Example Funding Request Form

Full Review

Allocation Period 2023-2025

Jasmania HIV/TB Full Review Funding Request Form

Introduction

This example funding request form aims to support applicants in their development of funding requests to the Global Fund by demonstrating how the responses to the questions can be structured in a way that is complete, concise and with an appropriate level of detail and length.

Please note the points below, on how to best use this resource:

- Jasmania is a fictional country; all data and references to in-country entities included in this example are illustrative and fictional.
- When developing their funding request, applicants should always refer to the funding request approach instructions which include information, resources, a description of necessary documents to be submitted along with the form, and detailed elements related to each question. These elements all need to be addressed for a response to be considered complete.
- This example only covers the funding request narrative and not the required annexes. In many sections, the narrative refers to these annexes rather than repeating information that would be included in those annexes. It should be inferred that these annexes include the various analyses, descriptions, or plans requested in the instructions.
- In case of any apparent contradiction between what is provided in this example and what is requested in the funding request instructions, the guidance provided in the funding request instructions should be followed.
- Although this example was designed as an HIV/TB funding request using the Full Review application approach, applicants with different components and different application approaches may also find it a useful reference.

Funding Request Form

Full Review

Allocation Period 2023-2025

Summary Information

Country(s)	Jasmania
Component(s)	HIV and TB
Planned grant start date(s)	January 1, 2023
Planned grant end date(s)	December 31, 2025
Principal Recipient(s)	Jasmania Ministry of Health
Currency	USD
Allocation Funding Request Amount	$89.6 million
Prioritized Above Allocation Request (PAAR) Amount	$28.4 million
Matching Funds Request Amount (If applicable)	Not applicable

Refer to the Full Review Instructions for detailed elements related to each question which should be addressed for a response to be considered complete. The Instructions also include information, resources, and a description of necessary documents to be submitted along with this form.

Section 1. Funding Request and Rationale

1.1 Prioritized Request

Module #1

Module #1	**HIV prevention package, and differentiated testing services for men who have sex with men, trans and gender diverse people, and sex workers of all genders, and their sexual partners**
Intervention(s)	Condom and lubricant programming - ☐ New, ☐ Scale-up, ☒ Continuation, or ☐ Scale-down - $
	Pre-exposure prophylaxis (PrEP) programming - ☐ New, ☒ Scale-up, ☐ Continuation, or ☐ Scale-down
	HIV prevention communication, information, and demand creation - ☐ New, ☒ Scale-up, ☐ Continuation, or ☐ Scale-down
	Community empowerment - ☐ New, ☒ Scale-up, ☐ Continuation, or ☐ Scale-down
	Sexual and reproductive health services - ☐ New, ☒ Scale-up, ☐ Continuation, or ☐ Scale-down
	Removing human rights-related barriers to provision - ☐ New, ☐ Scale-up, ☒ Continuation, or ☐ Scale-down
	Community-based testing for key populations programs - ☐ New, ☐ Scale-up, ☒ Continuation, or ☐ Scale-down
	Self-testing for key populations programs- ☐ New, ☐ Scale-up, ☒ Continuation, or ☐ Scale-down
	Services for men who have sex with men, trans and gender diverse people, and sex workers, to include: • HIV information sharing; • Promoting and ensuring access to condoms and lubricants; • Counseling on health issues; • Personal risk assessment and regular (every 6 months) HIV testing, with prompt linkage to antiretroviral therapy (ART) and adherence support services for those testing positive; • PrEP counselling for those who test negative and are at highest risk of infection; • Annual sexually transmitted diseases (STI)/tuberculosis (TB)/viral hepatitis screening and prompt linkage to STI/TB/viral hepatitis care, mental health, legal counselling, and a comprehensive package of sexual and reproductive health and rights (SRHR) services; and

	• Shelter for those experiencing domestic violence, Post-Exposure Prophylaxis (PEP), community empowerment activities and legal aid. Building on the 2020-2022 allocation cycle success, the modalities of testing include community-based testing, self-testing, a modified version of partner (index) testing to ensure the safety of key populations, and social network-based testing. Key strategies to deliver the services include: 1) the expansion of community-based organization (CBO) operated access points (APs) in high burden areas, the majority of which will be key population-led; 2) community-based testing and linkages to care; 3) expansion of technology-based services (online, social media, smartphone app counselling and ordering of self-tests and supplies); 4) employment of additional peer and outreach workers (POWs); 5) specific training of CBOs focused on making access points welcoming and safe for trans and gender diverse people and other key and vulnerable populations (men who have sex with men, sex workers and their partners); and 6) targeted information, education and communication materials, for use through social media and venue-based outreach. The CBOs will be trained on several issues including a newly introduced three-test algorithm which will be implemented in conjunction with the ART providers. The recommendations from a broad community consultation on safety and security in 2022 will be fully implemented in 2023-2024 by updating the prevention information management systems, standard operating procedures of services, etc. The major change from current programming is the expansion of access points, POWs, and PrEP, and the specific training of APs and POWs on working with trans and gender diverse people. The app is also a new facet of this grant. A series of meetings for sensitizing local community leaders (including law enforcement, health providers, other HIV service providers, local business operating venues for sex work, gay and other men who have sex with men, trans and gender diverse people, and others) is planned to support the opening of new sites and reinforce acceptance and support for services and key population leaders in one third of the APs sites (71) in Year 1, further one third of APs sites (72) in Year 2 and the remaining APs sites (71) in Year 3.
Population, geographies and/or barriers addressed	**Population:** Men who have sex with men, sex workers and trans and gender diverse people and their sexual partners. Population size estimates will be established under the grants made from the funding request. **Geography:** focus on the urban centers of West Lake, East Lake, and Emma City (lowest-income areas), where men who have sex with men, sex workers and trans and gender diverse people are concentrated in Jasmania. **Barriers**: provide services in APs operated by (key populations-led) CBOs where men who have sex with men, sex workers and trans and gender diverse people feel safe; POWs; strengthened last mile supply chain of commodities to avoid stock-outs.

List of activities	The following are the major activities to be performed:
	
	• Condom and lubricant programming
	  • Map locations for strategic expansion of APs
	  • Generate demand for condoms and testing through outreach in cruising hotspots and online platforms, especially platforms used by trans and gender diverse people and geographies where there are concentrations of trans and gender diverse people

	• Build skills and capacity of POWs • Procure, assure quality and target distribution of commodities for prevention (condoms, lubricants, and PrEP) • HIV prevention communication, information, and demand creation • Target internet-based information, including social media, on HIV, safer sex, condom use and PrEP • Establish an app for POWs to conduct one-on-one risk reduction interventions to ensure key population retention as negative (including reminders for testing and prevention messages, and access to PrEP services) • Ensure prompt linkages to ART initiation and index partner testing services for those testing positive • PrEP: Scale up of PrEP services to reach high-risk key populations and their sexual partners in high bhigh-burden (highest risk and lowest income areas only) • Procure and deliver drugs and additional tests for monitoring of PrEP clients • Develop and implement PrEP register, with respect for confidentiality and human rights, to allow for PrEP monitoring and evaluation (M&E) efforts • Train AP staff and POWs in working with and making trans and gender diverse people feel welcome and safe, including recruiting trans and gender diverse people as POWs • Community-based screening (CBS), network-based testing and partner (index) testing • Improve CBS implementation including skills enhancement for motivators, and testing guidelines • Support linkages to ART services to ensure HIV confirmatory testing, ART initiation and ART adherence support for clients who were screened reactive • Self-Testing • Procure and distribute self-test kits • Support linkages to ART services to ensure HIV confirmatory testing, ART initiation and ART adherence support for reactive clients • Community delivery in safe spaces: Enhance and expand APs as one-stop-shops- see learnings from the Barriers to Access Study about APs operated by CBOs
Amount requested	$21.4 million
Expected outcome	The expected outcomes below draw from the indicators list in the modular framework and include a mix of outcome, output, and coverage items that correspond to Jasmania's program and data we collect or plan to collect. Outreach efforts will reach 80% of men who have sex with men in 2025 (up from 50% in 2022). The men who have sex with men prevention efforts expect to show the following impact and outcomes by 2025 in comparison with 2022: (a) knowledge on HIV prevention and transmission from 32% to 90%, (b) self-reported condom (& lubricant) use during last anal sex from 38% to 75%, (c) men who have sex with men who have been tested in the past 12 months and know their HIV status from 29% to 55%, and (d) men who have sex with men having access to condoms from 48% to 90%.

	PrEP coverage is expected to increase from 10% of men who have sex with men started on PrEP in 2022 to 25% of those indicated eligible in 2025 (to be estimated with program data). The efforts with trans and gender diverse people expect to increase: (a) knowledge on HIV prevention and transmission from 12% to 50%, (b) condom (& lubricant) use during last anal sex from 26% to 60%, (c) trans and gender diverse people who have been tested in the last 12 months and know their HIV status from 13% to 65%, and (d) trans and gender diverse people having access to condoms from 22 to 60 percent. trans and gender diverse people on PrEP are expected to reach 10 percent. The efforts with sex workers expect to increase coverage by 20% between 2022 and 2025 and decrease new cases of HIV cases among female sex workers from 264 in 2022 to 150 in 2025; HIV cases among male sex workers from 412 in 2022 to 250 in 2025; HIV cases among trans and gender diverse people sex workers from 180 in 2022 to 120 in 2025. The condom use rate for female sex workers is expected to increase from 83% in 2022 to 90% in 2025 (allocation); from 41% in 2022 to 78% in 2025 among male sex workers; and from 32% in 2022 to 68% in 2025 among trans and gender diverse people. The sex workers efforts also expect to increase: (a) knowledge on HIV prevention and transmission from 38% to 90% among female sex workers, 35% to 85% among male sex workers, and 31% to 85% among trans and gender diverse people sex workers, (b) condom (& lubricant) use during last anal sex from 24% to 70% among female sex workers, 39% to 75% among male sex workers, and 36% to 75% among trans and gender diverse people sex workers, (c) sex workers who have been tested in the last 12 months and know their HIV status from 25% to 55% among female sex workers, 30% to 60% among male sex workers, and 18% to 50% among trans and gender diverse people sex workers, and (d) sex workers having access to condoms from 58% to 90% among female sex workers, 52% to 90% among male sex workers, and 48% to 90% among trans and gender diverse people sex workers.

Module #2

Module #2	**HIV prevention package, and differentiated testing services for people who use drugs (injecting and non-injecting) and their sexual partners focused on East Lake and Emma Cities**
Intervention(s)	Community-based testing for key populations programs - ☐ New, ☐ Scale-up, ☒ Continuation, or ☐ Scale-down
	Condom and lubricant programming - ☐ New, ☐ Scale-up, ☒ Continuation, or ☐ Scale-down
	PrEP programming - ☐ New, ☒ Scale-up, ☐ Continuation, or ☐ Scale-down
	HIV prevention communication, information, and demand creation - ☐ New, ☒ Scale-up, ☐ Continuation, or ☐ Scale-down
	Community empowerment - ☐ New, ☒ Scale-up, ☐ Continuation, or ☐ Scale-down
	Sexual and reproductive health services - ☐ New, ☒ Scale-up, ☐ Continuation, or ☐ Scale-down
	Removing human rights-related barriers to provision - ☐ New, ☐ Scale-up, ☒ Continuation, or ☐ Scale-down

	Self-testing for key populations programs- ☐ New, ☒ Scale-up, ☐ Continuation, or ☐ Scale-down
	Services for people who use drugs, as well as their sexual and injecting partners, include: • HIV information-sharing; • Access to clean needles and syringes; • Overdose prevention and management (including provision of naloxone); • Condoms and lubricants; • Personal risk assessment and regular (every 6 months) HIV testing, including through self-testing, with prompt linkage to ART and adherence support services for those testing positive; and • PrEP counselling for those who are testing negative but at the highest risk. Complimentary services will include: • Annual STI/TB/Viral hepatitis screening and prompt linkage to STI/TB/viral hepatitis care; • Counselling on legal issues, literacy, and gender-based violence; and • A comprehensive package of SRHR services. Services will be tailored to women, girls and other young people who use drugs (including those under 18), to users of stimulants and new psychoactives. This will expand the reach of services, which are currently focused on heroin users. Key strategies to deliver the services include: peer and network-based outreach; dark-net outreach; engagement of private practitioners; specific training of providers concerning making APs welcoming and safe for people who use drugs; and the expansion of access to commodities in drug treatment facilities and in pharmacies (both state-run and private). The sensitization work for services and communities of people who use drugs and their partners will be conducted in conjunction with the work described in Module #1. The activities continue and expand upon existing efforts. The key changes are the addition of new CBS guidelines, collaboration with the private sector, development of tailored services for underserved sub-populations, and linkages to mental health services for people who use drugs.
Population, geographies and/or barriers addressed	**Population:** female, male and trans and gender diverse people who use drugs and their sexual partners **Geography:** East Lake and Emma Cities **Barriers:** Reluctance to uses services and discrimination against people who use drugs

List of activities	The following are the major activities to be performed:
	• Social, drug use, injecting and sexual network testing and partner (index) testing
	  • Build capacity of POWs to map social and sexual networks of people who use drugs, including sexual and drug partners,
	  • Identify and target testing outreach for sub-populations of people who use drugs, including: young injectors; users of stimulants and new psychoactive substances, and women & girls who use drugs,

	• Collaborate with men who have sex with men, sex workers and trans and gender diverse people services to reach sub-populations who use drugs. • Provide drug-specific and harm reduction services: needles/syringes, hepatitis C virus (HCV) testing and linkage to care, opioid agonist (substitution) therapy, vein and wound care, overdose (naloxone), drug testing, counseling on strategies for safer drug use, and mental health screening and referrals • PrEP: Scale up of PrEP services to reach people who use drugs & their sexual partners in high burden areas (highest risk and lowest income areas only). • Procure and deliver drugs and additional tests for monitoring of PrEP clients. • Develop and implement PrEP register to allow for PrEP M&E efforts. • CBS • Improve CBS implementation including skills enhancement for motivators, and CBS guidelines. • Support linkages to ART services to ensure HIV confirmatory testing, ART initiation and ART adherence support for people who use drugs reactive clients for CBS motivators and clients who were screened reactive. • Self-Testing • Procure and distribute 90,000 self-test kits. • Support linkages to ART services to ensure HIV confirmatory testing, ART initiation and ART adherence support for people who use drugs reactive clients. • Private sector collaboration • Build capacity of private practitioners to promote HIV testing to diverse sub-populations of PUD and link to HIV testing facilities or CBS motivators. • Strengthen referral between private practitioners and HIV testing facilities. • Community Engagement • Expand the People Who Use Drugs Care model as safe spaces and HIV APs for people who use drugs. • Build the capacity of the people who use drugs' community for CBS (in 3 lowest income districts) • Implement a comprehensive mentorship, supervisory, M&E system to support CBS activities. Complementary services for people who use drugs are to be expanded including: mental health; introducing new methodology for mental health screening; SRHR; Hepatitis; wound and vein care; drug use management; group sessions on drug care and harm reduction; and group sessions for partners and family members of people who use drugs.
Amount requested	$15.8 million
Expected outcome	New cases of HIV registered among people who use drugs are expected to fall from 225 in 2022 to 150 in 2025. The combined package is expected to reach 80% of the estimated number of people, with 95% among them knowing their status and 95% of them successfully linked to ART.

Module #3

Module #3	TB diagnosis, treatment, and care
Intervention(s)	TB screening and diagnosis - ☐ New, ☒ Scale-up, ☐ Continuation, or ☐ Scale-down
	TB treatment, care and support - ☐ New, ☒ Scale-up, ☐ Continuation, or ☐ Scale-down
	The interventions to move closer to optimal TB services in this module focus on: • Case detection and diagnosis; • Treatment, care, and support. Improved case detection and diagnosis includes: a) increased use of rapid molecular diagnosis technologies; b) a revised screening algorithm; c) improved sample transport; and d) increased collaboration with the private sector. Improved treatment, care, and support is achieved through: a) the use of a new six-month case regimen; b) decentralized patient management; c) increased national funding of supplies, nutrition kits, and patient travel costs; d) use of digital adherence technologies; and e) enhanced involvement of community health workers (CHWs). The interventions involve changes to previous programming as follows: • Adding 12 new TB Treatment Care facilities (TTCs), 6 equipped with rapid molecular diagnostic technologies machines • Updating the screening algorithm • Private transport contracts for sputum sample transport • New case treatment regimen • Decentralization of TB patient management • Advocacy in collaboration with the Faith Based Council of Communities (FBCC) • Strengthening of work on TB with CHWs
Population, geographies and/or barriers addressed	**Population:** All Jasmanian women, men and children (see Module #4 on key and vulnerable populations - TB below) **Geographies:** National **Barriers:** Availability of TB screening, testing, and treatment

List of activities	The following are the major activities to be performed:
	• Case detection and diagnosis
	  • Set up and operationalize (including half with rapid molecular diagnostic technologies) additional TTCs, bringing the total number from 20 in 2022 to 32 in 2025
	  • Revise the screening algorithm to include the use of digital X-ray screening and rapid molecular diagnostic technologies as a first-line diagnostic test at TTCs

	• Improve sample transportation system; contract with private companies for the transport of sputum samples from primary health centers and private facilities to TTCs. • Develop a plan to improve for- and not-for-profit private sector service provider involvement, focus on urban areas, particularly in Eastern Region • Build capacity and train for- and not-for -profit private health provider facilities (e.g., certification, training in case finding, treatment, and infection control) • Link private provider facilities to the sample transportation system to diagnostic facilities (TTCs) that have rapid molecular diagnostic technologies capacity • Treatment, care, and support • Treat using the new six-month case regimen: 2(ERHZ)/4(RH), for all forms of TB (bacteriologically confirmed pulmonary forms (PTB+), clinically diagnosed pulmonary forms (PTB-), extrapulmonary TB) as recommended by the World Health Organization (WHO) • Conduct systematic rapid molecular diagnostic testing for all re-treatments • Decentralize TB patient management to primary health centers and CHWs to reduce patients lost to follow-up • Procure first-line anti-TB drugs including supply costs and nutritional kits for TB patients and provide funding for patient travel costs to access treatment • Improve access and adherence to treatment employing mobile phone based Digital Adherence Technologies (DAT), psychosocial support through social workers, and the conduct of nutritional assessment followed by nutritional supplements when appropriate • Conduct advocacy actions in collaboration with the FBCC to reduce stigmatization of patients, promote their rights and foster community involvement in treatment success • Train CHWs to refer presumed TB cases to primary health centers and TTCs for screening and diagnosis • Provide incentives to improve CHW performance in identifying possible TB cases
Amount requested	$14.5 million
Expected outcome	The expected outcomes in 2025 (compared to 2022) are the following: • TB mortality: 22% (48%) • Case notification per 100,000 population: Eastern Region: 300 (281); Central Region: 290 (245); Western Region: 220 (153) • TB treatment coverage: 70% (55%)

Module #4

Module #4	**Key and vulnerable populations – TB**
Intervention(s)	Children and adolescents - ☒ New, ☐ Scale-up, ☐ Continuation, or ☐ Scale-down

	People in prisons/jails/detention centers - ☒ New, ☐ Scale-up, ☐ Continuation, or ☐ Scale-down
	Miners and mining communities - ☒ New, ☐ Scale-up, ☐ Continuation, or ☐ Scale-down
	Others (people living with HIV, household contacts, people with diabetes) - ☒ New, ☐ Scale-up, ☐ Continuation, or ☐ Scale-down
	The interventions in this module are designed to combat TB among key and vulnerable populations by addressing TB case detection, diagnosis, and treatment and supporting services for: children, people in prisons/jails/detention centers, mining communities, people living with HIV, contacts in TB households, and people with diabetes. The interventions for children include child-specific packages of TB services and the integration of pediatric TB with other child health services. We include interventions to address the specific challenges of malnourished children. A partnership with the Ministry of Justice will address TB in prisons/jails/detention centers. A collaboration with mining companies and mining trade unions aims to prevent and manage TB and HIV in mining communities. The integration of TB and HIV services and the diagnosis and treatment of TB among people living with HIV will increase. We will increase case finding, diagnosis, and treatment of household contacts and provide TB preventive treatment to children under 5 and people living with HIV in TB households. We will collaborate with the Jasmanian Association on Diabetes (JAD) to address TB among diabetic patients. The interventions that involve changes to previous programming are the collaborations with the units focused on malnourishment, mining companies and mining trade unions, and JAD.
Population, geographies and/or barriers addressed	**Population:** Children (especially the malnourished), incarcerated people, personnel at 3M Red River and QRS Lithium mining companies and surrounding communities, people living with HIV, household contacts of people with TB, and people with diabetes **Geographies:** National **Barriers:** Availability of screening, testing, and treatment

