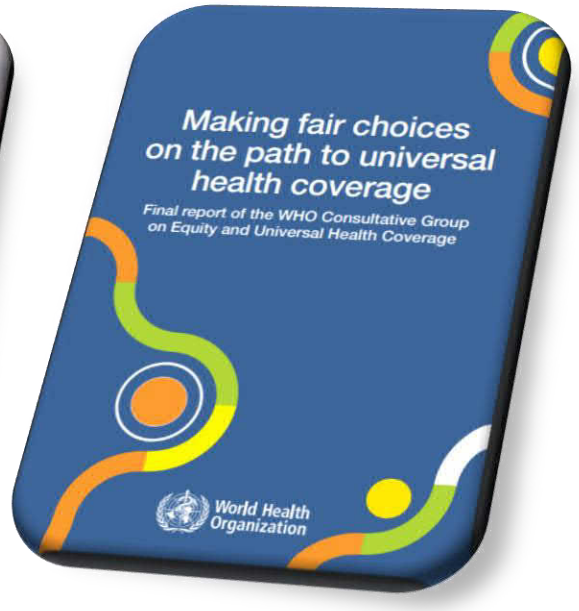
Recommend actions: Formulate and finalize decisions



WHO Resources:

Contact: whochoice@who.int





Operational guidance and global prioritization exercise

Think of the global prioritization exercise findings like a basic cake recipe—it gives you the structure, but you still need to choose your own ingredients.

Clarice Pinto,

Department of HIV, viral Hepatitis, and STIs (WHO)

What works in one country or sub-national level might be too sweet, too dry, or missing key flavors in another.
The real art is in using local ingredients, tailoring to different tastes, and what's available in your pantry.

WHO Rapid Global Assessment Exercise

World Health Organization

Operational Guidance
PRIORITE Framework (country guidance)

Objective: Enable countries to set their own priorities for essential health services in a transparent, inclusive, and technically sound way.

Scope: Adaptable across all health areas, addressing local contexts and needs. Country-identifies set of criteria.

Process: Proposes a comprehensive, participatory process, and built-in steps for operationalization, financing and accountability, among other areas.

Output: Nationallyand sub-nationally adaptable and tailored priorities, guiding implementation plans development to ensure sustainability and relevance.

Rapid Global Assessment Exercise
(adapted version PRIORITE)

Objective: Provide indicative global exercise on priority-setting for HIV, viral hepatitis, and STI services

Scope: Global-level analysis based on WHO normative guidance, using 6 criteria

Process: Conducted rapidly by WHO with global expert input, without direct implementation planning.

Focused on one scenario:

- Generalized epidemic,
- High-burden,
- LMIC)

Output: Consolidated, indicative global priorities to inform—but not dictate—country decisions.

Limitations of the Global Exercise (Adapted PRIORITE)

⚠ Not directly implementable: Global results must be adapted to local contexts—countries should not adopt them as-is.

⚠ Limited local nuance: The global assessment does not fully capture country-specific challenges, resources, or social/political dynamics.

⚠ No operational plans: The global process stops at prioritization—it does not address implementation, financing, or monitoring for countries.

WHO Rapid Global Assessment Exercise: Methodology

Roles and Responsibilities

WHO Global Programme on HIV, Hepatitis and STIs	Manages and oversees the process
Dept. Health Financing and Economics & Ethics group at WHO	Designs the process, with inputs from ethics and WHO experts
Expert Group	Conducts the assessment, the appraisal and makes recommendations
Peer Review Group	Reviews the full guidance, including the results of the assessment and appraisal
WHO Steering Group	Informed by expert group recommendations, makes final decisions

Expert Engagement

Selection Process

- 24 experts confirmed interest and participated in the process. Identified reference groups, and expression of interest
- 5 ministries of health, 6 civil society/CBOs/NGO, 8 academic/ research/clinical institutions, 5 implementing partners

Participation

- 17 joined initial consultation (methodology discussion)
- 14 completed assessment exercise (intervention scoring)
- 10 joined deliberation meeting (review/prioritization)
- 10 provided peer review of the draft guidance

Representation

- Gender: 14 women, 10 men
- Regions: AFRO (11), EMRO (4), AMRO (3), EURO (3), SEARO (3), WPRO (1)
- 3 contributors openly from the PLHIV community

Areas of Expertise

- 24 engaged in some level of the HIV cascade (prevention, testing or treatment)
- Including areas of expertise related to the mapped activities: STIs, Viral Hepatitis, Mental Health, Service Integration/DSD, Key Populations, Harm Reduction, Strategic information, Health Systems.

WHO Rapid Global Assessment Exercise: Methodology

Key Steps	Description
1. Mapping & Framework Development	Developed a rapid prioritization framework (adapted from PRIORITE) based on WHO guidance and health technology assessment principles. Used to map and assess interventions.
2. Expert & Stakeholder Consultations	External expert group from all WHO regions—including community reps, governments, and partners—reviewed mapped interventions to ensure relevance, feasibility, and alignment with country realities.
3. Ethics & Governance Review	The WHO Ethics and Governance Steering Group reviewed the framework to ensure consistency with ethical principles.
4. Evidence-Informed Deliberative Assessment	Interventions were scored using six criteria: health impact, cost-effectiveness, equity, feasibility, budget impact, and social/economic impact. The scoring guided (not prescribed) initial tier assignments.
5. Consensus-Building & Peer Review	WHO's Economic Evaluation and Analysis Unit led deliberations. Trade-offs were reviewed and consensus on tiered priorities was achieved with input from all WHO regions.

1a. Mapping Services and Interventions

PREVENTION

- Prevention of mother-to-child transmission of HIV, hepatitis B and syphilis
- Follow-up of syphilis-exposed newborns
- Post-exposure HIV prophylaxis (PEP)
- Pre-exposure prophylaxis (PrEP)
- Blood banks
- Opioid Agonist Maintenance Therapy (OAMT) to treat and monitor opioid dependence, and provision of naloxone
- Harm reduction services, including needle and syringe programmes
- Voluntary medical male circumcision (VMMC)
- Provision of condoms and lubricants

TESTING

- Differentiated HIV Testing Services (HTS)
  - Facility-based HTS
  - HIV self-testing (HIVST)
- Network-based testing services
- Linkpage to care
- Facility-based testing for syphilis
- Facility-based testing for viral hepatitis
- Community- based testing for HIV, viral hepatitis, and syphilis

TREATMENT AND CARE

- Routine ART for Adults, adolescents and pregnant, breastfeeding women
- Routine ART for Children
- Preventives and diagnostics for patients with advanced HIV disease (AHD)
- TB-HIV coinfection services
- Management of Mpox (essential for outbreak control)
- Reduced frequency of ART refills 3- to 6-month - Multi-month dispensing (MMD) and Differentiated service delivery (DSD) for HIV treatment models
- Routine screening for people with HIV
- ART treatment monitoring
- Viral hepatitis treatment and monitoring
- Syndromic management of STIs (genital discharge; ulcer disease)
- Task sharing
- Prevention and continuation care of common comorbidities in HIV infection Cervical cancer screening and treatment
- Adherence and Psychosocial support for HIV treatment and care
- Tracing and Re-engagement support

1b. Setting Criteria for prioritization

Disease Burden, Epidemiological Impact, Progress Towards Global Targets	Cost-Effectiveness and Resource Optimization
Ethical and Equity Considerations	Feasibility and Health System Readiness
Social and Economic Impact	Acceptability and Community Engagement

1c. Stepwise Three-Tier Prioritization Approach

Tier 1
- Must continue to fund.

Tier 2
- May not be able to fund at this time due to limited funding, but important to reevaluate in the short term.

Tier 3
- Not possible to continue to fund until additional resources become available.

World Health Organization

TIER 1: ESSENTIAL

PREVENTION

Interventions	Key Rationale and Decision-Making Notes
Prevention of mother-to-child transmission of HIV, hepatitis B and syphilis (includes PrEP)	Critical for elimination of vertical transmission; integration enhances service delivery.
HIV Post-exposure prophylaxis (PEP)	Critical intervention, not limited to occupational settings & delivered through community networks
Blood product safety and health care infection control	Foundational component of a functioning health system ⟷
Harm reduction services (including OAMT, needle and syringe programmes and naloxone provision for opioid overdose management)	Moved to Tier 1 in countries where already implemented; interruptions carry significant risk.
Provision of condoms and lubricants	Important for primary prevention, especially among key populations.

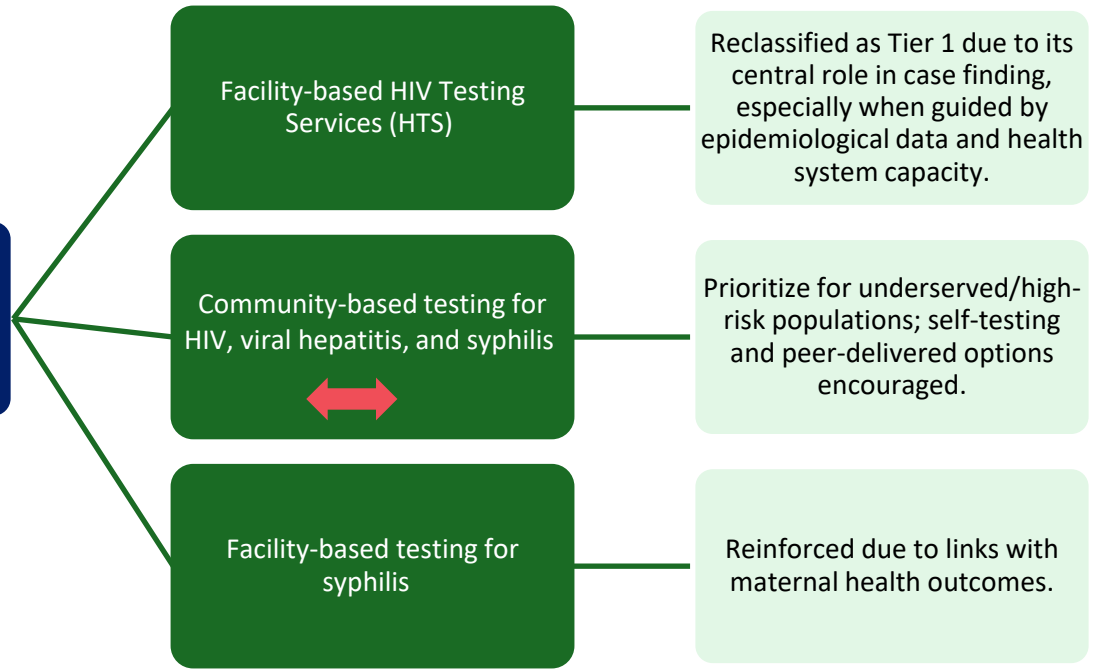
TIER 2: IMPORTANT

Interventions	Key Rationale and Decision-Making Notes
Pre-exposure prophylaxis (PrEP) – including Long-Acting PrEP ⟷	Should be made available and accessible, particularly for key populations, and those already on PrEP. Delivered through community networks
Voluntary Medical Male Circumcision (VMMC) ⟷	Rec for 15 high-priority countries in East/South Africa; Tier 2 overall, elevated to Tier 1 in priority contexts
Vaccination for HBV ⟷	Birth vaccination should be prioritized; adult catch-up tailored to context and resources

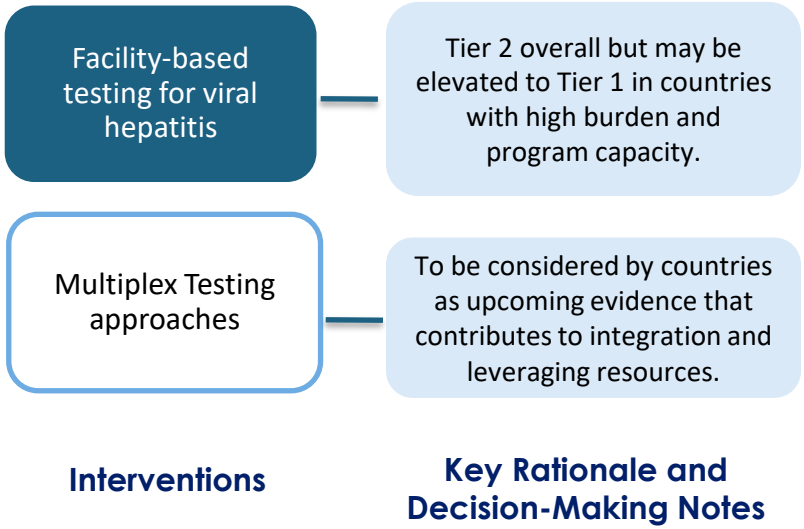
⟷ Indicates movement between tiers depending on contextual and population needs factors

TESTING

TIER 1: ESSENTIAL



TIER 2: IMPORTANT



↔ Indicates movement between tiers depending on contextual and population needs factors

World Health Organization

Results from a Rapid Global Assessment Exercise

TREATMENT AND CARE

TIER 1: ESSENTIAL

Interventions	Key Rationale and Decision-Making Notes
Routine ART (ALL children, adolescents, adults, pregnant, breastfeeding women and key populations)	Universal access is foundational to HIV treatment programs & access tracking through CLM.
ART treatment monitoring (viral load monitoring)	In resource-limited settings, reduced frequency may be applied to ensure cost-effectiveness.
Routine screening for people with HIV (CD4 and other screening tests)	Moved to Tier 1; interruptions carry significant risk to AHD identification.
Advanced HIV disease (AHD) management	Early identification and comprehensive management is required for effectiveness.
TB screening, diagnosis, treatment and prevention in PLHIV	Early identification and management prevent TB mortality among PLHIV
Adherence for HIV treatment and care	Classified Tier 1 as an integral part of ART programs.
MMD 3- to 6-month ART (Reduced Frequency of ART pick-up) ⟷	Improves client convenience, reduces HF burden, and supports adherence, part of Community led services. Depends on commodity availability
Tracing and Re-engagement support ⟷	Tracing is going to be important and cost-effective for some but not all. Should be prioritized, especially for AHD, pregnant women, and children.
Syndromic management of STIs (genital discharge; ulcer disease)	
Cervical cancer screening ⟷	

TIER 2: IMPORTANT

Interventions	Key Rationale and Decision-Making Notes
Viral hepatitis treatment and monitoring ⟷	Tier 2 overall but may be elevated to Tier 1 in countries with high burden and program capacity.
Mental health support for HIV treatment and care	Valuable and increasingly recognized; should be integrated with differentiated service delivery, depending on available resources.
Prevention and continuation care of common comorbidities in HIV infection	NCD treatment in people living with HIV should be continued. Important for holistic care but often outside core HIV package and constrained by resources.
Management of Mpox (essential for outbreak control) ⟷	Should be prioritized where relevant, based on outbreak dynamics and national/WHO guidance.

