World Health Organization

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

Department of Global HIV, Hepatitis and Sexually Transmitted Infections Programmes

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Executive summary

This operational guidance provides a structured approach to support countries in sustaining priority services for HIV, viral hepatitis and sexually transmitted infections in the context of reduced external funding. The guidance is intended for national governments, public health programmes, community-led organizations, civil society, technical partners and donors working to safeguard priority services, support phased adaptation, protect health outcomes and preserve hard-won gains.

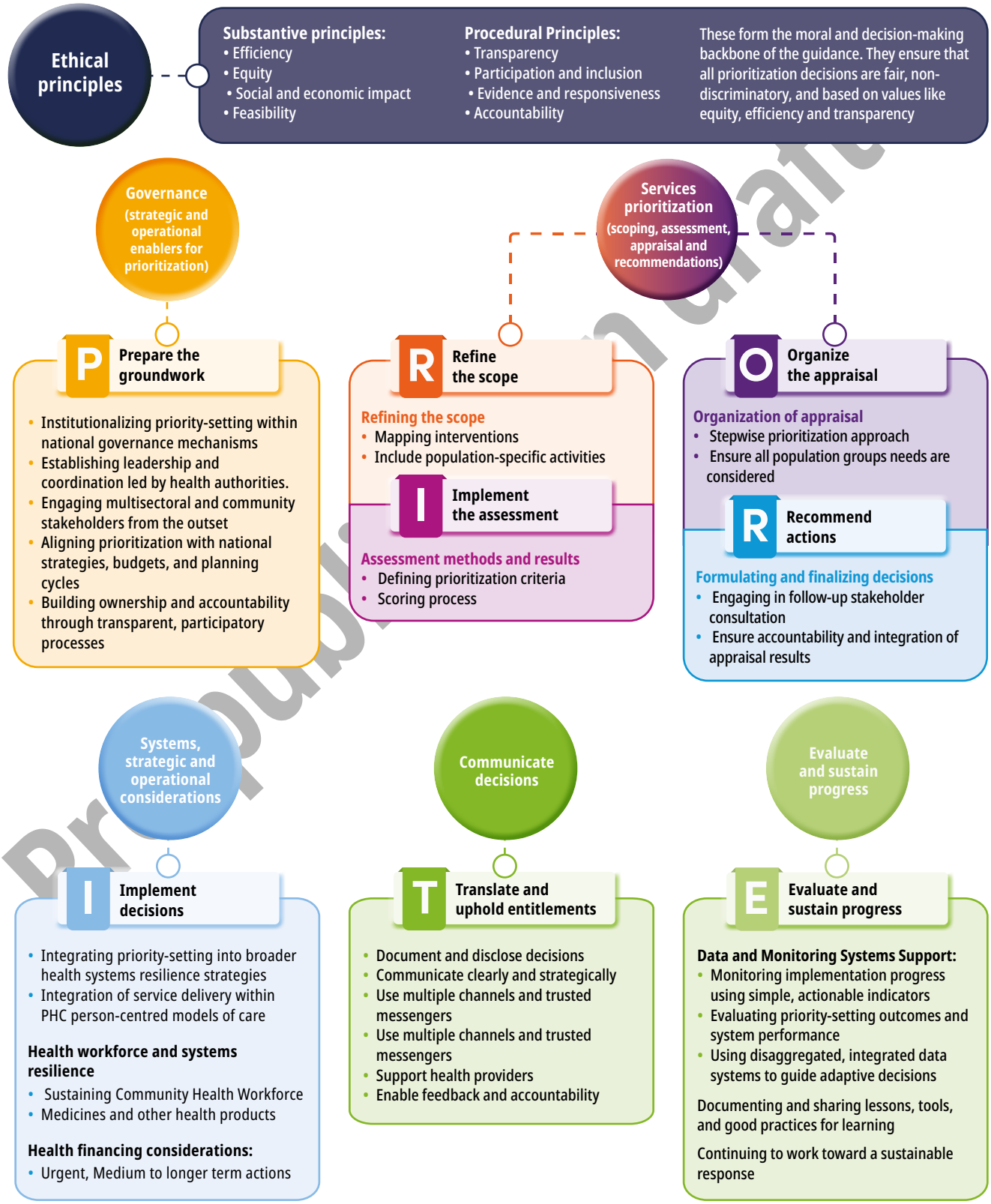
The publication outlines practical steps to support countries in assessing risks, setting priorities and adapting services and systems (Fig. 1). It introduces a stepwise priority-setting framework that organizes services into three tiers based on their contribution to achieving national and global health outcomes.

Key elements of the guidance include:

- key steps to assess and monitor service disruptions and health financing risks;
- a systematic process for setting priorities for services and interventions;
- cross-cutting enablers such as health workforce strategies, resilient supply chains, integrated data systems and inclusive governance;
- emphasis on people-centred approaches and sustained community engagement to ensure that services remain accessible, acceptable and responsive to those most severely affected;
- opportunities for service integration, especially within primary health care, to enhance efficiency and sustainability; and
- strategic recommendations for financing transitions, including alignment with public financial management systems and domestic resource mobilization.

Although the publication focuses on HIV, viral hepatitis and sexually transmitted infections, the approaches and tools presented can inform broader efforts to strengthen health system resilience. WHO will continue to update and provide technical guidance and support to Member States as they navigate service disruptions, funding shifts and recovery strategies, ensuring continuity of care and the protection of public health.

Fig. 1. The ASK: WHO prioritization process guidance

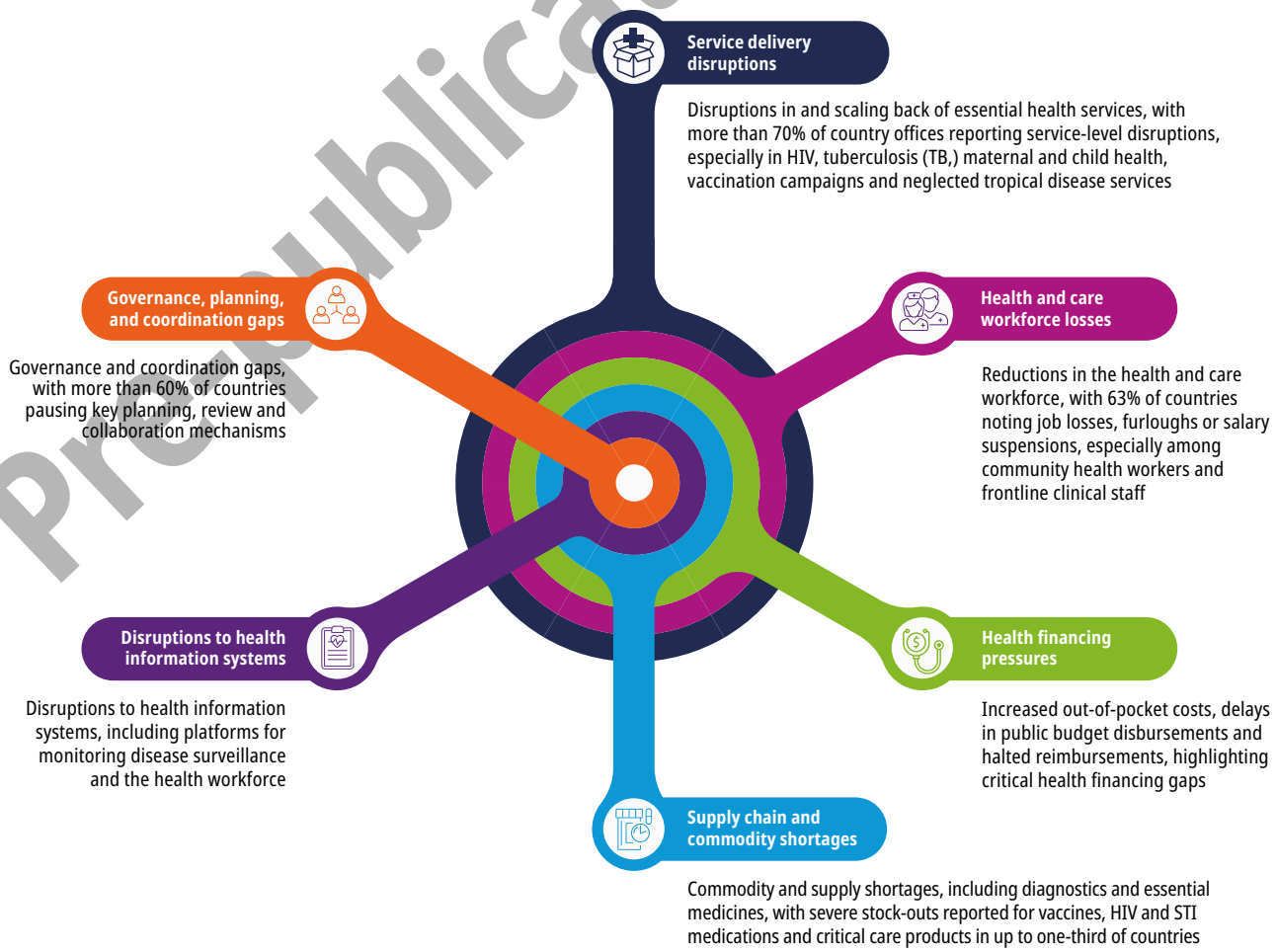


1. Introduction and rationale

In early 2025, sudden reductions in official development assistance *(1)* and programmatic support triggered widespread disruptions across health systems, including services for HIV, viral hepatitis and sexually transmitted infections (STIs) *(2)*. Countries have been compelled to reassess priorities and reallocate resources, placing recent and longstanding progress at risk. Sustaining access to prevention, testing and treatment for HIV, viral hepatitis and STIs while supporting continuity of care remains critical.

A rapid stock-taking exercise in March and April 2025 of 108 WHO country offices found system-wide effects across service delivery, health workforce, commodities, data systems and governance (Fig. 2) *(3)*. Although the findings offer early insight, the long-term effects remain uncertain because of the rapidly evolving funding landscape. Emerging evidence underscores the gravity of potential long-term effects, especially in the context of HIV services and the related systems and enabling actions required to secure HIV impact *(1)*.

Fig. 2. Reported disruptions, system gaps and health impact pillars



Source: The impact of suspensions and reductions in health official development assistance on health systems: rapid WHO country office stock take – summary of results from 108 WHO country offices, 7 March–2 April 2025

A modelling study *(4)* estimated that the combined effect of a 24% reduction in international HIV aid and discontinuation of official development assistance could result in 4.4 million to 10.8 million additional people acquiring HIV and 770 000 to 2.9 million additional people dying from HIV-related causes in low- and middle-income countries between 2025 and 2030. These effects are most pronounced in sub-Saharan Africa and among key populations. Disruptions to prevention and testing – especially those affecting community-based, community-led and key population–focused services – may drive disproportionate increases in the number of people newly infected amid ongoing stigma and discrimination. In the worst-case scenario, projected HIV incidence and mortality in some countries could revert to those in the early 2000s, effectively reversing two decades of global progress *(4)*.

Governments and partners are implementing mitigation measures, including reallocating domestic funds, transitioning health-care workers to the public sector payroll, strengthening partnerships and optimizing service delivery, but the full extent of the negative health effects will only become apparent over time. Continual monitoring will be essential to assess and respond to evolving effects on health outcomes across diseases and populations. These funding shifts have also accelerated the momentum for integrating disease-specific programmes into broader primary health care (PHC) systems. In this evolving context, people-centred community engagement approaches will be critical to maintain access, equity and resilience (Box 1).

Box 1. Understanding Context, Prioritizing Populations, Enhancing Impact

As countries grapple with funding cuts, ensuring that resources are strategically aligned with local contexts and epidemiological needs becomes increasingly vital. HIV, hepatitis and STI epidemics are not uniform; they are shaped by local patterns of transmission, risk behaviour and social determinants. Effective responses must therefore be data-driven, targeting the populations and interventions that will yield the greatest public health impact. When resources are scarce, failing to provide the most effective services to reduce the burden of disease not only wastes limited funds but also risks reversing hard-won gains, for example in HIV treatment. Key populations – such as gay men and other men who have sex with men, transgender people, sex workers, people who use drugs and incarcerated individuals – often carry a disproportionate share of the HIV, hepatitis and STI burden in all WHO regions. Nevertheless, these people have been frequently overlooked in national funding allocations because of stigma, political resistance or criminalization. Similarly, interventions such as harm reduction or comprehensive sexuality education may be given less priority because they are politically sensitive despite their proven effectiveness. Public health planning must resist these pressures by grounding decisions in evidence and not ideology. Protecting and giving priority to marginalized groups, including key populations, is not only a moral imperative but also a pragmatic strategy to control epidemics, reduce onward transmission and save lives.

"As countries grapple with funding cuts, ensuring that resources are strategically aligned with local contexts and epidemiological needs becomes increasingly vital"

Objective and audience

This operational guidance aims to support countries in identifying priorities, making strategic decisions and sustaining essential HIV, viral hepatitis and STI services amid funding reductions. It will be a critical tool for guiding the prioritization and integration of these services within country-level planning processes, including national HIV Response Sustainability Roadmaps and other strategic frameworks. This document provides guidance for those involved in planning, financing, delivering or monitoring service continuity and integration as follows: national ministries, health programmes, civil society and community organizations, donors, technical agencies and implementing partners.

Methods

This operational guidance was developed through a structured, consultative process aligned with WHO's normative principles and established procedures, ensuring transparency, inclusiveness and use of evidence-informed methods *(5)*. The process was led by WHO technical staff in collaboration with expert groups, technical partners and stakeholders.

It involved cross-departmental work to align existing WHO priority-setting, response to shocks and systems guidance for developing a priority-setting framework, methods and mapping of WHO HIV, viral hepatitis and STI normative guidance services and interventions (all referenced in this publication). Various external and internal expert groups were engaged through several virtual consultations and participatory exercises. Expert groups engaged representation from affected communities, community-based organizations, civil society, government representatives, technical partners and researchers from all WHO regions. The WHO Ethics and Governance Steering Group was engaged at all stages of the guidance development, including content writing, review and refinements.

An expert-led assessment was conducted for setting priorities for services and interventions that were later refined through a deliberative consultation. WHO consolidated the results, incorporating external feedback. The process was complemented by peer review and consensus-building to ensure that the priority-setting framework was robust, contextually relevant and aligned with WHO standards for inclusiveness, transparency and technical rigour (see the section on priority-setting for services for more details).

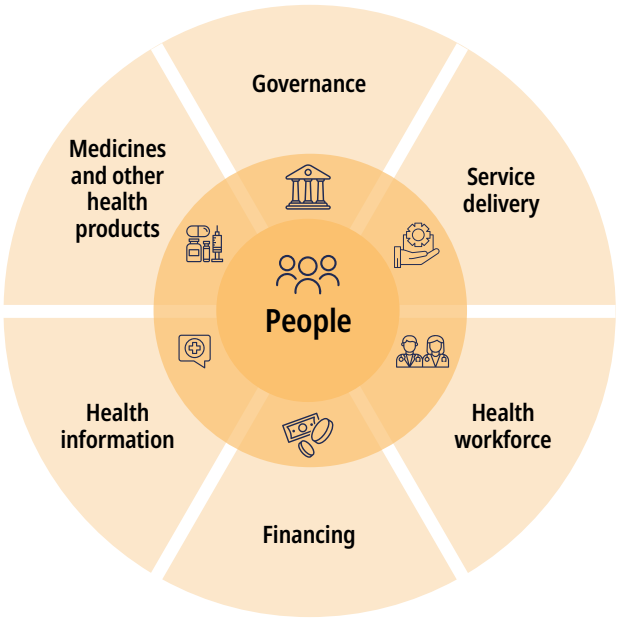
Scope and foundational pillars

This guidance focuses on providing planning and implementing guidance for rapid (re)setting of priorities for services in response to acute shocks – such as public health emergencies or sudden reductions in external funding – requiring urgent, adaptive decision-making that may differ from standard planning and priority-setting processes, such as reviewing health benefit packages and strategic planning. However, this guidance is based on similar underlying principles and practices to ensure cohesion with these medium-term strategic priority-setting processes.

The guidance is anchored in three foundational pillars.

- It adopts a systems approach, recognizing that service delivery decisions occur within and affect broader health system functions, with many areas also needing to adapt to sudden changes. In accordance with the WHO health system framework, it addresses six core system building blocks (Fig. 3): governance and planning, service delivery, health workforce, financing, health information and medicines and other health products as enablers of sustainable services for HIV, viral hepatitis and STIs. These building blocks are examined not in isolation but as interdependent enablers of sustainable service delivery. By assessing

Fig. 3. WHO health systems framework



disruptions and opportunities across these domains, the guidance aims to help countries make coordinated, evidence-informed decisions that strengthen system resilience, protect equity and align with broader universal health coverage goals *(6)*.

- The PRIORITE framework (P – prepare the groundwork, R – refine the scope, I – implement the assessment, O – organize the appraisal, R – recommend actions, I – implement decisions, T – translate and uphold entitlements and E – evaluate and sustain progress) (Fig. 4) provides a stepwise approach to setting priorities – from preparation and stakeholder engagement to implementation, accountability and sustainability.
- The PHC strategic and operational levers provide a practical framework and can serve as a checklist for identifying opportunities to jointly strengthen PHC and meet HIV-specific goals, ensuring that all aspects of service and programme disruption are considered *(7)*.

Together, these approaches ensure that the guidance is technically sound, context-sensitive and responsive to urgent priority-setting needs in resource-constrained settings and aligned with sectoral priority-setting processes and policies.

How to use this guidance

Each section outlines system-level actions framed around the six building blocks, and the structure and sequencing of the guidance align with the PRIORITE framework.

Users are encouraged:

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

Planning and self-check question boxes:

Each section has planning and self-check question boxes that serve as a link between normative guidance and practical implementation, supporting reflection on how recommendations are being applied and helping to identify areas requiring further action to ensure effective delivery.

This publication offers a flexible framework for sustaining HIV, viral hepatitis and STI services in settings facing reduced external funding.

2. Principles for setting priorities for health services

Section summary: This section highlights how ethics underpins priority-setting decisions and proposes four substantive ethical and four procedural principles. It underscores the need to weigh these principles carefully, justify trade-offs and engage affected communities in the priority-setting process.

Ethical principles

In the context of declining external HIV funding, this guidance applies ethical principles to ensure that decisions on continuing services are both technically sound and morally justifiable. The allocation of scarce health-care resources involves ethical values and principles even if they are not always made explicit. Sound decision-making, however, requires making ethical considerations explicit so that the relevant values can be properly assessed and weighed and transparently justified to relevant stakeholders *(8, 9)*. This, in turn, requires that decisions be explicitly informed by and grounded in ethical values and principles. Ethical principles express rules or criteria that delineate what is right or wrong (or more right or more wrong) and form the basis of ethical decision-making.

Unlike a typical health technology assessment and other priority-setting processes used to allocate health expenditure, reducing access to accepted health-care interventions involves setting priorities for interventions that have already benefitted from rigorous assessment and appraisal within evolving and often uncertain budget constraints. Hence, priority-setting decisions in this context involve continuing or discontinuing highly impactful, often life-saving interventions and services that people would otherwise be expected to benefit from and would otherwise have an ethical claim to receive. It is therefore critical that priority-setting decisions be informed by explicit ethical principles that help to explain why some people may not receive an intervention or service they might otherwise expect to receive.

Four fundamental substantive ethical principles should guide the allocation of and priority-setting for health-care interventions under resource constraints: efficiency, equity, social and economic impact and feasibility. They should be interpreted and operationalized considering existing obligations (such as human rights instruments, treaties and national laws), with explicit and clear justifications if they depart from such obligations. Box 2 summarizes the four substantive principles to guide priority-setting decisions.

"It is critical that priority-setting decisions be informed by explicit ethical principles that help to explain why some people may not receive an intervention or service they might otherwise expect to receive"

Box 2. Substantive principles to guide priority-setting decisions

Efficiency

Description

Use available resources to maximize benefits and minimize harm, such as maximizing population health outcomes. This requires assessing the effectiveness and overall health impact of an intervention or service. This assessment can be expressed in terms of disability-adjusted life-years (DALYs) saved, quality-adjusted life-years saved etc., which must be clarified when applying the principle and reflect population valuation of health improvements.

Efficiency seeks to maximize population health outcomes with available resources. It therefore requires assessing cost–effectiveness – the magnitude of population health gains relative to costs – compared with alternative uses of the health-care resources. The intervention or service chosen should be the most cost-effective among alternatives since that intervention maximizes population health with resource constraints.

Maximizing population health outcomes sometimes also requires examining the proportion of an overall budget consumed by an intervention or service – financial sustainability and budget impact – since interventions and services that consume a large portion of the budget may crowd out several alternative impactful interventions and services.

Explanation

Efficiency assesses how much a service or intervention can reduce morbidity and mortality. High-impact interventions have strong evidence of effectively preventing infections or saving lives (such as large trials or meta-analyses) and are likely to address large proportions of the population in need. Lower-impact interventions may target less prevalent causes or have more limited efficacy and effectiveness.

A highly cost-effective intervention or service has a low cost per health outcome unit (such as quality-adjusted life-years) averted – or, like some vaccines, may even save money per unit of health outcome compared with other interventions and services provided within the current health sector budget.

Some interventions and services may maximize short-term population health outcomes but have fewer optimal health effects or cost–effectiveness in the long term or vice versa. For example, forgoing preventive interventions in favour of treatment interventions may produce worse population health outcomes in the longer term. If delaying an intervention or service in the short term substantially increases morbidity and mortality, this should be reflected in the assessment of its health impact. Irreversible harm (such as death) should receive greater priority in averting (through antiretroviral therapy (ART) and treating opportunistic infections), since it cannot be rectified or compensated for in the future.

High-sustainability interventions have low absolute cost or are co-funded by domestic budgets already and thus can be continued with minimal disruption. This principle also identifies interventions that, although effective, might consume a large portion of the government health budget. Lower scores indicate interventions that require substantial reallocation and may crowd out expenditure on several more impactful interventions.

It is important to consider efficiency alongside equity; setting priorities according to efficiency alone can obscure inequalities in the distribution of health outcomes, emphasizing overall gains while neglecting the needs of marginalized or underserved populations.

Equity

Description

Ensure that allocation decisions do not discriminate for or against individuals or

Box 2. Substantive principles to guide priority-setting decisions (cont'd.)

populations based on characteristics such as race, ethnicity or religion. Equity also means not worsening the situation of people who are disadvantaged by systematic disparities in health or the social determinants of health (such as income, education and racism) by allocating resources.

Explanation

Priorities for interventions and services should be set such that they do not create or exacerbate existing inequities (systematic disparities in health or in the social determinants of health between groups with different levels of social advantage or disadvantage) and, when possible, actively strive to reduce such inequities. This often entails giving priority to people at the greatest risk as a result of structural disparities and/or those who face barriers to accessing interventions and services. An intervention or service scoring high on equity preferentially reaches people who are currently most disadvantaged or at greatest risk of becoming significantly worse off as well as key populations (such as sex workers, gay men and other men who have sex with men, people who inject drugs and impoverished communities) or regions with high disease burden and poor services. Lower equity scores indicate that an intervention primarily benefits groups already better off or has minimal impact on reducing disparities.

Social and economic impact

Description

Maximize broader, non-health impact associated with the intervention or health service, including contributions to productivity, educational attainment and poverty reduction and minimize unintended negative social and economic impact. These dimensions should be considered carefully, since other policy levers and investments outside the health sector address poverty. Nevertheless, for example, financial protection from the impoverishing aspect of ill health may be primarily addressed through health sector and may be considered alongside equity concerns.

Explanation

Health is only one dimension of well-being. Improving or worsening health can significantly affect non-health, social and economic outcomes. Improving health can lead to higher educational attainment and economic productivity. The allocation of health-care resources should enhance social and economic effects, such as productivity, educational attainment and poverty reduction. In addition, the allocation of health-care resources should minimize potential economic burdens on households, such as income loss from illness or financial hardship from out-of-pocket payments. However, these effects apply to most health interventions and should therefore only be considered in setting priorities for specific services with an exceptionally negative or positive impact beyond the equity considerations mentioned above.

Feasibility

Description

Feasibility is the practicality of implementing the intervention with existing infrastructure and human resources and within health system capacity.

Explanation

Allocation of resources should give priority to interventions that can be delivered with the lowest requirements and demands on existing health system infrastructure and capacity. An intervention scoring high on feasibility and health system capacity can be delivered without requiring additional capital investment in facilities, infrastructure or human resources. Conversely, a lower feasibility and health system capacity score indicates that an intervention cannot be delivered immediately within the existing infrastructure and available resources but would require additional investment.

In allocating scarce health-care resources, some stakeholders might suggest including the rule of rescue principle; however, this is not recommended. The rule of rescue is understood widely as giving priority to identifiable individuals (as opposed to statistical individuals or populations) facing serious harm or imminent death, even when doing so may incur broader human costs or consequences. However, applying this principle can result in significant inefficiency (negative overall health impact) or inequity (negative impact on disadvantaged groups). In the present context of substantial cuts, almost all allocative decisions will mean someone not receiving a previously available intervention, making the rule of rescue of little practical value.

Procedural principles

Whenever multiple principles are used to allocate resources, there will be trade-offs, and the principles must be weighed against each other. For instance, maximizing health might not improve the condition of the people who are worse off. Which principle – efficiency or equity, for example – should take precedence or be weighted higher is an important question. Reconciling such conflicts between the ethical principles is fundamental and should be done explicitly. Evidence supporting various interventions and services must therefore be assessed against each of the principles to determine the extent to which those interventions and services advance each ethical principle.

Once evidence is assessed against each of the principles or criteria, conflict between principles may still exist. For example, the balance between equity and efficiency may be challenging in HIV programming, since services for the most vulnerable people may not necessarily maximize impact and yet should continue to the extent possible to address and comply with the equity principle. The preceding four substantive principles are not ranked. When principles conflict, the aim should be to show either that one principle is of overriding importance in that context or that at least some requirements of each of the conflicting principles can be satisfied. Since all principles cannot always be upheld equally, explicit justifications should be offered about how the priorities for the principles have been set and traded off in each situation *(8)*.

