
Primary health care and HIV: convergent actions

Policy considerations for decision-makers



World Health
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Contents

Acknowledgements	iv
Abbreviations	v
Glossary	vi
Executive summary	viii
1. Introduction	1
2. Policy and operational frameworks	7
3. Policy dialogue to jointly strengthen PHC and HIV	13
4. The PHC levers and HIV: convergent actions	17
5. Priorities for guidance and implementation support	33
6. Conclusions	35
References	37
Annexes	39

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Abbreviations

GHSS 2022–2030	global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022–2030
PHC	primary health care
TB	tuberculosis
WHO	World Health Organization

Glossary

Community health workers (5). Health workers who have received standardized and nationally endorsed training outside the nursing, midwifery or medical curricula.

Community-led AIDS responses (2). Actions and strategies that seek to improve the health and human rights of their constituencies, specifically informed and implemented by and for communities themselves and the organizations, groups and networks that represent them.

Health system (3). All organizations, people and actions whose primary intent is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities. A health system is therefore more than the pyramid of publicly owned facilities that deliver personal health services. It includes, for example, family caregivers; private providers; behaviour change programmes; vector-control campaigns; health insurance organizations; and occupational health and safety legislation. The WHO health system framework identifies six health system building blocks: leadership and governance, health financing, health workforce, health services, health information systems and medical products, vaccines and technologies.

Integrated health services (4). Health services that are managed and delivered so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services, coordinated across the different levels and sites of care within and beyond the health sector and according to their needs throughout the life-course.

Key populations (1). Groups that have a high risk and disproportionate burden of HIV in all epidemic settings. These groups frequently face legal and social challenges that increase their vulnerability to HIV, including barriers to accessing HIV prevention, diagnosis, treatment and other health and social services. Key populations include men who have sex with men, people who inject drugs, people in prisons and closed settings, sex workers and transgender and gender-diverse people.

Lay provider (1). Any person who performs functions related to health care delivery and has been trained to deliver specific services but has not received a formal professional or paraprofessional certificate or tertiary degree.

Person-centred care (5). Care approaches and practices in which the person is seen as a whole, with many levels of needs and goals, the needs being derived from their personal social determinants of health.

People-centred care (4). An approach to care that consciously adopts individuals', caregivers', families' and communities' perspectives as participants in, and beneficiaries of, trusted health systems that are organized around the comprehensive needs of people rather than individual diseases, and respects social preferences. People-centred care is broader than patient and person-centred care, encompassing not only clinical encounters but also including attention to the health of people in their communities and their crucial role in shaping health policy and health services.

Primary care (5). A key process in the health system that supports first-contact, accessible, continued, comprehensive and coordinated patient-focused care.

Primary health care (5). A whole-of-society approach to health that aims to maximize the level and distribution of health and well-being through three components: (a) primary care and essential public health functions as the core of integrated health services; (b) multisectoral policy and action; and (c) empowered people and communities.

Primary health care-oriented health system (5). A health system organized and operated to guarantee the right to the highest attainable level of health as the main goal while maximizing equity and solidarity. A primary health care-oriented health system comprises a core set of structural and functional elements that support achieving universal health coverage and access to services that are acceptable to the population and equity enhancing.

Service package (5). A list of priority interventions and services across the continuum of care that should be made available to all individuals in a defined population. It may be endorsed by the government at national or subnational levels or agreed by actors where care is by a non-state actor.

Settings and sites of care (5). The varied types of arrangements for service delivery, organized further into facilities, institutions and organizations that provide care. Settings include ambulatory, community, home, inpatient and residential services, whereas facilities refer to infrastructure, such as clinics, health centres, district hospitals, dispensaries or other entities, such as mobile clinics and pharmacies.

Universal health coverage (5). Access for all people to the full range of quality health services they need, when and where they need them, without financial hardship. Universal health coverage encompasses the continuum of essential health services, from health promotion to disease prevention, treatment, rehabilitation and palliative care across the life-course.

Vulnerable populations (1). Groups of people who are vulnerable to HIV infection in certain situations or contexts, such as infants, children and adolescents (including adolescent girls in sub-Saharan Africa), orphans, people with disabilities and migrant and mobile workers. They may also face social and legal barriers to accessing HIV prevention and treatment. These populations are not affected by HIV uniformly in all countries and epidemics and may include key populations, indigenous people and ethnic minorities.

Endnotes

1. Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach, July 2021. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/342899>, accessed 6 June 2023).
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4. Executive Board. Framework on integrated, people-centred health services: report by the Secretariat. Geneva: World Health Organization; 2016 (<https://apps.who.int/iris/handle/10665/250704>, accessed 6 June 2023).
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Executive summary

The 2030 health-related Sustainable Development Goals call on countries to end AIDS as a public health threat and also to achieve universal health coverage. The World Health Organization (WHO) promotes primary health care (PHC) as the key mechanism for achieving universal health coverage, and the PHC approach is also essential for ending AIDS and reaching other Sustainable Development Goal targets.

The PHC approach is defined as a whole-of-society approach to health that aims to maximize the level and distribution of health and well-being through three components: (1) primary care and essential public health functions as the core of integrated health services; (2) multisectoral policy and action; and (3) empowered people and communities.

This publication helps decision-makers to consider and optimize the synergies between existing and future assets and investments intended for both PHC and disease-specific responses, including HIV. Specifically, it aims to:

- provide guidance to policy-makers, health system managers and programmatic leads from both PHC and HIV backgrounds regarding opportunities to jointly advance their respective efforts to strengthen PHC and end AIDS as a public health threat; and
- provide a resource for all stakeholders who seek to contribute to strengthening PHC and ending AIDS as a public health threat in a synergistic manner, including people living with HIV, members of key and vulnerable populations, community and civil society representatives, people working in all areas of health systems, researchers, funders and private-sector decision-makers.

In 2019, at the request of the World Health Assembly, WHO developed a PHC operational framework. The framework is based on a theory of change that describes how the core elements of the PHC approach can be translated into results through 14 interrelated levers for action and investment:

- political commitment and leadership;
- governance and policy frameworks;
- funding and allocation of resources;
- engagement of community and other stakeholders;
- models of care;
- primary health care workforce;
- physical infrastructure;
- medicines and other health products;
- engagement with private-sector providers;
- purchasing and payment systems;
- digital technologies for health;
- systems for improving the quality of care;
- primary health care-oriented research; and
- monitoring and evaluation

The PHC levers serve as a useful framework for identifying opportunities to jointly strengthen PHC and meet HIV-specific goals. This same framework can be applied to or adapted to other disease-specific responses such as those addressing viral hepatitis, sexually transmitted infections, tuberculosis and noncommunicable diseases.

Actions are presented in this publication in relation to each lever with the intention of offering illustrative examples of how PHC and HIV goals can be jointly advanced. PHC and HIV stakeholders should work together to decide which levers should be given priority in their specific national and subnational settings and should define the collaborative or synergistic PHC

and HIV actions that will be carried out in association with these levers. Throughout this process, the meaningful engagement of people living with and affected by HIV alongside the broader PHC-focused communities is essential. National and subnational multisectoral and multistakeholder advisory groups or consultations addressing PHC and HIV may help to inform and to coordinate policy dialogue.

Such an approach can accelerate efforts to strengthen PHC while also helping to overcome obstacles to ending AIDS as a public health threat. Despite the existence of effective prevention, testing and treatment tools, HIV continues to impose a heavy burden of disease worldwide. Progress toward targets associated with ending AIDS has slowed overall in recent years and has even been reversed in some countries. In 2021, 1.5 million people acquired HIV and 650 000 people died from HIV-related causes. Five key populations – men who have sex with men, people who inject drugs, sex workers, transgender and gender-diverse people and people in prisons and other closed settings – are disproportionately affected by HIV compared with the general population in all parts of the world. Key populations and their sexual partners accounted for 70% of new HIV infections in 2021, and the limited available data suggest that key populations lag behind in undergoing HIV testing and utilizing antiretroviral therapy.

People living with HIV and members of key populations experience high levels of stigma and discrimination, including in health care settings. Countering stigma and discrimination is an essential aspect of addressing their physical and mental health needs.

In the context of the HIV epidemic, vulnerable populations are groups of people who are vulnerable to HIV infection in certain situations or contexts. Vulnerable populations thus vary across national and subnational settings. Women, including pregnant and breastfeeding women and adolescent girls, as well as children, adolescents and young people, including young key populations, are vulnerable to HIV infection in specific contexts. Men and boys are less likely to use health services and have poorer health outcomes in some settings. Other vulnerable populations may include people with disabilities, indigenous peoples, migrants and mobile populations and people in settings of humanitarian concern, including people affected by conflict and civil unrest.

Achieving many of the Sustainable Development Goals, including ending AIDS as a public health threat, and sustaining these gains in the face of the complex demands being placed on health and development systems, will require using health system resources in new ways. Scaling up high-quality people-centred services through a PHC approach is critical for achieving both disease-specific and broader health aims. The PHC approach promotes the overall health and well-being of people who are living with or at risk of HIV, including members of key and vulnerable populations. Further, HIV resources and lessons can be channelled into many aspects of reorienting health systems towards PHC. Members of all populations must be able to access health services and benefit from health system resources free from stigma and discrimination.

Chapter 1

Introduction

The 2030 health-related Sustainable Development Goals call on countries to end AIDS as a public health threat and also to achieve universal health coverage (1). WHO promotes primary health care (PHC) as the key mechanism for achieving universal health coverage, and the PHC approach is also essential for ending AIDS and reaching other Sustainable Development Goal targets.

This publication helps decision-makers to consider and optimize the synergies between existing and future assets and investments intended for both PHC and disease-specific responses, including HIV. Although it mainly focuses on opportunities for addressing HIV and PHC approaches together, many of the suggestions can be applied to or adapted to other disease-specific responses as they relate to PHC.

1.1. Focus of this publication

The terms “primary health care” and “primary care” are often used interchangeably. Clarity on these terms is a critical starting-point for this publication, which addresses PHC as defined in the WHO/UNICEF Operational Framework for Primary Health Care (2). In sum, PHC is a whole-of-society approach to health that aims to maximize the level and distribution of health and well-being through three components: (1) primary care and essential public health functions as the core of integrated health services; (2) multisectoral policy and action; and (3) empowered people and communities.

Within the first component of PHC, which focuses on health services, primary care is emphasized as the entry point into the health system and the regular point

of contact for health service recipients. Primary care is a key process in the health system that supports first-contact, accessible, continued, comprehensive and coordinated patient-focused care. Primary care is intended to facilitate person-centred health service delivery, including through referral and counterreferral mechanisms that link primary, secondary, tertiary and community-based service providers (2).

Elements of HIV-focused initiatives clearly may intersect with efforts to improve primary care as well as efforts to strengthen all three components of the broader PHC approach to health. Box 1 discusses considerations regarding HIV and primary care. The main focus of this publication, however, is how countries might strengthen the relationship and interdependence between HIV responses and the broader PHC approach to health.

Box 1. Delivering services through primary care

Primary care is a person-centred process for promoting optimal health and well-being across the life-course. Primary care includes providing services to people who present at primary care facilities with health needs that do not require specialized care. Primary care links to referral and counterreferral networks encompassing community-based services and specialized services, such as services based at secondary and tertiary hospitals. When primary care works well, it connects the entire health service delivery system in ways that enable service users to access ongoing integrated person-centred health care.