⟷ Indicates movement between tiers depending on contextual and population needs factors

World Health Organization

Lessons Learned and key aspects to consider

- **Meaningful community engagement must inform all decision making:** Services that are deprioritized or discontinued should include community-designed alternatives to reduce harm and maintain trust. Global agencies (e.g. WHO, UNAIDS, GF) and partners must promote and ensure community engagement. Including safe-guarding CBO tools and interventions (e.g. CLM and Stigma Index).
- **Ethics must remain central:** Prioritization processes must explicitly safeguard marginalized and high-risk populations, grounded in ethical principles.
- **Country-specific context is key for meaningful prioritization:** the global results can be seen as a starting point, however, plans must reflect local disease burden, existing coverage, and implementation readiness.
- **Disaggregation enables more precise and effective decision-making:** Global-level interventions grouping obscured critical distinctions; countries must disaggregate (e.g. pop. specific) and assess activities individually to ensure context-appropriate prioritization.
- **Within Tier 1, prioritization may still be necessary:** Limited resources will require hard decisions, further prioritization of high-impact Tier 1 interventions into tiers 2 and 3. Countries are encouraged to go beyond the indicative tiers and undertake tailored prioritization aligned with national goals and realities.
- **Transparency strengthens adaptation and planning:** Clear narratives help justify prioritization, build stakeholder trust, and guide operational action.
- **Integration into PHC:** Integration of HIV, hepatitis, and STI services into primary health care must ensure people-centred, inclusive, high-quality, and stigma-free care to achieve equitable health outcomes.
- **Many Complementary tools:** UNAIDS, PEPFAR Sustainability Plans (Part A, RAFT & Part B), IAS Tier Toolbox, CQUIN network materials & Global Fund Guidance.

Next steps

Ongoing Dissemination

- Officially launched: Release the operational guidance at IAS 2025 in July, Kigali, alongside other new WHO publications.
- Continue promoting the guidance through global, regional, and national meetings and platforms.

A Living Document – ongoing learning and updates

- This guidance is intended to evolve over time.
- Feedback from countries and partners will shape future revisions, ensuring the guidance meets real-world evolving needs and challenges.

Country Support

- WHO will continue to provide tailored technical support to countries interested in adapting and implementing the guidance prioritization framework to their specific contexts.

Collaboration with Partners

- WHO will work closely with global, regional and national partners to align efforts, promote uptake, and share learnings.

Sustaining essential health services

- Strengthen WHO's mitigation efforts to support countries in maintaining essential health service packages, in collaboration with the Community Reference Group, Member States, and partners.

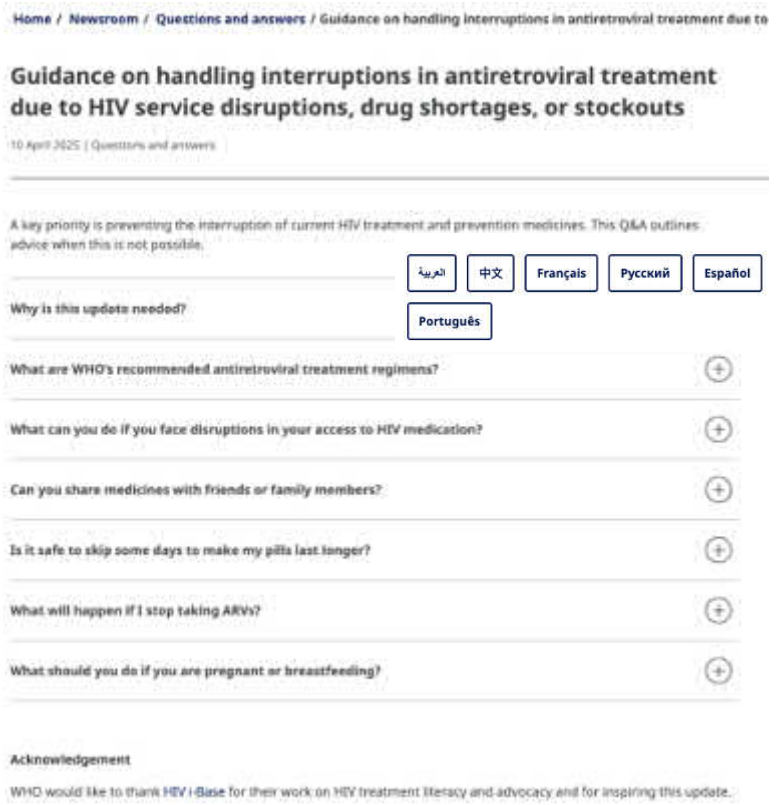
World Health Organization

WHO Resources:

World Health Organization

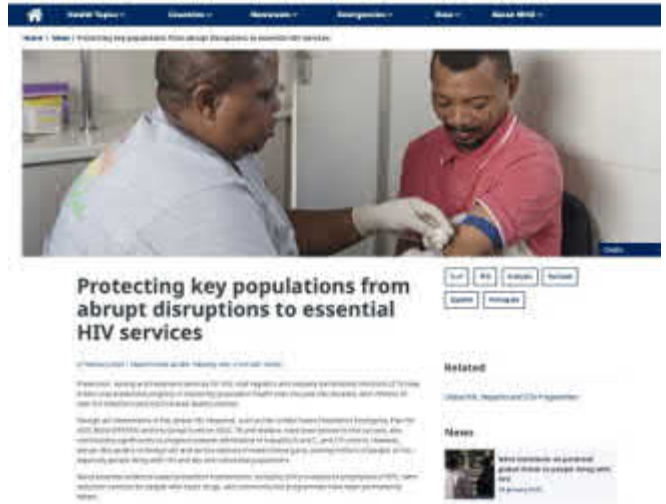
WHO webpage: Sustaining HIV, hepatitis and STIs services amid declining health aid

https://www.who.int/activities/sustaining-hiv-hepatitis-and-stis-services-amid-declining-health-aid



https://www.who.int/news-room/questions-and-answers/item/guidance-on-handling-interruptions-in-antiretroviral-treatment-due-to-hiv-service-disruptions--drug-shortages--or-stockouts

https://www.who.int/news/item/27-02-2025-protecting-key-populations-from-abrupt-disruptions-to-essential-hiv-services



Acknowledgements

External contributors and peer reviewers
Yasmeen Akhtar (Nai Zindagi Trust, Pakistan), Florence Anam (Global Network of People Living with HIV – GNP+, Kenya), Nadia Badran (Society for Inclusion and Development in Communities and Care for All, Lebanon), Baker Bakashaba (AIDS Information Centre, Uganda), Adele Schwartz Benzaken (AIDS Health Foundation – AHF Global Programme, Brazil), Byrone Chingombe (Centre for Sexual Health and HIV/AIDS Research, Zimbabwe), Tom Ellman (Médecins Sans Frontières, South Africa), Joseph Fokam (Comité National de Lutte contre le Sida, Cameroon), Anna Grimsrud (International Aids Society, South Africa), Ibtissam Khoudri (Ministry of Health, Morocco), Alvin Marcello (Asian Health Informatics Network, Philippines), Getrude Ncube (Ministry of Health and Child Care, Zimbabwe), Francis Ndowa (Skin & GU Medicine Clinic, Zimbabwe), Clara Nyapokoto (Ministry of Health, Eswatini National AIDS Programme), Nkechi Okoro (Network of People Living with HIV and AIDS in Nigeria), Leora Pillay (Frontline AIDS, United Kingdom), Jeremy Ross (TREAT Asia/amfAR, the Foundation for AIDS Research, Thailand), Suilanji Sivile (Ministry of Health, Zambia), Ketevan Stvilia (National Centre for Disease Control and Public Health, Georgia), Maureen Syowai (International Center for AIDS Care and Treatment Program, Columbia University - ICAP, United States of America), Iris Semini (Joint United Nations Programme on HIV/AIDS – UNAIDS, Switzerland), Beatriz Thome (Global Fund to Fight AIDS, Tuberculosis and Malaria, Switzerland) and François Venter (University of the Witwatersrand, South Africa).
The ICAP CQUIN Network contributed to the drafting of the quality of care section.

WHO Ethics and Governance Steering Group contributors
Maxwell J. Smith (Western University, Canada) drafted the section with input and review from Anant Bhan (Yenepoya University, India), Voo Teck Chuan (SingHealth, Singapore), Ezekiel J. Emanuel (University of Pennsylvania, United States of America), Sharon Kaur (Universiti Malaya, Malaysia), Keymanthri Moodley (Stellenbosch University, South Africa), Owen Schaefer (National University of Singapore), Ehsan Shamsi (Monash University, Australia) and Ross Upshur (University of Toronto, Canada). Ross Upshur co-chaired and presented at the expert group consultation meetings.

World Health Organization

WHO staff and consultants

Overall coordination
This publication development process was coordinated by Clarice Pinto with guidance from Nathan Ford and under the leadership of Meg Doherty, Director, Department of Global HIV, Hepatitis and Sexually Transmitted Infections Programmes.

Department of Global HIV, Hepatitis and Sexually Transmitted Infections Programmes
Wole Ameyan, Magdalena Barr-Dichiara, Carlota Baptista Da Silva, Maeve Brito de Mello, Shona Dalal, Adriana De Putter, Diana Faini, Hiwot Haile-Selassie, Cheryl Case Johnson, Anne Bekelynck, Pascal Jolivet, Ivy Kasirye, Celine Lastrucci, Olufunmilayo Lesi, Daniel Low-Beer, Niklas Luhmann, Ismail Maatouk, Annelise Monroe-Wise, Antons Mozalevskis, Busisiwe Msimanga, Boniface Dongmo Nguimfack, Mateo Prochazka Nunez, Morkor Newman Owiredu, Remco Peters, Ajay Rangaraj, Harilala Nirina Razakasoa, Françoise Renaud, Michelle Rodolph, Nandita Sugandhi, Annette Verster, Marco Vitoria, Olanrewaju Edun and Elena Vovc.

WHO regional and country offices
The following individuals contributed to developing the first drafts of the document: Po-lin Chan (WHO Regional Office for South-East Asia), Agnes P. Adilakshmi Chetty (WHO Regional Office for Africa), Lastone Chitembo (WHO Country Office in Zambia), Mónica Alonso Gonzalez (WHO Regional Office for the Americas), Akudo Ezinne Ikpeazu (WHO Regional Office for Africa), Kiyohiko Izumi (WHO Regional Office for the Western Pacific), Danièle Simnoue Nem (WHO Country Office in Cameroon), Kafui Senya (WHO Country Office in Ghana) and Arouna Tena (WHO Country Office in Cameroon).

WHO Steering Group
These individuals contributed to developing and finalizing the indicative list and document: Stela Bivol (WHO Regional Office for Europe), Po-lin Chan (WHO Regional Office for South-East Asia), Muhammad Shahid Jamil and Ahmed Sabry Alaama (WHO Regional Office for the Eastern Mediterranean), Tiara Mahatmi Nisa (Western Pacific Regional Office), Georges Perrin (WHO Regional Office for Africa), Andrew Seale (WHO headquarters) and Omar Sued (WHO Regional Office for the Americas).

Other WHO HQ department contributors
Under the leadership of Anna Vassall (Economic Evaluation and Analysis Unit) and Kalipso Chalkidou (Director of the WHO Department of Health Financing and Economics), Filip Meheus, Altea Sitruk, Andrew Mirelman, Vittal Mogasale, and Karin Stenberg (Economic Evaluation and Analysis Unit) developed the framework for priority setting, provided valuable guidance and input on the overall methods and process, including the consideration of economic evidence, and drafted relevant sections of the guidance. Helene Barroy and Susan Sparkes (Financing and Policy for Health Unit) contributed with their expertise and drafted inputs on health financing.

Onyema Ajuebor, Giorgio Cometto and Pascal Zurn, from the Health Workforce Department contributed with expertise on health workforce considerations. Andreas Reis (Health Ethics & Governance Unit, Research for Health Department) and Katherine Littler (WHO Health Ethics & Governance, Research for Health Department) contributed expertise throughout the guidelines process. Annabel Baddeley (Global Tuberculosis Programme), Mercedes Bonet Semenas (WHO Department of Sexual and Reproductive Health and Research) and Maria Barreix Etchegoimberry (WHO Department of Sexual and Reproductive Health and Research) provided comments to the final draft document.

Global HHS and HF Technical support focal points

WHO HHS and UHL/HF

- Clarice Pinto, pintoc@who.int
- Nirina Razakasoa, razakasoan@who.int (in coordination with ROs)
- Altea Sitruk, cicoa@who.int
- Susan Sparks, sparkess@who.int

Countries and communities sharing experiences of navigating aid cuts, their impacts, and the strategies used to prioritize and sustain essential services.