List of activities	All the below activities are aligned with the Jasmania National TB Program (JNTP):
	
	• Children:
	  • Provide digital X-rays or rapid molecular diagnostic tests at the ten equipped TTCs
	  • Improve skills of child health workers, CHWs, and TTC and primary health center workers on diagnosis of TB in children according to the existing national guidelines and standard operating procedures (SOPs)
	  • Incorporate TB in children into activity packages of CHWs trained on nutrition and Integrated Management of Childhood Illness
	  • Link TB and child-specific health services such as immunization programs, reproductive, maternal, newborn, child, and adolescent health (RMNCAH) programs, and Regional Centers for Nutritional Rehabilitation (RCNR) and Outpatient Centers for Rehabilitation for Severe Malnutrition (OCRSA) are implemented
	  • Focus on malnourished children:
	  ▪ Sign agreements with 3 RCNR and the 42 (25 in the Eastern Region) OCRSA for diagnosis and treatment of TB and HIV

	▪ Train nurses at RNCR and OCRSA on TB and HIV and provide support for case identification and sample collection and transport ▪ Register children who test positive for TB and/or HIV at TTCs; provide treatment at the RNCR or OCRSA centers o Continue HIV-positive children on ART once they have completed their TB treatment • People in prisons/jails/detention centers: o Provide TB care in the central prison, 12 other prisons and 3 detention centers with infirmaries under a partnership between the Ministries of Justice and Health o Conduct systematic screening of people on arrival to detention and in prisons (annually) o Train prison infirmary staff to identify presumed TB and how to collect and transport sputum samples to the nearest rapid molecular diagnostic technologies site; treat TB or multidrug-resistant TB (MDR-TB) detected at the prison infirmary o Offer HIV testing routinely to people in prisons with presumed TB/MDR-TB o In cases of TB/HIV co-infection, give people in prisons ARVs in consultation with the Jasmania National HIV/AIDS Committee (JNHAC); monitor prisoners released during treatment at the nearest TTC o Conduct annual screening of prisoners using digital X-ray followed by rapid molecular diagnostic technologies and HIV testing at the central prison and every-two-year screening at the 12 other prisons with infirmaries o At each of the 13 prisons, train 10 TB and HIV peer educators to support prevention and treatment adherence o Treat people in prisons with MDR-TB in isolation rooms at prisons however only until medically necessary • Miners and mining communities: o Sign a memorandum of collaboration between mining companies and JNTP for the management of TB and HIV o Train mining company health care workers to diagnose presumed TB, collect, and send samples to rapid molecular diagnostic technologies sites for diagnosis, and manage people with TB and/or TB/HIV co-infection o Scale up capacity of primary health centers to treat people in mining communities at clinics nearest to their home o Implement household contact investigation for miners with TB and in mining communities o Advocate in collaboration with the Ministry of Labor and Work and miners' trade unions for the rights of people with TB (and TB/HIV) to keep their jobs and receive benefits incentivizing undertaking full course of treatment o Conduct mobilization and sensitization activities in mining communities, through: ▪ Providing health education for mining workers and at schools ▪ Social mobilization at gatherings: selection and training of volunteers with active TB as peer mobilizers; and distribution of leaflets/brochures having messages on TB prevention and control. • People living with HIV: o Provide all people living with HIV with TB symptoms a rapid molecular diagnostic technologies test for TB diagnosis o Employ TB-LAM testing for people with severe HIV disease (CD4 below 200) o Forward results of the above to providers to start TB or MDR-TB treatment or TB preventive treatment (TPT), with TPT adherence and monitoring; Household contacts: Conduct active case finding for TB index cases according to the JNTP's national guidelines and SOPs for contact investigation (CI) at all primary health centers and TTCs o Employ CHWs and health personnel to identify symptomatic close contacts, especially children and known people living with HIV

	○ Collect and transport sputum samples from presumptive TB cases among household contacts to nearest diagnostic center (TTC) ○ Provide TB preventive treatment to children under 5 and people living with HIV in whom active TB has been ruled out ○ Diagnose presumptive TB cases and enroll them for treatment at nearest primary health center when positive ○ Inform health personnel on the importance of CI and TPT through individualized mentorship and continuing medical education sessions specifically designed for mid- and low-level health personnel at all primary health centers and TTCs ○ Supply job aids and recording and reporting formats for routine use at all health centers and TTCs ○ Implement comprehensive mentorship, supervisory, M&E systems to support CI and TPT activities • People with diabetes: ○ Reach and sign collaboration agreements on the treatment of people with diabetes and TB between JAD, the 3 Endocrinology Departments of the Regional Hospitals, and the JNTP. ○ Build capacity for health staff at the above services. ○ Screen diabetic patients annually for TB by X-ray. If the X-ray suggests TB, send sputum samples to rapid molecular diagnostic technologies sites (TTCs) for diagnosis. ○ Treat patients identified with TB at nearest health center
Amount requested	$12.6 million
Expected outcome	The expected outcomes in 2025 (compared to 2022) are the following: Children: Increase CI by 100% from 2022 baseline (to be determined), 200% among malnourished children Children under 5 who are close contacts on TPT: 85% (63%) People in prisons/jails/detention: screened on arrival at detention facility or prison increases from 90% (55% in 2022); increase CI by 100% from 2022 baseline (to be determined); 100% of positives put on treatment; loss to follow-up of people discharged from incarceration who are on treatment less than 20%; people living with HIV in prisons/jails/detention who are close contacts for TB on TPT 85% (49%) Miners: 100% screened, at least 90% needing treatment receive it; loss to follow-up of less than 20% Mining communities: 50% screened, 90% of those needing treatment receive it, loss to follow-up less than 20% People living with HIV: screened for TB 80% (59%), people living with HIV positive for TB put on treatment 95% (78%), loss to follow-up of less than 25% People with TB: screened for HIV 90% (64%), found HIV positive put on ART 90% (68%), loss to follow-up of less than 25% Household contacts: Contact investigations from index cases: 80% (62%), 90% of close contacts screened, 90% of presumptive cases have sputum samples collected and diagnosed, 95% of positives are on TB treatment

	People with diabetes: 80% screened annually (no baseline available), 90% of those needing treatment receive it, loss to follow-up of less than 20%

Module #5

Module #5	**Reducing human rights-related barriers to HIV/TB services**
Intervention(s)	Eliminating stigma and discrimination in all settings - ☐ New, ☒ Scale-up, ☐ Continuation, or ☐ Scale-down
	Legal literacy - ☒ New, ☐ Scale-up, ☐ Continuation, or ☐ Scale-down
	Ensuring non-discriminatory provision of health care - ☒ New, ☐ Scale-up, ☒ Continuation, or ☐ Scale-down
	Increasing access to justice - ☐ New, ☒ Scale-up, ☐ Continuation, or ☐ Scale-down [Tick scale-up]
	Ensuring rights-based law enforcement practices - ☐ New, ☒ Scale-up, ☐ Continuation, or ☐ Scale-down
	Improving law, regulations and policies related to HIV and HIV/TB - ☐ New, ☐ Scale-up, ☒ Continuation, or ☐ Scale-down
	Community mobilization and advocacy for human rights - ☒ New, ☐ Scale-up, ☐ Continuation, or ☐ Scale-down
	The following interventions will be implemented: • stigma and discrimination reduction through training sessions, community engagement and advocacy; • legal literacy for target populations; • human rights and medical ethics training for health care providers; • sensitization of law-enforcement agents; • legal services; • community mobilization and advocacy targeting political decision makers at local, provincial and national levels; and • improving laws, regulations and polices. Most of the activities represent a continuation and expansion of previous initiatives. The work with the FBCC is new, as is the inclusion of legal literacy training (LLT) in pre-service training; the tool for assessing perceptions of safe spaces for services; and the Know your rights and opportunities (KYRAO) program. The dissemination of the Jasmania Patients' Charter for Tuberculosis Care; an update of M&E indicators for human rights; and the conduction of the baseline TB Stigma Index study all build on previous initiatives.
Population, geographies and/or barriers addressed	**Population:** People living with HIV and TB, men who have sex with men, trans and gender diverse people, and sex workers and other disadvantaged and underserved populations, with a focus on key and vulnerable populations for HIV and TB **Geography:** National with a focus on Jasmania's Eastern Region **Barriers:** stigma, discrimination, and legal

List of activities	The following are the major activities to be performed: • Sensitization programs for families of people living with HIV and people with TB, human resource managers, health service providers, and law enforcement officers • Collaboration on a human rights and HIV/TB program between the JNHAC and the FBCC that represents the Muslim, Buddhist, and Christian religious leaders • KYRAO program targeting the disadvantaged and underserved groups: (a) plantation agriculture workers and families in Western Province, (b) mine workers and families, and (c) migrants to low-income neighborhoods in the three major cities (mainly from Eastern Province), to promote the use of available HIV and TB services (much lower in these groups compared to the general population) and to ensure that populations know and can assert their rights • Dissemination (including follow-up activities in communities and with the media) of the Jasmania Patients' Charter for Tuberculosis Care • LLT on human rights for key populations, CBO personnel, trade union representatives, regional and district prosecutors, public defender lawyers, and lower court judges in high burden areas • Advocacy, training, capacity building and other technical support for integration of sensitization and LLT modules in pre-service training programs of the Jasmania People Management Association (JPMA), Ministry of Justice, Jasmania Judicial Academy (JJA), and police academies • Expansion of the pool of public defenders offering free or low-cost services • CBOs advocacy support at the district and municipal level for HIV, TB, gender rights and anti-discrimination measures • Organizational development support to key populations' networks and women's rights networks for engagement in strategic national and local policy platforms, including training on policy, evaluation, and budget advocacy for continued support for all Global Fund work from a range of donors, both domestic and external • Support to the Council for Jasmania's Children (CJC) to develop and advocate for child protection policies related to HIV • Advocacy and technical support to the MOLW for rights-responsive HIV workplace policies • Revision by JNHAC of human rights indicators in the national M&E framework, and technical support for the M&E system to collect HIV and human rights-related data • Development and deployment of a tool for POWs to assess perceptions by key populations of the safety of spaces for HIV services • Conduct a baseline TB Stigma Index study in 2023 • Develop, implement, and monitor a Jasmania Coordinating Committee (JCC) action plan for the implementation of policy recommendations from the TB Stigma Index, and HIV/TB gender assessment (2023-2025) Conduct an HIV and TB Stigma Index study in 2025
Amount requested	$8.2 million
Expected outcome	The expected outcomes in 2025 (compared to 2022) are the following:

	Improvement in all Stigma Index indicators from 2022 HIV and 2023 TB results in 2025; the JHNAC-FBCC program on human rights is established and active; the KYRAO is in place around plantations and mines and in low-income neighborhoods of our three cities; the LLT is in the permanent curriculum of the pre-service training programs of JPMA, Ministry of Justice, JJA, and police academies; the Jasmania Patients' Charter for Tuberculosis Care is featured on social media forums used by TB key populations and endorsed in key news media editorials; human rights indicators in the national M&E framework are revised; the JCC has established an active advocacy program for child protection and HIV; the Ministry of labor and Work has published guidelines for an HIV rights respective workplace; and the tool for assessment of the safety of spaces for key populations is created and deployed, with results used to modify the spaces.

Module #6

Module #6	**RSSH: Monitoring and evaluation systems**
Intervention(s)	Routine reporting - ☐ New, ☐ Scale-up, ☒ Continuation, or ☐ Scale-down
	Surveys - ☐ New, ☒ Scale-up, ☐ Continuation, or ☐ Scale-down
	Data quality - ☐ New, ☒ Scale-up, ☐ Continuation, or ☐ Scale-down
	Analyses, evaluations, reviews and data use - ☐ New, ☒ Scale-up, ☐ Continuation, or ☐ Scale-down
	Operational research - ☐ New, ☐ Scale-up, ☒ Continuation, or ☐ Scale-down
	All of the resilient and sustainable systems for health (RSSH) modules (6-8) make complementary investments to the expanding network of health facilities that make HIV and TB services accessible to all, with a focus on key and vulnerable populations. The system of facilities and improvements made to this network since the 2020-2022 submission are summarized below: The number of HIV testing centers is now proposed to reach 606, an increase from 544 in the 2020-2022 proposal to the Global Fund. The additional centers are designed to improve access to testing by an estimated 9%. The number of government TTCs remains the same, but each TTC now has at least one rapid molecular diagnostic technologies machine. There now are 13 private TB testing sites (from three in the previous submission) five of which have rapid molecular diagnostic technologies machines. The private sites are expected to increase access by 5%. 78 treatment hubs and primary care facilities (up from 72 previously) provide in-patient and out-patient HIV services. This has increased access by 7%. A network of 214 CBO operated AP) provide prevention services in high-risk HIV areas. Integrated HIV and TB services have been introduced since 2020-2022 in 19 of the 78 HIV treatment hubs that previously provided exclusively HIV services. This represents a 100%increase in access to integrated HIV and TB services. In addition, 13 of these treatment hubs and primary care facilities (up from 10 previously) will provide integrated sexual and reproductive health (SRH) services. The past support for Jasmania’s Health Management Information System (JHMIS) from the Global Fund makes it the bedrock of HIV and TB information. The activities in this module build on that bedrock and take advantage of mobile phone, smartphone app data transmission and geospatial information collected outside the health sector. We continue to conduct the specific studies and surveys

	needed to better understand the needs of and how to reach key and vulnerable populations and other disadvantaged populations, to analyze gendered needs and current service provision, and to adapt programmatic responses. We are adding efforts to develop the capacity for information systems through an investment in pre-service training. We maintain and enhance on-going support for data quality and use.
Population, geographies and/or barriers addressed	**Population**: Whole population of Jasmania, specifically KVPs **Geography:** National **Barriers:** Rapid and quality data used for decision making and capacity to produce and manage data

List of activities	The following are the major activities to be performed:
	• Strengthen routine reporting
	  ○ Enhancement of JHMIS for "instant" updating with data submitted using mobile phones, including government and private providers and service users (to provide feedback on the user experience, such as ARV stock-outs or unfriendly service or discrimination towards key populations)
	  ○ Integration of geospatial information into JHMIS through collaboration with the Jasmania National Statistical Office (JNSO) (JNSO is rapidly developing geospatial information used by the agricultural, mining, and business sectors)
	  ○ Conduct key surveys and operational research
	  ○ Obtain technical assistance for the integration of Stigma Index study data with routine JHIMS data
	  ○ Conduct operational research on services for people who use drugs to be better able to target the services for effectiveness and efficiency
	  ○ Conduct Spectrum estimations
	  ○ Conduct Integrated Bio-Behavioral Surveillance (IBBS) and population size estimations
	  ○ Collect and analyze HIV cascade data
	• Strengthen data quality and use
	  ○ Conduct annual on-site data validation for data quality
	  ○ Evaluate performance, quality, and impact of programs through annual in-depth review of key indicators to identify issues to address
	  ○ Develop pre-service training in health management informatics between the University of Jasmania School of Public Health (UoJ/SPH) and the Ibrahim Institute of Business Studies' (2IBS) Information Sciences program, including faculty development, research support, student stipends, and paid internships
	  ○ Conduct annual M&E meetings for analytical training, mentoring and supervision of district and regional staff on data analysis, management, and use

Amount requested	$4.8 million

Expected outcome	Improved timeliness, quality, and completeness of routine (JHMIS) and specific study (e.g., IBBS, Stigma Index) data for evaluation of the effectiveness of Jasmania's strategies to address HIV and TB, both nationally and sub-nationally and for planning course corrections and new initiatives; leveraging and preparing for new opportunities from developing information technologies (e.g., geospatial) and data availability (using mobile phone inputs directly, including from service users); and increased data production and management capacity (e.g. from the development of new capacity through the UoJ-2IBS collaboration). The picture of where we are, what we have accomplished/failed at, and where we should go on HIV and TB will be clearer with the new and better data and the capability to use it.

Module #7

Module #7	**RSSH: Human Resources for Health (HRH) and Quality of Care**
Intervention(s)	RSSH/Pandemic Preparedness (PP): CHWs: selection, pre-service training and certification - ☐ New, ☐ Scale-up, ☒ Continuation, or ☐ Scale-down
	Increasing the supply and improving supervision of CHWs has been a continuing effort for Jasmania. This request continues that work and aligns supported CHW development with the renewed JNCP and aligns with movement toward sustainability.
Population, geographies and/or barriers addressed	**Population:** Whole population of Jasmania, specifically KPs **Geography:** National **Barriers:** Access to care, treatment, and prevention in communities
List of activities	The following are the major activities to be performed: • Build the capacity of the UoJ/SPH and University of Western Jasmania School of Public Health (UoWJ-SPH) and their satellite campuses to select, train, and certify CHWs in alignment with the renewed Jasmania National CHW Program (JNCP) (currently under development with SIDA assistance) for multi-program CHWs (including Integrated Community Case Management) • Select and train CHWs to meet targets for CHW density • Pay CHW stipends 2023-2025 on a diminishing basis (Government of Jasmania (GoJ) payment of stipends to progressively increase to full GoJ coverage by 2026) • Develop and deploy mobile money (adapting existing commercial mobile money systems) to pay CHW stipends • In-service training of primary care nurses in supportive supervision of CHWs
Amount requested	$5.1 million
Expected outcome	Density of CHWs rises from 58 (2022) to 80 percent of communities by 2025; CHW remuneration through stipends on-time and in-full close to 100 percent, at least 50 percent of stipend payments via mobile money in 2025; at least quarterly supportive supervision

	of CHWs rises to 75 percent from 38 percent (2022) by 2025; UoJ/SPH and UoWJ-SPH and satellites have sustainable programs to select, train, and certify CHWs to meet health system needs.

Module #8

Module #8	**RSSH: Health Products Management Systems**
Intervention(s)	Storage and distribution capacity, design, and operations - ☐ New, ☐ Scale-up, ☐ Continuation, or ☒ Scale-down
	Supply chain information systems - ☒ New, ☐ Scale-up, ☐ Continuation, or ☐ Scale-down
	Augmenting national supply chain system with outsourcing - ☐ New, ☐ Scale-up, ☐ Continuation, or ☒ Scale-down
	The interventions build on past achievements and existing systems with upgrades to supply and logistics management equipment making information systems interoperable and easier to use for decisions, and with the introduction of outsourcing sample transport increasing value for money.
Population, geographies and/or barriers addressed	**Population:** Whole population of Jasmania **Geography:** National **Barriers:** Access to care, treatment, and prevention through (further) reduction in stockouts

List of activities	The following are the major activities to be performed:
	• Storage and distribution capacity, design, and operations
	  ○ The below activities complement the ABC Development Bank refurbishment of the Central Medical Stores (CMS)
	  ▪ Renewal of equipment for warehouse management at the CMS and its seven antenna sites throughout Jasmania—computers, forklifts, labelling equipment, and other smaller items
	  ▪ Installation of temperature and humidity monitoring systems linked to electronic dashboards at CMS and antenna sites (a need that became acute with highly temperature sensitive COVID-19 vaccines that needed storage and distribution sites beyond the capacity of the Jasmania Expanded Program of Immunization (JEPI))
	  ▪ Forensic analysis of remaining stockout issues (see below how we made major progress in reducing stockouts—but some stockouts remain) through contracting with local independent analysts (request for proposal to be issued)
	• Supply chain information systems
	  ○ Development and deployment of interoperability between the electronic Logistics Management Information System (eLMIS) system and JHMIS including dashboards displaying the integrated data for decision making
	  ○ Training of managers in the use of the integrated eLMIS and JHMIS data
	  ○ Augmenting national supply chain system with outsourcing
	  ○ Development of the management systems to ensure effective and efficient outsourcing of sputum sample transport by private sector vendors—including model contracts, performance monitoring methods, and contract management SOPs

	○ Evaluation after two years of implementation of outsourcing to determine to what extent expectations have been met, and whether the program should be continued, modified, or expanded
Amount requested	$7.2 million
Expected outcome	Stock-outs further reduced (as measured by on-shelf availability of tracer HIV and TB drugs) from 5% to near zero; all CMS facilities have up-to-date warehouse management equipment, including temperature and humidity monitoring systems; managers have data from eLMIS and JHMIS on integrated dashboards that provide the managers with information for decision making; and sample transport is effective and efficient—achieving greater value for money.