HIV and HIV-related services and commodities are delivered in multiple settings, including primary care facilities, dedicated HIV facilities and community-based service points. In some countries, the health system routinely delivers HIV services through primary care. In addition, dedicated HIV facilities and community-based services are available in many countries given the complex needs of people living with and affected by HIV. Dedicated sites continue to play an important role in making HIV services accessible to populations that experience high levels of stigma and discrimination, such as men who have sex with men and people who inject drugs. Further, some dedicated sites host initiatives that combine the provision of HIV services with services for common coinfections and comorbidities.





Advances in HIV prevention and treatment, reductions in dedicated HIV funding, opportunities for integration and linkage with services for common comorbidities and coinfections and other factors are leading policy-makers and health system managers to increasingly consider shifting various HIV services from dedicated sites to primary care facilities.

The simplicity and low resource requirements of many HIV prevention and treatment interventions make them well suited for use in primary care. Providing these interventions through primary care can serve as an efficient means of maintaining or accelerating progress toward HIV prevention and treatment targets. For example, improvements in HIV treatment in recent years have resulted in simplified one-pill-per-day regimens with a low side-effect burden and little toxicity. Having primary care providers manage treatment initiation and follow-up in uncomplicated cases may help to close HIV treatment gaps in some settings. Primary care providers may also serve as the first point of referral for community-based and lay HIV service providers. In both scenarios, situating HIV services under the umbrella of primary care may make it easier for HIV service recipients to benefit from prevention and care services for other infectious diseases, noncommunicable diseases, sexual and reproductive health and other health issues as defined through a health service package.

Nevertheless, the suitability of primary care for delivering HIV services is highly context specific, not only at the national level but also at the subnational, facility and community levels. The primary care workforce must have the appropriate competencies, and primary care health information systems should have the capacity to integrate data for service recipients who previously attended dedicated HIV service delivery sites. Service recipients who are required to transfer from dedicated HIV sites to primary care may encounter challenges that lead them to withdraw from care or experience interruptions in care. Ongoing HIV treatment is required to maintain treatment effectiveness. Thus, people living with HIV who withdraw from care and lose access to treatment risk experiencing HIV disease progression. Similarly, if people at high risk of acquiring HIV experience obstacles to accessing primary care-based HIV services, they may not be able to obtain the HIV prevention commodities they need.

1.2. Importance of jointly addressing PHC and HIV

PHC-oriented health systems across a wide variety of settings in low-, middle- and high-income countries have consistently produced better health outcomes, enhanced equity and improved efficiency (3). The PHC approach promotes the overall health and well-being of people who are living with or at risk of HIV, including members of key populations and other inadequately served populations (Box 2). Further, HIV resources and lessons can be channelled into many aspects of reorienting health systems towards PHC. Synergy is enhanced by shared principles guiding the PHC approach and the HIV response, such as the following:

- engaging people and communities as co-developers of health and social services;
- addressing broader determinants of health through multisectoral policy and action;
- striving to provide equitable access to health services;
- emphasizing government obligations to respect, protect and fulfil human rights;
- giving priority to people-centred and person-centred approaches to disease prevention and treatment, including community-based service provision;
- taking health systems-oriented approaches to achieving disease targets;
- identifying how services can be integrated or linked in accordance with the needs of service users throughout the life-course;
- promoting continuity of care and retention in care across service delivery levels, including the community level; and
- focusing on the quality of care and how it affects health outcomes and on adherence and long-term retention in care.

Box 2. Priority populations in HIV responses

WHO emphasizes the importance of effectively serving and engaging several priority populations in HIV responses and has developed guidance accordingly (4-6). Many of these populations experience high levels of stigma and discrimination, both of which present significant barriers to accessing high-quality health services and participating in health policy decision-making. Countering stigma and discrimination and their social and structural drivers is thus an important aspect of responding effectively to HIV.

People living with HIV must be made a priority population within country responses to HIV in all settings. This population comprises individuals with diverse intersectional identities, including children, adolescents, adults of all ages and people with different gender, racial, cultural and religious identities. People living with HIV have wide-ranging health needs. People living with advanced HIV disease require specialized care, often including inpatient care. In contrast, the health priorities of some people whose HIV disease is effectively controlled by treatment may be largely unrelated to HIV. Ageing with HIV may bring different health issues to the forefront at different life stages, and access to a comprehensive package of services remains important throughout the life-course. Indeed, managing HIV is only one aspect of health for people living with HIV, and health systems should take a person-centred and life-course approach to promoting holistic long-term health and well-being in this population.

Evidence indicates that five key populations – men who have sex with men, people who inject drugs, sex workers, transgender and gender-diverse people and people in prisons and other closed settings – are disproportionately affected by HIV compared with the general population in all parts of the world. In 2021, key populations and their sexual partners acquired 70% of new HIV infections. Interventions specifically addressing the needs of key populations, including interventions to reduce social and structural barriers to health care, are essential for achieving HIV prevention and treatment targets (5). These interventions should recognize the intersectional identities of key populations and should encompass person-centred prevention, screening and treatment for common comorbidities such as viral hepatitis, sexually transmitted infections and tuberculosis (TB) as well as comprehensive sexual and reproductive health services. Key populations experience high levels of stigma and discrimination, including in health care settings, and countering stigma and discrimination is an essential aspect of addressing their physical and mental health needs.

In the context of the HIV epidemic, vulnerable populations are groups of people who are vulnerable to HIV infection in certain situations or contexts. Vulnerable populations thus vary across national and subnational settings. Women, including pregnant and breastfeeding women and adolescent girls, as well as children, adolescents and young people, including young key populations, are vulnerable to HIV infection in specific contexts. Men and boys are less likely to use health services and have poorer health outcomes in some settings. Other vulnerable populations may include people with disabilities, indigenous peoples, migrants and mobile populations and people in settings of humanitarian concern, including people affected by conflict and civil unrest.

1.3. Common challenges

Advancing PHC and HIV goals in concert helps to ensure that the common challenges facing both are addressed efficiently.

Efforts to strengthen PHC are hampered by the medicalization of health at the expense of a broader preventive and whole-person approach. In addition, many countries have insufficient political commitment to social equity and to health as a human right, both of which are cornerstones of PHC. Other challenges include difficulties in working effectively across the health sector and other sectors to address social and structural determinants of health, separation of health system planning and health service delivery and health workforce shortages. With regard to primary care specifically, health systems in many countries cannot adequately staff primary care facilities, and the delivery of high-quality primary care is further undermined by poor infrastructure, insufficient financial resources and stock-outs of medicines and other commodities.

The HIV field also faces challenges with staffing and infrastructure and is increasingly facing political barriers to accelerating the work required to reach key populations in many contexts. HIV continues to impose a heavy burden of disease, even though effective prevention, testing and treatment tools exist. Progress toward targets associated with ending AIDS has slowed and has even been reversed in some countries (7).

Since 2016, WHO has recommended that all people living with HIV be provided with lifelong antiretroviral therapy regardless of their clinical status or CD4 cell count. Effective antiretroviral therapy both halts HIV disease progression and prevents onward transmission of HIV. Globally, 28.7 million people living with HIV were receiving antiretroviral therapy in 2021, representing coverage of 75% (7). Compared with people who began receiving antiretroviral therapy sufficiently early in the disease course, people with untreated HIV have higher death rates, as do people who did not begin receiving antiretroviral therapy until after they had developed advanced HIV disease (8).

Taken together, current levels of unmet need for antiretroviral therapy, inadequate access to and uptake of HIV prevention services, late diagnosis of HIV and ineffective care for advanced HIV disease are greatly

undermining progress toward the goal of ending AIDS as a public health threat by 2030. In 2021, 1.5 million people acquired HIV and 650 000 people died from HIV-related causes. Key populations and their sexual partners accounted for 70% of new HIV infections in 2021, and the limited available data suggest that key populations lag behind in undergoing HIV testing and utilizing antiretroviral therapy (8,9).

Available resources and expertise must be leveraged in new ways for health systems to reach more people with effective HIV prevention and treatment interventions in the face of resource limitations and other challenges and to achieve equitable progress against HIV in all populations. This especially applies to the needs of key and vulnerable populations. Likewise, strengthening PHC requires making better use of existing resources and expertise, not only in relation to service delivery but across the entirety of health systems.

1.4. Purpose of this publication

This publication aims to:

- provide guidance to policy-makers, health system managers and programmatic leads from both PHC and HIV backgrounds regarding opportunities to jointly advance their respective efforts to strengthen PHC and end AIDS as a public health threat; and
- provide a resource for all stakeholders who seek to contribute to strengthening PHC and ending AIDS as a public health threat in a synergistic manner, including people living with HIV, members of key and vulnerable populations, community and civil society representatives, people working in all areas of health systems, researchers, funders and private-sector decision-makers.

As noted, this publication highlights HIV, but many concepts and ideas presented are applicable to other health areas. Further, this publication recognizes that health systems in many settings may integrate HIV activities with activities addressing other health areas such as TB, viral hepatitis, sexually transmitted infections, sexual and reproductive health, mental health and noncommunicable diseases. These integrated health initiatives also warrant consideration in terms of potential synergy with efforts to strengthen PHC.

Chapter 2

Policy and operational frameworks

There is a well-established policy foundation for supporting efforts to jointly strengthen PHC and end AIDS as a public health threat. Policy and operational frameworks for PHC and HIV are described in Sections 2.1 and 2.2, respectively.

2.1. The PHC policy and operational framework

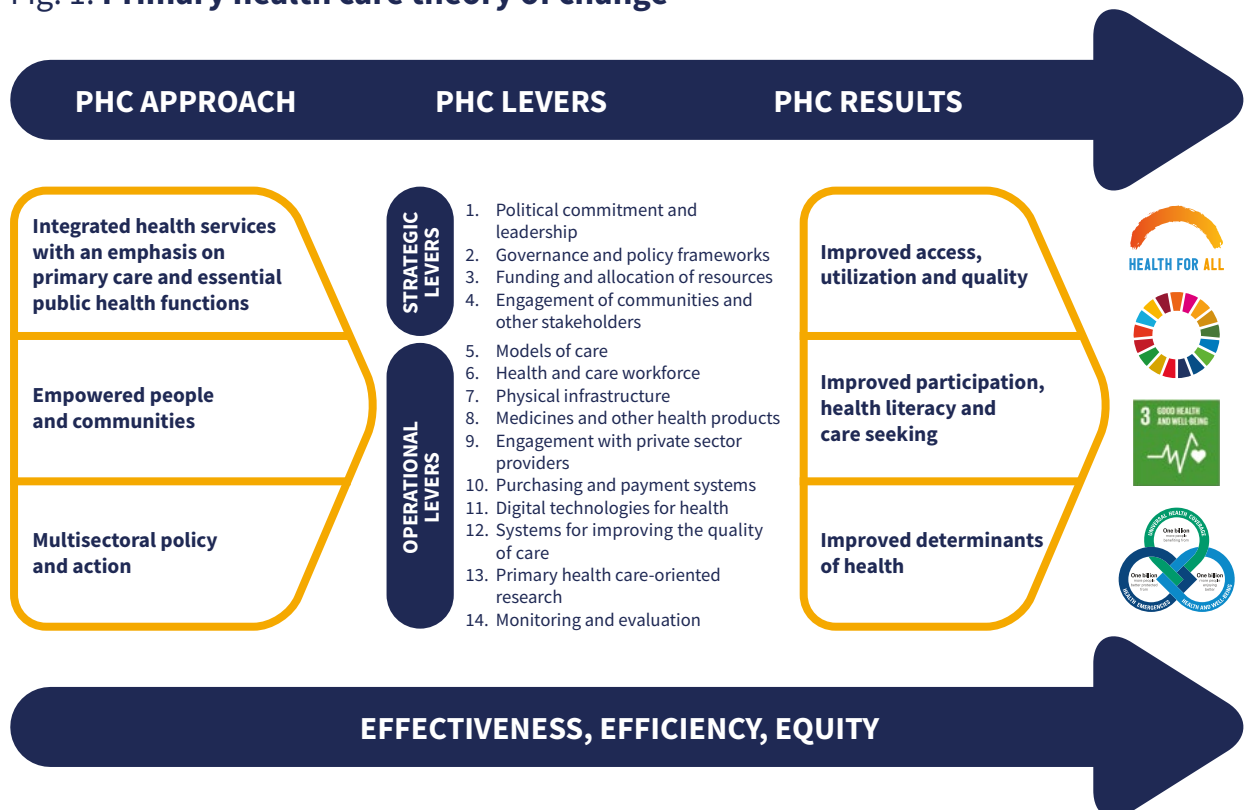
As previously described, PHC is a whole-of-society approach to health that combines three core components (10).