Panel discussion and presentations

Moderator:

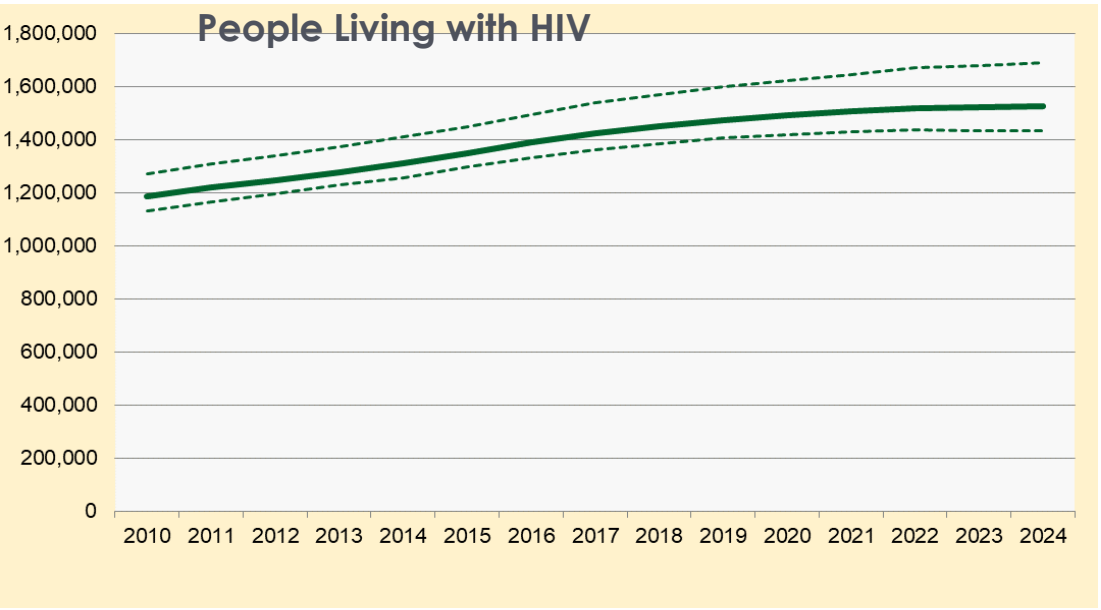
Nirina Razakasoa
(WHO HHS)

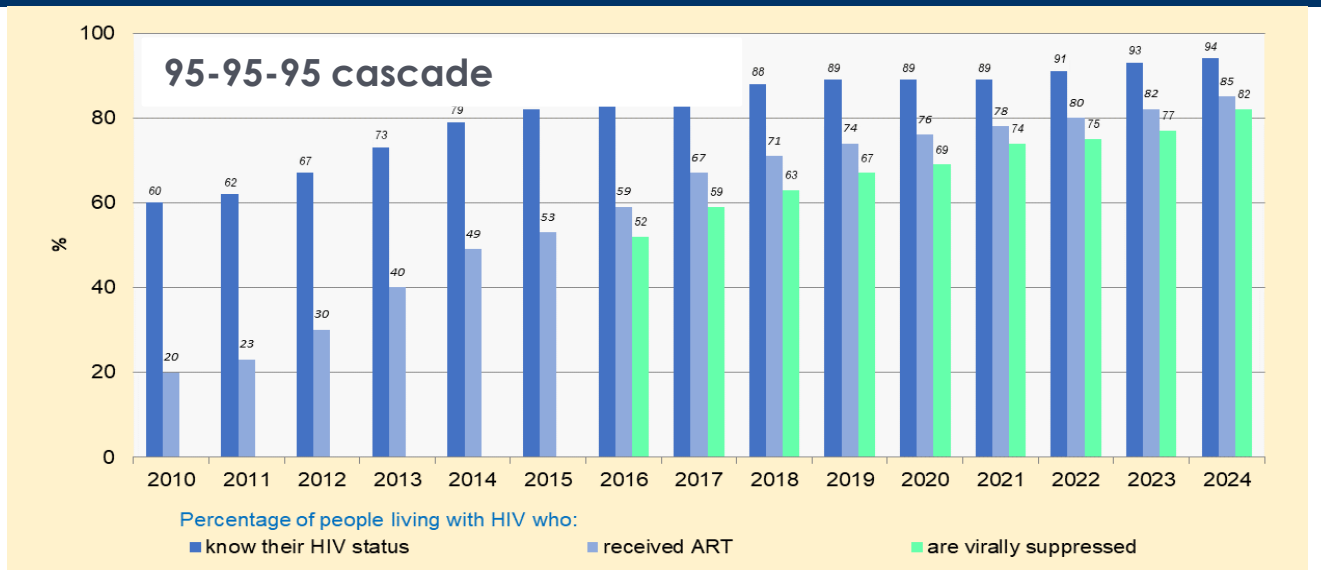
- Dr. Linda Kisaakye, Senior Program Officer PMTCT for the Ministry of Health of Uganda
- Dr. Sivile Suilanji, National HIV Technical Advisor for the Ministry of Health of Zambia
- Tariq EL Alaoui, Director of programs at Mena community network (network of PLHIV in Middle East and North Africa)

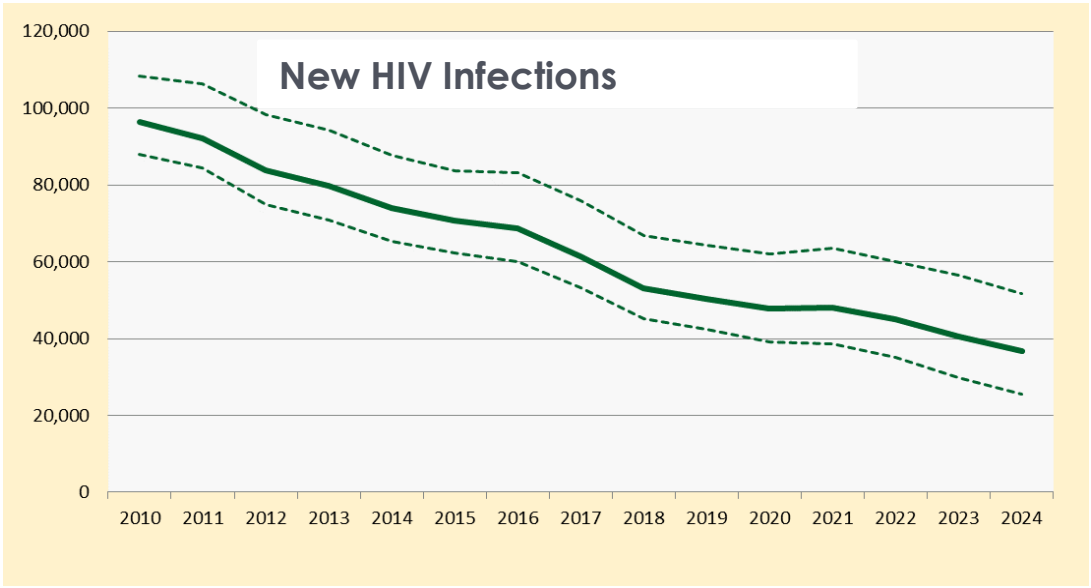
Sustaining HIV, viral hepatitis and STI priority services in a changing funding landscape

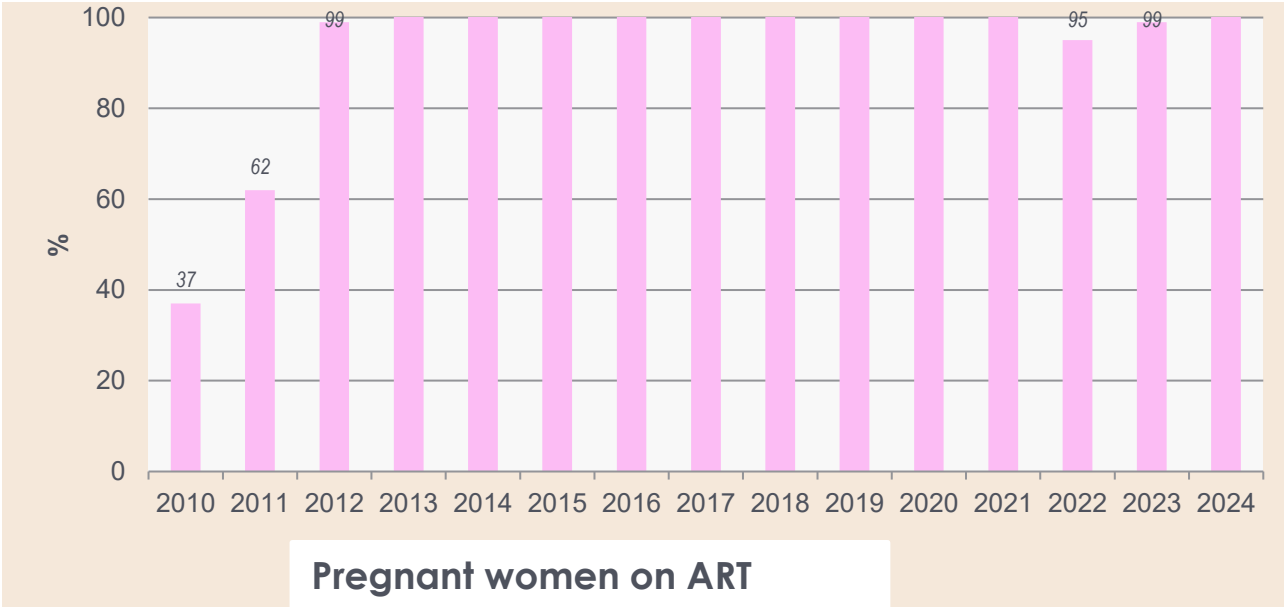
Dr. Linda Nabitaka
Senior Program Officer PMTCT
Uganda

Uganda's HIV Burden: 2024 SPECTRUM ESTIMATES









TRIPLE ELIMINATION OF HIV, SYPHILIS AND HEP B AND OTHER STIs

PMTCT of HIV

- Over **140,000 new HIV infections** among children have been prevented
  - **Mother-to-child transmission (MTCT) rate** for HIV infections stands at **2.9%**, while transmission at the end of breastfeeding is **5.85%**

Reduction in Pediatric HIV Cases:

- The number of children acquiring HIV from their mothers has significantly decreased from **25,000 in 2009 to 5,057 in 2022**

Hepatitis B

- Overall HBV prev: 4.3%
- HBV prev in Pregnant women: 1.4%
- HBV prev in Children U5: 0.96%
- HBV prev in Children 0-14 years: 0.6%
- Annual birth cohort: 2.2 million
- Birth dose :

Syphilis

Prevalence : 1.4-1.7 in pregnancy

March 2016: HIV/Syphilis DUO Assay evaluated before pilot. Lab validation, Pilot Phase, trainings done

Adoption (2018): Integrated into HIV guidelines and scaled up nationally

Used for pregnant women and their partners and key populations

Single syphilis test kits for other population plus women already HIV positive

Triple Elimination Approach:

- Uganda leverages existing HIV and maternal-child health (MCH) platforms to integrate services
- This includes screening, testing, and treatment services for Hepatitis B and syphilis

Learning from HIV EMTCT:

- Insights from successful HIV EMTCT programs are being applied to implement Hepatitis B and syphilis EMTCT

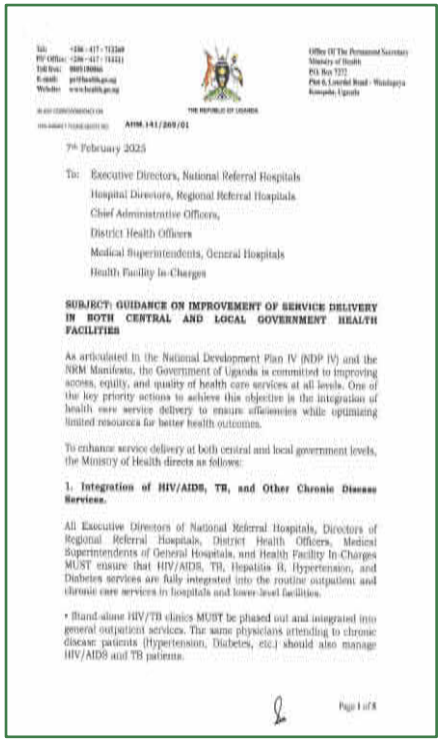
Other STIs:

Mainstay is still syndromic management

GeneXpert for chlamydia, Gonorrhea, and Trichomonas in 28 sites to be rolled out in all facilities with GeneXpert (252)

Management part of PHC

Government Response:
Shift from disease-based to patient-centred care



7th February 2025

To: Executive Directors, National Referral Hospitals
Hospital Directors, Regional Referral Hospitals
Chief Administrative Officers,
District Health Officers
Medical Superintendents, General Hospitals
Health Facility In-Charges

SUBJECT: GUIDANCE ON IMPROVEMENT OF SERVICE DELIVERY IN BOTH CENTRAL AND LOCAL GOVERNMENT HEALTH FACILITIES

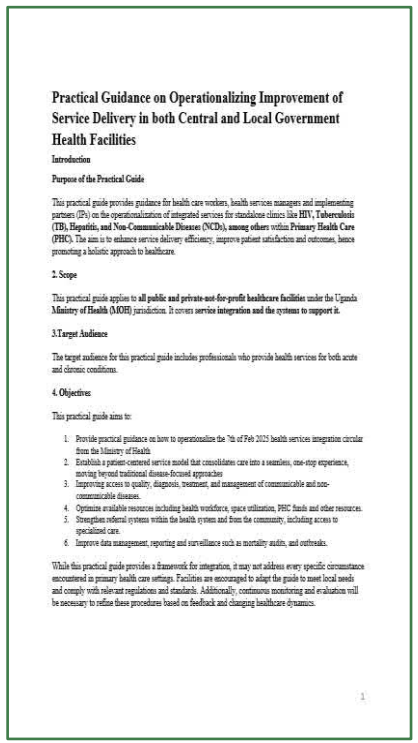
As articulated in the National Development Plan IV (NDP IV) and the NRM Manifesto, the Government of Uganda is committed to improving access, equity, and quality of health care services at all levels. One of the key priority actions to achieve this objective is the integration of health care service delivery to ensure efficiencies while optimizing limited resources for better health outcomes.