1.2 Rationale

A. Overall approach for selection and prioritization of requested interventions

The JCC leads the formulation and oversight of Global Fund funding requests, including this one, drawing on extensive country dialogues, national strategies and policies and data available.

The considerations presented below were used to select and nominate for priority the interventions eventually proposed in Question 1.1.: 1) assessment of the situation and identification of critical needs, considering progress delivering the national strategic plans for HIV/STI/Hepatitis, TB, Health Financing and Sustainability, and the operational plan for greater integration of HIV/TB; 2) alignment with normative guidance from the WHO, including progress to deliver program essentials; 3) consideration of how best to build on previous investments and achievements with domestic, Global Fund and other support; 4) studies and assessments undertaken, including the Gender Assessment, HIV Stigma Index and Barriers to Access Study; 5) points of view of all stakeholders, notably communities and representatives of people living with HIV and TB, and key and vulnerable populations; 6) value for money, 7) impact on long-term sustainability, 8) consideration of current and planned investments from domestic sources and other external partners; and 9) ability to leverage resources from communities, mining companies, the private sector, and other external partners (see the Funding Landscape Table for information about support from other sources than the Global Fund for HIV and TB in Jasmania).

The JCC concluded that the key programmatic gaps that hinder progress are HIV prevention among key populations; addressing the needs of people who use drugs; enhancing TB diagnosis, treatment, and care; addressing key TB populations; attacking human rights barriers; and ensuring that elements of supporting information, human resources development, and health products management systems are improved. The selection of the modules follows this analytical logic.

The choices made in interventions reflect a triangulation of gaps (supported by evidence from the JHMIS and specific studies), normative guidance (e.g., from WHO) and evidence (e.g., from our own experience (e.g., the PrEP pilot effort) or from other countries in similar circumstances), value for money, and opportunities (such as the willingness of the FBCC to collaborate on advocacy). The interventions build on and do not duplicate high-value initiatives and actions with other support, notably the GoJ (purchase of ARVs, support for program management and implementation) and major investments from other external sources (e.g., USA Government support for reduction in mother-to-child transmission of HIV and the ABC Development Bank CMS warehouse renovation).

The priorities reflect that Jasmania is already well on track to deliver the HIV and TB program essentials and RSSH critical approaches. Government investments to date, combined with contributions from external partners (notably US and Belgian governments as well as the ABC Development Bank), have advanced progress and many targets are already achieved. Resources from this allocation will be deployed to boost action and reach countrywide implementation of all HIV program essentials with the exception of item 4 (voluntary male medical circumcision is not considered to be a priority), and prevention of mother-to-child transmission (PMTCT) services, which is covered by US government resources. Interventions to advance HIV Human Rights program essentials (19, 20, 21, 22) are included in this funding request, recognizing that they have had limited attention to date. In time these will supplement the domestic funds also deployed for this work. There have been more challenges with the systems to deliver access to optimal TB services. However, there is progress on all except for 5.3 (engagement of private health care providers) although only one program essential - priority interventions informed by cascade analysis (5.2) - has been implemented countrywide. This funding request includes requests for support for all the TB program essentials to scale up beyond current levels of implementation “in some sites (<50%)” and to start work on optimal private provider engagement (5.3).

B. Decision process for interventions selected for allocation versus those included in the PAAR

While many interventions were considered to be of high quality in the development of this funding request, some interventions were either scaled back or given a lower priority in cases where allocation was

insufficient and other funding sources have not yet been identified. Some priority interventions selected for inclusion in the PAAR and corresponding rationale are as follows:

- Expansion of the HIV preventive package to near-urban areas around West Lake and Emma Cities, as these areas are next in priority for action, but where the need is not as acute.
- More rapid scale-up of PrEP, since although we consider the rate of scale-up in the allocation rapid, we could be even more ambitious, in particular to reach sexual partners of key populations.
- Adding West Lake City to East Lake and Emma Cities for the work with people who use drugs, since this is in an area that, although with a lower concentration of this key population, drug use is a rising issue.
- Deepening TB diagnosis, treatment, and care through doing more drug susceptibility testing, diagnosing and treating DR-TB, and completing the equipping of TTCs with rapid molecular diagnostic technologies.
- Complement the allocation work with priority groups for TB, by extending to reach the urban poor and slum dwellers and communities and mobile populations involved with plantation agriculture.
- Provide support for the scale-up of a community-based initiative to reform discriminatory laws.
- Begin work on bringing Jasmania's weak system of civil registration and vital statistics back to life to be able to serve as source of evidence.
- Complement the training and support for CHWs in the allocation, with the pre-service training of additional primary care nurses.
- Add to the capacity of the health products management system by adding additional CMS antenna facilities.

1.3 Context

Below we describe the main changes to Jasmania's context since our funding request submitted to the Global Fund for the 2020-2022 allocation period. In the 2020-2022 submission we provided information and data about Jasmania's HIV and TB interventions in terms of governance and program implementation; health and community systems, HIV and TB epidemiology; the HIV cascade; human rights, gender and age-related barriers to progress and inequities in access to services, including socio-economic, geographic, and racial inequities; community responses and engagement; the role of the private sector (profit and non-profit); the funding landscape, including domestic and donor resources; and implementation structures. The information provided in 2020-2022 remains valid unless specifically updated below.

Political economy

The 2021 general election returned the People's Party for a Prosperous and Peaceful Jasmania (4PJ) to power, but with a smaller majority for the center-left coalition led by 4PJ in the People's Assembly. Thus, the Prime Minister continues to lead the government, though a few members of the Cabinet of Ministers were reshuffled, not including the Minister of Health. 4PJ and its coalition partner Jasmanians for Equity (JFE) campaigned on a commitment to quality health and education for all and enhanced human rights efforts to live up to the inspirational words in the Constitution of Jasmania.

Macroeconomic situation

Jasmania's 13.9 million inhabitants had a per capita income of $1,128 in 2021, in an economy that continues to be reliant on mining (lithium, tin), agriculture (both plantation for export (soybeans) and individual farming for subsistence and domestic consumption markets), tourism (on the sea and lake shores), and rapidly growing light manufacturing (benefiting from important Chinese investment) and call centers (concentrated in West and East Lake Cities). The restrictions on activities and global slowdown in economic activity caused negative economic growth in 2020 (GDP growth was a negative 2.5 %) and only slightly positive growth in 2021 (plus 0.8%). Economic growth is projected to be moderate in 2022 (plus 2.1%).[1] This situation is expected to result in stagnation of per capita income and government revenues in the near term.

[1] All economic growth figures from Jasmania's Ministry of Finance

Governance

The most significant change in health sector governance since 2020-2022 has been the separation of the monitoring and evaluation of HIV, TB, and other health interventions from a function of the Ministry of Health (MOH) to a quasi-independent agency of the MOH called the Jasmania Epidemiology Bureau (JEB). JEB analyses routine data from the JHIMS, producing and posting the following on the JHIMS website (www.JHMIS.jas.gov): constantly updated information; conducts and contracts for periodic evaluations of health initiatives; and conducts or contracts for special studies. Notably concerning HIV and TB, the JEB coordinates the registration of people with HIV and TB on treatment (including data on viral suppression and other key markers) and commissions regular Integrated HIV Behavioral and Serologic Surveillance studies. The JNHAC continues to facilitate and coordinate Jasmania's national response to HIV/AIDS. The JNTP implements and coordinates the national response to tuberculosis. Both programs have made notable progress (see below) but have much yet to do to attain their ultimate objectives. We anticipate making additional progress on key challenges with the assistance of the Global Fund.

Implementation

The pyramidal system of government and private providers and community-based organizations (led by key and vulnerable populations) described in 2020-2022 continues to implement HIV and TB services (please refer to the Implementation Arrangements Map for more details).

With the help of PEPFAR, Jasmania has increased the number of HIV testing centers (currently 606 versus 544 in 2020-2022). The additional centers have improved access to testing by an estimated 9%. While the first 544 centers were sited in well-targeted areas, the additional ones are reaching secondary sites that include populations that have been underserved. See the epidemiology section below for data on changes in coverage.

The number of government TB TTCs remains the same, but each TTC now has at least one rapid molecular diagnostic technologies machine due to the COVID-19 response, where they were used for bidirectional screening (see below). PEPFAR also assisted with enhanced collaboration with the for- and not-for-profit private sector concerning TB testing. With the PEPFAR support, there are 13 additional private TB testing sites (from three that were in place in the previous submission) five of which have rapid molecular diagnostic technologies machines. The private TB testing sites are expected to increase access by 5%.

In-patient and out-patient HIV services are provided by 78 treatment hubs and primary care facilities (up from 72 in the previous funding request). This has increased access by 7%. A network of 214 community-based organizations operated APs provide prevention services in high-risk HIV areas. POWs assist key populations with information and promote prevention and testing. Both APs and POWs receive government funding. The APs, POWs, and CHWs (see below) are components of Jasmania's community-led and community-based approach.

Integrated HIV and TB services have been introduced since 2020-2022 in 19 of the 78 HIV treatment hubs that previously provided exclusively HIV services. This represents a 100% increase in access to integrated HIV and TB services. In addition, 13 of these treatment hubs and primary care facilities (up from 10 previously) provide integrated SRH services. CHWs continue to provide outreach HIV and TB services in rural communities. See below for plans to expand CHW coverage.

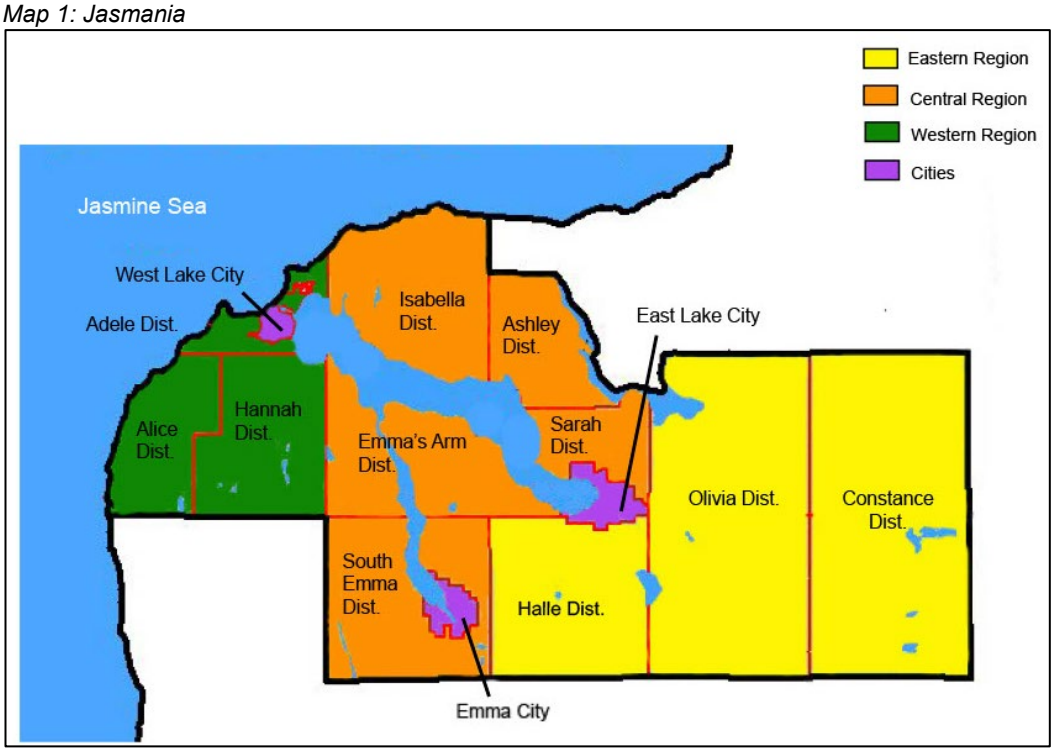
The combination of increased HIV testing centers, availability of rapid molecular diagnostic machines, increased treatment hubs and primary care facilities, and integrated HIV and TB services is making incremental, but important, progress in access and service coverage that is expected to be seen in future access and coverage data.

HIV Epidemiology

Jasmania has a slowly growing HIV epidemic with 2% increase in new adult HIV infections in 2022 (3,954 new HIV infections in 2022), and a slightly higher increase in HIV infections among children and young people. The estimated number of people (of all genders) living with HIV was 278,000 in 2022 with a 2% prevalence among adults. There were 70,500 men who have sex with men and 48,750 sex workers (of all genders) in 2021, according to the latest estimates. Other key population size estimates will be established under this allocation. Jasmania's HIV epidemic continues to be largely concentrated among key

populations, namely men who have sex with men, trans and gender diverse people, people who use drugs, and sex workers. The key and vulnerable populations are concentrated in Jasmania's three cities: West Lake (capital), East Lake and Emma Cities (see Map 1). West Lake City is in the Eastern Region, East Lake and Emma Cities are in the Central Region. The Eastern Region has no large cities.

Map 1: Jasmania



The following population figures include multiple overlaps between populations; see the Integrated HIV Behavioral and Serologic Surveillance (IHBSS) (annex 1) for detailed information about the overlaps of sex workers with people who use drugs, men who have sex with men and trans and gender diverse people as well as further disaggregation of vulnerabilities.

Men who have sex with men – Men who have sex with men accounted for 67% of new adult HIV cases in 2020 (2564 new cases in 2020). The population size estimate for this and other populations has been developed and overseen by JEB, and the detailed analysis is provided in annex 2. According to the 2021 IHBSS, 60% of men who have sex with men engaged in anal sex in the past 12 months, with higher rates reported by men who have sex with men who are also selling sex, and lowest rates among men who have sex with men under 25. Knowledge concerning prevention and preventive behaviors remains low. 32% had comprehensive knowledge of HIV prevention and transmission, 38% used condoms during last anal sex, and only 29% had been tested in the past 12 months and knew their HIV status. Higher rates of knowledge and prevention behavior were found among men who have sex with men under 25 and lowest rates were among men who have sex with men married to women. 52% had no access to condoms and lubricants, either free or purchased, with lowest access seen among those over 40 and among all men who have sex with men with lowest socio-economic status (in the bottom two income quintiles). A pilot PrEP effort was conducted in Emma City at two APs in neighborhoods known for men who have sex with man populations.

Trans and gender diverse people – Trans and gender diverse people accounted for 9% of new HIV cases in 2020 (325 new cases in 2020). The 2021 IHBSS showed that 58% of trans and gender diverse people engaged in anal sex in the past 12 months; 88% of the 204 trans and gender diverse people who sell sex, and 74% of trans and gender diverse people who use drugs reported engaging in anal sex. 12% had comprehensive knowledge of HIV prevention and transmission, 26% used a condom during last anal sex, and 13% had been tested in the last 12 months and knew their HIV status. 78% had no access to condoms, whether free of charge or purchased.

People who use drugs – New HIV cases among people who use drugs are less than 6% of total cases (estimated 225 cases in 2022) and are concentrated in East Lake City (62% of people who use drugs

cases, estimated 140 new cases in 2022) and Emma City (38% of cases, estimated 86 new cases in 2022). 80% of people who use drugs are male, 12% are women and 8% are trans and gender diverse people. Jasmania's programs to provide sterile needles and syringes and opioid substitution therapy (OST) is in its infancy. The rate of supply of sterile needles and syringes is 200 per person who uses drug per year. The OST rate is 5 per 100 person who uses drug per year.

Sex workers – Sex workers make up 17% of new HIV cases (estimated 676 new cases in 2022). 61% of sex workers with HIV are female (estimated 412 new cases in 2022) and 39% of new cases are among male and trans and gender diverse people sex workers (estimated 60 men and 204 trans and gender diverse people living with HIV in 2022). Condom use is relatively high for female sex workers (83%), but only 31% among male and trans and gender diverse people sex workers.

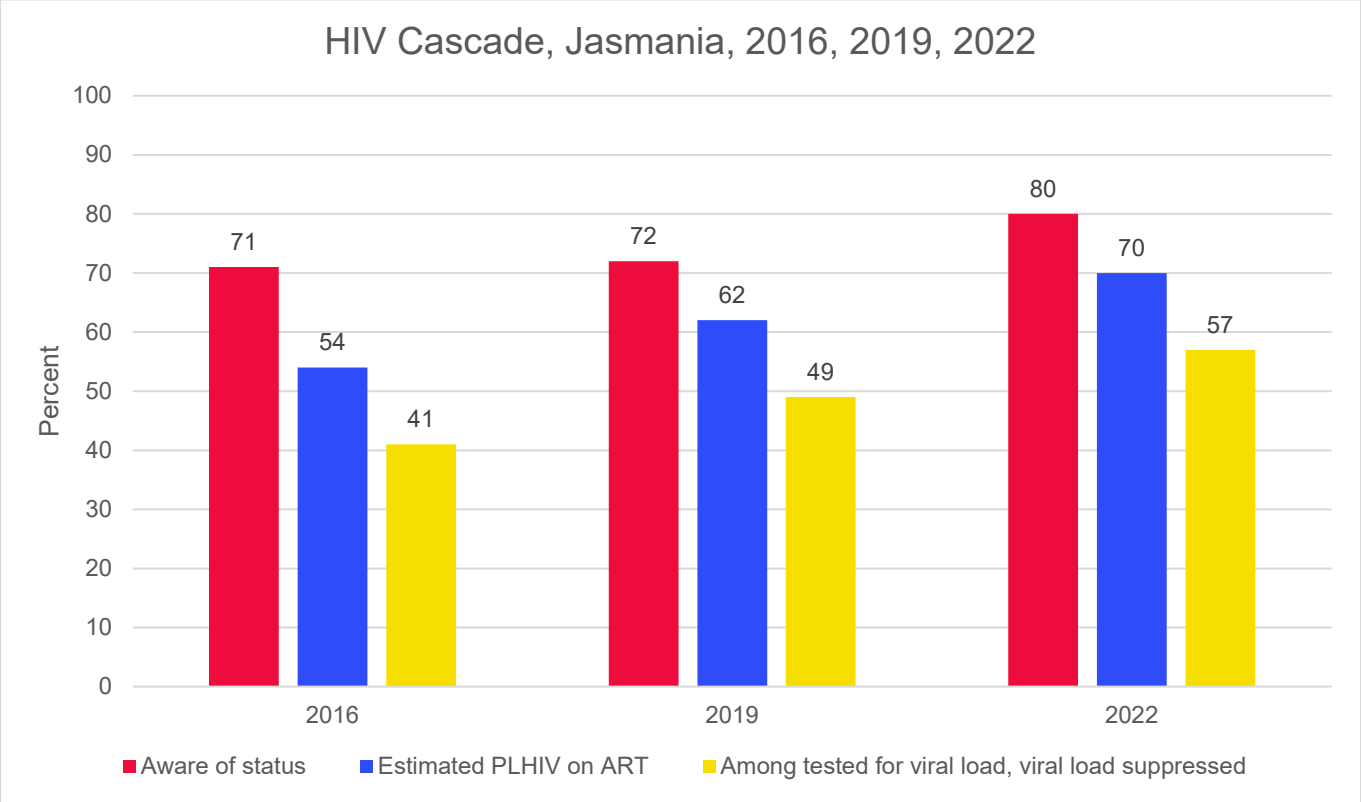
Partners of sex workers – Regular sexual partners of sex workers make up 9% of new HIV cases (estimated 338 cases in 2022) The majority of these partners (86%) are male.

