

HIV Information Note

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I. Introduction

01 Purpose of this information note

The **purpose of this Information Note** is to provide guidance to Global Fund applicants on employing strategic investment thinking when developing funding requests for HIV-related programming for the 2017-2019 funding cycle. Applying the **HIV strategic investment approach** throughout the funding request design process is critical for ensuring optimal resource allocation in line with the epidemiological context and for maximizing multiplier effects across broader health and development issues.¹ It incorporates a **human rights-based and gender-responsive** approach.

All applicants that are requesting funding for HIV and joint TB/HIV programs from the Global Fund are encouraged to use this Information Note. It provides technical guidance to applicants on **developing funding requests tailored to their contexts**, and on prioritizing cost-effective interventions for accelerating access to services, particularly for **key and vulnerable populations** who are at much higher risk of acquiring HIV, and whose ability to access key prevention, testing, treatment, care and other support services is often severely compromised due to stigma, discrimination and criminalization.

Based on published technical guidance, the note emphasizes that **priority setting and focus are more important than ever before**, and takes note of the need to accelerate and **fast track measures** to reverse the HIV epidemic in order to achieve the global goal of ending it by 2030. Maximizing the impact of HIV investments requires differentiated approaches for diverse country contexts based on an in-depth understanding of national and subnational epidemics.²

While the introduction of the strategic investment approach in 2011 has contributed to a new era of data collection and new methods to identify underserved populations safely, gaps still remain in community and health systems and in areas needing service saturation. Developing **optimal investment scenarios** and explicitly linking national HIV response investments with impact will be important for countries to build on these optimal investment scenarios. This will **ensure that country responses to HIV continue to improve and to address remaining challenges and barriers**, which are still significant in many countries.

This note should be **read in conjunction** with other information notes and technical briefs provided by the Global Fund as well as technical guidance published by its partners. Access to more detailed information is provided via links to key documents, which are listed in the “Key references” section at the end of this Information Note. General guidance on how to develop a funding request for the Global Fund is provided in the updated Global Fund [Applicant’s Handbook](#) and the [Funding Request Instructions](#).³

02 How this information note relates to global HIV targets

By providing investment guidance, this Note also aims to contribute to the alignment of global strategies and targets with regards to country responses. The **Global Fund Strategy 2017–2022, “Investing to End Epidemics,”** aims to rapidly reduce HIV incidence and mortality through the scaling up of universal access to HIV prevention and treatment.⁴ Its strategic goals and targets are explicitly linked to the following partners’ global plans:

- The **UNAIDS 2016–2021 Strategy, “On the Fast-Track to end AIDS,”** calls to reach the 2020 Fast-Track goals and targets, including prevention targets and the 90-90-90 treatment targets, grounded in a human-rights based approach. In full alignment with Sustainable Development Goal (SDG) 3, the strategy envisions ending the AIDS epidemic as a public threat by 2030, with zero new HIV infections, zero discrimination and zero AIDS-related deaths (please

¹ Schwartländer B. et al. (2011): Towards an improved investment approach for an effective response to HIV/AIDS. *Lancet*, 277:2031–2041.

² UNAIDS (2015): Focus on location and population: on the Fast-Track to end AIDS by 2030.

³ [Global Fund \(2016\): The Applicant’s Handbook: A practical guide to preparing a funding request](#). The Global Fund has revised its approach to funding applications and reviews to align with the new Global Fund Strategy 2017-2022 and have a bigger impact on the three diseases. Changes to the 2017-2019 funding cycle are designed to better serve people in need by enabling tailoring of funding application approaches to different country circumstances.

⁴ [Global Fund Strategy 2017-2022 “Investing to End Epidemics.”](#)

refer to Appendix 1 for more details on the Fast-Track targets).⁵ In June 2016, countries committed to the Fast-Track targets in the Political Declaration on HIV and AIDS.⁶

- The **WHO Global Health Sector Strategy on HIV, 2016-2021** is fully aligned with the UNAIDS Strategy and strives to achieve universal health coverage. It reinforces the 2020 targets of the UNAIDS Strategy and includes additional targets on HIV, TB and viral hepatitis co-infection and integration of HIV in the delivery of other health services.⁷

03 Key messages of this information note for the preparation of Global Fund funding requests

This section summarizes the key messages of this Information Note. While the section highlights the most critical aspects to keep in mind for the development of HIV or TB/-HIV funding requests to the Global Fund, it is not comprehensive. Applicants are thus strongly advised to read the entire Information Note.

1. Adopting **HIV strategic investment thinking** throughout the funding request design process is critical to realizing optimal resource allocation, by targeting investments to the locations and populations in which they will have maximum impact. It ensures that funding requests are tailored to local contexts, and prioritizes cost-effective interventions for accelerating access to services, particularly for key and vulnerable populations who are at much higher risk of acquiring HIV, and whose ability to access services is often heavily compromised.

2. HIV national strategic plans and HIV investment cases and related documents form the basis of Global Fund funding requests. Countries might want to consider a **“light update” of their national strategic documents and HIV investment scenario modelling** in the funding request design process to ensure that the most effective strategies are incorporated and aligned with the Fast-Track goals. This light update should consist of a re-run of previous modelling efforts, which many countries have conducted in past years to determine the optimal combination of HIV interventions and enablers, and their impact. Such a focused update should be based on updated epidemiological and response data and would also consider unit cost changes and/or the adaptation of new policies, guidelines, service delivery models and technologies. Updating the entire national HIV strategic document is usually not necessary.

3. Introducing the HIV strategic investment approach contributed to the development of technically sound national HIV strategic plans and/or investment cases. It is important to build on these achievements. In their funding requests, applicants are strongly advised to clearly describe their **implementation approach and how they intend to operationalize interventions to achieve maximal impact**.

4. **Real-time and disaggregated data** are absolutely critical to inform effective programs and to drive interventions towards impact. Without strong data, it is difficult to determine whether programs are implemented at scale with high coverage and quality, whether epidemics are waning or worsening, or whether responses are leaving certain populations behind. An in-depth understanding is required of the extent and dynamics of the national epidemic, based on actual epidemiological data and data on the current response. This includes having an understanding of locations and populations with the greatest HIV burden and the greatest unmet needs for key services as well as structural obstacles to service uptake and reach.

5. Applicants are strongly advised to review **key normative guidance**, including the WHO Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection; UNAIDS Prevention Guidance among Adolescent Girls and Young Women; WHO Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations; WHO PrEP Implementation Guidelines; and upcoming WHO guidance on HIV self-testing and partner notification services.

6. A key component of the 2017-2022 Global Fund Strategy is the mainstreaming of **program quality**. Program quality and efficiency result from the efforts of countries, partners and Global Fund staff to ensure

⁵ UNAIDS (2015). UNAIDS 2016–2021 Strategy, “On the Fast-Track to end AIDS”.

⁶ Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030.

⁷ WHO (2016). Global health sector strategy on HIV, 2016-2021.

that each step of the grant cycle is designed and implemented in an optimal manner, and that critical bottlenecks at different levels of country systems are identified and addressed. One key aspect of improving program quality is tailored (differentiated) services. Differentiated care is a client-centered approach that simplifies and adapts HIV services across the prevention, testing, treatment and care cascade to reflect the preferences and expectations of various groups of people living with HIV (PLHIV), including key populations living with HIV, while also reducing unnecessary burdens on the health system. Adapting ART delivery and support services to specific client populations and context is essential for reaching the UNAIDS fast track prevention and treatment targets.

7. Joint TB/HIV programming is essential for an effective response to both diseases. Emphasis should be placed on synergized program management and in-country collaboration between TB and HIV programs. Integrated program planning, budgeting, procurement, implementation and monitoring as well as sharing resources between programs is strongly encouraged.

8. Building resilient and sustainable systems for health (RSSH) is a core objective of the Global Fund's 2017-2022 strategy. Integrating RSSH investments in HIV or TB/HIV funding requests is crucial to ensure that people have access to effective, efficient, and accessible HIV services through well-functioning and responsive health and community systems.

9. Key and vulnerable populations are central to impactful responses to the HIV epidemic and the Global Fund requires that funding requests from all countries include programs that respond to key and vulnerable populations. Applicants are expected to focus national responses with the view to serving key populations by (i) improving the collection, analysis and use of data and strategic information on key populations to inform effective program design and implementation; (ii) strengthening the engagement of key populations in the development of national plans and funding requests as well as in grant monitoring, data collection, and program implementation; (iii) ensuring that sufficient funding is allocated to enable access to comprehensive services to key populations; (iv) improving expertise on and quality of programming for key populations; and (v) promoting and protecting the human rights of key populations by ensuring their active program involvement, including by removing policy and legal barriers to services and by making sure that programs meet the five human-rights standards required for all grants.⁸

10. HIV investments should be complemented with resources for strengthening linkages with **sexual, reproductive, maternal, newborn, child and adolescent health** interventions. The Global Fund has prioritized four areas of integrated service delivery for women, children and adolescents, all of which comprise important links to HIV programming: antenatal care; integrated community case management; integrated sexual and reproductive health and HIV services; and adolescent health.

11. The Global Fund also requires that funding requests from all countries include programs that respond to **human rights and gender-related barriers and vulnerabilities** in order to put in place and scale up specific programs aimed at removing human rights and gender equality-related barriers, especially for key and vulnerable populations. Many past proposals have referred to human rights and gender-equality issues but have failed to include cost, budget, and specific interventions and programs to address these. Applicants are thus strongly encouraged to identify (i) the main human rights and gender-equality issues that act as barriers for particular key and vulnerable populations to access services; (ii) the groups, communities, and health-care services most affected by these barriers; and (iii) effective programs to remove these barriers. Applicants should also estimate costs for these programs and allocate appropriate budgets to them. Selecting strong Principal Recipients and implementing partners is also critical, as is the establishment of a budget for monitoring and evaluation (M&E). In addition, all interventions, services and programs should meet the five human rights standards⁸ required by the Global Fund, including non-discrimination, safety, confidentiality and informed consent.

