HIV Information Note

The Global Fund

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1. Background

This Information Note provides guidance to applicants preparing funding requests to the Global Fund to Fight AIDS, Tuberculosis and Malaria, to accelerate progress in preventing, testing, and treating HIV. It supports funding requests for HIV and joint TB/HIV programs for the 2020-2022 allocation period.[1]

Unprecedented progress has been made in fighting AIDS over the last twenty years: the number of new HIV infections globally has declined from 3.4 million in 1996 to 1.8 million in 2017 and the expansion of treatment has led to a 34 percent reduction in deaths from AIDS-related causes between 2000 and 2017.[2] Yet, progress varies considerably across regions, population groups and interventions, and the pace of progress does not match the global ambition set forth in the WHO, UNAIDS, and Global Fund strategies, to be achieved by 2021 and 2022 respectively.[3]

This note guides applicants on Global Fund investment principles and areas of funding priority in HIV programs for the Global Fund. Given the urgency to accelerate progress, this information note has been significantly revised from the last allocation cycle. It explains the "*what*", using the frame of the HIV cascade: prevention, testing, treatment and care, and retention, and cross-cutting human rights and strategic information requirements. It also covers the "*how*", including collecting the right data to designing effective programs, and delivering quality services to prevent HIV transmission, improve HIV diagnosis, treatment and care; stressing the importance of sustainable support for programs.

Countries with a high TB and HIV co-infection burden are required to submit joint TB/HIV funding requests that present integrated quality programming for the two diseases.[4]

Applicants should also consult the following resources:

- Applicant's Handbook: how to develop a funding request.
- Funding Request Instructions: to complete the Application Form.
- Modular Framework: sets out the interventions that the Global Fund supports, associated budget and indicators against which progress is measured.
- Information Notes & Technical Briefs

Box 1: Icons on this information note

! Key changes and additions to the 2020-2022 allocation period.

👥 Illustrative case studies from previous allocation cycles.

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[1] Current allocation period: 2017-2019 and Next allocation period: 2020-2022.
[2] UNAIDS (2018). Data 2018.
[3] The WHO (2016). Global Health Sector Strategy on HIV 2016-2021 Towards Ending AIDS, UNAIDS Strategy (2015). On the Fast-Track to end AIDS and the Global Fund (2017). Global Fund Strategy 2017-2022 Investing to End Epidemics. The UNAIDS' fast track targets include reaching the ambitious 90-90-90 treatment targets (90% of all people living with HIV will know their HIV status, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy (ART), 90% of all people receiving ART will have viral suppression by 2020) and 90% coverage prevention targets.
[4] Countries with a high co-infection burden of TB and HIV (WHO, 2019): 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, Papa New Guinea, South Africa, eSwatini, Tanzania (United Republic), Thailand, Uganda, Zambia and Zimbabwe. (Note: China and Brazil are not eligible for Global Fund funding.)

Links to key applicant materials and technical guidance.

2. Key investment principles

! **The following principles are fundamental for all applicants:**

Figure 1: Five key investment principles for the 2020-2022 allocation period

1 Allocative efficiency	2 Implementation quality & efficiency	3 Resilient & sustainable systems for health	4 Equity & removing human rights barriers	5 Sustainability
Optimizing the distribution of resources to achieve the maximum health impact	Delivering interventions that are of high quality, including through differentiated service delivery	Accelerating progress towards UHC through integrated, people-centered health services for HIV	Reaching underserved populations and responding to human rights and gender-related barriers	Maintaining and scaling up service delivery by addressing key sustainability factors

1. *Allocative efficiency* – Optimizing the distribution of resources to achieve maximum health impact (lives saved, infections averted). Allocative efficiency is realized by strategically apportioning program resources across interventions, population groups and sub-national geographies to maximize health impact. Funding requests should demonstrate how priorities have been determined, and resources allocated through all health funds available to the country including the portion requested from the Global Fund.[5] Allocative efficiency is essential in view of continued increases in demand within a resource constrained environment.[6]

