GLOBAL ACTION PLAN ON SKIN DISEASES (GAP-SKIN) 2026-2035

Guidance for Countries on Developing a National Action Plan for Skin Diseases (NAP-Skin)

An adopt-and-adapt framework for country-led, integrated, costed and measurable skin health action

Status	Pre-publication technical draft. Not official WHO guidance.
Alignment	WHA78.15 and the draft Global Action Plan on Skin Diseases 2026-2035, with direct linkage to national public health planning and all seven strategic objectives.
Primary audience	Ministries of Health; national planning and finance authorities; subnational health administrations; public-health programmes; professional and regulatory bodies; civil society and people affected; development partners.
Date	22 July 2026
Document version	Version 1.2, with a full communication, advocacy and stakeholder engagement section and country template, plus Annex Q containing RACI governance and implementation tools; prepared for technical review, clearance and national adaptation.

SKIN HEALTH FOR ALL

From a shelf document to a living national management cycle

Pre-publication status

This document is a technical draft prepared to support review, clearance and national adaptation. It is not official WHO guidance and should not be cited as such until formally cleared and published. The draft GAP-SKIN and companion indicator and workforce frameworks remain subject to validation and approval.

Contents

How to use this guidance

Countries may use this document to prepare a stand-alone NAP-Skin, a dedicated skin health component within a broader national health strategy, or an integrated implementation framework spanning several existing plans. All three options should meet the same minimum standards for priorities, accountability, costing, monitoring and participation.

Executive summary

WHA78.15 recognizes skin diseases as a global public health priority and urges Member States to strengthen action within national health programmes and universal health coverage. The draft Global Action Plan on Skin Diseases 2026-2035 proposes country-led National Action Plans for Skin Diseases, or equivalent mechanisms, with defined priorities, targets, timelines and accountability arrangements [1,2].

This guidance translates that policy direction into a practical country planning method. It does not copy a single planning manual. It combines the most reusable elements of existing WHO guidance: the national health planning cycle; the four-part architecture of the WHO African Region country NTD master-plan framework; the flexibility of WHO tuberculosis strategic planning; the multisectoral process and implementation-matrix discipline used for noncommunicable diseases; and the costing, financing and monitoring tools developed for antimicrobial resistance [3-10].

NAP-Skin as the country-level integration mechanism. GAP-SKIN defines the strategic direction. NAP-Skin translates it into country-specific priorities, targets, milestones, accountabilities, costs, financing assumptions, indicators and annual review arrangements. Countries should use the companion package together: the Two-Phase Prioritization Framework for disease and service priorities; the PHC classification for recognition, management and referral actions; the Training and Competency Framework for workforce requirements; the Indicator Compendium for measurement; GSHA for aligned partner support; and SHRIEF for research, innovation and learning priorities. This guidance does not replace clinical standards or indicator metadata.

Recommended adoption decision

Adopt the WHO country NTD master-plan architecture as the main document spine: situation analysis, strategic agenda, operational framework and budgeting for impact. Adapt it to integrated skin health by organizing national action around the seven draft GAP-SKIN strategic objectives, embedding services in primary health care and universal health coverage, and adding explicit requirements for equity, stigma reduction, mental health, referral, laboratory systems, digital governance and participation of people affected.

What a completed country process should produce

- **An endorsed national policy instrument.** A time-bound NAP-Skin or equivalent mechanism approved through the country's established policy process.
- **A credible evidence base.** A concise situation analysis that triangulates epidemiological, service, workforce, financing, commodity, laboratory, information-system and lived-experience evidence.
- **A prioritized strategic agenda.** A small number of measurable national results, targets and milestones, rather than an inventory of every desirable activity.
- **An operational accountability framework.** Named lead and supporting institutions, implementation levels, annual milestones, dependencies and review arrangements.
- **A costed financing pathway.** Activity-based costs, existing allocations, financing gaps, domestic resource-mobilization actions and sustainability assumptions.
- **A monitoring, evaluation and learning framework.** Baselines, targets, indicators, data sources, reporting responsibilities, disaggregation and scheduled reviews.
- **A participation and equity record.** Documented involvement of affected people, communities, frontline workers and underserved populations in design, validation and review.
- A communication, advocacy and stakeholder engagement plan. Audience-specific objectives, messages, channels, responsibilities, costs, feedback mechanisms and measures of effectiveness that support policy action, implementation, service uptake and stigma reduction.
- A national research and learning agenda. A completed country process should identify evidence gaps, implementation bottlenecks, innovation needs and evaluation questions arising from the situation analysis, prioritization process and readiness assessment. This agenda should be structured using SHRIEF and linked to national monitoring, evaluation and learning.

Minimum national standard

A plan should not be considered implementation-ready merely because it has been written or launched. At minimum, it should be formally endorsed, current, prioritized, costed, measurable, operationally assigned, communication-ready, integrated with national systems, equity-responsive and linked to an annual management cycle. Annex M provides a ten-criterion verification standard. Companion-document use standard: the plan should map priorities, PHC actions, workforce requirements, indicators, partner roles and research or learning priorities to the relevant GAP-SKIN companion documents.

PART I

Foundations for a National Action Plan for Skin Diseases

1. Background and policy mandate

Skin diseases occur across the life course and can cause pain, itch, infection, wounds, disability, disfigurement, stigma, mental distress, reduced participation in education and work, and avoidable death. Many conditions can be prevented, recognized or managed closer to where people live when frontline workers have appropriate competencies, essential medicines, decision support, referral pathways and access to specialist advice [1,2].

WHA78.15 calls on Member States to prioritize skin diseases within national health programmes and universal health coverage, strengthen primary health care capacity and improve prevention, detection, treatment, rehabilitation and research. It also requests WHO support for countries to develop or revise relevant policies and plans [1].

The draft GAP-SKIN 2026-2035 proposes seven mutually reinforcing strategic objectives: coordination and financing; national planning and policy integration; integrated people-centred services; workforce capacity; equity, mental health and stigma reduction; surveillance and data systems; and laboratory networks and dermato-epidemiology research [2]. A national plan should convert these directions into country-specific priorities, commitments, budgets and accountability.

Operational translation. The seven GAP-SKIN strategic objectives should remain the organizing frame for national planning. Companion-document objectives, domains, criteria, pillars and indicator sets should be used as implementation architecture supporting those objectives, not as additional parallel national or global strategic structures.

2. Purpose, scope and intended users

2.1 Purpose

This guidance supports countries to develop, revise, cost, endorse, implement and review a National Action Plan for Skin Diseases or an equivalent national mechanism. It provides both a recommended document structure and a country process, recognizing that a technically elegant plan will still fail without ownership, financing, operational discipline and regular use.

2.2 Scope

- All skin conditions prioritized through national epidemiology, service demand, severity, inequity and feasibility, including common skin diseases and priority skin NTDs.
- Health promotion, prevention, early detection, diagnosis, treatment, self-care, rehabilitation, palliative care where relevant, mental health and stigma-responsive support.
- Community, primary, secondary and tertiary levels, including referral, counter-referral, laboratory and digital support.
- Public, private, faith-based, community and traditional-care interfaces where nationally relevant.
- National and subnational planning, including settings affected by fragility, displacement, climate hazards or humanitarian emergencies.

2.3 Intended users

Primary users are Ministries of Health and national planning teams. Other users include ministries responsible for finance, education, labour, social protection and local government; subnational health administrations; national programmes; professional councils and societies; training institutions; laboratories; civil society; organizations of people affected; research institutions; private providers; development partners and funders.

2.4 What this document is not

This is not a clinical guideline, a disease list, a curriculum or a funding proposal. It is a planning framework that should point to approved technical standards and transform them into a coherent, costed national programme of action.

3. Review of existing guidance and adoption decision

The targeted review found no single WHO document that covers the full policy, technical, operational, costing and monitoring needs of an integrated national skin health plan. The reusable building blocks already exist, however. The most efficient approach is a modular hybrid, with one source supplying the overall spine and other sources strengthening specific planning functions.

Source	Best function	Decision	Application to NAP-Skin
WHO Country NTD Master Plan 2026-2030 framework [3]	Primary document architecture	Adopt and adapt	Use four parts: situation analysis; strategic agenda; operational framework; budgeting for impact. Retain the management-cycle logic, country ownership, mainstreaming and impact-accountability emphasis.
WHO national health strategy handbook [4]	Overall planning cycle	Adopt	Use participatory situation analysis, priority setting, strategic formulation, operational planning, costing, budgeting, monitoring and evaluation.
WHO tuberculosis national strategic planning guidance [5]	Plan format and strategic coherence	Adapt	Allow stand-alone or integrated plan formats; translate global commitments into national targets, priority interventions and cross-sector coordination.
WHO NCD multisectoral action plan toolkit [6]	Stakeholder process and implementation matrix	Adapt	Use structured stakeholder mapping, governance roles, consultation, prioritized interventions and matrices specifying leads, timelines, outputs, resources and indicators.
WHO AMR implementation handbook [7]	Implementation management	Adapt	Use staged implementation, political commitment, governance, prioritization, resource mobilization, monitoring and communication of progress.
WHO AMR costing and budgeting tool [8]	Costing and financing	Adapt	Cost prioritized activities, identify existing resources and gaps, assign financing sources and support investment-case development.
WHO AMR and NTD M&E guidance [9,10]	Monitoring and accountability	Adapt	Build on routine systems, specify indicators and metadata, review data for action, and integrate monitoring into national health information systems.
WHO skin NTD strategic framework and practical handbook [11,12]	Skin-specific service content	Integrate	Use integrated skin NTD service-delivery, case-recognition, management and referral content as technical inputs, not as the planning architecture.
Draft GAP-SKIN and companion frameworks [2,13,14]	Policy results and skin-health standards	Align	Organize the plan around the seven strategic objectives and use the indicator and workforce companion drafts to specify measurable national results.

3.1 Why the NTD master-plan architecture is the preferred spine

The 2025 WHO African Region framework is the closest operational analogue because it is designed for comprehensive, country-owned, multi-year public-health planning. Its four sections move cleanly from evidence to strategic choices, from choices to implementation, and from implementation to financing. It also explicitly promotes mainstreaming into routine health systems, accountability for impact and greater domestic ownership [3].

The NAP-Skin adaptation differs in important ways. It covers common skin diseases, skin NTDs, chronic inflammatory conditions, skin cancers, wounds, severe presentations and other nationally prioritized conditions. It must therefore connect several programmes and professions, use a people-centred service package, address stigma and mental health, and define referral and specialist support across the health system.

