2016–2021 Global Health Sector Strategies for HIV, Viral Hepatitis and Sexually Transmitted Infections

Online Consultation Report
6 August 2015
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Executive Summary

More than 300 individuals and/or organizations responded to an online survey in support of developing 2016–2021 Global Health Sector Strategies for HIV, viral hepatitis and sexually transmitted infections. Responses were highly supportive of the need for the strategies, and positive about proposed content in the early drafts of the strategies developed to support the consultation. They reinforced the need for ambitious, yet technically feasible strategies to help ensure appropriate action at country level. A number of common themes were expressed across the three health areas including:

- The need for stronger data and strategic information;
- A clear focus on equity, key populations and specific populations with clarity and consistency in definitions applied across the strategies;
- Determining pathways to ensure sustainable financing for responses;
- A focus on innovation in the context of shifting contexts and new opportunities.

The following graphics offer an indication of the key themes expressed by respondents across the three health areas.

HIV: key themes expressed in the consultation

- Prioritize young people
- HIV vaccination
- Roll out of PrEP
- Voluntary medical male circumcision
- Greater focus on men in addition to continued gender focus

- Treatment access
- Point-of-care testing
- Strategies for testing children and expanding paediatric ART
- Improve ineffective referral systems
- Generics and patents for optimal access

- Increased guidance for adolescents
- Increased focus on girls and women
- Inclusion of migrants and refugees
- Focus on men and masculinities
- Human rights, criminalization, stigma and discrimination

- Alignment and co-ordination with UNAIDS
- Promotion and empowerment of community initiatives
- Integration with SRH and other areas
- Further emphasis for links with TB
Viral hepatitis: key themes expressed in the consultation

**Burden of disease**
- Address awareness gaps
- Poor data needs to be addressed
- Need for strong advocacy

**Prevention**
- Harm reduction and NSP
- Decriminalize key populations
- HBV vaccine inc birth dose
- Health literacy and education

**Screening and treatment**
- Improved screening inc POC testing
- Improve monitoring of fibrosis etc
- Improved HCW training
- Treatment access

**Partnership and Integration**
- Link with HIV, STI and WASH
- Learn from HIV but build a clear hepatitis focus

**Targets**
- Over ambitious
- Harm reduction too low
- “Zero” targets unrealistic

Sexually Transmitted Infections: key themes expressed in the consultation

**Urgent need for a strategy**
- Neglected health area
- Rapidly changing epidemiology
- Antimicrobial resistance
- Opportunities with HIV linkages

**Key populations**
- Clearer definitions
- Harm reduction
- Increased health literacy and education
- Youth and adolescents

**Draft requires greater ambition**
- HSV, chlamydia and trichomoniasis should be included in targets
- Expand national HPV vaccination programs
- Invest in point of care testing

**Partnership and Integration**
- Stronger links to HIV and viral hepatitis
- Active participation of communities

Recommendations from respondents helped to shape revised drafts of the strategy documents.
Introduction

Three Global Health Sector Strategies (GHSS) are being developed by WHO departments of HIV and Reproductive Health and Research and will be finalized for submission to the 69th World Health Assembly in 2016. These proposed strategies seek to harness opportunities to help address the HIV, viral hepatitis (VH) and sexually transmitted infections (STI) epidemics in a post Millennium Development Goal environment defined by a new set of Sustainable Development Goals. The 2016–2021 strategies cover a critical phase for all three health areas as they guide actions needed to meet ambitious 2030 targets focused on elimination goals and/or the ending of epidemics. Engagement from key stakeholders in the development of these strategies is a central component to their development.

Rationale for a GHSS on HIV

The enormous effort, resources and ingenuity directed at the epidemic over the past 15 years is paying off:

- New HIV infections in 2013 were estimated at 2.1 million (1.9 million–2.4 million] – 38% lower than in 2001.
- Fewer people are dying of HIV-related causes: an estimated 1.5 million (1.4 million–1.7 million) in 2013, down 35% from the peak in 2005.

Shadowing the gains are three major challenges:

a) Fewer than half the people in need of antiretroviral therapy (ART) globally were receiving it in 2014, and the decline in the rate of new, sexually-transmitted HIV infections has been much too low;

b) HIV incidence is declining overall, but it is also increasing in some countries and regions and the progress is not reaching all priority populations sufficiently and quickly enough, which causes substantial disparities in access to treatment and care;

c) The global epidemic has reached a point where a steady-state response – maintaining coverage at current levels – will soon see new HIV infections and HIV-related deaths rebound. Human rights violations along with widespread stigma and discrimination continue to hinder access for key populations to health information and services to help prevent and treat infection by HIV. National HIV responses are too often poorly targeted to the national epidemiological situation, and of HIV interventions being delivered, many are of poor quality, are not necessarily those which are most effective, and do not adequately focus on the populations most in need.

An HIV response that only aims to try and hold the line and to maintain the status quo invites failure. New infections will rebound, the number of people living with HIV will keep growing, the long-term
need for treatment and the associated costs will rise indefinitely, and the epidemic will outpace the response.

**Rationale for a GHSS on Viral Hepatitis**

The need for the world’s first GHSS on viral hepatitis stems from the scale and complexity of the hepatitis pandemic, along with growing recognition of its massive public health burden and significant new opportunities for action. To date, few countries have seized these opportunities and action has tended to be fragmented and inadequate. The time has come for a coherent public health response that identifies effective services and delivery approaches, brings together key programmes and establishes clear institutional responsibility and accountability. Viral hepatitis is the eighth highest cause of mortality globally. It is responsible for an estimated 1.4 million deaths per year from acute infection and hepatitis-related liver cancer and cirrhosis — a toll comparable to that of HIV and tuberculosis (TB). Of those deaths, approximately 55% are attributable to hepatitis B virus (HBV), 35% to hepatitis C virus (HCV) and the remainder to hepatitis A (HAV) and hepatitis E (HEV). Viral hepatitis is also a growing cause of mortality among people living with HIV. About 5–15% of all people living with HIV are co-infected with HCV and 5–20% with HBV.

**Rationale for a GHSS on Sexually Transmitted Infections (STIs)**

Infections with sexually transmitted infections impose an enormous burden worldwide by compromising quality of life, and have a negative impact upon the sexual and reproductive health of people of all ages, including infants and children. STIs also indirectly facilitate the sexual transmission of HIV and cause cellular changes which precede some types of cancers. STIs rank among the top five disease categories for which adults seek healthcare in middle- and low-income countries and are a substantial strain on the budgets of both national health systems and households. It is estimated that almost 400 million people aged 15–49 years acquire one of four STIs each year: chlamydia trachomatis (146 million), Neisseria gonorrhoea (51 million), syphilis (5 million), or trichomoniasis vaginitis (239 million). The prevalence of some viral STIs is similarly high, with an estimated 417 million people infected with herpes simplex type 2, and approximately 291 million women living with the human papillomavirus (HPV). The prevalence of these STIs varies by region and gender. These epidemics have a profound impact on the health and lives of children and adults worldwide:

- Fetal and neonatal deaths — syphilis in pregnancy leads to over 300 000 fetal and neonatal deaths each year, and places an additional 215 000 infants at increased risk of early death;
- Cervical cancer — HPV infection is responsible for an estimated 530 000 cases of cervical cancer and 275 000 cervical cancer deaths each year;
- Infertility — STIs such as gonorrhoea and chlamydia are important causes of infertility, especially in sub-Saharan Africa;
- HIV risk — the presence of an STI, such as syphilis or herpes simplex virus infection, greatly increases the risk of acquiring or transmitting HIV infection (by up to 50% in some populations);
- The physical, psychological and social consequences of STIs severely compromise people’s quality of life
Methodology

The Survey Tool

The 12 question online survey tool was supported by the WHO Data Col platform and made available through the three HIV, viral hepatitis and STI homepages on the WHO website in all official WHO languages. Eight of the 12 questions were open ended and four requested rating against perceived levels of relevance. A copy of the survey is annexed to this report.

Survey questions were designed and pre-tested internally to ensure ease of use and clarity and to ensure the survey could be completed in a relatively short period of time. Background material, including draft strategies, was developed to support the survey and was made available on the three web pages.

The survey was launched on 26 March 2015 and stayed open until 8 May 2015. Communication outreach to stakeholders via group emails, listservs and social media generated 308 responses. Three key phases of outreach generated feedback: an initial “launch”; a midpoint “reminder”; and a communication to extend the opening time by one week from the initial end of April deadline until a new deadline of 8 May 2015. A total of 308 organizations or individuals completed the survey (see below for the breakdown of respondents by language and disease interest).

<table>
<thead>
<tr>
<th>Language</th>
<th>HIV</th>
<th>Hepatitis</th>
<th>STI</th>
<th>TOTAL</th>
</tr>
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<tr>
<td>English</td>
<td>103</td>
<td>83</td>
<td>47</td>
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<td>1</td>
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<td>4</td>
</tr>
<tr>
<td>TOTAL</td>
<td>139</td>
<td>96</td>
<td>73</td>
<td>308</td>
</tr>
</tbody>
</table>

Data Analysis

The surveys generated nominal, ordinal and qualitative data which was exported into Excel sheet format for analysis. Nominal and ordinal data was straightforward to analyse and are presented in this report both numerically and in the form of bar charts. For the analysis of the open ended questions various qualitative data analysis (QDA) approaches were considered. The use of software analysis tools – usually referred to as Computer Assisted Qualitative Data Analysis or CAQDAS was considered yet given the manageable number of responses it was decided to run the analysis manually without the support of CAQDAS.
Thematic analysis, commonly used to interpret survey data of this type, was used to organize the feedback as it allows exploration of broad patterns and themes. There are two main forms of thematic analysis: deductive and inductive. Deductive approaches rely on the use of predetermined codes and frameworks which can limit the interpretation of the data. Inductive thematic analysis uses no predetermined structure or framework to analyse data and allows the data generated to determine an emerging analytical structure. Most analyses use a combined inductive/deductive approach.

In this case an intern joined the WHO technical teams to conduct an initial inductive thematic analysis that involved: familiarization with data; generation of initial codes; searching for themes among the codes; reviewing themes; defining, naming and renaming themes; and producing a draft report. The process then shifted to a deductive analytical approach which involved a WHO strategy consultant revising and regrouping the themes for this final report.

Asterisks are used throughout this report to indicate more than one respondent suggesting the same idea. The report is largely descriptive.

**Limitations**

While there are clear limitations to this type of survey and analysis (participant bias, stakeholder sample etc.) the online consultation offered an important additional opportunity to hear the perspectives of stakeholders interested in HIV, viral hepatitis and STIs. The consultation complemented a series of face-to-face consultation opportunities and rich and useful feedback was generated, which will help to shape future drafts of the three strategies.

**Acknowledgments:** Andrew Ball, Nathalie Broutet, Hande Harmanci, Rachel Katterl, Marcel Kalau, Elizabeth Noble and Andy Seale.
HIV: Analysis of Responses to Online Consultation

The survey tool followed a similar structure to the draft strategy (introduction, principles, goals and targets, strategic directions etc.) and asked questions related to each of the proposed sections. Despite this structure many respondents chose to focus their responses on similar themes (for example key populations or treatment access) or key messages they wanted to communicate in their answers throughout the survey. In reading this report a number of key themes are therefore repeated.

Importance of the Strategy

Survey respondents expressed overwhelming support and appreciation for the draft strategy. Key themes emerging from the 139 responders included: the ongoing need for, and appreciation of, global technical and normative guidance; an increased focus on key populations and a renewed focus on adolescents; support for the integration of HIV work with sexual and reproductive health approaches and TB; and aligning the strategy with the multisectoral strategy of UNAIDS.

Comments expressed regarding the need for a strategy:

- Global guidance and alignment with health systems strengthening will help ensure HIV does not fall off the sustainable development agenda.
- Support for 90–90–90 targets.
- Changing epidemics require strategy that is responsive to time specific challenges.
- Strategy will help mobilize and guide country health sector response.
- Strategies are successful reference documents for the development of regional and local strategies, and ensure that resources are focused on priority areas.
- It provides a tool for measuring progress and ensuring accountability.
- Articulating how goals/targets are reached requires flexibility to dynamic and different contexts.
- Propose strategies are reviewed every 2–3 years.
- The draft clearly states that maintaining current levels of effort may lead to rebound of HIV infection and deaths.

It is imperative that organizations and individuals have a guiding tool at all times, a strategy that is relevant and response to time specific challenges. The world of HIV has faced a lot of changes in the past years, some positive, others negative, so it’s important to have a strategy that responds to these changes.

- Zimbabwe Community Health Intervention Research project

Equity and Key Populations

- Need stronger guidance for adolescents and young people******.
- Increasing efforts to identify and treat children from infancy through childhood.
In order to achieve the 90–90–90 target we must focus on populations that continue to be left behind from prevention, diagnosis, care and treatment.

- Generalized HIV epidemics are often high gender on inequality index – need to strengthen gender focus.
- A focus on groups currently not being adequately met (e.g. girls and women) should be an important part of the strategy
- Targeting injecting and non-injecting drug users.

HIV and AIDS education for young people plays a vital role in global efforts to end the AIDS epidemic. Young people remain at the center of the epidemic and they have the power, through their leadership, to definitively change the course of the AIDS epidemic.

- Universitas Pelita Harapan, Karawaci, Indonesia

**Linkages, structure, framing and language**

- Neglected tropical diseases (NTD) should be further integrated.
- Female Genital Schistosomiasis (FSG) should be targeted since there is a likely association with an increase in HIV infection in women.
- The HIV testing and laboratory/POC components should support for the strengthening of integrated and sustainable laboratory networks
- Need to see stronger inclusion of TB.

***

- Integration into a broader concept and strategy of sexual and reproductive health. **
- Needs to be ambitious and evidence based.
- Propose inclusion of AIDS in the title – should read “global health sector strategy in HIV/AIDS”. **
- Needs to be linked with viral hepatitis, STI as well as universal health coverage of SDG. ***
- Changing the strategy and action plans every 5–6 years may be more expensive and difficult for countries.
- Stronger diagnostic section required.

The integration into a broader concept and strategy of sexual and reproductive health and in support of strengthening the health system shall be an overall guiding principle

- SDC (160788)

**Link to UNAIDS Strategy**

- Should be well aligned with UNAIDS ***

A WHO HIV strategy that is in line with the Sustainable Development Goals, UNAIDS Fast Track Targets, and other global initiatives strengthens collaboration and ensures a comprehensive and coordinated partner effort around HIV

- Anon
General comments including for the introductory sections of GHSS HIV

This section of the report summarizes the key themes and messages that emerged from open ended questions in the survey. Responses are grouped thematically:

**Key and Specific Populations and Human Rights**
- Combining key populations and other vulnerable/at risk/priority populations is problematic.
- Geographic distribution and settings focus are not the same – avoid conflation.
- Information on key population should be more comprehensive.
- The need to reach the people who have been left behind and addressing stigma should be further emphasized.
- Need for a clear unambiguous standpoint in support of human rights and the concept that all lives matter.
- The importance of human rights in this discussion cannot be overstated: human rights as it relates to economic inequality and access to HIV services, food insecurity, violence against women and girls, stigmatization and discrimination against high risk populations and people living with HIV.
- To ensure that the fight against HIV is well-resourced, the paradigm must shift to combat HIV by placing human rights and universal health coverage as the core principles in how we plan programmatic interventions.
- Stigma and discrimination should be more clearly emphasized.

**Children and adolescents**
- Half of infants living with HIV will die before their second birthday, which is why pediatric testing, care and treatment warrant higher priority in the strategy.
- Children need to be referenced as a population that is not being reached sufficiently and quickly enough by the current response.
- Intersectoral (interdepartmental) collaboration and cooperation of the health care system and education is a critical component of child and youth focused prevention work.
- Prioritize children: Children, adolescents and young people are rarely regarded as key populations and they consistently fall off the agenda of policy makers with the result that there is now a general recognition that addressing vertical HIV transmission to end new infections of children is essential, that the number of children living with HIV on treatment is woefully low, especially in comparison to adults, and that HIV is the leading cause of adolescent mortality in Africa.
- The need to address the gap in pediatric diagnosis and treatment deserves additional emphasis.

**Women**
- Treatment and prevention efforts must be inclusive and emphasize respect for the rights, dignity, and autonomy of people living with HIV and particularly women living with HIV.
- A major contributing factor to generalized HIV epidemics is high gender inequality.
- Women living with HIV should not just be consulted but must be at the center of developing programming strategies and should serve as monitors of treatment and care programs to protect against stigma, discrimination, and violation of rights.
- Poverty, wealth and gender inequalities increase HIV vulnerability and risk, and the interaction between these factors is complex. Tackling these interrelated issues implies a strong gender perspective in designing HIV policies.

**Aging population**
- Few HIV strategies in LMICs address the needs and rights of people living with HIV in older age groups, yet people aged 50 and over hold important implications for HIV responses.
- The strategy does not address issues related to older people over 50.