To enhance service delivery at both central and local government levels, the Ministry of Health directs as follows:

1. Integration of HIV/AIDS, TB, and Other Chronic Disease Services.

All Executive Directors of National Referral Hospitals, Directors of Regional Referral Hospitals, District Health Officers, Medical Superintendents of General Hospitals, and Health Facility In-Charges MUST ensure that HIV/AIDS, TB, Hepatitis B, Hypertension, and Diabetes services are fully integrated into the routine outpatient and chronic care services in hospitals and lower-level facilities.

- Stand-alone HIV/TB clinics MUST be phased out and integrated into general outpatient services. The same physicians attending to chronic disease patients (Hypertension, Diabetes, etc.) should also manage HIV/AIDS and TB patients.



Practical Guidance on Operationalizing Improvement of Service Delivery in both Central and Local Government Health Facilities

Introduction

Purpose of the Practical Guide

This practical guide provides guidance for health care workers, health services managers and implementing partners (IPs) on the operationalization of integrated services for standalone clinics like **HIV, Tuberculosis (TB), Hepatitis, and Non-Communicable Diseases (NCDs), among others** within **Primary Health Care (PHC)**. The aim is to enhance service delivery efficiency, improve patient satisfaction and outcomes, hence promoting a holistic approach to healthcare.

2. Scope

This practical guide applies to **all public and private-not-for-profit healthcare facilities** under the Uganda **Ministry of Health (MOH)** jurisdiction. It covers **service integration and the systems to support it.**

3.Target Audience

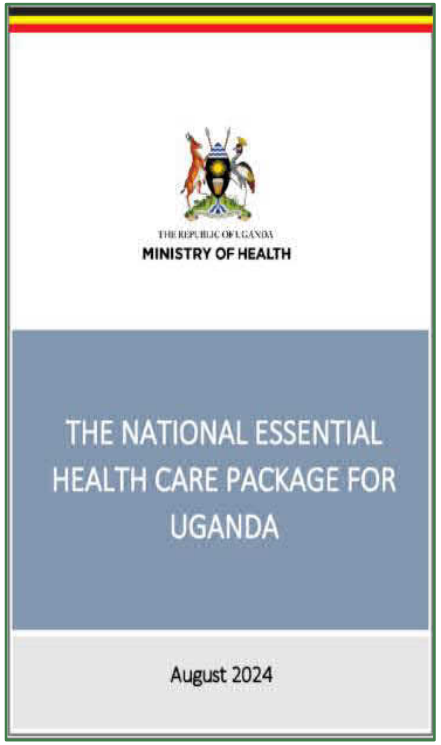
The target audience for this practical guide includes professionals who provide health services for both acute and chronic conditions.

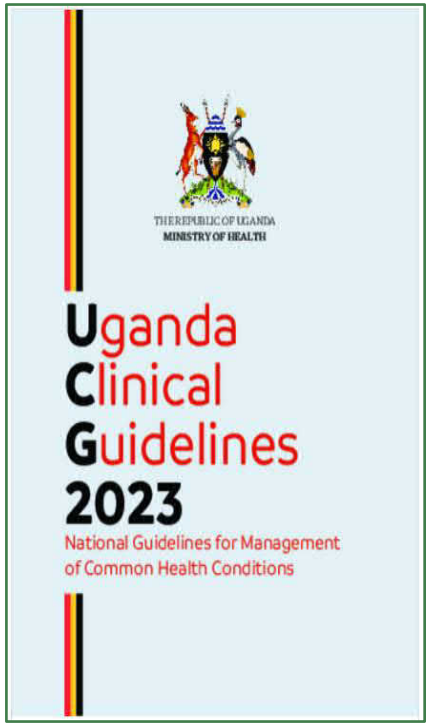
4. Objectives

This practical guide aims to:

1. Provide practical guidance on how to operationalize the 7th of Feb 2025 health services integration circular from the Ministry of Health
2. Establish a patient-centered service model that consolidates care into a seamless, one-stop experience, moving beyond traditional disease-focused approaches
3. Improving access to quality, diagnosis, treatment, and management of communicable and non-communicable diseases.
4. Optimize available resources including health workforce, space utilization, PHC funds and other resources.
5. Strengthen referral systems within the health system and from the community, including access to specialized care.
6. Improve data management, reporting and surveillance such as mortality audits, and outbreaks.

While this practical guide provides a framework for integration, it may not address every specific circumstance encountered in primary health care settings. Facilities are encouraged to adapt the guide to meet local needs and comply with relevant regulations and standards. Additionally, continuous monitoring and evaluation will be necessary to refine these procedures based on feedback and changing healthcare dynamics.





- MoH is re-emphasizing a strategic shift towards integrated service delivery to promote a patient-centered, holistic approach that optimizes resources for greater efficiency and sustainability.
- Goals:
  - Improve integration across programs (HIV, NCDs, maternal health, etc.)
  - Strengthen primary health care platforms for greater service integration
  - **Progressively increase Government-led financing** to sustain quality service standards
  - Reduce fragmentation and waste in the support systems for PHC
  - Empower individuals and communities in their health care, health promotion and disease control.

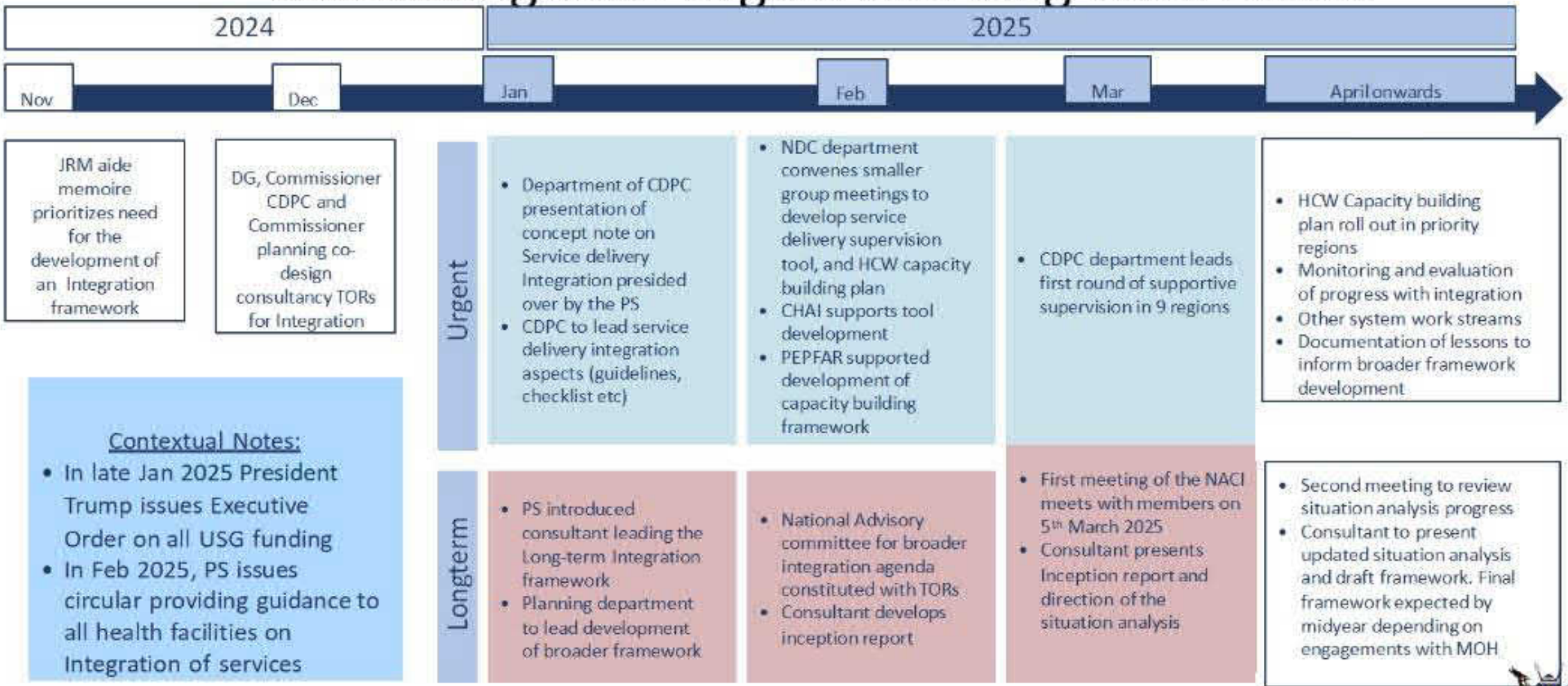
Table 4: Key components of the UNMHCP

Cluster	Components
Cluster 1: Health promotion, environmental health, disease prevention, and community health initiatives, including epidemic and disaster preparedness and response	Health promotion and education
	Environmental health
	Control of diarrhoeal diseases
	School health
	Epidemics and disaster preparedness and response
	Occupational health
Cluster 2: Prevention, management, and control of communicable diseases	Sexually transmitted infections / HIV/AIDS
	Tuberculosis
	Malaria
	Diseases targeted for eradication / elimination (leprosy, guinea worm, sleeping sickness, onchocerciasis, schistosomiasis, trachoma, lymphatic filariasis, and poliomyelitis)
Cluster 3: Prevention, management, and control of NCDs	NCDs
	Injuries, disabilities, and rehabilitative health
	Gender-based violence (GBV)
	Mental health and control of substance abuse
	Integrated essential clinical care
	Oral health
	Palliative care
Cluster 4: Maternal and child health	Sexual and reproductive health and rights
	Newborn health and child survival
	Management of common childhood illnesses
	Expanded Program on Immunization
	Nutrition

Source: Health Sector Service Standards and Service Delivery Standards, 2016

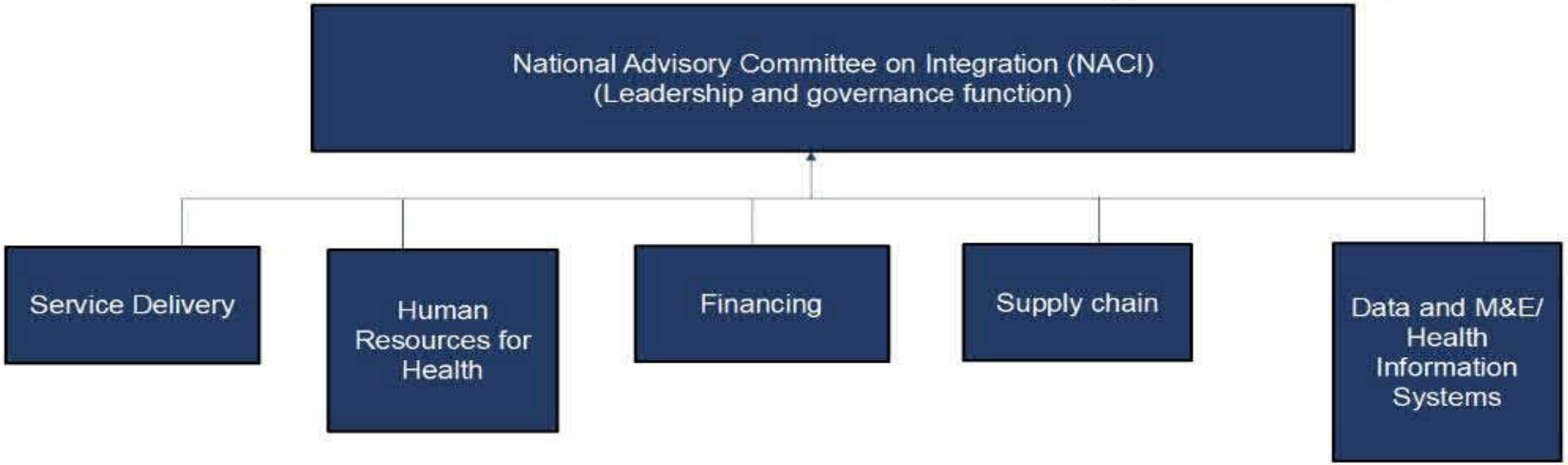
Government Response:

Uganda's MOH has already made progress on Integration addressing both Urgent and long-term needs



Integration: Progress

Coordination: The NACI committee and linkage to other pillars



Sub-groups

- The service delivery sub-group (Task Force) is part of the broader NACI and is fast-tracking the implementation of the PS circular.
- The NACI in parallel oversees the development of the broader integration framework led by the consultant and will ensure lessons from other subgroups feed into the framework development
- This mechanism has been put in place to ensure all WHO health system building blocks are accounted for in the design of the framework.