12. The Global Fund strongly encourages the inclusion of interventions to strengthen **community systems and responses** within HIV and TB/HIV funding requests. Meaningful involvement of communities is essential to designing effective interventions, improving access, implementing and evaluating the robustness

⁸ The five minimum human rights standards are: non-discriminatory access to services for all, including people in detention; employing only scientifically sound and approved medicines or medical practices; not employing methods that constitute torture or that are cruel, inhuman or degrading; respecting and protecting informed consent, confidentiality and the right to privacy concerning medical testing, treatment or health services rendered; and avoiding medical detention and involuntary isolation, to be used only as a last resort.

and quality of health services including client-centered differentiated care and creating a demand for services. Community systems strengthening is particularly important for ensuring that HIV programs reach excluded and marginalized populations, including key populations whose health and human rights are compromised. Funding requests should include community sector service delivery alongside service delivery by other sectors and describe how effective linkages between community- and facility-based services will be ensured.

13. The Global Fund introduced a new [policy on Challenging Operating Environments](#) (COEs) to ensure sufficient flexibility throughout the funding cycle tailored to each COE in order to maximize coverage and ensure access to services. COE applicants should refer to the [Operational Policy Note on Challenging Operating Environments](#) (*forthcoming*), which includes guidance on access to funding and grant management.

14. The Global Fund's new policy on [Sustainability, Transition and Co-financing](#) outlines principles for enhancing sustainability and provides a framework to support countries in transitioning successfully from Global Fund financing. Programs that serve key and vulnerable populations, including critical interventions to remove human rights and gender-related barriers to access, often lack adequate political commitment. In order to safeguard against these critical interventions ceasing when programs transition from Global Fund support, key and vulnerable populations must be meaningfully engaged in the national response – not only as recipients and implementers of services, but as advocates for well-planned, data-driven transitions that maintain and expand effective evidence-informed and human rights-based interventions as well.

04 Key priority area: joint programming approach

Joint programming will allow targeting resources better to scale-up services and to increase their effectiveness and efficiency, quality and sustainability.

TB and HIV joint programming

To optimize investments in TB and HIV programs, and maximize synergies between TB and HIV programs for better health outcomes, **countries with high burden of co-infection of TB and HIV⁹ are required to submit a single TB and HIV** funding request that presents integrated and joint programming for the two diseases. This funding request needs to present prioritized, high impact interventions and activities for the TB and HIV programs (including collaborative TB/HIV activities), and provide a detailed description on how the two programs will work jointly to address the burden of TB and HIV co-infection. Countries preparing a single TB and HIV funding request should also consider addressing common health system-related constraints, which interfere with the successful implementation and integration of TB and HIV programs as well as other cross-cutting areas for joint TB and HIV programming.

The **purpose of joint TB and HIV programming** is to maximize the impact of Global Fund and other investments for better health outcomes. These programs will require financing for cross-cutting areas such as building resilient and sustainable systems for health, the removal of human rights and gender related barriers to TB and HIV services, more effective use of health information, health personnel and commodities in the course of targeted scale up of integrated TB and HIV services.

Joint programming allows for better targeting of resources and harmonization of efforts to increase the **effectiveness and efficiency, quality and sustainability of programs**. Emphasis should be placed on gaining efficiency through synergized program management and consistent in-country collaboration¹⁰ between the disease programs during the preparation of funding requests, implementation and monitoring of grants and investment in quality data systems. Furthermore, integrated program planning, budgeting, development of joint activities and sharing resources between the disease programs is strongly encouraged.

Joint programming is an opportunity to **strengthen delivery of key services for persons with TB, HIV and TB/HIV co-infection**, including regular screening of PLHIV for TB, HIV testing of TB symptomatic

⁹ The 28 countries with high TB/HIV burden that are eligible for Global Fund funding include: Angola, Botswana, Cameroon, Central Africa Republic, Chad, Congo, Congo (Democratic Republic), Ethiopia, Ghana, Guinea-Bissau, India, Indonesia, Kenya, Lesotho, Liberia, Malawi, Mozambique, Myanmar, Namibia, Nigeria, Papua New Guinea, South Africa, Swaziland, Tanzania (United Republic), Thailand, Uganda, Zambia, and Zimbabwe.

¹⁰ Recommended by the Technical Review Panel (TRP; an impartial team of independent experts responsible for providing a technical assessment of funding requests for strategic focus and technical merit) in The technical review panel's consolidated observations on the 2014-2016 allocation-based funding model

people and patients, provision of antiretroviral (ARV) and TB medicines for co-infected patients and provision of TB preventive therapy for PLHIV without active TB. There are several models to provide integrated services to TB and HIV patients, including “one-stop-shop,” although there is no “one-size-fits-all” approach.

Lessons learned from the development of single TB/HIV concept notes and joint programming during the first allocation-based funding cycle showed that single concept note development processes resulted in **greater harmonization of cross-cutting areas**, such as procurement and supply chain management, supervision, monitoring and evaluation and delivery of integrated service for TB and HIV. It was also found that a single concept note can ease administrative burden of developing a proposal and simplify the management of grants. A single concept note could therefore be a suitable application tool for countries that seek efficiencies in the application for and management of grants. However, **weaknesses** identified include independent disease efforts that were only combined at the concept note submission stage with limited in-country collaboration between the disease programs during implementation. Furthermore, TB/HIV activities were rarely **classified by target population**, despite the fact that groups most affected by TB and HIV often overlap. Programs that do explicitly refer to key populations (e.g., migrants, people who inject drugs or prisoners) or are categorized as joint community based interventions show several best practices.

Country-led dialogue and related decision-making by TB and HIV stakeholders, including civil society organizations and affected communities, firmly based on the principles of human rights and gender equality, are essential for joint TB and HIV programming. The **country context** determines the scope of joint programming. The epidemiology of the local TB and HIV epidemic, maturity and capacity of programs, diverse health infrastructures and management as well as barriers to care and client needs should determine the scope and critical areas of joint programming with a flexible approach. Efficiencies can be gained at several levels of the programs, from planning and coordination to service delivery and data collection. This reduces duplication, fosters synergies and targets resources to achieve maximum impact. This will also contribute to an increasingly sustainable program response.

For further details, please refer to the Global Fund [TB Information Note](#), the [UNAIDS/WHO Technical Guidance Note on HIV/TB](#), the [WHO End TB Strategy](#), the [Stop TB Key Population Briefs](#) and the WHO guidelines [Integrating collaborative TB and HIV services within a comprehensive package of care for people who inject drugs](#) and the Report of the consultation meeting to draw lessons from development of Single TB and HIV Concept Notes and defining the way forward for joint TB and HIV programming, Addis Ababa 2015.

Resilient and sustainable systems for health

Building **resilient and sustainable systems (RSSH)** for health is crucial to ensuring that people have access to effective, efficient, and accessible HIV services through well-functioning and responsive health and community systems. RSSH is one of the core objectives of the Global Fund Strategy 2017-2022 “Investing to End Epidemics”. Systems for health, differently from health systems, do not stop at a clinical facility but run deep into communities and can reach those who do not always go to health clinics, particularly the most vulnerable and marginalized. Systems for health focus on people, not issues and diseases.

Funding for RSSH can be requested across the **seven RSSH sub-objectives** of the Global Fund’s new RSSH Strategy, which can also be found in the [Modular Framework Handbook](#): (1) strengthen community responses and systems; (2) support reproductive, maternal, newborn, child and adolescent health and platforms for integrated service delivery; (3) strengthen global and in-country procurement and supply chain systems; (4) leverage critical investments in human resources for health; (5) strengthen data systems for health and countries’ capacities for analysis and use; (6) strengthen and align to robust national health strategies and national disease-specific strategic plans; and (7) strengthen financial management and oversight.

RSSH support should be used to **alleviate service delivery constraints faced by HIV programs, increasing the efficiency** of the programs and allowing for national health system strengthening. For example, and as also emphasized by the Technical Review Panel (TRP),¹¹ Global Fund grants that call for rapid ARV therapy scale-up, while procurement and supply chain management systems remain poor, have a weak capacity to deliver services. The TRP therefore recommended that funding requests analyze health system

¹¹ The Technical Review Panel (TRP) of the Global Fund is an impartial team of independent experts responsible for providing a technical assessment of funding requests for strategic focus and technical merit

limitations and needed investments.¹² As PLHIV continue to live longer lives, robust national procurement and supply management systems for essential drugs and diagnostics as well as improved laboratory capacity are crucial. This is especially true now that WHO normative guidance recommends the use of viral load as the preferred treatment monitoring approach, and the fact that reaching the first and third of the three 90-90-90 targets relies on well planned, high quality, and fully integrated laboratory systems.

Strong health information systems are also core to improving HIV program quality and decision-making, allowing, for example, routine monitoring of early warning indicators for HIV drug resistance. In addition, human resources for health challenges have been recognized as a critical bottleneck for the scale-up and delivery of high quality services for HIV. Investments in RSSH can help alleviate these constraints. Community HIV and TB drug distribution can reduce costs and contribute to increased adherence and retention. Investments in antenatal care (e.g. improved infrastructure, improved laboratory services, supported supervision for staff) can greatly support the **prevention of mother-to-child transmission (PMTCT)**, which directly impacts the HIV epidemic and contributes to the use of healthy behaviours such as skilled attendance at birth, early postnatal care and family planning.

Applicants are recommended to present their **cross-cutting RSSH funding request** integrated with a disease-specific funding request for HIV or TB/HIV. Such integrated conceptualization and planning of investments in diseases and health systems increases efficiency and maximizes health impact beyond HIV. More information on how to request support for RSSH can be found in the [funding request instruction guide](#).

Detailed information on activities that the Global Fund invests in under these sub-objectives are outlined in the Information Note on [Building Resilient and Sustainable Systems for Health Through Global Fund Investments](#), [The Role of the Global Fund in Supporting Countries to Build Resilient and Sustainable Systems for Health](#), and the [Strategic Support for Integrated Laboratory Services: Briefing Note for Global Fund Applicants](#). Please also refer to the section on community systems and responses in this Note.

II. Key Areas of Guidance Related to HIV

There are a number of key guidance documents that applicants should consider when they prepare their HIV and/or TB/HIV funding requests. Although not an exhaustive list, particular attention should be placed on the following recent guidance documents.

WHO consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection

The Global Fund welcomes the “Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection,” released by WHO in June 2016.¹³ The guidelines bring together new evidence of the benefits of the “test and treat all” approach, together with clinical, service delivery and programmatic guidance for low- and middle- income countries across all age ranges.