**Mother to child transmission**
- Widespread implementation of prevention of mother-to-child transmission (PMTCT) services has been a resounding success and must be included as an area for continued investment.

**Drug Users**
- A gap still remains especially among the key populations like injecting drug users, prisoners, and migrants.
- Drug-related infectious diseases, for which the early diagnosis situation is inadequate, lead to a consequent deficiency in early access to therapy for individuals who have contracted these infections.

**Migrants and Refugees**
- Refugees should be mentioned as most vulnerable populations.
- Migrants as a key population. Migrants account for about 40% of new HIV diagnosis in Europe. Undocumented migrants account for more than 40% of new infections in Europe. This health issue calls for new responses.
- Improving health policies for migrants means promoting better information and increasing the number of cultural mediators dedicated to health care services.

**Treatment**
- We are entering a period where first line HIV medicines will be rendered ineffective. We must begin the campaign to make second line drugs available so that they can be affordable to those entering into the next phase of their infection.
- New recommended regimens especially for children should be made available to improve the treatment retention against coverage.
- There is an urgent need for funding for research and making second line drugs broadly available.
- The need for continued scale-up needs to be balanced against the need to ensure that people already on treatment are stable and have consistent access to medicine and support services. Whilst it is preferable that all of those living with HIV should begin treatment immediately, in reality many people do not have access or are not able to start treatment.
the face of dwindling HIV resources, governments will need to make difficult choices about how to scale-up and maintain successes. Special attention should be paid to the data on financial expenditures on treatment of patients with HIV in various countries, as well as on the effects of treatment, care and etc. for the countries at various levels of economic development.

**Prevention**
- Much focus is given to (medical) tools and products whilst interventions such as primary prevention including comprehensive sexuality education and condom promotion or also more broad health promotion are missing. Primary prevention is cost-efficient and related benefits go far beyond HIV/AIDS.
- Female Genital Schistosomiasis has been neglected until now as a condition increasing the risk of HIV acquisition; it should now be included in the prevention strategy.
- If broader prevention measures are not enhanced, older individuals such as gay men, in the era of new therapy, may relax safe sex practices and cause new infections.

**Health Systems**
- Data collection in countries is often incomplete or inadequate. More training is needed to support countries with data collection, surveillance and monitoring and evaluation.
- There is vast potential for promoting and supporting health through mobile phone technologies and social media in low and middle-income countries.
- Explicit strategies are needed to help ensure that health workers do not stigmatize and discriminate, including work-place programmes to assist health workers with their own health and possible self-stigma issues. Proper ethical training, which includes knowledge about different key population issues, and attitude issues; how to work with patients with complex needs and chaotic lifestyles, is needed.
- Regular training of involved physicians with HIV care (including general practitioners (GPs), family physicians and who work in prisons) about HIV/AIDS care and treatment outpatient protocols is one of our important activities for ART scale-up. All trained GPs could be engaged in a national web based network of AIDS GPs in order to contribute to improvement and unification of services delivery.
- Laboratories play a leading role in reaching the 90–90–90 targets by ensuring access to timely, accurate diagnostics. WHO should align to PEPFAR laboratory investments to achieve maximal impact to support these efforts while balancing efforts through current laboratory investments for sustained epidemic control. It is especially critical for laboratory to clearly demonstrate its impact aligned with core and near-core activities. Targets to achieve 90:90:90 goals will require 1) increased HIV testing in high-yield populations, 2) ensuring accuracy of HIV-positive patients prior to putting patients on treatment and 3) measurement of viral load to confirm suppression. These key laboratory activities should continue to be supported as core elements since they are critical to achieve 90–90–90 goals and should be funded appropriately. Increased access to testing should not compromise quality of testing (both laboratory and point-of-care-testing (POCT)). Therefore investments in processes that enhance and ensure quality and accuracy of testing and support uptake and coverage, as outlined in this document, are critical.
• More emphasis on laboratory services is needed – without this, we will not be able to diagnose patients and ensure they are virally suppressed, which are two of the three "90s" in the 90–90–90 goals.
• Explicit reference to quality laboratory capacity and well-trained human resources required.
• More rigorous data collection in particular sex and age disaggregated data.
• Again, without specific actions, the section on Strategy implementation: Accountability, monitoring and evaluation remains quite general.
• There is minimal acknowledgement of frontline service providers and the health-care workforce in this draft strategy. Like many such documents before it, this Draft Strategy effectively reduces the strengths and importance of the health workforce in coordinated national HIV responses. It removes agency from health workforce organizations and neglects the position of health care workers as affected populations in HIV epidemics.

**Partners and Linkages**

• The need for country ownership of the fast-track strategy and for countries to produce plans with targets appropriate for their contexts is of paramount importance.
• The strategy needs to reflect the need for sustainable funding for strengthened and better linked health and community systems, integration and decentralization of services, sustainable task-shifting at the community level, and better financing in both low and middle income countries.
• The development and implementation strategies of UNAIDS and WHO must be adequately coordinated. **
• Although this is a health sector strategy, the section should be explicit about the multisectoral aspect of the HIV/AIDS response and provide information about sectors with which the health sector needs to work in priority (e.g. education sector, health education and more specifically sexuality education). The role of UNAIDS and the role of WHO within UNAIDS needs to be stated in the introduction and not only on the last page.
• Accountability of governments – governments should be made aware of the consequences of failing in implementation, and they should be invited to mobilize resources domestically and, where appropriate, through donor support.
• Link and integrate HIV interventions and services within broader sexual and reproductive health services and programmes.
• It could be a common framework for a combined HIV/STI strategy.
• HIV infection and several other diseases, such as STIs and viral hepatitis share the same transmission routes; therefore, the principles and measures of prevention are identical. However, the prevention strategies for these diseases were often formulated in separate plans and the linkage among these plans is deficient. In addition, the management of the co-infection and comorbidity of those diseases is essential in the care of people living with HIV. Thus, the resources invested in the prevention of HIV infection and these diseases should be integrated to utilize the resources efficiently.
• Much more integrated approach is needed in HIV, Hepatitis and STI fields.
Community and Civil Society

- More attention should be placed on the role of civil society and community-based efforts in each of the strategic directions as well as their contribution to securing an enabling environment for delivery and impact.

General Supportive Comments

- The draft introduction section is well written and not only highlights the importance of a strengthened HIV response, but the need for accelerated action ('fast-track').
- The introductory sections are properly structured and define the essential stages for the countries' agenda, by creating a direct connection between the level of development, the poverty degree and the sustainability of the national programs.
- I appreciate the proposed strategy and feel it has the right ingredients for a successful guiding document.
- In general, a really well-considered and articulated strategy, congratulations to all who contributed to this!
- Very good leadership!
Guiding Principles

A number of guiding principles were proposed in the early draft of the strategy that was shared to inform the online consultation. Respondents were asked to offer a relevance rating for each of the proposed principles and provide comments to open-ended questions. Figure 1 shows that the majority of respondents found the proposed guiding principles to be either highly relevant or relevant. Additional feedback from the survey follows:

Rating of the Proposed Guiding Principles

![Figure 1: Rating of the Guiding Principles for HIV. N = 137](image)

The following comments were made in relation to different draft principles:

Accountability and Transparency
- Who is accountable, what is the role of government?
- The use of (long) existing evidence lies at the basis of any rating of accountability.
- This should be holistic and based on a region or nation’s baseline, so as to ensure there is improvement in all regions.
- Trial data should be disclosed so that independent researchers can have access.

Human Rights and Gender Equality
- Gender equality and human rights must be mainstreamed through the program design, they are central to the success within the global HIV response.
- It is crucial that the strategy is human rights based and addresses inequalities.
- All principles should be grounded in human rights. HIV and AIDS is a social justice imperative that must be addressed outside of hospitals and laboratories. HIV is a human rights issue.
- Human rights should ensure emphasis on key populations by clearly naming them.
• Given the effects of criminalization, marginalization and abuse of key populations on individual rights as well as public health, this strategy needs to suggest action to be taken in countries where criminalization and/or blatant exclusion and abuse are forcing key populations to live in secrecy and fear, and ultimately not accessing the services and support they need for their own health and as a public health issue.

• Human rights and Access to care: In many countries with strong economic growth, cross border migrants are therefore increasing either legal or illegal migration. Health security among them should be our concern and, individuals should also receive country’s health security.

• Need to focus on women as they still remain vulnerable.

Evidence Based Action
• It is crucial for players to engage in action that is evidence based as this avoids unproductive or inefficient program implementation.
• Are cost effectiveness and epidemiology included in evidence based action?
• In the case of HIV care and prevention evidence based action may not always possible or feasible.

Reducing inequalities in disease burden and access to services
• This should include inequalities based on age and gender.
• Evidence-based action should be encouraged but not at the expense of human rights and equity.
• This should be the foremost driving force.
• Equity is more important than inequality.

Partnership, integration and linkage across sectors, programmes and strategies
• It is important to adequately fund and address other infectious diseases that impact on HIV transmission as well, as they are certainly a contributing factor for onward transmission.
• This is important as there is a persisting view that HIV is a problem of the health sector.
• Partnership should cover more than just engagement with affected communities. The roles of research, clinical capacity, service delivery and policy development needs to be embraced as part of the partnership response.
• It is important to increase the role of NGOs in HIV prevention.

Ensuring quality and affordability
• Cost effectiveness is important.

Suggestions for additional principles
• Meaningful involvement of people living with HIV, key populations and affected communities.
• Not to demand a high burden of proof prior to integrating interventions known to be safe and are already in use in public health settings.
• Civil society engagement in health systems strengthening and better linked health and community systems.
• Strengthening health systems that are able to provide all people in need with comprehensive and integrated services including HIV services, intersectoral actions to address health and other inequities.
• “Sustainability” as not just financial and technical concept but with reference to effective use of resources.
• Providing services free of judgment, stigma and discrimination.
• Universal access to health care services, from community to primary health-care to hospital care.
• Centrality of civil society and of people living with HIV.
• The role of civil society and community as equal partners.
• Belief in the dynamic face of HIV and related/treatment process.
• Adaptability to different cultures features of HIV in each country.
• Epidemiological coverage principle aiming to ensure optimum geographical and population coverage in every country.
• Community engagement in providing HIV service delivery.
• Key populations should be addressed as WHO priorities.
• Reduce stigma and discrimination.
• Prevention should be a priority.
• Ensuring strategic investments in targeted high yield geographic areas and populations where disease is most prevalent to achieve epidemic control.
• Cultural sensitivity, response sustainability and local ownership.
• Including young people in decision making roles.
• Monitoring and evaluation.
• Comprehensiveness, multidimensionality, value system, situational and individual adequacy.

Overall comments
• All principles must be applicable to children and young people.
• The first three principles of accountability and transparency, human rights and gender equality, and evidence based action are high-level perspectives of governance that are above and beyond general population health and areas specific to HIV related healthcare. They need more specific articulation in the context of HIV and AIDS.

Vision, Goal and Targets

The GHSS for HIV seeks full alignment with the vision, goal and targets of the evolving UNAIDS Multisectoral strategy. Respondents were asked to reflect on the vision, goal and targets proposed to frame the strategy. Once again in responding to a request to rank the relevance feedback was broadly positive (see Figure 2) with the majority of respondents ranking the proposed vision, goals and targets as either highly relevant or relevant. Nevertheless it is important to note that a significant minority (around 19 per cent) were less enthusiastic about the overall vision indicating ambivalence (neither relevant nor irrelevant) or only “slightly relevant”. Many respondents used the open ended questions to document concern that the vision in particular was unrealistic and overly ambitious; some respondents also noted the same concerns for the goals and targets.
The following excerpts summarize survey feedback on the vision, goals and targets from the open ended questions:

**Overly ambitious and unrealistic**
- The vision is overly ambitious and unrealistic. *******
- The goal is overly ambitious and unrealistic. ****
- Targets are overly ambitious and unrealistic. ***
- The vision should be 50% decrease in infection, deaths and discrimination.
- Treating 90% of people with HIV may be too broad – there is no global expert consensus on the clinical benefits of ART for asymptomatic persons with more than 500 CD4. There may be coercion to treat people if they are asymptomatic and have more than 500 CD4, or people may not yet be informed that this is a grey area and that choice is available to them. They may face adverse events and even early resistance with no clinical benefit. Since the START trial is taking place in many countries it should be wise to wait for the outcomes.
- The targets seem to contradict the three Zeros.
- The targets to “End AIDS” by 2030 will not mean an end to HIV. For the over 17 million women currently living with HIV, the epidemic is far from over. Highly ambitious language around treatment scale-up, particularly tied to resource distribution, must be carefully monitored. Unrealistic treatment targets may have unintended, but potentially harmful, consequences for PLHIV. In particular, the drive to reach targets may encourage human rights violations in pursuit of getting everyone on treatment as opposed to ensuring that quality treatment and treatment options are available.

**Some commented that the vision, goals and targets were not ambitious enough**
- 85% is a better reduction target for prevention (rather than 75%).
- 90–90–90 should be considered as minimum.
**A prospective vision – zero new cases, mortality etc. is great, but based on the current realities of the epidemic development, as well as knowledge of HIV biology, the vision should be worded in a less ambitious way.**

- Republican Research and Practical Center for Epidemiology and Microbiology (RRPCEM)

Respondents also felt that some areas deserved specific mention in the vision, goals and targets:

**Key and Specific Populations**

- Targets should include gender and key populations and define key populations.
- Sexual minorities “LGBTQIA” should be clearly stated.
- 90–90–90 as an approach leaves key populations behind.
- Good that infant infection included.
- Specific interventions for children are needed.
- The children of key populations must have a special strategy. If the parents are excluded, their children are doubly so.
- The vision will not be achieved if sections of the population, including those aged 50 and over are excluded. The target provides an opportunity to address low testing uptake, late diagnosis and poor treatment outcomes in older age. The prevention and discrimination targets must also include older people.
- A strategy must include funded linkages to community support services that will be advocates for key populations, protecting them from harm in the health care system, and support testing and adherence.
- By saying “these targets apply to everyone – children, adolescents and adults, rich and poor, women and men, key populations”, does it mean it is expecting equal % reduction in each of these groups?

- The target should have a gender perspective, as there is enough evidence about the need to smartly tackle the differences between women and men at all ages. It is important that children, adolescent and adult population needs will be addressed from a broad gender perspective.
- Other relevant targets maybe setting up specific targets for key affected populations or groups that have yet to gain recognition as a key affected population (Indigenous; Migrants, refugees, internally displaced persons, and non-status).
- Important to include targets for HIV testing and counselling among key populations and young people.

**Discrimination**

- Clarity around ‘discrimination’ (how it is it measured, outcome indicators)
- Why is an ambitious goal such as zero mother to child transmissions not coupled with an equally ambitious goal of zero persons experiencing stigma and discrimination?
- Discrimination should be removed as a target as this is difficult to measure.
- Discrimination target should be added in terms of outcome indicators i.e. discrimination training program.
- How is zero discrimination quantified?
Human Rights
- Universal health care and human rights should be worked in as a specific target, as well as goal and vision.

Other Health Systems and Initiatives
- Unclear how this links with UNAIDS strategy – should complement UNAIDS and other international bodies.
- It should promote community initiatives.
- The vision should be consistent and link the goals and targets that will contribute to the Millennium Development Goals.
- Nearly all of what is included as targets are based on UNAIDS estimates that have been generated in non-transparent ways with little country consultation or input.

Supportive Comments
- The overall goal of the strategy is realistically achievable by 2030.
- The strategy will help reduce global maternal mortality; the end of preventable deaths of newborns and children under 5 years; the end of TB epidemic and the elimination of viral hepatitis, by 2030.
- Targets are good and well-articulated.
- This is challenging but achievable.

Specific Health Concerns
- Need greater harmonization with TB.
- Female genital schistosomiasis should be included in the plan for prevention.
- The value of male circumcision is overstated. The researchers who have advocated circumcision have used a statistical deception in presenting HIV cases averted in terms of relative risk reduction while presenting adverse outcomes in terms of absolute risk reduction.

Comments regarding wording and structure
- The goal should read "end of the AIDS epidemic, as a global public health threat, by 2030, promote sexual health and ensure... "
- The targets could have a similar structure to the other strategies (including targets for 2030 and milestones), and include some additional specific targets and milestones.
- Goal: End HIV/AIDS as a public health threat by 2030.
- It would be good to have 2020 targets as milestones to achieve 2030 targets (like other two strategies).
- The goal is clumsy as it joins two quite different levels of ideas – Ending AIDS (quite a specific goal) and health for all (a very general goal).
- Quality of life is not addressed in the vision.
- How does the goal of the strategy relate to the SDG and universal health access mentioned before?
Framing the Strategy

The survey tool then asked respondents to rank the relevance of a number of statements that proposed an overall framing approach for the draft strategy. Respondents were asked to indicate their ideas about whether the strategy should be (a) ambitious yet technically feasible, achievable and measurable, (b) comprehensive, and (c) focused only on new or high impact interventions or things that required a different approach. Responses are captured in Figure 3 below. There was a clear interest in ensuring a strategy that is ambitious yet technically feasible, achievable and measurable and a preference for a comprehensive rather than a focused strategy.