Prisoners – 8% of prisoners have tested HIV positive, a total of 2,215 prisoners currently living with HIV. Estimated new cases of HIV among prisoners in 2022 numbered 66: 54 male prisoners, 6 trans and gender diverse people and 6 female prisoners.

Additional cases – An additional 4% of adult HIV cases have been noted, the majority among men, and the JEB will take steps to analyze further information about this estimated 146 cases in 2022.

15 boys and 27 girls under 18 are estimated to have HIV, with an increase of 4% since 2020, likely from the weak PMTCT cascade and from young people in key populations acquiring HIV in adolescence.

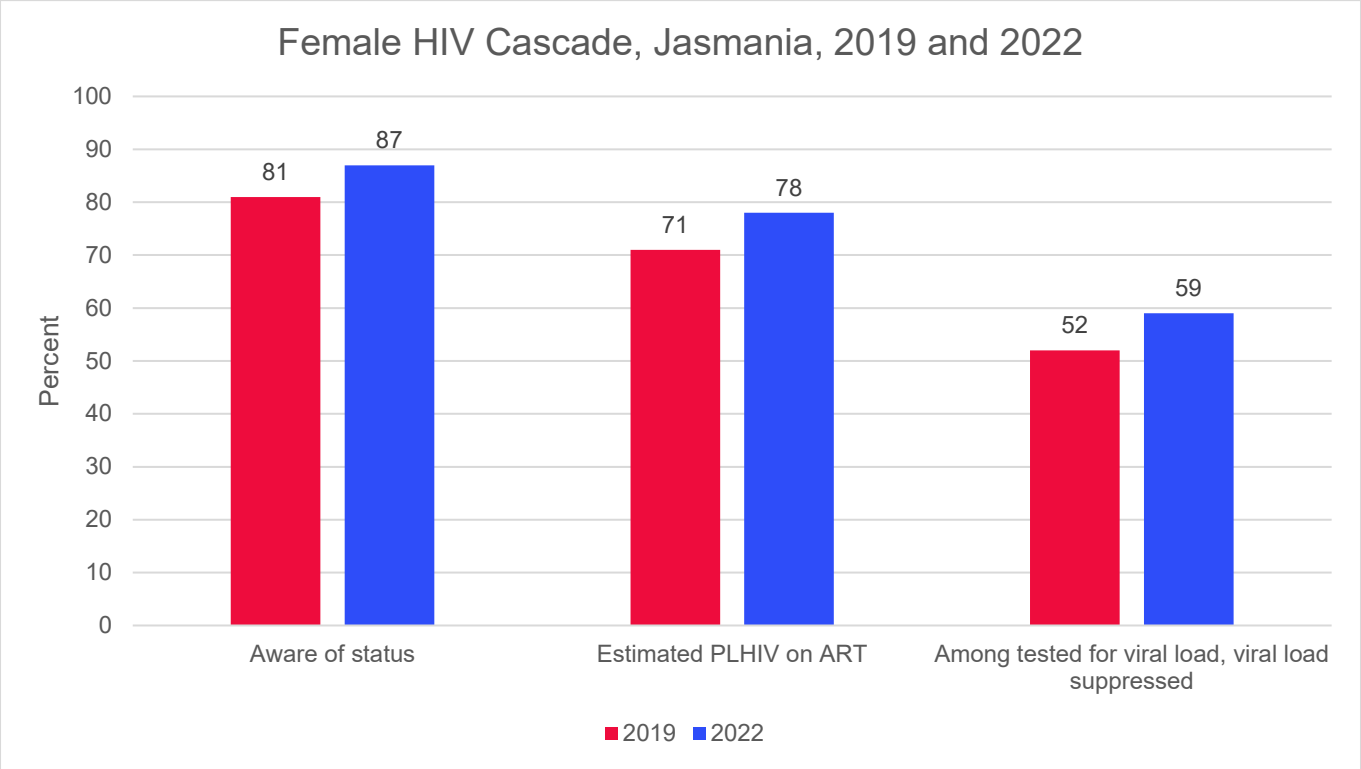
Figure 1: HIV Cascade



Source: Jasmania National AIDS Committee survival rate survey report, 2022

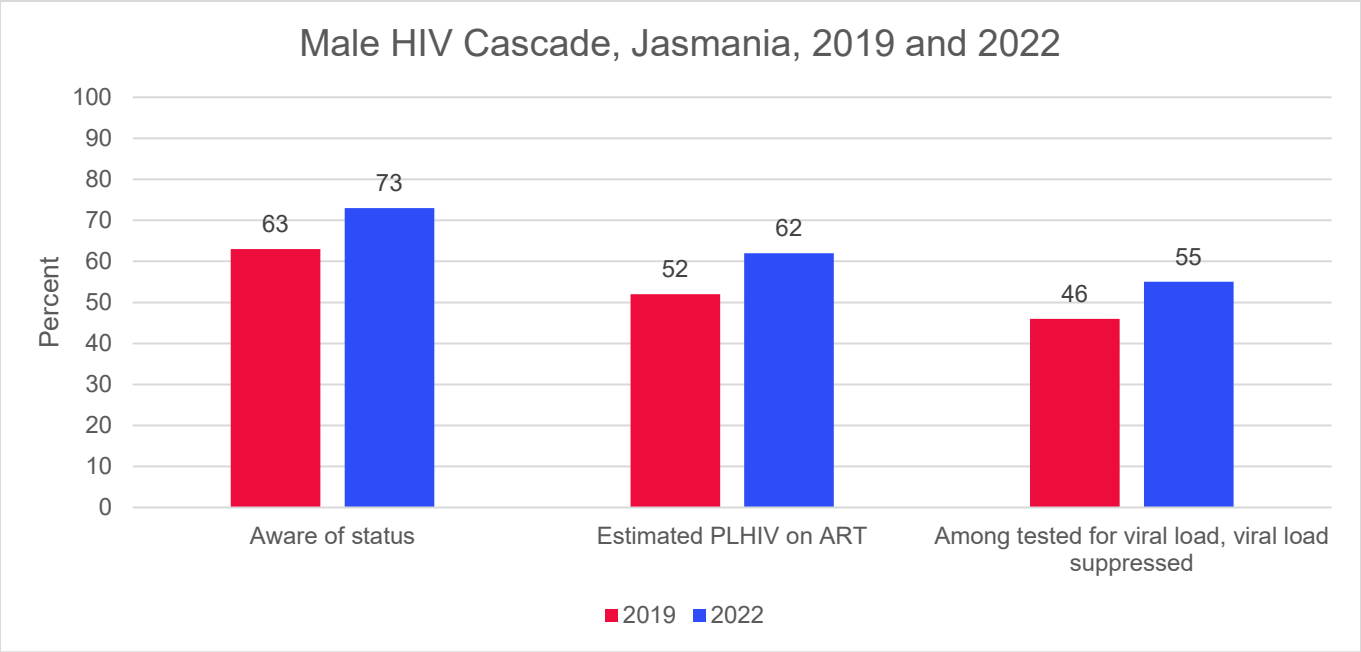
Figure 1 shows Jasmania's HIV diagnosis and care cascade since 2016. We have made progress in the three dimensions (greater than 11% improvement in all between 2019 and 2022) but we remain far from the 95-95-95 target. Jasmania continues to apply the test and treat approach. Figures 2, 3, and 4 break out the HIV cascades for females, males, and trans and gender diverse people comparing 2019 and 2022. Figure 5 puts all three groups' cascades for 2022 into one graphic. Figure 5 highlights that females are more likely to be aware of their status, be on ART, and have their viral loads suppressed than males and that trans and gender diverse people are far behind both females and males.

Figure 2: Female HIV Cascade 2019 and 2022



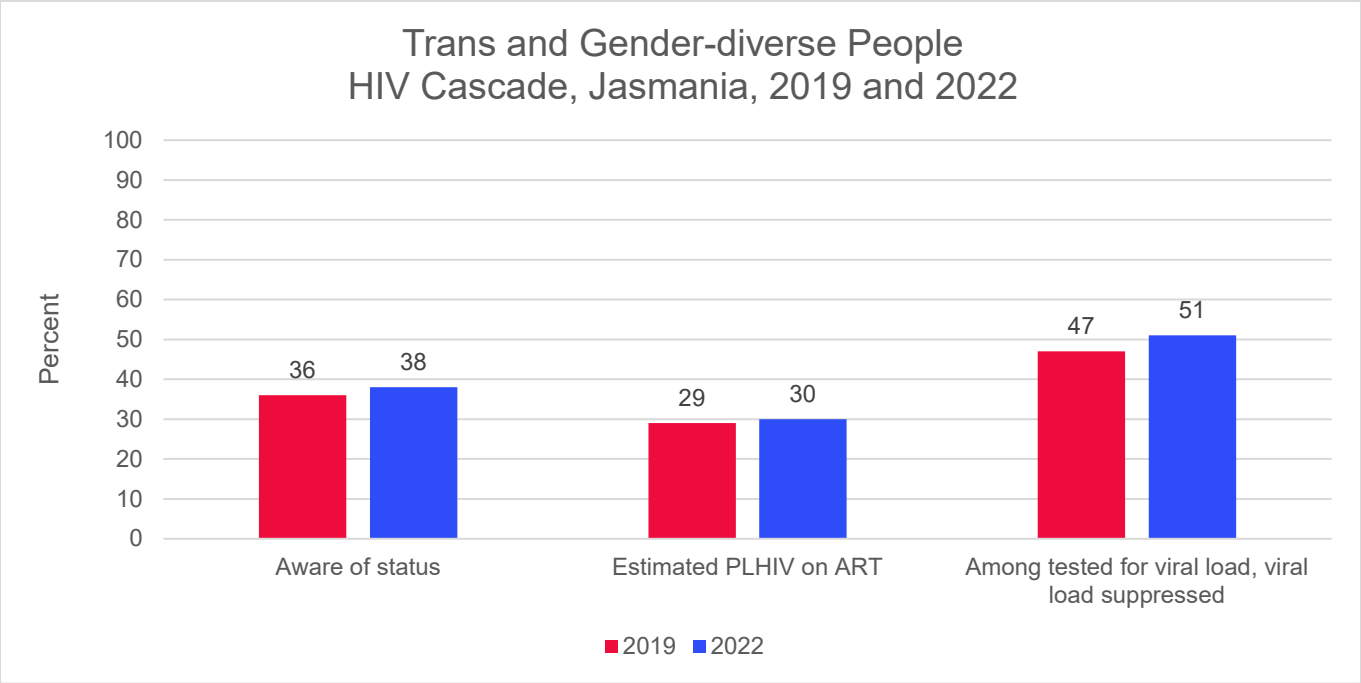
Source: Jasmania National AIDS Committee survival rate survey report, 2022

Figure 3: Male HIV Cascade 2019 and 2022



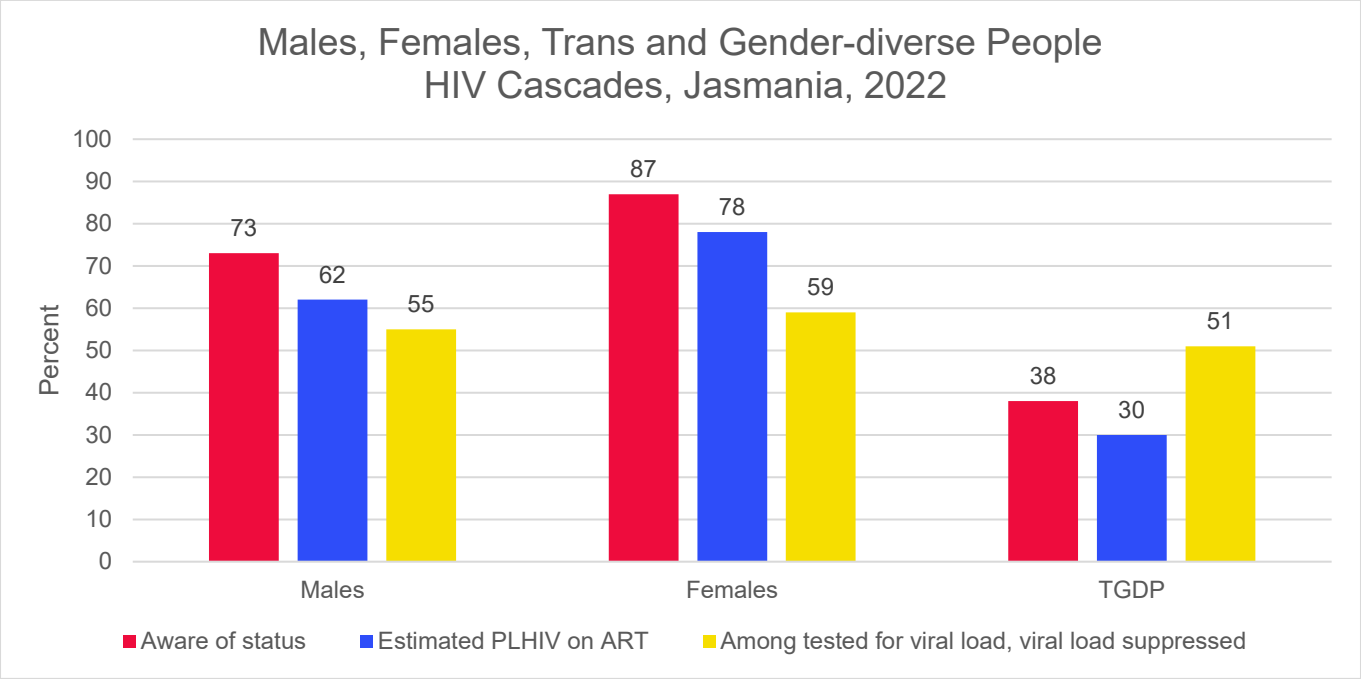
Source: Jasmania National AIDS Committee survival rate survey report, 2022

Figure 4: Trans and gender-diverse people HIV Cascade 2019 and 2022



Source: Jasmania National AIDS Committee survival rate survey report, 2022

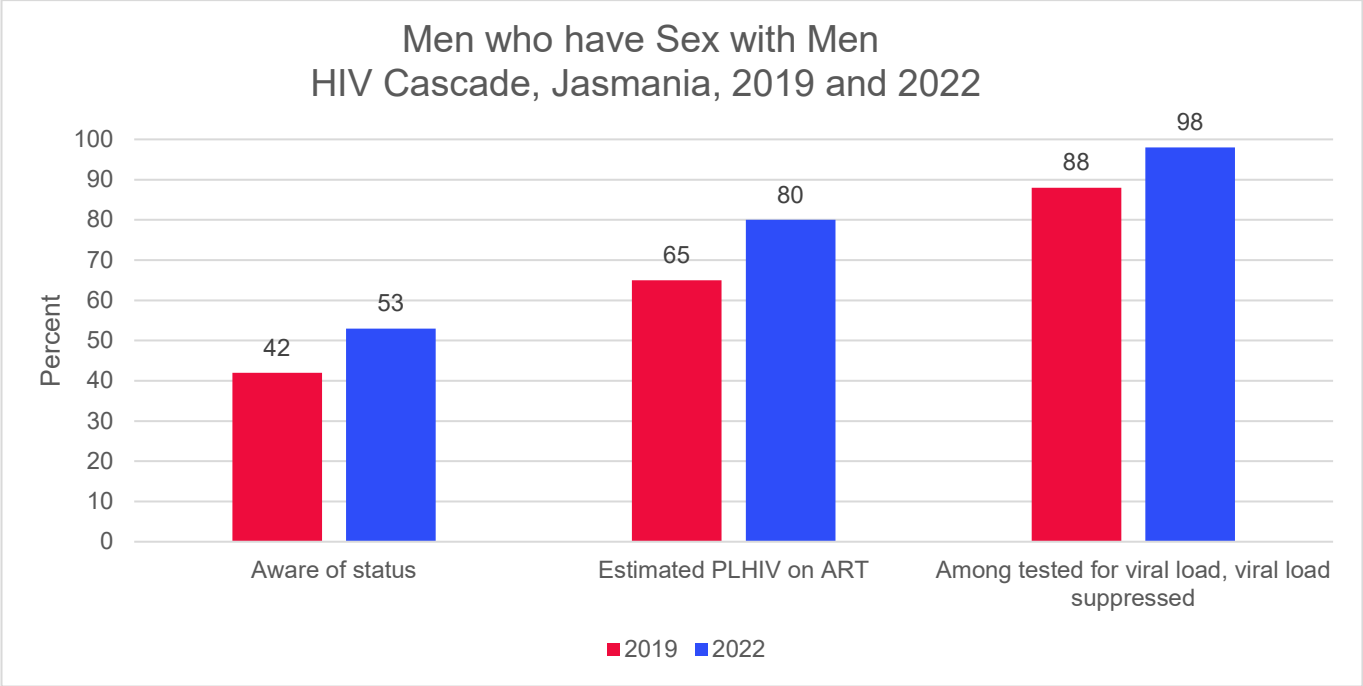
Figure 5: Comparison of cascades across groups for 2022



Source: Jasmania National AIDS Committee survival rate survey report, 2022

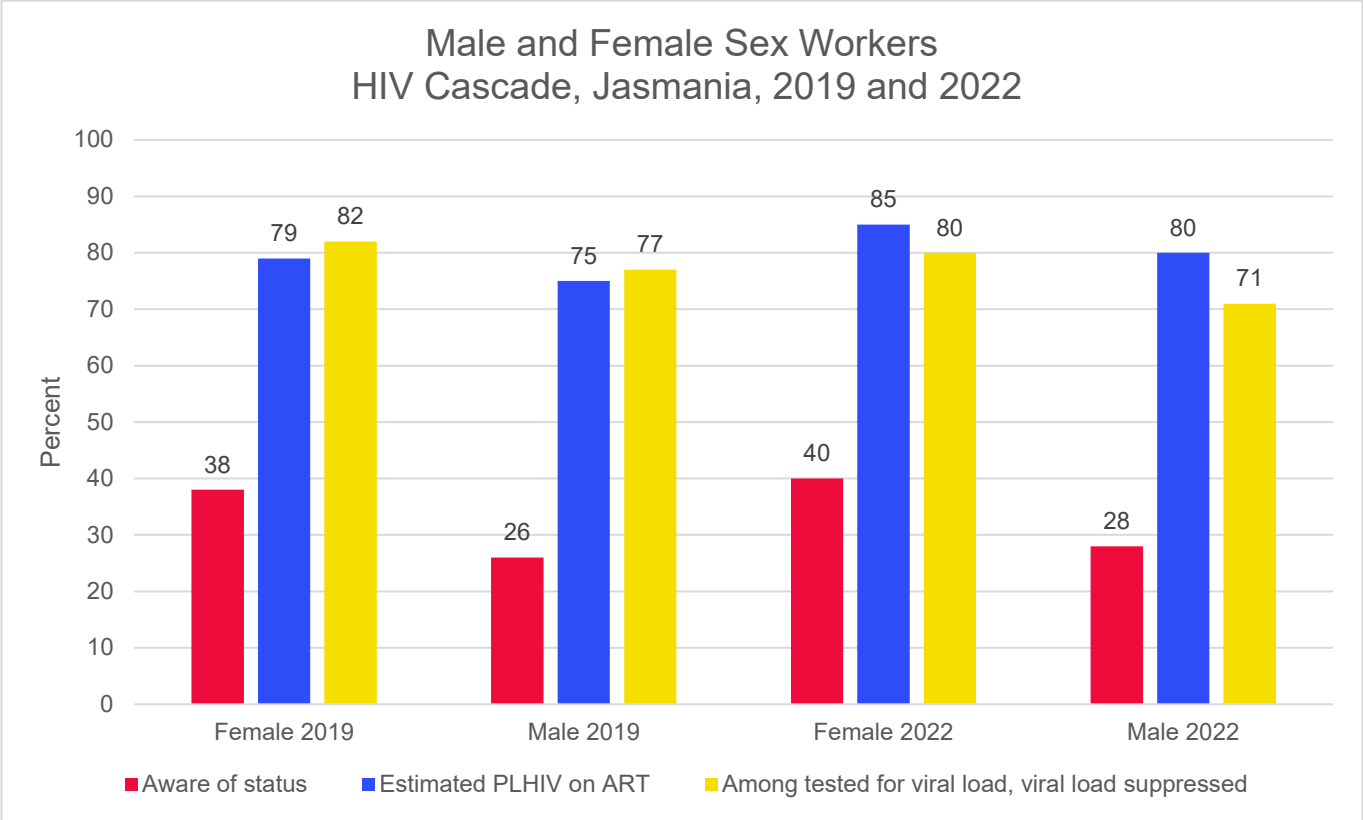
Figures 6 and 7 show the HIV cascade disaggregated for man who have sex with men and sex workers for 2019 and 2022. Both indicate that efforts to reach key populations with testing (followed by treatment) are falling short. Performance is better for putting those testing positive on treatment and for treatment to be successful in suppressing viral load. The issue of reaching sex workers for testing is more acute than it is for men who have sex with men. The breakout of sex workers by sex in Figure 7 shows that testing, treatment, and viral load suppression is better for female sex workers than male sex workers. A breakout of trans and gender diverse people sex workers is not available in the Jasmania's Health Information System (JHIS) but is planned to be implemented in 2023. JEB is providing further analysis of the additional factors influencing access to services.