The process of making trade-offs and justifying weighing one ethical principle over another should be done by adhering to procedural principles. The procedural principles that guide decision-making processes should inform the assessment and appraisal process as well (applying a scoring system).

There are four fundamental procedural principles: transparency, participation and inclusion, evidence responsiveness and accountability (Box 3). Procedural principles concern how decision-making is conducted and should not be confused with substantive principles, which concern what decisions should be made *(9)*.

"Procedural principles concern how decision-making is conducted and should not be confused with substantive principles, which concern what decisions should be made"

Box 3. Procedural principles to guide decision-making processes

Description

Publicly communicate decisions, decision-making processes and reasons supporting decisions in an accurate, honest, understandable and timely manner.

Participation and inclusion

To the greatest extent possible, set priorities with the involvement and/or representation of those expected to be affected by such decisions. This means not only the individuals with a specific condition or who might receive an intervention but also those who pay for the intervention and might not receive an alternative intervention since they may be affected. Enabling the participation and inclusion of those expected to be affected should aim to calibrate decisions to the extent to which the intervention or service is accepted, culturally appropriate and trusted by the communities it is intended to serve. Opportunities should also be provided to revisit and revise decisions based on stakeholder input and feedback.

Evidence responsiveness

Inform decisions with the best available evidence. Assess evidence against each principle of decision-making. Regularly review and revise decisions based on evolving data, such as evolving cost–effectiveness assessments and concerning which populations might benefit or are unfairly disadvantaged.

Accountability

Be answerable for decisions and actions. Decisions should be made with clearly defined objectives and responsibilities, transparently communicated and based on reasons that can be understood by the affected communities.

When an intervention is discontinued or withheld from individuals or populations who would otherwise benefit, there is an ethical obligation not to abandon these individuals and populations. Health systems together with key stakeholders should proactively identify and provide alternative forms of support or other appropriate measures to alleviate suffering and support their health needs.

For example, in settings in which key population–friendly services have been discontinued, health systems should work with the affected communities to identify acceptable and appropriate alternatives. Although these alternatives may be less enhanced than the original services, efforts should be made to ensure that they remain responsive to the needs and priorities of key populations. This collaborative approach can help to maintain trust and support among communities while addressing their ongoing health and psychosocial needs.

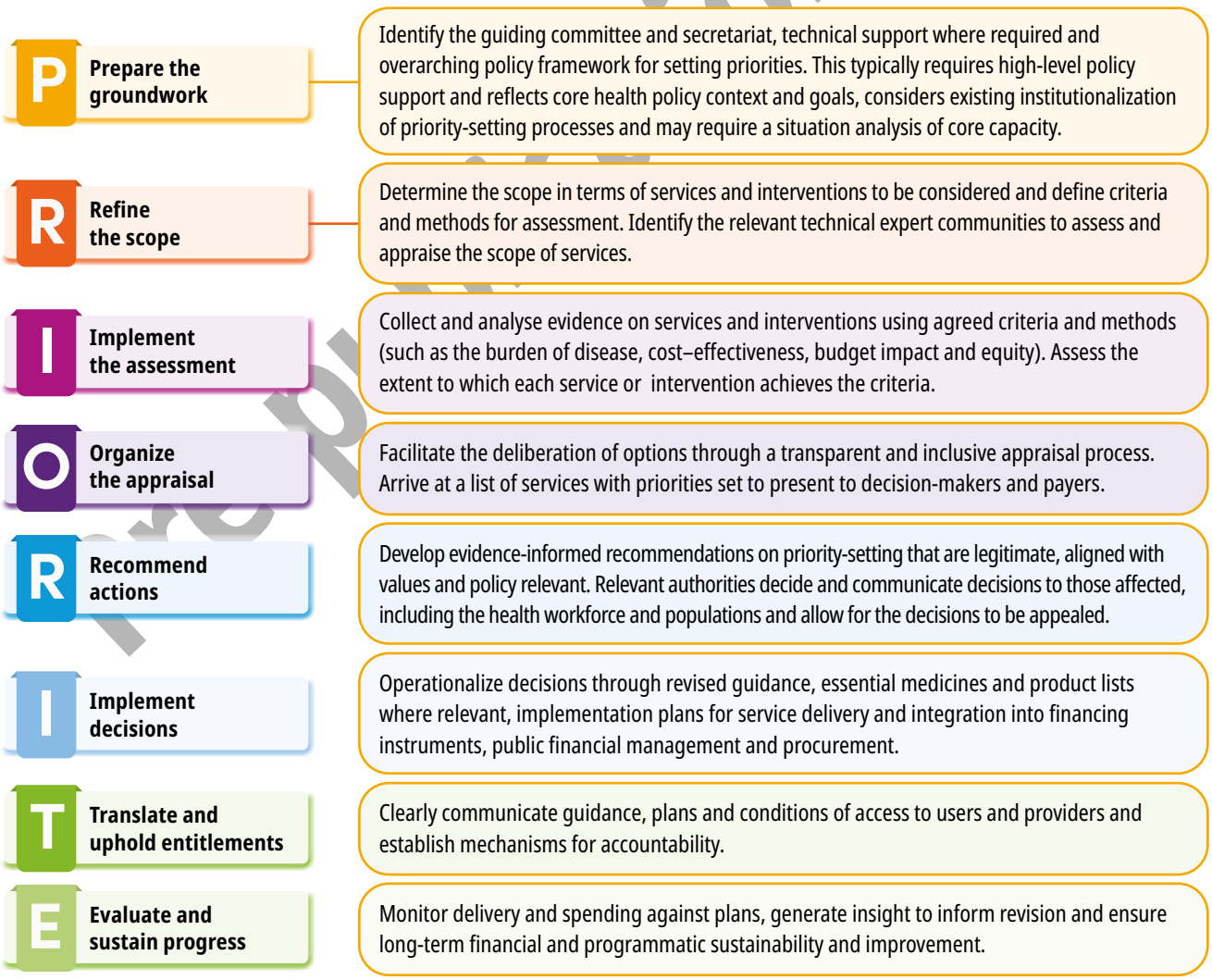
Planning and self-check questions

- Has how substantive ethical principles can be assessed for each intervention or service been clearly defined and documented?
- Have clear processes been established to reconcile and justify trade-offs between conflicting principles?
- Are affected communities and key populations meaningfully involved in the priority-setting process, and are their perspectives reflected in the decisions?
- Have the decisions, decision-making processes and reasons supporting decisions been publicly communicated? Are the decisions informed with the best available evidence?
- Have the decision-making roles and responsibilities been clearly defined and communicated to all relevant stakeholders (such as individuals, groups or institutions)?

3. Steps in setting priorities

WHO proposes using the PRIORITE framework as a structured, transparent and inclusive process to guide evidence-informed deliberative priority-setting in health, that adheres to both the ethical and procedural principles outlined above. WHO developed the framework based on reviewing existing priority-setting frameworks and its own experiences in supporting countries in allocating health resources through evidence-informed priority-setting. It is currently being further developed and will be available in the forthcoming interim WHO guidance for evidence-informed deliberative priority-setting for health (Fig. 4).

Fig. 4. Steps for evidence-informed deliberative priority-setting in health



4. Governance and planning the priority-setting

As an initial step, the groundwork for priority-setting should be prepared by identifying the appropriate governance and institutional structures and by outlining the decision framework and purpose.

In contexts of constrained resources, setting priorities for health-care services requires more than technical assessment; it demands robust governance and inclusive decision-making to ensure the implementation of the ethical principles outlined above. Effective priority-setting is anchored in transparent, accountable processes and coordinated leadership that ensure alignment with national strategies and system-wide priorities. Strong governance and community engagement are essential to build coalitions, manage resources and uphold equitable, evidence-informed responses that meet population needs.

Section summary: This section outlines practical steps for initiating a priority-setting process in resource-constrained settings. It highlights the importance of governance, coordination and initial planning mechanisms.

Planning and self-check questions

- ☐ Do leadership and coordination mechanisms ensure transparent priority-setting and the engagement of all relevant stakeholders and community groups?
- ☐ Are service disruptions and gaps being assessed across system functions, using both real-time and retrospective data?
- ☐ Has the full delivery and financing landscape been mapped out, including dependence on external funding and the alignment between donor support and domestic financing priorities?
- ☐ Do the findings from these assessments directly guide adaptive planning and inform priority-setting decisions?

Strategic and operational enablers for priority-setting

Priorities are not set in isolation. National programmes should embed priority-setting within existing governance structures for priority-setting, health benefit package reviews and health technology assessment, including interministerial committees, finance ministries or other budget oversight entities and health system coordination bodies. Many countries have established institutional structures for establishing priorities for services, which should provide the basis for priority-setting, rather than each disease area setting up separate processes. If these do not exist, governance structures may need to be established to support rapid priority-setting. The

responsible structures for designing the process (such as defining the criteria and intervention scope), assessing interventions against the criteria, appraising the evidence and making final decisions or recommendations should be identified or created.

Priority-setting should also be embedded in broader transition and health sector strategic planning frameworks, supported by high-level leadership, community engagement, civil society organization and strong coordination mechanisms. Structured processes ensure that difficult decisions are based on evidence, reflect population needs and are sustainable within available resources. Leadership is critical for framing priority-setting processes and procedures and ensuring that decisions are transparent, legitimate and aligned with health system reforms. Health ministries and government agencies coordinate the process through clear procedures, inclusive dialogue and intersectoral collaboration *(10)*. The active engagement and participation of civil society organizations and affected communities in decision-making processes is essential to ensure that priority-setting efforts are grounded in lived experience, respond to local needs and promote accountability. Ensuring linkage with strategic planning enables countries to leverage routine and response-related assets and opportunities, apply lessons learned and phase adjustments across early, intermediate and long-term timelines *(11–13)*.

Effective priority-setting requires a governance-informed understanding of system conditions, including institutional capacity, accountability and stakeholder engagement mechanisms and existing service gaps. A comprehensive baseline mapping and assessment enables planners to visualize existing resource flows and identify potential areas for consolidation or transition, supporting priority-setting that is responsive to current challenges while aligning with national goals and stakeholder expectations. Ideally, priority-setting mapping and assessments are introduced, including identifying service disruptions (such as programmatic gaps), evaluating financial flows (such as funding source and funding direction) and assessing where external dependence or system vulnerabilities exist (such as salaries, goods and services and capital) *(9, 14)*.

"Structured processes ensure that difficult decisions are based on evidence, reflect population needs and are sustainable within available resources"

1. Identifying, mapping and engaging stakeholders

In alignment with the ethical principle of participation and inclusion, identifying and engaging key stakeholders and any existing mechanisms for engagement and participation are critical for effective priority-setting and decision-making. Sustained, inclusive engagement with key stakeholders, including affected communities representing key populations, civil society, health-care workers and technical and funding partners, ensures that decisions are transparent, legitimate and responsive to the needs of those most severely affected *(6, 8)*.

Establish a baseline map of in-country stakeholders (including communities), services and programmes, including those supported by external funding. It is also important to define key stakeholders, ensuring a multidisciplinary expert group that will support planning, implementation and monitoring of the process. This group will also identify and agree on the methods used for setting priorities. (Box 4).

Box 4. Community Leadership as a Catalyst for Stronger Governance

WHO defines community engagement as building and maintaining relationships that empower stakeholders to collaboratively address health problems and promote well-being *(14)*. Community engagement is a critical governance enabler for equitable health planning and accountability, ensuring that priority-setting decisions reflect the needs of those most severely affected.

As external funding declines, community leadership becomes critical to sustaining services, especially for the populations most severely affected by HIV, viral hepatitis and STIs. Community-led structures and lay providers are often the first point of contact and are vital for ensuring that services remain trusted, accessible and responsive.

Community-based organizations have played a key role in delivering HIV, TB, viral hepatitis and STI services, including health promotion, disease prevention, rapid testing, treatment support, contact tracing and referrals. Given their visibility and trust within communities, community-based organizations are also well positioned to continue navigating people through the continuum of care for various health-care services.

WHO strongly recommends meaningful community engagement across the planning, delivery and monitoring of services. Evidence shows that community-led services – such as outreach, education, peer navigation and adherence support – are linked to improved service uptake, retention in care and reduced stigma *(15)*.

Countries can maintain these efforts by adopting system-wide adaptations that leverage community strengths and align with WHO frameworks on engagement, social participation, integrated service delivery and self-care *(16)*. The framework emphasizes five guiding principles: transparency, inclusiveness, trust-building, accountability and empowerment. Institutionalizing these principles within national governance and accountability frameworks enables community voices to influence strategic decisions *(17)*.

The UNAIDS Joint Programme guidance on optimizing community-led AIDS responses provides detailed actions and strategies to improve the health and human rights outcomes and can support the implementation at the country level *(18)*.

2. Baseline service disruption mapping

The following steps to assess service disruption can help guide adaptive responses and inform evidence-informed priority-setting and planning during transitions.

- **Assessing and monitoring the extent of service disruption**
  Health ministries, in coordination with key partners, should regularly assess the risks of service disruptions caused by funding constraints, workforce shortages, including donor-funded positions, or supply chain issues *(2, 15)*. Community-led monitoring can be effective in supporting the mapping of service disruptions. Such assessments should be governed by transparent protocols, with oversight from national steering bodies and mechanisms to ensure accountability across levels.
- **Ensure the timely and strategic use of data**
  Gather and interpret programme data to monitor service disruptions, identify emerging gaps and guide strategic responses during transition planning *(18)*. This enables adaptive planning and supports evidence-informed priority-setting

of the services at the most severe risk.

- **Real-time and retrospective programme data**
  Analyse data from interrupted services or at-risk programmes. Estimate the scope of disruptions and gaps in coverage of treatment and prevention services. Use both electronic and paper-based tools when needed to ensure data continuity and community-led monitoring *(18)*.

These insights inform which services require urgent intervention or phased adjustments under constrained budgets. More details are available in the section on evaluating and sustaining progress.

3. Baseline assessment of budget constraints

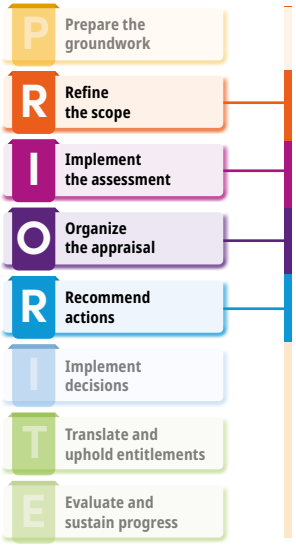
At the beginning of the process, the process should be framed in the context of budget constraint scenarios. During a funding shock, future fiscal and budget space can be hard to predict, but in the short term, obtaining estimates of planned funding changes and outlining possible short- and medium-term scenarios in terms of future budget availability are important. This can be important to determine the extent of priority-setting required and enable eventual priorities to be adjusted as different scenarios emerge. Importantly, any major areas of operational efficiency that may free up budgetary space for service delivery should be identified.

Key steps to assess the financing flow alignment with domestic systems and identify efficiency includes:

- assessing current and planned donor support and alignment with domestic systems and national priorities as a basis for reform and changes;
- assessing current and planned domestic fiscal and budgetary space, considering different policy responses; and
- using tools to identify potential efficiency gains by reprogramming or rechannelling existing or planned commitments (such as cross-programmatic efficiency analysis) and to monitor public financial management alignment as an initial assessment to inform later priority-setting and planning *(9, 16, 17)*.

This analysis helps to determine where external support can be sustained, integrated or redirected to preserve essential services. More details are available in the section on health financing.

5. Setting priorities for services in the context of reduced resources



As one of the six interdependent building blocks of the WHO health system framework, service delivery lies at the heart of health system performance. Although governance provides the overarching architecture for coordinated planning and accountability, service delivery translates policies into specific health outcomes *(11)*. In the context of HIV, viral hepatitis and STIs, ensuring continuity, quality and equity of services becomes even more critical when systems face funding constraints, workforce gaps or supply chain disruptions.

Anchoring service delivery decisions within this broader systems approach enables countries to protect health gains and address population-specific vulnerabilities and progress toward universal health coverage, even in the face of limited resources.

Section summary: This section provides scoping, assessment and appraisal guidance to support countries in setting priorities for HIV, viral hepatitis and STI services and interventions. It offers two key elements:

- guidance on the priority-setting process: a framework to help countries systematically identify and set priorities for services to maintain continuity, including an example of a rapid priority-setting approach countries can use to develop their own procedures while awaiting further WHO guidance; and
- setting priorities for indicative services and interventions: a structured, globally informed starting-point list of priority services for national adaptation, a stepwise approach that begins with essential services, aiming to maintain critical care and optimize health outcomes.

Note: Countries are encouraged to adapt this guidance based on local epidemiological, social and budgetary contexts and existing national mechanisms for setting priorities for services and technologies.

Planning and self-check questions

- Has a decision-making framework for setting priorities for services been clearly defined?
- Are all relevant stakeholders actively engaged in the scoping, assessment and validation processes to ensure contextual relevance?
- Have existing services and interventions been comprehensively mapped, aligning them with national and global policies?
- Are the priority-setting criteria transparent, evidence informed and agreed by multidisciplinary expert panels?
- Have robust processes been established for appraisal, validation and peer review to ensure transparency and accountability?
- Have services and interventions been categorized into the respective tiers, and have plans been developed for re-engagement as resources permit?
- Are the specific needs of vulnerable and marginalized populations being actively considered, and is there a mechanism for periodically reviewing and adjusting priority-setting decisions?

This guidance is intended to complement existing WHO institutional guidance on priority-setting and designing benefit packages, including the health technology assessment resource guide and the WHO guide on institutionalizing health technology assessment mechanisms, which should be used as the basis for the planned transition of services and to support country-led priority-setting systems *(19, 20)*.

During periods of instability, processes may need to be reapplied iteratively as funding or service delivery contexts shift. This guidance provides an overview of the steps that are typically used to consider the trade-offs and make explicit and ethically based decisions using structured expert input, defined criteria and practical tools to identify which services must be protected, scaled down or temporarily discontinued within available budget envelopes.

Priority-setting: scoping, assessment and appraisal

This section lays out the foundational process for setting priorities for services during resource constraints. Based on the values and principles introduced in the previous sections, these next four steps of the PRIORITE process aim to provide an adaptable priority-setting framework for rapid changes in funding that are in accordance with best practices but also consider experiences with adaptive health technology assessment for rapid decision-making around health interventions and technologies.

Refine the scope

First, priority-setting criteria and methods for analysis should be defined and a list of candidate interventions should be carefully selected through a stakeholder consultation process. This specifically entails the following.

- Mapping interventions: the responsible expert group or committee maps and compiles a comprehensive list of interventions to be considered in the priority-setting process. The basis of the list may be interventions that are already included in national policies and strategies. WHO recommendations and guidance can provide support for identifying granularities withing specific services and interventions that can support deciding the baseline list *(12)* Annex 1 lists all services and interventions proposed). At this stage,

defining interventions with sufficient specificity is critical, including distinctions between general population services and those tailored to specific population groups. This enables more accurate scoring against priority-setting criteria (see the section on tailored priority-setting considering population-specific needs).

- A set of criteria for setting priorities also needs to be selected and defined through a consultative process via the appropriate institutional structures. Priority-setting criteria help countries to decide which interventions are most critical by considering not just cost–effectiveness and efficiency (maximizing population health impact) but also such factors as equity and feasibility. This ensures that decisions are fair and effective, even when resources are limited *(13)* (see the section on defining priority-setting criteria). These criteria may already be established within existing health technology assessment or priority-setting processes.
- Other elements of the process, such as defining priority tiers, are also established and agreed at this stage.

> **"During periods of instability, processes may need to be reapplied iteratively as funding or service delivery contexts shift"**

Implement the assessment

Next, evidence is compiled and generated to assess the interventions against the criteria selected for priority-setting. When rapid decision-making is necessary and comprehensive evidence may be lacking for many of the priority-setting criteria, expert-led assessments and other health technology assessment methods may be conducted. In such cases, multidisciplinary panels of external experts systematically and independently assess each intervention against the agreed criteria using available evidence, fact sheets and expert judgement. Following individual scoring, the appropriate structures convene to review and compare the scores and establish scores for each intervention. Any discrepancies in the scoring should be clearly documented and explained to ensure transparency and inclusiveness in the priority-setting process.

Organize the appraisal

Once the assessment has been completed, each intervention is appraised and allocated to a tier through a deliberative process designed to ensure transparent, inclusive and evidence-informed decision-making.

- Deliberation and categorization of interventions: based on the scoring, interventions may be recommended for inclusion or exclusion or grouped into priority levels or tiers. This step enables the categorization to be deliberated and validated (see the subsection on the stepwise priority-setting approach). As a result of the deliberation, recommendations for priority-setting for services and interventions are brought forward for a final decision.
- At the country level, this appraisal should set priorities for different budgetary scenarios, since all challenging decisions should be made as part of the explicit process adhering to ethical principles rather than during implementation. In some cases, this requires a two-stage process: appraisal with intervention-specific experts and then a further process with a health sector–wide group of experts who can consider overall financing and health system considerations.
- Peer review: the lists of services and interventions with priorities set are reviewed by peer reviewers (outside the expert group) to validate the categorization, identify potential gaps and reinforce the credibility of the final output.

Recommend actions

Based on the results of the assessment and appraisal and through subsequent deliberation by the committee or governance structure responsible for making the final decision, a final list of services or interventions to be sustained, temporarily given lower priority or assessed again at a later time is then formulated. This step involves presenting the initial results, facilitating additional deliberation and validating the priority-setting process to ensure broad buy-in and transparency. Mechanisms for ensuring that the results of the appraisal are considered in the decisions should be built in (for example, written justification for any divergence from the results of the appraisal may be required).

Stakeholder participation and consultation are typically required at several points of the process, such as when selecting the criteria and/or interventions for consideration, when designing the priority-setting approach or when conducting the assessment or appraisal. As such, appropriate mechanisms for stakeholder involvement need to be established (for more guidance on mechanisms, please refer to *Voice, agency, empowerment: handbook on social participation for universal health coverage (21)* and forthcoming operational guidance for strengthening social participation in universal health coverage priority-setting processes for sexual and reproductive health). The final goal of these consultations is to review and validate the process and the results, ensuring contextual relevance, transparency and stakeholder ownership (including communities and civil society organizations).

Assessment methods and results

The assessment step is a rapid evidence review and scoring process that evaluates proposed health interventions against explicit criteria. Assessment uses evidence, including, as mentioned above, evidence generated from expert judgement, to clarify how well options fulfil agreed goals (such as health impact and equity) while recognizing that ultimate decisions require deliberation and judgement. Thus, the results of the assessment phase serve as a guide and not an automatic rule for what should be given priority. An evidence-informed, deliberative approach should be emphasized: data are systematically reviewed but the appropriate committee or group discusses and interprets the findings before any action is taken. This helps to ensure that the process is fair and transparent, with evidence providing input to a decision-making dialogue. The assessment step thus sets the stage for informed discussion, making trade-offs explicit without dictating the outcome.

"The final goal of these consultations is to review and validate the process and the results, ensuring contextual relevance, transparency and stakeholder ownership

Defining priority-setting criteria

To assess each intervention fairly and comprehensively under a funding shortfall, the assessment should use a framework with multiple criteria. Priority-setting criteria should reflect the ethical principles presented previously, reflecting a balance of efficiency, equity, social and economic impact and feasibility, considering local health technology assessment or priority-setting processes.

The following subsection provides examples of priority-setting criteria such as disease burden, feasibility, cost–effectiveness and equity (as previously outlined in this guidance) that are commonly used to guide priority-setting exercises in a transparent and evidence-informed manner. These criteria help ensure that priority-setting decisions are consistent with broader health system goals and population health needs.

However, countries are encouraged to recognize that additional context- and disease-specific criteria may be required based on local realities and stakeholder perspectives (such as progress towards the 95–95–95 global targets). Expert groups and multidisciplinary panels should have the flexibility to identify and incorporate such criteria as needed, ensuring that priority-setting remains both comprehensive and responsive to the unique challenges and opportunities within each country context *(10, 13)*.

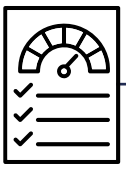
This non-exhaustive list is a starting-point that can help countries to identify which criteria may best fit their exercise for making decisions on priority-setting and ensure that they can make transparent, evidence-informed decisions that protect health outcomes and equity, even under resource constraints (Table 1).

Table 1. Possible criteria for making decisions on priority-setting for services and interventions

Criteria	Description	Explanation
Health impact and effectiveness	Expected magnitude of improvement in population health outcomes and reduction in disease burden from the intervention	Assesses the magnitude of reduction possibly from the service or intervention on morbidity and mortality. High-impact interventions have strong evidence (such as large trials or meta-analyses) of effectively preventing infections or saving lives and are likely to address large proportions of the population in need. Lower-impact interventions may target less prevalent causes or have limited efficacy and effectiveness.
Cost–effectiveness	The magnitude of population health gains relative to costs compared with alternative uses of resources	Evaluates whether the intervention will improve or reduce population health within the health sector funding by comparing the health gains of the intervention to the gains for displaced services from alternative uses of the funding. The metric used is cost per unit of health outcome such as a DALY or quality-adjusted life-year. A highly cost-effective intervention has a low cost per DALY averted compared with other interventions provided within the current health sector budget.
Equity considerations	Extent to which the intervention benefits those who are most in need, marginalized or vulnerable and reduces disparities	Gives priority to interventions that protect those most at risk or who face access barriers. An intervention scoring high on equity preferentially reaches those who are most in need, key populations (such as sex workers, gay men and other men who have sex with men, people who inject drugs and impoverished communities) or regions with high disease burden and poor services. Lower equity scores indicate that an intervention primarily benefits groups already better off or has minimal impact on reducing disparities.

Table 1. Possible criteria for making decisions (cont'd.)