Framework for Integration

Domains for the National framework for Service Integration

Component	Strategic Actions
1. The Core (Individual)	- Build awareness on healthcare rights and services, - Establish/adopt standard tools for holistic assessment, - Involve patients and caregivers in care planning, - encourage progressive lifestyles, wellbeing and health promotion
2. Service Delivery	- Integrate services at PHC level (e.g., one-stop clinics). - Invest to ensure adequate essential medicines/supplies, - Strengthen referral systems, - Promote care continuity and transitions,
3. Workforce	- Train multidisciplinary teams. - Define new roles (e.g., care coordinators). - Strengthen staffing to address workload implications, - Support community health workers and VHTs.
4. Policy & Leadership Governance	- Form national and district-level coordination bodies. - Develop shared integration policies and legal frameworks. - Engage and ensure cross-MDAs commitments on health determinants.
5. Financing	- Align funding streams from donors and government. - Introduce bundled or performance-based payment models. - Protect against catastrophic health spending.
6. Technologies	- Scale interoperable EMRs. - Expand mHealth and telemedicine. - Ensure access to diagnostic and assistive technologies.
7. Information & Research	- Strengthen HMIS for integrated data. - Use data for risk stratification and quality monitoring. - Fund implementation research and innovation.

Integration: Pre-Assessment

Support Supervision Tool

Health facility Integration Support and Learning Tool

INTRODUCTION

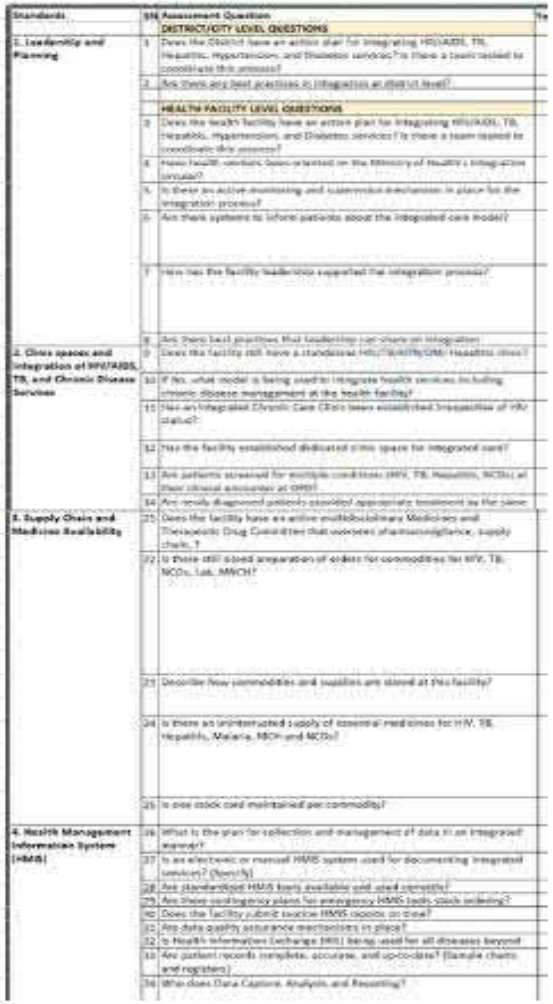
This monitoring and mentorship tool is intended to assess progress, check best practices and identify challenges in need of solutions to support the integration of standalone services into the primary health care system in Uganda. It checks implementation of the February 7th 2025 Ministry of Health circular on improving service delivery in both central and local government health facilities in Uganda.

Date	
Region	
District/City/Division/Municipa	
Health Facility Name	

Assessors/Mentors	Name	Organization

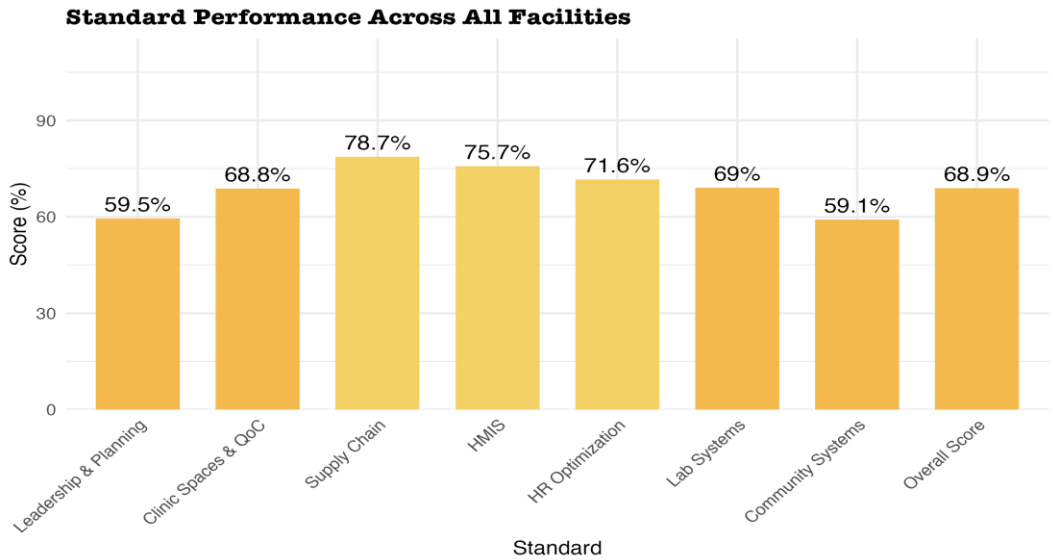
Layout

Standard	Description
Standard 1	**Leaders and managers must ensure they develop an action plan** for service integration
Standard 2	Health facility managers must **establish clinic spaces** for integrated services to manage Acute and Chronic Disease conditions, including Chronic Care Models
Implementation Procedure 1	Conduct comprehensive patient-centered Clinical Assessment and Care
Implementation Procedure 2	Implement service delivery approaches fostering efficiency and quality of care
Standard 3	Pharmacy in-charges must ensure **uninterrupted supply of essential medicines and diagnostics**
Standard 4	Functionalize the **National Integrated HMIS**
Standard 5	Prioritize **Human Resource Optimization**
Standard 6	Integrate **Laboratory Systems, Networks, and Diagnostic Services**
Standard 7	Deliver integrated **Community Health Services**

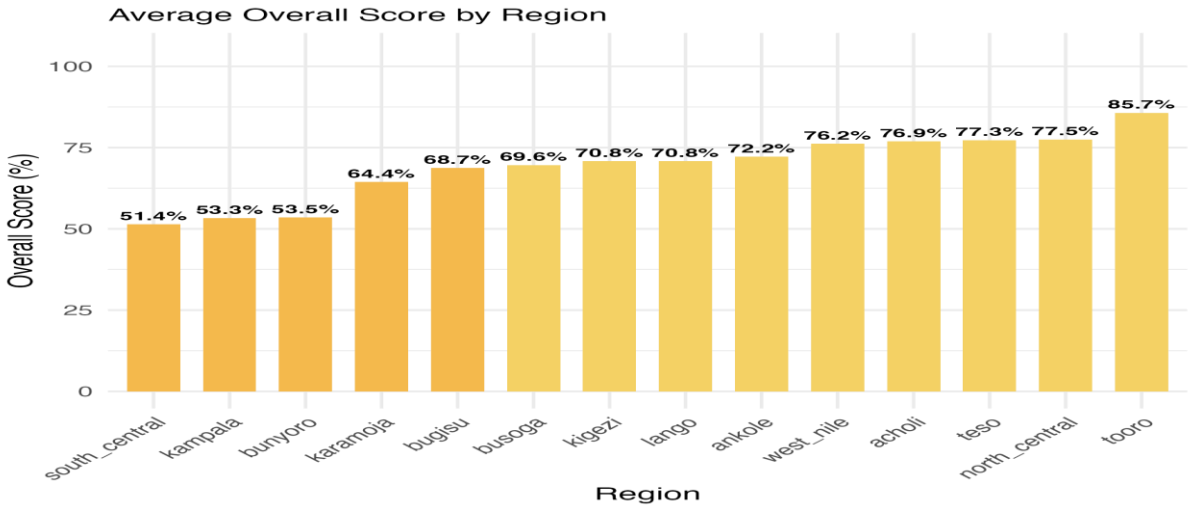


Integration Pre-Assessment : Findings

Overall achievement by integration standard (S1–S7) across the 67 health facilities



Overall achievement by integration standards (S1–S7) across regions



Performance against integrated standards (S1-S7) by Facility Type

Level	% Score	Strength	Challenge
Regional Referral	71.2%	HR Optimization	Community Systems
District Hospitals	75.4%	Clinic Spaces	Laboratory Systems
HC IV	64.1%	Supply Chain	Leadership
HC III	62.8%	Community	HMIS

Health Workforce Composition

Category	Average (%)
Medical Officers	36.8%
Clinical Officers	53.7%
Nurses	46.6%
Laboratory Staff	49.1%
Consultants	15.1%
HIV/AIDS	48.6%
Hepatitis	32.0%
NCDs	42.5%
Other Health Conditions	41.8%

Integration: Lessons Learnt

- Leadership is critical
- Reorganize space, Screening for multiple disease conditions including infectious diseases of outbreak potential
- Consider the information systems very critical
- Optimize available human resources, build their capacity and recruit where wage is available
- Integrated pharmacy systems coordinated by one main pharmacy
- Integrated laboratory systems coordinated by main laboratory
- Integrated Community workforce, activities, and data systems

Funding support- presently

Government of Uganda	Procurement of commodities – ART, **All Hep B products (tests, medicines and viral load**), HIV/Syphilis Duo test kits and other test kits, ART, BPG and TDF, EID & VL both conventional and POC, All STI medicines HR- staffing and capacity building Infrastructure , Data systems including EMR
Global Fund	Procurement of products- HIV ,HIV/Syphilis test kits, Hep B test kits, ART, EID & VL both conventional and POC, **no Hep B lab and TDF** Other programming-mentorship, training, waste management **Within Allocation**
PEPFAR	Procurement of products- HIV, HIV/Syphilis test kits, Hep B test kits **no Hep B lab and TDF** , EID &VL both conventional and POC Other programming- National level TA, mentorship, training, waste management, EMR and other data systems Implementing partners- sub-national support to service delivery
Other ADPs : UNICEF, WHO,	General program support: Policy and guidelines development, Elimination plan development , National Level TA, Mentorship, Support supervision , Global Alliance activities (advocacy, quality assurance, campaigns)

Where are we:

- Developed an integrated training package –completed
- Regular CMEs and Update meetings
- National TOT and Regional TOTs- Completed
- District trainings –Ongoing
- Facility trainings- Aug- Nov
- Reorganizing data flow and data systems
- Planning for evaluation
- Regular meetings at different levels-NACI, serviced delivery, M and E, QI teams
- Professional organizations to be onboarded- Obs/Gyn, Paed, Physicians etc

Way Forward

- Global Fund –reprioritization ongoing (cuts up to 13% for HIV grant)
- Discussions on private sector contribution:one-dollar fund for HIV
- Health Insurance discussions rejuvenated
- Increased government funding for health and HIV
- Exploring other non-traditional funding sources: CIDCA, Gates Foundation, PATH/UNITAID

THE REPUBLIC OF UGANDA

Thank you all for listening

Q&A

Zambia's Experiences in HIV Services Prioritization Planning

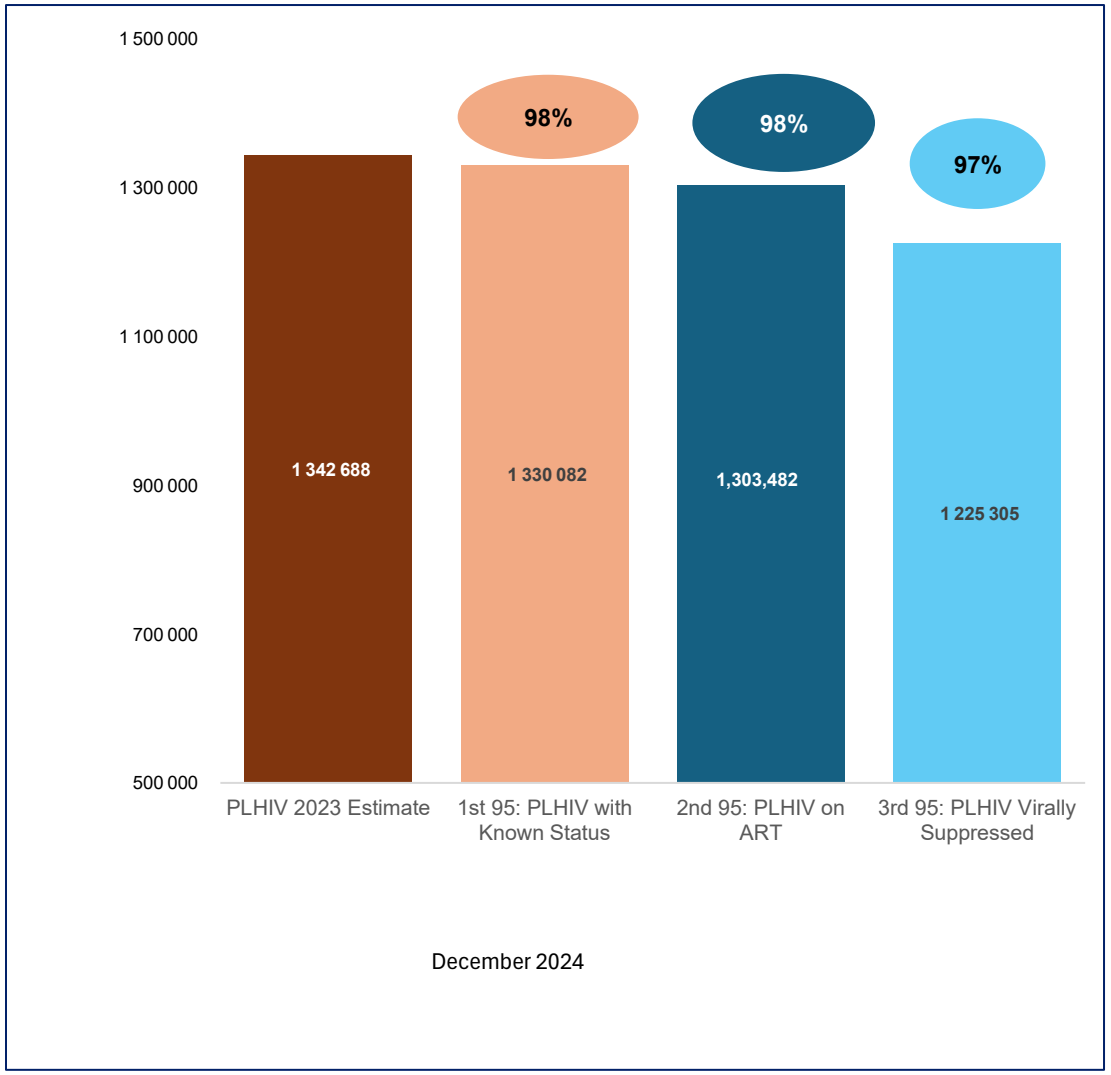
Dr Suilanji Sivile
HIV Coordinator
Ministry of Health
Zambia