Figure 6: HIV Cascade for men who have sex with men, 2019 and 2022



Source: JHIS, routine data, 2022

Figure 7: HIV Cascade for sex workers, 2019 and 2022

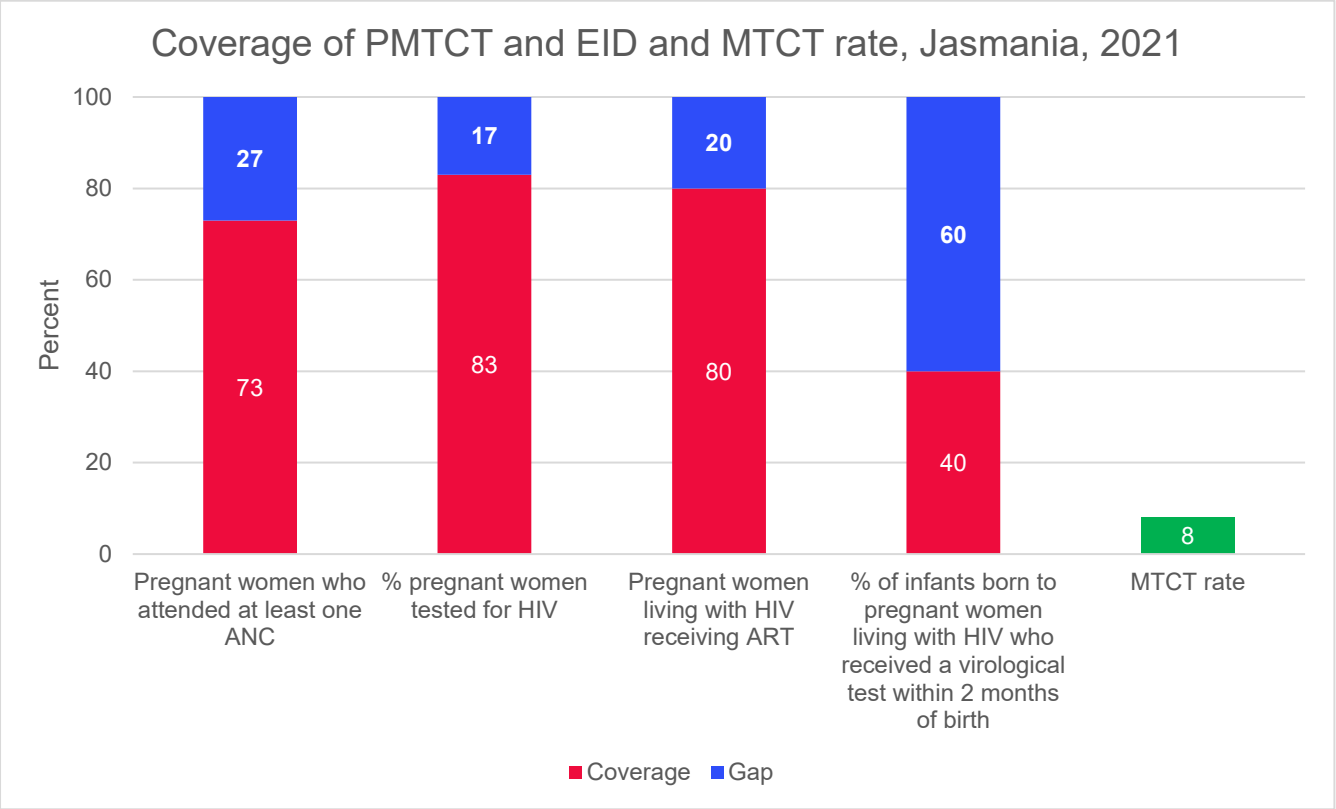


Source: JHIS, routine data, 2022

We are pleased to be able to present the above cascade data with the disaggregation shown. It has taken us time to have this level of disaggregation, allowing us to better understand challenges and target interventions. However, we are aware that additional sub-population cascades, such as for people who use drugs and intersectional sub-populations, would be valuable, but our data do not yet permit us to create them. Wherever possible we will use resources provided through this allocation to enhance the granularity of our analyses in order to target interventions and resources to better effect.

PMTCT of HIV continues to be a challenge for Jasmania (Figure 8). Attendance of pregnant women at least one antenatal care (ANC) session is below desired levels (73%). Early infant diagnosis (EID) via virological test within two months of birth also is below desired levels (40%).

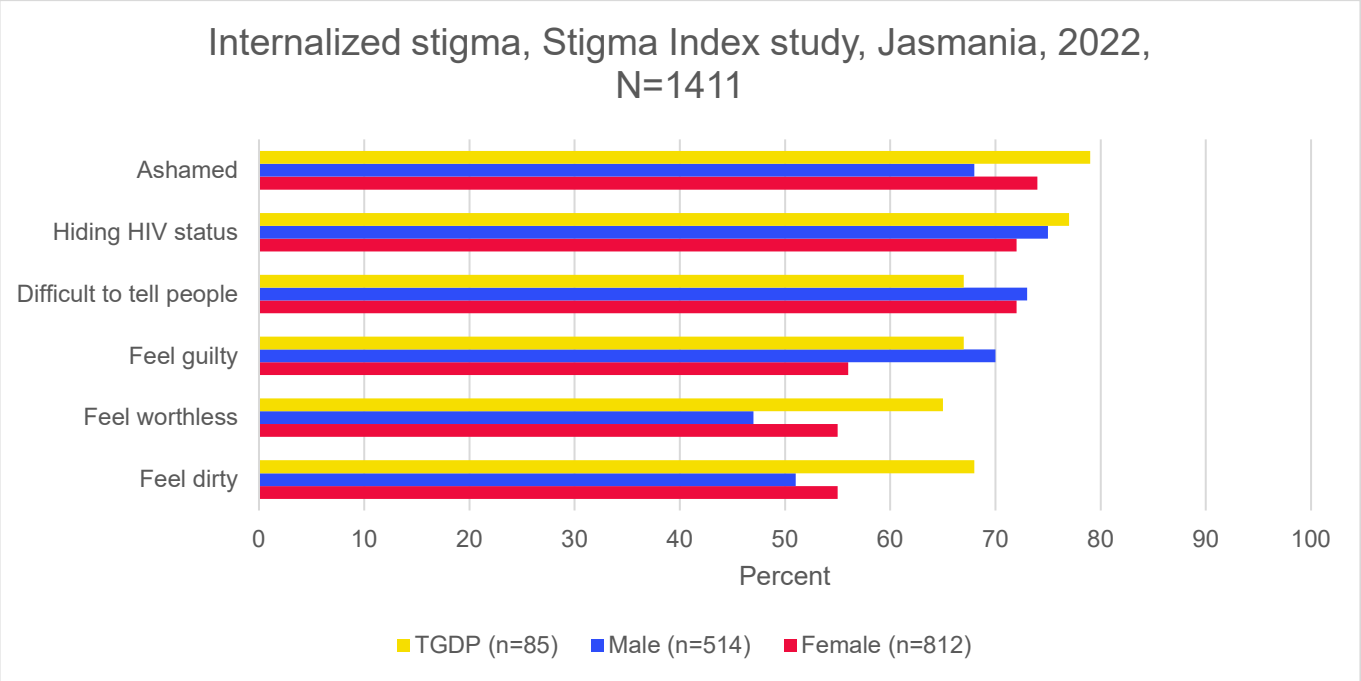
Figure 8: PMTCT, EID, and MTCT, 2022



Sources: PMTCT and EID data from Jasmania Demographic and Health Survey, 2021; MTCT rate UNAIDS estimate.

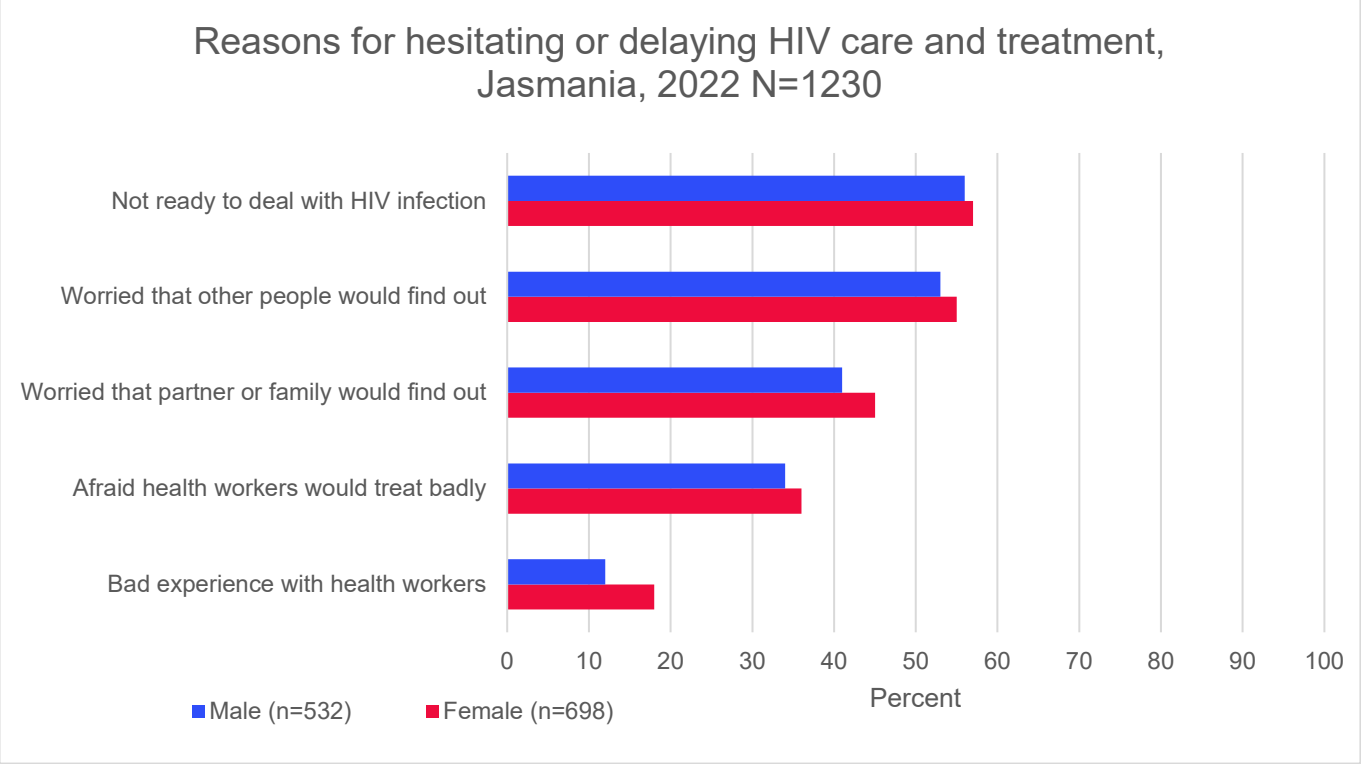
A national HIV Stigma Index study was conducted in 2022. Figures 9 and 10 from the Stigma Index studies show significant gaps in addressing stigma issues, with little reduction compared to the first Stigma Index undertaken in 2017 (see annexes 3 and 4). Internalized stigma (Figure 9) measures the expectation of discrimination that is likely to prevent Jasmanians from talking about their experiences and may prevent them from seeking help concerning HIV. Figure 10 indicates that the fear of receiving poor care is not matched by experiences, although these still remain unacceptably high, at nearly 20% for women with HIV.

Figure 9: Internalized stigma



Source: Stigma index study, Jasmania, 2022.

Figure 10: Reasons for hesitating or delaying HIV care and treatment

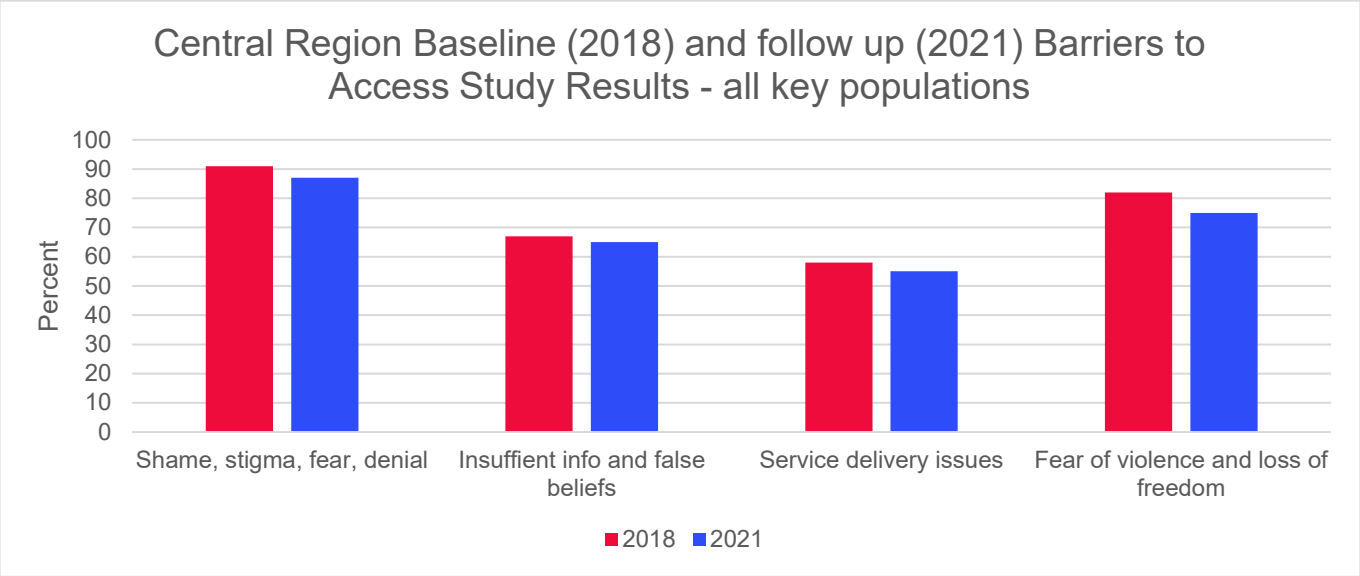


Source: Stigma index study, Jasmania, 2022.

A Barriers to Access study conducted in the Central Region in 2021 found that only slight progress has been made in reducing the barriers to testing and treatment for HIV among key populations (Figure 11). The 2021 Barriers study found small improvements from a baseline Barriers study in the Central Region in 2018 (see annexes 5 and 6) but large gaps remain in measures of 1) shame, internal stigma, fear, and denial; 2) insufficient information and false beliefs about the benefits of knowing HIV status and accessing treatment; 3) service delivery problems including location, timing, confidentiality, quality, and discriminatory treatment; 4) fear of violence and loss of freedom if identified as a key population; and 5) criminalization

of their behavior and HIV transmission and exposure in Penal Code and active application of law by the police.

Figure 11: Barriers to access in the Central Region 2018 and 2021

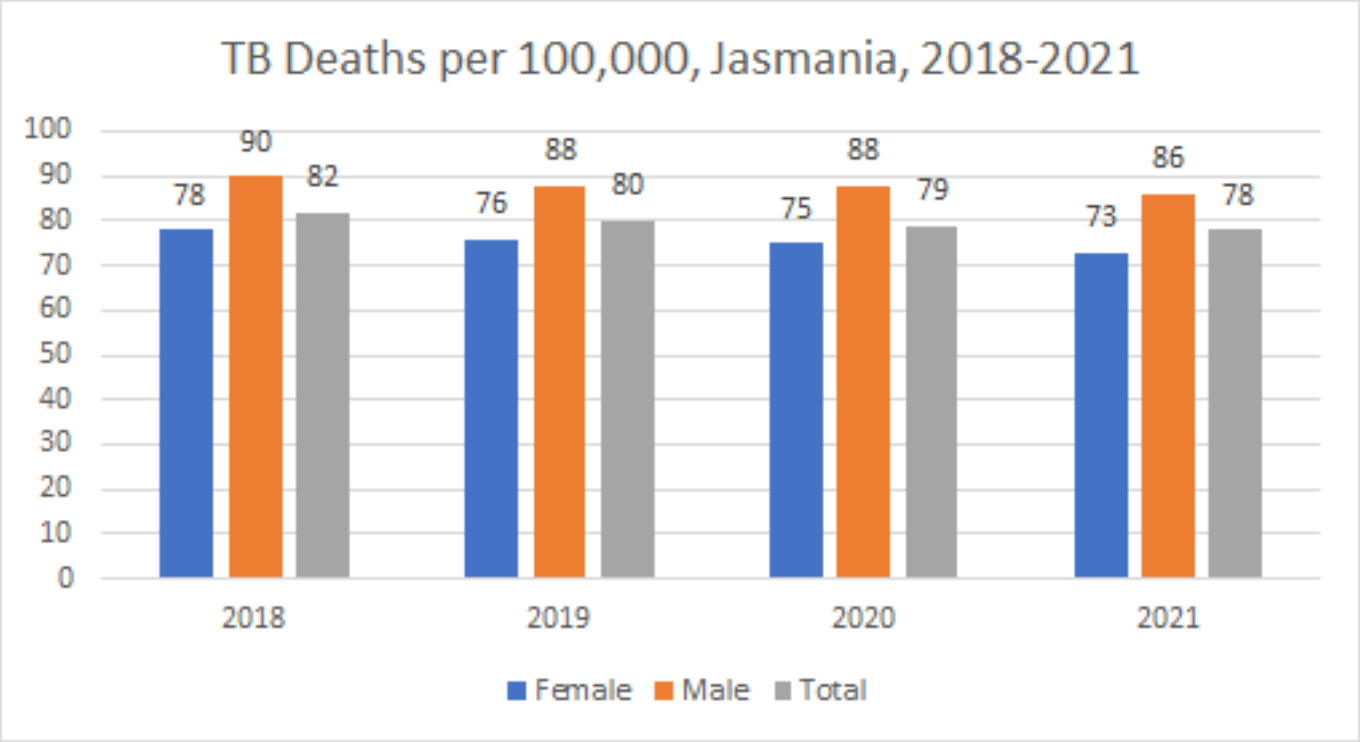


Source: Barriers to Access Study, Jasmania, 2021

TB epidemiology

TB-related mortality (all forms, excluding people living with HIV) decreased from 82 (48–125) deaths per 100,000 in 2018 to 78 (46–120) per 100,000 in 2021 (see Figure 12). TB-related deaths have been stable since 2018. TB-related mortality (all forms) among PLHIV has been on a downward trend since 2018. It was estimated at 1.4 (0.92–2.1) deaths per 100,000 inhabitants and giving an estimated total of 380 (240–540) deaths. Mortality among new and relapse cases was estimated at 4.1% in the 2020 cohort.