Major recommendations include:

1. **Providing lifelong ART** to all children, adolescents and adults, including all pregnant and breastfeeding women living with HIV, regardless of WHO clinical stage and CD4 cell count.
2. **Initiating alternative first-line treatment regimes**, including fixed-dose combinations containing dolutegravir (an integrase inhibitor) or a reduced dosage of efavirenz, as new options in an increased number of settings, to improve tolerability and reduce costs.¹⁴

¹² Global Fund : The technical review panel’s consolidated observations on the 2014-2016 allocation-based funding model

¹³ WHO (2016) Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection Recommendations for a public health approach - Second edition.

¹⁴ These drugs are recommended by WHO as alternative first-line options pending further data to support use in pregnant women, TB co-infected people and children.

3. **Offering pre-exposure prophylaxis (PrEP)** to individuals at substantial risk of acquiring HIV (as part of a combination of HIV prevention approaches).
4. **Expanding the use of viral load** as the preferred ART treatment monitoring approach with priority for roll-out of services to pregnant and breastfeeding women, and children.
5. **Routine monitoring** of early warning indicators for HIV drug resistance (HIV-DR) and conducting HIV drug-resistance surveys.
6. **Routine testing** of children presenting in nutrition and inpatient wards. Strategic use of nucleic acid testing at birth and point of care testing for early infant HIV diagnosis.
7. **Enhanced infant prophylaxis**, including six weeks of dual prophylaxis for infants born to mothers with HIV who are at high risk of acquiring HIV, and an additional six weeks for high-risk infants who are breastfed.
8. **Enhanced management of suspected TB among PLHIV who are seriously ill**, including latest recommendations on Lateral Flow lipoarabinomannan (LAM) and a new algorithm that incorporates Xpert MTB/RIF, Lateral Flow LAM assay, and presumptive TB treatment.
9. **Less frequent clinical visits (3-6 months) and medication pickups (3-6 months) for people stable on ART.** In addition, programs should provide support for community support for PLHIV to improve retention in HIV care.

For countries in the process of transitioning to the 2016 guidelines, national HIV program managers are encouraged to take into account national governance processes, HIV epidemiology, equity of access, health systems capacity and availability and sustainability of financial resources. Funding requests should show clear operational frameworks for scale-up, ensuring service quality and attention to the treatment cascade.

WHO consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations

Guidelines on HIV prevention, diagnosis, treatment and care for key populations bring together all existing WHO guidance relevant to five key populations: men who have sex with men, people who inject drugs, people in prisons and other closed settings, sex workers and transgender people.¹⁵ Recommendations cover HIV prevention, harm reduction, HIV testing services, HIV treatment and care, prevention and management of co-infections and comorbidities and sexual and reproductive health. New recommendations include offering PrEP as an additional HIV prevention choice for anyone at substantial risk of acquiring HIV (in many settings this will include men who have sex with men, transgender women, and sex workers, particularly in sub-Saharan Africa), and the provision of naloxone to people likely to witness an opioid overdose. Comprehensive harm reduction programs remain the most effective way to prevent HIV, hepatitis B virus (HBV) and hepatitis C virus (HCV) infection for people who inject drugs. The guidelines stress the need to assess and address country-specific circumstances including the human rights and gender-related barriers that may impede progress.¹⁶

HIV testing, including viral load and self-testing, and services

In its 2015 Consolidated Guidelines on HIV Testing Services, WHO provided programmatic guidance and encouraged countries to start piloting demonstration projects to evaluate self-testing within their particular contexts.¹⁷ Following these guidelines, the Global Fund issued an operational research note and expedited review panel for diagnostics to support countries to implement HIV self-testing.¹⁸ WHO is currently developing

¹⁵ WHO (2016) Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations.

¹⁶ This includes review and revision of laws, policies and practices which affect key populations and their access to services; implementation of anti-discrimination and protective laws to eliminate stigma, discrimination and violence against people from KP; health services should be made available, accessible and acceptable to KPs; enhanced community empowerment, and, addressing violence against people from KPs.

¹⁷ WHO's (2015) Consolidated guidelines on HIV testing services.

¹⁸ [Global Fund Briefing Note on Operational Research to Improve Implementation and Uptake of HIV Self-testing.](#)

new guidance on HIV self-testing and assisted partner notification, planned for release in December 2016.¹⁹ These new guidelines advise countries to offer HIV self-testing as an additional approach to delivering HIV testing services as well as voluntary assisted HIV partner notification services as part of a comprehensive package of services. WHO also recommends HIV testing by trained lay providers.²⁰ The 2014 WHO technical and operational considerations for implementing HIV viral load testing provides guidance on implementing and scaling up HIV viral load testing programs, which is the preferred treatment monitoring approach to diagnose and confirm treatment failure according to the latest WHO guidance.²¹ WHO has also issued guidance on improving the quality of testing.²²

WHO pre-exposure prophylaxis implementation guidelines

WHO issued guidelines on pre-exposure prophylaxis (PrEP) for HIV in 2015 recommending use of a regimen containing the anti-retroviral drug tenofovir as PrEP as an extra prevention choice to people at substantial risk of HIV.²³ The implementation guidelines are currently in preparation. Applicants can find more information on implementing PrEP in (national HIV) programs in the UNAIDS Oral pre-exposure prophylaxis: questions and answers.²⁴

UNAIDS prevention guidance among adolescent girls and young women

For behavioral and biological reasons, adolescent girls and young women are disproportionately affected by HIV infection. UNAIDS' prevention guidance among adolescent girls and young women²⁵ provides an overview of the latest science on HIV prevention in young women, adolescent girls and their male partners in order to inform policy direction. It recognizes the differences in epidemics among young women and between different regions and countries.

The document provides concepts and examples on how to understand the epidemic situation, design effective responses, deliver programs and measure and sustain program impact. Based on evidence and programming experience, the document proposes a menu of priority programmes that countries can use to tailor their response depending on HIV incidence levels amongst adolescent women and girls.²⁶ The guidance also recognizes the imperative of working with both women and men within each program.

The global action plan on HIV resistance, 2017-2021

Signals of high levels of pre-treatment HIV Drug Resistance (HIVDR) to first-line ARVs have been reported in several countries. This is concerning as preventing and responding to HIVDR is an important part of meeting the 90-90-90 targets, and in particular the third 90 target of achieving viral load suppression among patients on ART. WHO recommends the routine implementation of Early Warning Indicators and HIVDR surveys as a critical component of every national ART scale up plan.²⁷ After extensive consultations with stakeholders, WHO will launch a Global Action Plan on HIV drug resistance in early 2017. The Plan calls for routine surveillance to be performed in all fast-track countries, reliable data to inform guidelines, strengthened programmatic data and laboratory capacity and ensuring that enabling mechanisms, such as advocacy and country ownership, are in place to support an effective response.²⁸ More information about the plan and the process can be found in the [Global action plan for HIV drug resistance 2017-2021 Brief](#).

¹⁹ WHO website: <http://www.who.int/hiv/mediacentre/news/hiv-self-testing-2016/en/>.

²⁰ A lay provider is any person who performs functions related to health-care delivery and has been trained to deliver specific services but has received no formal professional or paraprofessional certificate or tertiary education degree. WHO: Policy Brief WHO recommends HIV testing by lay providers (2015).

²¹ World Health Organization, "Technical and operational considerations for implementing HIV viral load testing: Interim technical update," no. July. p. 28, 2014.

²² World Health Organization, "Improving the quality of HIV-related point-of-care testing: ensuring the reliability and accuracy of test results," December. p. 90, 2015; World Health Organization, "WHO Guide for the Stepwise Laboratory Improvement Process Towards Accreditation in the African Region (Checklist)," pp. 1–60, 2015.

²³ WHO (2015) Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV.

²⁴ UNAIDS (2016): Oral pre-exposure prophylaxis: questions and answers.

²⁵ UNAIDS (2016) HIV prevention among adolescent girls and young women: putting HIV prevention among adolescent girls and young women on the Fast-Track and engaging men and boys.

²⁶ For example, the priority programmes of a standard service package include: male and female condoms and lubricants; HIV testing and counselling services; anti-retroviral therapy; voluntary medical male circumcision (VMMC); harm reduction for people who use drugs; prevention programmes for young sex workers and a comprehensive sexuality education. In addition, it provides the option for extra programme elements to be added, depending on the level of HIV incidence, such as PrEP access.

²⁷ WHO (2015). HIV Drug Resistance surveillance guidance: 2015 Update.

²⁸ In addition, WHO is developing recommendations on the management of HIVDR at programmatic level, aiming to guide country decision-making on policy interventions in response to an agreed upon level of national pre-treatment drug resistance. This guidance is

III. Strategic Investments for Comprehensive HIV Programs

In 2011, the **HIV strategic investment approach** was developed by an international group of experts, from UNAIDS, the Global Fund, the Bill & Melinda Gates Foundation, civil society organizations, the World Bank, WHO, UNICEF and the U.S. President's Emergency Plan for AIDS Relief to increase the impact of HIV funding for an effective, efficient and sustainable HIV response.¹

The introduction of this approach has paved the way for a new era in the global HIV response. Countries are increasingly adopting strategic investment thinking in their HIV programming by **prioritizing investments in high-impact locations and in key and vulnerable populations**, while at the same time reallocating resources from less effective activities. This also contributed to the development and availability of technically sound **HIV national strategic plans (NSPs)** and/or **investment cases**, which form the basis for Global Fund funding requests.²⁹

Building on a human rights and gender-responsive approach, the strategic investment approach also highlights meticulous analysis of epidemiological and other relevant evidence (see below), a realistic appraisal of existing resources and quantification of the returns on investments. It also suggests a **four-step process for prioritizing the different components** of a country's HIV response (Box 1). These four steps remain highly relevant for the development of updated HIV NSPs and/or investment cases (or new ones if deemed necessary) to ensure that **funding requests to the Global Fund are robust, prioritized and costed**.