- 1. Integrated health services with an emphasis on primary care and public health functions:** meeting health needs through comprehensive promotive, protective, preventive, curative, rehabilitative and palliative care throughout life, by prioritizing key health services through primary care and essential public health functions as central elements of integrated health services.
- 2. Multisectoral policy and action:** systematically addressing broader determinants of health (including social, economic and environmental factors as well as individual characteristics and behaviours) through evidence-informed policies and actions across all sectors.
- 3. Empowered people and communities:** empowering individuals, families and communities to optimize their health as advocates of policies that promote and protect health and well-being and as co-developers of health and social services.

This vision has its roots in the 1978 Declaration of Alma-Ata, which called on governments and the global community to recognize the centrality of PHC in achieving better health outcomes (11). Four decades later, in the 2018 Declaration of Astana, countries and international partners committed themselves to orienting health systems towards PHC to accelerate progress on universal health coverage and the health-related Sustainable Development Goals (12). In 2019, World Health Assembly resolution WHA72.2 called for the implementation of the Declaration of Astana and requested the development of a PHC operational framework (13).

The resulting framework is based on a theory of change that describes how the core elements of the PHC approach can be translated into results through 14 interrelated levers for action and investment (Fig. 1) (2). The dimensions of the health system building blocks (governance and leadership, financing, health workforce, commodities, service delivery and health information systems) are reflected in various levers (14).

Fig. 1. Primary health care theory of change



Source: Operational framework for primary health care: transforming vision into action (2).

Box 3 describes major PHC and universal health coverage resources published by WHO and colleagues.

Box 3. PHC and universal health coverage resources

- WHO, UNICEF. **Operational framework for primary health care: transforming vision into action.** Geneva: World Health Organization; 2020 (<https://apps.who.int/iris/handle/10665/337641>).
- WHO, UNICEF. **Primary health care measurement framework and indicators: monitoring health systems through a primary health care lens.** Geneva: World Health Organization; 2022 (<https://apps.who.int/iris/handle/10665/352205>).
- **UHC compendium: health interventions for universal health coverage** [website]. Geneva: World Health Organization; 2022 (<https://www.who.int/universal-health-coverage/compendium>).
- **Voice, agency, empowerment – handbook on social participation for universal health coverage.** Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/342704>).
- **WHO UHC service package delivery and implementation tool** [website]. Geneva: World Health Organization; 2023 (<https://uhcc.who.int/uhcpackages>).
- **Step-by-step guide to conducting a cross-programmatic efficiency analysis.** Geneva: World Health Organization; 2022 (<https://apps.who.int/iris/handle/10665/352903>).

2.2. The HIV policy and operational framework

The global response to HIV and AIDS has been guided by a series of United Nations General Assembly political declarations, the most recent of which called for accelerated efforts to end AIDS as a public health threat by 2030 and pledged to end inequalities faced by people living with and affected by HIV (15). This declaration highlighted the importance of PHC, universal health coverage, people-centred and community-based services and strong referral systems between primary care and other levels of care.

WHO's succession of global health sector strategies on HIV and AIDS, the first of which was published in 1985 (16), have defined the health sector response to HIV in increasingly broader terms in recognition of the limitations

of highly disease-specific approaches (17–19). In 2022, the Seventy-Fifth World Health Assembly approved the implementation of the global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022–2030 (GHSS 2022–2030) (Fig. 2) (20). Emphasizing the benefits of taking a coordinated approach to diseases that share major commonalities, the GHSS 2022–2030 consolidates strategies for HIV, viral hepatitis and sexually transmitted infections into a single document that puts forth a common vision for all three disease areas:

End epidemics and advance universal health coverage, primary health care and health security in a world in which all people have access to high-quality evidence-based people-centred health services and can lead healthy and productive lives.

Fig. 2. **GHSS 2022–2030: strategic framework**



Source: Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022–2030 (20).

By presenting strategic responses to HIV, viral hepatitis and sexually transmitted infections in an integrated manner and by defining shared actions to be taken in relation to health system functions, multisectoral collaboration, social and structural determinants of health, service integration across multiple disease areas, community engagement and person-centred care, the GHSS 2022–2030 speaks to central objectives of PHC. Further, action items 16 and 17 in the GHSS 2022–2030 call for measures to advance universal health coverage and PHC, respectively. Other action items call for enhancing integration and linkage to address a range of health-related issues that are relevant for people living with and at risk of HIV, such as TB, other communicable diseases, noncommunicable diseases, sexual and reproductive health, mental health, disability and gender-based violence.

The fourth strategic direction of the GHSS 2022–2030, “engage empowered communities and civil society”, speaks to the principle of the meaningful involvement of people living with and affected by HIV. This principle has shaped responses to HIV since the earliest years of the epidemic. An influential 1983 manifesto by people living with AIDS, the Denver principles, declared that people living with AIDS must “be involved at every level of decision-making” and must “be included in all AIDS forums with equal credibility as other participants” (21). The principle of meaningful involvement was taken up in commitments in the United Nations General Assembly 2001 Declaration of Commitment on HIV/AIDS (22) and 2006 Political Declaration on HIV/AIDS (23) and continues to be a central pillar of policy and programmatic responses to HIV worldwide.

The principle of meaningful involvement applies to all aspects of the response to HIV, including policy development, strategic planning, service delivery and quality assurance, monitoring and evaluation and resource mobilization. The meaningful involvement of people living with and affected by HIV, including key populations, has been at the heart of WHO's own work on HIV. Inspired by this approach, other health areas such as noncommunicable diseases have adapted the principle to their own contexts (24).

The GHSS 2022–2030 is aligned with the Global AIDS Strategy 2021–2026, which is a multisectoral strategy coordinated by UNAIDS (25). The Global AIDS Strategy 2021–2026, like the GHSS 2022–2030, addresses issues that are central to strengthening PHC. One of its three core strategic priorities is to “fully resource and sustain efficient HIV responses and integrate them into systems for health ... and pandemic responses.” It calls on countries to leverage and support “the systems integration that is needed to ensure that people affected by HIV have effective and equal access to the full range of services (medical and nonmedical) they need to protect themselves against infection and to survive and thrive when living with HIV”. The Strategy's priority actions to achieve results include ensuring that affected communities and key populations are at the forefront of the decision-making process; integrating HIV into systems for health and ensuring that the integrated approaches are comprehensive and people-centred; strengthening health system capacity to address the care needs of people living with HIV across their life-course; and strengthening the multisectorality of the HIV response. The Joint United Nations Programme on HIV/AIDS (UNAIDS), which includes a Secretariat and 11 Cosponsoring United Nations agencies, including WHO, has provided multisectoral support to HIV responses for more than 25 years. Lessons learned from UNAIDS are especially relevant to the multisectoral policy and action, leadership and community engagement aspects of PHC.

Key HIV funding partners are aligned with WHO and UNAIDS priorities that resonate with the PHC agenda. The new 2023–2028 strategy of the Global Fund to Fight AIDS, Tuberculosis and Malaria outlines a shift in its investment approach. It calls for action to rise above disease-specific silos toward building resilient and sustainable systems for health in a way that places people and communities, not diseases, at the centre of the health system to achieve universal health coverage. The new strategy also recognizes the importance of PHC to deliver integrated, people-centred services (26). Similarly, the current strategy for the United States President's Emergency Plan for AIDS Relief includes a focus on “engaging in integrated national planning”, with an aspect of this work addressing capacity-building in relation to health systems. It also promotes improved person-centred care for people living with HIV (27).

At the operational level, significant HIV resources are available to support the further integration of activities into primary care and the broader health system in settings where this is warranted (Annex 1). Simplified guidance published by WHO defines a comprehensive set of interventions along the full HIV service continuum through prevention, diagnosis, treatment and chronic care (4), while monitoring across the HIV service engagement cascade provides an implementation framework. WHO together with partners has provided guidance on integrating HIV services with services addressing other health issues such as TB, hepatitis B and C, sexually transmitted infections, sexual and reproductive health, noncommunicable diseases, mental health and key population services such as harm-reduction services for people who inject drugs (4,5,28–30).

Chapter 3

Policy dialogue to jointly strengthen PHC and HIV

Strengthening the interface between PHC and HIV requires convening relevant stakeholders, including communities, to identify the approaches that are most suitable for specific national, subnational and local contexts and populations.

National multisectoral and multistakeholder advisory groups or consultations may help to inform and to coordinate policy dialogue. In some settings, stakeholders may wish to convene subnational advisory groups.

PHC and HIV advisory groups or mechanisms may take a variety of forms. Their effectiveness may be enhanced by building on existing policy mechanisms, including those at subnational levels, for example, as part of the Fast-Track Cities initiative (31). They may only operate for the period required to hold a single consultation or may have a longer lifespan, with measures incorporated to promote accountability for implementing decisions. They may be virtual and informal and may be facilitated via social media, or they may be guided by formal governance structures.