Figure 12: TB Mortality 2018-2021

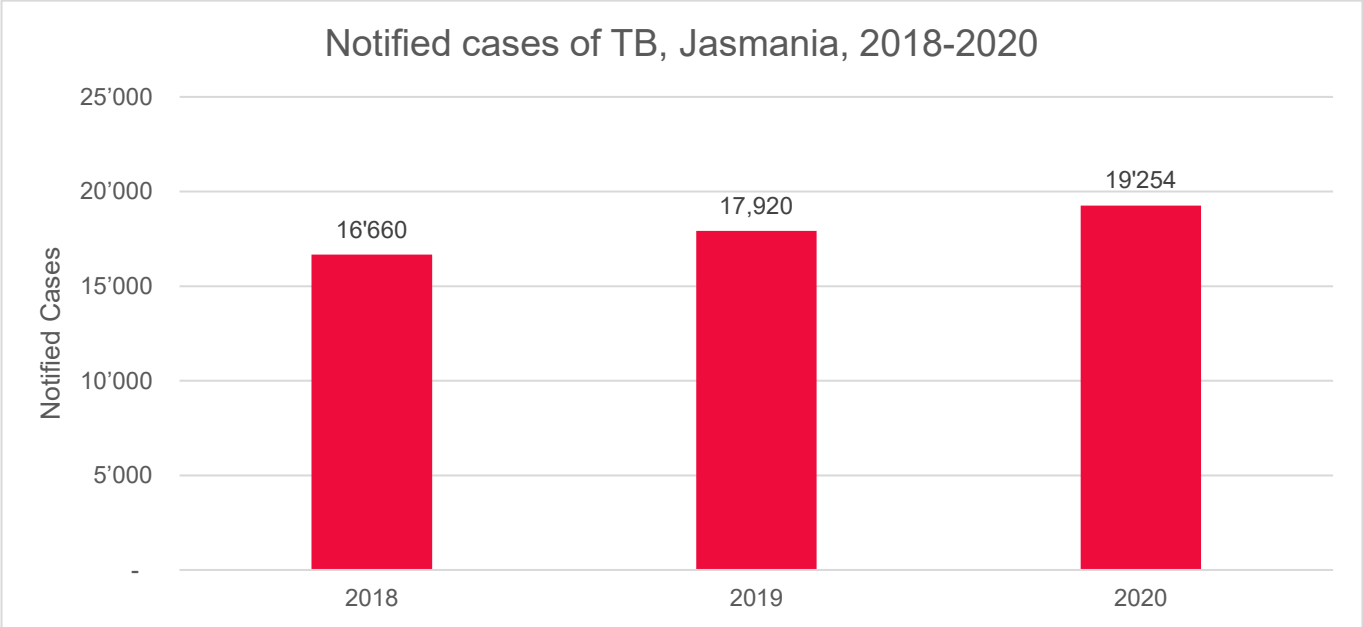


Source: JHIS, routine data, 2022

According to WHO estimates, the incidence of TB in Jasmania has remained stable at 233 cases per 100,000 inhabitants 2018-2020. In 2020, the National Tuberculosis Control Program (NTCP) notified a

15.6% increase in new cases between 2018 and 2020 (see Figure 13). According to WHO, TB treatment coverage (notified/estimated incidence) was only 55% (39–85) in 2020.

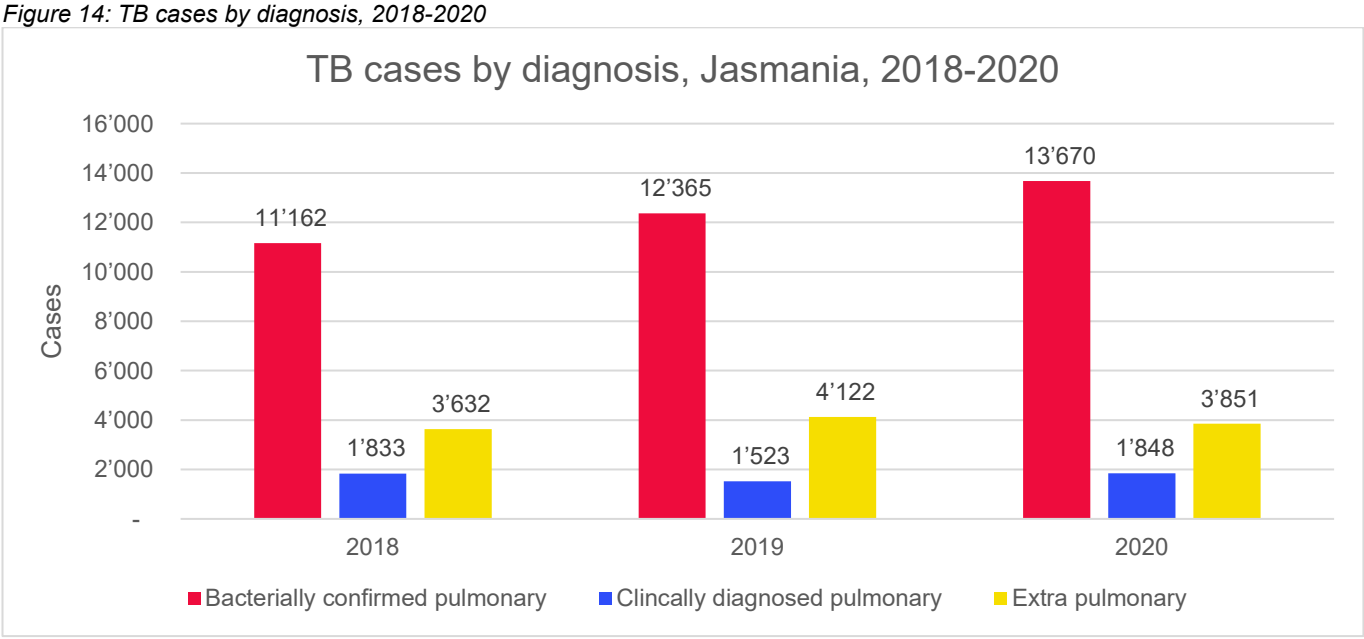
Figure 13: Notified TB cases 2018-2020



Source: JNTP

PTB+ and clinically diagnosed pulmonary forms PTB- accounted for an average of 68.8% and 9.6% of cases, respectively, 2018-2020. Extrapulmonary forms accounted for an average of 21.5% over the same period (see Figure 14).

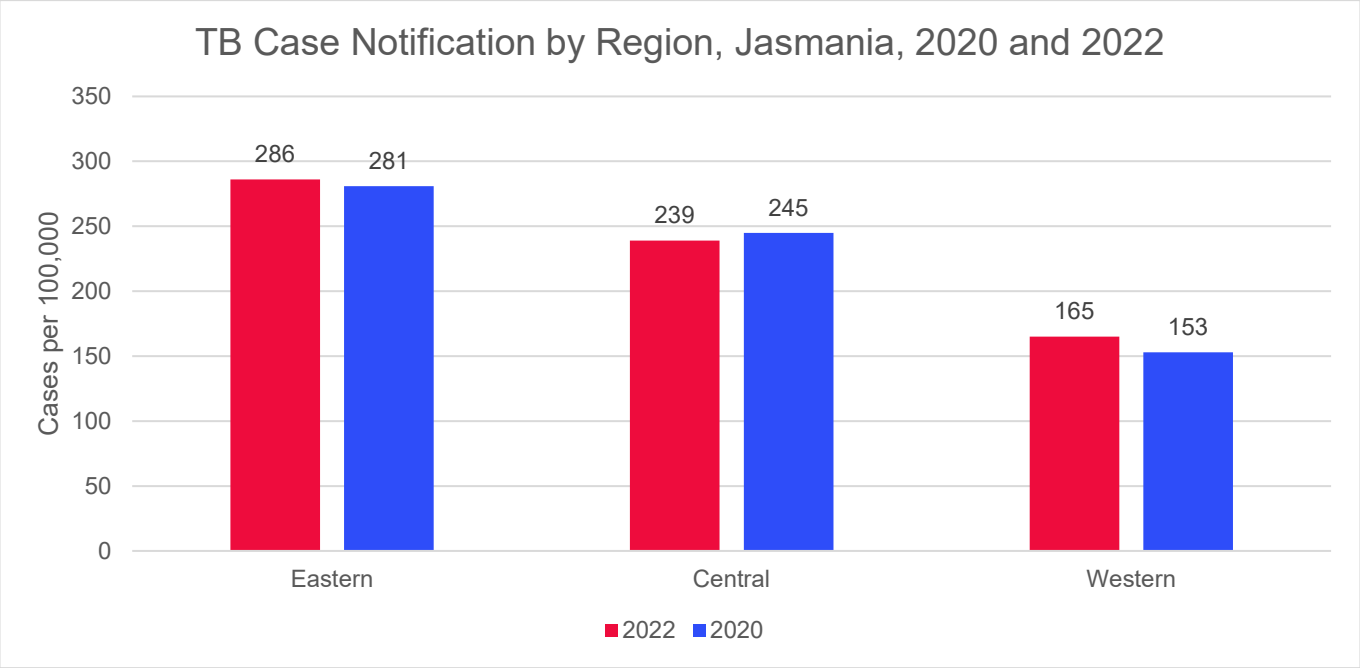
Figure 14: TB cases by diagnosis, 2018-2020



Source: JNTP

There were significant regional differences in the TB case notification rate in 2022 (see Figure 15). The sparsely populated Eastern Region notified 286 cases per 100,000 inhabitants, accounting for 30% of all cases. The Central Region notified between 239 cases per 100,000 inhabitants (35% of cases). The Western Region (where the capital West Lake City is located) had a notification rate of 165 cases per 100,000 inhabitants, accounting for 35% of cases. It is likely that there is an under-notification problem in the Western Region (case notification rate in West Lake City of 185/100,000).

Figure 15: TB case notification rates by region



Source: JHIS, routine data, 2022

The high notification rates observed in the rural Eastern Region may be linked to the fact that this region is a priority area and has seen greater health-related investment (annex 7). The Eastern Region also is an area of lower income levels and high levels of malnutrition.

The male/female sex ratio continues to be 1.5 in 2020 (it has fluctuated between 1.5 and 1.6 since 2015). Most TB cases also continue to occur in the 25–34 years age group (54% in 2018 and 58% in 2020). Cases diagnosed in children under aged 15 years accounted for 6.9% of cases in 2020, a decrease from 8.3% in 2018.

Notification of multidrug- and rifampicin-resistant TB (MDR/RR-TB)

MDR-TB prevalence was estimated by WHO[2] in 2020 at 0.49% (0.09–1.2%) among new cases and 5.9% (0.59–17%) among re-treatment cases. The estimated number of MDR/RR-TB cases in 2020 compared with cases detected was 5.1% screening coverage. This coverage is highly inadequate.

Between 2018 and 2020 of the 67 men and 30 women found to have MDR/RR TB, only 30 men and 18 women started treatment on the 18-month long regimen: 6 Km-Lfx-Eto-Cs-Z / 12 Lfx-Eto-Cs-Z. 6 died before starting treatment, 31 abandoned treatment early (including 16 of the 18 women) and 12 refused treatment. No cases of extensively drug-resistant (XDR) TB have been detected by the program to date.

HIV/TB Co-infection

HIV and TB overlap substantially in Jasmania (Figure 16). 52% of Jasmanians with TB are also estimated to have HIV.

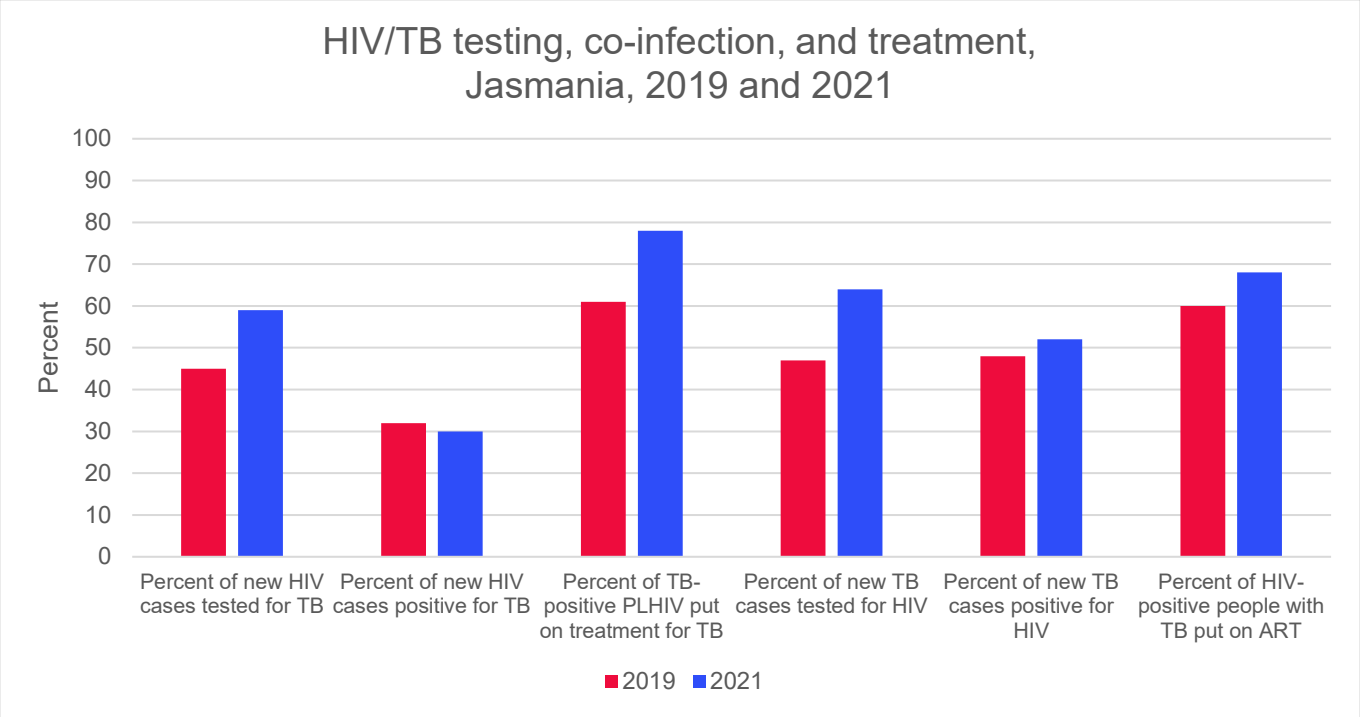
59% of people with HIV were screened for TB in 2021, compared to 45% in 2019; of these 30% (42% of women and 17% of men) were found to be infected. 78% of people living with HIV found to have TB in 2021 were put on TPT.

In 2021, 64% of people with TB were screened for HIV (compared with 47% in 2019) with a positivity rate of 58%. Of the people with TB found to be HIV-positive, 68% were put on ART.

Increasing cross-testing between HIV and TB, and follow up treatment, is a high priority for Jasmania and is a focus of this funding request.

Figure 16: HIV/TB testing and co-infection

[2] WHO, Global Health Observatory, https://www.who.int/data/gho.



Source: JHIS, routine data, 2021

Treatment success rate

The treatment success rate for new and relapse cases of TB was 84% in 2020, below the 90% target. This figure has been relatively static since 2015. One of the main challenges is the loss to follow-up rate, which has been over 8% since 2015. The loss to follow-up rate is high (12%) in the Central Region.

Among people with MDR/RR-TB, the treatment success rate was 60 %in the 2018 cohort; 27% of people died, and 13% were lost to follow-up (the majority female). Causes of loss to follow-up and death relate to the long distances that must be traveled between testing and treatment centers for case detection and the limited number of treatment sites, leading to long delays to treatment initiation, early abandonment, and treatment refusal, in particular from people with caring responsibilities, including mothers who were not willing to leave their families to seek treatment.

Key and vulnerable populations

The key and vulnerable populations identified by the NTCP are, in order of priority: people living with HIV; people working in mining companies and surrounding communities; household contacts; children, including those that are malnourished; people in prisons; and people with diabetes. The situation of people living with HIV concerning TB is explained in the HIV/TB co-infection section above. People working in mining companies (and in related communities) have not been assessed for TB, but the conditions of work in the mines would indicate that TB could be a significant problem. It is a blind spot for us. Jasmania offers TPT to household contacts of people with TB, but uptake has been low at less than 20%. We are aware that malnourished children in TB households are vulnerable, but we have yet to systematically assess this situation, though where malnourished children are concentrated geographically (Eastern Region and disadvantaged neighborhoods of the three cities) is known. People with diabetes are older and concentrated in cities with little specific information about their TB status available and little action is taken to address it.

In 2020, the Ministry of Justice counted 27,687 inmates (see annex 8). Only the central prison has a doctor and 12 other detention facilities[3] (out of 16) have infirmaries; 2 of the facilities (both have infirmaries) are for women only and all other detention facilities are for males. Trans and gender diverse people are housed with male inmates. In 2020, 483 cases of TB among inmates were notified and placed on treatment, but routine NTCP data does not allow for their treatment success rate to be analyzed. Belgian Cooperation is financing a prison project in Central Region called Jasmania Improving Prisoner Life (JIPRIL). JIPRIL was

[3] Each of the three major cities has its own jail and each region has a regional prison and satellite prisons.

launched in November 2020 with a 5-year duration. JIPRIL's main activities are: (i) TB and HIV treatment; (ii) capacity building for prison medical staff; (iii) awareness-raising activities on the risk of TB and HIV transmission; and (iv) psychosocial support and assistance with economic reintegration after release from prison. The Ministry of Justice, non-governmental organizations, and the Catholic Prison Chaplaincy implement JIPRIL. The screening, treatment and patient support activities developed by the NTCP will complement and be implemented in synergy with this project.

The prevalence of malnutrition is 44% in the general population and the prevalence of diabetes is 5% among those 20–79 years. Two mining companies (3M Red River in Constance District and QRS Lithium in South Emma District) have nurses, but there is no formal collaboration between the NTCP and these companies.

Inequities and barriers

Jasmania is placed in the second quintile of the Gender Inequality Index, scoring well on reproductive health indicators, reflecting the move to integrate HIV and SRH services. However, empowerment results are weak, and still, only 20% of parliamentarians are women. A Gender Assessment has been undertaken and the findings (see annex 9) have been central to the development of this funding request. The Gender Equity Taskforce is a standing body of the JCC and will monitor the implementation of interventions to address gender inequity, drawing on the perspectives of woman's groups in civil society.

The uneven results from the Stigma Index reflect the delayed progress in training healthcare workers on discriminatory attitudes (further stalled by COVID-19). Religious leaders, especially outside of Jasmania's urban centers, often promote prejudice against key populations. Civil society organizations have been developing advice services to support individuals that experience verbal and physical abuse as well as discrimination at work and in education and housing.

It is certain that stigma experienced by people with TB reduces their access to treatment, and the high rates of drop out from MDR-TB services by women are a concern. TB related stigma was made more challenging by COVID-19 with additional fears of quarantine slowing access to services. However, no systematic analysis of TB stigma has been conducted. The Jasmania Patients' Charter for Tuberculosis Care, developed with help from WHO in 2020 has yet to be widely disseminated.

COVID-19 Impact

The COVID-19 pandemic has affected the Jasmania health system in several ways. First, 238 health workers (87 doctors and 151 nurses, midwives, and technicians) perished from COVID-19 through July 2022, and there has been substantial absenteeism among health workers who acquired COVID and survived, presumably because of persistent symptoms for Long COVID, although no services exist for this. Second, COVID-19 put more attention on health as a concern of government than ever before. Third, the restrictions on activities and requirements for masking and distancing were at first accepted, but then became increasingly unpopular and reduced trust in government and government's health efforts. Many key and vulnerable populations reported additional challenges with COVID measures which restricted access to income for sex workers and substantial fear of quarantine and exclusion was reported by key population-led community organizations. There were also reports of significant increases in gender-based violence and SRHR services reported a significant increased demand. The stop and start of COVID-19 vaccinations (as supplies were limited and unevenly available) and questions about prioritization of who would have access to the limited supplies further eroded population confidence. TB case notifications declined in 2021 and 2022 (though complete data are not yet available). In addition, the number of people seeking testing for HIV reduced in the same period. All the above means that the trust required to work on HIV and TB has been damaged and will take time to rebuild.