Criteria	Description	Explanation
Feasibility and health system capacity	Practicality of implementing the intervention with existing infrastructure and human resources	Gives priority to interventions that can be delivered within the existing infrastructure and system capacity. An intervention scoring high on feasibility and health system capacity can be delivered without requiring additional capital investment (such as facility infrastructure and human resources). A lower feasibility and health system capacity score indicates that an intervention cannot be delivered immediately within the existing infrastructure and available resources but would require additional investment.
Financial sustainability and budget impact	The cost of the intervention relative to available domestic public sector resources	From an economic perspective, health sector resources should be allocated to the interventions with the highest health impact. However, in some cases, interventions take up large proportions of the overall budget. High-sustainability interventions have low absolute cost or are co-funded by domestic budgets already and thus can be continued with minimal disruption. This criterion also flags interventions that, although effective, might consume a large portion of the government health budget. Lower scores indicate interventions likely to be financially untenable under current fiscal space or those whose cessation would free up substantial funds for reallocation.
Acceptability	The degree to which the intervention is accepted, culturally appropriate and trusted by the communities it is intended to serve	Acceptability is a multidimensional construct. The focus should be on the acceptability to the communities where the intervention is intended. This includes both those receiving and delivering the intervention. Although acceptability may intersect with other criteria (such as feasibility or equity), it focuses specifically on community perspectives, values and willingness to engage.
Social and economic impact	Broader impact of the intervention, including contributions to productivity, educational attainment and poverty reduction	Assesses the social and economic impact the intervention may have on productivity, educational attainment and poverty reduction in accordance with national development priorities. Also considers potential economic burdens on households – such as income loss from illness or financial hardship from out-of-pocket payments, especially if the intervention is not accessible or affordable.



Scoring process: Criteria may be scored in different ways. For rapid exercises, a simple colour-coded scoring may be used as a minimal approach for scoring each criterion: green, yellow or red indicating high, moderate or low performance on that criterion. Table 2 presents guidance on how common criteria may be scored (Annex 2 has a complete scoring threshold table).

Table 2. Example of scoring thresholds

Score	What it means	Criteria
High	Strong value for money	Consistent evidence suggesting an incremental cost per DALY averted <0.5 times GDP per capita or cost-saving
Moderate	Acceptable value	Consistent evidence suggesting an incremental cost per DALY averted between 0.5 and 1 times GDP per capita
Low	Weak value for money	Limited evidence of an incremental cost per DALY averted >1 times GDP per capita
Criteria	**Impact**	**Explanation**
Health impact and effectiveness	High	Robust evidence that the intervention substantially reduces the disease burden by reducing transmission or by improving survival or outcomes (such as a large effect size or >x% reduction in incidence)
	Moderate	Evidence shows moderate effect on the magnitude of population outcomes (such as smaller or context-dependent impact) or the intervention addresses a more limited segment of the epidemic
	Low	Little to no evidence of significant health outcome improvement or the intervention targets a very small portion of the burden with minimal overall impact
Cost–effectiveness	High	Consistent evidence suggesting an incremental cost per DALY averted <0.5 times GDP per capita or cost-saving
	Moderate	Consistent evidence suggesting an incremental cost per DALY averted between 0.5 and 1 times GDP per capita
	Low	Limited evidence of an incremental cost per DALY averted >1 times GDP per capita

Even when evidence is limited and expert opinion is used, a structured scoring process will improve consistency and transparency. The expert group or committee responsible for the assessment should apply the chosen criteria to each intervention under review.

Preparing formal evidence summaries on costs Cost–effectiveness and impact or other criteria may not be feasible within a very short time frame. Nevertheless, several global resources can support this process, including this guidance, and Box 5 provides further information.

In some cases, generating rapid evidence on the impact and cost–effectiveness of interventions and combinations of interventions may be possible using modelling *(22)*. Multiple tools are available for modelling the resources required. Many of these tools also enable projections of the associated changes in health status or health impact. For HIV, WHO and UNAIDS commonly use the AIDS Impact Model and GOALS models to project HIV health outcomes such as the number of people acquiring HIV, the number of people developing AIDS and the number of people dying from HIV-related causes. The AIDS Impact Model and GOALS models are directly linked to the Resource Needs Model, which estimates the costs of implementing HIV and AIDS activities.

In addition to these HIV-specific models, WHO supports the use of sector-wide analysis that enables users to generate scenarios for more services than just HIV. Similarly, the Syphilis Interventions Towards Elimination tool exists as a dynamic transmission model to evaluate and project the impact, cost and cost–effectiveness of syphilis interventions (screening, treatment and prevention) to support national control programmes *(23)*. Using modelling approaches with existing tools and prepopulated data, planners can rapidly generate scenarios to project the impact on health outcomes under different scenarios *(18, 24–26)*.

For each intervention, experts should review any available evidence but also consider their expert knowledge corresponding to each criterion. However, even while using shortcuts, good principles of evidence-informed practice should be maintained. Keep in mind the interim nature of such a rapid assessment under urgent circumstances: its findings can later be revisited or refined when more data or time becomes available. The intent is not to conduct a perfect assessment and appraisal but to use the best possible evidence to guide urgent decisions.

Fact sheets may be prepared to help in understanding scoring thresholds and to ensure that scoring is done consistently across experts (see fact sheet examples in Annex 3). Before scoring, ensure that all group or committee members understand the threshold definitions by jointly scoring a pilot example intervention to test whether everyone interprets the thresholds consistently.

Initially, each expert or small breakout groups can assign preliminary scores (such as green, yellow and red) for each criterion and each intervention. A scoring sheet should be prepared for this exercise (see the scoring sheet example in Annex 4).

"Rapidly synthesizing evidence on cost-effectiveness requires using approaches that balance speed and rigour"

Box 5. Rapid evidence synthesis

Rapidly synthesizing evidence on cost–effectiveness requires using approaches that balance speed and rigour. Since the timelines for conducting a full systematic review or developing a new cost–effectiveness model are not feasible, approaches that synthesize existing literature and transfer or adapt them to the setting of interest should be used. Rapid synthesis methods enable informed decisions in settings with limited data, time or capacity and help to identify which interventions offer the best value for the resources available. These approaches generally consider the drivers of cost–effectiveness across contexts, including epidemiology, costs and health system characteristics. These methods enable countries to reduce the time required to conduct assessments, but considerable expertise and capacity is still required to implement them. They may need to be revisited more frequently and validated in the short term as well. In addition, the uncertainty of the evidence needs to be optimally maintained and clearly reported. For further information on or technical support for rapid synthesis approaches, please contact the WHO-CHOICE team (whochoice@who.int).

Once individual scoring is done, the full group or committee should convene to agree on consensus scores. To do this, each intervention would be discussed criterion by criterion, focusing on any divergences. For example, if one expert scored an intervention "green" for feasibility and another "red", the facilitator or chair could invite them to explain their reasoning and evidence. Through dialogue, the panel should seek a consensus score for each criterion or at least understand the range of views.

With the criteria in place to ensure that priority-setting decisions are comprehensive and grounded in evidence and values, countries can then operationalize these decisions through a structured approach.

Organizing appraisal

Once consensus scoring is finalized and the assessment is completed, its results can be used to inform and structure (not replace) the appraisal. The aim of the appraisal is to review the assessment results and to use them to inform recommendations for the final decisions.

As part of the appraisal process, the responsible expert group or committee, which may or may not be the same as the one conducting the assessment, deliberates through one or more consultative meetings. The scores are a starting-point to highlight the strengths and weaknesses of each option. During deliberation, qualitative nuances should be noted. For example, an intervention might score "yellow" on impact because of limited data, but if it addresses a severe inequity, the group or committee might still consider it essential.

Stepwise priority-setting approach

A stepwise approach for priority-setting for services and interventions in the context of reduced resources supports a structured, adaptive and transparent decision-making process based on resource availability and emerging needs.

Countries may choose to use tiers to clearly differentiate services and interventions that must continue to be funded, those that can be temporarily reduced or paused and those that can only be supported if additional resources become available. Such an approach supports dynamic adjustments in the scope and reach of services and interventions as resource availability and country contexts evolve. Fig. 6 presents an example of the use of three tiers to categorize and set priorities for services.

In this example, countries begin with tier 1, which includes services and interventions that must continue under any circumstances. Tier 2 includes services that remain important but may be temporarily limited or paused, with a commitment to review and potential re-engagement in the short term (such as within six months). Tier 3 comprises services and interventions that cannot be continued until additional resources become available. Any approach used should align with national priorities and service delivery contexts. In some cases, countries may choose to combine tiers (such as from three to two), redefine or split (such as from two to three or more) tiers to better reflect their situation, but all may have specific limitations and might need to be re-evaluated. Countries might choose to include more extensive definitions and remove qualifiers (Table 3).

"The aim of the appraisal is to review the assessment results and to use them to inform recommendations for the final decisions"

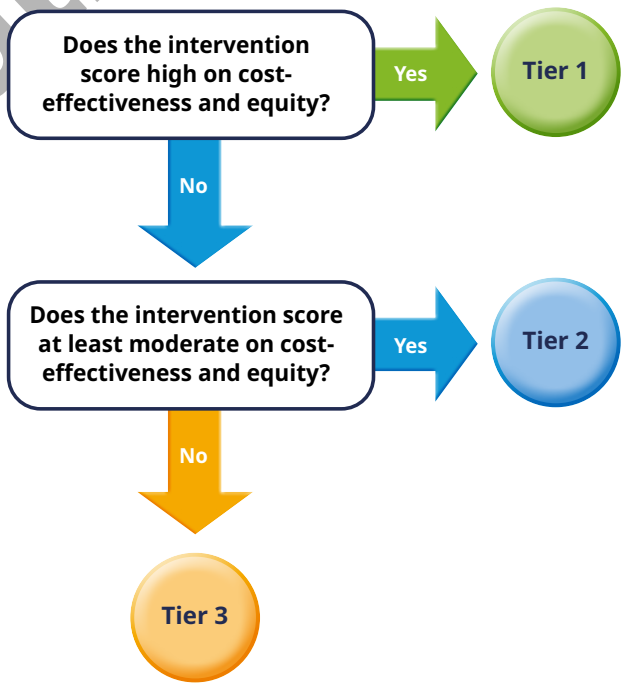
Table 3. Example of a tiered approach for priority-setting for services and interventions in the context of reduced resources

Tier 1: essential	Tier 2: important	Tier 3: expanded
Must continue to fund	May not be able to fund at this time because of limited funding but important to re-evaluate in the short term	Not possible to continue to fund until additional resources become available

Note: The term "essential" is only being used for the context of this exercise under the present conditions of severe cuts and is not to be generalized or made equivalent to other contexts in which the term essential is used while resources are available (such as the COVID-19 pandemic, in which essential services were identified, but funding was not the main reason for the disruption).

Decision rules (or in some cases weighting) related to criteria scoring may also be established to guide the appraisal process (Fig. 5). These can serve as a starting-point to identify preliminary recommendations that can then be evaluated and modified through deliberation. For rapid decisions, however, quantitative multi-decision criteria analysis is not recommended because of the underlying uncertainty around both the evidence and robustness of any rapid processes to establish criteria weights. It is important to document the deliberation and to transparently document the group or committee's final recommendation, the stakeholder views and rationale for the recommendations and areas of ongoing disagreement or uncertainty. The ideal outcome is that, through deliberation, the panel reaches a consensus on the relative priority and therefore a recommendation regarding the status of each intervention. If consensus cannot be reached on a particular point, a fair mechanism (such as a majority vote) can be established to finalize the recommendation.

Fig. 5. Example of decision rules for preliminary assignment into tiers



Note: This exercise should be undertaken within a clearly defined time frame to enable decision-makers to assess the implications of delayed or halted investments. By doing so, countries can better plan for future transitions, mitigate disruptions in service delivery and sustain health outcomes.

Tailored priority-setting considering population-specific needs

The impact of service disruptions can vary across populations, and ensuring that priority-setting decisions do not exacerbate health inequities is therefore important. Moreover, in some cases services that are not cost-effective on average may be provided to specific populations. Considering allocation to tiers with subpopulations in need may therefore be important.

For example, service disruptions may have a greater impact on populations already facing barriers to health care. During priority-setting, tailored approaches are needed to ensure equity, continuity of access and service responsiveness. Setting priorities for services should be informed by the local epidemiological context, including the prevalence of HIV, viral hepatitis and STIs among population groups. Considering the type of epidemic (such as generalized or concentrated) is also important to ensure that services are appropriately tailored and resources are allocated in ways that maximize health outcomes.

Differentiated prioritization means that although the tiering framework offers a broad categorization of interventions by level of importance, population-specific considerations – such as those outlined in this section – are intended to guide more nuanced priority-setting within tiers. Countries should use local epidemiological and service disruption data to identify where interventions in tiers 2 or 3 may remain essential for certain populations. This approach ensures that vulnerable groups are not left behind and that resources are allocated based on both overall public health value and equity in access (Table 4). Countries should consider that, even when a service or intervention has been categorized as tier 2 or tier 3 (in accordance with the above example) for the general population, the service may remain essential for specific populations. This underscores the need to go beyond the broad tier categorization and apply a population-specific lens to ensure that all groups continue to have equitable access to services that are critical for their health and well-being (Annex 1 provides details on the interventions and services across the cascade).

Planning and self-check questions

- ☐ Are population groups involved in planning and monitoring processes?
- ☐ Does the priority-setting plan consider the specific access needs and preferences of each group?
- ☐ Are disaggregated data (by age, gender and population group) being used to inform priority-setting decisions?
- ☐ Is the prevalence of HIV, STIs and hepatitis among specific groups used to guide service priorities?
- ☐ Are services aligned with the type of epidemic (generalized, concentrated or low-level)?

The population group barriers and needs highlighted in this section represent aspects that should be considered as potentially keeping specific populations from accessing HIV, viral hepatitis and STI services during disruptions. However, each country's context is unique and may also require tailoring approaches to fit inevitable service delivery changes. Countries are therefore encouraged to systematically assess their own contexts and identify which of these populations may face disproportionate effects from service disruptions. This ensures that priority-setting efforts are both inclusive and equity focused.

Addressing stigma and discrimination in service delivery settings is critical to ensuring equitable access and continuity of care for populations who face systemic and social barriers. Tailored prioritization should incorporate measures to reduce stigma and promote respectful, rights-based, and person-centred care.

Common barriers to maintaining engagement in HIV, viral hepatitis and STI services

These barriers are consistently observed across population groups and are likely to be exacerbated if not adequately addressed during funding cuts and service disruptions:

- stigma, discrimination and fear of disclosure;
- limited availability of flexible and tailored services, especially for children, adolescents, caregivers and key populations;
- fragmentation or lack of integration between services (such as HIV, maternal health and child health services) can create additional barriers during critical periods, including transitions from paediatric to adult care or during pregnancy and postpartum periods;
- inadequate understanding of treatment needs and service delivery options, especially among children, adolescents and caregivers;
- competing social and economic priorities, such as work or caregiving responsibilities;
- lack of peer or community support and safe spaces; and
- reducing the priority of services for vulnerable groups during funding cuts can further marginalize those already at risk, reversing hard-won gains in health equity.

Key considerations for aligning priority-setting for services with population needs:

- use local data on the prevalence of HIV, viral hepatitis and STIs among specific populations to inform priority-setting for services and resource allocation;
- align services with the type of epidemic (generalized, concentrated or low-level) to ensure that they are appropriately targeted and efficient; and
- identify and protect the minimum essential services that address the needs of the most vulnerable and marginalized populations, even when resources are constrained.

Table 4. Interventions in tiers 2 or 3 that may remain essential for certain populations

Pregnant and breastfeeding women	
Persistent barriers and amplified disruptions	• Interruptions in services can compromise both maternal health and child survival, particularly through missed early testing and treatment, which may lead to new infections among children *(3)*. • Pregnancy-related health issues, fear of disclosure and infant health concerns add barriers. • Reduced availability of integrated services and testing (for HIV, syphilis and hepatitis B) further increases these barriers.
Ensuring continuity of access (how?)	• Maintain uninterrupted access to HIV, STI and hepatitis B testing and treatment through maternal and child health platforms, including antenatal, delivery and postnatal care. • Postnatal prophylaxis for HIV-exposed infants is critical, especially if the mother's suppressed viral load is not assured *(15, 27)*.
Programmatic priorities (what?)	• Services for male partners and household contacts should be included and expanded to strengthen prevention outcomes and reinforce shared responsibility *(15)*.
Recommended actions	• Give priority to timely HIV testing and immediate ART initiation for pregnant and breastfeeding women, ideally on the same day. • Use routine maternal and child health platforms as opportunities to deliver HIV, STI and hepatitis B services *(28)*. • Tailor outreach and re-engagement strategies to reach pregnant and breastfeeding women who are lost to follow-up *(29)*.
Infants, children and adolescents	
Persistent barriers and amplified disruptions	• Infants and children living with or at risk for HIV often experience rapid disease progression compared with adults. • Many rely on additional nutritional and educational support through programmes for orphans and vulnerable children *(30)*. • Dependence on caregivers, limited understanding of HIV status and service fragmentation increase the risks of missed care. • Adolescents require tailored psychosocial and adherence support to maintain uninterrupted access to care. These services are frequently provided by peer supporters and lay providers, whose roles may be lost if they depend on external funding.
Ensuring continuity of access (how?)	• Health systems must ensure uninterrupted availability of child-appropriate HIV, viral hepatitis and STI diagnostics and medicines, including timely infant testing and age-appropriate antiretroviral drug formulations *(15)*. • Adolescents should have access to adolescent-friendly services that are confidential, non-judgemental and responsive to their needs *(31)*.
Programmatic priorities (what?)	• Ensure that paediatric medicines and commodities for infant diagnosis are included in planning. • Adolescents should have access to psychosocial interventions integrated within HIV services, in accordance with WHO guidance *(31)*.
Recommended actions	• During priority-setting processes, countries should refer to the WHO compendium of interventions for adolescents and young adults living with and affected by HIV, which promotes practical, contextual and sustainable approaches *(31–33)*. • Challenges related to adherence and retention should be addressed through peer-driven, adolescent-friendly and responsive service models within integrated care systems *(34)*.

Table 4. Interventions in tiers 2 or 3 (cont'd.)

Women and girls	
Persistent barriers and amplified disruptions	• Women and girls may fear disclosing their HIV status due to anticipated stigma or violence, including intimate partner and sexual violence. • Young women and girls engaging in transactional sex may face high risk but fall outside traditional sex worker programmes, remaining underserved. • Funding cuts risk giving lower priority to services tailored to the needs of women and girls, especially related to violence and reproductive health.
Ensuring continuity of access (how?)	• Integrate HIV, viral hepatitis and STI services with sexual and reproductive health platforms. • Ensure consistent availability of essential services through maternal and child health platforms.
Programmatic priorities (what?)	• Use community networks to reach young women who engage in high-risk practices but are not captured by existing service entry points.
Recommended actions	• In low-resource settings, preserve integrated maternal and child health and HIV services to support care across the life-course. • Ensure that data collection captures age, gender and risk behaviour to better identify and respond to overlooked subgroups, including young women in transactional sex.
Key populations	
Persistent barriers and amplified disruptions	• Key populations – including gay men and other men who have sex with men, sex workers, people who inject drugs, trans and gender-diverse people and people in prisons – face multiple structural barriers to accessing care, often compounded by stigma, discrimination and criminalization. • Services tailored for their needs often depend on external donor funding and are not given priority in national budgets, often because of political sensitivity and criminalization policies *(4, 35)*.
Ensuring continuity of access (how?)	• Community-based, peer-led service delivery models are often the only trusted and accessible service channels for key populations and must be sustained. • National political will, decentralization of services, integration into national plans and protection of community-led systems that can operate even under constrained environments are important for continued access to services *(34, 36)*.
Programmatic priorities (what?)	• To ensure equitable access to HIV, viral hepatitis and STI services, programmes must give priority to key populations across the prevention, testing (in particular using HIV self-testing), treatment and care cascade and detection and treatment of STIs. • Services should remain accessible through both community-based and facility-based settings, including PHC, where stigma and discrimination should be proactively reduced *(36, 37)*.
Recommended actions	• Engage peer navigators to help to mitigate the effects of facility-based stigma, while virtual and digital interventions offer additional pathways for prevention, treatment and care. • Collaborate directly with key population networks to identify safe, effective service delivery channels with greater reach *(36)*.

Table 4. Interventions in tiers 2 or 3 (cont'd.)

Boys and men	
Persistent barriers and amplified disruptions	• Men are underrepresented in health services and must be addressed alongside HIV. • The abrupt funding crisis may exacerbate already significant gaps in service access for men.
Ensuring continuity of access (how?)	• Countries are encouraged to leverage WHO guidance on engaging men in person-centred, integrated health services across HIV and other related areas. • WHO has published a package of evidence-informed interventions available for men *(38)*.
Programmatic priorities (what?)	• Platforms effective in reaching men (such as workplaces, community-based services and faith-based initiatives) should be leveraged and adapted to reach others as well. • Men have diverse experiences and identities, with specific but diverse health needs. Men should be reached in all their diversity, paying particular attention to men from key populations and marginalized groups.
Recommended actions	• Approaches to reaching men should be context specific and integrated within health systems. • Countries should focus on leveraging routine entry points for men into health systems, including outpatient and community-based services that encompass workplace and faith-based approaches. Social network approaches for testing and distribute HIV self-testing can be useful. • Other approaches, including self-care and virtual interventions, can be used to expand reach, along with peer-led supportive services. • Faith-based organizations could be strategically positioned to address gaps since they possess trusted networks that extend deep into communities *(38, 39)*.
Migrants and displaced populations	
Persistent barriers and amplified disruptions	• Unplanned or forced mobility often interrupts HIV, viral hepatitis and STI care. • Language, documentation and unfamiliarity with services hinder access. • Stigma, fear of deportation and discrimination reduce care-seeking. • Funding cuts can eliminate migrant-friendly services such as mobile outreach.
Ensuring continuity of access (how?)	• Provide multimonth ART refills to reduce facility visits. • Offer flexible, community-based services at border areas and worksites. • Issue and accept client-held medical records and treatment cards to ensure care continuity across locations, especially when formal transfer systems are not feasible.
Programmatic priorities (what?)	• Maintain simplified, non-discriminatory access to testing and treatment regardless of legal status or documentation.
Recommended actions	• Integrate migrant services into primary care using task sharing. • Partner with civil society or migrant networks to reach displaced populations. • Ensure coordination between health facilities, humanitarian agencies and national programmes to reduce the fragmentation of services for displaced individuals.

Table 4. Interventions in tiers 2 or 3 (cont'd.)

Older people	
Persistent barriers and amplified disruptions	• Service disruption and funding reduction may affect both HIV and the management of age-related comorbidities. • Older people living with HIV often manage ART alongside multiple treatments, increasing the risk of polypharmacy and adverse drug reactions. • Disruptions may delay diagnosis, access to ART and clinical monitoring, all of which are often already delayed in this group *(40–42)*.
Ensuring continuity of access (how?)	• Integrated care (such as from health promotion to palliative care) is vital for the well-being of older adults living with HIV. • Their needs often span health-care and social support, and services must be people-centred and multidisciplinary. Stigma and discrimination related to both age and HIV further increase risk *(43, 44)*.
Programmatic priorities (what?)	• Recognize that older individuals may face multiple forms of stigma – including ageism, ableism and sexism – in addition to HIV-related discrimination *(45, 46)*.
Recommended actions	• Give priority to integrating HIV into other health and care services (primary care health centres etc). • Build the capacity of health and care workers to meet the specific needs of older people living with HIV. • Including long-term care (such as home- and community-based care and support, rehabilitation, assistive devices and palliative care) within universal health coverage or social protection packages to ensure sustainable financing and equitable access for older people living with HIV *(43, 47, 48)*.

Formulating and finalizing decisions

After the assessment and appraisal processes are completed, the designated committee or group responsible should prepare a summary for presentation to the decision-making authority (commonly senior leadership in health ministries). Based on the findings, they should compile a definitive list of services or interventions to be sustained, temporarily given lower priority or earmarked for future reassessment. The final decision-making phase must be informed by evidence from the appraisal and guided by agreed criteria to promote fairness, consistency and strategic alignment with broader goals.

Engaging in follow-up stakeholder consultation

After the initial categorization of interventions, and if time permits, a second round of structured consultation may be undertaken with key external stakeholder groups around the final decision. This phase would involve sharing the preliminary outcomes of the priority-setting exercise, facilitating open dialogue and further deliberation and soliciting feedback to validate the results. The purpose of this step is to enhance transparency, build consensus and strengthen legitimacy and ownership of the final decisions.

Ensure accountability and integration of appraisal results

To maintain the integrity of the decision-making process, clear mechanisms must be established to ensure that the final decisions directly reflect the outcomes of the assessment and appraisal. For instance, any departure from the appraisal findings should require formal written justification. Such accountability measures help reinforce transparency and ensure that decisions are evidence informed while enabling flexibility if broader contextual or strategic considerations justify deviation.

Results from a rapid global assessment exercise: indicative stepwise priority-setting for HIV, viral hepatitis and STI services

This section outlines the results from a rapid global priority-setting exercise led by WHO to develop a structured, transparent, inclusive and evidence-informed list of starting-point service interventions with priorities set for HIV, viral hepatitis and STIs. WHO will also provide further guidance for processes and procedures for country-led priority-setting of all health-care services in the forthcoming interim WHO guidance for evidence-informed deliberative priority-setting in health.

This rapid assessment exercise provides an indicative global analysis of priorities for sustaining HIV, viral hepatitis and STI services based on WHO normative guidance and input from global experts (Table 5). The exercise focused on one scenario – a high-burden, generalized epidemic in low- and middle-income countries – to enable rapid, high-level priority-setting. However, this scenario is limited in scope and does not account for the full diversity of country contexts, specific population needs or local social, political and economic dynamics. Country-level implementation should consider subnational priority-setting, with a focus on prevention among the populations driving the epidemic and in areas with the highest transmission, guided by local epidemiological evidence. As such, the global assessment should be viewed as a starting-point for discussion and not as prescriptive for country-level implementation.