4. Definitions and guiding principles

Term	Working definition
NAP-Skin	A time-bound national action plan for skin diseases or skin health, or an equivalent formally approved mechanism that defines priorities, targets, milestones, accountabilities, costs and monitoring arrangements.
Integration	Coordinated planning, implementation, monitoring and evaluation across skin conditions, health programmes or sectors to improve efficiency, continuity, sustainability and impact.
Mainstreaming	Embedding skin-health functions within routine service delivery, financing, workforce, supply chain, laboratory, information and accountability systems so that they become standard health-system functions.
Operational plan	A detailed one-year or multi-year schedule translating strategies into activities, responsible actors, timing, deliverables, resources and monitoring.
Costed implementation pathway	A documented estimate of resources required, existing allocations, financing gaps, sources and actions to close gaps over the plan period.
People affected	People living with, at risk of, treated for or experiencing consequences of skin diseases, including caregivers and representative organizations.

4.1 Guiding principles

- **Country ownership and policy coherence.** Use national planning, budgeting, regulatory and review processes; align with the national health strategy, UHC roadmap and relevant programme plans.
- **People-centredness and participation.** Design around needs across the life course and document meaningful involvement of affected people, caregivers, communities and frontline workers.
- **Equity and non-discrimination.** Identify who is missed, why they are missed and what differentiated action is required, including gender, age, disability, poverty, geography, ethnicity or migration status where lawful and relevant.
- **Primary health care orientation.** Deliver safe and feasible care as close to communities as possible, supported by clear referral, specialist and laboratory pathways.
- **Integration with safety boundaries.** Share platforms and competencies where this improves care, while retaining disease-specific expertise, emergency escalation and specialist functions where necessary.
- **Evidence-informed prioritization.** Use the best available data, transparent criteria and explicit assumptions. Data gaps should trigger learning actions, not paralysis.
- **Sustainability and domestic financing.** Use existing systems first, protect recurrent costs and establish a realistic path from external support to durable domestic or pooled financing.
- **Accountability for results.** Link every strategic result to responsible institutions, milestones, indicators, data sources, review forums and corrective action.
- **Ethics, privacy and digital inclusion.** Protect consent and confidentiality, validate digital tools, maintain human oversight and preserve non-digital alternatives.
- **Adaptation and learning.** Treat the plan as a living management instrument, reviewed annually and adjusted when evidence, context or implementation performance changes.

5. Choosing the national plan format

Countries should choose the format that has the strongest legal authority, financing pathway and implementation probability. The title matters less than the evidence that skin health priorities are owned, costed and managed.

Format	Description	Best used when	Main safeguard
A. Stand-alone NAP-Skin	A dedicated national strategy and implementation framework.	Skin health requires concentrated visibility, coordination or rapid system-building.	Risk of creating a new vertical programme or parallel reporting system.
B. Skin health chapter or result area within the national health strategy	A defined section, outcome or programme in the national health sector plan.	The national planning cycle is open and skin health can secure measurable targets, budget lines and accountability.	Skin health may be diluted unless the content is sufficiently explicit and operational.

Format	Description	Best used when	Main safeguard
C. Integrated implementation framework across existing plans	A formally endorsed crosswalk and action framework linking PHC, NTD, NCD, cancer, mental health, disability, workforce, medicines and data plans.	Several plans already cover substantial skin-health functions and a new strategy would duplicate them.	Fragmented ownership unless one coordination mechanism tracks the complete result chain.

Non-negotiable rule

Whichever format is chosen, the country should be able to point to one current, approved package of documents that clearly shows: priorities; targets and timelines; implementation milestones; accountable actors; costed actions; financing arrangements; indicators and data sources; and review mechanisms.

PART II

Country process for developing or revising a NAP-Skin

6. The development and management cycle

A good national plan is produced through a managed policy process, not by drafting chapters in isolation. The recommended cycle has four phases and twelve steps. A first plan can usually be developed in six to nine months when leadership, data access and consultation arrangements are secured early. Revision of an existing plan may be faster.

Priority-setting distinction. Countries should distinguish programmatic priorities from research and learning priorities. Programmatic priorities identify the diseases, clusters, service gaps or population groups requiring action; research and learning priorities identify unanswered questions, implementation barriers and innovation needs that must be addressed to improve that action.

Phase	Core steps
Phase 1. Mobilize	1 Mandate and focal point; 2 Governance and terms of reference; 3 Planning roadmap and document inventory
Phase 2. Assess and prioritize	4 Situation analysis; 5 Stakeholder and community consultation; 6 Transparent priority setting
Phase 3. Design and cost	7 Theory of change and results chain; 8 Strategic framework and targets; 9 Operational, accountability and communication framework; 10 Costing and financing
Phase 4. Assure and manage	11 Monitoring, evaluation and learning; 12 Validation, endorsement, publication and launch; then annual implementation and review

6.1 Twelve development steps

Step 1. Secure the mandate and designate leadership

Obtain written authorization from the competent authority, designate a focal point or unit, confirm the plan period and clarify whether the product will be stand-alone or integrated. Record the expected approval route and budget calendar.

Step 2. Establish an inclusive planning mechanism

Create a steering committee and a smaller technical drafting group with clear terms of reference, decision rights, conflict-of-interest management, membership and reporting. Include affected people and frontline providers as contributors, not ceremonial observers.

Step 3. Prepare a planning roadmap and evidence inventory

Set deliverables, methods, consultation points, deadlines, document owners and quality gates. Inventory existing policies, plans, guidelines, budgets, datasets, partner projects and evaluations to prevent reinvention.

Step 4. Conduct the situation analysis

Describe burden, service demand, inequities, health-system readiness, programme performance, financing, data and research. Explain uncertainty and disaggregate evidence where possible. Summarize strengths, gaps, opportunities and threats.

Step 5. Consult stakeholders and communities

Use a combination of technical interviews, subnational consultations, affected-person dialogues, frontline workshops and written review. Publish or retain a consultation record showing issues raised and how they were resolved.

Step 6. Set priorities transparently

Apply agreed criteria to select the problems and interventions that require national focus. Distinguish essential system foundations from disease-specific priorities. Record excluded or deferred items and the reason.

Step 7. Build the theory of change and results chain

Describe how inputs and actions are expected to improve system outputs, service coverage, health outcomes, equity and impact. Identify assumptions, dependencies and possible unintended effects.

Step 8. Define the strategic framework, targets and milestones

Set a vision, goal, strategic results and a small number of measurable targets. Align with draft GAP-SKIN while adapting scope and ambition to country baselines, capacity and epidemiology.

Step 9. Develop the operational and accountability framework

Translate each strategy into priority actions, deliverables, responsible actors, implementation levels, timing and dependencies. Clarify what will be delivered through existing programmes and what requires new arrangements. Develop the communication, advocacy and stakeholder engagement plan at the same time so each priority has the audiences, messages, feedback loops and implementation support needed to move from policy to practice.

Step 10. Cost the plan and define the financing pathway

Cost prioritized activities using explicit assumptions; map existing domestic and external resources; quantify gaps; identify budget holders and financing actions; test affordability and recurrent-cost sustainability.

Step 11. Design monitoring, evaluation and learning

Define indicators, baselines, targets, disaggregation, data sources, frequency, reporting flow, data-quality methods, review forums and evaluation questions. Use existing information systems wherever feasible.

Step 12. Validate, endorse, publish and launch for implementation

Complete technical and policy review; confirm legal, clinical and financial consistency; document consultation responses; secure formal approval; publish accessible versions; and launch with an approved first annual operational plan, communication and engagement plan, financing actions and review calendar.

6.2 Indicative timeline

Timing	Main outputs
Month 1	Mandate, focal point, steering group, TOR, planning roadmap, evidence inventory
Months 2-3	Situation analysis, subnational evidence gathering, stakeholder and community consultation
Month 4	Priority-setting workshop, theory of change, strategic results and preliminary targets
Months 5-6	Draft plan, implementation matrix, costing, financing map, M&E framework
Month 7	Technical validation, policy and legal review, budget dialogue, revisions
Months 8-9	Endorsement, publication, dissemination, first annual operational plan and launch

The timeline should be synchronized with national health-sector planning and the annual budget cycle. A plan endorsed after the relevant budget ceiling has closed may remain unfunded for an additional year.

6.3 Governance and participation

Actor	Minimum role
Senior policy sponsor	Provides political mandate, resolves cross-programme barriers, champions financing and submits the plan for approval.
Lead Ministry of Health unit or focal point	Coordinates the process, safeguards coherence, maintains the action tracker and owns annual review.
Steering committee	Approves methods, priorities, drafts, costing assumptions, consultation responses and final recommendations.

Actor	Minimum role
Technical drafting group	Conducts analysis, drafts sections, prepares matrices and integrates evidence and comments.
Subnational representatives	Test feasibility, quantify operational needs and ensure decentralized responsibilities and budgets are realistic.
People affected and civil society	Identify access barriers, stigma, patient-safety concerns, acceptable interventions and accountability expectations.
Finance and planning authorities	Align costs with budget classifications, ceilings, medium-term expenditure frameworks and domestic resource-mobilization opportunities.
Partners and funders	Disclose current and planned support, align investment with national priorities and avoid parallel systems.
Independent reviewers	Assess technical validity, coherence, feasibility, safeguards and completeness before endorsement.

National coordination role. The national skin health coordination mechanism should serve as the integration point for the companion documents. It should ensure that disease prioritization, service-package decisions, workforce planning, indicator selection, research priorities, partner engagement and financing are reviewed together through the NAP-Skin annual management cycle.

6.4 Evidence standards for the situation analysis

- **Triangulate rather than wait for perfect data.** Combine routine information, surveys, facility assessments, registries, procurement data, workforce records, research, claims where available, partner reports and qualitative evidence.
- **Separate absence of disease from absence of reporting.** A zero, blank and non-applicable value have different meanings and should not be collapsed.
- **Show the denominator.** Counts alone can conceal population growth, uneven facility coverage or differences in reporting completeness.
- **Disaggregate purposefully.** Prioritize variables that reveal actionable inequity, such as age, sex, disability, geography, socioeconomic position or population group, subject to ethics and law.
- **Make uncertainty visible.** Document source, year, coverage, completeness, limitations and confidence; use sensitivity scenarios where decisions depend on uncertain assumptions.
- **Convert gaps into actions.** Each major data limitation should produce a practical surveillance, research or data-quality action in the plan.

Evidence-gap mapping. Evidence gaps should be categorized where useful as burden and data gaps; clinical or diagnostic gaps; service-delivery and referral gaps; equity, stigma and participation gaps; economic or financing gaps; workforce and supervision gaps; laboratory gaps; digital-health gaps; or policy-implementation gaps. Material gaps should feed into a SHRIEF-aligned national research and learning agenda.

6.5 Priority-setting method

Prioritization should prevent the plan from becoming a catalogue. Countries may score proposed problems or interventions from 1 to 5 against the criteria below, apply nationally agreed weights, and then review the ranking through an equity and feasibility lens. The score informs judgment; it does not replace it.