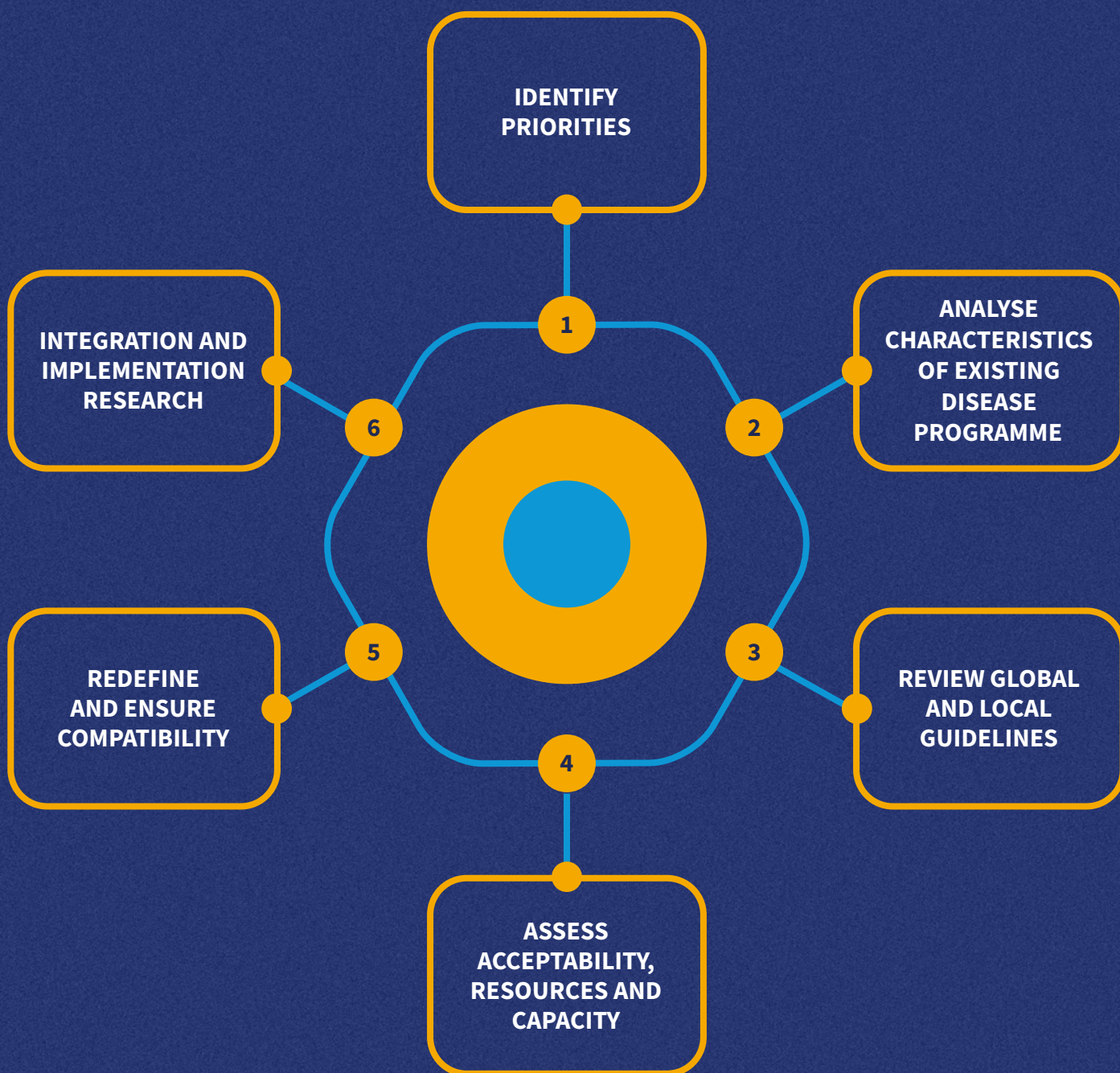
The WHO publication *Voice, agency, empowerment: handbook on social participation for universal health coverage* (32) notes examples of HIV stakeholder engagement in broader health governance initiatives including through the country coordinating mechanisms of the Global Fund and through an example shared of constituency selection at Thailand’s National Health Assembly. These early examples can be built on, with attention to relational community engagement approaches recently explored, such as in Cambodia, where the focus was on how relational community engagement could better support people living with HIV (33).

Should a PHC and HIV advisory group be established, it may decide to develop a strategic framework to guide the joint activities of PHC and HIV stakeholders. If this is not feasible, then identifying key principles or publishing a meeting report documenting proposed actions may be helpful. PHC and HIV advisory groups that want to explore opportunities to integrate specific health services may be aided by WHO’s implementation guidance for integrating noncommunicable disease services into HIV, TB and sexual and reproductive health programmes, since much of this guidance can be extrapolated to other types of service integration (30). Approaching service integration in terms of the six steps identified in this guidance may be beneficial (Fig. 3). These efforts require consistent attention to designing and implementing an overall package of services based on the needs of the population.

In all PHC and HIV policy discussions, efforts must be made to ensure that all participants, regardless of their respective areas of expertise, draw on learnings from PHC, HIV and the health field more generally. Meaningfully engaging people living with and affected by HIV, including key populations, alongside the broader PHC-focused communities is essential.

PHC and HIV advisory groups are encouraged to link to or reference existing PHC and universal health coverage advisory bodies, such as national health assemblies, where they exist, to synergize their efforts with other work that is underway in this domain (32).

Fig. 3. Steps for integrating services for noncommunicable diseases into other programmes



Source: Integrating the prevention and control of noncommunicable diseases in HIV/AIDS, TB, and sexual and reproductive health programmes: implementation guidance (30).

Chapter 4

The PHC levers and HIV: convergent actions

The four core strategic levers and 10 operational levers of the PHC approach (Box 4) serve as a useful framework for identifying opportunities to jointly strengthen PHC and meet disease-specific goals, including those for HIV (2). Although HIV responses have successfully driven progress in each of the 14 domains in recent decades, these responses have been highly diverse depending on the epidemiological, social, legal and political context. There may have been missed opportunities in relation to optimizing the impact of HIV investments on broader health systems as well as on broader health outcomes for communities. The actions presented below in relation to each lever offer illustrative examples of convergent actions that can advance PHC and HIV goals in specific national and subnational settings. PHC and HIV stakeholders should decide which levers should be given priority in their contexts and should define the collaborative or synergistic PHC and HIV actions that will be carried out in association with these levers. Understanding the interdependence of the 14 levers is crucial in taking these joint decisions. Further, planners and implementers should consider how the synergistic PHC and HIV actions that they have chosen to undertake will contribute to the longer-term trajectory of reorienting health systems towards PHC.

4.1. Political commitment and leadership

Political commitment and leadership encompass the involvement of heads of state and government, other political leaders, health ministers and other government sectors, civil society and community leaders and influential cultural, religious and business figures. Political commitment and leadership can drive efforts to reform laws and policies, including discriminatory and punitive laws that negatively affect health and well-being. In addition, political commitment and leadership are required to ensure the implementation of existing laws and policies that promote gender equality and protect human rights. Political commitment and leadership are important for formalizing plans to jointly address PHC and disease-specific goals, including those for HIV; effectively delivering integrated health services in settings where greater integration meets service users' needs; and addressing social, economic, environmental, and commercial determinants of health through multisectoral policy and action. Political commitment and leadership also can further the meaningful involvement of communities in health decision-making, including communities whose members experience discrimination based on race, ethnicity, gender, sexual orientation and other intersectional identities, including real or perceived HIV status.

The history of efforts to implement PHC highlights an important pitfall to avoid. Although a comprehensive approach to PHC should be positioned as foundational to achieving universal health coverage, this has not always happened, since focusing on selective approaches that have ready-made constituencies and clearly delineated interventions is often easier. Jointly developing political





commitment and leadership can enable immediate disease-specific needs to be highlighted while maintaining a strong comprehensive vision for PHC as a national priority.

PHC and HIV actions




- **Develop a comprehensive and collective vision of how HIV assets and investments contribute to achieving PHC objectives and how the PHC approach contributes to ending AIDS.** Such a vision should specify intended outcomes and pathways for achieving these outcomes. It should also anticipate the post-2030 health landscape, for example by considering how PHC-oriented health systems can sustain achievements related to ending AIDS as a public health threat.
- **Cultivate champions for the convergent PHC and HIV agenda.** This may take place through formal structures such as high-level groups or through individual relationships.
- **Strengthen PHC accountability and inclusiveness by seeking to address the comprehensive health needs of people living with HIV and key and vulnerable populations in the HIV response.** Stakeholders might build on or adapt accountability mechanisms developed in the HIV response, such as civil society “shadow” reporting on country-level progress and community-led monitoring of health system performance. The principle of meaningfully involving people living with and affected by HIV may be an instructive model for how to conceptualize the roles of communities in inclusive health policy-making (34,35)
- **Create an enabling environment for the meaningful participation of communities in PHC policy-making, including marginalized communities.** Mechanisms for doing so include fostering community empowerment,

Box 4. The four core strategic levers and 10 operational levers of the PHC approach

STRATEGIC LEVERS

- 1**  **Political commitment and leadership**
 Political commitment and leadership that place PHC at the heart of efforts to achieve universal health coverage and recognize the broad contribution of PHC to the SDGs
- 2**  **Governance and policy frameworks**
 Governance structures, policy frameworks and regulations in support of PHC that build partnerships within and across sectors, and promote community leadership and mutual accountability
- 3**  **Funding and allocation of resources**
 Adequate funding for PHC that is mobilized and allocated to promote equity in access, to provide a platform and incentive environment to enable high-quality care and services and to minimize financial hardship
- 4**  **Engagement of community and other stakeholders**
 Engagement of communities and other stakeholders from all sectors to define problems and solutions and prioritize actions through policy dialogue

OPERATIONAL LEVERS

- 5**  **Models of care**
 Models of care that promote high-quality, people-centred primary care and essential public health functions as the core of integrated health services throughout the course of life
- 6**  **Primary health care workforce**
 Adequate quantity, competency levels and distribution of a committed multidisciplinary primary health care workforce that includes facility-, outreach- and community-based health workers supported through effective management supervision and appropriate compensation
- 7**  **Physical infrastructure**
 Secure and accessible health facilities to provide effective services with reliable water, sanitation and waste disposal/ recycling, telecommunications connectivity, and a power supply, as well as transport systems that can connect patients to other care providers
- 8**  **Medicines and other health products**
 Availability and affordability of appropriate, safe, effective, high-quality medicines and other health products through transparent processes to improve health
- 9**  **Engagement with private sector providers**
 Sound partnership between public and private sectors for the delivery of integrated health services
- 10**  **Purchasing and payment systems**
 Purchasing and payment systems that foster a reorientation in models of care for the delivery of integrated health services with primary care and public health at the core
- 11**  **Digital technologies for health**
 Use of digital technologies for health in ways that facilitate access to care and service delivery, improve effectiveness and efficiency, and promote accountability
- 12**  **Systems for improving the quality of care**
 Systems at the local, subnational and national levels to continuously assess and improve the quality of integrated health services
- 13**  **Primary health care-oriented research**
 Research and knowledge management, including dissemination of lessons learned, as well as the use of knowledge to accelerate the scale-up of successful strategies to strengthen PHC-oriented systems
- 14**  **Monitoring and evaluation**
 Monitoring and evaluation through well-functioning health information systems that generate reliable data and support the use of information for improved decision-making and learning by local, national and global actors

Source: Operational framework for primary health care: transforming vision into action (2).

removing barriers to community participation, allocating resources to build community capacity for policy dialogue and establishing and regularly evaluating policy dialogue mechanisms. HIV responses have benefitted greatly from meaningful community participation in policy-making and can provide knowledge, tools and other resources in relation to this undertaking. In many countries, civil society organizations and community-based organizations representing HIV key populations have considerable health and multisectoral policy expertise. Opportunities should be identified for HIV key population organizations to work collaboratively with representatives of other communities to strengthen community voices in PHC policy-making.

- Follow through on PHC commitments to adopt human rights-based approaches to achieving health objectives.** In many contexts, HIV stakeholders have worked across the health sector broadly, including in the context of sexual and reproductive health and rights, to pioneer human rights-based approaches to health through different types of interventions spanning service delivery, health system strengthening and social and structural determinants of health (36–39). For example, in partnership with country stakeholders, civil society, technical partners and others, the Global Fund’s Breaking Down Barriers initiative developed programmatic guidance on the most effective ways to reduce or remove human rights-related barriers to HIV, TB and malaria services (40). Stakeholders who are knowledgeable about human rights aspects of HIV responses, including civil society and community-based organizations, are well placed to contribute to developing, assessing and implementing human rights-based approaches to strengthening PHC.