In contrast, the PRIORITE framework that forms the basis of this guidance offers a comprehensive, participatory process for countries to establish country-owned, context-specific priorities. Countries should carefully interpret the results of the global assessment, adapting recommendations to reflect local circumstances, engaging stakeholders, ensuring equitable and acceptable service delivery and incorporating sustainable implementation, financing and monitoring plans.

Countries are encouraged to set priorities based on their epidemiological profile, health system capacity, population needs and locally appropriate and criteria as outlined in the preceding sections.

Note: The recommendations resulting from this exercise are meant to be indicative starting point for country discussions, as due to their global nature, they do not fully account for context complexities. They are not meant to replace country processes but to serve as a transparent process to guide downstream priority-setting (Table 5).

Table 5. Rapid global assessment exercise process

Key steps	Description
Mapping intervention and services and developing an assessment framework	Services and interventions were mapped, drawing on WHO normative guidance, technical documents and global standards. Adapted from the PRIORITE framework, a rapid priority-setting framework was developed to guide the rapid assessment and scoring of interventions, incorporating recognized health technology assessment principles.
Expert and stakeholder consultations	External expert groups reviewed the initial priority-setting framework and the mapped interventions. These panels included representatives from affected communities, governments, technical partners and researchers from all WHO regions. Their input was essential to ensure the framework's relevance, feasibility and alignment with country realities.
Ethics and Governance Steering Group review	The WHO Ethics and Governance Steering Group reviewed the draft priority-setting framework and mapping exercise to ensure alignment with ethics principles.
Evidence-informed deliberative assessment	The priorities for services and interventions were set using a set of six criteria: health impact and effectiveness, cost–effectiveness, equity considerations, feasibility and health system capacity, budget impact and social and economic impact. Interventions were scored, and this scoring step served as a guide rather than a prescriptive rule and informed deliberative consultations. This provided a basis for the preliminary assignment of services and interventions into tiers.
Consensus-building and peer review	The WHO Economic Evaluation and Analysis Unit consolidated the priority-setting results. Deliberative consultations enabled explicit consideration of trade-offs and the WHO Steering Group (including representatives and experts from all WHO regional offices) guided the final consensus on the priority-setting outcomes.

Note: The 24 external experts stated that the indicative tiered priority-setting of services and interventions presented in this section could not reflect the complex balance between population health needs, political and legal environments and the feasibility of implementation within constrained budgets but is based on the criteria provided in the table above. Tier 2 should not equate to permanent lower priority. In the real world, countries would need to re-evaluate, implement context-specific adaptations and invest in health system strengthening to expand equitable access to these important services as resources allow.

Expert engagement summary

A total of 24 individuals supported the global assessment and deliberation process at different stages, through a structured and inclusive approach. Contributors were identified through multiple channels such as WHO regional/country offices and technical departments references, through the civil society and community reference group on the HIV service crisis and the CQUIN network. Invitations were extended to individuals from ministries of health, research institutions, community and civil society organizations, implementing partners and donor agencies. A second outreach was conducted to promote balance across sectors and regions. The group demonstrated strong gender balance (14 women, 12 men) and regional diversity, with participants from all six WHO

regions: 11 from the African Region (AFRO), 4 from the Eastern Mediterranean (EMRO), 3 each from the Americas (AMRO), Europe (EURO), and South-East Asia (SEARO), and 1 from the Western Pacific (WPRO). Institutional representation included ministries of health *(5)*, civil society and community-based organizations *(6)*, academic/research/ clinical institutions *(8)*, and implementing partners *(5)*. Importantly, three participants openly represented the community of people living with HIV (PLHIV), ensuring meaningful inclusion of lived experience from national, global, and service delivery perspectives.

All technical contributors had expertise in at least one area of the HIV service cascade (prevention, testing or treatment). Additional areas of expertise included: sexually transmitted infections, viral hepatitis, mental health, service integration and differentiated service delivery, key population programming, harm reduction, digital health and informatics, and health systems strengthening.

Ultimately, the 24 experts contributed across various phases of the process. Of these, 17 joined the initial consultation session, 14 participated in the global assessment exercise, 9 of those also joined the deliberation meeting, and 10 provided peer review of the draft report.

Assessment and appraisal methods in the global priority-setting exercise

Each expert from the group of 23 external experts received a presentation and materials explaining the assessment process and the subsequent steps and was invited to score the interventions against the criteria, using the scoring sheet, fact sheets and synthesis of cost–effectiveness evidence provided. Experts were advised to assume the perspective of a low- or lower-middle-income country with a generalized HIV epidemic when

Table 6. Example of summary scores and preliminary tier assignments

HIV PrEP					
Criteria	**Summary of scores**				**Overall score**
	Green	**Yellow**	**Red**	**Cannot score**	
Health impact and effectiveness	3	11	0	0	🟠
Cost–effectiveness	4	7	3	0	🟠
Feasibility and health system capacity	4	6	4	0	🟠
Equity and vulnerability	11	2	1	0	🟢
Budget impact	3	4	7	0	🟠
Social and economic impact	7	6	1	0	🟠

• Preliminary assignment to tier: **tier 2** • Final assignment to tier: **tier 2**

Notes for deliberation: Three experts indicated that this intervention is not cost-effective. Further, seven experts determined that this intervention had a high budget impact, and four determined that it had low feasibility. Do these considerations affect the tier assignment?

assigning the scores. Once scores were received, they were first checked for errors and adjusted if needed. Individual scores were then combined into preliminary cumulative group scores per intervention and per criterion using a weighted average, with the following weights:

- Green – 3
- Yellow – 2
- Red – 1.

When "cannot score" was selected, these instances were excluded from the calculation of the cumulative score. Interventions were then initially assigned to tiers using the algorithm in Table 6.

The appraisal was conducted through one virtual consultative meeting chaired by WHO. During the meeting, summary scores and preliminary tier assignments were presented for each intervention along with preliminary considerations for deliberation (Fig. 6).

For each intervention, experts were invited to voice their opinions either verbally or through the meeting chat function. If diverging opinions were presented, the final tier assignment was assigned based on the judgement of the majority of the experts. The appraisal resulted in a list of interventions categorized into either tier 1 or tier 2.

Informed by the experts' recommendations, the WHO Steering Group – comprising experts from the headquarters, regional and country levels – then conducted final deliberation to finalize the categorization of interventions. This categorization underwent peer review as part of the broader operational guidance document (Fig. 6–8). Any decisions that diverged from the experts' recommendations were transparently justified and documented.

"During the consultative meeting chaired by WHO, summary scores and preliminary tier assignments were presented for each intervention along with preliminary considerations for deliberation"

Fig. 6. Prevention: Results from the rapid global assessment exercise

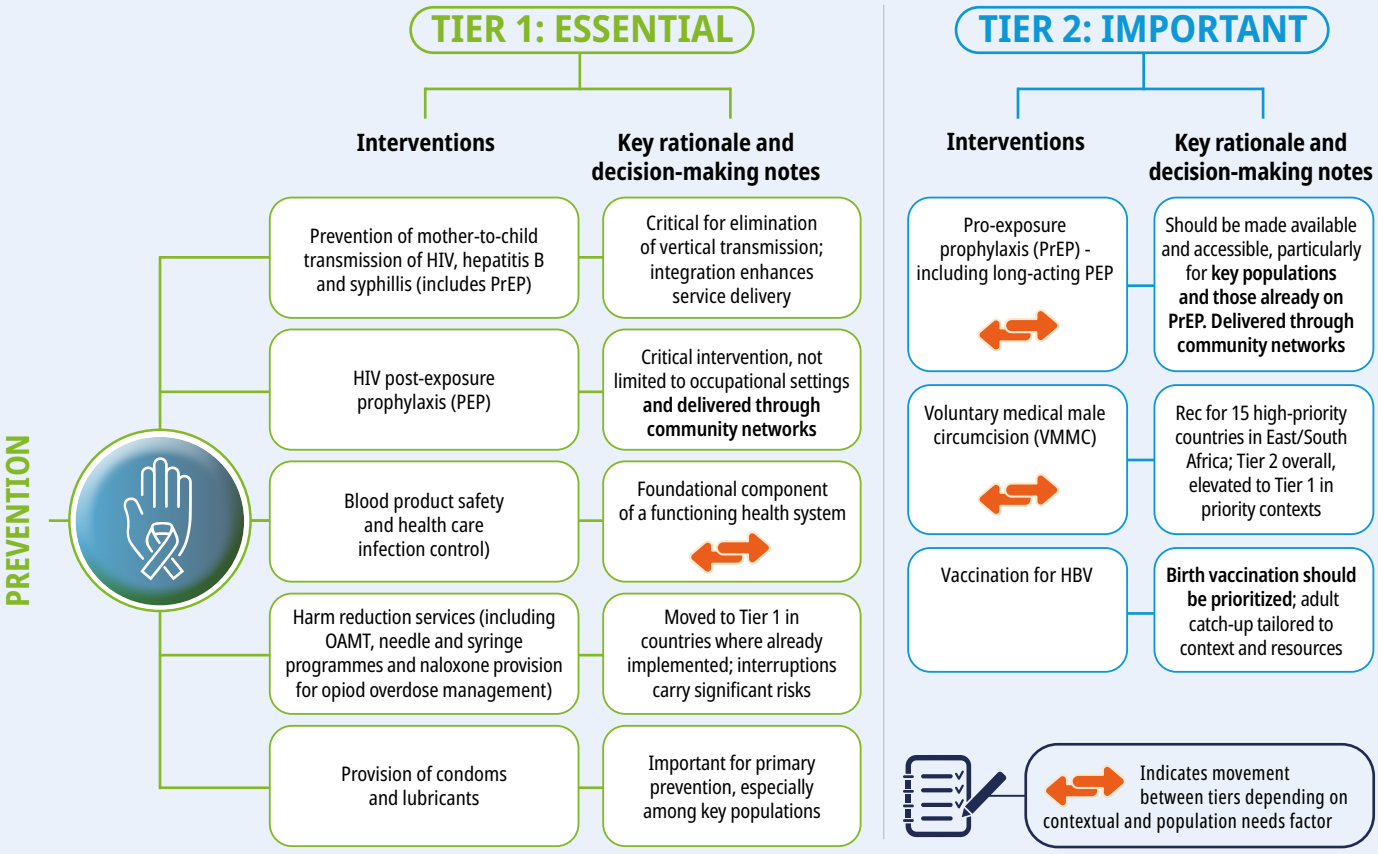


Fig. 7. Testing: Results from the rapid global assessment exercise

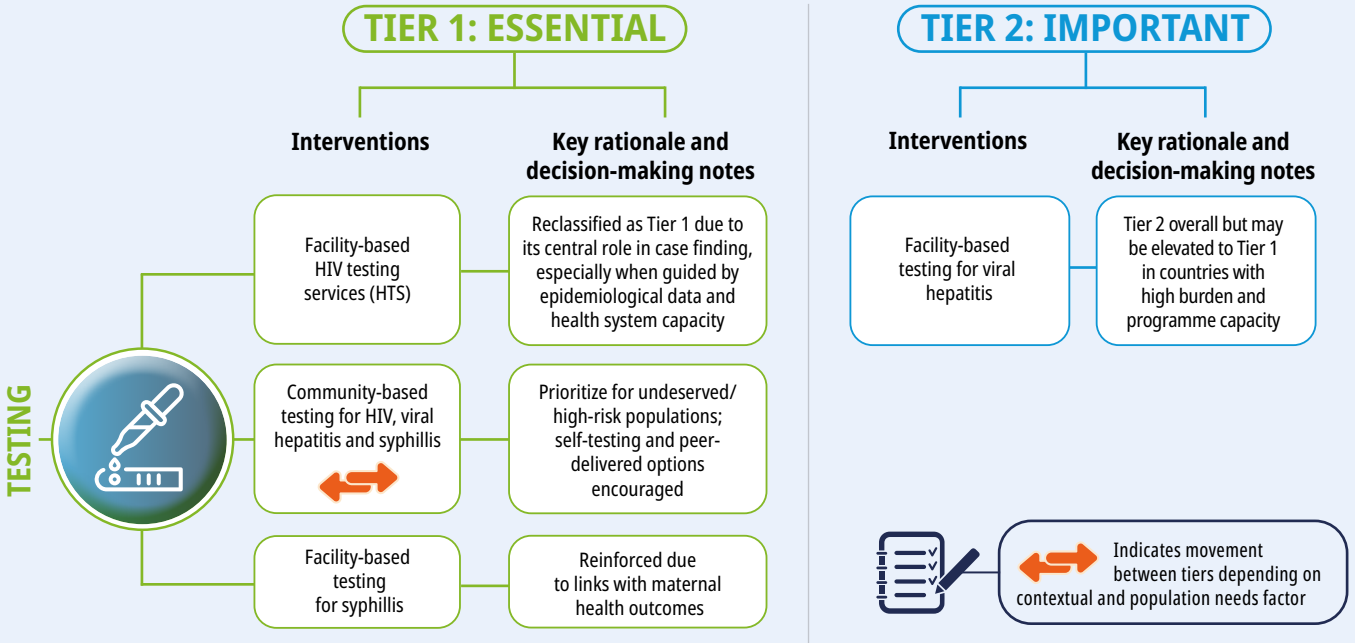
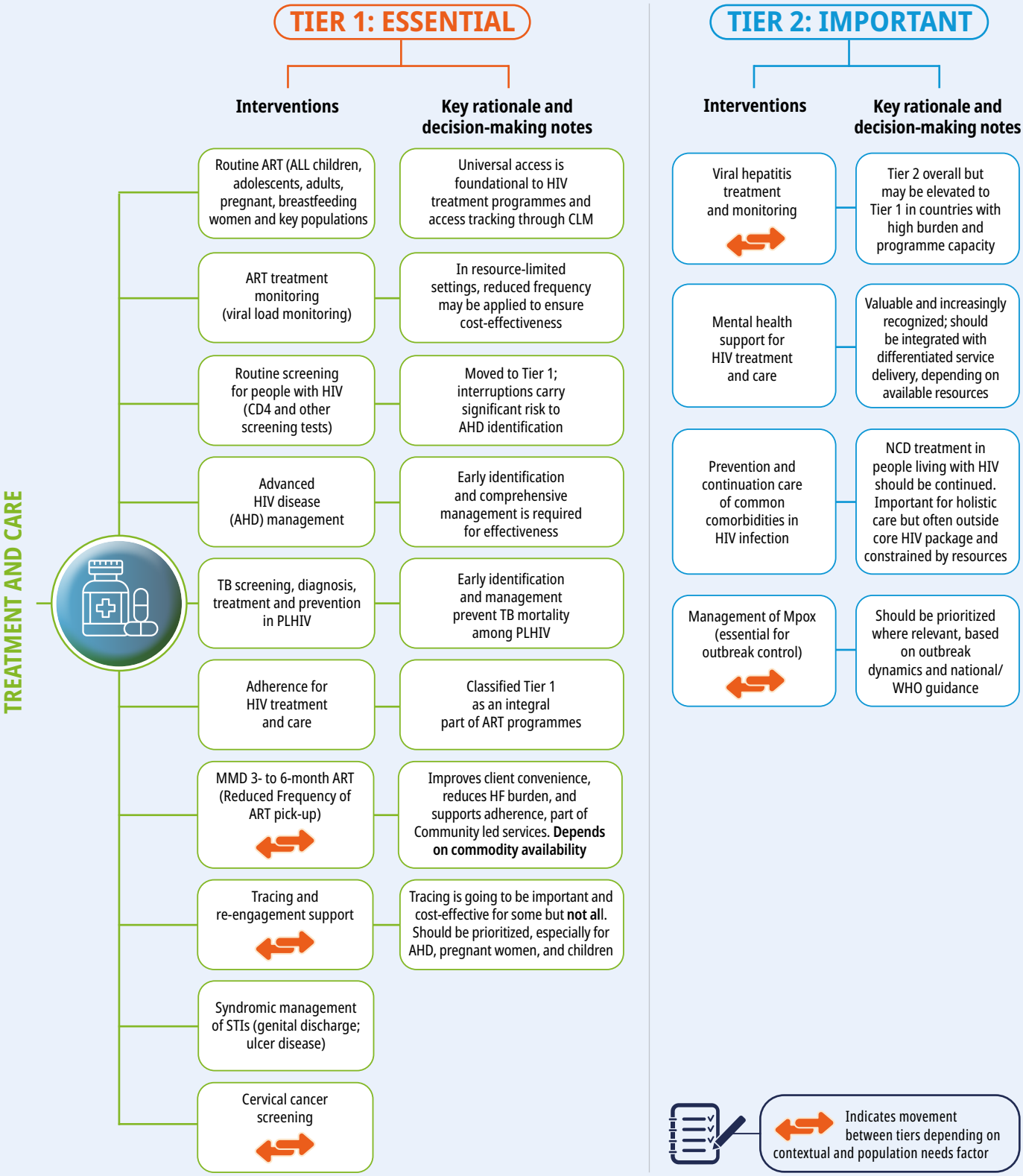


Fig. 8. Treatment and care: Results from the rapid global assessment exercise



Although the priority-setting framework included three tiers, no interventions were allocated to Tier 3 in this global exercise. This reflects the nature of the process, which aimed to rapidly prioritize services and interventions globally, without detailed baseline and mapping information. In practice, however, countries will prioritize based on available funding, system capacity and specific epidemiological and programmatic needs. This approach acknowledges the real-world constraints under which national stakeholders operate and reinforces the importance of flexible, context-driven decision-making (Tables 7 and 8).

Table 7. Rationale for tier 1 priority for services and interventions: expert and WHO Steering Group decision-making notes

Tier 1: essential	Rationale and decision-making notes
Prevention	
Prevention of mother-to-child transmission of HIV, hepatitis B and syphilis, including pre-exposure prophylaxis (PrEP)	Critical to eliminating vertical transmission and improving maternal, neonatal and child health outcomes. Integrated antenatal screening and timely preventive measures, including PrEP, are cost-effective and have a high public health impact. Maintaining these services is essential to achieving global elimination targets and sustaining long-term health gains.
HIV post-exposure prophylaxis (PEP)	Critical post-exposure intervention and should not just for occupational exposure. Delivery through community networks might support targeted reach.
Provision of condoms and lubricants	Recognized as important for HIV prevention, especially for key populations.
Harm-reduction services (including opioid agonist maintenance therapy, needle and syringe programmes and naloxone provision for opioid overdose management)	The expert group classified this intervention as tier 2, acknowledging the equity value of these interventions while also considering feasibility and legal barriers within their contexts as very difficult. However, the WHO Steering Group had noted the need to upgrade it to tier 1 – especially for the settings in which these programmes already exist. Continuing opioid agonist maintenance therapy for clients who have been enrolled in the programme needs to be considered lifesaving since sudden disruptions of opioid agonist maintenance therapy may result in immediate increased mortality.
Blood product safety and health care infection control	Strong consensus on safety as foundational to health systems.
Testing	
Facility-based HIV testing services	The expert group was asked to score differentiated HIV testing services, which were categorized under tier 2. However, the expert group recommended further disaggregation to distinguish between specific testing approaches. Following this, the WHO Steering Group reviewed the recommendation and reclassified facility-based testing as tier 1, recognizing its central role in case finding, especially when priorities are set according to local epidemiological patterns and health system capacity.
Community-based testing for HIV, viral hepatitis and syphilis	Countries are encouraged to give priority to targeted community-based testing for populations at higher risk and limited access to facility-based services, based on epidemiology and resource availability. Integration with broader initiatives, along with the use of self-testing and network-based approaches, should be encouraged.
Facility-based testing for syphilis	Especially when linked to maternal health priorities.

Table 7. Rationale for tier 1 priority for services and interventions (cont'd.)

Tier 1: essential	Rationale and decision-making notes
Treatment and Care	
Routine ART for all children, adolescents and adults (including pregnant, breastfeeding women and key populations)	Lifelong ART is the foundation of HIV treatment and prevention. It reduces morbidity, prevents HIV transmission, and supports viral suppression across populations. Routine ART remains one of the most impactful.
ART treatment monitoring (viral load monitoring)	In settings with budget constraints, countries may consider adopting less frequent viral load testing approaches to ensure cost-effective monitoring and maximize the impact of treatment programmes. Countries might further give priority to: clients at initiation or re-engagement in care, those with previously unsuppressed viral load or signs of treatment failure, pregnant and breastfeeding women and individuals who have never had a viral load test.
Routine screening for people living with HIV initiating (and reinitiating) ART	The expert group highlighted the importance of CD4 for identifying people presenting with or at risk of advanced HIV disease. Although WHO supports clinical staging where CD4 testing is unavailable, CD4 testing is strongly encouraged, since it is more sensitive and detects more cases of advanced HIV disease.
Advanced HIV disease management	Screening and management of advanced HIV disease are essential to ensure early identification and comprehensive care that can prevent mortality among people living with HIV; this requires implementation of the full advanced HIV disease package to be effective.
TB screening, diagnosis, treatment and prevention in people living with HIV	Although previously scored as TB and HIV coinfection screening, diagnosis, treatment and prevention, the activity description included ensure early identification and comprehensive management that prevents TB mortality among people living with HIV. The steering group approved editing the intervention title, with no impact to the tier 1 classification.
Multimonth dispensing, 3- to 6-month ART refills and less-intensive differentiated service delivery models	Multimonth dispensing and less-intensive differentiated service delivery models should be given priority in Tier 1, given their proven benefits in reducing the burden on health systems, improving client convenience and retention in HIV care. Assessment of antiretroviral drug stock levels will guide the optimal refill and supply planning that ensures equitable distribution of antiretroviral drugs.
Syndromic management of STIs (genital discharge and ulcer disease)	Syndromic management is widely used for people with STI symptoms, especially where timely laboratory diagnosis is unavailable. Despite its limitations, it remains a key component of STI service delivery in many resource-limited settings.
Adherence for HIV treatment and care	The experts were asked to score adherence and mental health support for HIV treatment and care but considered that these two interventions should be split, with adherence support as tier 1 (as an integral part of ART programmes) and mental health as tier 2 interventions.
Tracing and re-engagement support	Tracing is going to be important and cost-effective for some people but not all. Tracing interventions should be given priority for people with abnormal laboratory results or who have missed a scheduled appointment by more than 28 days, with particular attention to those with advanced HIV disease, active opportunistic infections, pregnant and breastfeeding women and children.
Cervical cancer screening	Ensuring that women living with HIV are provided screening for cervical precancer is critical, using a screen, triage and treat approach. WHO recommends using human papillomavirus DNA testing as the preferred primary tests. In situations where it is unavailable, programmes may consider using other testing modalities, such as visual inspection with acetic acid and Pap smears.

Table 8. Rationale for tier 2 priority for services and interventions: expert and WHO Steering Group decision-making notes

Tier 2: important	Rationale and decision-making notes
Treatment and Care	
PrEP	Countries should ensure that oral PrEP services are available and accessible to all people who may benefit from and already PrEP. In several countries, this will be primarily key populations. Delivery through community networks might support targeted reach. Particular emphasis should be placed on addressing access barriers faced by key populations and adolescent girls and young women. While cost-effectiveness and budget concerns were flagged, ethical prioritization grounded in equity principles requires maintaining or expanding PrEP access in populations at disproportionate risk.
Vaccination for hepatitis B	Although hepatitis B vaccination was included in tier 2 as part of the exercise, note that the expert group flagged that hepatitis B vaccination at birth or childhood should be given priority. Adult catch-up programmes should be tailored based on epidemiological context and available resources (Annex 1 addresses this difference with a split between the two populations).
Voluntary medical male circumcision	Voluntary medical male circumcision is an essential part of the HIV prevention response. Countries should consider voluntary medical male circumcision as a tier 2 intervention overall but high-priority countries may elevate it to tier 1. For voluntary medical male circumcision, WHO considers 15 countries in eastern and southern Africa with high HIV prevalence and low voluntary medical male circumcision coverage high-priority countries: Botswana, Ethiopia, Eswatini, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, South Sudan, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe.
Testing	
Facility-based viral hepatitis testing	The WHO Steering Group flagged that, in alignment with the expert group recommendation to further split differentiated HIV testing services, the same should apply to viral hepatitis, changing the approach from differentiated viral hepatitis testing services to focus on facility-based viral hepatitis testing, keeping the expert group decision to classify it as tier 2.
Treatment and Care	
Viral hepatitis treatment and monitoring	In the context of the HIV programme, viral hepatitis treatment and monitoring should be classified as a tier 2 intervention overall, with consideration for elevating to tier 1 in contexts with a high burden of hepatitis B or C and available resources for programme scale-up.
Mental health support for HIV treatment and care	Mental health services for people living with HIV depends on available resources and is integrated within the broader framework of differentiated HIV care.
Prevention and continuing care for common comorbidities in HIV infection	Prevention and continuation of care for common comorbidities among people living with HIV should be considered a tier 2 intervention, recognizing its importance for holistic health while acknowledging that it is often outside the direct HIV care package and may be limited by budget constraints. Treatment for noncommunicable diseases for people living with HIV should be continued.
Management of mpox (essential for outbreak control)	Mpox management should be considered a tier 2 intervention, with priority-setting driven by outbreak-specific context and aligned with national and WHO guidance.

Lessons learned from the rapid global priority-setting exercise

Meaningful community engagement must inform all decision-making processes

In line with the ethical principle of accountability, any services deprioritized or discontinued should be accompanied by transitional or alternative support measures, co-designed with affected communities to minimize harm and maintain trust. The role for international agencies, donors and partners is to ensure this engagement is upheld, including safeguarding of community-based organization (CBO) tools and interventions such as community-led monitoring (CLM) and Stigma Index.

Country-specific context is essential for meaningful priority-setting

The global priority-setting exercise was intended as a starting-point for national dialogue and planning. Countries are encouraged to interpret the results within their specific epidemiological, programmatic and health system contexts. This includes assessing the local burden of disease, current service coverage and implementation capacity. Such contextualization is critical to ensure that priority-setting reflects national realities and maximizes the impact and efficiency of available resources.