Figure 3: Rating of ‘Framing the Strategy’ for HIV. N = 132

Greatest Opportunities affecting HIV during 2016–2021

To help ensure that the strategy anticipates the dynamic and evolving environment impacting on HIV, survey participants were asked to identify what they felt would be the greatest opportunities affecting HIV during 2016–2021. Some respondents chose to use this section of the survey to reflect areas they felt should be a priority focus for WHO. A wide range of responses were submitted and these are now grouped thematically:

Key and Specific Populations

Youth and Adolescents **
- Need specific strategies for testing children. Universal testing to ensure that no child is left behind.
- In terms of issues related to pediatric HIV, the game-changers are point of care diagnostics to improve EID.
- Cash transfers with appropriate care interventions (e.g. positive parenting, psychosocial support, school feeding etc.) are a key opportunity to reduce
HIV infection amongst adolescents together with improved access to sexual and reproductive health (SRH) knowledge and access to services.

- More aggressive, effective action on providing appropriate, acceptable, accessible, knowledgeable, supportive services for adolescents and young people.

Women
- We need a holistic approach to the cascade of care, addressing the full range of concerns of women living with HIV along the lifespan, not merely as mothers and vectors of transmission.
- Gender based analyses and actions.

Older Age
- There has never before been such a sizeable group of people living with HIV in older age – at least 4.2m people 50+ (UNAIDS 2014), with numbers rising rapidly. There is limited understanding of older people’s specific needs, particularly in relation to the health complexities of ageing with HIV.
- With consistently low levels of condom use among older people, significant attention needs to be given to their prevention needs.

Migrants
- Addressing migrant populations with specific and tailored actions will become increasingly critical.

Mental Health
- Countries with better mental health care and less stigma on mental health issues will likely fare better in ensuring access to HIV testing, and adherence to treatment.
- Better education of psychologists in the field of HIV and mental health is urgently needed.

Human Rights
- There will be increasing need for human rights based polices. **
- Decriminalization of several behaviors and specific groups that undermine people-centered response to the epidemic (such as drug injectors, sex workers, and men who have sex with men (MSM)) will occur in some contexts whereas the situation will worsen in others. **
- Bringing Universal Health Coverage and human rights together.

Treatment
- One ‘game-changer’ for WHO in 2016–2021 will be the ability to adopt new innovations quickly. There are several new drug formulations and diagnostics in the pipeline – including pediatric formulations and early infant diagnosis (EID – with the potential to greatly impact the response to the epidemic.
- We will increasingly secure universal access and adherence to ART. **
- There is the potential to have better fixed dose combination ARVs at reasonable cost for treatments. The development of point-of-care viral load tests will reduce the risks of misidentifying treatment failure and the use of second-line therapy.
- ARV price reductions will present big opportunities.
- More emphasis on viral load measurement through developing country-specific viral load implementation and scale-up strategies and networks to
systematically implement viral load monitoring.

Financial Issues
- Public private partnerships. Merging of SRH and HIV funding.
- Reduction of treatment costs. **
- Smarter approaches to funding HIV interventions.

Community Initiatives
- Progress in community-based approaches for HIV testing services and ART-related services.
- Involvement and empowerment of communities.
- HIV/AIDS is a social disease as much as it is a medical disease. It can be impacted by changing behavior. But this type of work can’t be done in a hospital or laboratory; it must be done in community through the building of relationships and the sharing of stories.
- 'Community systems' need to be strengthened and welcomed, supported and collaborated with by 'health systems' agencies.
- Collaboration with civil society (community based organizations) should be maintained.
- Support and development of local workforce is essential to reduce reliance on fly-in consultants.
- Enhancement of the role of NGOs including equal recognition of those agencies along with the medical organizations.

Prevention
- HIV vaccination. ****
- Key to highlight that the prevention, screening and management of STI is a key component of HIV prevention and care.
- Invest in primary prevention.
- Pre-Exposure Prophylaxis (PrEP) is in its experimental phase. Using PrEP at large scale while still many HIV positive people still don’t have access to ARVs is unethical. There are major concerns about drug resistance linked to possible PrEP scale-up.
- To take into consideration Female genital schistosomiasis as one of the key condition of sub-Saharan women’s susceptibility to HIV infection
- Roll out of PrEP. **
- To ensure better accessibility of preventive services includes information, skills for children and adolescents to safeguard themselves for the increased vulnerability by creating a non-stigmatizing and accepting environment.
- Female controlled methods are important.
- Besides the importance of scale-up, and the harm reduction interventions in settings where people inject drugs, we need to find new harm reduction methods for stimulant drug users, especially amphetamine derivatives users to promote HIV transmission prevention.
- Improving health literacy and education, especially for young people. **
- Male circumcision. **
- The creation of linkages with other diseases programs which strategies contribute to reduce the transmission of HIV or improve the health of people living with HIV in poor areas.
Testing

- To scale-up HIV testing**
- The development of point-of-care viral load tests will reduce the risks of misidentifying treatment failure and the use of second-line therapy. **
- Expand quality assurance programs for HIV rapid testing.
- Developing country specific Early Infant Diagnostics.
- Improved treatment access will have a huge impact on decreasing onward transmission of HIV, AIDS related deaths and new infant infections. This will only occur following increased access to quality testing and monitoring. The roll-out of HIV POCT, including viral load, and/or home testing will require resources to be channeled into training, referral for confirmatory testing, and into ensuring that data is not lost, especially if testing is performed in remote or under-resourced areas or communities where communications technology is limited. This is an important issue that needs to be addressed, as having an effective communications system in place will link patients to treatment and health monitoring services, and result in improved surveillance data.

Referral Systems

- Research indicates that among key populations we routinely lose 30–50% of the newly-diagnosed people through our ineffective 'referral' systems – particularly where the HIV testing is done in an agency which does not provide HIV treatment.
- Propose greater emphasis on strengthening the whole 'referral' to ensure that newly-diagnosed people move on to ART very soon after they are diagnosed. Part of the current problem is that this issue straddles the clinical and community interface – and neither the clinical agencies nor most of the community agencies have seen it as their responsibility – or their mandate.
Strategic Directions

There were many supportive comments from respondents on the proposed strategic directions. Several areas were highlighted as needing more attention and there were also some general comments about the structure of the strategic directions and proposals for reorganizing them. At the time of the consultation WHO was proposing four strategic directions (see Figure 4) of the four the strategic direction focused on achieving impact and equity resonated most clearly with respondents with almost 80% describing this as “highly relevant” – the focus on finance was also strongly endorsed.

Rating of the Strategic Directions

![Figure 4: Rating of the Strategic Directions for HIV. N = 132](image)

Survey respondents were encouraged to provide feedback on the strategic directions through open ended questions. The following section summarizes the key themes and comments that emerged.

Key Populations

- To achieve equity, key affected populations and groups with high burdens of HIV but not yet recognized as key affected populations (indigenous populations; migrant people, refugees, internally displaced persons, non-status persons) must be meaningfully engaged.

Children

- WHO must push for a separate target in the Fast Track Initiative for children on ART and not have them included together with adults. There is an urgent need to increase access to HIV paediatric treatment and to reduce loss to follow-up for the 3.2 million children living
globally with HIV. While 38% of adults living with HIV obtained ART therapy in 2013, only 24% of children (ages 0–14) living with HIV received HIV treatment.

- The issue of children living with HIV should be highlighted specifically in several paragraphs as a key issue needing priority attention.
- Under PMTCT and Prevention of Infection in infants, more attention is needed on addressing transmission during breastfeeding and updated guidance is needed on breastfeeding (provided by WHO and adapted in national guidance). Infant testing (re-testing) is also needed on cessation of breastfeeding at around 12 months. Likewise addressing the loss to follow-up for mother-baby-pairs should be prioritised. Expanding paediatric ART should also specifically include co-trimoxazole prophylaxis, as per WHO guidance for which coverage is only 44%.
- In SD2 refer to children, specifically as a population that is frequently overlooked and whose treatment needs must be urgently addressed.
- In SD3 include PoC diagnostics for more accurate early infant diagnosis, as well as mobile health applications to increase retention and adherence.
- We strongly support intensified efforts to eliminate mother-to-child transmission rates globally. We support efforts to increase testing and treatment to key populations but urge the specific mention and strategy for the testing of their children.

Adolescents
- To increase adolescents’ adherence to treatment the WHO agenda for scaling-up HIV treatment must include an emphasis on the need for care and support, including psycho-social support.

Women and Girls
- Programs must prioritize the human rights and autonomy of PLHIV and careful monitoring and accountability must be ensured. Women and girls must be recognized as a key population deserving of specific targeted interventions and support.
- Move adolescent girls/young women out of the KP section. They need their own section.
- Innovation for acceleration” defines also some key areas for gender based service delivery innovation – new interventions to get better results can’t be the same for women and men. Barriers for access to preventive, diagnosis and treatment services are not the same for women and men.

Men and boys
- Suggest more specific strategies for reaching boys and men for services (test and get on treatment which reduces vulnerability and risk in young girls/women).
- We appreciate a much more concrete gender approach of the fast-track actions proposed. That can lead an important change in reducing inequalities between men and women.

Migrants
- Migrants should be better identified as a potential vulnerable population. **
Drug Users

- A number of studies indicate that the use of recreational drugs through non-injecting route is also associated with the risk of HIV and other STIs infection. This strategy mentions “harm reduction for people who inject drugs” only. Many countries had experienced HIV epidemic in the people who inject drugs (PWID) – however the epidemic pattern has shifted to MSM who are also at high risk of using recreational drugs. This issue should not be neglected.

Older People

- WHO must address the neglect of people aged 50 and over in information systems and epidemic monitoring. Quality services: for older people – addressing low levels of condom use and testing, late diagnosis, poor treatment outcomes, integration of services, particularly HIV and non-communicable diseases.

Human Rights

- The fight both against stigma and discrimination – at all levels and in all aspects of the HIV response – should be a strategic priority.

Community Involvement

- Community Systems Strengthening. **
- Community empowerment and creating enabling environments in each strategic direction will be useful to inform countries on necessary steps to include in their national responses.
- Ensure communities or countries come up with home grown solutions that are sustainable.
- Community participation to encourage ownership and acceptability of services

Prevention

- Need improved methods of condom promotion and distribution (the draft section seems only to emphasize female condom cost and design).
- Clearly differentiate primary, secondary and tertiary prevention and put a stronger emphasis on primary prevention.
- Consistent condom use could not be highly effective in some cultures, and also in high risk groups. Many street sex workers report intermittent use of condoms and of course their customers’ pressure in not using condom. Key populations often do not use condoms. So, further researches should be invested for finding other acceptable methods for prevention. In this regard using topical pre exposure prophylaxis can be an effective method but still need more evidence based document.

Testing

- There is need to prioritise the introduction of point-of-care infant diagnostics, especially in remote locations, and this will require training of health-care workers.
- Include frequency of testing, time/age of testing, testing in non-HIV settings and barriers to testing in the fast track actions for WHO.
- Using “self-testing” should be considered with caution in low and middle income countries due to misuse of it in several clinical setting and need to more studies.
Treatment
- Generic treatments and medications should take precedence over patents and trade agreements protecting profits. Innovation for acceleration can only be successful if such technologies are widely adopted by all affected by HIV, whereas the protection of intellectual property rights over human rights would only prolong and perpetuate the existence of HIV.

Financing
- Financing that is not sustainable sometimes leads to more problems as it leaves communities and beneficiaries with high expectations that are finally destroyed.
- There needs to be a point about collecting and monitoring cost data to inform decision-making around improving efficiency, i.e. costing and cost effectiveness studies or data. How can we plan for transition or appropriately prioritize when we don’t know costs?
- Innovating financing and new funding approaches are important. These must be made however, within a comprehensive health sector strategy and priority setting exercise, and not in concurrence to or to the disadvantage of other health priorities.
- Strategic priorities/directions should reflect different national and regional financial possibilities and legal frames.

Innovation
- Why a separate chapter for innovation? Innovation is important in all areas and should rather be integrated as a cross-cutting issue in all strategic directions.
- Innovation for acceleration: current patent systems hinder access to innovations in many countries. The abusive prices of hepatitis C new drugs are a clear example of this situation. It is therefore necessary to qualify this strategy including affordability of innovations and possibly reforms of patent systems.
- The majority of the non-service delivery innovations are still under development (or in the research stage). As a result, most are not currently available and some may never become available. Consequently, achieving success is not only in the hands of the health sector, but also the scientific community and manufacturers. The challenge around innovation is that it sometimes leads to a dead end, which means that investments into innovations could be risky and potentially costly. Robust validation processes are required so that decisions about which innovations to channel resources into are evidence-based

Integrations of Services
- Further integration of services is needed – services dedicated for HIV and co-infections, such as STIs, hepatitis and TB adequate to specific national and regional epidemiological patterns.

Structure of Strategic Directions
- The first strategic direction is unequally weighted in comparison to the others. Suggest possibly splitting this strategic direction into two: one focused on evidence-informed interventions, and the other on quality of services and interventions (already split in this manner within section). The subsequent section on ‘enabling environment’ could also be a strategic direction, otherwise reflection is needed on better placing within the strategies.
- The subtheme entitled, "Reduce vulnerability and risk among most affected populations," would be better placed in the equity section. Innovations sections repeat earlier sections and may benefit from integration. There are too many redundancies or overlaps between the sections.
- It is important that the reader should be able to "get" the uniqueness of what WHO brings to the table in terms of HIV-supply, access and use of services. Does this mean strengthening health systems? It could build on the powerful 90–90–90 treatment cascade, while underscoring that the potential benefits transcend the specific disease challenge and cascade across and beyond the health sector.
- The four strategic directions are sound but they are very general and not unique to WHO or to health more broadly.
- The fast-track boxes are very helpful.
- In detailing the actions for each strategic direction, it would be appropriate to indicate how these actions are been implemented now give that this is not a zero-game. The strategy will not be implemented from nothing.
- The description of areas for service delivery innovation to reach the 2020 targets is interesting and useful as ways to optimize service delivery.

In this final section of the survey respondents were most keen to communicate around the following themes:

- Human rights, stigma and discrimination
- NGO, community health, involvement and systems strengthening
- "Neglected" populations: children, adolescents, migrants, and older people
- Primary prevention: condoms and behavioural focus
- Integration of HIV/AIDS with SRH and TB
- Lab and diagnostic capacity: HIV diagnosis and viral load testing
- Gender: women and girls; men and boys

In addition several respondents focused on the specific challenges of middle income countries and the need to use the 2016–2021 period to aggressively pursue a vaccine and cure for HIV.
Viral Hepatitis: Analysis of Responses to Online Consultation

All three surveys (HIV, viral hepatitis and STIs) applied the same survey format and also broadly organized early drafts of the strategy document that informed the consultation around a similar structure (introduction, principles, goals and targets, strategic directions etc.). While the online survey asked questions related to each of the proposed sections many respondents chose to focus their responses on similar themes (for example on the needs of specific populations or the cost of HCV treatment) throughout the survey. Therefore in reading the survey analysis a number of key themes are repeated.

Importance of the Strategy

Survey respondents expressed overwhelming support and appreciation for the draft of the first global hepatitis strategy. Key themes emerging from the 96 responders included: the need for a global effort guided by a strategy as hepatitis was considered by many to be a relatively neglected health area in comparison to other areas or issues; the need to ensure a comprehensive approach across the continuum of prevention, testing and treatment; and the need to focus efforts on those most in need.

Comments expressed regarding the need for a strategy:

- Experience shows that global disease specific strategies mobilize and drive action.
- Development of a global strategy will help to achieve visible results in HCV diagnostics and treatment scale-up.
- This is a useful overarching document that will provide direction for, and drive activities in each region by communicating priorities and the scope of intended action. It will also ensure that resources are focused on priority areas.
- To prevent progression to advanced liver diseases, a strategy to ensure effective integration from diagnosis to treatment is crucially needed. This is particularly important in the population of PWID.
- The 2016–2021 GHSS is very important including community management of detected hepatitis B and C, particularly raising their awareness the threat to their families, providing scientific guidance to prevent infection.