4.2. Governance and policy frameworks

Governance refers to ensuring that strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system design and accountability (14). Given the role of the private sector (for-profit and not-for-profit) and communities in service delivery and other functions, effective governance requires that governments oversee and guide the entire health system and not merely the public system. Further, shifts in governance should be supported by policy frameworks that reflect the broad definition of PHC as having three interrelated components – integrated health services, multisectoral policy and action and empowered people and communities – that should be embedded in key policy frameworks that govern

the health sector. Another important dimension of governance is community participation in health system decision-making and monitoring. Leveraging community participation to improve the quality of health services and make health systems more sustainable and equitable requires effective governance structures and processes at the national, subnational and local levels. Monitoring and evaluation, which are addressed in subsection 4.14, contribute instrumentally to good governance by promoting transparency and accountability.

PHC and HIV actions

- Ensure accountability for PHC in the health ministry in a manner that works across traditional departmental boundaries and is linked to teams responsible for universal health coverage, the broader determinants of health and the health-related Sustainable Development Goals, including disease-specific functions.** A careful understanding and strengthening of linkages between departments and teams responsible for HIV and those responsible for wider PHC-driven health system reforms can steer convergences in governance.
- Strengthen the health ministry’s technical capacities to facilitate multisectoral arrangements with other ministries and institutions and to engage the private sector and other actors (such as professional associations and civil society) when and where useful and appropriate.** Historical and current multisectoral HIV governance platforms, such as the joint United Nations teams on AIDS (41) and the Global Fund country coordinating mechanisms (42) provide lessons that may inform multisectoral PHC governance initiatives. With the Global Fund increasingly broadening its focus to address health system resilience and sustainability in a non-disease-specific manner (43), exploring how to harmonize the work of PHC-oriented governance mechanisms and Global Fund country coordinating mechanisms in countries where the Global Fund is active may be beneficial.
- Legitimize the role of communities in health governance and in processes that enable greater community and civil society involvement.** Initiatives to build community capacity to participate in HIV-related governance, including those developed by community-based organizations and coalitions, provide lessons learned and templates for strengthening community involvement in broader health governance (44). As HIV and health funding models continue to evolve, there is further incentive to leverage meaningful community participation in health governance as a means of ensuring attention to inadequately served populations, including

HIV key populations. Increasingly, PHC-oriented local health systems are central to sustaining HIV prevention and treatment achievements and promoting the holistic long-term well-being of people living with HIV.

4.3. Funding and allocation of resources

Health funding comes from multiple sources, including domestic public revenue, private prepaid insurance schemes, out-of-pocket payments and external development aid. PHC is underfunded in many countries. In general, efforts to raise resources for PHC and use them most effectively should be embedded in a broader health funding strategy that encompasses the entire health sector.

Such a strategy should also address key issues related to the allocation of resources within the health sector. Within the scope of PHC, funds should be rationally allocated among primary care, public health interventions and initiatives that promote community engagement and multisectoral coordination. At the broader health system level, a major challenge in many countries is that tertiary care facilities receive disproportionately large shares of health budgets. This imbalance both reduces the money available for PHC and increases costs in the entire health system. As demonstrated during the COVID-19 pandemic, health emergencies may require that health resources and assets be repurposed. Adequately funded PHC-oriented health systems can protect all populations from losing the health resources that they need during health emergencies.

PHC and HIV actions

- **Monitor the level of spending on PHC by analysing national health accounts as well as deeper investigations, including public expenditure reviews.** In countries supported by HIV-specific external funding, analysing national HIV spending through a PHC lens can help to identify how HIV spending is contributing to strengthening PHC. It may also identify opportunities to refocus HIV spending in ways that contribute to making health systems more PHC-oriented. Tools and methods have been developed to support this work (45). Such an approach does not necessarily require investing less in the HIV response. Instead, the objective should be to seek opportunities to address HIV and PHC objectives synergistically: for example, by using HIV resources to strengthen primary care in settings where primary care can be a platform for expanding access to HIV prevention, testing and treatment services along with services addressing common comorbidities and coinfections.

- **Assess how HIV investments can optimally promote health and well-being for all populations across the life-course.** Although maintaining investment in specialized HIV services may be desirable in some settings, the role of primary care in supporting the long-term well-being of people living with and affected by HIV should also be considered, recognizing that this population has diverse health needs. Similarly, investing HIV resources in other aspects of health system strengthening such as integrated health information systems should be considered in terms of the holistic benefits for health service recipients. For example, since people living with HIV experience higher incidence of some noncommunicable diseases than the general population, integrated national health information systems can aid service providers in addressing the full spectrum of health challenges that this population may experience over the life-course.
- **Coordinate the timing of disease-specific funding cycles across multiple disease areas to encourage the alignment of funding proposals in relation to opportunities to collaboratively contribute to strengthening PHC and health systems.** In countries where significant external funding for diseases such as HIV, TB and malaria continues to be available, funders may wish to encourage disease programmes to contribute to broader health system strengthening. The concurrent development of funding proposals across multiple disease programmes may create opportunities for coordination and collaboration: for example, to develop interoperable data platforms that can facilitate the sharing of health information between specialized disease services and primary care facilities.
- **Strengthen public financial management systems to enable more effective, efficient and equitable budgeting and budget execution in the health sector, including for PHC.** As part of this effort, siloed disease-specific financial management systems should be integrated into the broader financial management of the entire public system.
- **Build community health financing literacy.** Community stakeholders can make greater contributions to inclusive health governance when they have the capacity to directly monitor budget and expenditure review processes.

4.4. Engagement of communities and other stakeholders

Building collaborative relationships that enable stakeholders to jointly define health needs, identify solutions and set priorities for actions through contextually appropriate and effective mechanisms is central to PHC. Communities and other stakeholders comprise a diversity of actors, such as individual users of health services and their families, lay public members, for-profit constituencies, professional and trade associations, consumer groups and community-based, faith-based and nongovernmental organizations.

Community engagement in health can be considered at three interlinked levels: in the governance of health systems, in planning and setting priorities and in implementing and delivering health services. In each of these, community engagement seeks to identify the interests and priorities of stakeholders and to align shared goals and actions. People are both co-owners and co-producers of health, with a central role in influencing national and local health planning, improving service delivery and monitoring health system and health service performance. Governance approaches must support these roles by creating enabling environments that foster meaningful dialogue, partnership and joint action. The needs, rights and inclusion of inadequately served populations must be given priority, with resources invested in building these constituencies' capacity to contribute to strengthening health systems that meet the overall health needs of the population while also reflecting disease specificities. Private-sector constituencies should be engaged with explicit consideration of their interests, which may not always be aligned with the public good.

PHC and HIV actions

- **Engage in dialogue with policy-makers and leaders to foster the creation of environments and cultures that support collaborative action and facilitate interprofessional ways of working.** Engagement processes that build bridges between those who focus on diseases and those who focus on wider PHC-oriented health systems can enhance synergies in planning and implementation.
- **Conduct stakeholder mapping and analysis to ensure the optimal engagement of relevant PHC communities and stakeholders, including private-sector constituencies.** PHC stakeholder mapping should be carried out in ways that deliberately seek to identify inadequately served populations. Applying an HIV lens to this mapping can help to identify key areas of intersectionality and relevant bodies of expertise and

can help to ensure that lived experiences relating to all health issues and life stages are valued and welcomed.

- **Support efforts of community-based and civil society organizations to engage more actively in improving health system performance.** Transparency about stakeholder interests is important, as is recognition of potential power imbalances among stakeholders. Compared with other stakeholders in PHC strengthening, some HIV stakeholders may bring more governance experience to discussions and should be encouraged to focus on holistic person-centred approaches in their engagement. Ensuring that PHC optimally benefits everyone over the life-course, including people living with and affected by HIV, requires giving voice to constituents with diverse perspectives, such as constituents focusing on noncommunicable diseases, women's health and local health system strengthening.
- **Provide opportunities for individuals and communities to give feedback on their care and service experiences and identify actions to be taken in response to this feedback.** Follow-up processes should be established to ensure that actions are implemented and that they have the intended outcomes. Effective feedback mechanisms are particularly important for countering the stigma and discrimination experienced by service users who are members of marginalized or inadequately served populations. Many people living with or affected by HIV report experiencing high levels of stigma and discrimination in health care settings, including members of key populations (people who inject drugs, sex workers, people in prisons and other closed settings, transgender and gender-diverse people and men who have sex with men). Involving these and other inadequately served populations in activities to improve service user experiences is an important aspect of community engagement.
- **Partner with community-based organizations to build local health literacy, establish community-based accountability mechanisms and conduct local advocacy initiatives that address participation in health governance, planning, priority-setting and implementation.** As demonstrated in HIV and intersecting responses, including those advancing sexual and reproductive health and rights, viral hepatitis, sexually transmitted infections and TB, meaningful community engagement requires providing communities with the resources and capacity

to participate effectively in decision-making about individual and population health.

4.5. Models of care

Models of care conceptualize how to deliver health-related services in regard to service delivery processes and the organization of service providers, including community-based and lay service providers. Although models of care should be tailored to communities and local contexts, some principles are relevant across all settings. First, models of care should seek to promote integrated health services, strategically giving priority to primary care and public health functions and ensuring adequate coordination between them. Second, at the level of individual health care services, health systems need to be reoriented to facilitate access to services closer to where people live, work and socialize, considering contextual factors, people's preferences and cost-effectiveness. Third, models of care should promote continuous, comprehensive, coordinated and holistic people-centred care. Finally, models of care should recognize the crucial role of PHC in addressing both existing and emerging health problems.

HIV service delivery innovations have led to the institutionalization of evidence-informed and people-centred models of care that may be easily adapted to primary care settings with minimal training or resource requirements. For example, differentiated service delivery simplifies and adapts service provision to reflect the diverse needs and preferences of beneficiary populations while also optimizing the use of health system resources. WHO HIV guidelines employ a differentiated service delivery approach in recommending that people who are successfully established on antiretroviral therapy and have no current illnesses attend clinic visits and obtain antiretroviral therapy refills less frequently than other people taking antiretroviral therapy, with six-month intervals being preferable. The guidelines also specify that antiretroviral therapy can be initiated outside health facilities, thus promoting linkage to care at community-based service delivery points (4)

PHC and HIV actions

- **Support the uptake and implementation of evidence-informed models of care through targeted training for policy-makers, health system and health service managers and health service providers.** The evidence base for recommending new models of care needs to be communicated effectively to different audiences. All of these audiences should understand how new models of care support the provision of person-centred and

people-centred health services, make effective use of health system resources and contribute to improving health outcomes. It may benefit communities to advocate for scaling up and maintaining the funding of models of care that address their priorities by providing community-generated evidence on the accessibility, acceptability and quality of the services provided.

- **Explore the feasibility of developing and scaling up models of care that use community-based and community-led service delivery.** The distinction between community-based and community-led services should be understood in light of the notable impact of HIV key population-led services in some settings. Community-led services are one form of community-led HIV responses, which are defined as “actions and strategies that seek to improve the health and human rights of their constituencies, specifically informed and implemented by and for communities themselves and the organizations, groups and networks that represent them” (46). Community-based services, in contrast, do not necessarily include community members among their leadership.