Use of prioritization outputs. The GAP-SKIN Two-Phase Prioritization Framework should guide transparent programmatic prioritization. For each selected priority, countries should document associated evidence gaps and implementation questions and transfer these into the SHRIEF-aligned national research and innovation agenda.

Criterion	Questions to consider
Burden and severity	Magnitude, disability, mortality, complications, transmissibility or service demand
Equity and rights	Disproportionate impact, stigma, exclusion, catastrophic cost or neglected population
Effectiveness and safety	Evidence that the proposed intervention improves outcomes with acceptable risks
Feasibility and system fit	Workforce, commodities, laboratory, referral, information and governance readiness
Affordability and value	Cost, opportunity cost, efficiency gains, shared platforms and fiscal feasibility

Criterion	Questions to consider
Acceptability and participation	Community, patient and provider acceptability; cultural and ethical fit
Measurability and learning	Ability to establish a baseline, monitor implementation and generate learning
Sustainability and resilience	Recurrent financing, institutionalization, climate and emergency resilience

PART III

Recommended structure and content of the country NAP-Skin

7. Recommended document architecture

Section	Minimum content
Front matter	Title and approval page; foreword; acknowledgements; abbreviations; contents; list of tables and figures if needed; consultation and endorsement record.
Executive summary	Why action is needed, national priorities, headline targets, strategic results, cost, financing gap, governance and immediate next steps.
Part 1. Situation analysis	Country and health-system context; burden and inequalities; service and programme performance; policy and financing; gap analysis; priority problems.
Part 2. Strategic agenda	Vision, goal, principles, theory of change, national results, targets, milestones and strategic objectives.
Part 3. Operational framework	Priority interventions and actions; responsibilities; implementation levels; partnerships; risks; annual operationalization and accountability.
Part 4. Budgeting and financing for impact	Costing methods, multi-year costs, current resources, gaps, financing sources, domestic resource mobilization and sustainability.
Part 5. Communication, advocacy and stakeholder engagement	Communication objectives; audience segmentation; message architecture; advocacy; community engagement; internal communication; accessible channels and products; misinformation and issue management; budget, responsibilities, monitoring and feedback.
Part 6. Monitoring, evaluation and learning	Results framework, indicator metadata, data flows, review cycle, evaluation and learning agenda.
Annexes	Implementation matrix, detailed budgets, communication and engagement template, indicator reference sheets, governance TOR, consultation summary, risk register and other supporting tools.

Recommended length

The main policy document should remain readable, usually about 25-40 pages excluding annexes. Detailed implementation, costing and indicator tables belong in annexes or linked operational workbooks. A concise plan that is actively managed is stronger than a large plan nobody can navigate.

8. Front matter and executive summary

8.1 Approval and status information

- Official title, plan period and responsible authority.
- Approval date, approving body and legal or administrative instrument.
- Version-control information and date of next scheduled review.
- Relationship to the national health strategy, UHC roadmap, disease programmes and subnational plans.
- Statement on consultation, conflicts of interest and use of evidence.

8.2 Executive summary

The executive summary should be capable of standing alone for senior decision-makers. It should identify the national problem, the strategic choices made, the headline targets, the first three implementation priorities, the

total estimated cost, the financing gap, the governance arrangement and the first-year deliverables. Avoid repeating the background chapter.

9. Part 1: Situation analysis

The situation analysis should be analytical rather than encyclopedic. It should explain what is happening, to whom, where, why, how the current system responds, where performance breaks down and which problems require national action.

Suggested subsection	Questions and evidence
9.1 Country and policy context	Demography, decentralization, economic and fiscal context, health financing, emergencies and climate risks, national development and health-policy commitments.
9.2 Burden and epidemiology	Priority conditions, incidence/prevalence where available, service demand, complications, disability, mortality, outbreaks, geographic variation, trends and uncertainty.
9.3 Equity, stigma and lived experience	Access barriers, discrimination, mental health, gender and age patterns, disability, poverty, remote or displaced populations, patient costs and community priorities.
9.4 Service delivery and referral	Community and PHC functions, facility readiness, service package, clinical pathways, referral/counter-referral, emergency escalation, rehabilitation, palliative and specialist support.
9.5 Workforce and education	Cadres, distribution, scopes of practice, pre-service and in-service training, competency assessment, supervision, mentorship, specialist capacity and retention.
9.6 Medicines, commodities and supply chain	Essential medicines, diagnostics, dressings, protective equipment, forecasting, procurement, storage, availability, affordability and antimicrobial stewardship.
9.7 Laboratory and pathology systems	Specimen pathways, microbiology, histopathology, quality assurance, turnaround time, referral laboratories, biosafety and access gaps.
9.8 Surveillance, information and digital systems	Indicators, case definitions, reporting completeness, registries, data flows, interoperability, dashboards, data use, image governance, teledermatology and AI safeguards.
9.9 Governance, partnerships and financing	Institutional mandate, coordination, policies, budget lines, external support, civil-society role, private sector, research networks and accountability.
9.10 Programme performance and gap synthesis	Progress against existing commitments; root causes of underperformance; strengths, weaknesses, opportunities and threats; priority bottlenecks to be addressed by the plan.

9.11 Recommended situation-analysis outputs

- A one-page national skin health profile with major burden, inequity and system indicators.
- A map or table of prioritized conditions and affected populations by subnational area.
- A service-delivery and referral pathway map.
- A policy, programme and partner landscape crosswalk.
- A quantified readiness and gap table for workforce, medicines, laboratory and data systems.
- A concise list of priority problems framed as causes to solve, not merely topics.

10. Part 2: Strategic agenda

10.1 Vision and goal

The vision should describe the desired long-term state. The goal should state the overall change expected during the plan period. Both should be short enough to guide choices. Avoid listing interventions in the goal.

Illustrative formulation
Vision: Everyone can attain the highest possible standard of skin health without stigma, discrimination or financial hardship. Goal: By [year], reduce preventable morbidity, disability and inequity from priority skin diseases through integrated, people-centred services and stronger national health-system capacity.

10.2 Theory of change and results chain

The theory of change should connect system foundations to service delivery and outcomes. It should name the assumptions that must hold, such as political commitment, commodity availability, workforce retention, referral capacity and community trust. A simple logic is: governance and financing plus competent workforce, commodities, laboratory and information systems lead to accessible quality services, earlier detection and continuity of care, which improve health, equity and patient experience.

10.3 Targets and milestones

- **Use baselines.** A target without a credible starting point cannot guide resource allocation or performance review.
- **Distinguish targets from milestones.** Targets describe the result to be achieved; milestones are dated intermediate achievements on the pathway.
- **Combine system and health results.** Include enabling indicators as well as coverage, quality, equity and outcome measures.
- **Avoid false precision.** Use ranges or staged targets when data or implementation capacity is uncertain, and specify when targets will be recalibrated.
- **Align vertically.** Ensure national, subnational and facility targets connect logically and do not double count.

11. Strategic content under the seven draft GAP-SKIN objectives

Countries may retain the seven-objective structure or combine objectives where this improves national coherence. Any consolidation should preserve the full intent and clearly show where each function is addressed.

11.1 Coordination, partnerships and sustainable financing

Element	Country guidance
Strategic intent	Establish durable leadership, coordinated action and financing for skin health.
Situation-analysis questions	Is there a formally designated lead? Which programmes and sectors must coordinate? What is financed domestically? Where do partners create duplication or gaps?
Minimum plan content	Governance structure and TOR; focal point or unit; partner compact; affected-person participation; budget ownership; domestic financing pathway; annual accountability forum.
Illustrative actions	Designate a national lead; establish coordination and technical groups; map financing; align partners; advocate for budget lines; integrate skin health into benefit packages and planning cycles.
Illustrative outputs or milestones	Approved governance mechanism; annual workplan and meeting record; financing map; costed pathway; partner alignment matrix.
Critical safeguard	Avoid creating a committee without authority, budget access or action tracking.

11.2 National public health planning and policy integration

Element	Country guidance
Strategic intent	Embed skin health priorities in national policies, plans, UHC and accountability mechanisms.
Situation-analysis questions	Which national policies already cover skin health? What is missing or inconsistent? Which plan format will carry the strongest authority and budget linkage?
Minimum plan content	NAP-Skin or equivalent mechanism; crosswalk to health-sector and programme plans; regulatory actions; national targets and milestones; subnational adaptation requirements.
Illustrative actions	Develop or revise the plan; integrate skin health into PHC and UHC policy; harmonize clinical terminology and standards; establish annual and mid-term review.
Illustrative outputs or milestones	Current endorsed plan; policy crosswalk; documented milestones; accountable institutions; first annual operational plan.
Critical safeguard	Do not treat mention of skin diseases in a policy as equivalent to an operational plan.

11.3 Integrated people-centred services, quality and referral

Element	Country guidance
Strategic intent	Deliver a defined minimum skin health service package through PHC with safe referral and continuity.
Situation-analysis questions	What can be safely managed at each level? Which danger signs require urgent escalation? Are medicines, diagnostics, rehabilitation and counter-referral available?
Minimum plan content	Essential service package; PHC algorithms; quality standards; referral/counter-referral; emergency pathways; commodities; infection prevention; private-sector and community interfaces.
Illustrative actions	Define service package; adapt clinical pathways; improve commodity availability; strengthen referral and teleconsultation; introduce quality improvement and patient-safety review.
Illustrative outputs or milestones	Approved service package; national tracer commodity list; referral map; quality indicators; facilities implementing the package.
Critical safeguard	Integration must not blur emergency, cancer, severe drug-reaction or specialist referral thresholds.

11.4 Workforce capacity, competency and health-system enablers

Element	Country guidance
Strategic intent	Ensure relevant cadres can perform assigned skin-health functions safely and maintain competence.
Situation-analysis questions	Which cadres perform which functions? What competency gaps exist? Who assesses, certifies, supervises and mentors? How will specialist capacity be developed?
Minimum plan content	Role-based competencies and scopes; pre-service and in-service pathways; assessment and certification; supervision; specialist support; equitable deployment; digital and image governance.
Illustrative actions	Adopt competency framework; update curricula; train and assess priority cadres; establish supervision and mentorship; develop specialist and laboratory capacity; monitor competence retention.
Illustrative outputs or milestones	Approved competency standards; trained and assessed workforce; supervision coverage; specialist-access pathway; workforce indicators.
Critical safeguard	Attendance alone is not evidence of competence; training without commodities, supervision or referral support rarely changes care.