Box 1: Four key steps of the HIV investment approach³⁰

- **Understand:** To maximize impact of HIV investments, a thorough understanding is required of the extent and dynamics of the national HIV epidemic, based on the latest epidemiological evidence and the current response. This includes an understanding of the key locations and populations with the greatest HIV burden and the greatest unmet needs for HIV services, as well as structural obstacles to service uptake and reach.
- **Design:** Based on this evidence, countries have to decide on the combination of interventions to prioritize – considering the effectiveness of interventions in reducing their HIV epidemic and keeping people alive with a view to achieving the greatest impact.
- **Deliver:** To increase impact, the response needs to be delivered at scale, i.e. aimed at reaching all those in need. It is thus recommended that countries identify major inefficiencies in HIV programs, and strategies to address key bottlenecks and barriers to access, delivery and quality of HIV services. In this context, pursuing efficiency gains through the minimization of commodity procurement costs and cost-efficient delivery methods can be important. Particular attention will also be required to devise effective means for overcoming human rights and gender-related barriers and reaching key populations and vulnerable groups, including mothers and children.
- **Sustain:** Countries should address challenges related to a sustainable AIDS response, e.g., by synergizing health investments with investments in other development sectors that can have a positive effect on HIV programs and outcomes,¹ integrating key services and avoiding duplications. It also emphasizes the need for more sustainable financing of the HIV response through identifying new and innovative sources of domestic and external funding.

Focus on location and population: designing evidence-based intervention packages tailored to specific contexts

Going forward, applying strategic investment thinking continues to be of key importance to reach the Fast Track targets by 2020 and to end the AIDS epidemic as a public health threat by 2030. As **epidemics have become more heterogeneous**, with the proportion of new infections increasing among people from key populations in all regions, it is critical to further improve the understanding of national epidemics to mount

expected to be released by mid-2017 as an update of the 2016 consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection.

²⁹ UNAIDS (2015): Focus on location and population: on the Fast-Track to end AIDS by 2030.

³⁰ UNAIDS (2013): Making the case for investing in HIV more strategically: An investment case tool.

more differentiated, tailored and efficient responses. In Southern and East Africa, for instance, access to and uptake of HIV prevention, testing and treatment services continue to be significantly lower among men compared to women, and increased efforts should be made to diagnose men with HIV and connect them to services. More than ever before, **attention to location and population** is required to optimally prioritize and redistribute resources to improve access.³¹

It is critical for countries to continue and further expand the collection and analysis of different data on the current and evolving epidemiological situation, the health and community systems context, the effectiveness and efficiency of the actual national HIV response, and service delivery barriers, including those related to human rights and gender equality. The WHO Consolidated Strategic Information Guidelines outline key HIV indicators and data systems for the health sector. Programmatic reporting systems for HIV testing, care, treatment and laboratory services can be facilitated by Electronic Medical Records and/or District Health Information Software or other locally implemented tools, using unique identifiers. The TRP explicitly recommends that countries invest and strengthen quality data systems, prioritize interventions based on evidence, and that data is routinely analyzed and used to inform and improve programming.¹²

The following types of data are critical for a strategic allocation of HIV investments:

- Updated epidemic dynamics and patterns at a national and sub-national level, which provide data on all populations that are key to the epidemic and response. This would include disaggregated data, ideally by key and vulnerable populations,³² sex, and age group, as well as data on HIV and TB incidence, morbidity, and mortality, which is necessary for linking epidemiological trends to program efforts. This includes identifying populations and sub-populations that may have disproportionately low access to HIV prevention, treatment, and care and support services and the reasons why this is the case.
- Information on geographic areas with high HIV burden/transmission, and any recent epidemiological changes, particularly for key and vulnerable populations.
- Disaggregated data on behavioral health indicators and trends where relevant, e.g. preventative measures, testing, treatment and referrals.
- Evidence on factors that may cause inequity in or constitute barriers to access to services for HIV prevention, testing, treatment, care and support. These factors include stigma and discrimination, including in service delivery, gender norms, gender-related inequality and gender-based violence, human rights violations, punitive or harmful policies, regulations, laws and policing practices, unethical or unscientific health services, policy barriers and policies related to poverty. Such data is critical as human rights and gender-related barriers should be addressed with programs aimed at removing those barriers, to ensure optimal delivery of HIV services.
- Data on systems-related capacity and constraints at the national, sub-national and community levels that could be affecting the HIV/AIDS burden. This includes analyses on constraints related to the involvement of communities and community based organizations in implementing programs.
- Information emerging from national M&E assessments of the existing systems that can be used to inform the strengthening of M&E activities at the national and sub-national level.
- HIV case-based surveillance and patient monitoring systems.³³

³¹ UNAIDS (2015): Focus on location and population: on the Fast-Track to end AIDS by 2030.

³² Collecting data on key populations can pose risks to key population individuals and groups. The ethical principle of 'do no harm', confidentiality of data, informed consent and additional safeguards should be ensured throughout the process. For the estimation of the size of key populations, the [WHO/UNAIDS Guidelines on Estimation the Size of Populations Most at Risk to HIV](#) can be used.

³³ WHO HIV Patient Monitoring and Case Based Surveillance Guidelines (to be released December 2016).

- Program data on the 90-90-90 treatment cascade, based on five indicators,³⁴ and data on the HIV service cascade.

Given that many countries still face challenges in routine surveillance and patient monitoring,³⁵ and that the **right bundle of interventions can only be determined if a thorough situation analysis** of the changing patterns in the local epidemic have been conducted, continued efforts are needed to collect and analyze data.

While the best package of prevention and treatment services will differ from context to context, there are **high-impact HIV prevention and treatment interventions** that form the core of the investment approach, and are supported by the Global Fund (Box 2). In this context, it is important to highlight that recent evidence shows that HIV prevention efforts must be increased in order to stay on the Fast-Track to ending AIDS by 2030,³⁶ and should focus on the **five prevention pillars**.³⁷

Box 2: High-impact HIV interventions and programming

Applicants are **strongly advised** to review the most recent technical and normative guidance related to these high impact interventions. Key guidance documents are listed at the end of this Information Note. All interventions, services and programs should be built upon human rights principles, including non-discrimination, participation, safety, confidentiality and informed consent.

- **Male and female condom and lubricant promotion and distribution**, including through social franchising methods. Condom use remains complimentary to all other HIV prevention methods, as they are the only devices that both reduce the transmission of HIV and other sexually transmitted infections (STIs) and prevent unintended pregnancy. Condom interventions should address barriers that hinder access to condom use, particularly by young people and key populations, and ensure people have the knowledge, skills and empowerment to use them correctly and consistently.³⁸ Condom distribution and sales can be strengthened by combining public sector distribution, social marketing and private sector sales.³⁹
- **Prevention of mother to child transmission of HIV (PMTCT)**,⁴⁰ including a focus on pregnant and breastfeeding adolescents and young women and female sex workers.
- **Oral pre-exposure prophylaxis (PrEP)** as an extra prevention of choice for people at substantial risk of HIV. “Substantial risk” has no strict definition and depends on national epidemic priorities. However, PrEP becomes a cost-effective intervention when the incidence rate in the population accessing PrEP is around 3 per 100 person years or above.²⁴
- **Voluntary male circumcision (VMMC)**: provides high protection to men, particularly in sub-Saharan Africa. The vast majority of VMMCs have been successfully and safely performed using conventional surgery. WHO recommends use of prequalified non-surgical adult circumcision devices together with tetanus immunization for use in low-resource settings which can provide an alternative to conventional surgical male circumcision.⁴¹ VMMC with a focus on adolescents and young men is a unique opportunity to reach and provide information, select services and a gateway to other services.

³⁴ The five indicators of the 90-90-90 treatment cascade include: (1) estimated number of PLWH, (2) number and percentage of PLHIV who are aware of their status, (3) number and percentage of PLWH who are receiving HIV care (including ART), (4) number and percentage of PLWH who are receiving ART, (5) number and percentage of PLHIV who are virally suppressed (<1000 copies/mL).

³⁵ UNAIDS 2016: Fast-Track Update On Investments Needed in the AIDS response.

³⁶ The UNAIDS *Prevention gap report* shows that an estimated 1.9 million adults have become infected with HIV every year for at least the past five years and that new HIV infections among adults are rising in some regions.

³⁷ The five prevention pillars are: (1) combination prevention, including comprehensive sexuality education, economic empowerment and access to sexual and reproductive health services for young women and adolescent girls and their male partners in high-prevalence locations; (2) evidence-informed and human rights-based prevention programmes for key populations, including dedicated services and community mobilization and empowerment; (3) strengthened national condom programs, including procurement, distribution, social marketing, private-sector sales and demand creation; (4) voluntary medical male circumcision in priority countries that have high levels of HIV prevalence and low levels of male circumcision, as part of wider sexual and reproductive health service provision for boys and men; and (5) pre-exposure prophylaxis for population groups at higher risk of HIV infection. See UNAIDS 2016: Prevention gap report

³⁸ UNFPA, WHO and UNAIDS (2015): Position statement on condoms and the prevention of HIV, other sexually transmitted infections and unintended pregnancy.; WHO, UNFPA, FHI (2010; revised 2013): Male latex condom. Specification, prequalification and guidelines for procurement.

³⁹ USAID, PEPFAR, SHOPS (2015): Using Total Market Approaches in Condom Programs

⁴⁰ PMTCT consists of four prongs including primary prevention to women and girls, preventing unwanted pregnancies in HIV positive women, antiretroviral treatment during pregnancy, at time of delivery and during breastfeeding and prevention, diagnosis and treatment to children and other family members.

⁴¹ WHO (2016) [A framework for voluntary medical male circumcision](#); WHO (2016) [List of prequalified male circumcision devices](#).

- **Comprehensive sexuality education** and behavior change programs, including for people engaging in casual sex and young people, to increase demand for evidence-based services.
- **HIV-testing services** which adhere to the “5Cs” (consent, confidentiality, counselling, correct result, and connection) includes countries choosing a strategic mix of evidence-based community-based and facility-based HIV testing approaches, e.g. provider initiated testing and counselling, couples and partner HIV testing, assisted HIV partner notification, index-case testing, home-based HIV testing, mobile outreach, workplace programs, and HIV self-testing.⁴²
- **Antiretroviral therapy for all PLHIV** (including for preventing HIV transmission). Treatment of HIV, including opportunistic infections, should be delivered within the context of sustained, high quality differentiated care, using HIV viral load testing to evaluate adherence and diagnose and confirm treatment failure.⁴³

Furthermore, the Global Fund requires that all countries **make sufficient investments in programs to remove the human rights and gender-related barriers to HIV services**, and to promote gender equality (see also Section 4 below).