4.6. PHC workforce

The PHC workforce includes all occupations engaged in the continuum of promotion, prevention, treatment, rehabilitation and palliative care, including the public health workforce and those engaged in addressing the social determinants of health. It also includes caregivers, most of whom are women, complementing the actions of salaried workers (47). Beyond service provision, health workers also include management and administrative personnel, who are crucial for the functioning of the health system across care settings: for example, information officers and planners. An adequate, well-distributed, motivated, enabled and supported health workforce is required for strengthening PHC, progressing toward universal health coverage and achieving and sustaining an end to AIDS as a public health threat.

PHC and HIV actions

- **Mobilize adequate funding from domestic and donor sources to sustain the training, recruitment, deployment and retention of the PHC workforce and minimize premature exit.** HIV-specific health workforce needs should be quantified and considered in broader decision-making about the PHC workforce and facility staffing, with recognition of the central role of primary care in helping people living with HIV

to address their wide-ranging health needs. Financial incentives that provide unequal compensation for HIV-related work or negatively affect other service delivery areas should be avoided.

- **Improve the distribution of the PHC workforce through appropriate strategies (for example, regulations, financial and non-financial incentives and education) to deploy PHC workers in underserved communities and facilities.** In many countries, a robust community-based health workforce provides HIV services. This workforce may increasingly be called upon to carry out duties within the context of PHC, and hence should be formalized and adequately funded through the health sector. Across HIV and other health areas, the needs of the community-based health workforce must be addressed on par with the needs of the formal health workforce in terms of regulation, training and supervision. Additionally, strong links are needed between community health services and institutional health services.
- **Ensure that PHC workers have the core competencies required to deliver the defined package of health services.** People living with HIV and members of key populations are at high risk of experiencing stigma and discrimination as well as other human rights violations in health care settings. All health workers should receive training in the non-clinical competencies that will enable them to serve these populations in a respectful manner free from any stigmatizing or discriminatory behaviour. Health workers should also be educated on their role in upholding the human rights of people living with and affected by HIV, including in relation to issues such as privacy, confidentiality and patient autonomy. Accountability for discrimination-free health care should be strengthened across the entire health system.
- **Promote decent work that ensures gender-sensitive employment free of violence, discrimination and harassment; manageable workloads; adequate remuneration and incentives; and occupational health and safety.** Health systems must address stigma and discrimination toward health workers, including health workers who are living with HIV and those from communities of key and vulnerable populations. Health systems must ensure the equal treatment of all health workers as described in the global health and care worker compact (48). Health systems also must ensure that all health workers, including community health workers and lay providers, are protected from HIV infection with necessary protective equipment and the means to implement universal precautions. Post-exposure prophylaxis should be provided in accordance

with clinical guidelines when occupational accidents put health workers at risk of acquiring HIV (4).

- **Enhance the accountability of PHC personnel at the community, outreach and facility levels through regular monitoring and feedback on performance.** Service users and communities should be recognized as important participants in accountability mechanisms, including mechanisms to remediate stigmatizing and discriminatory actions by service providers.

4.7. Physical infrastructure

The physical infrastructure of health facilities strongly affects the ability of service providers to do their jobs and also affects patients' experiences. These factors, in turn, can affect the uptake of health services. Key elements of physical infrastructure include having reliable water and power supplies, sanitation and waste disposal and recycling and telecommunications connectivity. Transport is another critical aspect of infrastructure, since a lack of access to transport to facilities may result in some service users having unequal access to care.

The physical infrastructure of health facilities also plays an important role in fostering trust in service providers and health systems. Waiting areas, examination areas and other spaces for service recipients should be physically accessible to everyone and should meet people's medical and non-medical needs, considering gender, religious identity and other relevant issues.

Non-facility-based health services can play an important role in expanding service access and providing people-centred care. The physical infrastructure of community service delivery points should be assessed and strengthened as necessary in accordance with the goal of equitably improving health outcomes for all populations.

PHC and HIV actions

- **Develop implementation plans to ensure that all health facilities have WASH systems (water, sanitation, health care waste management, hygiene and environmental cleaning infrastructure and services across all parts of the facility), transport, telecommunication connectivity and a reliable power supply.** Joint planning between those involved in supporting physical infrastructure in health facilities can ensure maximal benefits to the entire population from investments that are derived from HIV sources. Joint planning can also focus on high-yield priorities that can

be addressed swiftly, while keeping a view of the longer-term trajectory.

- **Establish protocols to ensure that the physical organization of health facilities and community service delivery points reflects sensitivity to gender and does not create stigmatizing or discriminatory experiences for service users.** Various measures can be taken to make health service settings gender-sensitive, such as ensuring that service users have privacy to discuss personal issues with service providers. Physical spaces should be planned and managed in ways that do not foster stigma and discrimination. For example, communities in some settings might indicate that signs prominently identifying HIV clinics could cause clinic attendees to experience self-stigma and put them at risk of discrimination because of other people's perceptions about their HIV status.
- **Use established mechanisms to solicit feedback on health facility standards and functions from service users and community members (for example, citizens' scorecards).** A key characteristic of PHC-oriented health systems is that service users and communities have a central role in determining how the health system should meet their needs. This includes obtaining input from service users, communities and civil society organizations about multiple aspects of health service delivery, such as perceptions about the physical infrastructure of health facilities. Input should be solicited in a manner that does not present language or literacy barriers. In settings where the clinical management of HIV has shifted from specialized facilities to primary care facilities, seeking feedback about the perceived suitability of the facilities from HIV service recipients can help to promote their engagement and retention in care.

4.8. Medicines and other health products

Health products include medicines, vaccines, medical devices, in vitro diagnostics, protective equipment and assistive devices. These must be of assured safety, efficacy and performance and quality. In addition, they must be appropriate, affordable and available to service users. Ensuring that appropriate health products are available and affordable depends on policy decisions and integrated processes related to product assessment, selection, pricing, procurement, supply chain management, maintenance (in the case of medical devices), prescribing and dispensing.

Procurement practices and policies that favour the purchase of generic medicines have a key role in ensuring

high-quality products at affordable prices. Purchasing generic medicines can contribute to the effective use of government resources and can reduce out-of-pocket expenditure for service users.

PHC and HIV actions

- **Establish pricing policies through multi-partner collaboration to make full use of generic products and employ other procurement strategies that maximize resources and reduce out-of-pocket payments.** In 2020, for example, a product development collaboration involving WHO, UNICEF, UNAIDS, the United States President's Emergency Plan for AIDS Relief, the Global Fund, Unitaid, the Elizabeth Glaser Pediatric AIDS Foundation and the Clinton Health Access Initiative, in collaboration with low- and middle-income countries, secured significantly lower prices for generic HIV treatment for children, bringing the average annual cost of treatment down from more than US\$ 480 per child to less than US\$ 120 per child (49,50).
- **Review evidence on the costs and benefits of new health technologies, including projections of cost savings that may be achieved by bringing the use of new technologies to scale and incorporating them into national essential health benefits packages.** Health service providers, health service users and communities should be consulted about the feasibility, acceptability and potential market demand for new health technologies. Operational research should be conducted to inform policy decision-making and guide scale-up.
- **Strengthen local capacity, including community capacity to procure and distribute health products during health emergencies.** During the COVID-19 pandemic, many community-based organizations mobilized health resources in unprecedented ways to ensure the continuity of HIV-related services for clients and community members whose access to services was limited by lockdowns and stock-outs of health commodities, including HIV treatment (51). The lack of a larger health system infrastructure to support these efforts placed a severe strain on community-based organizations and put the health of community-based health workers at risk. Preparedness planning for future health emergencies should recognize the role of communities in helping to manage health product supply chains and to dispense health products in emergency situations.

4.9. Engagement with private-sector providers

The private sector refers to all non-state actors involved in health: for-profit and not-for-profit, formal and informal and domestic and international entities. Almost all countries have mixed health systems with goods and services provided by the public and private sectors and with health consumers requesting these services from both sectors. The private sector's involvement in health systems is significant in scale and scope and includes providing health-related services, medicines and other health products, health insurance, supply chain management, health workforce training, information technology services and infrastructure and support services.

In many countries, diverse private-sector entities are major providers of services and commodities for HIV and related health issues. Indeed, services for sexually transmitted infections are mainly provided through the private sector in the majority of countries worldwide. People base their decisions about whether and where to utilize services on not only the availability of services but also perceptions about aspects of care such as cost, confidentiality, user-friendliness and efficacy. Coordination between the private sector and the public sector is required to meet both individual and public health needs.

PHC and HIV actions

- **Conduct provider mapping or assessments to ensure that accurate information about the scope of private-sector health service delivery is available to health system stakeholders.** In settings where primary care is increasing assuming a larger role in the HIV response, and especially where HIV and sexually transmitted infection services are integrated, considering existing private-sector assets in planning how to meet service uptake, coverage and quality requirements is important. Stakeholders may explore how public-private partnerships associated with HIV and related programmes can be leveraged to support primary care-based HIV service delivery and laboratory monitoring.
- **Assess the current status of coordination between public-sector and private-sector health service providers and identify priority areas in which greater coordination should be fostered.** Public-sector and private-sector referral systems should be organized in ways that facilitate the continuity of care as service users move between the two sectors. Public-sector health information systems should be able to integrate data from private-sector platforms into public-sector datasets to contribute

to the evidence base for PHC-oriented decision-making. Regulatory functions in countries should be strengthened to ensure that private-sector services and commodities meet WHO's quality and normative standards, including for HIV. There are numerous examples of public-private collaboration in HIV: for example, an HIV self-test is now available for US\$ 1 to the public sector in low- and middle-income countries, the lowest price ever for a WHO-prequalified HIV self-test, as the result of a public-private partnership (52).

4.10. Purchasing and payment systems

When supported by adequate PHC-oriented resource flows, purchasing and payment systems can increase the accessibility of priority interventions to the entire population, including through primary care-based service integration where this is feasible and appropriate. Components of strategic purchasing include benefits design, provider payment methods and contracting arrangements.

Disease-specific goals and requirements help to drive actions to advance a PHC approach in countries including in efforts to strengthen strategic purchasing. For example, should a country identify retention on HIV treatment as a key priority, then primary care facilities must be financially incentivized to support this effort, such as through performance-based capitation at the primary care level to incentivize retention in care of people living with HIV. Similarly, if multimonth dispensing and decentralized service delivery models have been given priority, then strategic purchasing can help to ensure that referral policies are in place to provide case management to people living with HIV at the appropriate facility level. In contexts in which routine HIV viral load testing needs to be scaled up, more efficient procurement can lead to improved pricing for viral load diagnostic products.

The process of defining essential health benefit packages in countries should use WHO tools and seek input from affected communities (53). Benefit packages should reflect a comprehensive spectrum of services that address the entire population's needs across the life-course. Changes to access conditions in benefit packages, such as reducing or removing user fees, can encourage greater uptake of primary care services, including HIV prevention and treatment services delivered through primary care.

PHC and HIV actions

- **Using the universal health coverage compendium (54), OneHealth (55) and other tools, assess whether**

essential health benefit packages sufficiently reflect the comprehensive health needs of inadequately served populations, including HIV key populations (people who inject drugs, sex workers, people in prisons and other closed settings, transgender and gender-diverse people and men who have sex with men). When nationally representative data reflecting the health needs of specific populations are lacking, other types of evidence should be considered in determining whether benefit packages equitably serve these populations.