11.5 Equity, mental health, compassion, stigma reduction and person-centred care

Element	Country guidance
Strategic intent	Remove barriers and ensure respectful, rights-based care and psychosocial support.
Situation-analysis questions	Who experiences delayed or denied care? What forms of stigma and discrimination occur? Are mental health, disability, rehabilitation and social-support needs addressed?
Minimum plan content	Equity analysis; participation mechanisms; anti-stigma actions; counselling and mental-health pathways; accessibility; financial protection; safeguarding and complaints mechanisms.
Illustrative actions	Co-design interventions; train providers; integrate psychosocial screening/referral; improve accessibility; monitor patient experience; engage schools, workplaces and communities.
Illustrative outputs or milestones	Equity actions and budget; affected-person participation; patient-experience measures; stigma-reduction interventions; accessible services.
Critical safeguard	Avoid generic awareness campaigns that are not linked to measured barriers, service access or accountability.

11.6 Surveillance and data systems for action

Element	Country guidance
Strategic intent	Generate and use reliable skin-health information for planning, quality improvement and accountability.
Situation-analysis questions	Which indicators are essential? Are definitions harmonized? What is the reporting burden? Are data reviewed and acted on? Are privacy and image governance adequate?
Minimum plan content	Minimum indicator set; case definitions; data flow; HMIS integration; registries where justified; data-quality assurance; dashboards; review forums; interoperability and governance.
Illustrative actions	Agree indicators and metadata; integrate into national systems; improve completeness; train users; establish review dashboards; document decisions arising from data.
Illustrative outputs or milestones	Approved minimum dataset; routine reporting; data-quality reviews; action-oriented dashboards; annual analytical report.
Critical safeguard	Do not create parallel databases without a sustainability, interoperability and data-governance plan.

11.7 Laboratory networks and dermato-epidemiology research

Element	Country guidance
Strategic intent	Ensure diagnostic support and nationally relevant research accelerate safe, effective action.
Situation-analysis questions	Which diagnoses require laboratory or pathology confirmation? Where are specimens sent? What are turnaround times and quality gaps? Which knowledge gaps block policy or implementation?
Minimum plan content	Diagnostic algorithms; specimen referral; laboratory tiers; histopathology; quality assurance; biosafety; research governance; implementation-learning agenda; ethical data and specimen use.
Illustrative actions	Map and strengthen pathways; define test menus; establish EQA; improve turnaround; prioritize operational research; create national or regional networks; translate evidence into policy.
Illustrative outputs or milestones	Documented laboratory referral pathway; quality-assurance coverage; research agenda; completed priority studies; evidence-to-policy mechanism.
Critical safeguard	Do not expand testing without quality assurance, specimen logistics, clinical interpretation and financing for recurrent costs.

12. Part 3: Operational and accountability framework

The operational framework is the bridge between strategy and delivery. Every priority action should be sufficiently specified to permit budgeting, assignment, monitoring and correction.

Implementation-matrix field	Specification
Strategic result or objective	The result to which the action contributes.
Priority intervention and activity	The intervention and concrete work to be completed.
Deliverable or milestone	The verifiable product, coverage threshold or implementation state expected.
Lead and supporting actors	One accountable lead plus named contributors.
Implementation level and geography	National, subnational, facility or community; targeted areas or populations.
Timing and sequencing	Start, completion, annual phase and dependencies.
Cost and financing source	Estimated cost, budget classification, current allocation, gap and proposed source.
Indicator and verification	Measure, data source, reporting frequency and evidence required.
Risks and safeguards	Key assumptions, potential harm, mitigation and contingency.
Status and corrective action	Traffic-light or narrative progress, decision, owner and deadline.

12.1 Roles and accountability

Use a simple RACI or equivalent model for high-level results: responsible, accountable, consulted and informed. Avoid assigning several accountable institutions to the same deliverable. Shared responsibility often becomes orphaned responsibility. Annex Q provides a blank stakeholder-by-activity matrix, a compact role-allocation worksheet and an illustrative NAP-Skin example.

12.2 Subnational adaptation

The national plan should specify which elements are standardized nationally and which must be adapted locally. Subnational plans should use the same result architecture and indicators while adjusting epidemiological priorities, service delivery, staffing, referral routes, implementation timing and costs.

12.3 Annual operational plans

A multi-year NAP-Skin should be activated through approved annual operational plans. The first annual plan should accompany endorsement so implementation does not wait for a second planning exercise. Annual plans should reflect current budget ceilings, procurement lead times, workforce calendars and partner commitments.

13. Part 4: Costing and financing for impact

Costing should begin after priorities and core activities are sufficiently clear, but before the plan is finalized. Costing is a design test: it exposes activities that are vague, duplicated, unaffordable or disconnected from implementation capacity.

13.1 Minimum costing method

1. Define the costing perspective, price year, currency, inflation and exchange-rate assumptions.
2. Break each priority activity into costable inputs or use standard unit costs where valid.
3. Separate capital, start-up and recurrent costs, and identify which costs continue after the plan period.
4. Assign costs by year, level of the health system, responsible budget holder and strategic objective.
5. Map existing domestic allocations, external commitments and in-kind resources.
6. Calculate the financing gap and identify specific actions, sources and decision points to close it.
7. Conduct affordability and sensitivity analysis for high-cost or uncertain assumptions.
8. Reconcile the final costed plan with the operational matrix and M&E framework.

13.2 Financing strategy

- Integrate skin-health activities into established PHC, UHC, workforce, laboratory, medicines and information-system budgets where feasible.
- Protect recurrent costs such as staff time, supervision, commodities, maintenance, data hosting and quality assurance.
- Use partner financing to catalyse national priorities, not to create parallel priorities or systems.
- Specify domestic resource-mobilization actions, responsible decision-makers and budget-cycle deadlines.
- Develop an investment case where additional financing requires demonstration of health, equity, productivity or system-efficiency benefits.
- Update costs and financing status annually as prices, implementation choices and funding commitments change.

Costing integrity check

The total in the budget table, the activities in the implementation matrix and the deliverables in the results framework should reconcile. Three different versions of the plan create three different realities, and only one can be managed.

14. Part 5: Communication, advocacy and stakeholder engagement

Communication is not a launch event or a collection of publicity materials. It is an implementation function that helps decision-makers act, health workers deliver the plan consistently, communities obtain and shape services, affected people exercise their rights, partners align resources and the programme learn from feedback. The national communication plan should be derived from the NAP-Skin results framework and

implementation matrix, and should use the WHO principles of accessible, actionable, credible, relevant, timely and understandable communication [16]. Community engagement should be two-way, locally adapted and linked to visible action on concerns, rather than treated as one-directional dissemination [17].

14.1 Purpose and expected contribution

The communication, advocacy and stakeholder engagement plan should specify how communication will contribute to measurable NAP-Skin results. Depending on national priorities, it should support the following functions:

- Political commitment and policy action, including approval of policies, standards, budget allocations and accountability arrangements.
- Implementation readiness and change management among national, subnational, facility and community-level actors.
- Accurate public understanding of skin diseases, available services, referral pathways, prevention and self-care, without encouraging unsafe self-diagnosis or treatment.
- Earlier care seeking, treatment adherence, continuity of care and appropriate use of referral services.
- Reduction of stigma, discrimination, misinformation and harmful practices, including respectful representation of people with visible skin conditions.
- Meaningful participation of affected people and communities in design, implementation, monitoring and review.
- Partner coordination, resource mobilization and transparent communication of progress, gaps, decisions and results.

14.2 Planning principles

- Result-linked. Every communication objective should be connected to a strategic result, implementation bottleneck, behaviour, policy decision or accountability need.
- Audience-centred and two-way. Define what each audience currently knows, believes, experiences and can realistically do; create mechanisms to listen and respond.
- Actionable. Messages should make the requested action, location, timing, eligibility, referral or decision clear.
- Credible and coordinated. Use evidence, acknowledge uncertainty, align messages across institutions and identify trusted messengers.
- Equitable and accessible. Use appropriate languages, literacy levels, disability-accessible formats, offline channels and differentiated approaches for underserved groups.
- Rights-based and safe. Protect privacy, dignity and informed consent; avoid sensational images, blame, fear, diagnostic claims without clinical assessment and messages that may reinforce stigma.
- Locally adapted. Pre-test messages and products with intended audiences and adapt to local terminology, explanatory models, media habits and service availability.
- Resourced and measurable. Include responsibilities, production and dissemination schedules, costs, indicators, feedback loops and review points.

14.3 Communication diagnosis and minimum plan components

Begin with a concise communication diagnosis. It should identify the policy and implementation decisions that are stalled, the information and trust environment, audience needs, access barriers, stigma and misinformation, trusted channels and messengers, existing communication assets, institutional approval pathways and lessons from previous campaigns. The diagnosis should be proportionate and may combine document review, service data, media and social listening, key-informant interviews, community dialogue and rapid message testing.

Planning component	Minimum specification
Communication problem or opportunity	Define the decision, behaviour, practice, perception, coordination gap or accountability issue that communication can reasonably influence. Do not use communication to disguise a service, commodity, workforce or policy failure.
Communication objective	State the intended change for a defined audience, timeframe and NAP-Skin result. Use measurable verbs such as approve, allocate, adopt, refer, attend, complete, report, participate or seek care.
Audience segmentation	Identify primary audiences expected to act, secondary audiences that influence them and internal audiences responsible for delivery. Segment by role, location, language, access, trust, risk, gender, age, disability and other relevant factors.
Audience insight and desired change	Document current knowledge, beliefs, incentives, barriers, information sources and service experience, then define the feasible change expected.

Planning component	Minimum specification
Message architecture	Develop one core proposition and audience-specific supporting messages, calls to action, evidence points, responses to common questions and statements of uncertainty.
Messengers and influencers	Select spokespersons, health workers, professional bodies, affected-person representatives, community leaders, educators, media voices or digital influencers based on trust, reach, competence and safeguarding requirements.
Channels and products	Choose interpersonal, organizational, community, broadcast, print and digital channels based on audience access and the action required. Specify products, language, format, accessibility and distribution arrangements.
Advocacy and resource mobilization	Link policy briefs, investment cases, high-level meetings and budget messages to named decisions, decision-makers and national planning and budget-cycle deadlines.
Community engagement and feedback	Specify co-design, dialogue, participatory monitoring, complaint and referral mechanisms, feedback response standards and how affected people will influence programme decisions.
Internal communication and change management	Provide policy circulars, implementation briefs, job aids, orientation, supervisory messages, question-and-answer channels and regular updates across implementation levels.
Risk, misinformation and issue management	Define priority risks, rumour and media monitoring, response thresholds, verified information sources, spokespersons, escalation routes, correction methods and crisis or adverse-event communication procedures.
Governance and clearance	Name the accountable lead, technical reviewers, approving authority, spokespersons, partner coordination mechanism, version control and maximum clearance timelines.
Schedule, budget and procurement	Cost design, pre-testing, translation, accessibility, production, media placement, travel, community facilitation, monitoring and evaluation. Align timing with implementation milestones and procurement lead times.
Monitoring, evaluation and learning	Specify output, reach, engagement, quality, outcome, equity and feedback indicators; data sources; frequency; responsible unit; review forum; and rules for adapting activities.