Further comments on the need for a draft strategy are organized around common emerging themes:

Burden of disease

- We need to address the very high burden of hepatitis disease.
- The peak in the number of patients suffering from the advanced stages of HCV-related liver disease has not yet been reached and that the burden of disease is expected to increase.
- A lack of quality population-based data, especially in low- and middle-income countries, (LMICs) limits knowledge of the burden of disease. With the perspective of more effective innovative antiviral therapies, the potential of future therapeutic strategies to prevent progression of liver disease and its associated burden is considerable.
• 240 million persons are infected with HBV globally and up to 1 million die each year of cirrhosis or hepatocellular carcinoma (HCC). 150 million are infected globally with HCV. Liver cancer is one of the top 5 leading causes of death in some regions of the world.
• Epidemics of HEV and HAV occur globally and cause much morbidity and with HEV mortality in pregnant women. Vaccines can prevent both.
• Incidence of hepatitis is still high because basic problems persist – unsafe water, unsafe sex, unsafe medical practices, unsafe injection of drugs, unsafe tattooing
• In Canada HCV infection has grown to be the leading cause of years of life lost due to an infectious disease; this is most likely also true in other countries.

Neglected health area
• Most interventions are limited in scope and context.
• Awareness of the disease is low in the public and also among medical doctors.
• Few national strategies exist.
• Viral hepatitis has long been relatively ignored by international health bodies.
• There is a lack of awareness on HCV related issues among persons at risk, and lack of national strategies on HCV developed within countries.

Screening
• Lack of awareness on HCV among persons at risk and as a result low demand for screening, diagnostics and treatment which results in high HCV morbidity and mortality.
• Point of care serologic testing is inexpensive. Point of care tests for HBV and HCV viral loads are crucial to select patients for treatment for HBV and HCV and monitor results of treatment.
• HCV screening strategy: a systematic HCV test should be proposed by physicians to the general population to enable scale-up and avoid liver complications, late-stage diagnostics and morbidities. This strategy in regards to screening should be improved.

Vaccination and Treatment
• Particularly now that we have effective therapies for HBV and HCV, developing a strategy for their rational use globally is critical if we are to see the biological advances translated into public health benefits.
• Treatment for chronic hepatitis has tremendously improved and, for hepatitis C, may bring cure to all the infected which can lead to at least control if not elimination of the disease. However, the lack of awareness, cost and logistics as well as stigma pose barriers which might be successfully overcome with the help of a GHSS for Viral Hepatitis.
• Medications to cure HCV and to control HBV are now available and easy to administer though cost is still a major concern. **
• Tackling HCV has been wrought with difficulties primarily related to treatment cost, categorization of countries by income.
• Action is essential NOW to address the cost of the drugs and to set up treatment infrastructure to prevent a looming crisis in the near future.
Linkage with other strategies

- It is advantageous for a specific strategy to be developed interlinked with strategies for both HIV and STIs. Together, these three strategies have the opportunity to create joint action on these vastly interconnected health issues.
- Global viral hepatitis strategy should be developed in coordination with HIV/STI and safe-water-and-sanitation strategies.
- Important that you demonstrate linkages with HIV and STI strategies, and that they are similar in structure.
- WHO GHSS should include an international strategy on Viral Hepatitis, in particular HCV, and complement other international global health strategies: Thorough and meaningful consultation with endemic countries of the various types viral hepatitis, the Global Fund 2017–2021 Strategy, UNGASS 2016 special session on drugs, the UNAIDS Strategy 2016–2012 on HIV/HCV co-infection issues.

A key gap in the consultation document is ensuring that sectors other than the health sector are involved in responding to viral hepatitis including educational, employment and industrial relation.
- Anon

Scope of Strategy

- The viral hepatitis strategy should focus on hepatitis B (HBV) and hepatitis C (HCV) – two infections that cause significant morbidity and mortality globally – but should also encompass hepatitis A, hepatitis D and hepatitis E. Elimination targets should be set for HBV and HCV using a combination of prevention, care and treatment.
- Focus is on HBV and HCV, and HAV, HDV and HEV achieve very little attention. It may have therefore being preferable to leave them out.
- It is important to have a strategy that effectively addresses both prevention (behavioral / hygienic and biomedical / immunization) care & treatment (anti-virus) with follow-up. I am aware of Hepatitis frame and guidelines that focus on HB & C viruses only. I suggest dealing with all types of hepatitis groups.
- With increase of hepatitis E, it should be added in disease monitoring.

It is extremely important that the strategy on viral hepatitis is developed. Tackling HCV has been wrought with difficulties primarily related to treatment cost, categorization of countries by income, lack of integration into existing HIV infrastructure, lack of awareness on HCV related issues among persons at risk, and lack of national strategies on HCV developed within countries.
- Alliance Practice Center on HIV, Drug Use and Hepatitis (hosted by Alliance-Ukraine)
General comments on the draft strategy including for the introductory sections of GHSS Viral Hepatitis

This section of the report summarizes the key themes and messages that emerged from open-ended questions throughout the survey. Responses are grouped thematically:

Strategic information, research, data and disease burden

- Important to improve global data regarding the burden of viral hepatitis – morbidity and mortality, particularly avoidable morbidity and mortality. We need a particular focus on the disparate burden in high prevalence regions, and the low survival of liver cancer.
- In some regions mortality is underestimated, such as in many countries in sub-Saharan Africa. Better data is needed on incidence of cirrhosis, end stage liver disease, HCC and liver related death due to HBV and HCV in many of these countries.
- The role of research is not well articulated in the document. Social or qualitative research is needed to identify barriers to the implementation of the strategy. **
- Global data and figures are astounding but quoted too often to have impact. To make it relevant to each country's healthcare stakeholder, local data must be gathered and used to make the case at national and local level.
- Data collection in countries is often incomplete or inadequate. We would like to advocate for more training for countries in data collection.
- Countries need data on the prevalence of HBV infection, the prevalence of chronic and active disease that needs therapy, the annual incidence of complications and liver cancer. To highlight the importance, hepatitis burden should be ranked against other major health burden for each country/region, in terms of mortality and morbidity in standardized age-adjusted incidence e.g. against other cancers, ischemic heart disease, and other infections.
- Data on incidence and poor level of awareness in the population is a major issue.
- Existing mechanisms for monitoring and evaluation are not sufficient. Additional effects are needed to be able to monitor the continuum of care.
- The strategy effectively makes a case for action – this is nicely done, but would benefit from more facts and figures, including disability-adjusted life years (DALYs) and cost effectiveness ratios. Also, evidence of feasibility from demonstration projects would document that the problem is fixable, particularly in reference to resource-limited settings.
- The framing of viral hepatitis should clearly include all five hepatitis viruses. While the justification of greater attention on HBV and HCV is understood, it could be stated more clearly. It would also be important to create a better understanding of the others, especially as HAV and HEV are discussed further within the strategic direction sections. This includes creating a better link to safe food and water.

Prevention and immunization

- Prevention – harm reduction is effective.
- An evidence based approach to effective harm reduction needs to be championed – including HBV vaccine, access to sterile needle and syringes, opioid substitution therapy (OST) and education.
• In some countries transmission is predominately due to unsafe medical injections and practices often in non-traditional health services, in others the route of transmission is not known. More emphasis needs to be placed on understating virus spread and developing prevention plans for this area. Care – people at risk of HBV and HCV need to have access to affordable testing.
• There are effective vaccines for HBV, HAV and HEV, so the implementation of vaccination programs particularly for HBV should be a global priority, as this intervention has been highly successful in stopping mother / baby transmission.
• While the vaccine for HAV is effective more effort should be centered on providing clean drinking water than vaccinating people.

**Key to the success of HBV and HCV elimination is education, harm reduction, vaccines, testing and highly effective antiviral therapies that for HCV can cure the infection and for HBV can stop disease progression.**

- International Hepatitis Society

• Proposed language “Safer sex practices, including minimizing the number of sexual partners” is not acceptable.
• The draft does not reflect the understanding that the basic strategy for global control of hepatitis B is not treating carriers but immunization of children to prevent them. There is no mention of the great progress that has been made already with over 90% of countries having routine infant hepatitis B immunization, high coverage in most countries, essentially free vaccine in GAVI eligible countries, and most developing countries with high endemicity showing that children in those countries (including China) now have a carrier rate of 1% or less, down from 8–14%. It is this reduction in the carrier prevalence in children that will lead to the long term control of hepatitis B transmission and lead to the elimination of liver cancer and cirrhosis. While birth dose of hepatitis B vaccine still needs improvement, we are making remarkable progress and this is not reflected.
• Cooperation with other agencies, including UNODC, should have been mentioned particularly in relation to harm reduction.
• A catalogue of major reasons why the listed interventions have not deployed their potential despite proven efficacy may also be provided. What are, e.g., the barriers for current under- or non-use of HBV vaccination at birth or in prisons?

**Key Populations**
• Provision of increased access to HCV diagnostics and treatment at affordable prices for people who use drugs (risk group which is a driving force of HCV epidemic) as a driving force of the epidemic should be ensured.
• The introduction section to the draft strategy make more explicit links to the disproportionate effect on key populations (especially PWID and MSM), as well as a clearer understanding of how hepatitis is also a sexually transmitted infection.
Harm reduction services should target not only PWID but all people who use drugs. We need to go beyond injection paradigm and offer most effective and integrated harm reduction services that also address the risks that occur in other mode of consumption.

Populations affected, the communities at risk, the social context and implications of the infection are fundamentally different, and this needs to be recognized and addressed throughout the document.

Within the strategy, suggest a more clear definition of 'key populations' as less commonly discussed within the context of viral hepatitis.

Demonstrate better how the health sector may reach key populations in a non-discriminatory way.

An explicit point on prison health is missing.

In the area of HBV an important issue is how, not only to deliver the birth dose of vaccine, but how to fund it. Currently the GAVI program is not funding the birth dose and is not interested in including it in its grants. In addition to offering vaccine to health care workers, they should be offered screening, as many working in endemic countries could have chronic HBV and would need linkage to care.

Human Rights, Stigma and Decriminalization

The need to suppress criminalization of key populations in order to effectively fight HCV is not highlighted sufficiently.

Tools to reduce stigma should be addressed.

It would be helpful if the strategy describes how to work with advocacy and alternative service delivery in countries were harm reduction is not permitted or prioritized.

Activities addressing stigma and discrimination, and improving the human rights of people with viral hepatitis need to be highlighted in the strategy

Screening and monitoring

Low cost point-of-care tests need to be developed.

Programs require experts that can facilitate training of the physician / non-physician work-force and public health specialists in order to establish a proper diagnostic scenario (including screening wherever appropriate) and ensure linkages to care.

People already infected with HBV and HCV need regular monitoring of bloods and have their level of hepatic fibrosis accessed. This requires access to low-cost point-of-care tests.

Treatment

The issue of affordability of HCV diagnostics and medicine is not enough highlighted considering its determinant role and the critical barrier it constitutes to effective HCV response. It is too often missed as a key challenge / barrier. ***

Equity of access to antiviral treatment will be central to the elimination of these infections.

Important to discuss some of the cost-effectiveness data on therapy for HCV. The high costs of these therapies have grabbed a lot of negative attention (appropriately so) but even at these high costs they are generally thought to be cost-effective, meaning that if costs go down (not even all that dramatically), these therapies are actually likely to be cost-saving.
• We need drug pricing reform but this is certainly achievable and the strategy appropriately discusses this (although it could be emphasized further).
• The strategy should be bolder on estimating how many deaths would be averted if it were not for the greed of pharmaceutical companies.
• Treatment for HCV is expensive and misuse of therapy may lead to drug resistance. If risk factors for HCV are not modified, treated individuals may become re-infected.

Financing
• Making a case to add viral hepatitis to HIV, malaria and TB would also be helpful to allow access to resources from the Global Fund, Gates, PEPFAR and other major funding bodies, which to date have largely excluded/ignored viral hepatitis.
• Potential and existing resources, which are common to all settings, should be made explicit.
• The emphasis of financing in this document is on the government, which is supposed to ensure that programs are well resourced. We are forgetting the not for profit private sector which can deploy all sorts of alternative funding sources, including small personal loans, and can be the engines for up-scaling all efforts.
• Without a reasonable affordable financial plan, it will be difficult to persuade governments to respond actively, or the targets will be discounted.

Health systems and linkages
• The lack of a trained and existing health workforce needs to be acknowledged, as does the lack of clinical specialists in many Asia Pacific countries.
• Strengthened collaboration and partnerships across the health sector and other government sectors is very relevant. The WHO strategy should under this paragraph explicitly refer also to the need of better collaboration between health authorities and authorities in charge of trade, customs and intellectual property in order to inform them about health-related needs for the use of Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) flexibilities and the risks of enforcing TRIPS+ measures.
• Health professionals and professional associations are key to seize the opportunities including the provision of safe injections and to increase vaccination coverage. Involving them in design and development of strategy and planning of national actions is essential to bring innovative solutions.
• There is minimal acknowledgement of frontline service providers, the health care workforce, in this draft strategy.
• Health and HCV literacy is missing for the medical sector and patients. Evidence suggests that healthcare workers and PWID often lack sufficient health literacy on hepatitis, which negatively influences decisions regarding appropriate prevention and treatment options.

Delivery and implementation
• The draft strategy does not adequately address delivery policies even though we are facing the implementation of highly restrictive anti-diversion measures for delivery of new HCV DAAs that go far beyond what usual measures of anti-diversion. WHO should stand strong against these new delivery models that violate basic standards of patient confidentiality and
autonomy, interfere with doctor-patient and pharmacist-patient relationships, and may compromise adherence and treatment outcomes.

- Where it reads "universal health coverage" substitute to "universal access and universal health coverage" (throughout the whole document, not only in the introduction) this will help in the translation and implementation of the strategy.
- There are ambitious outcome indicators for 2030, but it's not clear how we get there. More indicators of input, process and output are needed along the way, making sure these indicators can have a measurable baseline today means of verification.
- High importance that the countries adhere to it and perform the Strategy with support provided by WHO. Only joint actions on the strategy will help to attain 90–90–90 targets set up.
- The report should better differentiate between high-, middle- and low-income countries, as well as high-, middle- and low-prevalence countries. It may be useful to break up the “Priority actions for countries” boxes into priorities for high-, middle- and low-income countries, inasmuch as action points may vary between countries.
- The reality of its implementation depends on identifying resources at the national and global level.

Supportive Comments
- The draft introduction section is well written and highlights the importance of addressing viral hepatitis.
- I strongly support the 2016–2021 GHSS on viral hepatitis and honestly think that its goals are achievable.
- IPPF is supportive of this proposed strategy especially of opportunities to integrate viral hepatitis interventions and services within sexual and reproductive health.
- This is an excellent Strategy and I look forward to seeing the development of details to implement these Goals and Targets
- This is a fantastic initiative and a very good and comprehensive document. It will provide a very useful framework for countries to develop their own strategic plans.
- It is great that voluntary licenses do not appear at all in all the document, and that the first recommendation in that frame is for WHO to support countries to use TRIPS flexibilities.
Guiding Principles

A number of guiding principles were proposed in the early draft of the global strategy that was shared to inform the online consultation. Respondents were asked to offer a relevance rating for each of the proposed principles and provide comments to open-ended questions. Figure 5 shows that the majority of respondents found the proposed guiding principles to be either highly relevant or relevant. Additional feedback from the survey follows:

Rating of the Guiding Principles

![Figure 5: Rating of the Guiding Principles for Viral Hepatitis. N = 90](image)

Accountability and Transparency

- Accountability and transparency is crucial so that resources allotted truly go to the benefit of running viral hepatitis programs and demonstrating the achievement of targets and goals.
- Transparency is a must to gain trust and organize a road map for cure plan.
- WHO needs to be more stringent about donor involvement with strategy meetings, the selection of priorities and evidence, and there needs to be more public engagement with guideline development and transparency, as well as stringent strategy on conflict of interests and how these are utilized and restrict undue influence or hinder countries from asking questions or challenging the opinions of donors.
- A core component should also be a set of standardized tools and methods to be used and promoted by countries. This would a) improve transparency b) increase comparability across countries (data, efforts, impacts) and thereby c) enable accountability

Human rights and Gender Equality

- This should be a core principle. The rights of people who use substances / drugs and the decriminalization of drug use should be one of the highest priorities to go along with a global
HBV/HCV viral hepatitis strategy. Harm reduction services should be upscaled and rights of prisoners (including access to clean injection supplies) must be practiced universally.

**Evidence Based Action**

- The strategy must be based on evidence-based examples so it is only way to ensure effective implementation of the strategy and achievement of the results.
- Evidence-based action should be encouraged but not at the expense of human rights and equity.
- It is not possible to provide evidence-based recommendations unless there are data, so it is important to have good quality local data on prevalence and disease burden and also resources available.

**Reducing inequalities in disease burden and access to services**

- For reducing inequities there needs to be strong linkage to critical enablers, social determinants and structural barriers.
- This should be the strategy’s key focus.
- Should include language acknowledging the need to reduce inequities in disease burden and access to services within and between HIV/AIDS and Viral Hepatitis, not just within and between countries.
- Policy makers are in denial about gross disparities in HCV and HIV/AIDS funding and programs. These policymakers overwhelmingly represent AIDS lobbyists, service providers, and the vast institutions the AIDS epidemic has spawned. Diseases evolve but policy and programs are slow to respond. They have usurped the fundamental right of HCV patients to have our own representation, policy, and funding. There is no program integration. HCV advocacy has been taken over wholesale by the AIDS lobby, undermining patient community confidence in public health institutions and values.