Session Outline

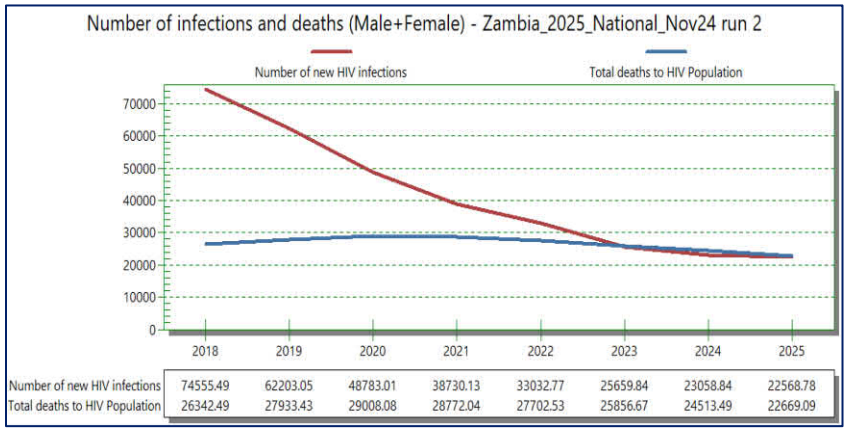
- key steps considered for the prioritization process:
  - Situational analysis,
  - key stakeholders engagement,
  - priority-setting steps were followed
  - Tools used

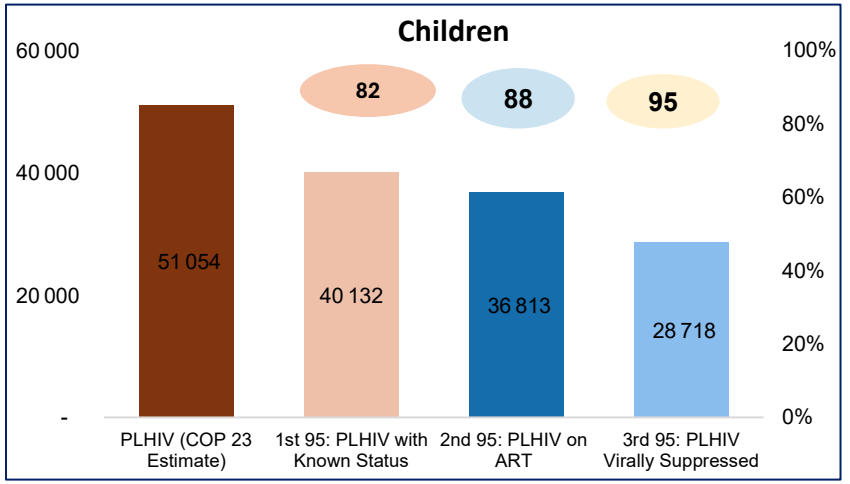
- Lessons learnt
- Areas needing for improvement

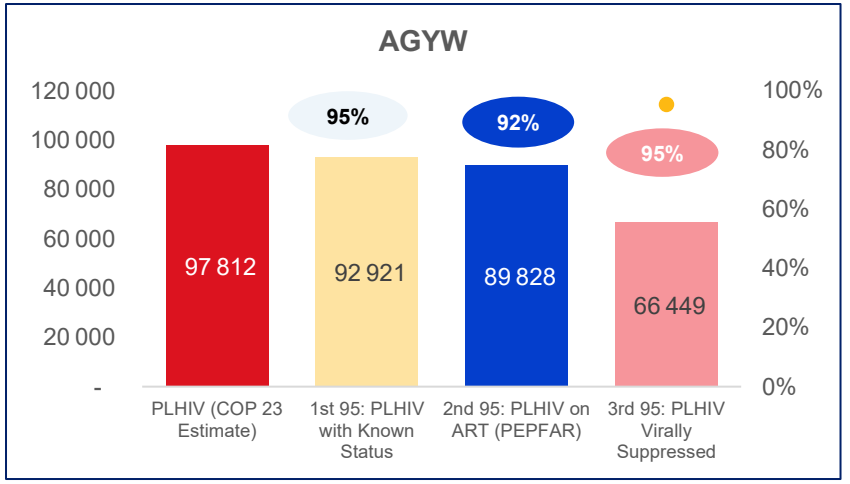
HIV Response and Epidemiology: Current Status and Trends



December 2024, Spectrum, MOH HMIS

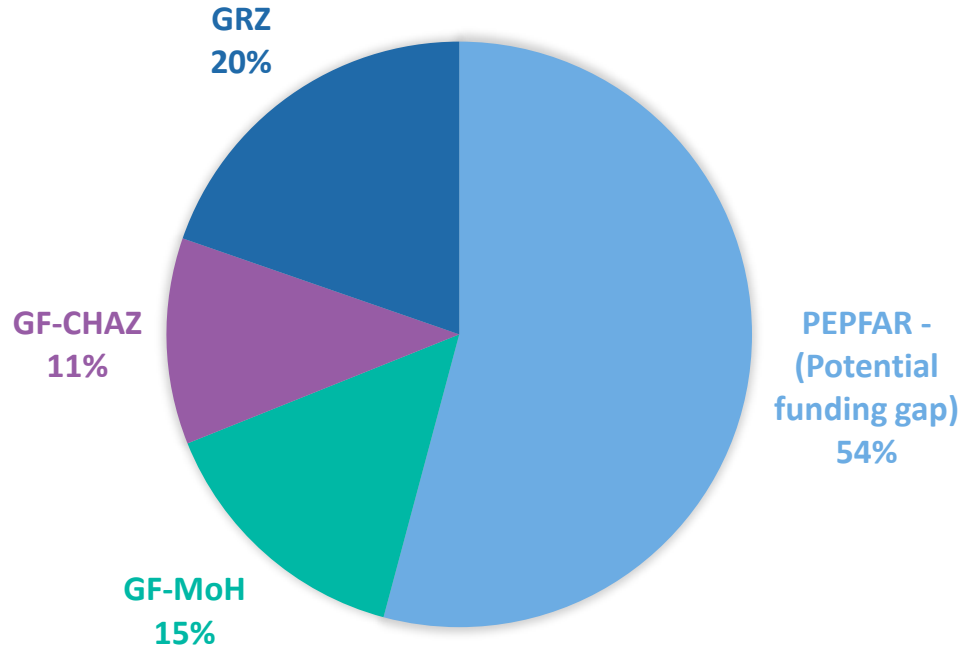






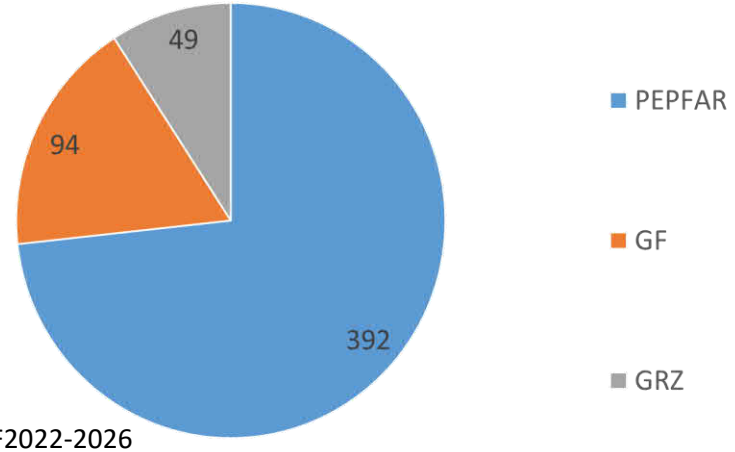
Financing: Understanding the Cost of HIV Service Delivery in 2024

HIV TREATMENT POTENTIAL FUNDING GAP - 2025



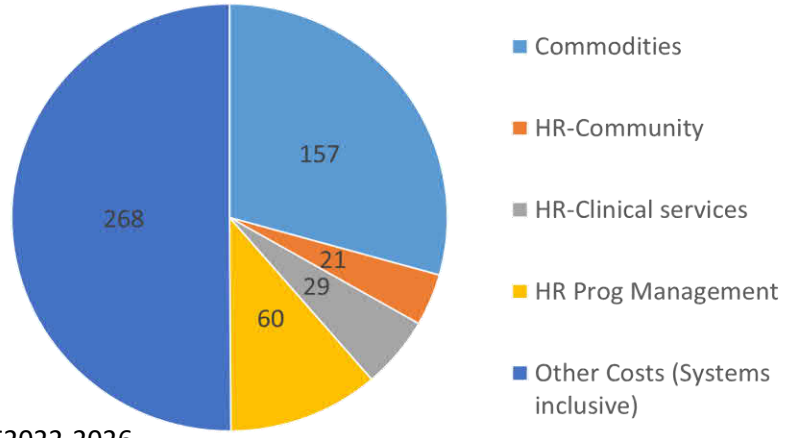
MOH Forecasting and Quantification Report

FYR 2024 HIV Funding Landscape (Million USD)



NASF2022-2026

Cost Elements Based on FYr 2024 Funding Landscape (Million USD)



NASF2022-2026

Ministry of Health

ZAMBIA MINIMUM PACKAGE FOR SUSTAINABLE HIV SERVICE DELIVERY

February 2025

Why the Minimum Package of Care

- Harmonization of HIV services across all facilities in the country
- Formation of sustainable and cost-effective package that can be afforded by domestic resource
- Package to strengthen national and subnational Government leadership and coordination for HIV services for HIV
- Package for quality assessment for HIV service across the country

Timelines

2023
- Program evaluation by MOH/GF/PEPFAR

2024
- Joint facility visits/assessment PEPFAR/MOH/GF

2024
- Stakeholders Solwezi Meeting to prepare the MPC

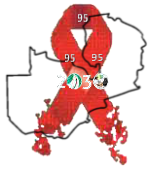
2024
- Stakeholders meeting adoption of the MPC

Feb2025
- Rprioritisation
- of the MPC
- following SWO

Feb2025
- Validation of the reprioritised MPC meeting

Now
- Dissemination and monitoring of MPC

Redefining the MPC: Coordination and Community Engagement



Process of developing the MPC

- The HIV roadmap sustainability technical working group spearheaded the redefining of the MPC.
- Multiple engagement meetings with CSO
- Feedback from major internal and external HIV stakeholders (UN-family, PEPFAR, IPs, IAS, GF, AHF)
- GRZ costed the MPC to ensure affordability

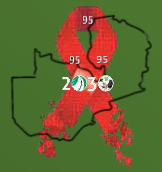
Key Principles

- ❑ **Sustainability**: The document considered the sustainability of prioritised interventions
- ❑ **Cost-effectiveness**: Interventions which were considered efficacious, safe with a high return on investments where prioritised.
- ❑ **Equity:** Consider the needs of all populations, including marginalized and vulnerable groups and regions
- ❑ **Integration**: The goal of this document is to have HIV services which are integrated in the main-line health service delivery systems
- ❑ **Inclusivity**: Engage a wide range of stakeholders in the guideline development process
- ❑ **Person-centeredness:** Recommended services must be respectful, responsive and tailor-made to the different needs of individual recipient of care
- ❑ **Contextual Relevance**: Adapt the Minimum HIV service package to the local context and resource availability

Priorite in Action

P Prepare the groundwork	*The Sustainability Steering Committee provided oversight for the process and the Sustainability technical working was the secretariate*
R Refine the scope	*Site visits gave insight on services/intervention to be considered for assessment in the prioritization process. The scope work motivated by the need to cost the intervention and HR and experts were engaged together with program/clinic expert.,*
I Implement the assessment	*Epidemiologic, program performance of interventions and cost were key considerations. UNAIDS Sustainability and prioritization tool was used*
O Organize the appraisal	***3 tiered appraisal (recommended and prioritised, recommended not prioritised and not recommended)***
R Recommend actions	*Appraised recommendations were reviewed MOH high level leaderships and costing assessment made. (Protea Chisamba Meeting)*
I Implement decisions	*Final document developed, costs submitted to treasury and shared with cooperating partners.*
T Translate and uphold entitlements	*Dissemination of the document. (Feedback still being received from implementers)*
E Evaluate and sustain progress	*Still being planned (site visits, M&E data evaluation)*