Disaggregation enables more precise and effective decision-making

The grouping of interventions and services during the global exercise, while necessary for high-level analysis, may have obscured important distinctions among individual activities. Countries should disaggregate interventions, especially those related to specific populations or service delivery modalities, to enable more accurate assessment of their relative importance, feasibility and impact. This disaggregation will support more nuanced priority-setting and facilitate more effective resource allocation and planning.

Within tier 1, priority-setting may still be necessary

Although tier 1 interventions represent high-priority activities globally, countries facing significant resource constraints will not be able to implement all of them simultaneously. In such cases, further prioritization of high-impact Tier 1 interventions into tiers 2 and 3 will be required. This should be informed by local data, including service gaps, cost–effectiveness and population needs. The absence of Tier 3 classifications reflects the limitations of this rapid, global process—not an assumption that all interventions are equally urgent or feasible. Countries are encouraged to go beyond the indicative tiers and undertake tailored prioritization aligned with national goals and realities. Documenting the rationale for such decisions in a clear and structured manner is essential for maintaining accountability and enabling future re-evaluation as circumstances evolve.

Transparency strengthens adaptation and planning

Countries are encouraged to clearly and transparently document and communicate the rationale behind priority-setting decisions (Table 7 and 8). This includes describing how service prioritization recommendations were interpreted, how disaggregation and contextualization were applied and how ethical and equity considerations were addressed. Transparent documentation enhances stakeholder understanding, fosters trust and supports coordinated planning, implementation and resource mobilization.

“Countries are encouraged to go beyond the 2 indicative tiers resulted from this exercise and undertake tailored prioritization aligned with national goals and realities

6. Systems, strategic and operational considerations

Priority-setting decisions take place within complex and dynamic systems. Any final recommendations should not simply outline interventions but need to provide corresponding actions for health systems. Strategic, operational and enabling factors specific to each country shape the level of investment and intensity and reach of services. WHO's systems thinking and complexity approaches can support countries in navigating transitions, especially during abrupt funding shifts. Health systems function as ecosystems, with interdependent elements and feedback loops. Changes in one area, such as service delivery, often require adjustments across others *(11, 49)*. Systems are characterized by constant positive and negative feedback loops as various elements in the system react to new inputs or changes to relationships. For example, redesigning or relocating services may require changes in supply chain coordination, workforce deployment, infrastructure and information systems *(11)*.

Section summary: This section outlines key health system enablers (such as workforce, financing, information systems and health products) that support the implementation of priority-setting for services during funding shifts. It highlights practical strategies, tools and planning actions to sustain HIV, viral hepatitis and STI services, drawing from WHO's systems thinking and PHC frameworks. The section also addresses how to strengthen resilience, protect equity and link priority-setting to broader universal health coverage goals while striving to maintain quality of care.

☑ Planning and self-check questions ☒

- ☐ Are population groups involved in planning and monitoring processes?
- ☐ Does the priority-setting plan consider the specific access needs and preferences of each group?
- ☐ Are disaggregated data (by age, gender and population group) being used to inform priority-setting decisions?
- ☐ Is the prevalence of HIV, STIs and hepatitis among specific groups used to guide service priorities?
- ☐ Are services aligned with the type of epidemic (generalized, concentrated or low-level)?

Maintaining quality of care during health systems transition

Sustaining the impact of HIV programmes requires that services not only remain uninterrupted but also uphold quality standards that are equitable, responsive and stigma-free. Quality must be an integral focus during periods of transition to ensure that expanded access translates into improved health outcomes. Without attention to quality, expanded access can lead to poor retention, missed diagnoses, treatment failure and drug resistance. A structured quality management approach (including the definition of standards, routine performance monitoring, gap analysis and continuous quality improvement (CQI) interventions) supports countries to maintain service effectiveness and accountability (refer to Measuring Quality of Care section for more details) *(82)*.

To translate quality management into practice and ensure that services are not only effective but also free from stigma and discrimination, a set of core principles and strategic priorities must guide implementation. These principles should be embedded across implementation, evaluation and accountability mechanisms in health systems *(37)*. Three key priorities underpin the delivery of quality, stigma-free care:

1. Person-centredness and quality of life: placing individuals at the centre of care through stigma awareness, community engagement, and workforce capacity-building.
2. Stigma reduction in quality improvement: embedding stigma-reduction within facility-based CQI through dedicated resources, inclusive workplace practices, and ongoing learning and reflection.
3. Enabling environments: creating supportive systems through multi-stakeholder collaboration, community-led models, strong networks, and investments targeting stigma linked to social determinants of health.

Together, these priorities reinforce quality as central to resilient, inclusive health systems, sustained progress and integrated care.

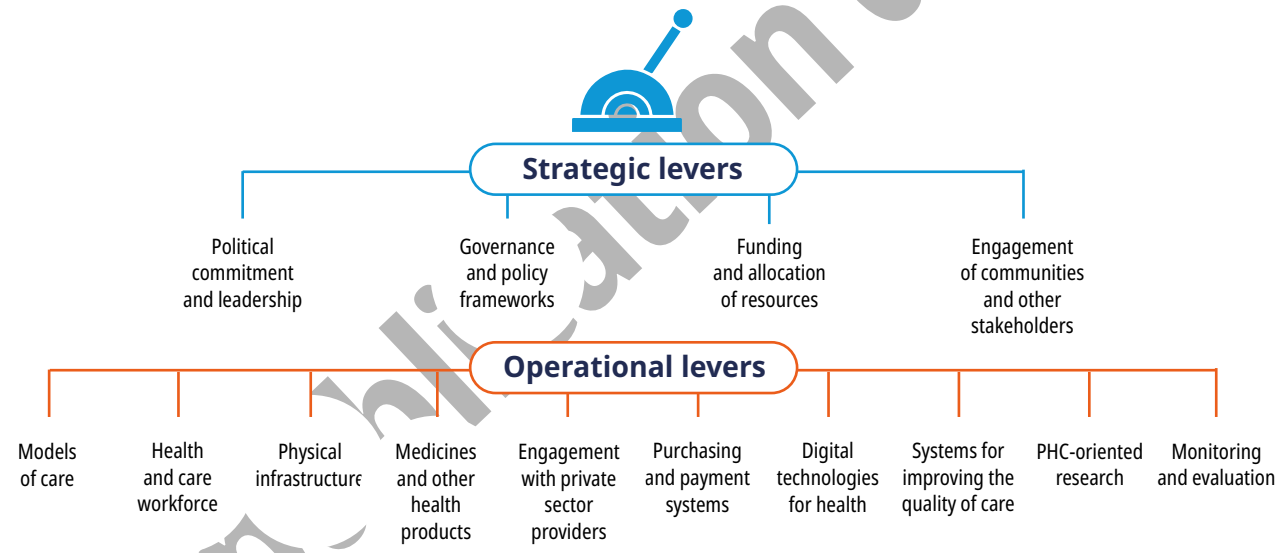
"To translate quality management into practice and ensure that services are not only effective but also free from stigma and discrimination, a set of core principles and strategic priorities must guide implementation"

Integrating service delivery within PHC person-centred models of care

PHC provides a platform for integrating HIV and other disease-specific services, improving resilience and continuity *(50)*. The WHO/UNICEF Operational Framework for Primary Health Care emphasizes three key components: primary care and essential public health functions as the core of integrated health services; multisectoral policy and action; and empowered people and communities. These three pillars offer pathways to rebuild inclusive and sustainable health systems *(7)*.

Strategic and operational enablers for PHC, drawn from WHO guidance, can help countries to identify actions to maintain access and service quality through people-centred care. The Operational Framework defines 14 interrelated levers that support PHC implementation (Fig. 9).

Fig. 9. Fourteen levers that support PHC implementation



These levers provide a practical framework and can serve as a checklist for identifying opportunities to jointly strengthen PHC and meet HIV-specific goals, ensuring that all aspects of service and programme disruption are considered. A WHO brief outlines actions for all 14 levers of the Operational Framework *(7, 50, 51)*. In some cases, opportunities to leverage HIV investments for broader system strengthening may have been missed *(52)*. The funding disruptions have unevenly affected system areas. Although antiretroviral drugs have been protected in many settings, disruptions in financing, workforce or governance have significantly compromised service delivery *(3)*. People-centred care, as endorsed by WHO, gives priority to the voices and needs of individuals, families and communities *(17)*. This approach helps to ensure that services remain effective, equitable and responsive – especially for those most severely affected *(53)* and may also require additional actions around any new priority-setting of services to ensure that services are integrated in a way that maintains local adaptation to specific community needs.

Integration may occur across governance, financing, human resources, delivery platforms or targeted prevention. It can also address shared barriers such as stigma, discrimination or harmful legal environments *(52)*. Depending on

the context, HIV services may be embedded into PHC or PHC may be leveraged to expand HIV access *(52)*.There are also opportunities for HIV service integration with TB, noncommunicable diseases and family planning. Any integration should strengthen – not disrupt – access to priority services, especially for key populations *(7, 50)*.

There are numerous opportunities for learning and system strengthening:

- conduct a cross-programmatic efficiency analysis to identify integration opportunities *(54)*;
- leverage PHC levers to integrate HIV services into broader health systems *(52)*;
- use joint programme reviews to identify, assess performance of and redirect integration efforts *(52)*;
- develop costed sustainability plans with clear transition timelines and steps *(7)*; and
- strengthen monitoring to capture coverage but also integration, equity and system resilience *(7)*.

Integrated delivery of priority services may improve both patient-centred care goals and efficiency. WHO's UHC Service Package Delivery and Implementation Tool can support context-specific adaptation of priority services within integrated models of PHC *(7, 55)*. Countries that are able to strengthen integrated PHC principles may be better positioned to adapt service delivery and maintain continuity of care in the face of funding disruptions and other crises (Boxes 6 and 7).

Box 6. Country examples of integrating HIV, TB, viral hepatitis and STI services into PHC

Before recent funding disruptions, countries had already begun integrating HIV and other health services into PHC, generating important lessons. The examples illustrate Ethiopia, Indonesia and Zambia's efforts to integrate HIV and other disease-specific services into PHC through long-term health system transformation. These examples highlight structured approaches to aligning service delivery with PHC principles, including decentralized systems, task-sharing, political leadership and universal health coverage reforms.

Ethiopia demonstrates a strong model of integrated HIV, TB, hepatitis and STI services within its PHC system. The country's success is underpinned by its nationally scaled Health Extension Program, which delivers essential health services to rural populations, alongside community-based health insurance schemes that improve financial access. Strong political commitment and coordinated governance have played a critical role in facilitating effective service integration and sustaining improvements in health outcomes *(56)*.

Indonesia has advanced integration of HIV, TB, STIs and hepatitis services into PHC through a decentralized health system and a comprehensive health transformation agenda. Extensive PHC infrastructure and a universal health coverage scheme support these efforts. However, Indonesia's geographical diversity and the varying health priorities across regions pose significant challenges to consistent and equitable implementation of integrated services *(57, 58)*.

Zambia's integration of HIV services into PHC has expanded to include noncommunicable diseases, reflecting a shift toward comprehensive person-centred care. The country's approach is strengthened by active collaboration with development partners and strong community engagement, which enhances service accessibility and responsiveness. These

Box 6. Country examples of integrating HIV, TB, viral hepatitis and STI services (cont'd.)

efforts exemplify a successful integration model adapted to local needs and health system capacity *(59, 60)*.

Common lessons learned: experiences from the three countries provided lessons that should be considered by other countries.

- Strong coordination and governance enabled effective planning and alignment across programmes.
- Sustainable funding, including domestic investment, was recognized as key to maintaining integrated services.
- Building PHC infrastructure and human resources laid the groundwork for more resilient systems.
- Task-sharing with ongoing mentorship helped to extend service delivery in resource-limited settings.
- Community engagement improved access and responsiveness, and efforts to reduce stigma and discrimination supported more equitable care.
- Private sector involvement also played a role in expanding service reach and innovation.

Box 7. Country examples of integrating HIV, TB, viral hepatitis and STI services into PHC during crisis responseduring crisis response

The examples of Nigeria and Uganda illustrate how crises can serve as powerful accelerators for reform. Both countries were compelled to act rapidly in response to service disruptions, demonstrating the importance of crisis preparedness, flexible financing and intersectoral collaboration. Countries demonstrate how integration efforts can be accelerated during crisis recovery, using contingency planning, inter-programmatic coordination and financial reprogramming to maintain essential HIV services.

Nigeria: national contingency planning for HIV and beyond: the Government of Nigeria developed a comprehensive contingency plan to address disruptions in HIV health services. This plan includes releasing national funds of 4.8 billion naira for HIV commodities and an additional 200 billion naira allocated for AIDS, tuberculosis and malaria interventions, demonstrating a commitment to self-reliance and national ownership of the HIV response. Despite logistical delays in distributing prevention commodities, the Government is accelerating transport from central warehouses to peripheral health facilities. A high-level ministerial committee is leading the coordinated implementation of the mitigation plan, which remains focused and resilient despite challenges such as slow data flow at health-care facility levels. Key opportunities for sustainable impact include expanding the HIV sustainability roadmap to integrate other priority diseases, reviewing factors for true national ownership of the health response, expanding donor coverage to fill critical gaps and strengthening existing integration efforts across disease programmes. In addition, there is continued engagement with regional initiatives such as the Organization of African First Ladies–led Free to Shine" campaign and the "triple elimination initiative". The WHO Country Office in Nigeria is actively involved, providing robust support through technical working groups.

Uganda: from crisis to institutionalized integration: in response to the disruptions, Uganda's national government and stakeholders

Box 7. Country examples of integrating HIV, TB, viral hepatitis and STI services (cont'd.)

initiated a full integration of services. This process included adjustments in human resources distribution and financial mobilization to respond to the shortage of trained HIV health-care providers and disrupted commodity distribution systems, which prevented the delivery of important health-care services. The Ministries of Health and Finance collaborated to explore response options using the national Contingency Fund to support restoring these affected areas. A comprehensive mitigation strategy was developed, informed by a public financial management bottleneck assessment and inter-programme efficiency analysis. Efforts are underway to create an integrated framework for communicable and noncommunicable diseases, expected to be completed by the end of 2025. The WHO Country Office in Uganda is actively involved, providing robust support through technical working groups.

☑ Planning and self-check questions ☒

- Has how existing PHC infrastructure and delivery platforms can be leveraged to integrate HIV and other services been assessed?
- Are mechanisms in place to ensure strong coordination and governance across programmes?
- Have ways to mobilize and sustain domestic funding to support integrated services been explored?
- Is task shifting and sharing being used to extend service reach, especially in underserved or resource-limited areas?
- Are community engagement and feedback mechanisms embedded to improve access and responsiveness?
- Have steps been taken to address stigma, discrimination and legal barriers that may limit access for key populations?
- Are integration efforts being used as an opportunity to strengthen health workforce capacity and PHC leadership?
- Do contingency or crisis response plans include strategies for maintaining integrated HIV service delivery?
- Are successful elements being adapted from other countries' models to fit the local system capacity and population needs?

Health workforce and systems resilience

Health-care workers are vital to delivering equitable, high-quality services. Their availability, competencies and distribution determine whether essential health needs are met or not. In low- and middle-income countries, where external support has historically contributed to workforce expansion and programme implementation, financial shocks can reverse hard-won gains in service access and system resilience *(3)*.

Understanding health workforce disruptions

Reductions in external health financing have directly and immediately affected the health workforce, especially in programmes relying on civil society and non-state partners. Workforce instability has been widely reported across HIV, TB and other essential service areas *(3)*.

> **"Without timely mitigation, years of investment in trained personnel may be lost"**

Donor funding previously supported full-time equivalent for health-care professionals, including community-based personnel serving people living with HIV, people with TB, orphans and vulnerable children and key populations. Funding cuts have especially affected roles managed by faith-based and civil society organizations in eastern and southern Africa *(1, 18)*. In addition, the absence of accurate data on the number, location and qualifications of affected workers limit redeployment or absorption into public systems. Without timely mitigation, years of investment in trained personnel may be lost.

Labour market impact

The WHO health labour market analysis framework provides a structured approach to understanding the implications of such shocks across three dimensions (61, 62):

- **demand**: programmatic scale-backs reduce workforce hiring and replacement, affecting access to care;
- **supply:** job losses and hiring freezes limit retention and future workforce entry; and
- **financing:** limited fiscal space constrains integration even when service needs persist.

Tools to assess and address workforce disruptions include:

- ***Health labour market analysis guidebook:*** assesses workforce demand, supply and funding capacity *(61)*;
- **national health workforce accounts portal:** strengthens workforce data systems *(63)*; and
- **rapid impact assessments and costing tools (UHC compendium):** estimates fiscal needs and guide priority-setting *(6)*.

These resources guide decisions on redeployment, targeted training to sustain task-shifting and task-sharing efforts and partnerships with non-state actors.

To inform immediate responses, rapid assessments should identify affected personnel, assess potential for redeployment, update workforce data and plans and estimate funding needs for critical posts *(62)*. Priority should be given to retaining functions critical for continuity of care, especially in high-burden areas. Supporting and protecting this workforce remains a critical enabler of prioritized service delivery. Training and supervision should be leveraged to optimise available resources and models of capacity-building, particularly in contexts where providers have newly initiated the provision of HIV

> "Training and supporting health workers to provide non-discriminatory, respectful and high-quality care is essential to sustain service use and build trust"

services and may require additional orientation on rights-based, person-centred approaches. In these settings, training and supporting health workers to provide non-discriminatory, respectful and high-quality care is essential to sustain service use and build trust, especially among marginalized populations.

Sustaining the community health workforce

Community health workers, community-based workers, peer supporters and lay providers play a pivotal role in expanding the reach of a variety of health-care services, especially among underserved populations. WHO and UNAIDS recognize community health workers and community-based workers as a critical cadre in delivering HIV, TB, malaria, maternal and child health and other communicable and noncommunicable disease services at the community and primary care levels *(56) (15, 18, 24, 36)*.

These workers typically operate in both communities and public health facilities, providing a range of services including health promotion, disease prevention, rapid testing, treatment support, contact tracing and referrals. Strategic alignment and regular interaction between community and facility-based personnel are critical to achieving coherent and coordinated service delivery. They often serve as the first point of contact for vulnerable groups and help bridge service gaps in areas with limited health professional coverage *(15, 18, 24, 36)*.

Formal recognition of community health workers and lay cadres

Looking at a long-term approach, low- and middle-income countries may consider developing formal recognized roles for community health workers and lay cadres that are aligned with health system structures and national workforce strategies and linked to the broader PHC service delivery teams and structures.

Task descriptions should reflect their qualifications, competencies and experience to serve individuals and populations to meet the specific service demands of catchment area populations within health facilities, household environments or community settings. Depending on the context, community health workers could focus on cross-cutting disease needs (such as rapid testing and counselling for HIV, TB and malaria) or broader health promotion roles *(24–26)*.

Priority for deployment should be given to positions serving populations that are underserved and/or living in vulnerable conditions. Health authorities are encouraged to take ownership and plan to gradually integrate community health workers into national health workforce strategies and the public sector payroll. Countries should map the widely varying types of community health workers and their current training levels (training ranging from one month to one year). As such, the aim is to standardize and strengthen the level of competence to improve the quality of care and further enable their future integration into the health system.

Integrating community health workers into national health systems is a promising approach to strengthen primary care and contribute to equitable access to services. A scoping review highlights that key components of successful integration include formal training, fair remuneration, supportive supervision and

effective use of data systems *(65)*. In Ethiopia, the Health Extension Program has integrated salaried health extension workers within the national system, supported by district-level supervision and national data integration *(66)*. Rwanda's community health worker programme relies on community-elected workers, performance-based incentives and alignment with national health strategies *(67, 68)*. Zambia's community health assistant programme ensures that community health workers are formally employed, well supervised and clearly linked to district health structures *(69, 70)*. These examples demonstrate that, with coordinated policies, dedicated financing and robust capacity-building efforts, community health workers can be integrated and result in impact, ensuring that frontline health workers are empowered and equipped to serve their communities effectively.

Planning and self-check questions

- Have workforce disruptions been assessed and documented, including the roles of community health workers?
- Are accurate, up-to-date data available to guide re-engagement and planning?
- Are rapid assessments and costing tools used to estimate the needs for critical posts?
- Are the roles and competencies of community health worker mapped and standardized to support high-quality service delivery?
- Are deployment efforts giving priority to underserved and high-burden areas?

"A scoping review highlights that key components of successful integration include formal training, fair remuneration, supportive supervision and effective use of data systems"

Medicines and other health products

Ensuring resilience in the supply chain system and continuity in procurement

An effective procurement and supply chain system is critical to sustaining essential HIV services, especially given funding constraints or system disruptions (Box 8). This section outlines key strategies to strengthen national responses by ensuring the consistent availability of optimized cost-effective quality-assured antiretroviral drugs, diagnostics and other critical commodities. It emphasizes the importance of aligning product selection with national guidelines and WHO guidelines and recommendations, improving forecasting accuracy, ensuring proper storage and distribution and maintaining robust monitoring systems even when digital platforms are unavailable. In addition, it highlights the role of strategic supplier collaboration, performance monitoring and technology integration in building a resilient and responsive supply chain capable of adapting to shifting programmatic and operational realities *(15)*. Accessing competitively or optimally priced, quality-assured generic antiretroviral drugs and diagnostic commodities is vital for sustaining and expanding HIV services, especially amid funding constraints and system disruptions. WHO highlights that lower-cost first-assay tests contribute to more affordable testing algorithms, improving accessibility. WHO has developed transparency tools to support the process *(71)*.

Box 8. Key supply chain considerations

Planning and priority-setting

- Give priority to the integrated national strategic responses to ensure the availability of effective, quality-assured antiretroviral drug formulations, diagnostics and other consumables.
- Give priority to maintaining procurement and supply chain systems to monitor commodity stocks.
- Give priority to forecasting critical HIV service commodities (see Annex 1).

Product selection and quantification

- Medicines and diagnostic products should be selected according to national guidelines and programme needs, with focus on optimized, cost-effective medicines and less-expensive diagnostic tests. Countries should minimize the number of regimens used in accordance with WHO guidelines and recommendations to optimize treatment and sourcing. In diagnostics, the focus should be selecting the least expensive initial assay since it contributes to more affordable testing algorithms, improving accessibility.
- Accurate data on treatment regimens, scale-up rates and product registration are essential for quantifying and forecasting the demand for antiretroviral drugs and diagnostics.

Procurement and supplier management

- Building strong, transparent relationships with suppliers helps to maintain consistency in product quality, pricing and delivery. Collaboration tools that facilitate communication and data sharing can streamline processes.
- • Supplier performance benchmarking: monitoring and improving supplier performance based on key metrics such as on-time in-full delivery rates, quality of goods and pricing accuracy helps to enhance supplier relationships and overall efficiency.

Storage and distribution

- Appropriate storage and distribution of HIV

Box 8. Key supply chain considerations (cont'd.)

medicines, diagnostics and other commodities are crucial to meet the increased demands on the supply chain and ensure the availability of these commodities at the service delivery sites.

Monitoring and information systems

- When online or digital systems are down, maintain a paper-based log system for recording stock availability at facilities, warehouses and at the subnational and national levels.
- Synchronize electronic systems and conduct data checks comparing before and after to ensure accuracy.
- Technology integration and supply chain management: investing in integrated tools such as logistics management and information systems and real-time data platforms enables inventory to be managed, shipments to be tracked and demand to be forecast with greater accuracy.

Supply chain resilience

- Anticipating and mitigating risks by incorporating flexibility, redundancy and real-time data monitoring can prepare for potential disruptions, ensuring minimal operational downtime.

☑ Planning and self-check questions ☒

- ☐ Is there a clear plan to ensure continuous access to HIV medicines and diagnostics?
- ☐ Have product selections been aligned with national guidelines and based on accurate forecasts and costs?
- ☐ Is supplier performance being monitored using clear and consistent indicators?
- ☐ Are storage and distribution systems ensuring timely and safe delivery to service points?
- ☐ Have reliable backup systems been established for stock monitoring when digital tools fail?
- ☐ What contingency measures are in place to manage potential supply chain disruptions?

Health financing considerations

Navigating funding shifts and sustaining progress in achieving universal health coverage

As outlined above, priorities must be set based on budgetary and fiscal constraints. However, these should be understood in the wider context of health financing policy. Health ministries in low- and lower-middle income countries should take several key actions aligned with and alongside priority-setting that will ensure the optimal response to funding shocks (Tables 9 and 10). They relate to both external and domestic health resources to address current health financing constraints to support critical services and safeguard progress towards universal health coverage. The actions are targeted for health ministries and require engagement at the sectoral level in coordination with finance authorities. The actions focus on areas for assessment and key policy measures as input into overall decision-making processes, including dialogue between health and finance authorities, within-sector priority-setting and donor-related funding allocations. They are differentiated between immediate and medium- to longer-term actions. Importantly, immediate-term measures should consider the longer-term consequences on the configuration of health financing systems and how this affects equitable coverage to protect poor and vulnerable people *(54, 72–77)*.

Planning and self-check questions

- ☐ Have current external and domestic health funding flows been mapped and urgent gaps or risks to critical services been identified?
- ☐ Is reprogramming or realigning of funding based on national priorities and equity considerations being coordinated with finance authorities and donors?
- ☐ Have immediate-term measures been taken to protect essential services and prevent increased out-of-pocket spending for vulnerable populations?
- ☐ Is a plan or roadmap in place to transition donor-funded services and inputs into sustainable domestic financing arrangements?
- ☐ Are available tools being used to model financing scenarios and estimate the cost and impact of priority-setting decisions?