- **Ensure community participation in designing and monitoring health purchasing and payment systems: for example, through policy dialogue, technical advisory committees and health insurance oversight boards.** A strategic purchasing approach should be driven by evidence-informed decision-making about the mix of services required and the volume of each respective service required to achieve programme objectives as well as health service provider resource requirements. Communities can provide valuable perspectives on these issues and can contribute to ensuring accountability for purchasing and payment decisions by participating in monitoring. Some communities, including some communities of people living with and affected by HIV, possess deep expertise on the merits of purchasing certain commodities or using certain service provider models from the standpoint of service users' needs and preferences.

4.11. Digital technologies for health

Digital technologies for health encompass information and communication technologies as well as advanced computing sciences relating to big data and artificial intelligence (56). Users of digital technologies for health include patients and clients, service providers, health service and health system managers and providers of data services in support of health service delivery and the broader health system (57).

Digital technologies can contribute in many ways to making health systems and services more people-centred and person-centred. However, there may be financial, logistical and cultural barriers to accessing these technologies, not only for service users but also for service providers and managers.

Effectively implementing digital health interventions requires an ethical and enabling environment, with consideration for factors such as infrastructure, health workforce skills and capacity, privacy and safety protocols,

legal and policy frameworks and compliance mechanisms (58). Data protection is critical to upholding the human rights to privacy and confidentiality (59).

Services developed to meet the needs of people living with and affected by HIV have leveraged diverse digital health technologies that can be used across a range of health areas (60). These include client communication to support medication adherence, self-monitoring of symptoms, self-care pathways and laboratory management systems. Digital health interventions can be used to effectively engage specific populations and to reach people who may want to avoid physical service delivery points because of concerns about stigma and discrimination. Digital technologies also have been widely used to collect data for HIV health information systems. In some settings, people living with HIV and affected communities have participated extensively in developing digital health tools and platforms, helping to make these products responsive to community members' needs and priorities.

PHC and HIV actions

- **Keep health equity considerations at the forefront of decision-making about digital health.** Digital health interventions have the potential to exacerbate existing inequalities within and across populations. When designing, piloting and scaling up digital health interventions, telecommunication access and digital literacy should be considered. Remedial measures should be taken if the scaling up of digital health interventions will not equitably meet the needs of all health system beneficiaries.
- **Establish mechanisms to assess how the privacy, security and confidentiality of digital data can be ensured for health service users, including people requiring HIV-related services.** The development of digital technologies to support HIV services has been characterized by a high level of attention to data security and the ethical use of data, reflecting concerns about safeguarding individual privacy, confidentiality and other human rights. This expertise can be leveraged to help to address similar concerns among other health system stakeholders as the applications of digital health technologies continue to be explored.
- **Build on knowledge about the use of digital health technologies acquired during health emergencies, both to prepare for future health emergencies and to advance the routine use of digital health.** During the COVID-19 pandemic, WHO worked with partners and communities in many countries to ensure that populations in need, including people living with HIV,

continued to receive timely high-quality health services and essential commodities. Service users and providers rapidly increased their use of digital technologies, including messaging and videoconferencing platforms, to compensate for the disruption of normal channels for delivering health services and commodities. Lessons learned may be applicable to the ongoing use of digital health, but work is needed to synthesize and analyse more of the evidence from that body of experience and to determine how lessons can be better translated into best practices.

4.12. Systems for improving the quality of care

According to estimates, poor-quality care causes more deaths in low- and middle-income countries than lack of access to care. High-quality health services must be effective, safe and people-centred. In addition, to realize the benefits of high-quality health care, health services must be timely, equitable, integrated and efficient (61).

Recognizing the critical role of the quality of care in universal health coverage, WHO along with the World Bank and the Organisation for Economic Co-operation and Development proposed a series of actions from key constituencies – governments, health systems, citizens, patients and health workers – that need to work together to achieve the goal of high-quality health service delivery (62). Central to this initiative was a call to set national strategic direction on quality. At the heart of such a national quality policy and strategy is a package of interventions reflecting the actions needed to shape the health system environment, reduce harm, improve clinical care and engage patients, families and communities. Further, WHO emphasizes the need for multilevel planning and implementation for quality of care (63).

Improving the quality of care is an ongoing process rather than a specific time-bound activity, and quality improvement mechanisms should be routinely integrated into health service delivery. Improving the quality of care further entails addressing how other components of health systems such as governance, health workforce management and health information systems affect the service user's experience.

In recent years, community-led monitoring has emerged as an effective mechanism for improving the quality of HIV and related services. The purpose of community-led monitoring, which is discussed further in subsection 4.14, is to enable service users to provide structured input on health services, based on evidence and experience, through a collaborative and solutions-oriented process (4).

People living with and affected by HIV experience high levels of stigma and discrimination in health care settings worldwide, with detrimental consequences, including delayed enrolment in HIV care and poor adherence to antiretroviral therapy. Ensuring stigma-free environments and eliminating discrimination should therefore be key objectives of efforts to improve the quality of all health services. WHO has identified a range of interventions for addressing different aspects of stigma and discrimination in health settings (4).

PHC and HIV actions

- **Develop national strategic direction on the quality of care involving diverse stakeholders, including those focused on specific disease areas.** Quality concepts should be incorporated into national HIV policies and strategic plans, and these policies and plans should be aligned with the national strategic direction on quality of care for all services. Disease-focused programmes often have quality-related capabilities in place at multiple levels of the health system that can provide a pathfinder for overall national strategic direction on quality.
- **Institute mechanisms to enable individuals, families and communities to provide feedback on the quality of health services and incorporate the feedback in improvement efforts.** Feedback mechanisms may take different forms such as service user questionnaires or public meetings. Community members should be able to access feedback mechanisms without encountering language or literacy barriers.
- **Develop and sustain governance, accountability and leadership for quality and safety at the local level: for example, district and primary care quality teams and focal points.** WHO has issued recommendations on HIV quality standards, quality HIV testing and improving the quality of HIV clinical services – all of which can be applied to primary care services and PHC (4,64).
- **In collaboration with communities that are affected by stigma and discrimination, establish mechanisms for monitoring and reducing stigma and discrimination in health service settings, including stigma and discrimination directed at people living with and affected by HIV.** There are multiple pathways for addressing stigma and discrimination in health care settings, such as identifying champions at all levels – facility, community and national – to foster awareness of the need to oppose stigma and discrimination; providing support for those working in health care settings who are living with and affected by HIV, to ensure they receive the services they need; ensuring that appropriate HIV-related workplace policies and

feedback mechanisms are in place; and ensuring that health workers have access to clearly understandable HIV and health literacy information.

4.13. Primary health care-oriented research

Health systems, policies, strategies and operational plans should be informed by the best available evidence regarding what works and why. Health system research and implementation research on interventions that support all three components of PHC are key to providing this evidence base. This operational lever links directly with all other levers in the PHC operational framework since health systems and implementation research should comprehensively foster the creation, management, dissemination and use of knowledge around all aspects of strengthening PHC.

PHC and HIV actions

- **Implement policies requiring recipients of public funding to involve relevant communities in designing and implementing PHC research and in reporting and disseminating research findings.** Community involvement in PHC research, including community-led research, is central to ensuring the relevance of proposed service delivery innovations and encouraging their future adoption. When community involvement takes the form of participation in community advisory boards for research studies, these bodies should be empowered to make meaningful contributions to decision-making.
- **Encourage a focus on implementation science to explore the optimal uptake of WHO guidance in a dynamic context.** Evidence indicates that, although key guidance from WHO on HIV prevention, testing, treatment and care is widely reflected in national policies (65), impact is often compromised because interventions are not consistently implemented or fail to reach the populations with the greatest needs (5). Other challenges to achieving intended impact may occur when countries experience major health system stressors or shifts, for example in the context of a large-scale public health emergency or a transition from external partner funding to domestic funding for key health system activities. Given the dynamic nature of health systems and the responses to HIV and other health challenges, implementation science can provide evidence to inform timely adjustments to health policy and programming frameworks.
- **Identify lessons from HIV research that may contribute to shaping PHC research objectives and the design and implementation of studies.** Countries should support

research and knowledge management activities to strengthen PHC by building on health system-focused research and evidence to also include research and evidence from disease-specific initiatives. A robust evidence base exists as a result of HIV investments and programming, including lessons learned about issues such as health governance, person-centred health services and community-based and community-led service provision. Stakeholders from disease-specific backgrounds, including HIV, are also well suited to contribute to research on how best to integrate disease-specific services into primary care and how to effectively scale up successful primary care-based service delivery models.

4.14. Monitoring and evaluation

The ultimate goal of strengthening PHC is health for all without distinction of any kind, as embodied in universal health coverage and the health-related Sustainable Development Goals. Thus, countries need to be able to track how their decisions, actions and investments in PHC are addressing and improving service coverage, financial risk protection, determinants of health and ultimately the health status of individuals and populations. This endeavour requires that countries establish a comprehensive, coherent and integrated approach to monitoring and evaluation based on a logical, results-based framework that encompasses equity dimensions and multisectoral components across its entirety.

Where HIV health information systems exist, they must be supported to fully integrate into nationally unified health information ecosystems to maximize the use of resources and support the delivery of integrated health care. HIV health information systems are encouraged to identify and close gaps in service access, coverage and quality through, for example, better tracking of the integration of sexually transmitted infections, viral hepatitis, TB and cervical cancer screening and treatment within person-centred HIV monitoring and surveillance systems (66). Harmonized approaches to strengthening health information systems, such as joint investments in strengthening vital registration and routine service monitoring systems, integrated disease surveillance, shared approaches to surveillance of antimicrobial resistance and combined surveys, provide opportunities to increase alignment and efficiency, enhance data quality across all service delivery areas and improve patient-level tracking across the health system. Community-level and community-generated data should be integrated or linked with clinical data management and other health information platforms.

PHC and HIV actions

- **Agree on nationally appropriate key indicators to track progress on PHC strengthening across all three components of the PHC operational framework: comprehensive integrated health services, multisectoral policy and action and empowered people and communities.** PHC monitoring and evaluation entails addressing some of the same issues that are monitored and evaluated to improve the effectiveness of the HIV response. Thus, there may be opportunities for performance indicators to be aligned and for PHC and HIV stakeholders to share lessons and technical expertise with each other. Specific examples of indicators proposed in WHO’s PHC monitoring guidance include multidisciplinary team-based service delivery; existence of facility budgets and expenditure meeting criteria; collaboration between facility-based and community-based service providers; geographical access to services; perceived barriers to access; and people’s perceptions of health systems and services (10).
- **Explore the roles of person-centred monitoring and community-led monitoring in strengthening PHC.** HIV investments have helped to advance the use of both person-centred monitoring and community-led monitoring. Person-centred monitoring helps to guide the delivery of differentiated services that meet people’s needs across the HIV service continuum, support long-term retention in health services and improve programme outcomes. Community-led monitoring – in which communities collect, analyse and use strategic information to monitor and improve service quality, address bottlenecks and hold service providers and decision-makers accountable – has become an important component of health information systems (4,67). Both person-centred monitoring and community-led monitoring can contribute to guiding service delivery in primary care settings. Further, these approaches can contribute to strengthening PHC monitoring and evaluation more broadly.
- **Invest in secure and confidential data systems, protected by policies that uphold ethical principles and safeguard human rights, using different data security levels as warranted for different data elements and health care users.** Data security and confidentiality are particularly important for members of marginalized and stigmatized populations, including people living with and affected by HIV. The criminalization and stigmatization of same-gender sexual activity, sex work and drug use or possession in many settings dissuades people from accessing health services and creates difficulty in collecting information about these issues for health-related purposes. Rigorously applying standards in gathering and using data about individuals is key to ensuring data security, strengthening the interoperability of data systems, protecting the confidentiality of individuals and communities and ensuring that data collection efforts cause no harm. In all of these matters, the large body of knowledge and experience acquired in HIV responses may serve as a resource for strengthening PHC monitoring and evaluation.