The role of National Strategic Plans and investment cases in the preparation of funding requests to the Global Fund

HIV investment cases, national strategic plans (NSPs) and other relevant documents outline the parameters for a strong national strategic response. Global Fund funding applications should be aligned with the national priorities set forward in these documents towards effective and country-owned national response. Regular review and updating of these documents should be appropriately undertaken by countries to ensure that most effective strategies are incorporated and aligned with the Fast-Track goals, 10 targets and strategic milestones for 2020 of the UNAIDS 2016-2021 strategy, which guides the global AIDS response.⁵

Various tools and guidance documents are available to countries from UNAIDS and other technical partners to support the strengthening of HIV NSPs and investment cases, provide support in developing strong and results-based national strategies within the frame of strategic investments, and help to address the most difficult allocation and prioritization choices required for impact.⁴³ This includes the UNAIDS’ HIV investment case tool and process guide which countries are encouraged to use.

Given that changes might have occurred since the investment approach was implemented, countries might want to **consider a light update** of the existing investment scenario modelling. This update will consist of a re-run of countries’ existing investment models, which they developed to determine the optimal combination of HIV prevention, treatment and enablers and related impact. The impact scenario update will include:

- Updated epidemiological data in terms of epidemic dynamics and patterns (transmission dynamics and geographic patterns, including sub-national level data);
- Update of new policies adopted (e.g., expanding programs for HIV prevention and “test and offer/start” policy) and coverage levels;
- Information on the inclusion of other service delivery models that will support quality and accelerated implementation;
- Most recent data on critical enablers and synergies; and
- New unit cost data.

Countries should also consider applying specific **HIV resource allocation tools and models** to compare different intervention scenarios and to identify the optimal intervention packages that maximize impact.

⁴² WHO (2012): Service delivery approaches to HIV testing and counselling (HTC): A strategic policy framework.

⁴³ UNAIDS (2012): Investing for Results. Results for People. A people-centred investment tool towards ending AIDS.

Examples of these tools include [OneHealth](#)⁴⁴, [AIDS Epidemic Model](#)⁴⁵, [Optima](#)⁴⁶, and [Socio-Technical Allocation of Resources](#).⁴⁷ These tools are described in more detail in the UNAIDS/WHO Guidance Notes for country programming.⁴⁸ Different tools may be utilized according to the specific country needs and circumstances as they have different strengths and attributes. The tools that incorporate a costing framework and rigorous epidemiological impact models, can help countries in making strategic investment decisions by quantifying the costs and health impacts of their investment scenarios with the tools.⁴⁹ These tools also support countries to conduct fiscal sustainability analysis based on the projection of future funding, facilitate policy dialogues and decision making by analyzing the costs and benefits of intervention options, and enabling the incorporation of other factors, such as equity and feasibility.

The results of the optimal allocations for the AIDS response can inform the review of NSPs in countries.⁵⁰ When reviewing their NSP and related national strategic documents, countries should also refer to the “**Joint Assessment of National Health Strategies**” (JANS) tool and guidelines.⁵¹ JANS is, however, not the most effective tool to assess aspects related to human rights, gender or community systems and responses. The Global Fund expects countries to also address these issues in its assessments, for example, by using the UNAIDS Gender Assessment tool and the People Living with HIV Stigma Index. For more information on the review process, please also refer to the Global Fund [Applicant’s Handbook](#) and to the [HIV, Human Rights and Gender Equality Technical Brief](#).

IV. Key Thematic and Cross-Cutting Areas

05 Key and vulnerable populations

Key and vulnerable populations, including people living with HIV, are central to impactful responses to HIV. **The Global Fund recognizes the critical inputs of key and vulnerable populations in developing, implementing and monitoring programs**, and places a high value on fostering an inclusive working relationship with them. In the context of HIV, key populations include: men who have sex with men, people who inject drugs, sex workers, transgender people and people in prisons and other closed settings.⁵² Stigmatization, discrimination, disenfranchisement and criminalization of key populations hamper country efforts to reach their respective goals and targets, and this is damaging to national responses. Vulnerable populations are those who experience a greater vulnerability to and impact of HIV. Depending on the country context, this might include groups such as orphans, (street) children, (pregnant) women and girls, people with disabilities, people living in extreme poverty, mobile workers, displaced populations and other migrants.

In every country that reliably collects and accurately reports surveillance data, **these groups have a higher risk of contracting HIV as well as higher mortality and/or morbidity rates** as compared to the general population. Access to, or uptake of, relevant services is also significantly lower for these populations. PLHIV also experience stigma and discrimination, which is a major impediment to improving health outcomes.

Countries seeking new grants are expected to focus national responses with the view to key populations by:

1. **Improving the collection, analysis and use of data** and strategic information on key populations to inform effective programs. Collecting data on key populations can pose risks to key population individuals and groups. The ethical principle of ‘do no harm’, confidentiality of data, informed consent and additional safeguards should be ensured throughout the process.

⁴⁴ <http://www.internationalhealthpartnership.net/en/tools/one-health-tool/>

⁴⁵ <http://www.eastwestcenter.org/>

⁴⁶ <http://optimamodel.com/>

⁴⁷ <http://www.health.org.uk/collection/star-socio-technical-allocation-resources>

⁴⁸ <http://www.unaids.org/en/ourwork/programmebranch/countryimpactsustainabilitydepartment/globalfinancingpartnercoordinationdivision/UNAIDSguidancenotesforcountryprogramming>

⁴⁹ Certain tools also provide optimal resource allocation across HIV programs for any given budget scenario.

⁵⁰ NSPs will aim to translate the high impact scenarios identified through the modelling into strategy implementation and link the investments in the next three to five years with long term impact.

⁵¹ A JANS approach is a process where country stakeholders and development partners carry out an independent assessment of a NSP against an internationally agreed set of criteria. IHP+ (2013): Joint Assessment of National Health Strategies and Plans – Combined Joint Assessment Tool and Guidelines.

⁵² [UNAIDS Terminology Guidelines \(2015\)](#)

2. **Strengthening the participation and engagement of key and vulnerable populations** and networks in NSP review processes and funding request development as well as in program design, grant monitoring, data collection and implementation. To maximize the critical inputs made by key populations, human rights principles – including non-discrimination, gender equality and diversity, safety and confidentiality of participation, transparency and accountability – should be integrated into these processes. Meaningful engagement of key populations in health governance is recognized as a necessary step towards increasing investments in evidence- and rights-based programming, which delivers greater impact on the responses to the three diseases and also strengthens local accountability.
3. **Ensuring that sufficient funding is allocated to key populations at country level** to respond to their needs, and because this is key to achieving the highest possible impact.
4. **Improving expertise in, and quality of, programming for and with key populations** (for example, through increased provision of targeted technical support – including by key populations). Differentiated service delivery strategies are key to improving the accessibility of and retention in care for key populations (see section 5.1: Differentiated models of care and service delivery).
5. **Promoting and protecting the human rights of key populations** by ensuring their active involvement in programs, by removing social, policy and legal barriers to services and by ensuring programs meet the five human rights standards required for all grants. Particular attention should be paid to ensuring gender diversity in promoting participation and gender-sensitive key population programming.

People who use drugs are at higher risk for HIV and HCV and HBV co-infection due to practices such as sharing injecting equipment, including cookers, or shared oral or nasal inhalation materials. The Global Fund’s Framework for Financing Co-infections and Co-Morbidities of HIV/AIDS, Tuberculosis and Malaria⁵³ allows countries to use some of their allocations to fund interventions to prevent or treat co-infections that have a disproportionate impact on people living with the three diseases. In the context of HCV, this involves expanding the harm reduction kit that is commonly provided to prevent HIV to also prevent HCV transmission and considering the provision of HCV treatment, including Direct Acting Antivirals, based on careful cost-effectiveness assessments.

Available data also suggests **adolescent key populations are disproportionately affected by HIV in almost all settings**.⁵⁴ Policy and legal barriers related to the age of consent for accessing a range of health services including HIV testing and counselling, sexual and reproductive health, harm reduction and other services provided specifically for key populations limit the ability of young individuals to exercise their right to independent decision-making and prevent them from accessing essential services. Specific considerations should be given to support adolescent and young key populations in accessing services based on principles and recommendations highlighted in the existing guidance.⁵⁵

Despite substantial evidence on the ineffectiveness of compulsory “treatments“ that aim to “cure” sexual orientation and drug dependence and rehabilitation programs for sex workers, such facilities and interventions continue to exist in a number of countries. Apart from myriad human rights violations and further stigmatization of key populations, these programs can also contribute to increased risk of HIV transmission. While advocating for their immediate closure, **the Global Fund will not fund any kind of interventions in compulsory facilities**, including drug detention centres.

The Global Fund has specific policies and eligibility requirements to ensure adequate focus on key and vulnerable populations. Guidance can be found in the [CCM Performance Framework](#) and the [Sustainability, Transition and Co-financing policy](#). More information on implementing comprehensive programs with key populations is provided in the Information Note on [Addressing Sex Work, MSM and Transgender People and](#)

⁵³ https://www.theglobalfund.org/media/4167/bm33_11-co-infectionsandco-morbidities_report_en.pdf

⁵⁴ UNAIDS (2013): Global Report

⁵⁵ [IATT technical briefs on young key populations](#)

06 Addressing human rights and gender equality-related barriers

Depending on their social and legal status, key and vulnerable populations continue to experience stigma, discrimination, as well as harsh and punitive policies and laws, including illegal police practices. While widespread gender inequality negatively affects everyone, it almost universally has a disproportionately detrimental impact on women and girls. Indeed, in all locations where the Global Fund invests, there are significant human rights and gender-related barriers to services that impact girls, boys, women, men and transgender communities; these act as major barriers to the access, uptake and retention of HIV prevention and treatment services.

Thus, to **maximize the impact of its investments** and move more effectively toward ending the three epidemics, the Global Fund has, in its Strategy for 2017-2022, intensified its commitment to “introduce and scale up programs that remove human rights barriers to accessing HIV, TB and malaria services” and “to invest to reduce health inequalities including gender-and age-related disparities.”