**Partnership, integration and linkage across sectors, programs and strategies**

- There needs to be more clear definition of the terms in the strategy i.e. “partnerships, integration, and linkages”.
- Affordable pricing for HCV treatment can be achieved only through engagement of all interested parties (with civil society lead on these issues) in price negotiations with key pharma-companies – as it was with joint efforts on prices for HIV treatment reduction.
- Integration and linkages across sectors, while important, may look different with HCV than with other diseases as it can be eradicated with current treatment.
- Integration between programs is essential not to duplicate or spread thin the efforts made.
- We should look into win-win strategies to engage government / NGO and private sector (pharmaceutical) partnerships.
- Intersectoral collaboration as well as involvement of community and collaboration with NGOs is essential.
- Partnership covers more than just engagement with affected communities. The role of research, clinical capacity, service delivery and policy development needs to be embraced as part of the partnership response. This is often lacking in policy development and program
rollout. This needs to be done across strategies so that learning in one area is transferred to other areas, populations and diseases.

- Access to high quality care through integrated programs (which makes treatment also more affordable) will be key issues for a successful strategy to tackle viral hepatitis.

**Ensuring quality and affordability**

- The issue of access to affordable HCV diagnostics and treatments is under-highlighted in the draft GHSS on Viral Hepatitis compared to the critical role it plays.
- Affordability of HCV treatment and diagnostics are one of the key principles, which should be clearly reflected in the principles guiding the strategy.
- Affordability will play a very important role for most Africans.
- The funding for viral hepatitis will come from national governments, who are expected to allocate the biggest funds, only in case international guidelines are developed, international diplomacy is in place, and international pressure made. It is important that international charitable organizations are engaged into viral hepatitis discourse and funding is allocated based on countries burden indices rather than nation’s gross national income.

**Suggestions for additional principles**

- Health literacy and Social and Behavioral Change Communication.
- Treatment access and equity. The cost of antivirals for both HBV and HCV to achieve elimination is unaffordable in many developed let alone resource limited countries. A clear strategy needs to be developed to improve access to these antivirals globally outside of the setting of HIV co-infection.
- Consider the principle of distributive justice, that is to say that people who need the treatment most get it first.
- Cost-effectiveness principle, for example vaccination strategy to eliminate smallpox.

**Overall comments**

- There are contradictory national and international policies, legislations and programs – as criminalization of drug using populations – that should be addressed in order to fulfill coherence with the proposed principles.
- The strategy needs to reinforce that there are clear social implications resulting from viral hepatitis infection, and that in many countries discrimination and stigma are clear barriers to testing, treatment, employment and social acceptability.
- These are all relevant overarching principles.
- These guiding principles are fine but it is not clear to what extent they have been taken into account while drafting the strategy. They could be better embedded throughout the document than by solely listing them.
- The needs of key affected populations and needs of groups which suffer from high disease burden but are yet to be recognized as key affected populations (Indigenous, migrants, refugees, internally displaced persons and non-status persons) should be addressed as WHO priorities.
Vision, Goal and Targets

The draft GHSS for viral hepatitis proposed a series of ideas for goals and targets to frame the first global hepatitis strategy. Respondents were asked to reflect on the vision, goal and targets proposed. Once again in responding to a request to rank for relevance feedback was broadly positive (see Figure 6) with the majority of the 84 respondents ranking the proposed vision, goals and targets as either highly relevant or relevant. Nevertheless it is important to note that only about half of respondents described the draft vision, goals and targets as “highly relevant” – significantly lower than for HIV for example. Many respondents used the open ended questions to document concern that the strategy’s vision, goal and targets were unrealistic and overly ambitious.

Rating of the Vision, Goal and Targets

![Figure 6: Rating of the Vision, Goal and Targets for Viral Hepatitis. N = 84](image)

Supportive/Appreciative Comments

- Comprehensive, appropriately ambitious and realistic.
- Excellent vision.
- Targets are reasonable but an additional explanation of how they were developed would be helpful.
- We need ambitious targets to propel real change in the hepatitis sector.
- Over ambitious targets are good to guide programming and interventions.
- Demonstrates linkages with HIV and STI strategy.
- Most seem realistic and achievable in the long term.
Comments relating to overly ambitious or difficult to achieve targets

Several respondents specifically indicated that the targets were overly ambitious or difficult to achieve, and one respondent indicated the goal and the vision were overly ambitious. Some comments included:

- The targets seems excessively ambitious and chosen in an arbitrary way and disconnected from the strategy.
- Targets and service coverage rates seem too ambitious given the size of the proposed programs and the anticipated challenges. More realistic targets may help improve acceptance of the strategy at the beginning, which in turn may impact positively on achieving more widespread mid-term implementation.
- While aspirational goals are important, there will be restrictions in regard to the feasibility of the global targets by 2030 given that in majority of countries, government commitment to HCV treatment are still fledgling, HCV civil society networks are practically non-existent, and Direct-Acting Antivirals (DAA) pricing strategies by pharma companies towards middle-income countries are rigid.
- The target may be easily achieved for some countries or regions, but may seem impossible to others.
- Targets are only achievable if a huge injection of funding were made available.

While aspirational goals are important, there will be restrictions in regard to the feasibility of the global targets by 2030 given that in majority of countries, government commitment to HCV treatment are still fledgling, HCV civil society networks are practically non-existent, and DAA pricing strategies by pharma companies towards middle-income countries are rigid.

- Alliance Practice Center on HIV, Drug Use and Hepatitis

Comments related to wording, structure and scope

- Propose the use of ‘halted’ instead of ‘stopped’ in the vision. There is room for more precision.
- The goal should read eliminate viral hepatitis as a major public health problem; **eradicating HCV, finding a cure for HBV, and enabling the universal access to viral hepatitis treatments.**
- The overall aim of the strategy should be written as a realistic goal to be achieved by 2030.
- The global target for 2021 should be defined first rather than going for 2030.
- The vision should also mention detection of infected people.
- Perhaps targets should be in the same structure as the other strategies rather than being for 2020 and 2030.
- The vision does not express the need of prevention tools and could be interpreted as stopping transmission through isolated measures.**
- Targets do not fully reflect the vision: aspects of safety, affordability and effectiveness are not covered by the vision.
- Difficult to understand the rationale behind some of the targets in particular on the reduction of HBV and HBC morbidities.
It is unclear how the targets have been developed. It would be useful to cite the evidence base (modelling based on real-world data?) behind these figures. Furthermore, some targets are not measurable (% people injecting drugs covered by harm reduction, infections from unsafe medical practices etc.)

- Targets to reduce HBV related deaths and HCV deaths will not be easy to evaluate in some countries. Reduction in liver cancer deaths and cirrhosis might be better alternatives.
- Separate strategies for screening for HBV need to be developed as most persons with HBV were infected at birth or in early childhood.

**Injecting drug users**
- The 50% target of PWID being covered by harm reduction services should be increased as currently around 90% of Hep C infections are due to injecting drug use. *****
- Percentage availability of safe injection equipment (not reusable with safe disposal mechanism) including safe waste management can be added to ‘other interventions’ under the global target.
- Target of 70% reduction in HCV incidence may be achievable through effective needle exchange programs and access to treatment.
- The legal issues associated with the roll out of effective harm reduction and the illegality of drug use and its impact on disease transmission needs to be clear.

*The targets regarding coverage of PWID with harm reduction services is very low (50%) and should be increased. If only 50% of PWID are covered by harm reduction services, it won’t be possible to achieve diagnostics and treatment goals, and reduction in new infections as it is estimated that currently around 90% of new hepatitis C infections are attributed to injection drug use*
- International HIV/AIDS Alliance in Ukraine

**Mother-to-child transmission (MTCT)**
- Zero mother-to-child transmission for HBV is too ambitious. To accomplish this, every infant would need the birth dose and mothers with HBV DNA levels >200,000 IU/ml would need antiviral prophylaxis in the third trimester -consider changing this to <5% or 10%.
- Reducing the new infection from MTCT by 95% will be difficult to reach in some nations with low morbidity due to successful immunization program.
- The goal of elimination of mother-to-child transmission by 2050 seems like it could be more ambitious, particularly given the vaccination goals.

**Vaccination**
- Where vaccines are available – there should be an emphasis on ensuring they are provided in a timely manner to prevent ongoing transmission – eg birth dose for HBV vaccine and are affordable (the HAV vaccine is too expensive). Also the need to develop vaccines for hepatitis D, HCV and HEV.
- Vaccination rates among health care workers should be more ambitious – aim for 90% by 2020.
- Vaccination for hepatitis B should be a priority.
• Hepatitis B vaccination: Birth dose and infant targets do not apply to all countries. Thus defining a target for adolescent vaccination coverage would be helpful for countries where universal vaccination applies to adolescents rather than newborns (e.g. in Switzerland where the policy is to screen in pregnancy and give vaccine and immunoglobulins at birth if the mother is HBsAg positive).
• We have known tools that work (HBV vaccine and HCV treatment), and targets around these interventions e.g. 90% HBV vaccine coverage by 2020, and 100 million HCV treatments by 2025. Propose using vaccination / treatment targets, drop mortality and incidence targets.

Unsafe Medical Practices
• Blood safety target of zero new infections due to unsafe transfusion is unrealistic.
• Reduction of HCV transmission by unsafe medical practices is very important since it is the dominant route. It is not clear however, that this can be measured or how that would be achieved by 2020. Great goal, just not clear how we would know.
• There is no mention of HBV transmission by unsafe medical practices.

The blood safety target of zero new infections due to unsafe transfusion is unrealistic. I would recommend targets as follows: by 2020 haemovigilance systems to be in place to identify and quantify viral hepatitis transfusion transmission rates, and by 2030 to reduce the rates of transmission by 99% compared with 2020.

- Anon
**Framing the Strategy**

The survey tool then asked respondents to rank the relevance of a number of statements that proposed an overall framing approach for the draft strategy. Respondents were asked to indicate their ideas about whether the strategy should be (a) ambitious yet technically feasible, achievable and measurable, (b) comprehensive, and (c) focused only on new or high impact interventions or things that required a different approach. Responses are captured in Figure 7 below. There was a clear interest in ensuring a strategy that is ambitious yet technically feasible, achievable and measurable and, like HIV, a preference for a comprehensive rather than a focused strategy.

![Figure 7: Rating of ‘Framing the Strategy’ for Viral Hepatitis. N = 87](image)

**Greatest Opportunities affecting Viral Hepatitis during 2016–2021**

To help ensure that the strategy anticipates the dynamic and evolving environment impacting viral hepatitis in coming years, survey participants were asked to identify what they felt would be the greatest opportunities affecting viral hepatitis during 2016–2021. Some respondents chose to use this section of the survey to reflect areas they felt should be a priority focus for WHO. A wide range of responses were submitted and these are now grouped thematically:

**Harm Reduction**
- Effective harm reduction. Work needs to be done to ensure the roll-out of needle and syringe programs (NSP) and OST globally.
- Decriminalization of and adoption of harm reduction measures for drug users outside central Western Europe.
- HBV – safe medical practices, harm reduction services for PWID; HAV, HEV – safe water and food.
• Important to ensure testing of blood donations through access to better technology and improved quality of laboratories, as well as introducing mandatory screening of blood for HBV, and HCV with assays that are CE In Vitro Diagnostics (IVD), FDA cleared or WHO pre-qualified or equivalent. Engagement with the injecting drug user population (clean needles, access to meds, and treatment for injecting partners) is also important.

• Provision of needles and syringes and OST are cheap and cost-effective in preventing both HCV an HIV in PWID yet global coverage remains poor.

Screening and Monitoring

• Provision of low cost diagnostics for point-of-care that lay providers can use – similar to HIV models. However the quality of testing and integration within HIV and TB services, and reaching PWID will be critical.

• Some communities with resources have faced issues in stigma / denial that compromise screening. Sorting out these issues would unlock a lot of potential.

• Simplification of screening with no need to do the genotype test.

• Low cost point of care testing – this includes liver function tests, HCV antibody and polymerase chain reaction (PCR) tests, HBV serology and the ability to assess hepatic fibrosis.

• Inexpensive, effective POCT will be critical for diagnosis of monitoring of both HBV and HCV and access to noninvasive tools for assessment of liver fibrosis will be critical.

• For identification of HBV infected persons in countries where the prevalence is >8%, this will require a universal screening strategy, not just targeting "Key Populations". What could be considered is a phased in screening strategy which has already begun with screening of blood donors and could be followed by testing household and sexual contacts of infected persons and linking HBV and HCV screening to screening for HIV.

• Implementation of monitoring tools such as a standard for assessment or registers for chronic infection and / or liver diseases can provide opportunities and reflect the urgency of tackling a disease.

Hepatitis B Vaccination

• Scaled-up vaccine coverage will be a big game changer particularly for pregnant women.

• The biggest game changer for HBV transmission is providing the birth dose for all newborns. This is currently not provided for by GAVI and in areas where 50% of HBV infected mothers are HBeAg-positive, not administering the birth dose and waiting to give the first dose of vaccine with the DPT (diphtheria, pertussis (whooping cough), and tetanus) vaccine will result in a reduction of transmission of only 50%. ***

• To maintain and improve the coverage of Hep B vaccination of infant, especially for timely birth dose coverage.

Treatment

• The greatest game-changer is no doubt the revolution on direct-acting antivirals (DAAs). This opens up the opportunity to map an eradication plan, beginning with proposals to pharmaceutical companies to provide ‘eradication prices’ to governments and ending with achievement of HCV eradication.
• New HCV treatment regimens are more effective, better tolerated, pan-genotypes and with less drug interactions. This is an opportunity for better cure rate, better adherence to treatment due to fewer side-effects.
• The biggest game-changer is the development of incredibly effective HCV therapy with extremely high cure rates.
• There is very active development of new HBV therapeutics – some of these will be reaching clinical use in the next 5 years and may provide a greater chance of cure.
• Proposals to pharmaceutical companies to provide ‘eradication prices’ to governments, i.e. the price for 12 weeks treatment, per person, to achieve eradication of HCV.
• There is a huge opportunity to make sure that the prices of these treatments become as close as possible to their real cost of production, to ensure the access for people and the sustainability of health systems worldwide.

National Strategy
• The main "game-changer" is setting up national strategies and action plans for the management of viral hepatitis, as well as setting up consensus guidelines. Importantly, all the structures involved (governmental institutions, experts and interdisciplinary medical professionals, NGOs etc.) should be involved and integrated.
• Include cost-effectiveness analysis of various national hepatitis control strategies for each specific country and calculated program costs.

Integration of services
• HCV diagnostics and treatment services should be integrated into existing HIV infrastructure, including integration into harm reduction programs.
• Integration of viral hepatitis related services within wider health sector areas, including sexual and reproductive health.
• The Health Workforce (including clinicians, researchers, policy makers and infrastructure) also overlaps with community. Often community organization and individual community members are the one providing these services. Developing capacity in this resource, to take on HIV, viral hepatitis and sexually transmissible infections is a logical way to expand capacity and get greater returns than dealing with each condition separately. Support and development of local workforce is essential to reduce reliance on fly-in consultants.
**Strategic Directions**

There were many supportive comments from respondents on the proposed strategic directions. Several areas were highlighted as needing more attention and there were also some general comments about the structure of the strategic directions and proposals for reorganizing them. At the time of the consultation WHO was proposing four strategic directions (see Figure 8). Of the four, the strategic direction focused on finance resonated most clearly with respondents with almost 80% describing this as “highly relevant” – the focus on achieving impact and equity was also strongly endorsed.

**Rating of the Strategic Directions**

![Figure 8: Rating of the Strategic Directions for Viral Hepatitis. N = 85](Image)

Survey respondents were encouraged to provide feedback on the strategic directions through open ended questions. The following section summarizes the key themes and comments that emerged.

**Essential, quality services and interventions**

- The section on harm reduction services needs to be revised. Harm reduction services should be viewed more broadly than only NSP and should be targeted also at solving long-term health problems among drug users, which will include viral hepatitis diagnostics and treatment.
- Targets for people who use drugs should be increased (currently 50%) as people who use drugs are considered to be a driving force of the epidemic. Due to marginalization and criminalization risk groups (especially people who use drugs) do not access HCV prevention, diagnostic, treatment and care. The need to suppress criminalization of key populations in
order to enable them to access HCV services is not highlighted in the draft strategy and should be expressed clearly. One of the priorities is to provide guidance to set up programs to eliminate stigma and discrimination in community and healthcare settings.