The health system made some positive adjustments to COVID-19 that will benefit our efforts going forward. We were able to mobilize POWs and CHWs to disseminate information about COVID-19 and assist both vulnerable populations and the public to take advantage of COVID-19 vaccinations. Though this taxed the energy of the POWs and CHWs, it demonstrated how they could integrate multiple messages and functions in their work. Another positive was the demonstration of the effectiveness of multi-month drug dispensing for ART. This has meant that multi-month dispensing (MMD) now is a standard procedure. The infrastructure and guidance for MMD have been developed by the National Department of Health.

In addition, the restrictions on activities and global slowdown in economic activity caused economic growth to be negative in 2020 (GDP growth was negative 2.5%), be only slightly positive in 2021 (plus 0.8%) and be projected to be moderate in 2022 (plus 2.1%), leaving per capita income and government revenues stagnant at best.

Another aspect of the COVID-19 response was the enhanced collaboration between government and the private sector for COVID-19 vaccinations. Private businesses and private healthcare providers both stepped up. Businesses provided space in buildings and contributed to the costs of messaging for vaccination activities. Private providers eagerly took up training and delivery of vaccinations in their individual practices and clinics. This collaboration could set the stage for additional collaboration in the future.

Jasmania received US$2 million of Global Fund C19RM funds in 2021 and 2022 for commodities (mostly PPE, C19RM 2020) and to strengthen the community health worker program to hold back slippage in HIV and TB case identification, prevention, and treatment success (C19RM 2021). Extension of C19RM grant implementation and deployment of more resources under C19RM GC7 towards surveillance, supply chain management and community health worker program present an opportunity to complement RSSH critical areas which have been prioritized in this funding request (see Modules 6-8).

At least one dose of COVID-19 vaccine has been delivered to 37.8% of the adult population in Jasmania (43.6% of women and 24.5% of men; data is not available for trans and gender diverse people) and 27.9% of the population received more than one dose (31.6% of women; 23.9% of men). The COVID-19 vaccinations have targeted the elderly (62 % of men over 60, and 58% of women over 60 have received at least one dose), immunocompromised (58% have received at least one dose), and health workers (78% - 84% of men and 71% of women - have received at least one dose).

We have not systematically analyzed the impact of COVID-19 on workforce participation, nor the impact of Long COVID. Increasing rates of absenteeism, and critical health workforce gaps, have made this a priority area for future study and monitoring.

Health financing

All elements of health financing in Jasmania continue to be guided by the Health Financing and Sustainability Strategy (HFSS) of 2019.

This section provides updates on the health financing situation since the previous request for funding.

The GOJ allocated 5.7 %of general government spending to health in 2022, in line with past years (between 5.5% and 6.0% in the period 2018-2021), but well below the target of 7.5% set in the HFSS for 2028. In addition to domestic resources allocated to health, households contribute 40% of current health spending (see below), and external financial partners contributed 12% of current health spending in 2021. External partner spending contributes to HIV and TB efforts, and is mostly concentrated on sexual and reproductive health, immunizations, and technical assistance on health systems issues (see more details on specific external support for HIV and TB below in the section on challenges to sustainability).

The stagnation of general government revenues since COVID-19 means that the health sector cannot expect greater government allocations in the next few years. However, the attention that health gained because of the negative impacts of COVID-19 on the economy could be an opportunity to obtain a greater commitment to health over the longer term. The GOJ was able to meet the co-financing requirements of its Global Fund support for 2020 and 2021, but it took a lot of effort to work with the Ministry of Finance to ensure it and this resulted in postponing work on the new hospital planned for Jasmania’s Eastern Region. This postponement means that the populations in that region still must travel long distances for referral care but GOJ financial support for HIV and TB met obligations. The Ministry of Labor and Work suspended until 2024 its effort to develop a social health protection system to provide health coverage to workers in the informal sector and their dependents.

The 2019 Jasmania National Living Standards (JNLS) survey results available since the last funding request found that only one in three Jasmanians use health care services annually (annex 10). Out-of-pocket health expenditure is high (40%) and nearly 23 percent of patients forego treatment for financial reasons. Households contribute 40% of current health spending (annex 11). Jasmania’s large rural

population uses health care when their harvests permit, resulting in use that varies by season, unrelated to need.

1.4 Lessons Learned

Already operationalized

Targeted TB screening of people in prisons. The annual chest radiography screening of prisoners in Jasmania's central prison and four additional prisons since 2019 resulted in much higher case finding (cases per 1000 prisoners) than in the prisons relying on passive case finding. Annual screening of prisoners in Jasmania's additional 12 prisons began in 2022 and continues in the central prison and in the four prisons included in the initial screening program.

Use of rapid molecular diagnostic technologies machines for MDR-TB diagnosis. Jasmania received five rapid molecular diagnostic technologies machines to address the COVID-19 pandemic through the redeployment of a portion of the World Bank's Jasmania Health VII loan. As the COVID-19 crisis waxed and waned, available rapid molecular diagnostic technologies machines were used for MDR-TB diagnosis. This use of rapid molecular diagnostic technologies machines for MDR-TB will be continued.

Drug stock-outs and adherence to treatment. The study conducted in 2018 by the UWJ-SPH on factors contributing to failure to adhere to ART and to TB treatment (annex 12) found that drug stock-outs (13% of a set of 10 essential drugs were found out of stock) were the leading factor. In 2019 and 2020 a focused effort to strengthen the ART and TB drug procurement and distribution system through the Central Medical Supply Division (CMSD) cut drug stock-outs by 60% (to 5%) and increased adherence to treatment by 11%.

Information is valuable for making decisions and targeting programs. All the data collected through the JHIS and special studies, such as the Barriers to Access study conducted in the Central Region and the HIV Stigma Index have proved to be essential to measuring progress, allocating resources, and targeting programs. This ensures the effectiveness of our efforts and that we are obtaining value for money. However, information gaps remain (see below), and this allocation will be deployed to address some of these gaps.

Risks of sexual exploitation, abuse and harassment. All partners engaged in delivery of programs supported by the Global Fund have undertaken a risk assessment to minimize any risk of sexual exploitation, abuse and harassment. Steps have already been taken to mitigate risks identified thus far. This taskforce will continue to meet throughout the implementation period in order to mitigate risks not yet identified and to redress individuals or communities impacted.

Planned for operationalization

Greater focus on men who have sex with men and sex workers. JHMIS data show that men who have sex with men and sex workers are not adequately reached for HIV testing and follow-up with treatment (see Figures 2 and 3). The program described in the modules targets working with men who have sex with men and sex workers through competitive, results-based contracting with civil society organizations (CSOs) for outreach to men who have sex with men and sex workers' communities, and paying attention to the distinct vulnerabilities of their sexual partners and the different needs of women, men and trans and gender diverse people selling sex.

Discrimination, stigma, access to care, and fear as important barriers. The 2021 Barriers to Access Study indicated that only small progress has been made on important barriers to service among HIV key populations. The Barriers to Access Study revealed that high-risk men who have sex with men consider centers operated by CBOs as safe spaces. The program described in the modules employs the findings of the Barriers to Access Study to target efforts to address the barriers.

Enhanced collaboration with the private sector (profit and non-profit). The GOJ and private sector collaborated in unprecedented ways in the response to COVID-19 (see description in the context section). Building on the relationships developed during the COVID-19 response the program described below will leverage private providers in terms of greater involvement in the delivery of HIV and TB services. In addition, the program will work with the private business sector in messaging. The program also will seek

collaboration with private mining companies concerning TB screening and HIV awareness. All of the above intend to improve program effectiveness and efficiency.

Climate change is causing migration and changing patterns of HIV and TB. Jasmania's Eastern Region, that already is sparsely populated relative to the rest of the country, has been stricken by climate-change related drought and flooding (too little rain during the traditional planting season, excessive rainfall at other times). The drought and flooding are pushing Eastern Jasmanians to migrate to the Central and, to a more limited degree, Western Regions, especially East Lake City and Emma City. The program described in the modules re-targets activities to account for the climate-related population impacts and migrations, to give more emphasis to the Central versus the Eastern Region.

Collection of additional information to understand the scope of challenges and to target programs. We continue to have "blind spots" concerning challenges with respect to HIV and TB. For example, we have no data on TB among people working in mining nor among malnourished children, and while we have assumptions about why loss to follow-up is higher among women than men, we do not have data to confirm that this is due to caregiving responsibilities and respect that there may be other factors involved. We would benefit from a Stigma Index study for TB. We have learned from the experience of other countries in our region that community-led monitoring (CLM) can produce additional insights into intervention successes and failures. Hence, we will develop and put into action a CLM system by 2025. We will be gathering data on these and other issues to help us to decide what to do and what resources to allocate to these areas.

Not addressed and why

Cumbersome public financial management (PFM) systems. Complex and slow PFM systems have inhibited the availability of allocated GOJ funds, especially concerning health and within health for HIV and TB. The PFM deficiencies have resulted in delays in HRH payment (harming morale), unavailability of fuel vouchers (limiting supervision), and refusal of contractors (for example, for motorcycle repair) to work with GOJ (including health programs). The PFM situation is being addressed by the Ministry of Finance on a GOJ-wide basis through an initiative called Effective and Fluid Financial Management (EFFIM). EFFIM began in 2022 with a focus on the Ministry of Education (it will work with PFM systems ministry by ministry) and has the MOH scheduled for attention in 2023 and 2024. Thus, EFFIM is expected to address the PFM issues and so they are not included in the program presented in this funding request.

No longer included

Inadequate quantification and forecasting for commodity procurement. The issues with inaccurate quantification of needs and related forecasting for HIV and TB commodities that plagued the Jasmania Central Government Procurement Agency (JCGPA) in the 2010s have largely been resolved. A World Bank loan and a grant from the Japan International Cooperation Agency funded the 2017-2021 Strengthening Government Performance Project (SGPP). The SGPP was complemented by UNICEF Supply Division technical assistance with health-related procurement. SGPP resulted in a transformation of JCGPA from an underperforming agency to a strength within the GOJ and the quantification and forecasting of health commodity procurement has dramatically improved.

1.5 Focus of Application Requirements

As a lower-middle income country with a high HIV and TB disease burden, Jasmania's funding request is consistent with the focus of application's requirements of having at least 50% of the allocation on disease-specific interventions for key and/or vulnerable populations and/or highest impact interventions.

Identified priorities show that interventions will target the most affected populations, namely key populations, other vulnerable populations, TB patients and people living with HIV. It should also be noted that there are plans to scale up several innovative strategies in order to substantially improve program performance. The funding request is focused as follows:

- The selected interventions for support align with our National Strategic Plans for HIV (NSP HIV 2021-2024) and TB (NSP TB 2021-2024), the overall Jasmania Strategic Plan for Health 2020-2029, and the HFSS 2019.

- The plans and commitments to domestic co-financing of the supported interventions emphasize the gradual uptake of intervention costs from domestic sources, principally general government revenues (in alignment with HFSS 2019).
- Alignment with the normal planning and budgeting cycles of the GOJ and improving public financial management systems and practices,
- Attention to effectiveness, efficiency, and value for money throughout the program.
- Selected interventions to support essential health systems components.
- Renewed and strengthened attention to addressing human rights and gender related barriers to access.

1.6 Matching Funds (if applicable)

No Matching Funds were designated.

Section 2. Maximizing Impact

2.1 Ending AIDS and TB

A. Primary Goal

The interventions in this funding request advance the primary goal of ending AIDS and TB. The interventions apply WHO-recommended approaches to HIV, TB, and HIV/TB that represent value for money to continue and accelerate the progress Jasmania has made on these challenges. They are fully aligned with Jasmania's Health, HIV and TB strategies and will advance towards these goals.

Value for money is achieved in terms of effectiveness and economy by a) targeting interventions to key and vulnerable populations based on the data available, including the HIV Stigma Index, and geographic areas prioritized by data indicating gaps in coverage (to be enhanced with geospatial information when it comes on line) including migration provoked by climate change (see details on geographic targeting in annex 13); b) employing best practices and WHO recommended interventions; c) introducing DAT to reduce loss to follow-up; d) employing systematic TB preventive treatment of household contacts; e) making dual use of rapid molecular diagnostic technologies machines; f) purchasing commodities through the WAMBO mechanism; g) continuing the reallocation of spending in favor of primary care relative to hospitals; h) enhancing and optimizing CHWs; and i) leveraging collaboration, notably with the private sector, including outsourcing of sputum sample transport (see annex 14 for details on value for money). Sustainability is enhanced further by increasing the share of HIV and TB intervention costs covered by Jasmanian resources (see section 2.5 for more details on sustainability), as well as securing multi-year contracts with CBOs for key interventions.

The funding request is based on information (survey, management, logistics, financial, and, increasingly, geospatial) so that it targets specific key and vulnerable populations (men who have sex with men, trans and gender diverse people, sex workers, prisoners), paying attention to the diverse needs of age, gender, and background, as well as geographies (the Eastern Region and urban areas). It also ensures that its activities complement and do not duplicate the activities supported by other donors or those funded with Jasmanian resources (see annex 15 for details on the stratification used for this prioritization). It uses a gender equality and health equity approach, by addressing barriers to the use of services identified through both a Stigma Index survey and through the inputs of representatives of key populations and by analyzing the socio-economic status of the people served and un-served (see annex 15) for details on the gender equality approach and annex 17 for details on the health equity approach).

The impacts of COVID-19 are addressed by increased efforts to build and restore trust with the general and key populations concerning health services. We take advantage of experience and added resources related to the COVID-19 response. This includes enhanced collaboration with the private sector (based on

collaboration started in the COVID-19 response) and the dual use of rapid molecular diagnostic technologies machines acquired for the COVID-19 response for TB diagnosis. In addition, the activities concerning the JHMIS information system will make it stronger overall and will improve its ability to prevent and detect disease outbreaks more quickly through the integration of data submitted from mobile phones.

B. Program Essentials

The below complements the information in the Essential Data Tables.

HIV Program Essentials:

Government investments to date, combined with contributions from external partners, have already advanced progress in Jasmania across all 18 key areas, with the exception of number 4, as voluntary male medical circumcision does not apply as Jasmania is not a high-incidence setting. However, in terms of implementation status, Jasmania is only able to “implement countrywide” item 11, “HIV treatment uses WHO recommended regimens”. For items 5-14, covering HIV testing and diagnosis, elimination of vertical transmission, and HIV treatment and care, implementation covers 50%-95% of sites. For HIV primary prevention, TB/HIV and differentiated service delivery, implementation is less than 50%. For this reason, modules are proposed in this funding request to move us to a higher level of implementation. Jasmania continues to receive extensive support from the US government for programs aimed at the elimination of vertical transmission, hence no support is requested from the Global Fund.

Structural barriers including criminal sanctions for individual and organized sex work, drug possession, high stigma and discrimination of people living with HIV, men who have sex with men, trans and gender diverse people and gender-related inequality (including of women who use drugs) continue to be high. Jasmania is already taking steps to advance Human Rights program essentials 19 and 20 (integrating actions to reduce barriers and addressing stigma and discrimination), but with incomplete implementation. To date there has been very limited action to advance legal literacy, access to justice and legal reform (21 and 22) and this funding request proposes to enhance work in all of these areas, which will in time be supported through national resources.

TB Program Essentials:

Jasmania has had challenges with the systems to deliver access to optimal TB services, however there is progress on all areas except for 5.3 (engagement of private health care providers) and only one program essential (5.2 priority interventions informed by cascade analysis) has been implemented countrywide. This funding request requests support for all of the TB program essentials to scale up beyond current levels of implementation "in some sites (<50%)” and to start work on private provider engagement (5.3). The MOH is also providing support to many aspects of the TB program essentials, as are other external partners, notably the prisoners program supported by the government of Belgium which addresses aspects of 1.1, 3.1 and 5.5.

2.2 Resilient and Sustainable Systems for Health

As noted above in Question 1.4 Lessons Learned, issues with the inaccurate quantification of needs and related forecasting for HIV and TB commodities that plagued the JCGPA in the 2010s have largely been resolved. The Global Fund has identified Jasmania as an RSSH priority country and the allocation letter recommended a stronger focus on the following critical RSSH areas: health information management systems, community health program expansion and further integration of HIV and TB services with other primary health care service delivery platforms.

In this funding request, we are pursuing integrated service delivery through the integration of HIV and TB programs, through multi-program CHWs, and through the integration of HIV services with maternal and sexual and reproductive health services. Where integrated services might inhibit use, such as by HIV key populations, we continue to offer differentiated services such as the CBO-operated APs. Multi-year government contracting with these CBOs aims to secure quality people-centered services that will be sustained beyond the duration of external support from the Global Fund and other partners. Social contracting will be further scaled up under this allocation.

The quality of services is assured (and when needed remediated) by the Jasmania Quality Mechanism (JQM). JQM comprises a multi-faceted approach to quality, including: facility self-assessment; community-led monitoring; reporting on key quality indicators through JHIMS; random quality audits performed by peer quality assessment teams (to validate self-assessments); annual district quality forums (to which private providers are invited); community quality scorecards; the formative Jasmania Supervision System; and a developing hospital and primary care certification scheme (to become operational in hospitals 2023-2025 and primary care facilities 2026-2029) supported by the Canadian International Development Agency (CIDA).

The for-profit private sector is involved in this funding request via collaboration on service delivery and through outsourcing of sputum sample transport. The not-for-profit private sector is involved via collaboration on service delivery and specifically the operation by CBOs of APs under GOJ-funded public contracting with the MOH.

A climate vulnerability assessment for the health system is planned for 2024 that will address the propensity for flooding and other extreme weather impacts on the vulnerability of people and communities and the resilience of the health system. The climate vulnerability assessment will be conducted with the assistance of the Italian Agency for Development Cooperation (AICS). Medical waste management is handled by the Jasmanian Waste Management and Hygiene Agency, which has received technical cooperation from the Chinese International Development Cooperation Agency (CIDCA).

This request includes participation by CHWs and POWs as key integrated health workforce members, with recurrent funding for training and stipends, built in to the MOH budget, in addition to training for existing human resources for health.

The MOH's laboratory network is fully integrated. There is no specific lab for HIV. This funding request addresses the dual use of rapid molecular diagnostic technologies machines for COVID-19 and TB diagnoses.

There are three focal areas concerning RSSH in this request: M&E systems (Module 6), HRH and quality of care (Module 7), and health products management systems (Module 8). The set of RSSH support will strengthen and build sustainability and resilience in the capacity of the JHMIS information system, enhance the community base of the health system, and increase the capacity of the system to deliver essential commodities and supplies effectively and efficiently (details are provided in the RSSH Gaps and Priorities Annex).

2.3 Engagement and Leadership of Most Affected Communities

The most affected communities of HIV and TB have been engaged and have displayed leadership in the formulation of this funding request as active participants in the JCC. Examples of ways that program priorities and design were informed by input from communities include: the expansions of APs and POWs focused on working with trans and gender diverse people; the expansion of access to commodities in drug treatment facilities for people who use drugs; and the new interventions focused on meeting the specific challenges of malnourished children.

In addition, people living with HIV, people with TB and communities of key populations are involved and will increase their involvement in implementation. CBOs led by people in the affected communities operate the APs that will be increased in number under this funding. The POWs are peers in the affected communities, and there is strong attention to good gender balance, in line with the needs of communities. Funding for community system strengthening is foreseen to strengthen the community system capacities and engagement in national and regional decision-making bodies beyond the JCC, including with the Parliament's Human Rights and Health Committees, the Gender Equality Council, the National Commission on Universal Health Coverage (UHC), the Prison Reform Task Force, the public council for oversights of national law enforcement, amongst others. Communities also engage in quality through their participation in Clinical Quality Safety. In this funding request, we plan to develop and begin implementation of CLM, beginning in 2025.