"Set service and programme priorities in alignment with budgetary and fiscal constraints, while situating these decisions within the broader context of national health financing policy to ensure coherence and sustainability"

Table 9. Urgent actions to respond to funding shocks

	Main actions	Detailed approach
External resources	☐ Rapidly map funding and its use	Rapidly map funding freezes and cuts, flows and channels, including on- versus off-budget support and budget holders to comprehensively understand funding needs, ensure that health and finance ministries have visibility of donor funding and identify opportunities for consolidation, reprogramming and rechannelling.
	☐ Initiate donor dialogue to realign aid priorities	Engage in dialogue with donors for urgent shifts in aid priorities to realign the remaining aid in accordance with local priorities based on context-specific evidence on cost–effectiveness and equity considerations.
	☐ Explore new opportunities for external funding	Identify new opportunities for external funding, including by engaging with philanthropies.
Domestic resources	☐ Rapidly assess the domestic macro fiscal and health financing environment	Rapidly assess the macro fiscal and health financing landscape by analysing recent trends in government revenue, overall public expenditure and health spending in relation to GDP on a per capita basis and as a share of government spending.
	☐ Set new priorities for health budgets and use mid-term reviews or contingencies	Engage in dialogue with leadership for setting new budget priorities within the health sector across the government budget and proactively contribute to mid-term review of the budget and, if applicable, supplementary budgets or activating emergency contingency funding to mitigate immediate funding shortfalls and to sustain equitable coverage for critical cost-effective services.
	☐ Optimize the use of existing health budget allocations by improving public financial management	Fully use existing health budget allocations by identifying areas for immediate action in public financial management, including the timeliness of cash flow requests and improving fund disbursement.
	☐ Implement safeguards to prevent increases in out-of-pocket spending	Put into place safeguards against increased out-of-pocket spending for critical services by: • incentivizing supply-side efficiency measures, including shifting funding to critical services and populations; and • if relevant, establish policies to eliminate user charges for critical services and/or population groups.
All resources	☐ Evaluate new domestic revenue and borrowing options	Evaluate additional sources of revenue, including health taxes and, based on debt status, explore with finance authorities potential avenues for additional concessional borrowing to augment fiscal capacity.
	☐ Review service benefits and target coverage	Rapidly review the benefit package and critical and non-critical service lists of programmes, considering local context, evidence on cost–effectiveness, equity, ensuring coverage to vulnerable groups and other criteria to ensure equitable and impactful resource allocation, in collaboration with relevant purchasers, providers and stakeholders (WHO-CHOICE).
	☐ Identify integration opportunities to reduce duplication and improve efficiency	Identify functional areas for integration by targeting duplication, overlaps and parallel services, including human resources and commodities, and assess the impact on cost.
	☐ Create a roadmap for integrating donor-funded services into PHC	Develop an integration framework and roadmap to carefully guide adjustments in health financing structures needed to support the integration of donor-funded vertically delivered services into multi-purpose PHC delivery platforms.
	☐ Estimate the costs of transition from external to domestic funding	Establish processes for evaluating scenarios and rapidly estimating the resource requirements and costs of transitioning previously externally funded services to domestic programmatic funding, including revising the scope of the health service package, unit costs and prices.
	☐ Identify technical efficiency gains to inform smarter purchasing	Evaluate areas for improving technical efficiency in delivery and resourcing, in addition to those related to integration, and assess how this affects costs. Use this information to inform shifts in purchasing to drive implementation.

Table 10. Medium- to longer-term actions to respond to funding shocks

	Main actions	Detailed approach
External resources	☐ Align donor aid modalities with national public financial management systems	Work with donors to support changes of financing modalities and realignment of aid, specifically for the funds that are channelled outside the budget with domestic planning and public financial management systems and processes.
	☐ Plan the transition of donor-funded inputs into domestic systems	Consider transition process and pricing of donor-funded inputs, such as human resources–related costs and their financial implications by focusing on salary alignment with domestic pay scales, cadre integration and provider payment and contracting modalities. Establish transitional domestic procurement mechanisms as necessary, retaining if possible the benefits of pooled procurement systems.
	☐ Negotiate new aid terms and explore transitional and blended financing	Discuss opportunities with donors for changing terms (such as co-financing requirements) and transitional financing to cover shifts in system reintegration, including through blended finance modalities. Work closely with multilateral development banks to target investment to best buys at the right price and to achieve the right terms of lending (degree of concessionality).
Domestic resources	☐ Strengthen domestic revenue through tax reform and administration	Advocate for improving tax administration and explore the potential for strengthening tax design, broadening the tax base and limiting tax loopholes and exemptions to improve public sector revenue capacity overall and allocations for health.
	☐ Explore debt restructuring and innovative relief mechanisms	Engage in dialogue regarding debt restructuring and relief initiatives, including debt swaps.
	☐ Analyse the effects of trade policy and explore local manufacturing	Assess how recent decisions on trade policies affect broader impact, including for purchasing medical products, and consider regional and local manufacturing options to clearly convey the financial implications to finance authorities for further budget adjustments.
	☐ Improve public financial management systems and align financial and health information	Streamline public financial management procedures within existing regulatory frameworks, ensuring that available domestic resources are better allocated and executed within the health sector and ensuring consolidated financial monitoring and reporting through established financial information systems in connection with health information systems to enable accountability for results.
	☐ Revise provider payment methods and allocation	Consider revising provider payment methods and rates, resource allocation formulas and purchasing arrangements, including through contracted nongovernmental organizations and shift to output-based payment methods to ensure the efficient use of resources and alignment with evolving service needs and models of care.
	☐ Expand or assess insurance contributions based on the context	Strengthen revenue in countries with mandatory health insurance systems by increasing contribution rates or the applicable base in collaboration with government tax authorities. Countries without social health insurance systems should consider the advantages and disadvantages of these sources, depending on the level of labour market informality. In both cases, assure alignment with universal health coverage goals, especially coverage equity considerations.
All resources	☐ Consolidate financing schemes and harmonize purchasing functions	Reduce financial fragmentation through the planned consolidation of existing financing schemes (if relevant, social health insurance agencies) and harmonizing health purchasing functions and consider the risks of new employment-based insurance mechanisms.
	☐ Identify systemic efficiency gains across inputs and services	Identify sources of additional efficiency gains, including by systematic shifting to generics, revisions in human resources practices and system orientation towards primary care services.

Table 10. Medium- to longer-term actions to respond to funding shocks (cont'd.)

	Main actions	Detailed approach
All resources	☐ Integrate transitioned services into national expenditure frameworks	Fully integrate transitioned services into domestic medium-term expenditure frameworks and strategic plan costing (including all sources of funding).
	☐ Institutionalize evidence-informed priority-setting and review of the benefit package	More broadly revise benefit packages as part of institutionalized domestic evidence-informed priority-setting processes connected with budgeting and broader public financial management processes as well as purchasing mechanisms, provider payment systems and price negotiation.
	☐ Streamline expenditure reporting and ensure public accountability	Consolidate expenditure reporting into existing and streamlined tracking, monitoring and accountability processes. Ensure transparency and budget literacy to enhance accountability to populations, including through leveraging digital platforms and digitization movement to ensure that health financing data flows are complete, accurate and timely.
	☐ Transition to national procurement and strengthen supply chains	Transition to and strengthen domestic procurement modalities and supply chains and engage in commodity price renegotiation to ensure that low-cost options are used, including through regional pooling.

"Ensure that immediate-term measures consider the longer-term consequences on the configuration of health financing systems and how this affects equitable coverage to protect poor and vulnerable people"

7. Communicating decisions

Public communication of decisions and rationale

All decisions resulting from the priority-setting along with their underlying justifications should be formally documented and made publicly available. Clear and strategic communication of the decisions is essential to ensure that health system users (patients and communities) and providers (clinicians, facility managers and public health officials) understand, accept and effectively implement changes in service delivery. Inclusive, transparent, inclusive and culturally sensitive communication is especially important in settings in which trust in public institutions may be fragile. Communication should also address concerns related to stigma and reassure communities about the continued availability of non-judgemental, quality services.

Priority-setting decisions should be communicated promptly after they are finalized. Multiple channels may be used – including community meetings, public broadcasts, social media, printed materials and health facility briefings – to ensure that diverse audiences are reached in both urban and rural areas. Partnering with local leaders, religious figures and civil society organizations can help to mediate communication and reinforce community acceptance of changes. These actors also act as trusted sources of information and feedback.

Information should be presented in clear, non-technical language and translated into local languages when needed. Messages should explain what services are being given more or less priority, why the decisions were made and how users can access available alternatives or voice concerns. Communicating the rationale for priority-setting – such as maximizing population health, ensuring fairness or reallocating resources to high-impact interventions – can help users and providers understand that decisions are not arbitrary but are intended to benefit the broader population.

"Messages should explain what services are being given more or less priority, why the decisions were made and how users can access available alternatives or voice concerns"

Supporting implementation and accountability

Health-care providers must be equipped with clear operational guidance on implementing the new priorities, including any changes to service packages, referral pathways or patient eligibility. Training sessions, updated protocols and question-and-answer materials can help to reduce confusion and ensure consistent delivery.

Accountability mechanisms ensure that priority-setting decisions are implemented as intended and that deviations are justified, monitored and corrected. Communities and providers should have structured channels to provide feedback or appeal decisions. These may include dedicated phone lines, community forums, suggestion boxes at facilities or digital platforms. The responses should be tracked and resolved in a timely manner.

Planning and self-check questions

- ☐ Have the decisions resulting from the priority-setting process, along with their justifications, been documented and disseminated using clear, accessible, and culturally appropriate language and formats?
- ☐ Have appropriate communication channels and trusted intermediaries (e.g. community leaders, CSOs, health providers) been engaged to convey the decisions and support community acceptance and understanding?
- ☐ Are there mechanisms in place to provide operational guidance and training for service providers and to allow users to ask questions, provide feedback or appeal the decisions?

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8. Evaluating and sustaining progress

Support for data and monitoring systems

The importance of person-centred health information systems: Data systems that maintain clinical and programme information on people living with HIV and people at elevated risk for acquiring HIV, while also supporting supply chain logistics management and laboratory functions, form a mainstay of health service delivery. Person-centred data, which are generated when an individual receives health-care services, are collected and used daily for client care. This information can provide regular, granular and timely evidence that clinicians, line managers, programme directors and policy-makers need to make informed decisions to direct resources and improve services. Disruption of such systems has downstream effects on service delivery and programme management *(3, 78)*.

Protecting data

Ensure the security and confidentiality of all health data, especially digital health data. Data security and confidentiality are especially important for the members of key populations, who are disproportionately affected by HIV, viral hepatitis and STIs – gay men and other men who have sex with men, sex workers, people who inject drugs, people in prisons and other closed settings and trans and gender-diverse people.

When data are disrupted, the guiding principles are to secure existing individual-level data, give priority to the functionality of data used for clinical services, enable offline functionality and linkage when possible and thoroughly review, check and secure data when restoration takes place. Table 11 covers some of these priorities, and others will be needed depending on the local context.

WHO monitors disruptions in HIV and across health with pulse surveys. According to these data, strategic information is a major area of disruption. Data systems are unlikely to return to where they were before *(3)*.

Strengthening routine person-centred data systems should remain a priority to ensure that they effectively support both service provision and programme monitoring. Significant data gaps may remain, especially because of the reduction in surveys and limited data for key populations. However, routine person-centred data supported by the health ministry and enhanced by emerging tools such as artificial intelligence are likely to form the backbone of future national data systems *(78)*.

Intensive work is therefore needed to transfer data to countries and health ministries to fill some precise gaps, such as among populations at higher risk and to strengthen routine data use as proposed in the WHO guidelines on person-centred data.

Table 11: Operational priorities: data security, health information systems and data entry

	Immediate actions to sustain the minimum package	Detailed approach
Data entry *(35, 36)*	☐ Enable offline data entry so that data can be entered and uploaded later. ☐ When data aggregation systems are offline or unavailable, establish paper-based backup systems. ☐ Establish a time frame for entering manual data. ☐ Conduct double data entry of all paper-based forms.	☐ Merge manual data entry with electronic records. ☐ Monitor the data quality on manually entered and compare with electronic data. ☐ Compare priority indicators before and after disruptions.
Data security *(35)*	☐ Ensure that systems determining access rights to all data systems with individual-level data are maintained to ensure privacy and confidentiality. ☐ Transition access rights to vetted individuals with higher authority access when necessary. ☐ Enter a temporary identification in situations when full identity is unknown. ☐ Log system logins and logouts and record all authentication violations.	☐ Review access rights to all electronic systems in which changes have occurred and provide password-protected access for authorized users. ☐ Review all temporary IDs and convert to permanent IDs, keeping a record of the link between both. ☐ Review authentication violations and determine the reasons and actions.
Health information systems *(2, 35, 36)*	☐ Give priority to tracking lost to follow-up and monitoring disruption to ART and viral load monitoring services ☐ Maintain the monitoring by health information systems of dispensation of antiretroviral drugs for treatment and prevention and viral load suppression monitoring. ☐ Give priority to health information systems that provide line lists of ART, PrEP and opioid agonist therapy appointments. ☐ Give priority to electronic medical record systems, since aggregate health information systems can be updated later. ☐ Enable deployment of offline and online functionality, including for laboratory data systems. ☐ Enable data exchange and efficient synchronization across multiple facilities and points of service when the Internet is available, even when it is intermittent and slow *(79, 80)*.	☐ Monitor the numbers of people initiating and receiving ART and those receiving viral load monitoring services and health outcomes. If possible, also monitor the number of HIV tests conducted and individuals tested. ☐ Review the number of records that are not yet synchronized and enable synchronization of updated data. ☐ Ensure that electronic medical records are updated with paper-based information. ☐ Compare results from electronic medical records with aggregate reporting systems and review the numbers of individuals receiving services. ☐ Continue implementing planned streamlined data quality assessment for HIV treatment and viral load testing data.

"Strengthening routine person-centred data systems should remain a priority to ensure that they effectively support both service provision and programme monitoring"

WHO has supported the shift in monitoring to routine person-centred data that has a value for service delivery and for reporting: collect once, use many times. This needs to be accelerated to stabilize and sustain country data systems.

Incorporating Community-led Monitoring (CLM) and Quality of care Measurement

Community-led Monitoring

Community engagement of people living with and affected by HIV through CLM will continue to be important to improve the quality of HIV and related services in constrained funding environments Community engagement creates an enabling environment for stakeholders to work together to address health-related issues and to achieve positive health impact and outcomes *(16)*. CLM is an accountability and advocacy strategy with the primary objective of improving quality, accessibility and utilization of HIV services. It is led and implemented by community-led organizations of people living with HIV, networks of key populations, other affected groups and other community entities at the local, national, regional and global levels *(15, 81)*.

CLM places the recipient at the centre of monitoring and advocacy. It may be undertaken independently or in collaboration with other key stakeholders (15). The recipients of health care services have the greatest stake in improving the quality and accessibility of HIV prevention, testing and treatment programmes, and they are often the first to detect problems and diagnose root causes. Thus, community groups, such as those involving people living with HIV, members of key populations, young people, women and girls, and other groups affected by HIV, should determine the focus of CLM. CLM compiles evidence on what works well, what is not working and what needs to be improved. The data collected complement local and national monitoring and provide key information to fill critical gaps in the decision-making process that leads to evidence-informed improvements of services.

Measuring Quality of Care

Each year poor-quality care contributes to 5.7–8.4 million deaths from all causes in low- and middle-income countries (LMICs), comprising 15% of total deaths in these countries *(82)*. People living with HIV and those accessing HIV prevention, testing, treatment and related services deserve high-quality care to attain and sustain optimal health outcomes and live long, healthy lives *(15)*. Continuing to measure quality of care in HIV programs is critical to rapidly identify areas of concern for action across the cascade of care in constrained funding environments.

Quality of care (QOC) must be measured within and across health system levels from the point of service delivery, to coordination of care between stakeholders, by evaluating adherence to national policies and comparison with standards *(83)*. Transitioning to the use of nationally adopted core quality standards enables a more consistent and structured approach to monitoring and improvement. These standards should be accompanied by both process and outcome indicators to provide a comprehensive picture of service quality and to support quality

"Quality of care must be measured within and across health system levels from the point of service delivery, to coordination of care between stakeholders, by evaluating adherence to national policies and comparison with standards"

improvement (QI) efforts at all levels. Ideally, QOC is measured through existing strategic information systems. Thus, QOC data depend on the strength of national health management information systems. Health systems should strive to increase interoperability of tools and systems, such as electronic medical records (EMRs) and existing patient tracking systems, to ensure a systems-level approach that will facilitates continuity and quality of care for people seeking and using HIV services.

QOC measurement should take into consideration the diversity of people seeking HIV services and use data collection and analysis strategies that safely explore and analyse this diversity, especially when determining how to disaggregate data for certain subpopulations *(15)*. Routinely collected data and existing tools should be the primary data sources, however in some situations additional approaches may be warranted, especially to gather data on client experiences and client satisfaction that may not be otherwise captured through routine programmatic data focused on service delivery. Comparing results with baseline data or a pre-determined benchmark or target also can help to assess whether performance is improving and whether a desired standard of care is being met *(84)*.

Three indicators in Table 12 (ART.1, ART.3 and VER.1) are indicators recommended for measuring and monitoring QOC for people receiving HIV services; in Annex 5, a list of additional quality indicators are provided to support countries in aligning quality measurement with their essential services package and conducting more comprehensive assessments *(78)*. Establishing clear, measurable facility-level standards aligned with essential and minimum packages of care empowers health teams to assess their performance and systematically address weaknesses. Service quality assessments (SQA) of these standards help determine whether key elements of care are being delivered effectively and when further diagnostic reviews and targeted QI activities are needed. Disaggregations by age, gender and subpopulation (for example, pregnant women, adolescents, men who have sex with men, people who inject drugs, sex workers, trans and gender diverse people, people in prisons and other enclosed settings and people living with HIV with TB) should be performed when possible and when there is a sufficient volume of data to avoid revealing information about individuals, especially members of groups that may be marginalized or criminalized. Through this ongoing process, quality management ensures that HIV service integration and programme transition are translated into sustained, tangible health impact.

"Establishing clear, measurable facility-level standards aligned with essential and minimum packages of care empowers health teams to assess their performance and systematically address weaknesses"

Setting priorities for indicators for action and monitoring

The person-centred strategic information guidelines provide 25 routine indicators with priorities set that cover the needs of a country programme and can be collected by one routine monitoring system linked, when feasible, to electronic monitoring records at the individual level *(78)*.

The priorities for the indicators can be set further within countries based on key criteria and using the minimum data set and definitions in the guidelines.

1. **Set priorities in terms of data systems:** review budget allocations considering additional support needed for surveys with priorities set, community monitoring, DHIS 2, electronic medical records and laboratory and logistics information systems and ensure that funding is directed towards priority data systems. Preference may be given to those supporting service delivery for routine programme monitoring.
2. **Assess priority services in the epidemic context:** priorities for indicators should only be set based on the services delivered and the data systems that need to be maintained.
3. **Convene partners to address gaps:** assess whether partners can contribute to filling the gaps (such as through wider demographic surveys), so that available funding can focus on core programme monitoring.
4. **Avoid unnecessary data collection and tools to reduce burden:** priority-setting should focus on indicators that produce actionable data, ensuring that resources are not allocated to indicators that are rarely used. Assess new approaches (such as artificial intelligence) and the data frequently used by the programme. Data are often seen as being free, but updating tools and collecting, cleaning and using data is expensive. Programmes should therefore consider managing programmes on a few high-level outcome measures linked to reduced incidence and mortality, such as viral load suppression or retention for treatment, people testing positive for HIV and linked to care for testing and people at risk remaining negative compared with similar populations in prevention programmes. This also enables greater freedom of implementation to achieve quality and impact in a programme.

Based on a country-by-country review of priority services, actual data use and programme reporting needs, a streamlined set of indicators, reduced by more than half, can be used as a basis for country and partner discussions. In some countries, the proposed set may be reduced further; in others, additional programme elements may justify using the original 25-indicator set. The full indicator descriptions are available in the WHO consolidated guidelines on person-centred HIV strategic information *(78)*, including metadata and country-specific implementation examples (Table 12).

"Based on a country-by-country review of priority services, actual data use and programme reporting needs, a streamlined set of indicators, reduced by more than half, can be used as a basis for country and partner discussions"

Table 12. Core person-centred indicators

	Indicators	Code[a]
1	Number and percentage of people living with HIV who know their HIV status	HTS.1
2	Number and percentage of people living with HIV receiving ART	ART.1
3	ART attrition: number and percentage of people living with HIV receiving ART at the end of the last reporting period and those newly initiating ART during the current reporting period who were not receiving ART at the end of the current reporting period	ART.2
4	Number and percentage of people living with HIV who have suppressed viral loads	ART.3
5	Advanced HIV disease – percentage of people starting ART with a CD4 count of less than 200 cells/mm^3 (or stage III or IV)	ART.5
6	Differentiated service delivery – percentage of people living with HIV and currently receiving ART who are receiving multimonth dispensing (three months or more) of antiretroviral medicine	DSD.1
7	Number and percentage of pregnant women who have suppressed viral loads at labour and delivery	VER.1
8	Number and percentage of pregnant women living with HIV receiving ART during pregnancy and/or at labour and delivery	VER.4
9	Total number of PrEP recipients	PRV.2
10	HBVHepatitis B test coverage: % percentage of people who were tested for hepatitis B surface antigen (HBsAg) during the reporting period	HEP.1
11	Hepatitis HCV C test coverage: percentage % of people who were tested for hepatitis C HCV (hepatitis C HCV antibody, hepatitis C HCV RNA or hepatitis C HCV core antigen) during the reporting period	HEP.2
12	Syphilis testing coverage: percentage of people tested for syphilis during the reporting period	STI.1

[a] **Reference code from Consolidated guidelines on person-centred HIV strategic information *(78)*.**

Planning and self-check questions

- ☐ Is there a national plan to transition data systems to health ministry ownership?
- ☐ Are essential indicators aligned with priority services and used for decision-making?
- ☐ Is offline data entry and delayed synchronization possible in low-connectivity areas?
- ☐ Are data protection measures in place, especially for key populations?
- ☐ Is a streamlined set of core indicators being used to reduce the data burden?
- ☐ Are data quality checks and system access audits conducted regularly?

Documenting and sharing best practices

Documenting and sharing lessons enable countries to transform experience into actionable knowledge. By capturing what works – and what does not – programmes can adapt, improve implementation and sustain impact. Embedding learning into planning, monitoring and review cycles ensures that evidence informs decisions, even amid shifting priorities or constrained resources *(85)*.

Planning and self-check questions

- ☐ Is learning built into regular planning and review processes?
- ☐ Are different types of data, including feedback and evaluations, being used to capture lessons?
- ☐ Are structured tools being used to document what works?
- ☐ Are the lessons learned being used to adjust programmes or policies in real time?
- ☐ Are insights being shared with others to support wider learning and improvement?

The following are steps countries can consider in identifying, documenting and sharing lessons from priority-setting experiences.

1. Embed learning in programme cycles from the outset

- Countries should define a diverse set of learning priorities by focusing on areas such as effective delivery models, equity trade-offs or integration strategies based on anticipated challenges or knowledge gaps *(86)*.
- Focal points, such as monitoring and evaluation officers, programme leads or implementation partners, should be designated to lead the documentation and review of lessons *(87)*.
- Learning moments should be aligned with existing opportunities, including quarterly meetings, mid-term evaluations or donor consultations to ensure that lessons feed into real-time decision-making *(88)*.

2. High-quality lessons are drawn from a diverse mix of data types, which together enrich the learning process

- Metrics on coverage, retention, stock-outs and service quality highlight patterns and emerging issues within routine programme and health system performance.
- Data on cost-efficiency, resource use and staffing availability provide insights that inform decisions around scale-up and priority-setting.
- Mid-term reviews, joint programme reviews and after-action reports offer structured insights into system performance *(89)*.
- Feedback gathered from focus groups, surveys and staff debriefing adds valuable local context and supports an equity-focused understanding of programme implementation *(86, 87)*.

3. Programmes should move beyond anecdotal evidence by documenting and analysing lessons systematically using structured learning tools

- After-action reviews and intra-action reviews identify what worked, what did not and what to improve, supporting team learning and preparedness *(89, 90)*.
- Learning agendas and tracking logs document programme adaptation, rationale and outcomes to build institutional memory and accountability *(86)*.
- Reflection workshops and peer exchanges support shared learning and problem-solving among regions and stakeholders *(87)*.

4. Documented learning should be actively used to inform and improve programme decisions and adaptations

- Integrate insights into planning meetings, donor dialogues and priority-setting processes to institutionalize evidence use.
- Monitor how lessons inform changes in policy, service delivery or resource allocation to reinforce a learning culture *(88)*.
- Share lessons through briefs, dashboards or platforms to promote system-wide learning and uptake.

To maximize the value of learning alongside enablers such as workforce, products and monitoring systems, countries should treat learning as a strategic function – connecting evidence to action and supporting programme sustainability in a changing environment.

"To maximize the value of learning alongside enablers such as workforce, products and monitoring systems, countries should treat learning as a strategic function – connecting evidence to action and supporting programme sustainability in a changing environment"

Continuing to work towards a sustainable response

The abrupt disruption of official development assistance has forced countries to accelerate plans to fully take on the ownership of and responsibility for HIV and related services. Although donor funding has always required plans for countries to increasingly invest in HIV and related areas, work towards sustainable responses has accelerated in recent years.

In 2024, the United States President's Emergency Plan for AIDS Relief (PEPFAR), UNAIDS and the Global Fund to Fight AIDS, Tuberculosis and Malaria, supported by WHO and other partners, started a process to support countries in planning towards sustainable responses that rely less on donors *(91)*.

Countries were encouraged to engage national leadership and stakeholders, including communities and partners and through technical working groups and multisectoral dialogues, to establish a shared vision, set sustainability goals and develop roadmap timelines (Box 9).