Communication should only promise services, commodities, referral pathways or entitlements that are available or have a confirmed implementation date. A publicity surge without service readiness can consume trust faster than a dry sponge consumes water.

14.4 Audience segmentation and objective setting

Avoid treating the “general public” as a single audience. Countries should distinguish at least four audience families and define the action expected from each:

- Policy and financing audiences: ministers, parliamentarians, finance and planning authorities, insurance or purchasing bodies, regulators and local-government leaders. Typical actions include endorsement, allocation, inclusion in benefits packages, adoption of standards and removal of policy barriers.
- Implementation audiences: programme managers, district teams, facility managers, clinicians, nurses, community health workers, pharmacists, laboratory staff, data officers, educators and social-service personnel. Typical actions include adoption of protocols, referral, reporting, supervision, respectful care and use of feedback.
- Communities and people affected: people living with skin diseases, caregivers, schools, workplaces, community organizations, traditional or religious leaders and populations facing access barriers. Typical actions include participation, timely care seeking, prevention practices, treatment completion, use of complaints mechanisms and anti-stigma action.
- Influence and accountability audiences: media, civil society, professional associations, academia, private sector and development partners. Typical actions include accurate coverage, professional stewardship, independent accountability, research support and alignment of resources.

Each objective should answer five questions: who must do what, by when, to contribute to which NAP-Skin result, and how will the change be verified? Reach alone is not an objective. “Disseminate 10 000 leaflets” is an output; “increase the proportion of priority facilities using the national referral pathway from the baseline to the target by Year 2” is a result-linked objective.

14.5 Message architecture, dignity and stigma reduction

- Use a message architecture consisting of a core proposition, audience-specific call to action, supporting evidence, practical instructions, referral information and answers to predictable questions.

- Use plain and locally meaningful terms while retaining clinical accuracy. Explain uncertainty and limitations where evidence or service availability varies.
- Frame skin health as part of health, dignity and quality care. Avoid language that labels people by disease, implies fault, promises cure where this is uncertain or treats visible difference as a spectacle.
- Obtain informed consent for identifiable stories or images, explain intended use and duration, allow withdrawal where feasible and provide non-identifiable alternatives.
- Pre-test messages with affected people, frontline workers and intended audiences for comprehension, cultural acceptability, actionability, emotional impact and unintended stigma.
- Maintain a controlled message bank and question-and-answer document so national and subnational actors communicate consistently while retaining space for local adaptation.

14.6 Channels, products and accessible formats

Channel choice should follow the audience and action, not fashion. A policy decision may require a two-page brief and a budget meeting; a referral change may require a directive, job aid and supervisory discussion; community participation may require facilitated dialogue and feedback rather than a poster. The plan may combine:

- Interpersonal and service channels: consultations, counselling, community health workers, hotlines, patient groups, schools, workplaces and outreach services.
- Organizational channels: ministerial circulars, district briefings, professional networks, supervision, learning sessions, partner forums and electronic workspaces.
- Community and public channels: dialogue sessions, radio, television, print, community theatre, local leaders, civil-society networks and public events.
- Digital channels: official websites, dashboards, email, messaging platforms, social media, webinars and digital learning tools, with moderation and privacy safeguards.
- Advocacy products: policy briefs, investment cases, budget notes, parliamentary or executive briefs, scorecards, human-interest stories and progress reports.
- Implementation products: service directories, referral maps, job aids, frequently asked questions, talking points, clinical alerts and patient information materials.

All essential products should use appropriate national and local languages, clear typography and accessible formats. Countries should plan alternatives for people with low literacy, visual or hearing impairment, limited connectivity, displacement or geographic isolation. Digital dissemination should supplement, not silently replace, trusted offline channels.

14.7 Advocacy and resource-mobilization communication

Advocacy should be organized around specific policy and financing decisions rather than generic awareness. For each decision, identify the decision-maker, influencing actors, evidence required, political and budget calendar, messenger, opposition or competing priorities and the follow-up action. The communication package may include a concise national burden and equity narrative, implementation readiness, expected health-system gains, cost and financing gap, consequences of inaction and a clear request. Any economic or return-on-investment claim should state its method, assumptions and uncertainty.

14.8 Community engagement, participation and feedback

- Engage affected people before priorities and messages are finalized, not only during launch or validation.
- Use representative and safe participation methods, including accommodations, language support, compensation or reimbursement according to national rules and protection from disclosure or retaliation.
- Create feedback routes that communities can realistically use, such as facility mechanisms, toll-free lines, community focal points, digital channels, civil-society forums and periodic dialogue.
- Define response standards: who receives feedback, how it is categorized, maximum response time, escalation for safety or rights concerns and how actions are communicated back.
- Integrate community feedback into supervision, annual reviews, service redesign and communication updates. Publishing what changed because of feedback closes the loop and strengthens trust.

14.9 Internal communication and change management

Implementation depends on the people asked to change workflows. The plan should therefore specify how policies, service packages, referral routes, indicator definitions, commodity changes and accountability expectations will reach each implementation level. Internal communication should include orientation, concise job aids, named question-and-answer channels, supervisory reinforcement, version control and rapid notice of changes. Communication should be sequenced with training, commodity availability, digital configuration and service readiness so staff are not instructed to deliver what the system cannot yet support.

14.10 Misinformation, risk and issue management

- Maintain a proportionate system for media, hotline, community and digital listening to identify recurrent questions, rumours, harmful advice, stigma and service complaints.
- Assess each issue by reach, speed, credibility, potential harm and affected population; not every inaccurate statement requires a public response.
- Use verified technical sources and approved response lines. Correct quickly, respectfully and in the channel where the issue is circulating, while avoiding unnecessary amplification.
- Pre-identify spokespersons and escalation routes for adverse events, service interruption, data breaches, disputed evidence, discriminatory incidents or high-profile misinformation.
- Protect patient confidentiality and clinical safety in all communications. Suspected cases, images and individual stories should never substitute for formal diagnosis, consent and referral.

14.11 Governance, coordination and approval

The Ministry of Health should designate one accountable communication lead or unit working with the NAP-Skin technical lead. The plan should name technical reviewers, community or affected-person representatives, legal and ethical review where required, approving authority, official spokespersons and partner coordination arrangements. Approval procedures should protect accuracy without creating delays that make information obsolete. Establish version control, a shared product register, maximum clearance times and a process for urgent corrections. Partners should use the nationally approved message architecture and disclose branding or visibility requirements that could distort priorities.

14.12 Implementation schedule, budget and financing

Communication activities should appear in the multi-year implementation matrix and annual operational plan, not in a detached appendix with no owner or budget. Costing should include formative research, co-design, pre-testing, translation, accessible formats, design, production, media or platform costs, community facilitation, spokesperson preparation, travel, monitoring, evaluation and maintenance of feedback channels. Separate start-up from recurrent costs, identify the budget holder and financing source, and protect essential recurrent functions such as community feedback, content updates and internal implementation communication.

14.13 Monitoring, evaluation and learning

Monitoring should move beyond counting products and impressions. Use a small set of indicators across the communication results chain and disaggregate where relevant:

- Readiness and outputs: approved plan, trained spokespersons, products pre-tested and available in required languages and formats, feedback mechanisms functioning.
- Reach and access: proportion of the intended audience reached through trusted channels, including underserved populations; distribution or airtime may be used only as supporting measures.
- Engagement and quality: comprehension, perceived relevance, credibility, actionability, respectful representation, response time to questions and proportion of feedback closed.
- Intermediate outcomes: policy or budget decisions, adoption of protocols, referral completion, service uptake, participation, knowledge, attitudes, trust, stigma or reported discriminatory experience.
- Equity and unintended effects: differences in reach and outcome by population group, harmful misunderstanding, privacy incidents, service overload, exclusion or increased stigma.
- Learning and adaptation: changes made to messages, channels, service arrangements or policy because of monitoring and feedback.

The review forum should combine communication data with service readiness and programme performance. A rise in demand is not automatically success if services are unavailable, waiting times become unsafe or poorer populations remain unreached. Annex P provides an integrated country template.

14.14 Minimum outputs before endorsement and launch

- An approved communication, advocacy and stakeholder engagement plan linked to NAP-Skin results and implementation milestones.
- An audience-objective-message matrix with calls to action, trusted messengers, channels, languages, accessibility requirements and pre-testing arrangements.
- A costed annual activity and product calendar with responsible units, approval deadlines, procurement needs and financing sources.
- A community engagement and feedback mechanism with response standards and escalation routes.
- A controlled message bank, frequently asked questions, spokesperson list and procedures for misinformation, adverse events and urgent corrections.

- Communication indicators, baseline actions, review dates and an adaptation log.

15. Part 6: Monitoring, evaluation and learning

The M&E framework should support decisions, not only reporting. It should combine a small national headline set with the detailed implementation measures required by programme managers. Countries should build on routine information systems and existing review forums wherever feasible [9,10].

Indicator classification. The national MEL framework should distinguish core GAP-SKIN indicators, companion-document implementation indicators, country-specific management indicators, and research or learning indicators linked to SHRIEF. This classification clarifies which data support global reporting, national programme management or implementation learning and helps avoid duplicative reporting.

15.1 Results hierarchy

Level	NAP-Skin application
Inputs	Resources, governance and capacities available, such as budget, personnel, standards or systems.
Activities	Work carried out, such as guideline adaptation, training, procurement or system configuration.
Outputs	Immediate products or implementation states, such as facilities equipped, workers assessed or indicators integrated.
Outcomes	Changes in service coverage, quality, access, timeliness, equity, behaviour or patient experience.
Impact	Changes in morbidity, disability, mortality, stigma, wellbeing or financial hardship.

15.2 Indicator selection rules

- Select indicators because they inform a decision or accountability question, not because data are easy to count.
- Use the draft GAP-SKIN core indicators as the national system spine, then add priority disease tracers and country-specific implementation indicators.
- Limit the headline dashboard to a manageable set and retain detailed indicators in annexes or programme systems.
- Specify precise definitions, numerator, denominator, disaggregation, source, frequency, responsibility and verification.
- Document reporting completeness and data quality separately from the measured result.
- Set baseline and target years, and identify when a baseline study or system configuration is required.

15.3 Review and learning cycle

Frequency	Minimum use
Monthly or quarterly	Operational review of activities, bottlenecks, procurement, workforce and corrective actions.
Semiannual	Cross-programme and partner review of milestones, financing, service performance, risks and equity.
Annual	National performance review, indicator update, expenditure review, next annual operational plan and target adjustment where justified.
Mid-term	Independent or jointly managed review of relevance, coherence, implementation, financing, effectiveness, equity and sustainability.
End-term	Evaluation of results and lessons, followed by decision on renewal, integration or revision of the plan.