This funding request includes collaboration with the FBCC on advocacy concerning human rights, stigma, and discrimination. Miners' trade unions will be engaged around human rights and job protections for their members related to TB.

2.4 Health Equity, Gender Equality and Human Rights

Health Equity

The programs supported by this funding request will maximize health equity by targeting activities to populations, geographies, and barriers where the diseases have the greatest impact (see section 1.1). A subcommittee of the JCC applied the methods of the WHO Innov8 tool since the previous funding request formulation. The JCC Equity Subcommittee performed an updating of the Innov8 analysis for this funding request. The analyses, using a variety of data sources, principally JHMIS data and the JNLS, revealed equity issues with respect to key and vulnerable populations (see gender and human rights analyses below), lower-income populations in the Eastern Region, in mining communities, plantation agriculture communities, malnourished children, and in urban slums. Each of the geographic areas and communities identified in the analysis is targeted for focus in the interventions proposed, such as the siting of new APs to increase access and through collaborations with organizations with common interests (such as mining trade unions and community organizations). Specific targets are set with respect to each group.

Gender Equality

This funding request seeks to address and maximize gender equality by targeting activities by gender (where relevant) and by setting and measuring achievements broken out by gender categories, male, female, and trans and gender diverse people, and adapting services and interventions as needed. The Gender Equity Task Force of the JCC commissioned and reviewed the Gender Assessment and also analyzed data from JHMIS, the HIV survival rate survey, the Barriers to Access study, and other sources with a focus on gender equity in the performance of HIV and TB interventions. The findings of the analysis reveal persistent inequities (such as use of access points or engagement in policy setting), with least reach to trans and gender diverse people (see, for example, the gender disaggregated HIV cascades in Figures 2-7 above). The interventions in the prioritized request tables above are differentiated to respond to the inequities found. Specific interventions are tailored to meet the diverse needs of different genders among key populations. We set gender-disaggregated targets for interventions and will continue to monitor and evaluate achievements throughout implementation.

Human Rights

The programs address human rights in a multi-faceted way (see engagement and leadership of most affected communities above), including affected communities in the development and design of the programs and in their implementation. The design of the proposed programs in this funding request used outputs from the JCC's Human Rights Working Group that analyzed data from the 2022 HIV Stigma Index study and the 2018 and 2021 Barriers to Access studies (see figures 9 and10 above) as well as the Gender Assessment. The program includes conducting a TB Stigma Index baseline study (we see the gap in knowledge we face concerning these issues and TB) and a follow-on HIV Stigma Index study. The JCC will work on developing a plan and leading on its implementation and monitoring for the implementation of the policy-focused recommendations arising from those gender, and human rights related studies. The interventions proposed in this funding request (see the prioritized request tables, specifically Module 5) to address human rights barriers (such as lack of safe spaces for community delivery, low sensitization in the public service, and low capacity for advocacy) include collaboration with the FBCC; sensitization on human rights issues for human resources managers, providers, and law enforcement personnel; a KYRAO program for the disadvantaged; dissemination of the Patients' Charter for TB Care; legal literacy training; advocacy work, including building the capacity of key populations for advocacy; updating human rights indicators in the M&E framework; and a tool to assess the safety of spaces for services for disadvantaged users (among others). This funding request also includes a specific initiative to work with incarcerated people on TB.

2.5 Sustainability, Domestic Financing and Resource Mobilization

A. Challenges to Sustainability

Jasmania faces some challenges to sustainability, as presented below. We have already made progress and plan to advance further to address these challenges in the period of this funding request.

Concerning financing, since the 2020-2022 funding period, Jasmania has covered all program management costs by integrating program management into the MOH structure and budgets. We are proud to have gone from complete dependence on the Global Fund for funding program management in 2010 to sustainable self-sufficiency since 2020. We continue to increase the GOJ share of funding of commodities for the HIV and TB efforts (tests, drugs, diagnostic equipment, and many of the supplies). The commodities paid for from this allocation and from GOJ funding use the Global Fund's WAMBO pooled purchasing mechanism. This saves us money and ensures high-quality quality commodities. Some supplies of good quality are available in local markets, so they are procured locally, not through WAMBO. The significant increases in prices of commodities, as well as supply chain challenges, created by global conflicts and exchange rate variations, is of concern to GOJ and we are monitoring the impact on budgets closely. The stagnation of government revenues that came with the COVID-19 pandemic may, however, make it difficult to increase GOJ allocations to health and therefore to the HIV and TB programs in the course of this allocation period.

Programmatically, the HIV and TB efforts are guided by our national strategic plans and overall health sector strategy. The strategic plans are aligned with WHO guidance. This process of developing strategies and aligning them with WHO guidance allows us to identify key challenges and systematically address them. Thus, though many programmatic challenges remain, such as targeting of prevention and treatment, reaching underserved populations, and addressing HIV and TB together, we feel that we are on a path to resolving them.

In terms of health and community systems, we have made and will continue to make progress. We have reduced the issue of drug stock-outs, but will do more. As noted above, we are using the WAMBO system to efficiently procure quality commodities. We are training more individuals to invest in and boost our human resources for health and deploying and targeting CHWs. We are using technology to reduce loss to follow-up and improve information systems. We have used and will add to surveys and data collection to better understand challenges and improve targeting. We are increasing our collaboration with the private sector.

The governance of HIV and TB efforts in Jasmania is spearheaded by the MOH through JNTP, with the assistance of the JNHAC and the newly quasi-independent JEB. Governance will be both enhanced and be more complicated during the period of this funding request through the development of collaborations with the Ministry of Justice (prisons), private mining companies and mining trade unions (mining communities), and nutrition programs (malnourished children).

B. 2020-2022 co-financing commitments

Jasmania met co-financing targets for overall health spending and specific spending on Global Fund supported activities in 2020 and 2021 but struggled to do so when economic growth faltered with COVID-19 (see section 1.3 on health financing). The commitment for 2022 has not yet been met but we anticipate that it will be.

Per capita government expenditure on health in US$ for the 2020-2022 allocation period was 3% lower than in the pre-pandemic years of 2017-2019. This was the result of a reduction in government health expenditure to address post-COVID-19 government debt, decreased tax collection, and appreciation of the US dollar. However, the share of total government spending on health in 2022 was 7.5%, only slightly below the recent past with a commitment to raise it above 8% going forward.

Table 1: Government spending on health 2018-2023 (US$ millions)

	2017	2018	2019	2020	2021	2022
Total Government Health Sector Spending	188	196	217	204	210	201
Share of Health in Government Expenditure	7.8%	7.7%	7.9%	8.0%	8.0%	7.5%

Source: Ministry of Finance Annual Budget Books. Actual expenditure to 2022

To meet the Global Fund's co-financing requirements for HIV and TB, Jasmania had to spend a total of at least US$10.8 million on the HIV response and US$1.56 million on TB in the 2021-2023 implementation period. While national expenditure is not completely available for the implementation period, as per the information included in the Funding Landscape Table, spending in the first two years of implementation plus budgeted funding for the final year indicate that Jasmania is likely to spend more than the minimum required amount. While no specific commitments were made as part of co-financing in the previous cycle, the increases in TB and HIV expenditure included increased domestic spending on ARVs, from 70% to 95% of the total cost, and increased domestic spending on first line TB medicines from 15% to 65% of the total cost.

C. 2023-2025 co-financing commitments

Jasmania is committed to increase the share of general government spending allocated to health for 2023-2025 (to 8.3%), but the absolute amount of funding for health may stagnate, since economic growth and government tax collection have been below pre-pandemic levels because of COVID-19 and given the broader global challenges. In addition, worldwide economic growth looks to be slowing. Jasmania is dependent on exports of minerals (lithium, tin), soybeans, and light manufactured goods to China and Europe for about 37%of its national income, so slowing in those markets will have knock-on effects. The co-financing contributions will be documented by letters to the Global Fund co-signed by the MOH and the Ministry of Finance.

The Jasmania government pays the salaries for all the human resources for HIV and TB service delivery and support functions, and also mobilizes CBOs to pay for human resources for APs that are under public contracts. This funding request includes support for training of human resources, including CHWs and also includes stipends for CHWs, though we intend to begin to fund CHW salaries, pegged to the national scales for human resources for health, through the MOH budget (GOJ funded) in 2026.

The funding requested from the Global Fund is catalytic to domestic funding of Jasmania's HIV and TB programs and complementary to funding received from other external partners, including Canada, Italy, Belgium, China, the US and the World Bank (see table below for details).

Table 2: Non-Global Fund external support related to TB and HIV

External Partner	Support	Value (USD millions)	Years
Canada (CIDA)	Hospital and primary care certification	2.9	2023-2029
Italy (AICS)	Climate vulnerability assessment	0.5	2023-2024
China (CIDCA)	Medical waste management	1.2	2023-2024
Belgian Cooperation	Improved prisoner life	1.6	2022-2025
ABC Development Bank	CMS warehouse renovation (in negotiation)	3.0	2023-2025
PEPFAR	HIV testing centers and private testing sites	4.3	2021-2024
World Bank	Health VII loan	8.6	2021-2024

World Bank	Strengthening Social Health Insurance (in negotiation)	5.3	2023-2025

Source: Ministry of Finance

The program minimizes costs through collaboration, including public contracting with CBOs and out-sourcing for private transport of sputum samples, leveraging geospatial information from JNSO, partnering on advocacy with FBCC, and protecting miners' rights with trade unions.

For the upcoming allocation period, overall government health expenditure is projected to remain constant as a percentage of total government expenditure. Both are expected to grow at 2% per annum in local currency real terms each year after 2023. The main constraint is limited projected GDP growth of 2.2% per annum (IMF March 2023).

Within the health allocation, efficiencies in priority areas such as procurement, are expected to allow for reallocation to the disease programs. The following table drawn from the Ministry of Finance Commitment Letter dated 18 March 2023, indicates the estimated* total GOJ spending on the disease programs for the previous allocation period and commitments for the 2024-26 period.

Table 3: Government HIV and TB co-financing commitment overview for 2024-26

Program	2021-2023	2024-2026
	Estimated Total program expenditure*	Commitment – Total Expenditure
	(USD)	(USD)
HIV/AIDS	10,950,000	11,850,000
Tuberculosis	1,610,000	1,740,000
Total	12,560,000	13,590,000

** 2021 and 2022 from MOH Actual expenditure records; 2023 provisional estimate based on budget and expected budget execution*

Specific commitments to new spending within the above programs have been made in line with NSP strategic priorities for impact and sustainability. Additional spending will focus on:

- Procurement of 40% of second line ARVs (US$400,000) to continue the trend towards full domestic funding of priority commodities.
- Procurement of additional TB tests and rapid molecular diagnosis technology machines to support a drive to identify missed cases of TB (US$60,000) to maintain TB control
- Reallocating posts for two senior managers in the MOH to manage public contracting of CBO-managed APs.
- Upgraded HIV and TB training and follow-up supportive supervision for CHWs and primary health care nurses to support integration of interventions and services in 60 priority locations.
- Refurbishment of the CMS to enhance sustainable supply chain operations. This will be supported by a US$3,000,000 loan under negotiation with the ABC Development Bank (the loan is not reflected in the government commitment above).

Due to robust health commodity procurement planning and dedicated budgeting systems, as demonstrated in the last grant period, Jasmania expects limited risk of under-budgeting and stock-outs when taking responsibility for the essential co-financed commodities. However, the substantial price increases created by broader global challenges are a concern. Commitments will be monitored quarterly, using official Budget, Expenditure, and procurement reports.

The People's Assembly of Jasmania (our legislature) and the Prime Minister's Office have a heightened awareness of the link between health and the performance of the economy because of COVID-19. We will try to leverage this greater awareness to obtain greater allocations for health overall and for the HIV and TB programs specifically.

The suspension of the Ministry of Labor and Work effort to develop a social health protection system (see above), one of the key elements of the HFSS 2019, was worrying since it was expected to address financial barriers to use of health services by families in the informal sector. Though the suspension is stated as temporary in the face of the economic effects of COVID-19, it is essential to achievement of UHC and

sustainability that this effort be re-started, since it will take an estimated 10 years to be fully put in place. Thus, the MOH will continue to lobby within the GOJ for the social health protection initiative.

D. Innovative Financing

Jasmania has begun to explore a possible debt swap with Spain under the Debt2Health initiative. We have had exploratory discussions with the Spanish ambassador around a €2,000,000 debt that will come due in 2024.

In addition, the Ministry of Finance of Jasmania is in discussion with the World Bank for a results-based loan to support the GOJ's reform of the Social Health Insurance System. Elements of the current proposal are being discussed between the Program, MoH and the Ministry of Finance to understand which areas of this funding request can be aligned with the future loan and this way attract additional World Bank resources in support of achieving UHC goals. Jasmania's current social insurance system is based on voluntary enrolment and has large focus on payroll tax in the context of large informal sector. Therefore, envisaged reforms are both costly and require long time to implement.

The expected timeline for the start of the World Bank loan is December 2023, later than the Global Fund grant start date (expected to start in January 2023), but Jasmania is interested in the opportunity to pool part of its allocation or above allocation resources with those of the World Bank and has therefore included preliminary request for such additional funds in the PAAR section of this application (detailed structure, implementation arrangement and other parameters are yet to be defined between MOH, Ministry of Finance and the World Bank).

2.6 Pandemic Preparedness

Jasmania's first task in pandemic preparedness is to build trust in the health system, especially by marginalized communities, which was seriously damaged during the COVID-19 crisis. We intend to build trust by the performance of the system overall and specifically concerning HIV and TB through all the activities described in this funding request. In addition, the funding request heightens engagement with communities, key and vulnerable populations and people affected by HIV and TB to tailor approaches, be responsive, and receive and act on feedback.

This funding request also strengthens pandemic preparedness through improvements to JHIMS, especially mobile phone reporting of disease outbreaks and integration of geospatial information.

Finally, the funding request describes how we will make dual use of rapid molecular diagnostic technologies machines for TB diagnosis. Twelve of Jasmania's rapid molecular diagnostic technologies machines were acquired as part of the response to COVID-19 and could be repurposed again in response to another disease outbreak.

Section 3. Implementation

3.1 Implementation Arrangements

A. Changes to Implementation Arrangements

Jasmania will only make small changes to its implementation arrangements from the 2020-2022 allocation period (see the Implementation Map and the Funding Landscape Table). These arrangements have proven to be successful based on good program results and smooth implementation, though we have more to achieve.

The integration of program management into MOH structures since 2020 has shown initial successes, with HIV and TB programs less and less thought of as "the Global Fund" programs. The MOH will add a position for coordination of community relations that cross cuts all programs but will serve the HIV and TB programs. This integration of management lowers overall management costs. All management personnel

are paid in alignment with GOJ scales (we completed the gradual transition to alignment in 2021, from a situation where the managers of Global Fund-supported programs enjoyed salaries and benefits 30 percent higher than GOJ scales in 2017).

The MOH also is increasing staffing for its health financing unit to have more capacity to interact with the Ministry of Finance and the People's Assembly on allocations of funds to the health sector (demonstration of health contribution to the economy, ability to perform cost-effectiveness analyses to ensure value for money), including the HIV and TB programs and adding positions to manage public contracting with CBOs.

Jasmania purchases its ARVs and TB medicines using the Global Fund's WAMBO mechanism to ensure quality and good prices, but also makes supply purchases from local markets where prices are better and quality meets standards (see sections 2.1 and 2.5.B).

B. CBOs/CLOs

Historically, and given the risks to key population-led organizations, stemming from criminalization of key populations' behavior and HIV transmission, FBCC has been instrumental in advocacy and community-based activities. With the support of this grant, FBCC will strengthen their involvement, with a new focus on countering prejudice against key populations, particularly among religious leaders, flagged by the Stigma Index.

Renewed emphasis will be on direct and - given the criminalization - safe and secure engagement of HIV community-led organizations in implementation (operating APs, providing POW services) as Sub-Recipients (SRs). All CBO and community-led organizations (CLO) SRs will undergo capacity assessments, to receive tailor-made capacity building to better engage in HIV and TB responses, and relevant advocacy concerning human rights, stigma, and discrimination. In addition to differentiated capacity-building interventions, a pre-defined package of training for CBO and CLO SRs will include the tool for assessing perceptions of safe spaces for services and KYRAO program essentials. These assessments and the KYRAO program will be implemented by the CBO and CLO SRs. CLOs and CBOs of people affected by TB will lead the dissemination of the Patients' Charter for TB Care and conduct the baseline TB Stigma Index study in 2023.

Key populations' networks and women's rights networks together with the JNHAC and the JNTP will develop and implement the strategy around CLM including piloting, data management and security, and the processes of data collection, analysis, sharing, and use.

3.2 Key Risks and Mitigation Measures

A. Procurement of health products, management of health products and laboratory related activities

The severe issues Jasmania once had with health products have been resolved such that this now is a strength (see "Inadequate quantification and forecasting for commodity procurement" in section 1.4 above on lessons learned).

Jasmania's laboratory system is fully integrated, including the dual use of rapid molecular diagnostic technologies machines for both COVID-19 and TB diagnosis as described in many other places in this funding request. We do not foresee risks to the laboratory system, but an evaluation of the system is planned for 2024 with the assistance of the AICS.

B. Flow of data from service delivery points

The flow of data from service delivery points has been slow and incomplete, compromising the value of this information. This risk is addressed by the JHMIS strengthening that is part of this funding request (see Module 5), including the use of mobile phones for the transmission of data (addressing the speed of data) and annual on-site data validation for data quality (addressing completeness).

C. Financial and fiduciary concerns

Difficulties with Jasmania's PFM situation (described in detail in section 1.4) are being addressed by the Ministry of Finance on a GOJ-wide basis through the EFFIM initiative (also described in section 1.4).

There is a risk that the slow growth of Jasmania's economy will result in fewer resources for health, even with Jasmania meeting co-financing requirements (see section 2.5.B). We plan to take advantage of the heightened awareness of health's impact on the economy to counter this risk (again, see section 2.5.B).

Jasmania State Auditor's Office (JSAO) conducts audits of all ministries annually; the audit reports are posted to JSAO website for public use. Two allocation periods ago, Jasmania had fiduciary issues that led to the Global Fund considering it "high-risk" under the Additional Safeguard Policy. Jasmania took remedial steps: upgraded financial management staff and procedures, increased transparency of financial data, and prosecuted personnel involved with misuse of funds. These steps satisfied the Global Fund, so that Jasmania is no longer considered at high fiduciary risk since 2017.

Annex 1: Documents Checklist

Use the list below to verify the completeness of your application package.
This checklist only applies to applicants requested to apply using the Full Review application approach.
Refer to the Full Review Instructions[4] for details, applicability and resources.

Documents Reviewed by the Technical Review Panel

☒	Funding Request Form
☒	Performance Framework
☒	Detailed Budget
☒	Programmatic Gap Table(s)
☒	Funding Landscape Table(s)
☒	Prioritized Above Allocation Request (PAAR)
☒	Health Product Management Template
☒	Implementation Arrangement Map(s)
☒	RSSH Gaps and Priorities Annex
☒	Gender Assessment (if available)
☒	Assessment of Human Rights-Related Barriers (if available)
☒	Essential Data Table(s)
☒	National Strategic Plans
☒	Innovative Financing Documentation (if applicable)
☒	Supporting Documentation Related to Sustainability and Transition (if available)
☒	List of Abbreviations and Annexes

Documents Assessed by the Global Fund Secretariat

☒	Funding Priorities from Civil Society and Communities Annex
☒	Country Dialogue Narrative
☒	CCM Endorsement of Funding Request
☒	CCM Statement of Compliance
☒	Additional documentation to support co-financing requirements
☒	Sexual Exploitation, Abuse and Harassment (SEAH) Risk Assessment (optional)

[4] Full Review Instructions - https://www.theglobalfund.org/media/5743/fundingrequest_fullreview_instructions_en.pdf