Box 9. Developing plans that address the 2025 context with a focus on sustainability

- Key stakeholders are encouraged to build on any work started in 2024 to develop HIV sustainability roadmap plans across five domains: political leadership; enabling laws and policies; sustainable and equitable financing; HIV services and solutions; and systems *(91)*.
- An initial response assessment phase should identify high-level outcomes, pathways of change and discuss strategies for sustaining progress beyond 2030, in alignment with commitments to universal health coverage *(92)*.
- Key stakeholders should engage in developing the next phase of the transformation plan, mobilizing resources for implementation and monitoring.
- For countries further along in sustainability planning, the focus should shift to developing operational plans, mobilizing resources for implementation and establishing robust monitoring systems.
- Develop or revise comprehensive plans to address the 2025 context. These plans should include phased catch-up strategies to address the gaps resulting from service disruption. The plans should be time-bound, aligned with epidemiological data and population needs and supported by clear context-specific criteria for priority-setting and resource allocation *(49, 54)*.
- The plans should also include a focus on sustainability – drawing on work undertaken in countries towards sustainability roadmaps, when appropriate. The plans should include strategic approaches to securing financial resources, optimizing service delivery models and embedding service adaptations into national health policies and financing frameworks.
- Sustainability efforts should also align with broader health system strengthening to reduce dependence on emergency measures and maintain service continuity *(91, 93)*.

Plans should also address absorbing human resources from implementing partners into government structures and can reference WHO guidelines on task sharing and community health worker policy. Government-funded health workers without previous HIV training should also be supported through on-site capacity-building *(24–26, 49)*.

9. Conclusions

This publication serves as flexible yet comprehensive operational guidance to help countries navigate severe funding disruptions and safeguard services. By giving priority to essential services in the context of the systems and enabling environments in which they are situated, ensuring meaningful community engagement and leveraging innovative and differentiated delivery models, countries can protect health gains while strengthening long-term sustainability. Although this publication focuses on HIV, viral hepatitis and STI services, much of the guidance provided here can support priority-setting across other health services.

Beyond immediate responses, this crisis is a turning point: an opportunity to embed HIV, viral hepatitis and STI services within stronger health-care systems that are resilient to future shocks. Success requires coordinated action from governments, civil society, communities, donors and technical partners – working together to build sustainable and equitable health systems that leave no one behind *(17, 91)*.

WHO remains committed to supporting Member States and communities through this complex transition.

"By giving priority to essential services in the context of the systems and enabling environments in which they are situated, ensuring meaningful community engagement and leveraging innovative and differentiated delivery models, countries can protect health gains while strengthening long-term sustainability"

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Annex 1.

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

	Services and interventions	Systems, operational and enabling contexts
Prevention of vertical transmission of HIV, hepatitis B and syphilis *(1–3)*	• Integrate testing into routine antenatal care contacts • Test all pregnant women as early as possible in pregnancy or during breastfeeding for HIV, hepatitis B surface antigen and syphilis • Provide partner testing of pregnant women diagnosed with HIV and syphilis and network-based testing for household members and partners of women diagnosed with chronic hepatitis B infection • PrEP options should be available for HIV serodiscordant couples • Use lower-cost, WHO-prequalified rapid diagnostics, including dual HIV and syphilis rapid tests and HIV self-testing • Immediate ART initiation or referral for initiation for all pregnant or breastfeeding women testing HIV positive • Prophylaxis with tenofovir disoproxil fumarate for all hepatitis B surface antigen–positive pregnant women with hepatitis B DNA >200 000 IU/mL or hepatitis B e antigen–positive (or to all hepatitis B surface antigen–positive pregnant women when hepatitis B DNA is not available) • Tenofovir disoproxil fumarate is recommended preferably from the second trimester of pregnancy until at least delivery or completion of the infant hepatitis B vaccination series. This should be accompanied by counselling and linkage to appropriate care and follow-up • For pregnant women with early syphilis, treat with single benzylpenicillin (penicillin G) injection given as one 2.4 million-unit injection or two 1.2 million-unit injections. For those with late or unknown stage of syphilis, treat with 2.4 million units of benzathine benzylpenicillin intramuscularly once weekly for three consecutive weeks. This can be given as one 2.4 million-unit injection or two 1.2 million-unit injections per dose. Penicillin G once weekly for three consecutive weeks • HIV retesting for pregnant women in the third trimester in settings with HIV prevalence ≥5% and for those with ongoing risk of infection • Tracing of pregnant women having positive results for HIV, hepatitis B and/or syphilis to ensure that they receive appropriate care and treatment • Infant antiretroviral drug prophylaxis for infants born to mothers living with HIV in accordance with the national protocol and co-trimoxazole prophylaxis from 4–6 weeks onwards until HIV infection is ruled out • Timely infant hepatitis B birth dose vaccination for all newborns within 24 hours of birth (regardless of maternal hepatitis B surface antigen status) followed by routine childhood vaccination series • After delivery, catch-up testing for mothers and early infant diagnosis for infants could be integrated into routine postpartum contacts • Early infant diagnosis for HIV-exposed infants at 4–6 weeks of life using nucleic acid amplification testing (DNA-polymerase chain reaction), with immediate ART initiation for all positive infants (see the section on treatment)	• Systems, operational and enabling contexts • Ensure that health-care personnel are equipped with the knowledge, skills and resources to provide services for preventing vertical transmission alongside routine maternal, newborn and immunization services • Align or integrate post-delivery follow-up contacts with routine postnatal and immunization schedules • Develop catch-up plans for mothers and newborns who miss follow-up visits, including HIV and syphilis testing, prophylaxis and treatment (such as infant antiretroviral drug prophylaxis). • If services are moved, relocated or co-located with related services, convene a multidisciplinary transition team and assess the related systems implications, opportunities including commodity supply chain coordination, health workforce training and roster planning, client information and any physical adjustments that may be required within facilities

Annex 1. Example of mapped baseline set of services and interventions (cont'd.)

	Services and interventions	Systems, operational and enabling contexts
	• Immediate infant or child ART initiation for positive infants or young children with redrawing of laboratory sample for confirmatory testing • Routine follow-up and repeat HIV testing at nine months and the end of breastfeeding using an age-appropriate test for breastfeeding infants exposed to HIV • For infants with confirmed congenital syphilis or born to mothers with untreated or inadequately treated syphilis, treat with benzyl penicillin or procaine benzylpenicillin using weight-based dosing for 10–15 days • Offer PrEP to reduce the risk of acquiring HIV for pregnant and breastfeeding women at high risk (serodiscordance)	
Hepatitis B vaccination – infants ***(4, 5)***	• Continue complete hepatitis B vaccine series through the Expanded Programme on Immunization: timely birth dose should be followed by 2–3 additional doses of hepatitis B vaccine, depending on the specific schedule used in the country; WHO recommends that all infants complete the full primary vaccination series by six months of age	• Coordinate hepatitis B vaccination with routine immunization schedules and maternal and newborn services to reduce missed opportunities and resource duplication
Hepatitis B vaccination – adults ***(4, 5)***	• Hepatitis B vaccination of adults (especially key populations) according to the national protocol	• Pre-vaccination serological testing for adults is preferrable but not essential
HIV PEP ***(6)***	• Maintain availability of HIV PEP in care settings for occupational exposure • Expanded availability of HIV PEP, including for non-occupational exposure • Use rapid diagnostic testing and HIV self-testing for PEP initiation and follow-up	• Distribute PEP through task sharing in primary care settings and pharmacies • Use simplified protocols and job aids to enable non-specialist health workers to initiate PEP
HIV PrEP ***(1, 7)***	• Uninterrupted access to HIV PrEP to reduce the risk of acquiring HIV, notably for key populations • Use oral PrEP over long-acting (long-acting cabotegravir and dapavirine vaginal ring) • Use rapid diagnostic testing and self-testing for HIV testing before initiating PrEP and for continuation.	• When possible, organize stocks and systems to facilitate multimonth dispensing of oral PrEP (3–6 months), including for clients initiating PrEP, depending on stock availability • Waiting for kidney function or hepatitis test results should not delay PrEP initiation or continuation. In addition, lack of available kidney function or hepatitis testing should not be a barrier to initiating or using PrEP
Blood product safety and health care infection control ***(8)***	• Mandatory screening of all blood donations for HIV, hepatitis B, hepatitis C and syphilis before use in clinical care in accordance with WHO's recommended essential in vitro diagnostics • Use sterile, single-use needles and syringes and properly dispose of sharps in puncture-proof containers; consider using safety-engineered injection devices where feasible	• Ensure linkage to care for people with positive screening results • Eliminate unnecessary injections, favouring oral medications when possible

Annex 1. Example of mapped baseline set of services and interventions (cont'd.)

	Services and interventions	Systems, operational and enabling contexts
Harm-reduction services, including opioid agonist maintenance therapy, needle and syringe programmes and naloxone provision for opioid overdose management ***(4, 9)***	• Distribution of sterile needles, syringes and other harm-reduction supplies through facility-based and community-based services • Using alternative distribution routes, including public or private pharmacies, secondary distribution through peers and vending machines • Offering facility-based opioid agonist maintenance therapy services to people with opioid dependence, ideally including psychosocial support • Offering take-home dosages of opioid agonist maintenance therapy for stable clients • Facility-based and community-based distribution (through opioid agonist maintenance therapy and needle and syringe programmes) of naloxone kits for overdose management and prevention to clients, families and peers • Medical withdrawal management when requested by clients, when opioid agonist maintenance therapy continuation is not possible or in other specific circumstances	• When setting priorities for harm-reduction interventions, consider that continuing opioid agonist maintenance therapy services for clients who are already in the programme and providing naloxone for overdose management should be given priority as lifesaving in the short term • Direct collaboration with communities and key population networks since they are essential to identify and provide safe, effective service delivery channels with greater reach • Engaging peer workers may mitigate stigma towards clients of harm-reduction services and improve the acceptability and uptake of services
Provision of condoms and lubricants ***(1)***	• Availability and distribution of condoms and lubricants at health-care facilities and, when feasible, at communities, giving priority to key populations and young people	• Integrate condom and lubricant distribution with other health services (such as family planning)
Voluntary medical male circumcision ***(10)***	• Give priority to voluntary medical male circumcision services in settings and districts with high HIV prevalence and lower circumcision coverage for adolescents aged 15 years and older and adult men • Ensure that adequate information is provided and informed consent and assent are obtained before each procedure and other preoperative necessities in accordance with the WHO manual for male circumcision under local anaesthesia. • Continue follow-up services for clients recently circumcised (such as post-operative checks) • A minimum package of services, including education on safer sex, condom promotion, offer of HIV testing services and management of STIs, must be delivered along with the surgical procedure • Transition to sustainable voluntary medical male circumcision services and integrate with other health services for men	• Voluntary medical male circumcision services should be provided based on the principles of sustainability as described in WHO voluntary medical male circumcision sustainability guidance (10) with a focus on men aged 15 years and older. • Client safety, infection prevention and control remain critical operational considerations in accordance with the WHO manual for male circumcision under local anaesthesia and HIV prevention services for adolescent boys and men
	• Give priority to testing based on HIV burden, latest epidemiology and ART coverage and information on viral suppression at the subnational level • Give priority to maintaining routine testing access and coverage to the facilities with the greatest number of HIV-positive diagnoses and ART initiations • Give priority to testing for specific populations based on public health impact and the ability to identify the greatest number of HIV cases and the potential to prevent new infections. HIV testing priorities should include:	• Simplify testing delivery and discontinue all non-essential retesting: biannual testing for key populations and annual testing for other groups with ongoing risk, one targeted retest exclusively for pregnant women from key populations or in high-HIV-burden settings (≥5% prevalence) during third trimester or labour and delivery

Annex 1. Example of mapped baseline set of services and interventions (cont'd.)

	Services and interventions	Systems, operational and enabling contexts
	○ sexually active adults and adolescents (15+): with HIV-related signs, symptoms or risk factors (including key populations) attending any clinic or hospital; ○ individuals with TB, hepatitis C or STI coinfections: testing should be tailored to the local burden; ○ children: those who are sick in high-HIV-burden settings (≥5% prevalence), HIV-exposed infants (optimally at six weeks) and any biological children of newly diagnosed people with HIV at any clinic or hospital; ○ pregnant women: first antenatal care (12) contact or as early as possible if missed (aligned with guidance on preventing vertical transmission); and ○ Partners of newly diagnosed people living with HIV and those in risk networks: at minimum, offering client referral with option of a self-test for all sexual and drug-injecting contacts as well as close contacts and associates identified to have substantial HIV risk. • Give priority to services to facilitate rapid ART initiation (or re-engagement) for all people following an HIV-positive diagnosis • Give priority to approaches that support low- cost rapid initiation and continuation of HIV prevention wherever available or offered for PEP and PrEP.	and one retest for HIV-exposed infants at the 6- to 9-month visit if breastfeeding • Discontinue all recency testing, Western blotting, use of other line immunoassays for routine HIV diagnosis and only use nucleic acid amplification for infant diagnosis <18 months. • Use lower-cost rapid tests and self-tests such as those prequalified by WHO: rapid diagnostic testing, dual HIV and syphilis tests and HIV self-testing • Use WHO-recommended flexible three-test rapid diagnostic testing strategy and simplified quality tools to ensure accuracy and prevent misdiagnosis and unnecessary ART initiation • Consider integrated testing and multiplexing (such as dual HIV and syphilis rapid diagnostic testing) based on epidemiology and resources • Task shift testing and test for triage using lay providers and self-tests across delivery
Facility-based testing for syphilis *(12)*	• Ensure that syphilis testing is available for pregnant women and key populations • Manage all positive cases with same-day treatment provided whenever possible. • Deliver prevention messages through community-based or remote channels. • Follow up with pregnant women and key populations who missed testing • Continue clinic-based syphilis screening for pregnant women and key populations • Offer catch-up testing and treatment for key populations and pregnant women who were affected by service interruptions	• Use network-based testing when community testing is no longer feasible to reach key populations and individuals at high risk of HIV infection outside facilities
Facility-based testing for viral hepatitis *(4, 5, 13)*	• Facility-based testing for hepatitis B and C, hepatitis B surface antigen and anti-hepatitis C serological testing in all settings for: ○ adults and adolescents living with HIV, TB or STIs; ○ key and high-risk populations, including migrant and indigenous populations, as well as populations from areas of high endemicity; ○ adults, adolescents and children with a clinical suspicion of chronic viral hepatitis (symptoms, signs and laboratory markers); and ○ blood donors. • All pregnant women should be tested for HIV, syphilis and hepatitis B surface antigen at least once and as early as possible during pregnancy (information aligned with the section on preventing vertical transmission)	• Use low-cost, WHO-prequalified rapid diagnostic testing or immunoassays • Ensure linkage to care for people with positive test results • Consider task shifting and hepatitis C self-testing approaches to reduce the burden on the health workforce

Annex 1. Example of mapped baseline set of services and interventions (cont'd.)

	Services and interventions	Systems, operational and enabling contexts
Community-based testing for HIV, viral hepatitis and syphilis *(11, 14)*	• Focus community-based testing for high-risk populations, with attention to the needs of key populations • Collaborate with community stakeholders to plan periodic (1–3 years) outreach testing activities based on the latest epidemiology and across disease areas • Workplace testing for men in high-risk industries through financing and partnerships with the private sector • Virtual service delivery and expand HIV self-testing access, including through pharmacies and user-paid delivery options • Consider options for hepatitis C self-testing distribution • When traditional community testing is no longer feasible, leverage facility network-based approaches to reach key populations and individuals at high risk of HIV infection	• Establish referral and follow-up systems that remain functional even when community-based services are temporarily disrupted • Integrate hepatitis and syphilis testing with HIV testing in community outreach to maximize efficiency

Routine ART for all children, adolescents and adults, including pregnant, breastfeeding women and key populations *(14)*	• Uninterrupted treatment to all individuals receiving ART, all populations (including pregnant, breastfeeding women and key populations) and regimens
	• Rapid ART initiation for all people diagnosed with HIV, including same-day ART initiation, including for individuals starting treatment outside a facility (such as during outreach or when attending mobile services)
	• Routine ART for children:
	  ○ uninterrupted dolutegravir-containing treatment to all children who are already receiving ART; and
	  ○ dispense three months of ART refills for children aged >2 years.
		• In situations of severe antiretroviral drug stock-out or limited access, consider giving priority to people living with HIV with symptomatic disease and/or with CD4 <350 calls/mL
		• In situation of forced ART interruption because of stock-outs, all drug components of the regimen should be stopped at the same time and reinitiated together as soon as possible
		• Ensure the stability of the supply chain for paediatric formulations: redistribution, confirm antiretroviral drugs in the pipeline and plan for future orders
		• On-site capacity-building and tools for non-trained government health workers for paediatric formulations and dosing, adherence support and referral for advanced HIV disease management for children

Routine screening for people living with HIV initiating (and reinitiating) ART *(1)*	• CD4 testing:
	  ○ for individuals newly initiating ART; and
	  ○ for those returning to care after a period of disengagement.
		• Establishing a stock threshold that triggers an alert when reached may help to prevent stock-outs and ensure the continuity of activities by enabling timely supply, response and coordination
		• Requires supply chain support to ensure the availability of reagents, maintain functional laboratory equipment and the presence of trained staff to support uninterrupted CD4 testing across all service delivery points

Annex 1. Example of mapped baseline set of services and interventions (cont'd.)

	Services and interventions	Systems, operational and enabling contexts

Advanced HIV disease management *(1)*	• Advanced disease package of care, including for those returning after having disengaged from treatment:
	  ○ screening and prophylaxis for common opportunistic infections (such as TB, cryptococcal meningitis and histoplasmosis);
	  ○ rapid ART initiation;
	  ○ treatment of identified opportunistic infections; and
	  ○ adherence support.
	• Use of device-free, point-of-care tests can facilitate continued implementation of the advanced HIV disease package of care – CD4 and lateral flow urine lipoarabinomannan assay can be conducted device-free, while cryptococcal antigen and GeneXpert can be conducted at the point of care
	• Preserve preventive prophylaxis with co-trimoxazole and fluconazole, repeat CD4 testing not required for stopping co-trimoxazole; can be discontinued after the individual is established on ART
	• Clinical screening to rule out signs and symptoms of meningitis
	• Referral and linkage reporting system for people transitioning in care (such as inpatient to outpatient) to minimize individuals lost to care
	• Offer TB preventive treatment
		• Consult WHO guidelines on bacterial meningitis and the WHO AWARE antibiotic book for management of severe bacterial infections and WHO policy brief on caring for seriously ill people living with HIV

TB screening, diagnosis, treatment and prevention for people living with HIV *(1)*	• Screening, diagnosis, treatment and prevention for TB • Provision of adequate stocks of TB prevention medicines to all clients to support treatment completion • Give priority to using shorter WHO-approved TB preventive treatment regimens in certain populations	• Decentralize TB screening and TB preventive treatment provision to primary care, avoiding reliance on TB specialists in low-resource settings • Optimize sample transport

ART (viral load) monitoring *(1, 15)*	• Routine annual viral load monitoring testing (unless clinically indicated)
	• Testing after unsuppressed viral load: viral load testing three months after a previously elevated result (>1000 copies/mL)
	• Pregnancy:
	  ○ viral load at 34–36 weeks for all pregnant women;
	  ○ viral load at first antenatal care contact if ART started pre-conception; and
	  ○ viral load at three months if ART started during pregnancy.
	• Breastfeeding: viral load at three months postpartum, then every six months
		• Develop catch-up testing for clients who missed a routine viral load test or had a previously unsuppressed result

Management of mpox (essential for outbreak control) *(16, 17)*	• Management of clients with suspected or confirmed mpox, following clinical and infection prevention guidelines • Clinical management of severe cases, especially among individuals with advanced HIV disease • Referral of severe cases to specialized care	• Develop referral pathways for severe cases for specialized care

Annex 1. Example of mapped baseline set of services and interventions (cont'd.)

	Services and interventions	Systems, operational and enabling contexts
Multimonth dispensing of 3–6 months of ART (reduced frequency of ART pick-up) ***(14)***	• Minimum of 3 multimonth dispensing for all clients, unless clinically unwell, with 6 multimonth dispensing preferred (if feasible) • Enrolment of eligible clients in less-intensive differentiated service delivery models • Alternative antiretroviral drug distribution routes, including public or private pharmacies, secondary distribution through peers, vending machines, faith-based groups or centres, community posts and community models led by trained clients (such as community ART groups)	• Assess antiretroviral drug stock levels to guide the optimal refill and supply planning that ensures equitable distribution of antiretroviral drugs • Transition from groups led by health-care workers to client-led groups when necessary • Use of early-warning indicators to monitor and manage stock levels of antiretroviral, antituberculosis and antimalaria medicines
Viral hepatitis B treatment and monitoring ***(4, 5, 13)***	• Uninterrupted treatment to all individuals already receiving hepatitis B treatment • Confirm eligibility for hepatitis B treatment for people with positive serology and assess level of liver disease and liver fibrosis and assess coinfections and comorbidities when indicated • Extended medicine supply at treatment initiation (with adherence support) to 3–6 months for hepatitis B treatment • Monitoring and follow-up: annual viral load monitoring for hepatitis B • Additionally, when enrolment into viral hepatitis treatment is continued: ○ Provide hepatitis B treatment to all adults and adolescents aged ≥12 years with chronic hepatitis B infection (including pregnant women and girls and women of reproductive age) meeting the eligibility criteria	• Consider integration, decentralization and task-shifting approaches, notably for clients without advanced liver disease, to reduce the health workforce burden in specialized settings • Consider using point-of-care solutions as well as reflex testing for hepatitis B DNA
Viral hepatitis C treatment and monitoring ***(4, 5, 14)***	• Uninterrupted treatment for all individuals already receiving hepatitis C treatment • Confirm chronic hepatitis C diagnosis and assess the level of liver disease and liver fibrosis and assess coinfections and comorbidities when indicated • Provide full treatment course (8, 12 or 24 weeks) for hepatitis C • Scheduling of hepatitis C confirmation of cure at 12 weeks post-treatment • Additionally, when enrolment into viral hepatitis treatment is continued: provide hepatitis C treatment to all adults, adolescents and children aged ≥3 years with chronic hepatitis C infection, regardless of stage of disease	• Consider decentralization and task-shifting approaches, notably for clients without advanced liver disease, to reduce the health workforce burden in specialized settings • Consider using point-of-care solutions as well as reflex testing for hepatitis C RNA

Annex 1. Example of mapped baseline set of services and interventions (cont'd.)

	Services and interventions	Systems, operational and enabling contexts
Syndromic management of STIs (genital discharge; ulcer disease) *(12)*	• Continue to provide syndromic management of STIs • Provide partner treatment, with a strong preference for same-day treatment whenever feasible	• On-the-job capacity building of health-care providers on the syndromic management of STIs • Steady supply of STI syndromic management medications and diagnostic at all primary care facilities • Collect and report STI data through existing health information systems, digitally if possible • Conduct integrated regular quality and compliance with syndromic management guidelines • Integrate awareness of syndromic management services through health outreach • Strengthen the referral system for clients requiring specialized care • Develop clear pathways for partner notification and testing
Prevention and continuing care for common comorbidities among people living with HIV *(1)*	• Prevention and continuity of care for people living with HIV who have common noncommunicable diseases, such as hypertension, cardiovascular disease and diabetes • In case of chronic diseases preceding the HIV diagnosis, it is essential to assure continuity of treatment and care of the respective chronic condition	• Use combined client visits (for example, ART + noncommunicable diseases refill) to reduce client burden and clinic congestion
Cervical cancer screening and treatment *(18)*	• Screening for human papillomavirus for women living with HIV who have never been screened before in their lifetime • Treatment for all women screening positive • Management for all women diagnosed with invasive cervical cancer disease	• On-the-job capacity-building of nurses and midwives to perform screening and basic treatment to maintain coverage under human resources constraints
Adherence support for HIV treatment and care *(1)*	• Provision of basic adherence assessment, support and follow-up to clients who self-report non-adherence or adherence barriers	• Support can be provided by trained nurses, pharmacists and other non-specialist health-care workers
Mental health support for HIV treatment and care *(1)*	• Screen for mental health concerns (such as depression and anxiety) by nurses and non-specialist health-care workers using simplified or multi-disorder tools	• Train nurses and other non-specialist health-care workers to screen for mental health concerns (such as depression and anxiety) and refer to available specialized services
Tracing and re-engagement support (19)	• Tracing clients with abnormal lab results, including viral loads >1000 copies/mL • Tracing for clients who missed scheduled appointment by more than 28 days, especially those with active opportunistic infections, presenting with advanced HIV disease, pregnant and breastfeeding women and children • Re-engagement pathways that include clinical assessment upon return to care • Same-day ART reinitiation for all clients returning to care after disengagement unless clinical guidelines recommend deferral • Same-day ART reinitiation for all clients transferring from another facility, including those without formal transfer documentation	• Develop referral pathways to specialized mental health services

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All references were accessed on 9 June 2025.

Annex 2.

Annex 2. Scoring threshold table

Criteria	Impact	Explanation
1. Health impact and effectiveness	High	Robust evidence that the intervention substantially reduces the disease burden by reducing transmission or improving survival or outcomes (such as a large effect size or >X% reduction in incidence)
	Moderate	Evidence shows moderate effect on the magnitude of population outcomes (such as smaller or context-dependent impact), or it addresses a more limited segment of the epidemic
	Low	Little to no evidence of significant health outcome improvement, or the intervention targets a very small portion of the burden with minimal overall impact
2. Cost–effectiveness	High	Consistent evidence suggesting an incremental cost per DALY averted <0.5 times GDP per capita or cost-saving
	Moderate	Consistent evidence suggesting an incremental cost per DALY averted between 0.5 and 1 times GDP per capita
	Low	Limited evidence of an incremental cost per DALY averted >1 times GDP per capita
3. Equity considerations	High	Primarily benefits high-burden or marginalized groups, significantly improves access for poor or stigmatized people and is essential for protecting vulnerable populations. Helps to close an identified gap in health outcomes
	Moderate	Some equity benefits: for example, the intervention has broad population benefit (neither disproportionately favouring nor neglecting vulnerable groups) or modestly addresses inequity
	Low	Little to no specific benefit for vulnerable populations; may even primarily serve already advantaged groups, or cancellation would not significantly worsen disparities
4. Feasibility and health system capacity	High	The intervention can be delivered within the existing infrastructure and with the currently available human resources
	Moderate	The intervention requires moderate additional investment (such as additional infrastructure or additional human resources) to be delivered.
	Low	The intervention requires significant additional investment (such as additional infrastructure or additional human resources) to be delivered
5. Financial sustainability and budget impact	High	Low budget impact or easily absorbed into domestic funding. The annual cost is small relative to the health budget or there are committed resources to sustain it. Likely to continue without external aid, or alternate financing is secured
	Moderate	Non-trivial cost that poses some strain – may require reallocation or efficiency gains to afford. Possibly sustainable for a short period or at reduced scale, but uncertain in the long run without additional funds
	Low	Very high cost relative to the available domestic budget, making it infeasible to maintain at current scale. Without donor support, funding this intervention would severely crowd out other services or is simply not possible; continuing it would quickly exhaust resources
6. Acceptability	High	There are no perceived issues of acceptability to the communities for which the intervention is intended
	Moderate	There may be some issues of acceptability to the communities for whom the intervention is intended
	Low	There are clear issues of the intervention being unacceptable in the communities for whom the intervention is intended
7. Social and economic impact	High	The intervention has important positive social and economic effects beyond the health effects and health-related cost-savings that need to be considered
	Moderate	The intervention has unclear or modest social and economic effects beyond the health effects and health-related cost savings
	Low	The intervention does not have important social and economic effects beyond the health effect and health-related cost savings

Annex 3.