15.4 Suggested evaluation questions

- Relevance: Are priorities still aligned with burden, inequity, policy and community needs?
- Coherence: Are programmes, policies, financing and partners pulling in the same direction?
- Implementation: Which actions were delivered, where, for whom and with what fidelity?
- Effectiveness: Did services, quality, timeliness, equity or health outcomes improve?
- Efficiency: Were resources converted into results with acceptable cost and administrative burden?
- Sustainability: Are governance, budgets, workforce, commodities and systems likely to continue?
- Unintended effects: Did integration create safety, workload, privacy, inequity or opportunity-cost problems?

- Learning: What should be scaled, stopped, redesigned or studied next?

PART IV

Implementation, quality assurance and review

16. From endorsement to implementation

Endorsement is a transition point, not the finish line. Launch should occur only when the minimum start-up package is ready: a responsible coordination mechanism; approved first-year operational plan; budget and financing actions; implementation guidance; an approved, costed communication, advocacy and stakeholder engagement plan; accessible priority products and feedback mechanisms; reporting tools; and a dated review calendar.

Start-up component	Minimum readiness
Governance	Lead unit active; steering and technical groups confirmed; action tracker and escalation route operational.
Operational plan	First-year activities, deliverables, responsibilities, timing and dependencies approved.
Financing	Budget submission or allocation pathway confirmed; partner commitments documented; high-risk gaps assigned.
Technical package	Service package, clinical/referral guidance, workforce tools, commodity specifications and data standards available or scheduled.
Implementation support	Subnational orientation, supervision, mentorship and change-management support planned.
Communication and engagement	Audience-objective-message matrix, annual calendar, feedback mechanism, spokesperson and clearance arrangements, accessible priority materials, budget and monitoring indicators approved.
Monitoring	Baseline actions, indicators, reporting templates, dashboards and review meetings scheduled.
Participation and accountability	Affected-person and civil-society participation in implementation and review confirmed; feedback and complaints mechanisms identified.

17. Quality assurance before endorsement

Quality assurance should examine both the document and the process that produced it. The JANS tradition identifies five broad attributes of a strong national strategy: sound situation analysis and programming; an inclusive development process; a credible costs and budget framework; feasible implementation and management; and a usable monitoring, evaluation and review framework. Annex L adapts these attributes for NAP-Skin.

Quality domain	Verification focus
Strategic validity	Priorities follow from the situation analysis; targets are realistic and measurable; interventions are evidence-informed and context appropriate.
Policy coherence	The plan is aligned with national health, UHC, disease, workforce, medicine, laboratory, digital and financing policies; contradictions are resolved.
Participation and equity	Consultation is documented; affected people and underserved groups influenced priorities and safeguards; equity actions are budgeted and measured.

Quality domain	Verification focus
Operational feasibility	Activities, roles, sequence, implementation levels, dependencies, commodities and workforce capacity are credible.
Financial credibility	Costs are transparent and reconciled; existing resources and gaps are identified; recurrent costs and domestic financing are addressed.
Communication and engagement	Objectives are linked to implementation results; audiences, messages, channels, feedback mechanisms, accessibility, governance, risks, costs and indicators are specified; affected people influenced communication design.
Monitoring usability	Indicators have baselines, definitions and owners; data systems and review forums are feasible; corrective-action mechanisms are explicit.
Safety and ethics	Clinical safety, referral, antimicrobial stewardship, consent, privacy, image use, digital tools, research ethics and complaints are addressed.
Document usability	The plan is concise, navigable, version controlled, accessible and accompanied by implementable annexes and tools.

18. Common planning failures and corrective design

Failure mode	What it looks like	Corrective design
An exhaustive disease catalogue	The plan contains descriptions of many conditions but no strategic choices.	Use transparent priority criteria; retain technical detail in annexes or clinical guidance.
A strategy without an operational bridge	Objectives are broad and no actor, timeline or deliverable is assigned.	Require an implementation matrix and first annual operational plan before endorsement.
Training as the default solution	Every gap becomes a workshop.	Diagnose the full system: scope, medicines, workload, supervision, referral, data and incentives.
Parallel systems	New coordination, supply or reporting platforms duplicate routine structures.	Apply a mainstream-first rule and justify exceptions with transition and sustainability plans.
Uncosted ambition	Targets are set without affordability or recurrent-cost analysis.	Cost priorities, stage implementation and define financing actions linked to the budget calendar.
Partner-owned planning	External funding determines priorities and operating models.	Disclose financing, use national governance and require partner alignment with national results.
Token participation	Affected people attend a launch or validation meeting but do not influence decisions.	Engage them during problem definition, priority setting, design, monitoring and review.
Launch-only communication	The plan funds a logo, event or mass materials but has no audience-specific objectives, implementation support, feedback loop or evidence of effect.	Use a two-way, costed communication and engagement plan linked to policy decisions, service readiness, annual activities and measurable results.
Data without decisions	Dashboards grow while performance problems persist.	Link each review to decisions, owners, deadlines and follow-up verification.
Premature digitalization	Technology is introduced before workflows, standards, privacy and support are ready.	Define the clinical and management problem first; validate tools locally; retain human oversight and offline alternatives.
Plan drift	Activities, budget and indicators evolve into conflicting versions.	Maintain one controlled implementation package and reconcile changes through annual review.

19. Updating, extending or closing the plan

The plan should specify conditions for amendment, including major epidemiological change, emergencies, new national health strategy, material budget shock, major evidence or safety issue, or failure of core assumptions. Changes should be documented through version control and approved at the appropriate level.

At end-term, the country should decide whether to renew a stand-alone plan, integrate mature functions into routine national strategies, or retain a focused transition plan for unfinished priorities. A successful NAP-Skin

may eventually make parts of itself unnecessary because skin health functions have become ordinary health-system practice.

ANNEXES

Country templates and practical planning tools

Annex A. Development checklist and indicative timeline

No.	Milestone	Indicative timing	Verification
1	Written mandate, focal point and plan format agreed	Month 1	Mandate/designation letter
2	Steering committee and drafting group established	Month 1	TOR, membership, conflict-of-interest declarations
3	Planning roadmap and evidence inventory approved	Month 1	Roadmap, document register, consultation plan
4	Situation analysis completed and validated	Months 2-3	Analytical report, data annex, gap summary
5	Stakeholder and community consultations completed	Months 2-3	Consultation log and response matrix
6	Priorities selected through transparent criteria	Month 4	Scoring matrix and decision record
7	Theory of change and results chain agreed	Month 4	Logic map, assumptions and risks
8	Targets and strategic framework drafted	Month 4	Results framework and target table
9	Operational framework completed	Months 5-6	Multi-year implementation matrix
10	Costs, resources and financing gaps documented	Months 5-6	Costing workbook and financing plan
11	Communication, advocacy and stakeholder engagement plan completed	Month 6	Approved audience-message matrix, annual calendar, budget, feedback mechanism and monitoring measures
12	M&E and learning framework completed	Month 6	Indicator matrix and review calendar
13	Technical and policy validation completed	Month 7	Quality review and response matrix
14	Plan formally endorsed and published	Months 8-9	Approval instrument and final plan
15	First annual operational plan launched	Months 8-9	Approved workplan, budget and dashboard

Annex B. Situation analysis template

Domain	Core question	Potential evidence
Country context	What political, administrative, demographic, fiscal, climate or emergency conditions shape skin health action?	National statistics; health accounts; policy documents; emergency and climate assessments

Domain	Core question	Potential evidence
Burden and distribution	Which conditions cause the greatest morbidity, disability, mortality, transmission, service demand or inequity, and where?	HMIS; surveys; registries; research; claims; hospital and outpatient data; programme reports
People and equity	Who is underserved or harmed by stigma, cost, geography, disability, gender, age or social exclusion?	Disaggregated data; qualitative research; community consultations; patient-experience data
Service package and quality	What services are available at each level? Are clinical pathways, medicines, rehabilitation and referral functional?	Facility assessment; clinical audit; service standards; referral records; patient journeys
Workforce	Which cadres are available and competent? Where are gaps in scope, distribution, supervision and specialist access?	HRH information system; curricula; training and assessment records; staffing norms
Medicines and commodities	What is listed, procured, available and affordable? Where do stock-outs or prescribing risks occur?	Essential medicines list; LMIS; procurement; price and availability studies
Laboratory and pathology	What tests and specimen pathways exist? What are access, quality and turnaround constraints?	Laboratory network map; EQA; turnaround data; diagnostic guidelines
Information and digital systems	What is reported, with what quality and use? What digital, image and privacy arrangements exist?	HMIS metadata; completeness audits; dashboards; digital-health policies
Governance and financing	Who leads, coordinates and pays? Which plans and partner investments overlap?	Organigrams; TOR; budgets; partner maps; expenditure data
Research and learning	Which uncertainties block decisions and which implementation questions require study?	Research inventory; ethics and funding records; policy briefs; programme reviews

B.1 Gap-to-priority summary template

Priority problem	Evidence and affected groups	Root causes	Current response	Strategic implication
[Describe the problem]	[Data, trend, location, inequality and limitation]	[System and behavioural causes]	[What exists and why it is insufficient]	[What the plan must change]
[Describe the problem]	[Data, trend, location, inequality and limitation]	[System and behavioural causes]	[What exists and why it is insufficient]	[What the plan must change]
[Describe the problem]	[Data, trend, location, inequality and limitation]	[System and behavioural causes]	[What exists and why it is insufficient]	[What the plan must change]
[Describe the problem]	[Data, trend, location, inequality and limitation]	[System and behavioural causes]	[What exists and why it is insufficient]	[What the plan must change]

Annex C. Stakeholder map and governance terms of reference

C.1 Stakeholder mapping template

Stakeholder	Interest or contribution	Influence	Engagement method	Planning and implementation role
[Name/group]	[Need, expertise, mandate or resource]	High / medium / low	[Interview, workshop, co-design, review]	[Specific role]
[Name/group]	[Need, expertise, mandate or resource]	High / medium / low	[Interview, workshop, co-design, review]	[Specific role]
[Name/group]	[Need, expertise, mandate or resource]	High / medium / low	[Interview, workshop, co-design, review]	[Specific role]
[Name/group]	[Need, expertise, mandate or resource]	High / medium / low	[Interview, workshop, co-design, review]	[Specific role]
[Name/group]	[Need, expertise, mandate or resource]	High / medium / low	[Interview, workshop, co-design, review]	[Specific role]

C.2 Minimum terms of reference

- Purpose, authority and reporting relationship.
- Membership, selection, tenure and representation of affected people and subnational levels.
- Chair, secretariat, quorum and decision-making method.
- Responsibilities during development, costing, validation, implementation and annual review.
- Conflict-of-interest declaration and management.
- Meeting frequency, documentation, action tracking and escalation.
- Data confidentiality, ethical conduct and communications.
- Resource and administrative support.