Criterion	What was Considered
Disease Burden, Epidemiological Impact, Progress Towards Global Targets	• Epidemiological Profile: Zambia has a generalised HIV epidemic at 11% prevalence. Children, including PBFW, and AYP were prioritised
	• Potential for Reducing Morbidity & Mortality: Interventions which directly relate to reduced incidence (PrEP) and mortality (AHD associated) where favoured)
	• Progress Towards Global Targets: Population left behind (KPs, children, AYP) had a favourable consideration.
Cost-Effectiveness and Resource Optimization	• Value for Money: Only high efficacious intervention were considered
	• Affordability, Sustainability & Cost: Other high intervention which could not be afforded by local resources were less considered (Index testing)
Feasibility and Health System Readiness	• Implementation Capacity: .Facility based services received a favourable consideration
	• Adaptability & Flexibility: More mature interventions like VMMC were adapted into routine surgical services
	• Scalability & Sustainability: None scalable/sustainable models (DREAMS) were less favoured
	• Long-Term Impact: interventions that would strengthen whole health systems in the long run were favoured (electronic health record systems for care)
Ethical and Equity Considerations	• Fairness & Inclusiveness: Services attending to needs of KPs were favoured
	• Human Rights & Stigma: All intervention must be non-discriminatory
Acceptability and Community Engagement	• Community Perspectives:
	• Stakeholder Engagement:
Social and Economic Impact	• Societal & Economic Consequences: Epidemic control is an economic issue in a generalised HIV setting



Revised MPC

Key Changes to the Minimum Package of Care

1. Minimum Package for HIV Testing Services

Recommended and prioritised HIV Testing Modalities

- Facility based Index testing and partner notification
- Facility based diagnostic testing for individuals presenting with symptoms suggestive of HIV infection or at high risk of HIV infection
- Use of HTS screening tool for adults at all clinical interaction
- Dual HIV/Syphilis testing in Antenatal Care (ANC) at booking
- PMTCT maternal HIV re-testing:
  - 2 re-test in ANC with one done three months after booking and the other one during labour and delivery.
  - 1 re-test in postnatal care (PNC) at 6 weeks during post-natal reviews or immunization clinic
- Early Infant diagnosis (EID): 6weeks_Nucleic Acid Test (NAT), 6 months_NAT, 9 months, 18 months Rapid Diagnostic Test (RDT), 24 months_RDT) and NAT confirmatory tests for all positives
- Hepatitis B testing for PLHIV and all pregnant women once in each pregnancy
- Know your child status Plus (KYCS plus)
- Client-initiated counselling and testing (Voluntary Counseling & Testing)
- HIV Testing during PrEP every three monthly

DSD Models for HIV Testing

- Higher learning institution HTS
- Community Health Post HTS

HIV Testing Modalities which may be considered but not a priority

- Provider-initiated testing for all populations at all facility entry points
- Community follow up of contacts of index cases
- Self-testing services in specific circumstances e.g specific populations, hotspots, self-test as A1 testing for screening etc.
- Peer based HTS approaches

HIV Testing Modalities which are not recommended

- Birth dose EID testing
- Recency testing
- Generalised non-targeted community testing

Required Tools

- ⇒ National testing algorithm
- ⇒ HIV Self Test Distribution Register
- ⇒ HIV and Syphilis Test Kits [1]
- ⇒ Index and Partner Notification Register
- ⇒ SOPs (Finger prick testing, Sample collection and handling, Zambia National HIV Testing Algorithm, Pre-Test, Post Test, Disclosure and EID)
- ⇒ Community HIV testing checklist
- ⇒ Partner Notification Guidelines
- ⇒ Know Your Child Status Plus Register
- ⇒ KYCS+ Guidelines
- ⇒ HTS Registers
- ⇒ Timer
- ⇒ HIV testing Tool kit[1]
- ⇒ Cooler box
- ⇒ Sharp box
- ⇒ Transport
- ⇒ Identification cards
- ⇒ Tester certificate
- ⇒ HIV screening tool (15+)
- ⇒ Known HIV-positive screening tools
- ⇒ DSD Guidelines
- ⇒ KYCS+ Package
- ⇒ Training of tasters
- ⇒ EQA support

Key Changes in HTS

Not Recommended

- **HIV Testing Modalities**
  - Birth dose EID testing
  - Recency testing
  - Generalized non-targeted community testing

May be considered but not a priority

- **HIV Testing Modalities**
  - Provider-initiated testing for all populations at all facility entry points
  - Community follow-up of contacts of index cases
  - HIVST in specific circumstances
  - Peer based HTS approaches

2. Minimum Package for HIV Prevention Services

Recommended and prioritised HIV Prevention Services

Biomedical
- Injectable PrEP
- Oral PrEP
- PEP for both occupational and non-occupational exposures
- Condom Provision
- STI screening
- HIV testing and treatment (TasP, U=U) promotion

Behavioural
- Demand creation for HIV prevention services must be integrate into mainstay health promotion activities and combined with other health promotion services
- Social Behavioral Change Communication (SBCC) Health education must be integrate into mainstay health promotion programming and activities and should not be a stand-alone program

GBV/IPV
- GBV/IPV screening, and treatment or referral services

Vaccination
- HPV vaccination for Adolescents

HIV harm reduction services
- Medication assisted treatment (MAT)

Required Tools
- ⇒ Condom distribution register
- ⇒ HTS register (facility and community)
- ⇒ Prep/PEP registers
- ⇒ GBV/IPV register
- ⇒ IEC materials
- ⇒ SBC tool kit
- ⇒ Public address system
- ⇒ SOPs
- ⇒ Guidelines

HIV prevention services which may be considered but not a priority
- Referral to socio-economic empowerment activities including social cash transfer, keeping girls in school and others for vulnerable populations must be done with other responsible line ministries
- Community HIV response addressing stigma and discrimination (community led service delivery, community lead monitoring and community advocacy) could be considered, preferably integrated into other established community systems and like Ministries
- Stand alone or parallel VMMC services. VMMC services will be incorporated into routine surgical services
- Dapivirine vaginal ring (DVR)

HIV Preventions Services which are not recommended
- Costly stand-alone community activities like DREAMS/DREAMs-like services, rented wellness centers and others

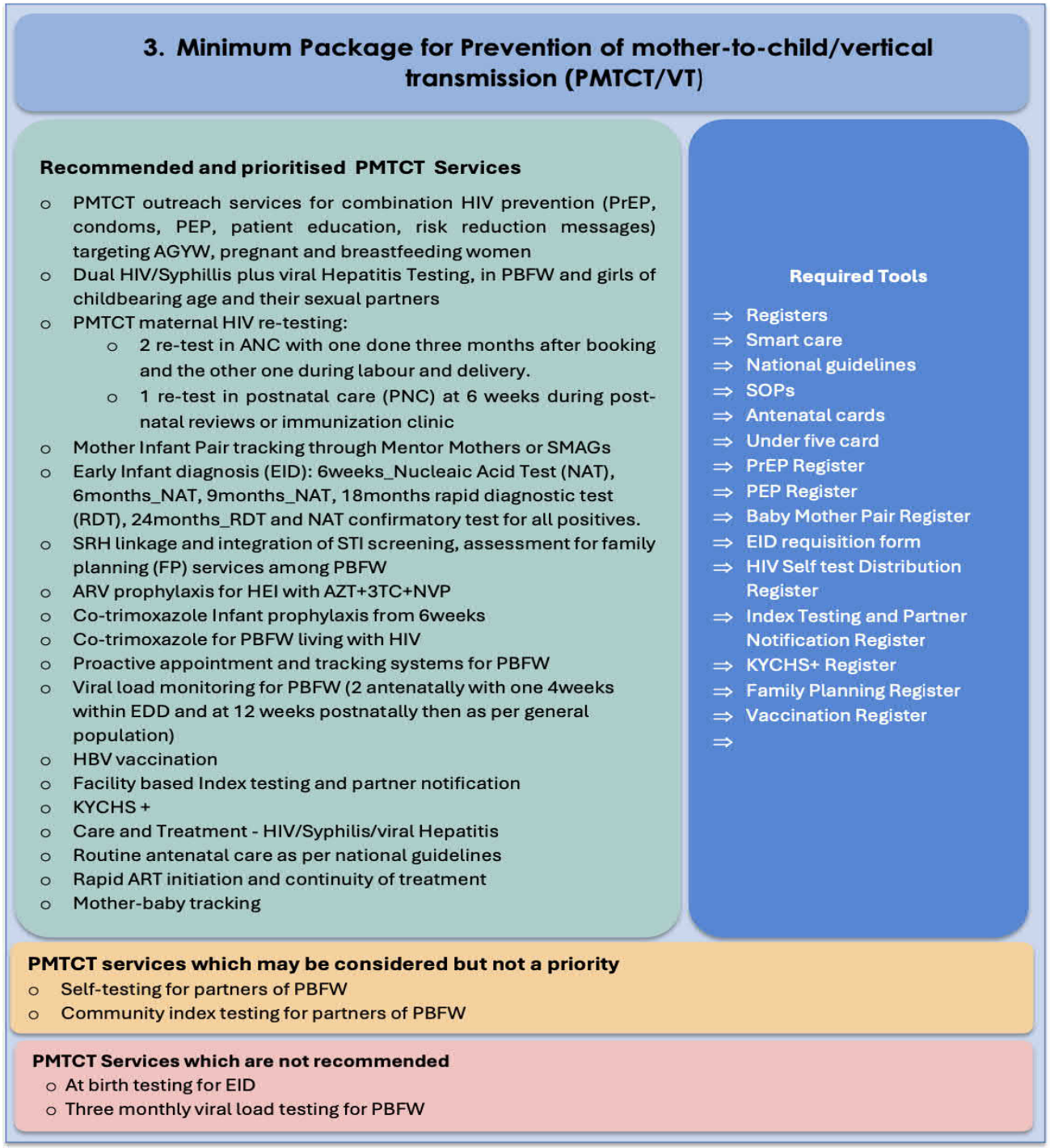
Key changes in HIV prevention services

Not Recommended

- **HIV prevention services**
  - Costly standalone community activities such as DREAMS/ DREAMs-like services

May be considered but not a priority

- **HIV prevention services**
  - Referral to socio-economic empowerment activities
  - Community HIV response addressing S&D
  - Standalone or Parallel VMMC services
  - Dapivirine Vaginal ring (DVR)



Key changes in PMTCT services

Not Recommended

- **PMTCT services**
  - At birth testing for EID
  - Three-monthly Viral Load (VL) testing for PBFW

May be considered but not a priority

- **PMTCT services**
  - HIVST for partners of PBFW
  - Community index testing for partners of PBFW

4. Minimum Package for HIV Treatment and Care Services

Recommended and prioritised HIV Treatment Services

Paediatric, Adolescents and Adults

- Rapid and same day ART initiation for first and second line care
- Intense case-management support in the first 6 months
- Opportunistic infections (OI) screening, prophylaxis and management
- Retention (including disclosure support; transition support; peer support groups, peer pairing, proactive appointment system and same-day tracking for those with missed appointments)
- Viral load monitoring
- Treatment Literacy including adherence support

Differentiated Service Delivery (DSD)

- Multi-month dispensation (MMD)
- Fast track
- Scholar models
- Weekend services (men, adolescents)
- Community ART delivery models
- DSDs for unstable recipient of care
- Family Centred Approach for CLHIV and their families
- Teen Clubs and Adolescent Friendly Spaces

Integration of NCD and Mental Health

- Screening and/or referral for hypertension, Diabetes Mellitus, Obesity, Renal disease
- Screen and/or refer for cervical cancer screening
- Screening and referral for common mental health disorders

TB Prevention Therapy (TPT) and Intensified Case Finding (ICF)

- Screen, diagnose and treat TB
- Provision of one off TPT to all eligible (old and new) recipient of care (RoC)
- Administrative controls for infection prevention

Advanced HIV Disease (AHD)

- Screen and identify RoC with AHD using WHO Clinical Stage (WCS) and when available CD4
- OI screening with LF-LAM and CrAg
- Treat with Anti Tuberculous Therapy (ATT)
- TB Preventive Treatment (TPT)
- Referral where service is not available
- Linkage to ART for treatment naïve or Clients returning to treatment

Sexual Transmitted Infections and Sexual Reproductive Health

- Screen, diagnose and treat STIs
- Risk reduction counseling including condom distribution
- Family Planning (mixed method) counselling and service provision
- Pregnancy screening and linkage to Antenatal Care (ANC)/Postnatal Care (PNC)

Required Tools

⇒ SOPs – including ZCGs, Caregiver Support Manual, Comprehensive Manual for Prevention and Treatment of HIV among Adolescents
⇒ IEC materials, appropriate registers and data capturing tools
⇒ DSD guidelines
⇒ Community HIV treatment literacy manual
⇒ ART Forms
⇒ Zambia Standard Treatment Guidelines (STG)
⇒ Patient Health Questionnaire-9 and Generalized Anxiety Disorder Assessment-7
⇒ Primary Mental Healthcare Package
⇒ TPT Guidelines
⇒ TB guidelines
⇒ AHD Guidelines
⇒ NCD guidelines
⇒ FP guidelines
⇒ ANC guidelines
⇒ STI guidelines
⇒ STI Register

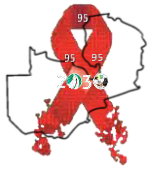
HIV treatment services which are NOT recommended

- Co-trimoxazole prophylaxis outside children and pregnant and breastfeeding women
- Repeat TPT for individuals who have received TPT before
- Baseline viral load testing
- HIVDR after first line treatment failure only

Key changes in HIV Treatment and Care services

Not Recommended

- **HIV Treatment services**
  - Co-trimoxazole prophylaxis outside children and PBFW
  - Repeat TPT for clients who have received TPT before
  - Baseline Viral Load (VL) testing HIVDR after first line treatment failure only.



Challenges of Community Services in the MPC

- Community HIV Services have been critical in the success of the HIV response
- Community HIV service provision mainly funded and provided by donors
- Inherent difficult in the Government human resource management systems to uptake community health volunteers
- Unique challenges in costing community health services (e.g, Renting a shop-space for health post models or a house for community safe spaces)

How do CSO continue to provide services post donor support?