The most significant human rights and gender-related risks and barriers to health services comprise the following:

- **Stigma and discrimination** based on HIV, gender, sexual orientation, social and/or legal status. These can be experienced in communities, health care settings, places of employment, housing and in education. In health care settings this can include disparaging attitudes, discriminatory treatment, demands for bribes and denial of health care.
- **Punitive practices, policies and laws** that include mandatory testing; lack of confidentiality; discriminatory inheritance laws; age of consent to HIV testing and other health services; mandatory registration of people who use drugs; criminalization of sex work, drug use, LGBT people, transmission of HIV; denial of harm reduction measures; denial of HIV prevention and treatment to prisoners, migrants and refugees; illegal policing (harassment, arbitrary arrests, extortion, and violence, including rape) as well as policing that undermines HIV prevention (using condoms as evidence, using needles and syringes provided for harm reduction as evidence, arresting people who use drugs outside of harm reduction services).
- **Gender inequality** including lack of sexual, economic and health-seeking autonomy for women and girls; gender-based and intimate partner violence; lack of equal access to all levels of education; forced or early marriage; denial of access to health care; discriminatory health care practices; lack of access to sexual and reproductive health services; harmful gender norms for HIV positive women; and rejection, blame, loss of property and custody rights, and/or violence if their HIV status becomes known. Sex workers, female drug users, transgender women, men who have sex with men, bisexuals and lesbians face particularly high levels of gender-based violence.

Since 2012, UNAIDS has advocated **seven key programs** that address human rights and gender-related barriers to HIV services.⁵⁷ These programs also serve to strengthen health and community systems. They are (1) stigma and discrimination reduction; (2) training for health care workers on human rights and medical ethics related to HIV; (3) sensitization of law-makers and law enforcement agents; (4) legal literacy (“know your rights”); (5) HIV-related legal services; (6) monitoring and reforming laws, regulations and policies relating to HIV; and (7) reducing discrimination against women in the context of HIV.

To achieve the goal of removing human rights and gender equality-related barriers to health services, interventions to address the **most serious barriers** for those most affected by them should be included in

⁵⁶ UNAIDS/WHO/UNDP/UNFPA (2016): [Implementing Comprehensive HIV and STI Programmes with Transgender People: Practical Guidance for Collaborative Interventions \(the “TRANSIT”\)](#); WHO (2015): [Implementing comprehensive HIV and STI programmes with men who have sex with men Practical guidance for collaborative interventions](#); WHO (2013): [Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions](#).

⁵⁷ [Seven Key Programs to Address Stigma and Discrimination and Increase Access to Justice](#), UNAIDS/JC2339E (English original, May 2012); ISBN:978-92-9173-962-2UNAIDS / JC2339E (English original, May 2012) ISBN: 978-92-9173-962-

all HIV proposals. Such interventions should be flexible, take cost-effective forms, and be tailored to different issues, populations and contexts. They should aim to achieve overlapping objectives and may be most effective if implemented in strategic combinations with other health and development programs.

Many past proposals have referred to human rights and gender equality issues but have failed to include the specific interventions, costs and budget needed to address them. To identify and scale up sustainable programs to remove human rights and gender equality-related barriers, applicants are strongly encouraged to take the following steps through inclusive and participatory processes to:

1. Identify the main **human rights and gender equality issues** that act as barriers to access to and uptake and retention of HIV services for key and vulnerable populations.
2. **Identify the groups, communities, and health care services** most affected by these barriers.
3. **Identify the most effective programs** to remove human rights and gender-equality-related barriers, and the levels of coverage necessary to make a difference.
4. **Estimate costs** for these programs, including an evaluation component embedded in the program design to measure the impact and outcomes of these programs and inform and improve programming, and allocate appropriate budgets to them.
5. **Identify Principal Recipients** and implementing partners for these programs.
6. Devise and budget for **monitoring and evaluation** of results.

Applicants should refer to the Global Fund [Technical Brief on HIV, Human Rights and Gender Equality](#), the FAQ [Scaling up programs to remove human rights barriers to health services](#) and the [UNAIDS Human Rights Costing Tool](#) and its [User Guide](#).

07 Strengthening sexual, reproductive, maternal, newborn, child and adolescent health

To maximize impact, HIV investments should be integrated and connected to resources for strengthening the linkages to sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) interventions. A key sub-objective under the Global Fund Strategy 2017-2022 “Investing to End Epidemics” is the provision of support for integrating SRMNCAH interventions and programs within the context of platforms for integrated service delivery.

The Global Fund has prioritized four areas of integrated service delivery for women, children and adolescents with direct relevance to effective HIV programming:

1. **Antenatal care (ANC):** HIV-related key elements of ANC that are supported by the Global Fund include primary prevention of HIV during pregnancy, the prevention of mother-to-child transmission of HIV (PMTCT) and the screening, prevention, diagnosis and treatment of TB in pregnant women. Retention at all points in the cascade of PMTCT services should be considered, from HIV testing of pregnant women and newborns, through completion of prophylaxis for exposed infants. In particular, hard-to-reach populations such as pregnant adolescents and key populations should be included in ANC programming.
2. **Integrated community case management (iCCM):** The Global Fund continues to recognize the need for quality, integrated child health programming at the facility level, but has identified iCCM as an additional tool for implementing the integrated management of newborn and childhood illness strategy where access to health facilities is poor. iCCM is a strategy to train, and support community health workers and other community stakeholders to diagnose and treat pneumonia, diarrhea and malaria in sick children. Community health worker training packages have been adapted to integrate actions for HIV and TB.

3. **Integrated sexual and reproductive health and HIV services:** Growing evidence documents the numerous benefits of integrating sexual and reproductive health (SRH) and HIV services (e.g., STI prevention and treatment, family planning, cervical cancer screening and HPV vaccination) to improve cost-effectiveness, uptake, access to and quality of care.⁵⁸ SRH services are often the first point of contact that many women and girls at risk of HIV have with the health system, and presents a unique opportunity for health providers to also reach these clients with HIV prevention and treatment services. Similarly, for women and girls living with or affected by HIV, access to quality SRH health services, including family planning and antenatal care, becomes essential for the prevention and treatment of HIV.
4. **Adolescent health:** HIV is the leading cause of death for adolescents in Africa and the second leading cause of death for adolescents globally.⁵⁹ Adolescents have poorer uptake of HIV testing services, linkage to care, retention, adherence, and viral suppression when compared to younger children and adults. Adolescents need comprehensive, educational, and social HIV services appropriate to their life stage and in a friendly manner, which are delivered where they can be reached (e.g., in schools, communities, clinics),⁶⁰ and that can be accessed without caregiver consent. Critical components of adolescent health related to HIV that are eligible for Global Fund support include comprehensive sexuality education, HIV and STI prevention including condom distribution, testing, counselling and treatment, harm reduction, contraception and family planning.

The Global Fund has recognized Adolescent Girls and Young Women (AGYW) as a priority, especially in countries in Southern and East Africa with highest HIV incidence and prevalence in women of 15-24 years of age. Preventing new infections among AGYW requires combined approaches that also reach out to men and adolescent boys. Investments in comprehensive, health, community and multi-sectoral targeted programs at-scale are critical for AGYW, particularly for AGYW within key populations, including differentiated care and comprehensive SRMNCAH services. This includes rights-based approaches addressing gender inequalities and gender-based violence, keeping girls in school and facilitating integration of HIV/ SRHR services.⁶¹

Applicants are encouraged to refer to the Technical Brief on [Strengthening sexual, reproductive, maternal, newborn, child and adolescent health \(SRMNCAH\) interventions in funding requests to the Global Fund](#), the Global Fund information note [Maximizing impact by addressing adolescents' needs in Global Fund funding requests - Strategic Investments for Adolescents in HIV, Tuberculosis and Malaria Programs](#), and the WHO [Global Strategy for Women, Children and Adolescents Health 2016-2030](#). The IAWG provides [guidance](#) on how SRH and HIV policies and programs can, and should be linked, including the integration of service delivery to maximize health outcomes.⁶²

08 Strengthening community systems and responses

The Global Fund strongly encourages the inclusion of interventions to strengthen community systems and responses within disease-specific and RSSH funding requests. Communities most affected by specific diseases and challenges have a unique ability and responsibility to identify, understand and respond to the needs of those who are marginalized and vulnerable in societies and who are, as a consequence, affected by inequitable access to health and other basic services. The impact of HIV and TB programs can be increased by paying sufficient attention to barriers related to human rights abuses, including gender and other inequalities and/or exclusions. A successful response depends on the **meaningful engagement of affected communities**. Communities are essential to designing effective interventions, to implementing and evaluating the robustness and quality of health services including client-centred differentiated care, and creating a demand for services. Systems for health that involve the community will always be the first to identify, report and respond to emerging health threats.

⁵⁸ Sexual & Reproductive Health & HIV Linkages: Evidence Review & Recommendations, IPPF, UCSF, UNAIDS, UNFPA, WHO, 2009

⁵⁹ UNICEF, 2016 <https://data.unicef.org/topic/hiv/aids/adolescents-young-people/>.

⁶⁰ For more information, please see UNAID's GAP Report 2014, available at: http://www.unaids.org/sites/default/files/media_asset/UNAIDS_Gap_report_en.pdf.

⁶¹ These include: HIV prevention and care, contraception, quality ANC, and HPV screening; childbirth and postnatal care; addressing GBV; with a particular focus on socially marginalized adolescents including LGBTI.

⁶² http://srhhivlinkages.org/wp-content/uploads/2013/04/top10questions_2010_en.pdf.

The new Global Fund Strategy 2017-2022 includes strengthening community systems and responses as one of the key pillars of the strategic objective to build resilient and sustainable systems for health. The Global Fund uses the term “**community responses**” to describe the means by which communities act on the challenges they face and the needs they have. “Community systems” is a broad term that describes community structures, mechanisms, processes and actors involved in community responses. Community Systems Strengthening (CSS) is an approach that promotes the development of informed, capable and coordinated communities, community-based organizations, groups, networks and structures.