Annex 3. Fact sheet examples (A. Cost–effectiveness and B. Budget impact)

A. Cost–effectiveness information sheet for rapid global HIV, viral hepatitis and STI priority-setting

Why it matters

Cost–effectiveness analysis explores which interventions deliver the greatest health benefit to populations within a budget or resource constraint. It is commonly used for determining how to use public funds for health system investment and spending. This is especially important in contexts with limited budgets, in which difficult choices may have to be made. Cost–effectiveness is not the same as choosing the intervention with the lowest cost. Rather, it identifies which options offer the highest value in terms of providing the best health for the resources available.

What is cost–effectiveness?

- Cost–effectiveness compares the additional cost of an intervention to the additional health benefit it delivers.
- The results are summarized using an incremental cost–effectiveness ratio (ICER).
- The ICER is usually expressed as the cost per DALY averted, representing a reduction in population disease burden.
- The ICER is a comparison to alternatives such as the current standard of care or no intervention.

The following considerations apply to ICER estimates:

- defining the comparator and intervention and considering how services are, or would be, delivered for the population in need;
- choosing a perspective (such as health system or societal) that determines what costs and benefits are included;
- using summary health outcomes such as DALYs or quality-adjusted life-years, which combine mortality and morbidity, and for this exercise, DALYs are the focus since they are more commonly used in low- and middle-income countries; and
- estimating costs and health outcomes over a sufficient time to capture all important costs and effects for the analysis.

Interpreting results

- A lower ICER (change in cost divided by change in effect) means better value for money.
- To establish whether the ICER is cost-effective in each context, a cost–effectiveness threshold is used. The threshold establishes whether money should be used on the intervention, given what is currently being provided in that context.
- Another conclusion from a cost–effectiveness study can be that it is cost-saving, meaning that the intervention provides better health at a lower cost. In this situation, the decision to adopt or maintain the intervention would be very strong based on the cost–effectiveness.
- Cost–effectiveness is usually considered in a specific context, since local prices, disease burden and health system and population health characteristics can influence it.
- Cost–effectiveness estimates can be highly uncertain, given the complexity of factors considered in an estimate. Good studies explore different populations and health systems, scenarios and assumptions and report the levels of uncertainty.

Scoring cost–effectiveness

A traffic light system illustrates the cost per DALY averted relative to a country-specific threshold based on the GDP per capita.

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

Evidence on cost–effectiveness

Some interventions are supported by extensive research; others have limited or no data. When evidence is interpreted, thinking in terms of a hierarchy of availability (adapted from GRADE principles) is helpful.

Level	Type of evidence	Description
I	Systematic review(s)	A high-quality review of multiple cost–effectiveness studies; most reliable
II	Multiple cost–effectiveness studies	Consistent findings across studies
III	Single cost–effectiveness study	Useful but more limited in generalizability
IV	No cost–effectiveness evidence	No published data available

How the cost–effectiveness evidence was compiled and categorized for the global exercise

In this rapid global exercise, there was insufficient time to conduct a full evidence review. The cost–effectiveness data presented here were compiled using available global evidence syntheses (including Disease Control Priorities, Institute for Health Metrics and Evaluation (IHME) and WHO-CHOICE) and literature shared by the WHO Department of Global HIV, Viral Hepatitis and Sexually Transmitted Infections Programmes and targeted PubMed searches intended to address key gaps. This was not a systematic review nor was it intended to serve as a comprehensive or exhaustive source of evidence on cost–effectiveness but rather an indicative starting-point that can help to inform expert judgement and complement expert knowledge on the cost–effectiveness of the interventions.

To facilitate a transparent and cautious interpretation of results, a standard set of inclusion and categorization rules was applied.

- All ICERs were converted to 2023 US dollars using the GDP deflator for the United States of America.
- For each publication, we compared the reported ICER to the GDP per capita of the study setting and applied the categorization thresholds defined earlier (based on 0.5 and 1 times GDP per capita) to classify the results as high, moderate or low.
- Publications were excluded if they met any of the following criteria:
  - no publication year or reference period provided;
  - no clearly identifiable country or region reported (such as unspecified or unclear geographical scope); or
  - the publication date was before 2010.

For publications reporting a range of cost–effectiveness estimates rather than a single point estimate, the following approach was applied.

- For IHME studies, we reported the country-specific median ICERs as presented in the main publication (based on meta-regression estimates) and noted the lower and upper ICER values provided in the supplementary materials.
- For other studies:
  - If both the minimum and maximum ICER values were below the 0.5 or 1 times GDP per capita threshold, the intervention was classified as cost-effective and used the average ICER for reporting purposes.
  - If the ICER range was wide, the intervention was stratified based on key characteristics (such as delivery model or population group). For example, community-based HIV self-testing was disaggregated by target population (young; women having transactional sex; adult men).

How interventions were summarized

To synthesize findings across the literature:

- A structured extraction and summary table listing each intervention was created and disaggregated into more specific delivery models or target groups when studies reported results at that level. This was done where the original intervention label was too broad to meaningfully reflect differences in cost–effectiveness across sub-interventions (the intervention as defined in the study).
- For each subintervention:
  - Each ICER was compared with the country-specific GDP per capita threshold.
  - A traffic light score was assigned (high, moderate or low) based on the threshold cut-offs from the table above.
  - The number of ICERs falling into each category was counted.
  - These results were summarized using two pivot tables for visual comparison across interventions, one for evidence only from low- or lower-middle-income countries and one for evidence for all low- and middle-income countries. The table for low- or lower-middle-income countries should be used for this exercise. The one for low- and middle-income countries is to show the differences by context and ensure that the experts fully understand the difference between evidence that may have been used for developing guidelines but may not apply to this contextual archetype.

These categories do not consider any formal quality grading. Rather, they provide a practical guide for interpretation under time constraints. This evidence process is therefore weak (subject to bias), and experts should treat this classification as indicative only, complementing it with their own knowledge and professional judgement.

Interpreting gaps, uncertainty and missing evidence

As such, the strength of the evidence varies considerably across interventions, reflecting context, methods and time point. The evidence should therefore be considered indicative and, in many cases, of weak quality. It is a starting-point for expert judgement and not a definitive assessment. Experts are encouraged to complement this information with their own knowledge and familiarity with the literature, including any additional studies or contextual information they consider relevant.

If no cost–effectiveness evidence is available for a given intervention, this does not mean the intervention should be automatically given lower priority or assumed not to be cost-effective. Depending on how the intervention scores on other priority-setting criteria, it may still be considered for inclusion or flagged for further assessment when more time and resources are available. If the evidence is weak or missing, experts may choose not to assign a score under this criterion.

B. Budget impact information sheet for rapid global HIV, viral hepatitis and STI priority-setting

What is it?

This criterion assesses whether an intervention can be financed and maintained within the country's health budget, especially when external donor support is uncertain or declining. It assesses the implication for the health budget, now and in the future. In principle, all interventions that are cost-effective should be afforded. However, in some cases when interventions take up large proportions of the budget, there may be concerns about sustaining funding.

Budget impact examines financial resource requirements, now and in the future compared with budget availability (the intervention's total cost compared with available financial resources). It is concerning that, when giving priority to an intervention requires rapid reallocation, assessing budget impact with high confidence may not be feasible.

It focuses on:

- the cost of the intervention at scale, although periods of scale-up can be included and should be specified;
- the relative size of the resources used compared with available health budgets; and
- in the case of transition from external to domestic spending, impact will depend on whether the intervention is already domestically financed, co-financed or fully donor or externally financed, and the additional cost to domestic budgets may also be considered rather than overall total cost.

Key concepts

Budget impact refers to the cost of implementing an intervention (usually at scale) and its relative size compared with the total health budget, which can be estimated by looking at the domestic government health spending (per capita) and the share of spending covered by external aid.

A high budget impact signals that an intervention may:

- crowd out other more cost-effective interventions before full setting of new priorities can be considered; and
- be infeasible in terms of adjusting public financial management systems.

Budget impact analysis is typically conducted from the budget holder's perspective (in this case, the health ministry, finance ministry, social security agency or government health insurance agency) and includes costs and savings but not health outcomes.

How to assess budget impact

Assessing budget impact can involve both quantitative indicators and qualitative judgements. It is important to consider total cost (population in need multiplied by unit cost) and not just the unit cost of an intervention. It is also important to think about the full costs: not just commodities but consequences for human resource budgets and even longer-term infrastructure investment and maintenance, for example.

In the global priority-setting exercise, some information is provided below.

- Consider the annual cost of the intervention per capita to annual health budget per capita as a rough benchmark for affordability.
  - Low-income countries domestic budget average (2022): US$ 9 per capita.
  - Low-income countries current external funding average (2022): US$ 12 per capita.
  - Typically, around 60–80% of budgets reach the service delivery levels.
  - Typically, of that 60–70% of the budget, up to half is spent on secondary and tertiary care.

For example, a screening programme may have low cost (less than US$ 1), but a large population (1 million people) may need to be screened, so it still may have a high cost per capita. In a population of 5 million people ((1*1 000 000)/5 000 000) the annual cost of screening is US$ 0.2 per capita (or 1% of the total health budget for this intervention, with US$ 20 per capita available in the health budget).

Scoring budget impact

Use the traffic light categories below to rate each intervention based on its financial implications and likelihood of being sustained through domestic resources.

Score	What it means	Criteria
🟡 **High**	Low budget impact	Low budget impact or easily absorbed into the health sector budget. The average annual cost is very small relative to the health budget or resources are committed to sustain it. Likely to continue without external aid, or alternate financing is secured.
🟢 **Moderate**	Moderate budget impact	Non-trivial cost that poses some strain. May require reallocation of other services currently funded by health sector budgets. Possibly sustainable for a short period or at a reduced scale, but uncertain in the long run without additional funds, efficiency improvements and setting new priorities for health sector budgets.
🔴 **Low**	High budget impact	Very high cost relative to the available health sector budget, making it infeasible to maintain at the current scale, since the budgetary shifts required would be too great. In a scenario of decreased external support, funding this intervention would severely crowd out other services or is simply not possible; continuing it would quickly exhaust resources.

Interpreting the evidence on budget impact
Evidence on budget impact may include:

- budget impact analysis, either in peer-reviewed studies or national policy documents;
- costing studies estimating unit costs and projected scale-up costs;
- programme budgets or expenditure reviews; and
- national plans, Global Fund notes or similar documents.

In this case, no evidence summary is provided since there was insufficient time to estimate the costs per intervention and the reader will need to judge budget impact for a low-income setting (see budget per capita above). In such cases, consider:

- your experience in programme and intervention delivery, including budgeting;
- rapid costing exercises or experiences with which you are familiar ("back of the envelope"); and
- judgements based on similar interventions or country contexts.

Benchmark percentages of spending per capita are not provided as high or moderate and low. For this, reflect on your experience of sustaining programmes or health planning. Similar to the other criteria, you should place this judgement in the context of a low-income country with a generalized epidemic. Similar to the other criteria, this scoring is intended to structure and inform expert deliberations and not to determine the selection of the interventions itself.

Annex 4.

Annex 4. Scoring sheet example

Service and interventions	Criteria						
	Health impact and effectiveness	Cost-effectiveness	Feasibility and health system capacity	Equity and vulnerability	Budget impact	Social and economic impact	Comments
Prevention and continuity of care for people living with HIV who have common non-communicable diseases (NCDs) such as hypertension, cardiovascular disease and diabetes	[select]	[select]	[select]	[select]	[select]	[select]	
Cervical cancer screening and treatment	[select]	[select]	[select]	[select]	[select]	[select]	
Provision of basic adherence assessment, support, follow-up to clients who self-report non-adherence or adherence barriers	[select]	[select]	[select]	[select]	[select]	[select]	
Screen for mental health concerns (e.g., depression, anxiety) by nurses and non-specialist healthcare workers using simplified or multi-disorder tools	[select]	[select]	[select]	[select]	[select]	[select]	
Tracing and re-engagement support							
Tracing clients with abnormal lab results, including viral loads >1000 copies/ml	[select]	[select]	[select]	[select]	[select]	[select]	
Tracing for clients who missed scheduled appointment by more than 28 days, particularly those with active opportunistic infections, presenting with AHD, pregnant and breastfeeding women, and children	[select]	[select]	[select]	[select]	[select]	[select]	
Re-engagement pathways that include clinical assessment upon return to care	[select]	[select]	[select]	[select]	[select]	[select]	
Same-day ART re-initiation for all clients returning to care after disengagement, unless clinical guidelines recommend deferral	[select]	[select]	[select]	[select]	[select]	[select]	
Same-day ART re-initiation for all clients transferring from another facility, including those without formal transfer documentation	[select]	[select]	[select]	[select]	[select]	[select]	

Annex 5.

Annex 5. Baseline set of quality of care (QOC) indicators for a country priority-setting exercise

The list below is a baseline set of QOC indicators that countries can select from once they have gone through their prioritization exercise. Countries are encouraged to align quality indicators with their essential services list to support routine monitoring, assess service delivery performance, and guide targeted quality improvement efforts.

Ref. no.	Short name	Indicator definition	QOC domain
Care stage: prevention			
PRV.1	Condoms distributed	Total number of condoms distributed during the reporting period	People-centred
Care stage: testing			
HTS.4	Linkage to ART	% of people newly diagnosed with HIV initiated on ART	Efficient
Care stage: treatment			
ART.1	People living with HIV on ART	Number and % of people on ART among all people living with HIV at the end of the reporting period	Effective
ART.3	People living with HIV on ART who have suppressed VL	% of people living with HIV on ART (for at least six months) who have virological suppression	Efficient
ART.6	VL testing coverage	% of people living with HIV on ART (for at least six months) with VL test results	Effective
DSD.3	Coverage of DSD ART models among people living with HIV on ART	% of people living with HIV enrolled in DSD ART models among those eligible for DSD ART (for facilities with electronic HIS) or among people living with HIV currently on ART (facilities with paper-based systems) during the reporting period	People-centred
DSD.5	VL suppression among people living with HIV engaged in DSD ART models	% of people living with HIV and engaged in DSD ART models who have virological suppression	Efficient
Coordination of person-centered care			
VER.1	Viral suppression at labour and delivery	% of HIV-positive pregnant women who are virally suppressed at labour and delivery	Efficient
VER.2	Early infant diagnosis (EID) coverage	% of HIV-exposed infants who receive a virological test for HIV within two months (and 12 months) of birth	Integrated
DFT.1	TB screening coverage among new ART patients	% of people living with HIV newly initiated on ART who were screened for TB	Integrated
DFT.5	TB treatment initiation among diagnosed	% of people living with HIV newly initiated on ART and diagnosed with active TB who initiated TB treatment	Integrated

Ref. no.	Short name	Indicator definition	QOC domain
Overarching enablers of person-centred care			
SDC.1	Avoidance of health care due to stigma and discrimination (key populations)	% of key population members who avoid health care because of stigma and discrimination	Equitable
SDC.2	Avoidance of health care due to stigma and discrimination (people living with HIV)	% of people living with HIV who avoid health care because of stigma and discrimination	Equitable
QOC.1a	Patient satisfaction with care	% of people attending HIV treatment or prevention services who self-report they are satisfied or highly satisfied with the quality of HIV-related care they receive Possible data sources: client satisfaction surveys, exit interviews with clients, focus group discussions	People-centred
QOC.2[a]	Self-reported referral and follow-through	% of people attending HIV treatment or prevention services who self-report receiving referral to a non-HIV-specific service and who self-report receiving that service National programmes should select the non- HIV-specific services that should be included in this indicator (for example, mental health, nutritional support) Possible data sources: referral registers, surveys	Integrated
QOC.3[a]	Patient feedback mechanism	% of health facilities having at least one mechanism to monitor patient feedback (for example, customer/patient satisfaction surveys, exit interviews) Possible data sources: health facility surveys and audits	People-centred
QOC.4[a]	Guidelines for HIV clinical care	% of health facilities that report adhering to clinical practice guidelines, clinical pathways and/or clinical protocols/ algorithms to guide a) HIV testing and b) HIV treatment Possible data sources: health facility surveys and audits. Countries should determine which guidelines, pathways or protocols should be included for HIV prevention, testing or treatment, such as national or WHO resources.	Effective

[a]Reference code from Consolidated guidelines on person-centred HIV strategic information.

Annex 6.

Annex 6. Summary list: Priority-setting process planning and self-check questions

This checklist can be used as a practical tool to guide teams through the priority-setting process in health planning, especially in contexts of limited or changing resources. Work through each section by including "Yes," "No," or "Partial," in the - text space and use the comments column to note gaps, action points, responsible actors or timeline for action.

Engage a range of stakeholders, including community representatives and key populations, to ensure decisions are inclusive and grounded in real needs. The checklist can be adapted to fit your country context—for example, by translating the content, simplifying technical language, selecting only the most relevant sections, or aligning the questions with national strategies and planning timelines. Use it flexibly during planning workshops, internal reviews, or as a tool to track progress and strengthen accountability over time.

PRIORITIZE phase	Checklist responses (Yes/No/Partial)	Comment/ action points/ responsable actors/ timeline for action
Overarching	**Ethical Principles for setting priorities for health services** ☐ Has how substantive ethical principles can be assessed for each intervention or service been clearly defined and documented? - ☐ Have clear processes been established to reconcile and justify trade-offs between conflicting principles? - ☐ Are affected communities and key populations meaningfully involved in the priority-setting process, and are their perspectives reflected in the decisions? - ☐ Have the decisions, decision-making processes and reasons supporting decisions been publicly communicated? Are the decisions informed with the best available evidence? - ☐ Have the decision-making roles and responsibilities been clearly defined and communicated to all relevant stakeholders (such as individuals, groups or institutions)? -	
P Prepare the groundwork R Refine the scope I Implement the assessment O Organize the appraisal R Recommend actions I Implement decisions T Translate and uphold entitlements E Evaluate and sustain progress	**Governance and planning the priority-setting** ☐ Do leadership and coordination mechanisms ensure transparent priority-setting and the engagement of all relevant stakeholders and community groups? - ☐ Are service disruptions and gaps being assessed across system functions, using both real-time and retrospective data? - ☐ Has the full delivery and financing landscape been mapped out, including dependence on external funding and the alignment between donor support and domestic financing priorities? - ☐ Do the findings from these assessments directly guide adaptive planning and inform priority-setting decisions? -	

PRIORITIZE phase	Checklist responses (Yes/No/Partial)	Comment/ action points/ responsable actors/ timeline for action
P Prepare the groundwork R Refine the scope I Implement the assessment O Organize the appraisal R Recommend actions I Implement decisions T Translate and uphold entitlements E Evaluate and sustain progress	**Setting priorities for services in the context of reduced resources** ☐ Has a decision-making framework for setting priorities for services been clearly defined? - ☐ Are all relevant stakeholders actively engaged in the scoping, assessment and validation processes to ensure contextual relevance? - ☐ Have existing services and interventions been comprehensively mapped, aligning them with national and global policies? - ☐ Are the priority-setting criteria transparent, evidence informed and agreed by multidisciplinary expert panels? - ☐ Have robust processes been established for appraisal, validation and peer review to ensure transparency and accountability? - ☐ Have services and interventions been categorized into the respective tiers, and have plans been developed for re-engagement as resources permit? -	
	– **Tailored priority-setting considering population-specific needs** ☐ Are the specific needs of vulnerable and marginalized populations being actively considered, and is there a mechanism for periodically reviewing and adjusting priority-setting decisions? - ☐ Are population groups involved in planning and monitoring processes? ☐ Does the priority-setting plan consider the specific access needs and preferences of each group? - ☐ Are disaggregated data (by age, gender and population group) being used to inform priority-setting decisions? - ☐ Is the prevalence of HIV, STIs and hepatitis among specific groups used to guide service priorities? - ☐ Are services aligned with the type of epidemic (generalized, concentrated or low-level)? -	
P Prepare the groundwork R Refine the scope I Implement the assessment O Organize the appraisal R Recommend actions I Implement decisions T Translate and uphold entitlements E Evaluate and sustain progress	**Systems, strategic and operational considerations** ☐ Are disruptions across governance, financing and the health workforce being identified and addressed in an integrated manner? - ☐ Have missed opportunities in which HIV investments could have contributed to broader system strengthening been mapped? - ☐ Are people-centred approaches that reflect the voices and needs of affected populations being applied in priority-setting and planning? - ☐ Are PHC levers being used as a tool not only for HIV goals but also to support the continuity of services across all disrupted programme areas? - ☐ Is there alignment between HIV-specific goals and broader PHC strategies to ensure synergy and reduce fragmentation? -	

PRIORITIZE phase	Checklist responses (Yes/No/Partial)	Comment/ action points/ responsable actors/ timeline for action
I Implement decisions	– **Integrating service delivery within PHC person-centred models of care** ☐ Has how existing PHC infrastructure and delivery platforms can be leveraged to integrate HIV and other services been assessed? - ☐ Are mechanisms in place to ensure strong coordination and governance across programmes? - ☐ Have ways to mobilize and sustain domestic funding to support integrated services been explored? - ☐ Is task shifting and sharing being used to extend service reach, especially in underserved or resource-limited areas? - ☐ Are community engagement and feedback mechanisms embedded to improve access and responsiveness? - ☐ Have steps been taken to address stigma, discrimination and legal barriers that may limit access for key populations? - ☐ Are integration efforts being used as an opportunity to strengthen health workforce capacity and PHC leadership? - ☐ Do contingency or crisis response plans include strategies for maintaining integrated HIV service delivery? - ☐ Are successful elements being adapted from other countries' models to fit the local system capacity and population needs? -	
	– **Health workforce and systems resilience** ☐ Have workforce disruptions been assessed and documented, including the roles of community health workers? - ☐ Are accurate, up-to-date data available to guide re-engagement and planning? - ☐ Are rapid assessments and costing tools used to estimate the needs for critical posts? - ☐ Are the roles and competencies of community health worker mapped and standardized to support high-quality service delivery? - ☐ Are deployment efforts giving priority to underserved and high-burden areas? -	
	– **Medicines and other health products** ☐ Is there a clear plan to ensure continuous access to HIV medicines and diagnostics? - ☐ Have product selections been aligned with national guidelines and based on accurate forecasts and costs? - ☐ Is supplier performance being monitored using clear and consistent indicators? - ☐ Are storage and distribution systems ensuring timely and safe delivery to service points? - ☐ Have reliable backup systems been established for stock monitoring when digital tools fail? - ☐ What contingency measures are in place to manage potential supply chain disruptions? -	

PRIORITIZE phase	Checklist responses (Yes/No/Partial)	Comment/ action points/ responsable actors/ timeline for action
I Implement decisions	**– Health financing considerations** ☐ Have current external and domestic health funding flows been mapped and urgent gaps or risks to critical services been identified? - ☐ Is reprogramming or realigning of funding based on national priorities and equity considerations being coordinated with finance authorities and donors? - ☐ Have immediate-term measures been taken to protect essential services and prevent increased out-of-pocket spending for vulnerable populations? - ☐ Is a plan or roadmap in place to transition donor-funded services and inputs into sustainable domestic financing arrangements? - ☐ Are available tools being used to model financing scenarios and estimate the cost and impact of priority-setting decisions? -	
P Prepare the groundwork R Refine the scope I Implement the assessment O Organize the appraisal R Recommend actions I Implement decisions T Translate and uphold entitlements E Evaluate and sustain progress	**Communicating decisions** ☐ Have the decisions resulting from the priority-setting process, along with their justifications, been documented and disseminated using clear, accessible, and culturally appropriate language and formats? - ☐ Have appropriate communication channels and trusted intermediaries (e.g. community leaders, CSOs, health providers) been engaged to convey the decisions and support community acceptance and understanding? - ☐ Are there mechanisms in place to provide operational guidance and training for service providers and to allow users to ask questions, provide feedback or appeal the decisions? -	
P Prepare the groundwork R Refine the scope I Implement the assessment O Organize the appraisal R Recommend actions I Implement decisions T Translate and uphold entitlements E Evaluate and sustain progress	**Evaluating and sustaining progress** ☐ Is there a national plan to transition data systems to health ministry ownership? - ☐ Are essential indicators aligned with priority services and used for decision-making? - ☐ Is offline data entry and delayed synchronization possible in low-connectivity areas? - ☐ Are data protection measures in place, especially for key populations? - ☐ Is a streamlined set of core indicators being used to reduce the data burden? - ☐ Are data quality checks and system access audits conducted regularly? -	
	– Documenting and sharing best practices ☐ Is learning built into regular planning and review processes? - ☐ Are different types of data, including feedback and evaluations, being used to capture lessons? - ☐ Are structured tools being used to document what works? - ☐ Are the lessons learned being used to adjust programmes or policies in real time? ☐ Are insights being shared with others to support wider learning and improvement? -	

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