- An additional priority for countries should be to reduce the number of unnecessary injections.
- Reducing the costs of treatment medicine is a priority. Accessibility also requires the best treatments available to be registered in countries, which is not the case for new HCV drugs. Registration and affordability of best treatment regimens (including fixed-dose combination) should be explicitly referred to under the priority of action "Include key medicines for treating HBV and HCV in the essential medicines list, and ensure adequate access to those medicines".
- The focus on "Enhance treatment and care" should highlight that new HCV DAAs lack accessibility due to no registration and patent status that block access to affordable generic versions.
- While emphasizing the provision of comprehensive harm reduction packages and removing "legal and other barriers", there should be mention of what kind of barriers exist and how harmful they actually are. These should be concretely mentioned to encourage countries to remove all these barriers immediately.

**Achieving impact and equity: Populations and location**

- Emphasize the need for equal access for populations at risk to get vaccinated, counselled, tested and treated.
- It may be helpful to combine this focus with essential quality services and interventions.
- Request WHO support programs to eliminate stigma and discrimination in community and healthcare settings, especially for HCV healthcare providers who are ignorant of drug use issues – this is a huge barrier for people who use drugs in accessing HCV prevention, diagnostic and treatment.
- In sub-Saharan Africa, it is estimated that 50% of chronic HBV carriers suffering from liver disease were infected through perinatal transmission. Reinforcing efforts against mother-to-child transmission (MTCT) as well as reaching out to rural populations to increase early HBV immunization for infants and young children is critical.
- To achieve equity, key affected populations and groups with high burdens of viral hepatitis but not yet recognized as key affected populations (indigenous people; migrants, refugees, internally displaced persons, non-status persons) must be meaningfully engaged in the whole process of the strategy development and lead the fight against viral hepatitis including HCV.

**Innovation for acceleration**

- We need HCV innovations to access what already exists and is effective. Achieving this will already greatly simplify diagnostics, treatment and monitoring. The priority is to identify the most effective combination that can be effective across genotypes, without side effects and with no drug-drug interaction. Such a regimen could suppress the need of genotype-test, greatly reduce side-effects and permit task-shifting.
• The majority of the Innovations mentioned are still under development (or in the research stage). As a result most are not currently available and some may never become available. Consequently to achieve success in this strategic direction it is not only in the hands of the health sector, but also the scientific community and manufacturers.

• Innovation for acceleration seems less necessary for HBV and HCV. We have highly effective treatment and prevention strategies; the issue is getting them to the people that need them.

Finance for sustainability
• Affordability of HCV treatment and diagnostics should be highlighted – people in need of treatment don’t get cured mainly because of high prices for diagnostics and drugs.

• Access to new DAAs regimen and their affordability can improve diagnostic, treatment and care – new HCV treatment regimens are more effective, better tolerated, pan-genotypes and with less drug interactions. This is an opportunity for better cure rate, better adherence to treatment due to less side-effects, but also for simplification of screening (no need to do the genotype test) and treatment monitoring (shorten treatment duration, entirely oral regimens permit task shifting, less side effects to manage). This is a great opportunity but only if those new DAAs are widely available.

• Critical to identify the most effective HCV treatment combination that will be better tolerated in patients and ensure its registration and availability in countries. Best treatment regimens should be included into essential medicines lists and be available at an affordable price.

• The issue of affordability and accessibility of diagnostics and treatments does not appear clearly enough. Access to quality and affordable diagnostics and treatments is an essential direction the strategy has to take, otherwise little will be achieved.

• Need more emphasis on "reducing the costs of medicines".

• "Reduce prices and costs and remove inefficiencies" is very relevant. The priority actions for countries "making full use of flexibilities of the Agreement on Trade-Related Aspects of Intellectual Property Rights" could expressly refer to core flexibilities such as compulsory licenses, parallel import, and strict patentability criteria’s and patent oppositions.

• Countries and WHO can oppose TRIPS+ measures and not sign agreements that include them. Data exclusivity is for example a major barrier to access generics even in countries where there is no patent.

• Finance for sustainability should consider financing to build or strengthening health systems that can sustain good quality services including hepatitis services but not only to cover the cost of hepatitis programs.

• Funding is crucial such as paying for the birth dose, introducing vaccination for HAV and HEV, expanding screening for HBV and HCV and procuring drugs to cure HCV and control HBV will all require resources.

• Finance for these HCV issues should be provided by government.

• Generic drugs should be provided in every country at an affordable price.

• Not only alternative funding sources should be identified by countries (“Innovate funding approaches to increase revenue”) but also more internationally and regionally coordinated pressure should be put on the pharmaceutical industry (“Reduce prices and costs and
remove inefficiencies”) to achieve a better balance between public health and shareholder value interests.

- The section on “finance for sustainability and reducing prices and costs and remove inefficiencies” is excellent.
- Sustainability is possible if countries and private multinational pharmaceuticals place human lives first over profits. Generic treatments and medications should take precedence over patents and trade agreements protecting profits.
- The biggest challenge is going to be financial sustainability. Innovative financial solutions are going to be key to convince governments to participate.

**Implementation and application of the strategy**

- Propose an additional strategic direction that underpins the rest of the strategy focusing on developing partnerships and comprehensive, coordinated and strategic national action plans. This will support a systematic and sustainable response to viral hepatitis.
- Many strategy users will not be health sector professionals, and the language used in the document needs to be clear, accurate and concise. Terms such as testing, screening and diagnosing need to be consistently and clearly defined. Testing of hepatitis occurs in a range of non-health services, with little information at the point of diagnosis provided and little regard for confidentiality. The strategy needs to be clear in the use of the term 'treatment' – most people don't need treatment, but need to be monitored. The term "clinical management" is more accurate.
- Ensuring the quality of interventions and services. A “continuum of activity” is assumed in the consultation document, and this can’t be assumed. The “cascade of care” needs defining.
- Innovation for acceleration activities in this section could be included in previous sections.
- Universal Health Coverage and human rights, should be allowed to drive work for viral hepatitis, especially the global HCV response, and should inform all strategic directions.

**Research**

- The document should signal a clear need for research – including HCV vaccine research, research to develop low cost tests and research for treatments for HBV and HDV cure. Better research and evidence is also required to improve the effectiveness of harm reduction.
- Research is required on the most cost effective models of care, the care cascade and the role of treatment as prevention in both HCV and HBV.
- Research is required to identify the most cost effective ways to roll out prevention programs, testing and treatment in resource limited settings and how this may need to vary, depending on the local context.
- There is an urgent need for ongoing basic science, clinical and epidemiological research. There are still many areas that need improvement and it would be helpful if things like an HCV vaccine, effective POCTs, tools for predicting / diagnosing HCC (HCC should be further emphasized throughout as a major need in terms of diagnosis and treatment), novel models of care etc. were highlighted as areas for future research in this area.
In this section respondents were most keen to communicate around the following themes:

- Involving people with hepatitis
- Health literacy and education
- Key populations
- Middle income countries
- Research and data
- Quality affordable screening
- Treatment cost

In addition several respondents focused on human rights, integration with HIV (both positive and negative perspectives) and the need to address transmission in health-care settings.
Sexually Transmitted Infections: Analysis of Responses to Online Consultation

While the survey followed a similar structure to the draft strategy (introduction, principles, goals and targets, strategic directions etc.) and asked questions related to each of the proposed sections, many respondents chose to focus their responses on similar themes (for example key populations or treatment access) throughout the survey. In reading this report, a number of key themes are therefore repeated.

**Importance of the Strategy**

Survey respondents expressed overwhelming support and appreciation for the draft strategy. Key themes emerging from the 73 responders included: the notion that STI work is an important yet neglected area that requires a boost; ongoing need for, and appreciation of, global technical and normative guidance; an increased focus on key populations; support for the integration of STI work with HIV and broader sexual and reproductive health approaches; and a clear focus on building country capacity.

The following comments from the first questions posed in the survey are grouped thematically:

**Comments expressed regarding the need for a strategy:**

- A GHSS 2016–2021 would offer tremendous support to national efforts to reinvigorate work on STIs.
- An overarching document will provide direction for and drive activities in each region by communicating priorities and the scope of intended action. It will also ensure that resources are focused on priority areas.
- It is of prime importance to have a global strategy on STIs to guide countries to set up or formulate their national strategies based on the framework, vision, strategic directions and targets of the global strategy.
- A global STI strategy will ideally provide directions, taking into account progress made and various settings (war, sexual violence), and have regional and sub-regional strategies.

**Neglected health area**

- Given the low visibility and lack of investment in prevention and treatment of STIs (apart from HIV) it is extremely important that there will be a global strategy to focus attention on the contribution of STIs to global ill-health and on the various strategies that are known to be effective in addressing them.
- Maintaining a separate focus on STIs, to distinguish them from HIV and viral hepatitis, is critically important to ensure that resources and initiatives for STIs do not become diluted in a wider strategy addressing all three areas.
- STIs have been forgotten in the light of all the attention that was given to HIV and yet STIs are opening pathways for HIV.
Shifting dynamic epidemics

- Epidemics have changed dramatically in the last 30 years. New technologic innovations and media appeared, affecting human relations in the whole world.
- New infections are increasingly affecting young people.
- Rapidly changing epidemiology of antimicrobial resistance (AMR) to gonorrhea and emerging challenges, mycoplasma genitalium and macrolide resistance in syphilis.
- WHO should press for engagement in use of novel diagnostic technologies that may transform detection / treatment of STIs and to investigate why the uptake of technologies may be poor.
- The 2006 strategies are outdated in terms of the relative burdens of different STIs, in tools and technologies and deliver mechanisms available and proven to combat STIs, and in challenges and opportunities for STIs in the context of overall health systems, other diseases / conditions and their control (HIV, hepatitis) etc.
- While some progress has been made with syphilis, prevalence rates of curable STIs are still very high in middle- to low-resource countries, due to a lack of government accountability and the continuing personal stigma associated with STIs. There is a need for service delivery models that target and detect asymptomatic individuals, with a changing focus away from syndromic management.
- There are 1 million STI infections daily happening worldwide. While WHO is busy with Ebola, more efforts are needed for STIs which are more frequent.
- There is a need to address increased transmission and new STIs (mobility, internet, decreased condom use, etc.)

Key populations

- Providing guidance for enabling at-risk / vulnerable populations to access care, including those with stigmatising behaviors, in conservative settings is important.
- Important to prioritize groups such as MSM and youth.
- STIs and reproductive tract infections (RTIs) are very common especially among women of reproductive age.
- It is vital to target the youth at risk since they are at high risk for complicating STIs and HIV.

Health education and promotion

- Reducing discrimination and prejudice remain a major challenge. It’s time to refresh the way health professionals, social movements, media and global commitments not only think about those subjects but also fight against them.
- Awareness and accessibility to information and facilities are lacking.
- Women usually hesitate to explain their problem to professionals.
- Strategic planning will help in creating mass awareness and effective and timely interventions.
- Health promotion among the youth is vital to ensure that there is a positive reduction in these diseases.
Integration with HIV and Hepatitis

- There is a need to keep attention on sexually transmitted infections due to the links with HIV transmission and the burden on specific sectors of society which are often disadvantaged in multiple ways.
- A renewed global strategy specifically on STIs is much needed.
- The interlinking with strategies for both HIV and viral hepatitis has the potential for creating much greater awareness of the importance of addressing STIs in their own right. ***
- This document is also important as lowering STI infections will not be adequately addressed without riding on existing HIV funded initiatives, and without effective strategies outlined for their implementation.
- Currently, a lot of countries have no funding or strategies to support the large number of individuals infected with these infections, many of which may be effectively managed with very simple access to testing and treatment.
- We need to scale-up the STI guideline and consider the importance of relation to both HIV and STIs in our planning.
General comments on the draft strategy including for the introductory sections of GHSS STIs

This section of the report summarizes the key themes and messages that emerged from open-ended questions throughout the survey. Responses are grouped thematically:

Burden of STIs

- Important to address the burden of STIs on specific groups; added risk of HIV transmission; risk of cancer resulting from some STIs; risk of untreatable gonorrhea.
- Highlight how focus on STIs pre-ART had quite an impact on STIs (i.e. drastic decrease in chancroid, syphilis, etc.) however this focus has since diminished, contributing to epidemics today.
- It would help to describe the STIs addressed by the strategy at the beginning of the draft and ensure reference to data on STI burden in key populations.
- In making the case it is important to include evidence on the personal, public health, economic and global security risks, (through the destabilizing effects on families, communities and countries), of widespread incidence of STIs and antimicrobial resistance.
- Case studies are very useful at highlighting these impacts in addition to metric data, as highlighted in the "hidden toll" box of the draft strategy.
- Epidemiology and vulnerability data on STIs should be more strongly highlighted.

Key populations and gender

- The concept of “key populations” is well understood in relation to HIV, however not so well when specifically referring to STIs. Suggest strengthening explanation of this term with explicit description of specific groups. Young people should also be specifically mentioned as highest rates of STIs are among 20–24 year olds, followed by 15–19 year olds.
- The draft needs data disaggregated by age groups, including young and older adolescents / youth. Such information is important when considering interventions.
- Studies on risk reduction in countries based on cultural issues should be highlighted – to find new and effective intervention methods for reducing vulnerability and risk among key populations.
- Evidence is required to support the assertion that STIs disproportionately affect women – statistics to support this would strengthen the case.
- There is no mention of men and boys – some acknowledgement of the types and scale of impact on males is essential.
- Unequal pathways to progress for males and females. Programs need strong gender differentiation and also a focus on young people and protection, as well as treatment action.
- Further discussion about key populations (as potentially less known as these within context of STIs specifically), but also highlighting the other most affected populations such as young people and people living with HIV.
- More specific description of key populations is needed. ***
- High-risk populations. The report mentions MSM and vulnerable populations such as adolescents, but the sections are very general. The draft refers to some additional documents which may be published on these populations. Each high-risk population
deserves a separate paragraph, e.g. stressing for adolescents the importance of providing integrated sexual health and reproductive health service; for MSM and transgender better access to services and specialist care including hepatitis C screening; and similarly for female sex workers (FSW) access to STI services, Hep B vaccinations etc.

- Discrimination especially against MSM and FSW should be mentioned more strongly.
- There is a mention of 'criminalization of behaviors such as sex work and sex between men' but this is not included as a priority action for countries or WHO. While there are several priorities throughout relating to addressing system-level stigma, there doesn’t seem to be any priorities targeting reduction of stigma in communities / populations including through decriminalization.

**Making a stronger case – building on previous efforts**

- The early sections of the draft should review major achievements and, more importantly, still existing gaps, from the previous strategy.
- We need a stronger rationale for this strategy – why is it needed? What was achieved in the previous strategy? What needs more attention?
- The hidden toll of STIs based on 2012 estimates makes a compelling case for action.
- By comparing this draft with the opening paragraph of the Reproductive Health Strategy (2004) which reads: "concerned with the slow progress made in improving reproductive and sexual health over the past decade ....", perhaps it is worthwhile to highlight the progress and gaps since 2004 and the STI strategy (2006).
- Successes from the two past strategies will help to make the case that this new strategy will go forward to lead the world towards the vision. The identified gaps will help to make the case that some re-focusing is required as put forward in this strategy.
- Propose the draft includes an assessment of the previous strategy and progress made, and clearly identifies where more effort is required.
- The draft introduction section is good. Beyond highlighting the data (ie. prevalence estimates), it can be effective to highlight the impact of an effective response to STIs on wider health outcomes, especially for those not so familiar (or comfortable) with sexual health issues.
- Descriptions of health outcomes could be strengthened, and also propose outcomes linked to combating AMR.

**Integration with broader sexual and reproductive health**

- Propose making a stronger link between STIs and the other areas of HIV and viral hepatitis (which are also STIs) within the introduction.
- Recommend that WHO develops a combined program with HIV and STIs.
- Suggest further explanation of how HIV and viral hepatitis are STIs.

**Research and training**

- The strategy should recommend training on STIs for General Practitioners and coordination among specialists (especially dermatology, infectious diseases, and gynecology).
- More emphasis on helping health workers better appreciate the STI risk from weekend drug and alcohol use with young people.
• Physician capacity is a huge issue even those who are STI experts lack adequate and up to date knowledge on STIs and GPs who treat a lot of STI patients require training.
• The importance of investment in training of health care workers and laboratory staff in STI care and diagnostic is not emphasized enough.
• Ensuring a well-trained workforce is a critical element for sustaining an STI program.
• Sharing of research: there are many different research facilities undertaking similar research – better coordination is needed to bring expertise together and to use resources more efficiently.

Resources
• Trichomoniasis is often overlooked in control efforts, but it is 1) highly prevalent, 2) easy to diagnose, 3) easy to treat and 4) may have a substantial impact on HIV prevalence in certain locations. This would be an inexpensive intervention that would remove one STI and could reduce HIV and potentially some poor pregnancy outcomes.
• Currently, programs for STIs are not well resourced. It should be emphasized that STIs are an important means of HIV transmission, and that adequate resources should be channeled into addressing the problem, either in conjunction with HIV funded programs, or standalone programs dedicated to addressing transmission of STIs.