Annex D. Priority-setting matrix

Score each option from 1, lowest priority, to 5, highest priority. Countries may assign weights. Add an equity override or minimum safety requirement where a low-volume issue has severe consequences.

Candidate priority	Burden and severity	Equity and rights	Effectiveness and safety	Feasibility and fit	Affordability/value	Acceptability	Measurability	Sustainability	Weighted total	Decision
[Priority option]	1-5	1-5	1-5	1-5	1-5	1-5	1-5	1-5	[ ]	Include / defer / exclude
[Priority option]	1-5	1-5	1-5	1-5	1-5	1-5	1-5	1-5	[ ]	Include / defer / exclude
[Priority option]	1-5	1-5	1-5	1-5	1-5	1-5	1-5	1-5	[ ]	Include / defer / exclude
[Priority option]	1-5	1-5	1-5	1-5	1-5	1-5	1-5	1-5	[ ]	Include / defer / exclude

Annex E. Theory of change and results framework template

Component	Country formulation
Problem statement	[Who experiences what preventable skin-health problem, where and why?]
Long-term impact	[Health, equity, wellbeing and financial-protection change]
Outcomes	[Service coverage, quality, timeliness, equity, behaviour and patient-experience changes]
Outputs	[Systems, services, workforce, commodities, data and partnership products]
Priority interventions	[Evidence-informed interventions needed to produce outputs]
Inputs and enablers	[Leadership, financing, workforce, infrastructure, evidence and partnerships]
Assumptions	[Conditions expected to hold]
Risks and unintended effects	[What could prevent impact or cause harm]

Component	Country formulation
Learning questions	[Uncertainties to test during implementation]

Annex F. Strategic objective drafting template

Field	Country entry
Strategic objective	[Concise result-oriented statement]
Rationale and baseline	[Evidence and root causes]
Target and milestone	[Baseline, target, date and intermediate milestones]
Priority interventions	[Small set of approaches selected]
Key activities	[Concrete actions and sequence]
Lead and supporting actors	[Accountable lead and contributors]
Implementation level	[National, subnational, facility, community]
Costs and financing	[Cost, allocation, gap, source and action]
Indicators and data	[Measure, definition, source and frequency]
Equity and participation	[Who benefits, who may be missed, co-design and safeguards]
Risks and mitigation	[Operational, clinical, financial, ethical and contextual risks]

Annex G. Multi-year implementation matrix

Result / objective	Priority activity	Deliverable / milestone	Lead and support	Level / area	Year / quarter	Cost and source	Indicator / verification	Risk / mitigation
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

Annex H. Annual operational plan template

Annual deliverable	Activity and task	Responsible person or unit	Start	Due	Budget line	Amount	Financing status	Progress	Corrective action
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	Funded / gap	Not started / on track / delayed	[Owner and deadline]
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	Funded / gap	Not started / on track / delayed	[Owner and deadline]
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	Funded / gap	Not started / on track / delayed	[Owner and deadline]
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	Funded / gap	Not started / on track / delayed	[Owner and deadline]
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	Funded / gap	Not started / on track / delayed	[Owner and deadline]

Annex I. Costing and financing template

Objective / activity	Cost category	Unit	Quantity	Unit cost	Year 1	Year 2	Year 3	Year 4	Year 5	Total	Existing funds	Gap	Proposed source
[]	Personnel / commodity / capital / operating	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]
[]	Personnel / commodity / capital / operating	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]
[]	Personnel / commodity / capital / operating	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]
[]	Personnel / commodity / capital / operating	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]

I.1 Financing action plan

Financing gap	Potential source or mechanism	Required decision	Decision-maker	Deadline	Evidence / status
[]	[Domestic budget, insurance, pooled fund, partner, grant]	[]	[]	[]	[]
[]	[Domestic budget, insurance, pooled fund, partner, grant]	[]	[]	[]	[]
[]	[Domestic budget, insurance, pooled fund, partner, grant]	[]	[]	[]	[]
[]	[Domestic budget, insurance, pooled fund, partner, grant]	[]	[]	[]	[]

Annex J. Monitoring, evaluation and learning framework

Result level	Indicator and definition	Baseline / year	Target / year	Disaggregation	Data source	Frequency	Responsible unit	Data quality and use
Input / output / outcome / impact	[Full indicator name and definition]	[]	[]	[]	[]	[]	[]	[Verification, limitations and decision use]
Input / output / outcome / impact	[Full indicator name and definition]	[]	[]	[]	[]	[]	[]	[Verification, limitations and decision use]
Input / output / outcome / impact	[Full indicator name and definition]	[]	[]	[]	[]	[]	[]	[Verification, limitations and decision use]
Input / output / outcome / impact	[Full indicator name and definition]	[]	[]	[]	[]	[]	[]	[Verification, limitations and decision use]
Input / output / outcome / impact	[Full indicator name and definition]	[]	[]	[]	[]	[]	[]	[Verification, limitations and decision use]

J.1 Review calendar

Review forum	Frequency and date	Participants	Inputs	Decisions required	Action tracking
[]	[]	[]	[Data, finance, risks, patient feedback]	[]	[Owner, deadline, follow-up]
[]	[]	[]	[Data, finance, risks, patient feedback]	[]	[Owner, deadline, follow-up]
[]	[]	[]	[Data, finance, risks, patient feedback]	[]	[Owner, deadline, follow-up]
[]	[]	[]	[Data, finance, risks, patient feedback]	[]	[Owner, deadline, follow-up]

Annex K. Risk register

Risk	Cause and consequence	Likelihood	Impact	Rating	Mitigation	Contingency	Owner	Review date
[ ]	[ ]	Low / medium / high	Low / medium / high	[ ]	[Preventive action]	[Response if risk occurs]	[ ]	[ ]
[ ]	[ ]	Low / medium / high	Low / medium / high	[ ]	[Preventive action]	[Response if risk occurs]	[ ]	[ ]
[ ]	[ ]	Low / medium / high	Low / medium / high	[ ]	[Preventive action]	[Response if risk occurs]	[ ]	[ ]
[ ]	[ ]	Low / medium / high	Low / medium / high	[ ]	[Preventive action]	[Response if risk occurs]	[ ]	[ ]
[ ]	[ ]	Low / medium / high	Low / medium / high	[ ]	[Preventive action]	[Response if risk occurs]	[ ]	[ ]

Annex L. JANS-aligned NAP-Skin quality checklist

Quality domain	Pass criteria
Situation analysis and programming	The plan uses current, disaggregated evidence; identifies root causes and gaps; makes transparent priorities; defines a coherent theory of change; and selects feasible evidence-informed interventions.
Development process	The Ministry of Health led an inclusive and documented process; subnational actors, affected people, frontline workers and relevant sectors participated; conflicts of interest and comments were managed.
Costs and budget framework	Activities are costed transparently; costs reconcile with the implementation plan; existing resources and gaps are shown; recurrent costs, affordability and domestic financing are addressed.
Implementation and management	Governance, roles, sequencing, annual operationalization, procurement, workforce, partnerships, risks and subnational adaptation are credible.
Monitoring, evaluation and review	Indicators, baselines, targets, data sources, disaggregation, data-quality methods, review forums, evaluations and corrective-action processes are specified.
Skin-health technical integrity	The service package, referral, safety, workforce, commodities, laboratory, stigma, mental health, data, digital governance and research components are technically coherent.
Equity and rights	The plan identifies underserved groups, includes affected people, budgets differentiated action, protects confidentiality and monitors patient experience and discrimination.
Policy and system integration	The plan is explicitly linked to the national health strategy, UHC, PHC, disease programmes, workforce, medicines, laboratory, digital health and financing systems.

Suggested rating: 0 not addressed; 1 partially addressed; 2 adequately addressed. A country may set minimum domain scores and require all critical safety and financing criteria to pass before endorsement.

Annex M. Minimum national standard for an implementation-ready NAP-Skin

Criterion	Verification requirement
1. Formal endorsement	Approved by the competent authority, with plan period, version, responsible unit and next review date documented.
2. Evidence-based priorities	Situation analysis and transparent priority-setting record are available, including data limitations and equity analysis.
3. Strategic results	Vision, goal, priorities, targets, timelines and milestones are explicit and internally coherent.

Criterion	Verification requirement
4. Comprehensive skin-health scope	The seven draft GAP-SKIN strategic functions are addressed or any exclusions are justified and covered through linked policies.
5. Operational accountability	Priority actions, deliverables, responsible actors, implementation levels, timing and dependencies are documented.
6. Costed financing pathway	Multi-year costs, existing resources, financing gaps, budget holders, sources and domestic financing actions are documented.
7. Monitoring and review	Indicators, baselines, targets, data sources, responsibilities, disaggregation, review calendar and corrective-action mechanism are defined.
8. Equity and participation	Affected people and underserved groups participated, and equity, stigma, mental health, accessibility and rights actions are visible in the plan and budget.
9. Health-system integration	The plan is linked to PHC, UHC, workforce, medicines, laboratory, information and relevant programme systems, avoiding unjustified parallel structures.
10. Implementation start-up	A first annual operational plan, governance mechanism, financing action list, approved communication and engagement plan, priority products and feedback mechanism, and launch-to-review schedule are ready.

Interpretation

All ten criteria should be met for the plan to be considered implementation-ready. A formally endorsed document that lacks costing, accountability or monitoring should be classified as an approved policy draft, not as an operational national action plan.

Annex N. Suggested concise country plan outline

n	Content	Indicative length
	Foreword, approval and executive summary	2-3 pages
	Country context and situation analysis	6-8 pages
	Vision, goal, theory of change, targets and principles	3-4 pages
	Seven strategic objectives and priority interventions	10-14 pages
	Implementation, governance, risk and partnership framework	3-4 pages
	Costing and financing summary	2-3 pages
	Communication, advocacy and stakeholder engagement	2-3 pages
	Monitoring, evaluation, learning and review	3-4 pages
	Annexes: implementation and communication matrices, budget, indicators, TOR and consultation record	As needed

Annex O. Glossary of planning terms

Term	Definition
Activity	A defined task undertaken to deliver an output.
Baseline	The value of an indicator at or near the start of the plan period.
Costing	Estimating the resources and monetary value required to implement prioritized activities.
Equity	Absence of avoidable, unfair or remediable differences among population groups.
Evaluation	Systematic assessment of relevance, coherence, implementation, effectiveness, efficiency, impact or sustainability.
Indicator	A quantitative or qualitative measure used to assess progress or performance.