Minimum Package for HIV Community Services

All HIV related community services must be integrated into routine national community health systems and should NOT be siloed or be implemented as parallel programs. The following community-based HIV should be provided in a cost effective and sustainable manner

Community DSD models for HIV testing
Community PMTCT models
HIV Other prevention community services
Community DSD models for HIV prevention
Community DSD models for HIV treatment and care including community ART delivery models
Community HIV services models for prevention and treatment targeted at high-risk groups
Community based health education and health promotion
Community led advocacy, literacy, stigma reductions and service feedback activities

Monitoring and Evaluation: Tracking MPC Adjustments

- Opportunity to realign HIV service monitoring to make the process Government-centric.
- Government hierarchy to led the monitoring, supervision and evaluation of the MPC services.
- Formation of dashboards for facility performance.
- Integrate into the standard SQA tools.

Minimum HIV Service Package Indicators

- Number of facilities oriented in the minimum HIV service package
- Number of facilities assessed in the minimum service package in the reporting period
- Number of facilities fully implementing the minimum HIV service package in the reporting period
- Number of facilities partially implementing the minimum HIV service package in the reporting period
- Number of facilities not implementing the minimum service package in the reporting period

Required Tools and Resources

Zambia SQA tools

Minimum HIV service package dashboard

Minimum HIV service package assessment tool

Best practices and Way Forward

Lessons Learnt

- Costing the need of MPC makes it easier to quantify the need and lobby for resources. The costed minimum package as **32%** cheaper than the conventional package.
- More information is required for an accurate costing of the services
- Integrating HIV services into the health systems (esp. **Leadership and coordination**) is critical for continuity of HIV services
- Government ownership of health information systems is critical to sustaining the gains in the epidemic response
- Redefine engagement terms with partners and role out of innovations

Barriers for MPC implementations

- Buy-in from the stakeholders e.g, Funders
- Building sustainable community strategies/models- Hold a meeting focus on community services/engagement
- Review the MPC processes with different scenarios using WHO tools and better data
- Government structures that are not able to accommodate CSO support for community work
- Fund to implement change management
- Use mathematic models to assess impact of priorities

Recommendations: Building a Resilient MPC

- Make the process iterative with robust stakeholder engagement
- Have costing and finance in mind
- Building a strong monitoring and evaluations, and implementation vehicles for the MPC is important
- MPC are a requirement for sustainable HIV services

Thank You

We'd Like to Hear from You!

Connecting Global Guidance with Local Realities

Scan the QR Code to share how your country could adapt and apply this operational guidance

https://docs.google.com/forms/d/e/1FAIpQLSc9PjtnHKXC4FOBu13P5pQoTVIB1RVngokIIDt7Ad4nujDwzg/viewform?usp=dialog

Key messages and closing remarks

Meg Doherty,

Director, Department of Global HIV, Hepatitis and Sexually Transmitted Infections Programmes (WHO)

World Health Organization

Key messages

Countries have been actively engaged in prioritization efforts since the pause in ODA funding.

National leadership is central to driving the prioritization process forward.

Countries are sharing valuable experiences and good practices, fostering peer learning and global/regional collaboration.

Prioritization is inherently complex—it requires strong national ownership and the flexibility to adapt priorities to each country's unique context.

Partner alignment and collaboration are essential to ensure coherence and maximize impact throughout the prioritization process.

Looking ahead, integration, cost-effectiveness, and long-term sustainability of HIV, hepatitis, STIs, and related programs within primary health care (PHC) must be considered.

WHO remains committed to supporting countries with technical guidance and tailored assistance needs.

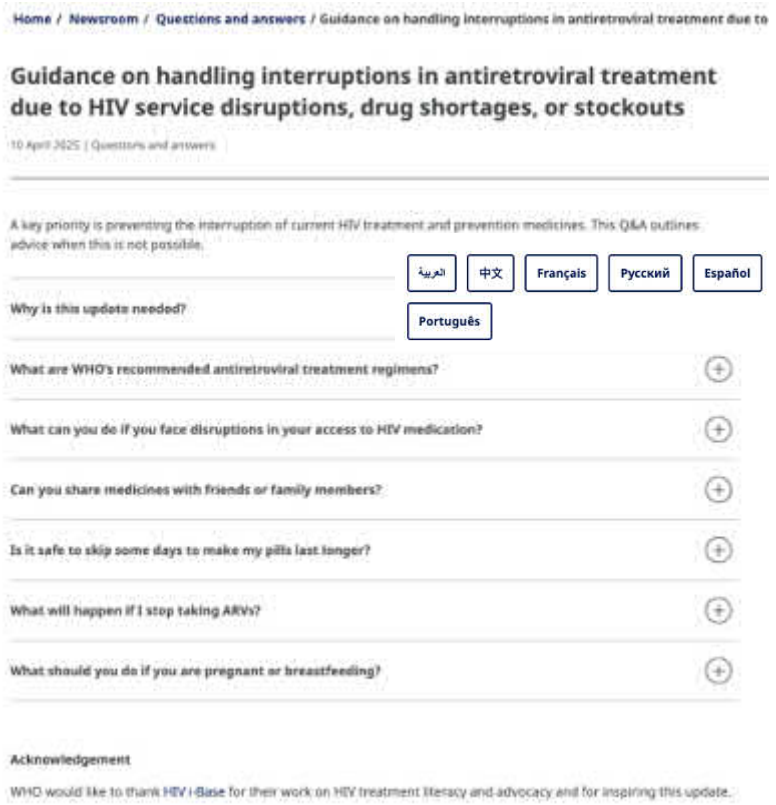
World Health Organization

WHO Resources:

World Health Organization

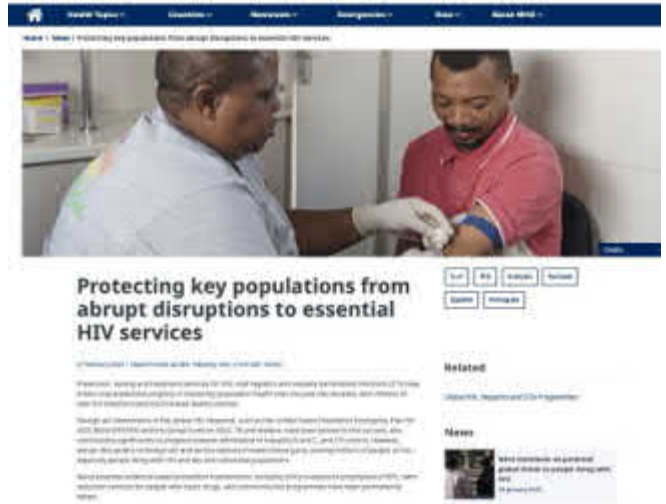
WHO webpage: Sustaining HIV, hepatitis and STIs services amid declining health aid

https://www.who.int/activities/sustaining-hiv-hepatitis-and-stis-services-amid-declining-health-aid



https://www.who.int/news-room/questions-and-answers/item/guidance-on-handling-interruptions-in-antiretroviral-treatment-due-to-hiv-service-disruptions--drug-shortages--or-stockouts

https://www.who.int/news/item/27-02-2025-protecting-key-populations-from-abrupt-disruptions-to-essential-hiv-services



WHO Resources:

Precipitated aid transition in health – priority actions for low-and-middle income-countries

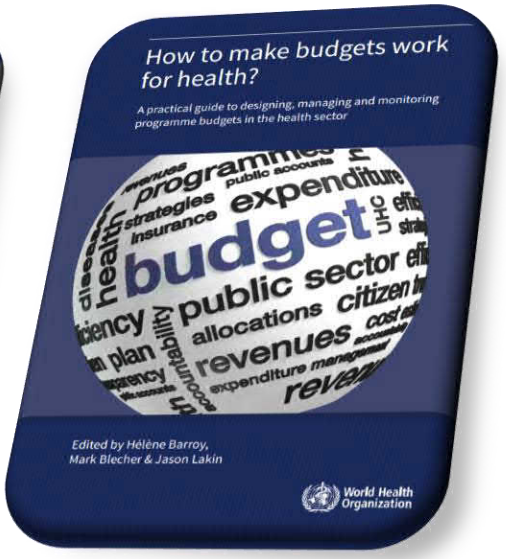
Hélène Barroy, Susan Sparkes, Kalipso Chalkidou (WHO/HQ)

With contributions from Christabel Abewe (WHO/Uganda), Kingsley Addai Frimpong (WHO/Ethiopia), Georgina Bonet (WHO/AFRO), Riku Elovainio (WHO/ Democratic Republic of Congo), Sophie Faye (WHO/AFRO), Jayendra Sharma (WHO/SEARO), Tsolmongerel Tsilaajav (WHO/Vietnam), Anna Vassall (WHO/HQ), Ding Wang (WHO/Cambodia), MyMai Yungrattanachai (WHO/HQ).

https://www.pfm4health.net/blog/precipitated-aid-transition-in-health-priority-actions-for-lowandmiddle-incomecountries

https://openknowledge.worldbank.org/entities/publication/8878fbd9-879d-43d4-ab1f-ecaed1a4576a

https://www.who.int/publications/i/item/9789240044982

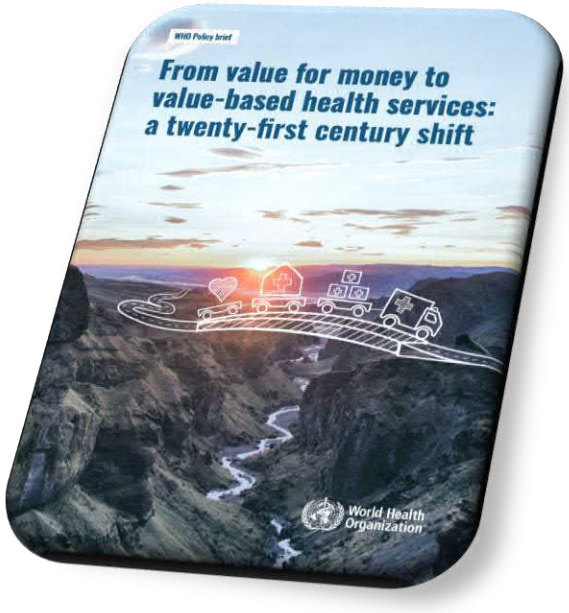


https://www.who.int/publications/i/item/9789240049666

Contact: healthfinancing@who.int

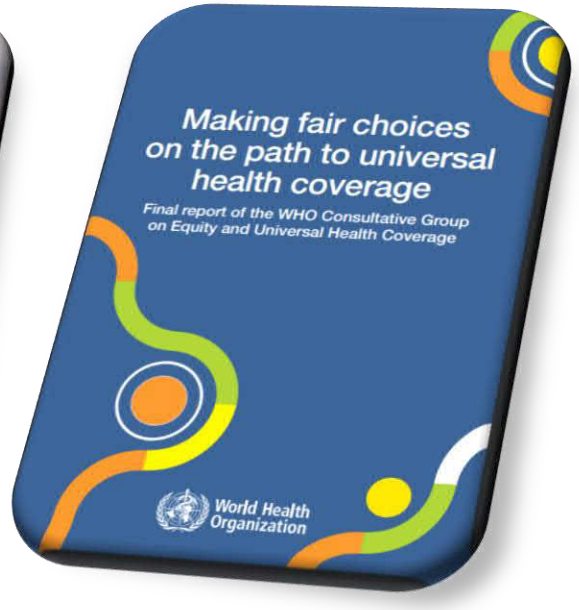
WHO Resources:

Contact: whochoice@who.int



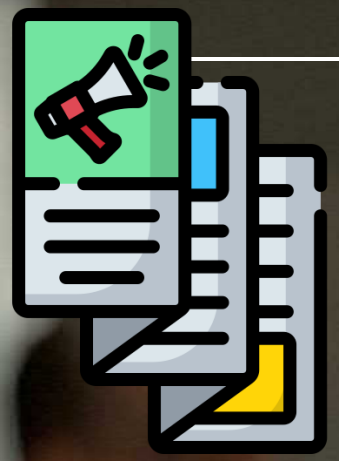
https://iris.who.int/handle/10665/340724

https://iris.who.int/handle/10665/340723



https://iris.who.int/handle/10665/112671

https://iris.who.int/handle/10665/340722



Supporting Materials from Partner Institutions

World Health Organization

IAS

The PATHS –
Planning and **A**ction **T**oolbox for **H**IV **S**ustainability

- *What is it?*

A toolbox; a rapidly deployable compendium of resources

- *Who is it for?*

National governments

- *What's the objective?*

Support responding to unexpected reductions in HIV funding by enabling swift reassessment and reorganization of HIV systems and services

- *What does it include?*

Key questions, tools and resources, and country examples

bit.ly/HIV_PATH

IAS

The TIER tool–

Tool for **I**ntervention **E**valuation and **R**anking

- *What is it?*

An excel workbook; a structured framework for prioritizing components of an HIV programme

- *Who is it for?*

National governments

- *What's the objective?*

Support countries in their planning and prioritization of HIV programme elements in the context of funding shifts

bit.ly/HIV_PATH

ICAP at Columbia University's CQUIN and HIVE Project Resource Links

Meetings

- 2025 CQUIN Network Meeting
- 2025 HIVE Strategic Planning Meeting

Emergency Response

- CQUIN Emergency Response and Sustainability Focus
- HIVE Emergency Response

HIV Impact Network for Vertical Transmission Elimination

PATA

icap Global Health

THE CQUIN NETWORK

Thank you! Merci!

This presentation has been designed to be accessible, for a positive and inclusive user experience for all.

World Health Organization