CSS is particularly important for ensuring that HIV programs reach excluded and marginalized populations whose health and human rights are compromised, including key populations. **Key populations often depend more upon community systems than members of the general population.** The development of social networks and organizations for support, advocacy and kinship is crucial for key populations who often fear and mistrust government-affiliated health systems, who receive poor treatment within those systems and who are afraid of reprisals as a result of disclosure. Many of the most effective HIV responses for key populations are delivered in community-based settings, often by peers. However, these communities often lack the resources they need to be effective partners in national HIV responses. Thus, funding applications that include a focus on strengthening these social networks and organizations can have a positive impact on the ability of key populations to engage in the delivery and management of HIV and health care services.⁶³ Investing in community systems and peer-led services can provide critical outreach, particularly to adolescent key populations, and improve treatment adherence and retention of care of adolescents living with HIV.

When deciding how the different high impact interventions for HIV will be delivered, applicants are encouraged to use **community and peer-led service provision** as a means of scaling up provision and ensuring services reach excluded groups. When applicants are in the early stages of planning their country dialogues, it is recommended that they give full consideration to the role community organizations will play in the implementation of programs. Governments are encouraged to ensure that policies are in place, which allow communities to meaningfully engage in country dialogues, program design, implementation and evaluation. Community sector service delivery should be included alongside service delivery by other sectors in funding applications, and describe how they will facilitate and ensure **effective linkages between community- and facility-based services**. The Global Fund’s Community, Rights and Gender Technical Assistance Program provides support for civil society and community organizations to meaningfully engage in the funding model during country dialogue and funding request development processes.⁶⁴

Guidance on how to include investments to strengthen community systems and responses in Global Fund grants is provided in the Strengthening Community Systems and Responses: Technical Brief [LINK]. Applicants are also encouraged to refer to the Information Note on Building Resilient and Sustainable Systems for Health through Global Fund Investments [LINK].

09 Challenging operating environments

Challenging Operating Environments (COEs) are countries or regions characterized by governance issues, poor access to health services and man-made or natural crises. Performance in COEs has traditionally been weaker than in other countries due to **major systemic and capacity gaps** that greatly impact ability to implement programs. Depending on the specific challenges of the context, COEs can be classified as experiencing acute emergencies or chronic instability. Tailored interventions, program implementation and management approaches based on the local context are crucial to achieve and maximize results in these countries and regions. The Global Fund COEs policy⁶⁵ ensures **flexibility** throughout the funding cycle tailored to each COE depending on the situation, in order to maximize coverage and ensure access to services. It allows for ad hoc classification to enable rapid responses to emergency situations.⁶⁶ Depending on the local context, key and vulnerable populations in emergency settings include refugees and (internally) displaced persons, women and armed forces, amongst others.

⁶³ [Global Fund Key populations action plan 2014-2017](#)

⁶⁴ <http://www.theglobalfund.org/en/fundingmodel/technicalcooperation/communityrightsgender/>

⁶⁵ Global Fund [Challenging Operating Environments Policy](#)

⁶⁶ An emergency situation in a country is defined as one in which an event or a series of events has resulted in a critical threat to the health, safety, security or well-being of a large group of people. It can be the result of an armed conflict and coup d’état, natural disasters, epidemics or famine, and often involves population displacement.

Countries identified as COEs can find guidance on access to funding and grant management in the [Operational Policy Note on Challenging Operating Environments](#) and refer to the [Global Fund Policy on Challenging Operating Environments](#).

10 Sustainability and transition of programs supported by the Global Fund

The Global Fund encourages all countries to build sustainability considerations into their program design. The principles are outlined in its new [policy on Sustainability, Transition and Co-financing](#),⁶⁷ which provides a framework to support countries in **transitioning successfully** from Global Fund financing, which is differentiated along the development continuum.

Programs that serve key populations, including critical interventions to remove human rights and gender-related barriers to access, often lack adequate political commitment. In order to safeguard against these critical interventions ceasing when programs transition from Global Fund support, key and vulnerable populations must be central not only as recipients and implementers of services, but also as advocates for well-planned, data-driven transitions that maintain and expand effective evidence-informed and human rights-based interventions.

Additional information for applicants to develop funding requests in accordance with the [Sustainability, Transition and Co-financing policy](#) can be found in the Sustainability, Transition and Co-financing Guidance Note (*forthcoming*).

V. Program Quality and Efficiency

A key component of the 2017-2022 Global Fund Strategy is the mainstreaming of program quality across the grant life cycle to maximize the impact of Global Fund investments. Program quality and efficiency are a result of the efforts of countries, partners and Global Fund staff to ensure that each step of the grant cycle is designed and implemented optimally, and that critical bottlenecks at different levels of country systems are identified and addressed.

The identification and replication of practices leading to better health outcomes is one key pathway to taking innovation to scale for greater impact. The Global Fund will have a strong focus on the improvements in implementation and service delivery. This includes, for example, reaching more people with tailored services, data-driven prioritization of investments to maximize program outcomes across different levels of financing, the quality of management capacity in national programs and the use of data at community level to drive improvements.

The Global Fund's approach to mainstreaming program quality and efficiency includes four pillars:

1. **Country-centric partnership approach:** drawing upon technical and financial resources in support of country needs and priorities. Country dialogue informed by evidence is the starting point for mobilizing technical and financial resources from within the partnership to support improvements in program quality and outcomes.
2. **Data use for action:** accurate and timely information, gathered through strong data systems, is critical to improving program quality and efficiency. Prioritization of investments, policies and decision-making should be driven by disaggregated national and sub-national data, addressing the HIV epidemic dynamics as well as bottlenecks to implementation. Actors, including communities and local providers, should be able to access, use, and act based upon the HIV epidemic and response data to highlight issues with program quality and barriers to accessing services. For more information on critical types of data for efficient programming, refer to section 3 of this Information Note: "Strategic investments for comprehensive HIV programs".

⁶⁷ Global Fund [Sustainability, Transition and Co-financing policy](#).

3. **Outcomes and impact:** Key performance indicators developed with countries and partners for the 2017-2022 Global Fund Strategy represent measurable statements about intended outcomes at the portfolio-wide level. Performance metrics are important for strengthening focus and action on measurable changes in quality, outcomes and efficiency.
4. **Value for money:** Careful prioritization of investments and interventions, where needed most and where action is likely to lead to the greatest return on investment, is required to improve quality and efficiency. Differentiation and prioritization are critical both within Global Fund systems and processes as well as within country programs and systems.

11 Differentiated models of care and service delivery

One key aspect of improving program quality and efficiency focuses on the improvements in implementation and service delivery to ensure more and more people are reached with **tailored (differentiated) services**. This will lead to an increase in impact and efficiency. Differentiated care is a client-centred approach, which simplifies and adapts HIV services across the prevention, testing, treatment and care cascade, to reflect the needs, preferences and expectations of various groups of PLHIV while also reducing unnecessary burdens on the health system. The recently updated WHO consolidated guidelines on the use of ART therapy show a shift in the delivery of HIV treatment, to recognizing the diverse needs of PLHIV; new guidance now includes service delivery recommendations based on a differentiated care framework. By providing differentiated care, the health system can refocus resources on those most in need. Adapting ART delivery and support services to specific client populations and context is required to reach the 90-90-90 targets.

Successful implementation of differentiated ART service delivery has the potential to realize site-level cost efficiencies of up to 20 percent⁶⁸ while maintaining or improving patient health outcomes. Overall, approaches to differentiated service delivery may not require additional health resources, but rather make more efficient use of existing resources. Differentiated ART care can be introduced step by step, with **'building blocks'** within the existing health system. These building blocks recognize the diverse needs of PLHIV and support shifting resources by appropriately supporting stable clients to have fewer and less intense interactions with the health system. Countries could start with quick efficiency gains, such as reducing the frequency of ARV refills (to once every 3-6 months), clinical visits (to once every 6-12 months) and laboratory testing for people stable on ART. By providing more appropriate care through a differentiated approach, retention in care and viral suppression can improve.

In addition to ART differentiated care, countries are encouraged to identify alternative service delivery modalities for other HIV-related programs. Diverse service delivery modalities can be explored to increase demand for HIV prevention, including VMMC and other programs. Similarly, confidential testing can be conducted through various types of service delivery, including door-to-door testing, community-based testing, lay provider testing and other models to ensure that hard-to-reach populations are tested and linked to treatment services. Differentiated service delivery may also include **community-based interventions** to improve the prevention and treatment cascade, including improving uptake of services and adherence. WHO differentiated service delivery strategies for key populations, which improve the accessibility of and retention in care include the integration⁶⁹ and decentralization⁷⁰ of services, task-shifting⁷¹ and community based approaches.⁷² Countries and country partners are encouraged to explore service delivery modalities that might have been implemented in country by other partners, including PEPFAR, or explore other countries' guidance and experiences.⁷³

⁶⁸ This 20 percent figure is based on published research and direct observations of The AIDS Support Organization (TASO) in Uganda for community HIV drug dispensing and ART refill.

⁶⁹ WHO recommends integration of HIV services into other relevant clinical services, such as TB, viral hepatitis, MCH, sexual and reproductive health services and drug dependence treatment.

⁷⁰ This includes initiation of ART in hospitals with maintenance in peripheral health facilities, both initiation and maintenance in peripheral health facilities, or maintenance at the community level between regular clinic visits.

⁷¹ Task shifting involves the rational redistribution of tasks among health-care workers. Where appropriate, tasks are reassigned from highly qualified health workers to health workers with shorter training and fewer complementary qualifications.

⁷² Community-led services, in which community members take the lead in delivering outreach and overseeing an HIV prevention program, have demonstrated significant benefits in terms of HIV outcomes. Outreach, mobile services, drop-in centers and venue-based approaches are useful for reaching those with limited access to, or underserved by, formal health facilities. These approaches allow for critical linkages and referrals between the community and health facilities, and they support decentralization.

⁷³ Republic of Kenya, Ministry of health: Improving the quality and efficiency of health services in Kenya: A practical handbook for HIV managers and service providers on differentiated care.; http://srhhivlinkages.org/wp-content/uploads/2013/04/top10questions_2010_en.pdf.