Term	Definition
Milestone	A dated intermediate achievement on the pathway to a target.
Monitoring	Routine collection, analysis and use of information to track implementation and results.
Outcome	A change in service coverage, quality, behaviour, equity or other intermediate result.
Output	An immediate product or implementation state resulting from activities.
Priority intervention	An evidence-informed approach selected to address a priority problem.
Result	A measurable change at output, outcome or impact level.
Strategic objective	A medium-term result statement that organizes interventions and accountability.
Target	A specific level of an indicator to be achieved by a defined date.
Theory of change	An explanation of how and why planned actions are expected to produce intended results, including assumptions and risks.

Annex P. Communication, advocacy and stakeholder engagement plan template

Use this annex as a working management tool. Countries may combine or expand the tables, but should preserve the connection between the NAP-Skin result, the audience action required, communication activities, service readiness, costs, feedback and measurable change. Complete the template with communication specialists, programme managers, affected-person representatives, frontline implementers and relevant partners.

P.1 Audience, objective and message matrix

Result / communication objective	Primary / influencing audience	Desired action / change	Audience insight / barrier	Core message / call to action	Messenger / spokesperson	Channel / product	Language / accessibility / pre-test	Timing / lead / approval	Indicator / feedback
[Result and measurable objective]	[Who must act; who influences them]	[Specific action, decision or practice]	[Knowledge, belief, incentive, access or trust issue]	[Core proposition, evidence and practical action]	[Trusted messenger and backup]	[Interpersonal, policy, print, broadcast, digital or community channel]	[Language, literacy, disability access, cultural adaptation, testing]	[Date/phase; owner; reviewer; approver]	[Reach, quality, outcome, equity and feedback measure]
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

P.2 Annual communication activity, product and budget schedule

Activity / product	Audience / NAP-Skin milestone	Production / pre-test tasks	Start	Due / dissemination	Lead / support	Technical review / approval	Budget line	Amount / financing source	Status / evidence / corrective action
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	Not started / on track / delayed; [evidence, action, owner, deadline]
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

P.3 Community feedback, misinformation and issue-management log

Feedback, rumour or issue	Source / audience / location	Risk or programme implication	Verified information and response action	Spokesperson / messenger	Channel and response deadline	Approval / escalation route	Owner and status	Learning / change made
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

P.4 Minimum completion check

- Each priority communication objective is linked to a NAP-Skin result, implementation milestone or named policy or financing decision.
- Primary and influencing audiences are segmented; the desired action and audience insight are explicit.
- Messages are accurate, actionable, dignified, pre-tested and supported by services or confirmed implementation dates.

- Channels, products, languages and accessibility formats match audience access and trust.
- Affected people and communities have a two-way feedback role, with response standards and escalation routes.
- Internal implementation communication, spokespersons, approval timelines, version control and partner coordination are defined.
- Activities are scheduled and costed; start-up and recurrent costs, budget holder, financing source and procurement needs are visible.
- Indicators assess quality and change, not only production or impressions; results and feedback are reviewed with programme performance and used to adapt the plan.

Annex Q. RACI matrix for NAP-Skin governance and implementation

A RACI matrix translates broad governance arrangements into a visible allocation of responsibility for each major decision, deliverable and recurring management function. Complete the matrix during plan development, validate it with the institutions named, attach the agreed version to the NAP-Skin, and review it whenever the annual operational plan, organizational structure or financing arrangements change.

Q.1 RACI definitions and operating rules

Code	Role	Practical test
R	Responsible	Who performs or coordinates the work and produces the deliverable? More than one R may be used only when responsibilities are clearly divided.
A	Accountable	Who owns the final result, has authority to decide or approve, and answers for completion? Assign exactly one A per row.
C	Consulted	Whose technical, operational, financial, legal or lived-experience input is required before the decision or action? Consultation is two-way.
I	Informed	Who must receive the decision, progress update or final product so they can act consistently? Information flow is normally one-way.

- Write each row as a concrete decision, deliverable or recurring management function. Avoid rows that are so broad that they conceal several different accountabilities.
- Assign exactly one accountable institution or unit and at least one responsible institution or unit for every row.
- Use named institutions, directorates, units or legally recognized bodies. Labels such as “stakeholders” or “partners” are too vague for accountability.
- Keep the number of responsible and consulted actors proportionate. A crowded matrix can become a diplomatic seating chart rather than a management tool.
- Distinguish consultation from information. An actor whose approval or technical input is required should not be listed only as informed.
- Reconcile the RACI matrix with the implementation matrix, annual operational plan, budget holder, indicator owner, communication plan and review calendar.
- Record the date, approving authority, matrix owner and next review point. Changes should be version controlled and communicated to all affected actors.

Q.2 Stakeholder-by-activity RACI matrix template

Enter R, A, C or I in each relevant cell. Cells may be left blank where an actor has no role. Replace the suggested actor headings with the country’s official institutional names and add or remove columns as needed.

Strategic result, activity or decision	MoH / NAP-Skin lead	Planning / policy	Technical programmes	PHC / services	Finance / procurement	Subnational authorities	Facilities / implementers	Civil society / affected people	Partners / other sectors
1.									
2.									
3.									
4.									
5.									
6.									
7.									

Strategic result, activity or decision	MoH / NAP-Skin lead	Planning / policy	Technical programmes	PHC / services	Finance / procurement	Subnational authorities	Facilities / implementers	Civil society / affected people	Partners / other sectors
8.									

Recommended attachment information: plan period; geographic level; approving authority; matrix owner; version and date; next review date; and any assumptions or exclusions.

Q.3 Compact role-allocation worksheet

Use this format where the country has many actors or where responsibilities must be recorded using full institutional names rather than abbreviations.

Activity or decision	Accountable (A)	Responsible (R)	Consulted (C)	Informed (I)	Timing / review point	Evidence / approval record
1.						
2.						
3.						
4.						
5.						
6.						

Q.4 Illustrative NAP-Skin RACI matrix

The example below is not prescriptive. Countries should adapt it to legal mandates, organizational structures and decentralization arrangements. “A/R” may be used where the accountable unit also performs the work, but routine use should not blur the distinction between ownership and execution.

Activity or decision	NAP-Skin lead	Planning / policy	Technical programmes	PHC / services	Finance / procurement	Subnational	Facilities	Civil society / partners
Approve the NAP-Skin and first annual operational plan	R	A	C	C	C	C	I	C
Develop and consolidate annual operational plans	A/R	C	C	R	C	R	C	C
Cost the plan, secure budget lines and track financing gaps	R	C	C	C	A/R	I	I	C
Define the integrated service package and referral pathways	A	C	R	R	C	C	C	C
Implement training, mentoring and supportive supervision	A	I	C	R	C	R	R	C
Ensure medicines, diagnostics, supplies and laboratory readiness	A	I	R	R	R	R	R	I
Monitor indicators, assure data quality and submit reports	A	C	R	R	I	R	R	C
Lead communication, advocacy, community engagement and stigma reduction	A	C	C	R	C	R	R	R
Conduct the annual review and authorize corrective action	A	R	R	R	C	R	C	C

Q.5 Minimum completion check

- Every row has exactly one A and at least one R.
- The accountable actor has the legal or delegated authority, resources and access to the decision forum required to fulfil the role.
- Responsible roles identify who will perform the work at national, subnational and service-delivery levels where relevant.
- Consulted and informed roles are selective, feasible and linked to defined communication or meeting mechanisms.
- People affected by skin diseases and civil society have a meaningful role in decisions that concern acceptability, equity, stigma, accessibility and accountability.

- The same institutional assignments appear consistently in the implementation plan, annual workplan, budget, financing actions, indicators, risk register and communication plan.
- The matrix is endorsed, dated, version controlled, owned by a named unit and scheduled for review at least annually.

Annex R. GAP-SKIN companion document alignment matrix

This matrix identifies the lead function of each companion document and the country-level output it should support. The documents are intended to operate as one implementation package, with NAP-Skin serving as the principal country integration and management mechanism.

GAP-SKIN implementation function	Lead companion document	Supporting interfaces	Country output
Define national disease or service priorities	GAP-SKIN Two-Phase Prioritization Framework	NAP-Skin; SHRIEF; Indicator Compendium	National priority disease, cluster or service-problem list with documented evidence and uncertainty
Define PHC recognition, management and referral actions	Common Skin Diseases for Management or Referral at PHC Level	Training and Competency Framework; NAP-Skin	National PHC service package, referral pathways and decision-support content
Build workforce competence and support systems	Integrated Skin Health Training and Competency Framework	PHC classification; NAP-Skin; Indicator Compendium; SHRIEF	Competency framework, curricula, assessment, supervision and specialist-support pathway
Develop, cost, implement and review national action	NAP-Skin Guidance	All companion documents	Endorsed and costed national action plan or equivalent mechanism with annual management cycle
Measure progress and support data-to-action	GAP-SKIN Indicator Compendium	NAP-Skin; Training; SHRIEF; GSHA	Core, tracer, supplementary and country-management indicator set with harmonized metadata
Coordinate partner support and resource alignment	Global Skin Health Alliance	NAP-Skin; SHRIEF; GAP-SKIN	Country-aligned technical support, knowledge exchange and transparent contribution mechanism
Generate and translate evidence and responsible innovation	SHRIEF	Prioritization Framework; NAP-Skin; Indicator Compendium; GSHA	National research, innovation and learning agenda linked to decisions and implementation

References and source documents

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4. World Health Organization. Strategizing national health in the 21st century: a handbook. 2016. Official source
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11. World Health Organization. Ending the neglect to attain the Sustainable Development Goals: a strategic framework for integrated control and management of skin-related neglected tropical diseases. 2022. Official source
12. World Health Organization. Recognizing neglected tropical diseases through changes on the skin: a practical handbook for health workers. Second edition. 2026. Official source
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14. World Health Organization. Training and Competency Policy Framework for Integrated Skin Health. Pre-publication draft, version 1.0. July 2026. Internal working document.
15. International Health Partnership. Joint Assessment of National Health Strategies and Plans: joint assessment tool and guidance. JANS quality domains used as an adapted quality-assurance lens.
16. World Health Organization. WHO Strategic Communications Framework for Effective Communications. 2017. Official source
17. World Health Organization. Risk communication and community engagement action plan guidance. 2020. Principles adapted for routine national skin-health planning and implementation. Official source

Reference status

References 2, 13 and 14 are draft or internal pre-publication documents. Their titles, objectives, indicators and requirements should be updated before formal WHO clearance and publication. Communication guidance in references 16 and 17 is adopted and adapted for routine skin-health planning; emergency-specific elements should be used proportionately. Country guidance should remain adaptable if the final GAP-SKIN architecture changes.