Community Involvement
• The draft should emphasize the active involvement of communities as fundamental to effective, efficient, community owned and sustainable strategies.

Suggestions for improvement
• Consistently include a reference to condom-compatible lubricant when referencing male / female condoms.
• Differentiate levels of STI control and link these levels to steps / priorities for country staging of action.
• Reduction of congenital syphilis is the most important target to reach, meaning it should be called as one of the target in special settings (antenatal clinics).
• Although the report acknowledges the importance of asymptomatic STIs, it doesn’t address this issue adequately, considering that many countries have adopted the recommended syndromic management approach. Considering that all goals are about targets on specific organisms, i.e. diagnostic, this point seems important, and deserves a separate paragraph or section. In particular: (A) There is little guidance on how to transition from a syndromic to a diagnostic model, and at what income level that may work. (B) How to create a laboratory infrastructure that has been desklled during syndromic management implementation. (C) How to monitor progress towards the “diagnostic” goals, if a diagnostic care model is not adopted.
• Antimicrobial resistance – the report focuses on resistance to gonorrhea, but emerging resistance against other organisms like chlamydia and mycoplasma has also been reported, and should be mentioned.
• The strategy should propose linkages between STI clinics and drug substitution therapy clinics.
• Counseling is a neglected area not only because there is a lack of trained counselors, but counseling as a whole has been seen with lower importance.
• Partner notification is neglected and difficult. Female partners of male STI patients often remain untreated.
• A cost-effectiveness study on syndromic management is required.
• There is minimal acknowledgement of frontline service providers, the health care workforce, in this draft strategy.

Supportive comments
• The STI Strategy document is generally comprehensive, and states concrete 2030 goals including 90% reduction in syphilis and gonorrhea incidence, and 80% HPV vaccine coverage. Overall, very supportive of this proposed strategy.
• The strategy is well-written and well-intentioned, focusing on protection of human rights, redressing gender inequalities, and providing a platform for integrated best practice models for all stages along the continuum of care pathway, while supporting the goals of acceleration and innovation and with deliberately ambitious vision and goals.
• Overall, the authors are to be congratulated for an excellent document that is comprehensive, strategic and which communicates its messages clearly.
• It is an interesting document with great potential for utility. At this stage, though, I find it overly theoretical in many parts. There should be more on the implementation part and advice for national policy makers.
Guiding Principles

A number of guiding principles were proposed in the early draft of the global strategy that was shared to inform the online consultation. Respondents were asked to offer a relevance rating for each of the proposed principles and provide comments to open-ended questions. Figure 9 illustrates that the majority (around 90 per cent) of the 70 respondents found the proposed guiding principles to be either highly relevant or relevant. Additional feedback from the survey follows:

Rating of the Guiding Principles

Figure 9: Rating of the Guiding Principles for STI’s. N = 70

The following comments were also included in reference to the proposed guiding principles:

Accountability and Transparency

- There needs to be more public engagement and transparency with WHO’s own guideline development processes.
- There should be a stringent strategy on conflict of interests and how these are utilized and restrict undue influence or hinder countries from asking questions or challenging the opinions of donors.
- Promoting accountability and transparency on sexual issues at individual, partnership and society level is critical for sexual health / halting sexually transmitted diseases.
- This is important at all levels from macro global levels to individual levels.
Human rights and Gender Equality
- The strategy needs to support human rights and gender equality, and target geographic locations with the greatest burden of disease and the need for improved access to services.

Evidence Based Action
- Criteria for evidence-based should be clarified in future drafts.

Reducing inequalities in disease burden and access to services
- For reducing inequities there needs to be strong linkage to critical enablers, social determinants and structural barriers. These terms need to be more clearly unpacked and what is meant and how they will be addressed or be linked to the strategy overall.

Partnership, integration and linkage across sectors, programs and strategies
- There needs to be more clear definition of the terms in the strategy of what you mean when you say partnerships, integration, and linkages.

Ensuring quality and affordability
- Reduction in burden will not occur without affordable and quality services

Suggestions for additional principles
- Health Literacy and Social and Behavioral Change Communication
- Cost-effectiveness.
- Knowledge and best practice transfer.
- The protection and promotion of child rights through special education in sexual health and focused STI prevention interventions prior to sexual debut.
- Adaptability of guidance to the cultural and epidemiological context.
- Propose a section on integrating services. We have for too long thought in silos of HIV, Malaria, MCH etc. We need better understand how to integrate services and make them available at all levels of care.
- Communication and networking, bridging the digital divide and knowledge gap.
- Sustainability and long-term commitment
- Accelerate interventions for the main target (MSM, sex workers, and youth) into friendly and quality services.
- Community mobilization.
- Innovation and building partnership with civil society and NGOs as well as considering monitoring and evaluation of implementation of the strategy at all levels by using appropriate indicators.
- Affordability and training for grass-root level health-workers is necessary.

Overall comments
- There are contradictory national and international policies, legislations and programs – as criminalization of drug using populations – that should be addressed in order to fulfill the coherence with these principles.
• These guiding principles are fine but it is not clear to what extent they have been taken into account while drafting the strategy.

• The important issue is how these principles are operationalized in global and national STI strategies and how they are monitored to ensure they are being implemented.

• The principles are wide ranging and perhaps highly subjective and open to considerable interpretation by those signing up to the strategy. This is important, particularly with regard to human rights and access to care. These principles therefore are potentially at risk of being too general so as not to effect meaningful change. Guiding principles could be re-phrased to include specific measurable, where appropriate.
**Vision, Goal and Targets**

The draft GHSS for STIs proposed a series of ideas for goals and targets to drive action during 2016–2021. Respondents were asked to reflect on the vision, goal and targets proposed. Once again in responding to a request to rank for relevance feedback was broadly positive (see Figure 10) with the majority of the 70 respondents ranking the proposed vision, goals and targets as either highly relevant or relevant. Nevertheless it is important to note that only about half of respondents described the draft vision, goals and targets as “highly relevant” – significantly lower than for HIV for example. Many respondents used the open ended questions to document concern that the strategy’s vision, goal and targets were too idealistic.

**Rating of the Vision, Goal and Targets**

![Rating of the Vision, Goal and Targets](image)

**Figure 10:** Rating of the Vision, Goal and Targets for STI’s. $N = 70$

While 70 respondents completed the section of the survey asking for a rating of the relevance of the proposed vision, goal and targets only 25 answered the open-ended questions that followed. Their comments are summarized as follows:

**Overly ambitious and unrealistic**

Approximately 30% of respondents indicated that the vision, goal and targets were either overly ambitious or unrealistic, and some thought not achievable within the time frame or without adequate funding. There were however some mixed opinions with some respondents suggesting that some of the targets were realistic and achievable or perhaps not ambitious enough:

- 90% reduction for syphilis and gonorrhea is too ambitious, however the target for congenital syphilis was stagnant or equal to the current one.
• 90% reduction in Neisseria gonorrhoea incidence by 2030 is very ambitious, but 90% reduction of Treponema pallidum incidence (comparing to 2015 baseline) is not realistic if we look back to history of elimination of syphilis.

A very idealistic vision which will hardly ever be achieved. It is probably better to define a vision that takes into account real-world contexts such that the implementation of a strategy seems more realistic. The targets are very ambitious inasmuch as only HPV (and HBV) is a vaccine-preventable STI and given the threat of antibiotic resistance.

- Federal Department of Home Affairs/Federal Office of Public Health Switzerland

The vision, goals and targets outlined are admirable, but will be very difficult to achieve without strong leadership from the WHO; increased political will and support from governments (particularly those from poorly-resourced countries with the greatest needs); strong inter-sectorial partnerships and collaboration; and evidence-based sustainable scale-up of best practice models across the continuum of clinical care.

- Flinders University International Centre for Point-of-Care Testing, Adelaide, South Australia

Equity and Key Populations

There was a comment that while elimination of discrimination is mentioned in the vision, little was elaborated in this regard in this draft. Another respondent felt the strategy ‘should be gendered’.

Suggestions for wording and coverage

There were several suggestions to re-word the vision and goal and some felt that they were too similar to the HIV vision and goal. One respondent suggested the goal should be ‘to reduce STI transmission’.

Suggestions for an alternative vision:

‘A world where the transmission of STIs is stopped and everyone affected by STIs has access to safe, affordable and effective care and treatment.’

‘A world without disease, suffering and death from sexually transmitted infections’.

‘Where everyone should be able to experience full, pleasurable sexual lives and have access to safe, affordable and effective services’ (adapted from WHO consolidated guidelines for KPs).

- International Planned Parenthood Federation (IPPF), UK

Specific suggestions for targets

Approximately 20% of respondents thought that there should be additional targets for the strategy, and in particular to include herpes simplex virus, chlamydia and trichomoniasis and targets to improving diagnosis and surveillance. There were also comments that many countries have not implemented a routine HPV vaccination program at national scale, and it may not be a public health concern in some countries.

One respondent commented that the target misses the behavioral and safer sex aspects which are critical while also implying that HIV and viral hepatitis are not STIs.
Chlamydia and trichomoniasis cannot be ignored in the targets when they are 2–10 fold more prevalent than gonorrhoea and syphilis and they are associated with negative outcomes. This is a critical flaw in the strategy
- University of Alabama Birmingham

The audience would appreciate a description of how much the targets set in the Reproductive Health Strategy (2004) have been met and what are the gaps to be overcome. Also, it is worth mentioning the planned activities in order to build reliable estimates for epidemiologic baselines in 2015, which are what the 2030 global targets based upon. Any measurement of the past success and reliable information of the current status will add to the confidence for the success for the future goals and objectives.
- Anon

Framing the Strategy

The survey tool then asked respondents to rank the relevance of a number of statements that proposed an overall framing approach for the draft strategy. Respondents were asked to indicate their ideas about whether the strategy should be (a) ambitious yet technically feasible, achievable and measurable, (b) comprehensive, and (c) focused only on new or high impact interventions or things that required a different approach. Responses are captured in Figure 11 below. There was a clear interest in ensuring a strategy that is ambitious yet technically feasible, achievable and measurable and, like HIV and viral hepatitis, a preference for a comprehensive rather than a focused strategy.

Figure 11: Rating of ‘Framing the Strategy’ for STI’s. N = 70
Greatest opportunities and threats affecting STIs during 2016–2021

To help ensure that the strategy anticipates the dynamic and evolving environment impacting STIs in coming years, survey participants were asked to identify what they felt would be the greatest opportunities affecting STIs during 2016–2021. Some respondents chose to use this section of the survey to reflect areas they felt should be a priority focus for WHO and chose to highlight risks and threats as well as opportunities. A wide range of responses were submitted and these are now grouped thematically:

Key populations

- It would be helpful to give special attention to a vulnerable group like sex workers. Due to the difficulties in involving them in ordinary health programmes for prevention and treatment, different ways to reach them must be found. For example, a devoted “health van” could be deployed periodically in areas where sex workers spend their nights in order to supply condoms, test kits for STIs and if necessary, appropriate therapy.
- Reaching young people and key populations is of crucial importance.

STI prevention

- The strategy should support the expansion of national HPV vaccination programs.
- The use of combination prevention interventions and development of vaccines should be encouraged.
- Increased access for adolescents to information and services via social media.
- Consistent condom use may not be highly effective in some cultures, and also in high risk groups. Further research should be invested in finding other acceptable methods for prevention. We need to understand the impact on condom use and STI transmission from the roll-out of PreP.
- Amphetamine derivatives have become the main problem of drug use in many countries that facilitates unsafe and risky sex. Beside scale-up of harm reduction interventions in settings where people inject drugs, we need to find new harm reduction methods for users of stimulant drugs, especially amphetamine derivatives users to promote STI transmission prevention.
- There is rapidly increasing use of condoms among sexually active non-married youth in sub-Saharan Africa (and elsewhere).
- Renewed focus on comprehensive sexuality education could enhance awareness of STI risks among adolescents starting to become sexually active.
- Increasing availability of new or greatly improved STI vaccines.
- New information technology for dissemination of information and knowledge, such as mobile apps for prevention, guidelines, etc. that can easily reach a wide range of populations, even some hard-to-reach populations.

Testing

- POCT and effective home based testing possibly linked to mobile technologies for reporting of results and treatment.
- The wider availability of affordable, rapid diagnostic tests for specific STIs should make a similar impact as the rapid, POCTs for HIV.
• Accessibility of STI testing.
• Quality assurance of online test and rapid tests.
• Health insurance covers STI testing.
• New cost effective models of diagnostic STI care and improved surveillance.
• Good POCT for syphilis that detects both specific and non-specific antibodies, being able to detect current active syphilis as distinct from resolved infection of syphilis.
• Wider availability of rapid diagnostic tests should increase early diagnosis and treatment.
• Implementation of effective use of novel diagnostic technologies such as rapid tests, mobile communication and remote care, that allow for more comprehensive coverage of clinical management in resource poor settings.
• Quality-assured, multi-platform, standardized models of POCT with a robust evidence base should be widely used across countries to increase rates of testing and early detection of STIs.

Integration with HIV and Viral Hepatitis
• This strategy interlinked with both HIV and viral hepatitis, will bring much needed global attention to the importance of addressing STIs. This includes allocation of resources on priority programmatic areas likely to have the greatest impact.
• Integration of the three strategies is critical and will help ensure a higher profile for STIs.

Treatment
• When medication is available, treatment should not only be given to those infected but also to their partners (e.g. chlamydia) – this would be a “game changer” after many years of unsuccessful promotion of “partner notification”.
• Antibiotic resistance is important as it will become more and more difficult to treat some STIs.

Financing
• Ill-preparedness of countries to completely or even partially finance existing programmes for prevention and treatment of these diseases.
**Strategic Directions**

There were many supportive comments from respondents on the proposed strategic directions. Several areas were highlighted as needing more attention and there were also some general comments about the structure of the strategic directions and proposals for reorganizing them. At the time of the consultation WHO was proposing four strategic directions (see Figure 12). All four strategic directions were thought to be either highly relevant or relevant (more than 90 percent) by the 70 respondents.

**Rating of Strategic Directions**

![Rating of Strategic Directions for STI's. N = 70](image)

Survey respondents were also encouraged to provide feedback on the strategic directions through open ended questions. The following section summarizes the key themes and comments that emerged:

**Essential, quality services and interventions**

- This section is highly relevant and well described within the draft strategy highlighting priority actions for both countries and WHO. The first strategic direction however, is unequally weighted compared to the other three.
- “Essential quality services and interventions” should be prioritised before we can tackle the other strategic directions.
- The third priority action bullet for WHO is unclear – is this referring to male involvement in reducing female STI vulnerability, or their own vulnerability or both? Previously men were considered a "bridging" population – is this what is being referred to here?
- "Sexual wellbeing" needs to be defined.
The significant issues of addressing asymptomatic infections and of notifying asymptomatic partners are not mentioned, even though they are major challenges. Reaching sex partners remains a challenge and this needs to be acknowledged and further research needs to be undertaken to determine better ways to do so.

- Prioritizing implementation of high impact prevention is most relevant at country level.
- Early diagnosis including those without symptoms is both extremely important and challenging.
- The triple elimination campaign (of MTCT of HIV, syphilis and HBV) should be given more emphasis.
- The link to the global AMR action plan (for AMR in neisseria gonorrhea and potentially other STIs) is extremely important.

Achieving equity and impact: Populations and locations
- Employing approaches to differentiate sexual networks can identify key risk populations and tailor more focused and targeted interventions.
- Age and geographical inequities also need to be better addressed.
- The population at risk become younger in age is alarming. Confront issues such as countries or regions disproportionately affected and geographical bridges.

Innovation for acceleration
- It is important to ensure optimization of STI diagnostics (POCT) supported by robust operational research and communication of evidence base for success.

Financing for sustainability
- It is critical to stress that there is still a major lack of funding for STIs.
- Proposals for terminology and changes in wording:
  - From: Develop and pursue comprehensive strategies to reduce prices of STI vaccines, diagnostics and treatment drugs, including by making full use of flexibilities of the Agreement on TRIPS, and various WHO mechanisms. To: Develop and pursue comprehensive strategies to deduce prices of STI vaccines, diagnostics and treatment drugs, including by various WHO mechanisms.
  - From: Provide support to countries to strengthen their capacities to negotiate price deductions with manufactures and to use the flexibilities of the TRIPS Agreement. To: Provide support to countries to strengthen their capacities to negotiate price reductions with manufactures. Justification: Price of medicine and availability of generic products are decided including various elements such as health administration, access to the health facilities, delivery system of medicines, etc. and we should not focus on only the viewpoint of intellectual property. Therefore, it is not necessary to mention flexibilities of the TRIPS and intellectual property.

Other comments
- A concise country report every two years would help policy makers better address financial and human resource gaps. In a country report, key elements on STIs could be arranged in few sections: (1) Epidemiological, laboratory and behavioral data. (2) Health care delivery
system, training and assistance for providers (health workers, counsellors etc.), patient education, engagement of patients’ association. (3) Innovation in drugs and medical devices and public-private collaboration in research and development.