Chapter 5

Priorities for guidance and implementation support

WHO seeks to support countries in developing frameworks, mechanisms and products for coordinating efforts to jointly achieve HIV and PHC goals. Priority areas in which WHO may be well suited to provide support include the following:

- supporting countries to adopt 2025 and 2030 health service integration-related targets outlined in the GHSS 2022–2030, including the target to ensure that 95% of people living with HIV and people at risk are linked to integrated health services, including viral hepatitis and sexually transmitted infection services, by 2025; the target to reduce the number of people dying from HIV-related causes per year (including disaggregation by HIV cryptococcal meningitis, TB and severe bacterial infections) from a 2020 baseline of 680 000 to a 2025 target of 250 000; and the target to ensure that less than 10% of people living with HIV, viral hepatitis and those affected by sexually transmitted infections experience stigma and discrimination in health settings (20);
- supporting countries to adopt and implement existing WHO guidance focusing on integrating services related to HIV through a PHC approach, including: integrating HIV, viral hepatitis and sexually transmitted infection services; services for HIV and TB; services focused on HIV and sexual and reproductive health; services focused on the triple elimination of the mother-to-child transmission of HIV, syphilis and hepatitis B; recommended service packages for specific groups, including people who inject drugs, men who have sex with men, transgender and gender-diverse people and other key populations; and integrating HIV services with services for cancer, noncommunicable diseases including mental health and diseases that present heightened risk for people living with HIV, including cervical cancer and Mpox;
- supporting countries to implement existing WHO guidance focused on integrating health system functions, including guidance related to the health workforce in countries with a high burden of HIV and guidance on optimizing testing and diagnosis through diagnostic technologies that can serve multiple functions, including testing for HIV, TB, Mpox, HIV early infant diagnosis, HIV viral load, and hepatitis C viral load;
- mapping WHO-recommended protocols and service delivery models that potentially may be coordinated or integrated across programmes such as communicable diseases, noncommunicable diseases, sexual and reproductive health, mental health and nutrition; for example, mapping community-based service delivery guidelines developed by WHO across programmes to identify opportunities for integrating elements of community-based service delivery to address multiple health needs;
- reporting on lessons and best practices drawn from WHO’s leadership on issues that have been important for responding effectively to HIV where they are also relevant for strengthening PHC, with potential focal areas including countering stigma and discrimination in health care settings; providing people-centred and person-centred health care for inadequately served populations; and fostering community and civil society engagement in health care planning and health system monitoring;
- publishing case studies on the experiences of national and subnational governments in relation to PHC and disease-specific services and programmes, including HIV, highlighting lessons from both successful and unsuccessful initiatives;
- contributing HIV-related content to training courses being developed through the WHO Special Programme on Primary Health Care to support mid- and senior-level health ministry officials in reorienting health systems to PHC, local health authorities and communities; and
- supporting countries in using or adapting theory of change models developed globally to describe associations between strengthening PHC and responding to HIV, when developing work plans or evaluating progress, gaps, and strengths such as the theory of change model developed to assess how UNAIDS has supported HIV and PHC integration through its activities (Annex 2).

Chapter 6

Conclusions

Achieving many of the health-related Sustainable Development Goals, including ending AIDS as a public health threat, and sustaining these gains in the face of the complex demands being placed on health and development systems, will require using health system resources in new ways. Scaling up high-quality people-centred services through a PHC approach is critical for achieving both disease-specific and broader health aims. Members of all populations must be able to access health services and benefit from health system resources free from stigma and discrimination.

Although there is no one-size-fits-all approach to pursuing HIV goals in the context of strengthening PHC, there are opportunities to jointly advance PHC and HIV goals in multiple domains. Global strategies and frameworks propose key pillars, principles, approaches and targets that can be used and adapted in countries to drive and monitor progress, including supporting the development and review of national strategic plans.

Guidelines are available to support the integration of services that cover common comorbidities and coinfections and intersecting areas of health, including HIV and sexual and reproductive health and rights. Indeed, opportunities for integrating, linking and co-locating services, including in primary care settings, are supported by a growing package of WHO guidance documents.

WHO guidance also highlights opportunities for health system efficiency in considering HIV needs in the context of other diseases and broader health needs, including guidance on health financing, monitoring and evaluation and optimizing infrastructure investments, including diagnostic technologies.

Beyond health services and essential health functions, there are also opportunities to jointly advance multisectoral policy and action and to support the further empowerment of people and communities – the other key focal areas of PHC.

Resources will be required to ensure the truly meaningful engagement of people living with and affected by HIV in mainstreaming their perspectives into the health sector at all levels – engagement is not a cost-neutral activity.

The ideas presented in this publication are intended to support ongoing discussions and prompt new discussions about how countries can address disease-specific needs through PHC. The WHO/UNICEF Operational Framework for Primary Health Care (2) offers a coherent pathway to select, implement and then learn from PHC and HIV convergent actions, based on the PHC strategic and operational levers that are most meaningful in respective country contexts.

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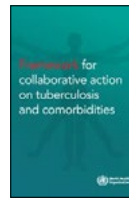
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Annexes

Annex 1. HIV-related resources that advance elements of primary health care



Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach
<https://www.who.int/publications/i/item/9789240031593>



Framework for collaborative action on tuberculosis and comorbidities
<https://www.who.int/publications/i/item/9789240055056>



Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations
<https://www.who.int/publications/i/item/9789240052390>



Optimizing community health worker programmes for HIV services: a guide for health policy and system support
<https://www.who.int/publications/i/item/9789240040168>



Consolidated guidelines on person-centred HIV strategic information: strengthening routine data for impact
<https://www.who.int/publications/i/item/9789240055315>



Integration of HIV testing and linkage in family planning and contraception services: implementation brief
<https://www.who.int/publications/i/item/9789240035188>



Integration of mental health and HIV interventions: key considerations
<https://www.who.int/publications/i/item/9789240043176>



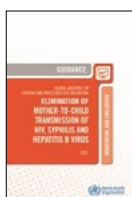
Enhancing uptake of voluntary medical male circumcision among adolescent boys and men at higher risk for HIV: evidence and case studies
<https://www.who.int/publications/i/item/9789240039797>



WHO implementation tool for pre-exposure prophylaxis (PrEP) of HIV infection
<https://www.who.int/publications/i/item/9789240057425>



Update on the transition to dolutegravir-based antiretroviral therapy: report of a WHO meeting, 29–30 March 2022
<https://www.who.int/publications/i/item/9789240053335>



Global guidance on criteria and processes for validation: elimination of mother-to-child transmission of HIV, syphilis and hepatitis B virus
<https://www.who.int/publications/i/item/9789240039360>



Health sector response to HIV, viral hepatitis and sexually transmitted infections: guidance for national strategic planning (forthcoming)



Implementing the end TB strategy: the essentials
<https://apps.who.int/iris/handle/10665/206499>



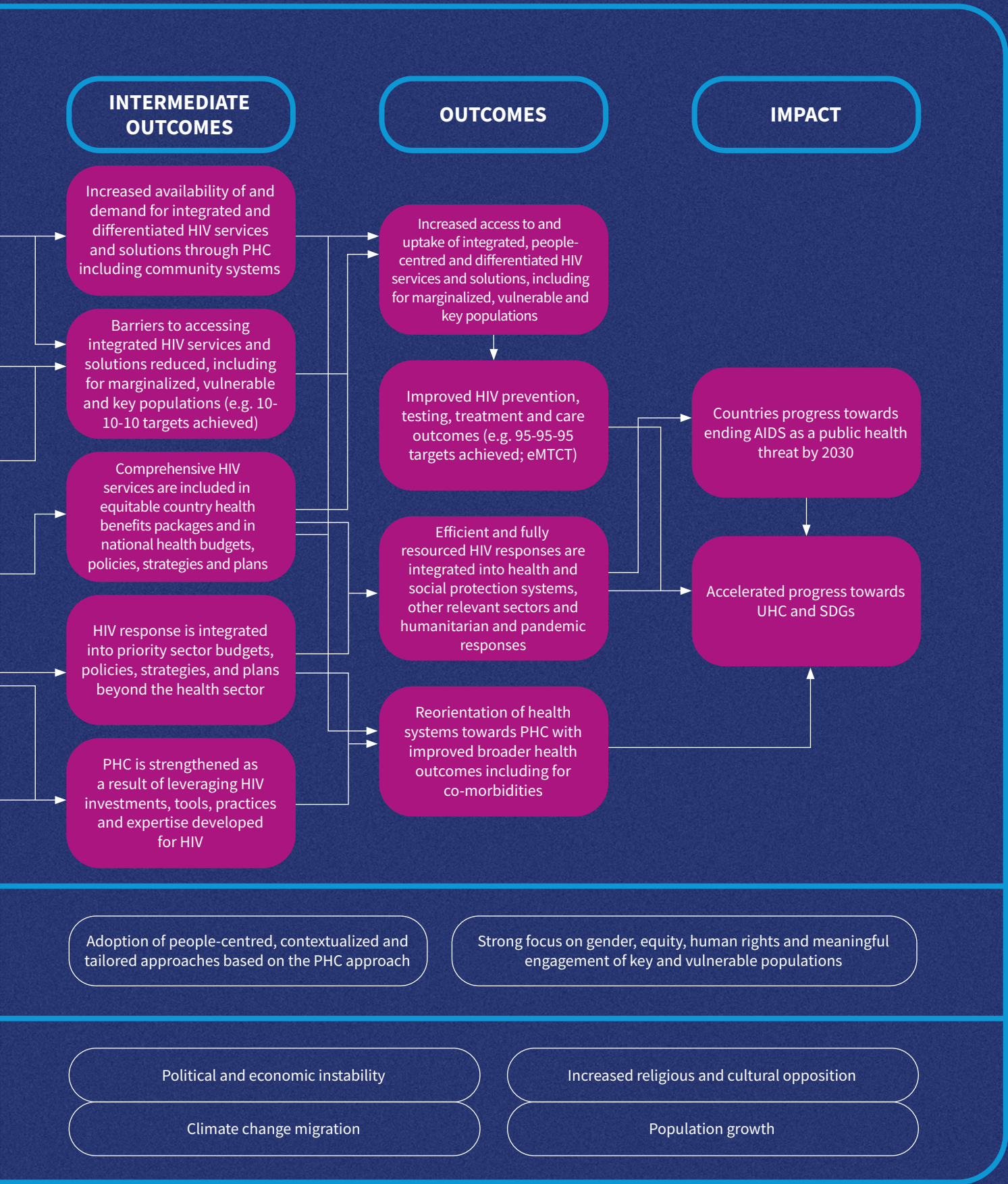
Guide to Conducting Programme Reviews for HIV, Viral Hepatitis and Sexually Transmitted Infections (forthcoming)



Integrating the prevention and control of noncommunicable diseases in HIV/AIDS, tuberculosis, and sexual and reproductive health programmes: implementation guidance
<https://apps.who.int/iris/handle/10665/366691>

Annex 2. HIV and PHC integration and linkages: UNAIDS Joint Programme Theory of Change.





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