The Global Fund published a [toolkit](#) for health facilities on differentiated care for HIV and tuberculosis. The website www.differentiatedcare.org includes examples of [differentiated models of care](#) for various patient groups and individuals. [The decision framework for ART delivery](#) contains a 5-step plan to guide ART program managers, and present the building blocks of service delivery with examples of differentiated ART delivery in sub-Saharan Africa. The [PEPFAR technical considerations for Country Operational Plans \(COP\)/Regional Operational Plans 2016](#)⁷⁴ place emphasis on reconfiguring service delivery approaches to achieve greater efficiency and reduce costs. Differentiated models of care are also applicable to other diseases, such as TB. For more information about quality of HIV programs, please refer to the WHO consolidated guidelines on the use of ART for treating and preventing HIV infection.¹³

12 Human rights standards in all service delivery

Five minimum human rights standards are now part of the Global Fund's grant agreement, establishing the Global Fund's expectations for all the programs it supports. Under the grant agreement, Global Fund recipients are required to let the Global Fund know if there is a risk that programs may violate any of the standards, and they may be asked to work with the Global Fund and address the risks with specific actions.

These standards ensure not only that health services are ethical and meet international human rights norms, but also that services are of quality and are delivered in a way that will encourage access and uptake. These standards require that implementers:

- Grant non-discriminatory access to services for all, including people in detention;
- Employ only scientifically-sound and approved medicines or medical practices;
- Do not employ methods that constitute torture or cruel, inhumane or degrading treatment;
- Respect and protect informed consent, confidentiality and the right to privacy concerning medical testing, treatment or health services rendered; and
- Avoid medical detention and involuntary isolation, which, consistent with WHO guidance, are to be used only as a last resort.⁷⁵

⁷⁴ The PEPFAR COP17, which includes updated technical considerations, will be published early 2017.

⁷⁵ See Global Fund *Human Rights Complaints Procedure Brochure*, available online.

VI. Key References

Global Fund Information Notes and Technical Briefs

- Global Fund Information Note: [TB Information Note](#) (2016).
- Global Fund Information Note: [Building Resilient and Sustainable Systems for Health through Global Fund Investments](#) (2016).
- Global Fund Technical [Brief: Addressing Sex Work, MSM and Transgender People in the Context of the HIV Epidemic](#) (2016).
- Global Fund Technical Brief: [Strengthening sexual, reproductive, maternal, newborn, child and adolescent health \(SRMNCAH\) interventions in funding requests to the Global Fund](#) (2016).
- Global Fund Technical Brief: [HIV, Human Rights and Gender Equality](#) (2016).
- Global Fund Technical Brief: [Strengthening Community Systems and Responses](#) (2016).
- Global Fund Briefing Note: [Operational Research to Improve Implementation and Uptake of HIV Self-testing](#) (2016)

Further selected Global Fund documents

- Global Fund: [Global Fund Strategy 2017-2022 “Investing to End Epidemics.”](#) (2016).
- Global Fund: [The Applicant’s Handbook. A practical guide to preparing a funding request](#) (2016).
- Global Fund: [Funding Request Instructions](#) (2016).
- Global Fund: [Frequently Asked Questions. The 2017-2019 Funding Cycle.](#) (2016)
- Global Fund: [The Role of the Global Fund in Supporting Countries to Build Resilient and Sustainable Systems for Health](#) (2015).
- Global Fund: [Framework for Financing Co-infections and Co-Morbidities of HIV/AIDS, Tuberculosis and Malaria \(COIM\)](#) (2015)
- Global Fund: IDUIT tool (2016).
- Global Fund: [Maximizing impact by addressing adolescents’ needs in Global Fund funding request: Strategic Investments for Adolescents in HIV, Tuberculosis and Malaria Programs](#) (2016).
- Global Fund: [Scaling up programs to remove human rights barriers to health services](#) (2016)
- [Global Fund: Sustainability, Transition and Co-Financing Policy](#) (2016).
- Global Fund Guidance Note: [Sustainability, Transition and Co-financing](#)
- [Global Fund: Challenging Operating Environments Policy](#) (2016).
- [Global Fund: Guide to Global Fund Policies on Procurement and Supply Management of Health Products](#) (2016)

UNAIDS key planning and guiding documents and tools

- UNAIDS: [2016-2021 Strategy: On the Fast-Track to end AIDS.](#)
- UNAIDS/WHO/UNDP/UNFPA: [Implementing Comprehensive HIV and STI Programmes with Transgender People: Practical Guidance for Collaborative Interventions \(the “TRANSIT”\)](#) (2016).
- [UNAIDS: Stronger together: from health and community systems to systems for health](#) (2016).
- [UNAIDS: Do no harm: health, human rights and people who use drugs](#) (2016).
- UNAIDS: [HIV prevention among adolescent girls and young women](#) (2016).
- UNAIDS/WHO: [Guidance notes for country programming](#) (2014).
- UNAIDS Guidance Note: [Reduction of HIV-related stigma and discrimination](#) (2014)
- UNAIDS (online, updated regularly): [HIV Prevention Toolkit](#).
- UNAIDS: Making the case for investing in HIV more strategically: an investment case tool (August 2013) [PowerPoint].
- UNAIDS: Making the case for investing in HIV more strategically: a process guide (August 2013) [PowerPoint].
- UNAIDS: [Smart Investments](#) (2013).
- UNAIDS: [Investing for Results. Results for People. A people-centred investment tool towards ending AIDS](#) (2012).
- UNAIDS: [Human Rights Costing Tool & The User Guide for the HIV-Related Human Rights Costing Tool](#) (2012).
- UNAIDS Guidance Note: [Key programmes to reduce stigma and discrimination and increase access to justice in national HIV responses.](#) (2016)
- UNAIDS/WHO: [TB/HIV Technical Guidance Note for Global Fund HIV Proposals](#) (2011)

- UNAIDS: [Supporting community-based responses to AIDS, tuberculosis and malaria. A guidance tool for including community systems strengthening in proposals for the Global Fund to Fight AIDS, Tuberculosis and Malaria](#) (2011).

WHO guidelines and key documents

- WHO: Recommendations on programmatic management of HIVDR (*forthcoming*)
- WHO: Global Action Plan on HIV drug resistance, 2017-2021 (*forthcoming*)
- WHO: PrEP Implementation Guidance (*forthcoming*)
- WHO: HIV self-testing and partner notification services recommendation (*forthcoming*)
- WHO: [Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection Recommendations for a public health approach - Second edition](#) (2016).
- WHO: [Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations](#) (2016).
- WHO: [Global health sector strategy on HIV, 2016-2021](#) (2016).
- WHO: [Integrating collaborative TB and HIV services within a comprehensive package of care for people who inject drugs. Consolidated guidelines.](#) (2016).
- WHO: [Global action plan for HIV drug resistance 2016-2021, Brief](#) (2016).
- WHO: [Global report on early warning indicators of HIV drug resistance. Technical report](#) (2016).
- WHO: [A framework for voluntary medical male circumcision](#) (2016).
- WHO: [Landscape for HIV rapid diagnostic tests for HIV self-testing](#) (2016)
- WHO: [HIV Drug Resistance surveillance guidance: 2015 Update](#) (2015)
- WHO: [Consolidated strategic information guidelines for HIV in the health sector](#) (2015).
- WHO: [Implementing comprehensive HIV and STI programmes with men who have sex with men Practical guidance for collaborative interventions.](#) (2015).
- WHO: [Consolidated guidelines on HIV testing services.](#) (2015)
- WHO: [WHO recommends HIV testing by lay providers,](#) Policy Brief (2015)
- WHO: [WHO recommendations to assure HIV testing quality,](#) Policy Brief (2015)
- WHO: [Improving the quality of HIV-related point-of-care testing: ensuring the reliability and accuracy of test results](#) (2015)
- WHO: [WHO Guide for the Stepwise Laboratory Improvement Process Towards Accreditation \(SLIPTA\) in the African Region \(with checklist\)](#) (2015)
- WHO: [Technical and operational considerations for implementing HIV viral load testing](#) (2014)
- WHO: [Implementation guidance on Adolescent HIV testing, counselling and care](#) (2014)
- WHO: [Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions](#) (2013).
- WHO: [Guide to conducting programme reviews for the health sector response to HIV/AIDS - Guidance](#) (2013).
- WHO: [HIV and adolescents: Guidance for HIV testing and counselling and care for adolescents living with HIV](#) (2013)
- WHO: [Making health services adolescent friendly](#) (2012)

Other key documents

- [Differentiated care for HIV: A decision framework for antiretroviral therapy delivery.](#) (2016)
- Differentiated care models: www.differentiatedcare.org
- PEPFAR: [PEPFAR Technical Considerations for COP/ROP](#) (2016)
- Stop TB Partnership: [Key Population Briefs](#) (2016)
- Médecins sans Frontières (MSF): “Making viral load routine. Successes and challenges in the implementation of routine HIV viral load monitoring. [Part 1: Programmatic Strategies](#) and [Part 2: The Viral Load Laboratory](#) (2016)
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- IHP+: [Joint Assessment of National Health Strategies and Plans – Combined Joint Assessment Tool and Guidelines](#) (2013).
- UNICEF: [Options B and B+: Key Considerations for Countries to Implement an Equity-focused Approach. Eliminating New HIV Infections Among Children and Keeping Mothers Living with HIV Alive and Well](#) (2012).

- UNDP/UNAIDS: [Understanding and acting on critical enablers and development synergies for strategic investments](#) (2012).

VII. List of Abbreviations

ANC	-	Antenatal care
ARV	-	Antiretroviral
AWYG	-	Adolescent Women and Young Girls
COE	-	Challenging Operating Environment
CSS	-	Community Systems Strengthening
DR	-	Drug Resistance
HBC	-	Hepatitis B Virus
HCV	-	Hepatitis C Virus
iCCM	-	Integrated Community Case Management
JANS	-	Joint Assessment of National Health Strategies
LAM	-	lipoarabinomannan
M&E	-	Monitoring & Evaluation
NSP	-	National Strategic Plan
PLHIV	-	People Living with HIV
PMTCT	-	Prevention of Mother-to-Child Transmission
PrEP	-	Pre-Exposure Prophylaxis
RSSH	-	Resilient and Sustainable Systems for Health
SDG	-	Sustainable Development Goal
SRH	-	Sexual and Reproductive Health
SRMNAH	-	Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health
TRP	-	Technical Review Panel