In this section respondents were most keen to communicate around the following themes:

In addition several respondents focused on human rights, integration with HIV (both positive and negative perspectives) and the need to address transmission in health care settings.
Annex 1: Identified Participants

Respondents were given the option to identify or respond anonymously. The following list includes individuals and/or organizations that agreed to be identified as part of the survey process.

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<td>Armenia</td>
<td>The National Center for Disease Control and Prevention</td>
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<td></td>
<td>MSMGF; GFATM Dev’d NGOs Delegation; APCASO Trustee; ICASO</td>
</tr>
<tr>
<td></td>
<td>Flinders University International Centre for Point-of-Care Testing, Adelaide, South Australia</td>
</tr>
<tr>
<td>Australia</td>
<td>Australasian Society for HIV Medicine</td>
</tr>
<tr>
<td></td>
<td>Burnet Institute</td>
</tr>
<tr>
<td></td>
<td>Kirby Institute for Infection and Immunity, UNSW Australia</td>
</tr>
<tr>
<td></td>
<td>National Serology Reference Laboratory (NRL)</td>
</tr>
<tr>
<td>Austria</td>
<td>EASL</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>Icddr,b</td>
</tr>
<tr>
<td></td>
<td>Project Lama</td>
</tr>
<tr>
<td>Belgium</td>
<td>European AIDS Treatment Group</td>
</tr>
<tr>
<td></td>
<td>KU Leuven / FIOCRUZ</td>
</tr>
<tr>
<td>Belarus</td>
<td>Republican Scientific — Practical Center for Epidemiology and Microbiology</td>
</tr>
<tr>
<td>Bhutan</td>
<td>Blood Transfusion Service, Ministry of Health</td>
</tr>
<tr>
<td></td>
<td>Gerência de Educação de Itajaí — SC</td>
</tr>
<tr>
<td></td>
<td>Articulação Brasileira de Gays</td>
</tr>
<tr>
<td>Brazil</td>
<td>Universidade Federal de Santa Catarina</td>
</tr>
<tr>
<td></td>
<td>Asmusadecar</td>
</tr>
<tr>
<td></td>
<td>Brazilian Department for IST, AIDS and Viral Hepatitis</td>
</tr>
<tr>
<td></td>
<td>Ministry of Health</td>
</tr>
<tr>
<td></td>
<td>GIV (Group for Life Incentive)</td>
</tr>
<tr>
<td></td>
<td>Longtemps responsable du secteur santé au SP/CNLS-IST; Beaucoup travaillé avec le secteur communautaire et les KP</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>Anciennement responsable du programme National de lutte contre les IST. Expert de l’OMS en 2008</td>
</tr>
<tr>
<td>Cambodia</td>
<td>FHI 360</td>
</tr>
<tr>
<td>Canada</td>
<td>Coalition for Children Affected by AIDS</td>
</tr>
</tbody>
</table>
Global Network of People Living with HIV North America
Public Health Agency of Canada
Toronto Centre for Liver Disease, Sandra Rotman Centre for Global Health
Global Network of People Living with HIV North America
Institute national de santé publique du Québec
University of Toronto
Toronto Western Hospital Liver Clinic
Semi-retraité- traducteur/communicateur/Webmestre
National Center for AIDS/STD control and prevention, China CDC
China Foundation for Hepatitis Prevention and Control
China
Love Green Education Foundation
Centre of Disease Control
Colombia
Hepatitis Virales Del Norte De Santander
Universidad de Antioquia
Czech Republic
National Institute of Public Health
Egypt
Pharco Pharmaceuticals
WHO
Ethiopia
Federal Ministry of Health
WHO
Ministry of Foreign Affairs
France
Avenir Health
Médecins du Monde
UNESCO
France/Brazil
Access (Director & Founder)
Georgia
Independent expert, member of HCV World CAB
Germany
Helmholtz Zentrum München / Technische Universität München
Helmholtz Centre for Infection Research
Guatemala
Actualmente no pertenezco a ninguna organización pero me interesa el tema y planeo hacerlo
Guine
Ministerie de la Sante
Consultor de ONUSIDA
Honduras
Centro de detección y tratamiento del cáncer cervical
Hong Kong
Asiahep Hong Kong Ltd
Member Presidential Prayer team, National Governor Prayer World, Federation Against Drug, UN PAN
CSR, Tata Motors
Islamic republic of Iran
Ministry of health
Israel
CHEN – Patient Fertility Association
Public local Health Service for Drug Users
Italy
Ministry of health
Japan
International Affairs Division, Ministry of Health, Labour and Welfare
Kenya
Population Council
Ethno-med Healthcare Inc

Kyrgyzstan
Centre of Epidemiology and Microbiology
The National Center for Disease Control and Prevention
Centre for Disease Prevention and Control of Latvia, Infectious Diseases Risk Analysis and Prevention

Latvia
Prevention Department
Ministry for Health

"My Commitment to Cure" Coalition

Malaysia
Asia Pacific Network of People Living with HIV (APN+)

México
Promotor de Educación para la Salud

Morocco
Direction de l'épidémiologie et de lutte contre les maladies Ministère de la santé

Nicaragua
Ministère de la santé

Pakistan
Aga Khan University, part of the Aga Khan Development Network

Paraguay
PRONASIDA

Perú
Hospital Antonio Lorena – Cusco
Colectivo Juventud en Defensa de la Salud

Portugal
Hospital Santa Maria

Slovenia
University Medical Centre Ljubljana
REPSSI, and RIATT-ESA

South Africa
CAPRISA
CABSA

Spain
MÉDICOS DEL MUNDO ESPAÑA
Hogar Residencia

Swaziland
Swaziland National Aids programme

Sweden
ECDC

Switzerland
Federal Department of Home Affairs, Federal Office of Public Health
Freelance MSF research consultant

Taiwan
Centres for Disease Control

Thailand
Bangrak STI, Bureau of AIDS TB and STIs, Department of Disease Control, Ministry of Public Health

The Netherlands
RIVM
Correlation Hepatitis C Initiative

Turkey
International Children’s Centre
United Nations Interim Force in Lebanon

Uganda
Gulu District Local Government
International HIV/AIDS Alliance in Ukraine

Ukraine
Alliance Practice Centre on HIV, Drug Use and Hepatitis (hosted by Alliance-Ukraine)
Medical University named after Bogomolets and the Emergency Hospital
HelpAge International
International Planned Parenthood Federation (IPPF)
Global Healthcare Information Network

United Kingdom
St George’s University of London, UK; Public Health England, UK; esti2.org.uk
World Vision International
Terrence Higgins Trust
RTI International
Merck
University of Alabama at Birmingham
Hepatitis Patient Advocacy Committee
USG Centers for Disease Control and Prevention (CDC)

United States of America
Daktari; Harvard School of Public Health
University of Michigan
Vanderbilt University
USAID
Westover Heights Clinic
Liver Disease and Hepatitis Program, Alaska Native Tribal Health Consortium

Uruguay
Soy auxiliar de enfermería del MSP y estudiante de la Licenciatura en Enfermería

Zimbabwe
Zimbabwe Community Health Intervention Research project
Annex 2: Survey

Defining 2016–2021 Global Health Sector Strategies for HIV/Viral Hepatitis/Sexually Transmitted Infections: Online Survey

As someone with an interest in one or more of the following draft health sector strategies, you are invited to participate in this online survey to help inform how these strategies develop.

You are welcome to respond to all surveys that are relevant to you.

Responses from individuals, organizations and/or consolidated responses are welcome.

1. DRAFT 2016–2021 Global Health Sector Strategy on HIV
2. DRAFT 2016–2021 Global Health Sector Strategy on viral hepatitis
3. DRAFT 2016–2021 Global Health Sector Strategy on sexually transmitted infections (STIs)

This particular survey concerns the draft strategy highlighted in bold above.

When responding to the following questions you may find it helpful to refer to the draft strategy document posted alongside this survey. These are available in full in English with shorter versions available in other WHO languages.

The deadline for responses is 30 April 2015.

Survey results will be compiled into a report to be published online in June 2015. Your responses may be posted on the WHO website as part of this process unless you indicate at the end of the survey that you prefer to remain anonymous.

For further information about this survey or the strategy development process please contact: sealean@who.int
1. **Which one of the three strategies would you like to comment on?**  
(If you would like to respond to more than one area please repeat the survey indicating each time which area you are responding to.)

Please mark one of the following options:

<table>
<thead>
<tr>
<th>HIV</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Viral Hepatitis</td>
<td></td>
</tr>
<tr>
<td>Sexually Transmitted Infections</td>
<td></td>
</tr>
</tbody>
</table>

2. **For the area you indicated in the last question – do you think it is important that a 2016–2021 Global Health Sector Strategy is developed?**  
(Maximum 100 words)

3. **The 2016–2021 Global Health Sector Strategies will be guided by a set of over-arching principles. What principles do you suggest?**

Each of the following issues can be expressed as a principle to guide strategic action. Please rate their relevance for inclusion in the strategy on the following scale: 1 (not relevant); 2 (slightly relevant); 3 (neither relevant nor irrelevant); 4 (relevant); 5 (highly relevant).

<table>
<thead>
<tr>
<th></th>
<th>Not relevant</th>
<th>Highly relevant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Accountability and transparency</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>2. Human rights and gender equality</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>3. Evidence-based action</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>4. Reducing inequities in disease burden and access to services (within and between countries)</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>5. Partnership, integration and linkage across sectors, programmes and strategies</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>6. The meaningful involvement of people living with or affected by the diseases, key populations and communities</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>7. Ensuring quality and affordability (for example for medical products and services)</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
</tbody>
</table>

4. **Do you have comments about the principles proposed above? Do you have suggestions for additional principles to guide the strategies?**  
(Maximum 100 words)
5. Introductory sections of the draft strategy seek to make a compelling case for action and to ensure programmes are well-resourced. What critical points should be mentioned here?

(Maximum 100 words)

6. Please refer to the draft strategy document. What do you think about the outline Vision, Goals and Targets proposed in the Draft Strategy?

For each of the following (Vision, Goals and Targets) please rate their strategic relevance on the following scale: 1 (not relevant); 2 (slightly relevant); 3 (neither relevant nor irrelevant); 4 (relevant); 5 (highly relevant). Please refer to the draft strategy for details.

<table>
<thead>
<tr>
<th></th>
<th>Not relevant</th>
<th>Highly relevant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>Goal</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>Targets</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
</tbody>
</table>

7. Do you have any comments about the proposed Vision, Goals and Targets?

(Maximum 100 words)

8. What are your thoughts about how the 2016–2021 Strategies should be framed and used?

Please rate your level of agreement for each statement on the following scale: 1 (strongly disagree); 2 (disagree); 3 (neither agree nor disagree); 4 (agree); 5 (strongly agree).

<table>
<thead>
<tr>
<th>Statement</th>
<th>Disagree</th>
<th>Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The strategic targets should be ambitious yet technically feasible, achievable and measurable.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>The strategy should be comprehensive, outlining all actions that countries and WHO should take.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>The strategy should only refer to new or high impact interventions and actions, or what needs to be done differently.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
</tbody>
</table>

9. In your opinion what are likely to be the greatest opportunities or 'game-changers' affecting this health issue during the period 2016–2020?

(Maximum 100 words)
10. The Draft Strategy proposes four strategic directions. For each of the four strategic directions please rate how important it is for these areas to be included and further defined in the strategy.

For each of the following areas please rate their strategic importance/relevance on the following scale: 1 (not relevant); 2 (slightly relevant); 3 (neither relevant nor irrelevant); 4 (relevant); 5 (highly relevant).

| 1: Essential Quality Services and Interventions |  
| **What and how** |  
| Define essential package for maximum impact across full continuum and leveraging combination interventions | 1 2 3 4 5 |

| 2: Achieving Impact and Equity: Populations and Locations |  
| **Who and where** |  
| Focus on key populations and key places (vulnerability; risk; access; exclusion) | 1 2 3 4 5 |

| 4: Innovation for Acceleration |  
| **Changing the trajectory** |  
| Moving beyond existing technologies and approaches to accelerate progress | 1 2 3 4 5 |

| 4: Finance for Sustainability |  
| **Covering the costs** |  
| Ability to access needed health services without financial hardship | 1 2 3 4 5 |

11. Do you have comments about the proposed four strategic directions?

(Maximum 100 words)

12. Do you have suggestions for additional or alternative priority areas?

Please list up to a maximum of three suggestions:
13. **Do you have any other comments on the proposed 2016–2021 Global Health Sector Strategy?**

Please include your comments here: (Maximum 100 words)

14. **Optional personal details**

Which of the following statements best defines your current position? You can check more than one box.

<table>
<thead>
<tr>
<th>I work as a clinician/health provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am a national or regional programme manager/officer.</td>
</tr>
<tr>
<td>I work for a non-governmental and/or civil society organization and/or community based organization.</td>
</tr>
<tr>
<td>I work at a university or academic institute.</td>
</tr>
<tr>
<td>I am involved in fund-raising, national or international donor agency, development agency or advocacy.</td>
</tr>
<tr>
<td>I am a public health policymaker/manager.</td>
</tr>
<tr>
<td>I work for a national or international public health organization/agency.</td>
</tr>
<tr>
<td>I work with communities and people living with and impacted by this issue.</td>
</tr>
<tr>
<td>I work for a private sector organization.</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

(Optional)

My country of residence is:
Name: Organization:

Please tick this box if you prefer that your responses remain anonymous
## Annex 3: List of abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMR</td>
<td>antimicrobial resistance</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral therapy</td>
</tr>
<tr>
<td>CE</td>
<td>Conformité Européenne</td>
</tr>
<tr>
<td>DAA</td>
<td>direct-acting antivirals</td>
</tr>
<tr>
<td>DALYs</td>
<td>disability-adjusted life years</td>
</tr>
<tr>
<td>FDA</td>
<td>US Food and Drug Administration</td>
</tr>
<tr>
<td>FSW</td>
<td>female sex workers</td>
</tr>
<tr>
<td>GHSS</td>
<td>Global Health Sector Strategy</td>
</tr>
<tr>
<td>HBeAg</td>
<td>hepatitis B e antigen</td>
</tr>
<tr>
<td>HBsAg</td>
<td>hepatitis B surface antigen</td>
</tr>
<tr>
<td>HCC</td>
<td>hepatocellular carcinoma</td>
</tr>
<tr>
<td>HAV</td>
<td>hepatitis A virus</td>
</tr>
<tr>
<td>HBV</td>
<td>hepatitis B virus</td>
</tr>
<tr>
<td>HCV</td>
<td>hepatitis C virus</td>
</tr>
<tr>
<td>HCV</td>
<td>health-care worker</td>
</tr>
<tr>
<td>HEV</td>
<td>hepatitis E virus</td>
</tr>
<tr>
<td>HIV</td>
<td>human immunodeficiency virus</td>
</tr>
<tr>
<td>HPV</td>
<td>human papillomavirus</td>
</tr>
<tr>
<td>IVD</td>
<td>In Vitro Diagnostics</td>
</tr>
<tr>
<td>LMICs</td>
<td>low- and middle-income countries</td>
</tr>
<tr>
<td>MSM</td>
<td>men who have sex with men</td>
</tr>
<tr>
<td>MTCT</td>
<td>mother-to-child transmission</td>
</tr>
<tr>
<td>NSP</td>
<td>needle and syringe programmes</td>
</tr>
<tr>
<td>OST</td>
<td>opioid substitution therapy</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>The United States President’s Emergency Plan for AIDS Relief</td>
</tr>
<tr>
<td>PCR</td>
<td>polymerase chain reaction</td>
</tr>
<tr>
<td>PMTCT</td>
<td>prevention of mother-to-child transmission</td>
</tr>
<tr>
<td>POCT(s)</td>
<td>point-of-care diagnostic test(s)/(ing)</td>
</tr>
<tr>
<td>PrEP</td>
<td>Pre-Exposure Prophylaxis</td>
</tr>
<tr>
<td>PWID</td>
<td>people who inject drugs</td>
</tr>
<tr>
<td>QDA</td>
<td>qualitative data analysis</td>
</tr>
<tr>
<td>SRH</td>
<td>sexual and reproductive health</td>
</tr>
<tr>
<td>RTI(s)</td>
<td>reproductive tract infection(s)</td>
</tr>
<tr>
<td>STI(s)</td>
<td>sexually transmitted infection(s)</td>
</tr>
<tr>
<td>TB</td>
<td>tuberculosis</td>
</tr>
<tr>
<td>TRIPS</td>
<td>Agreement on Trade-Related Aspects of Intellectual Property Rights</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
</tr>
<tr>
<td>VH</td>
<td>viral hepatitis</td>
</tr>
<tr>
<td>WASH</td>
<td>water, sanitation and hygiene</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>