2. *Implementation quality and efficiency* – Delivering high quality interventions in line with normative guidance and securing minimum costs of a mix of inputs to produce a given health output or achieve a given health outcome.[7] A funding request presenting strong technical efficiency might include the following features: i) evidence to justify that the interventions proposed are technically most appropriate and in line with the latest normative technical guidance ; ii) optimal use of existing capacity, such as common laboratory services or combined training across diseases; iii) mechanisms to address common bottlenecks in service delivery, such as stockouts or health worker constraints (for example, by task-shifting); and/or iv) efforts to deliver quality services through efficient modalities, for example through community systems, by integrating services, or by scaling up patient-centered, differentiated service delivery (DSD) models along the HIV cascade.[8] This reflects the need to critically review enablers and bottlenecks in performance, and to

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[5] Global Fund (2019). Value for Money Technical Brief.
[6] Institute for Health Monitoring and Evaluation (2019). Financing Global Health.
[7] For example, investing in rationalized use of viral load instruments that is strategically placed with sample transport networks to achieve the outcome of high access to testing. This in turn facilitates high-quality clinical decision-making and increased patient motivation for treatment retention.
[8] Global Fund (2019). Value for Money Technical Brief

continuously address barriers to delivery. A key mean to do this is via DSD models,[9] described further in Section 4.3. Further details on different ways to enhance efficiency are provided in the Global Fund Value for Money Technical Brief.

3. *Resilient and Sustainable Systems for Health* – Accelerate progress towards universal health coverage (UHC) through integrated people-centered health services for HIV. The Global Fund explicitly recognizes that resilient and sustainable systems for health (RSSH) that respond to emerging epidemics and provide more integrated, people-centered health services are fundamental to eliminating HIV and contributing to UHC. [10] Systems for health focus on people, not issues and diseases. In the context of HIV programs, Global Fund's investments in RSSH should be formulated to support the needs of HIV programs, for example: supply chains, data systems, human resources for health and laboratory systems, and address broader health system issues that are common bottlenecks to service delivery for TB, malaria and other health services. They can address duplications, overlaps or misalignments across core health system functions. RSSH investments can also be used to increase the effectiveness, efficiency and sustainability of disease programs, including through stronger alignment with the national health system.[11] The RSSH Information Note covers broader health systems investments that also apply to HIV programs.

4. *Equity and removing human rights barriers*– Reaching key and vulnerable populations, removing human rights and gender-related barriers to services and addressing inequities. Efforts to identify and remove human rights-, and gender-related barriers and to address inequities and to services must be intensified to ensure access to service among key and vulnerable populations and those underserved. These populations include gay and other men who have sex with men, sex workers, people who use drugs, trans people, and prisoners in all settings and adolescent girls and young women (AGYW) and their male partners in high burden settings.[12] The previous funding cycle revealed gaps in access to prevention

> Box 2: Definitions of key and vulnerable populations
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> Key populations refer to sex workers, men who have sex with men, transgender people, people who inject drugs, and people in prisons and other closed settings. Vulnerable populations are those who experience an increased vulnerability to and impact of HIV compared to the general population. Depending on the country context, this may include children and young people (aged 10-24 years), adolescent girls and young women (including those who are pregnant), orphans, people with disabilities, people living in extreme poverty, the homeless, mobile workers, displaced populations and other migrants.
> Source: adapted from UNAIDS Terminology Guidelines

services for groups at higher risk, along with low retention in antiretroviral therapy (ART) programs.[13] The Global Fund requires that all funding requests include programs that address the needs of key and vulnerable populations (Box 2), and programs that remove human rights and gender-related barriers and vulnerabilities (see Sections 3.4 and 4.2). In addition, the Global Fund promotes a rights-based approach in which HIV programs are designed and delivered in a non-discriminatory manner to reach all people in need of them regardless of age, sexual orientation and gender identity, health status, behavior and social and legal status. It supports HIV services that are acceptable, accessible, affordable and of sufficient quality and addresses structural and policy-related barriers to HIV services for key and vulnerable populations. A rights-based approach also ensures meaningful engagement and participation by key and vulnerable populations in the design and delivery of national

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[9] Differentiated service delivery is defined as "a client-centered approach that simplifies and adapts HIV services across the cascade [prevention, testing, treatment and care, and retain], in ways that both serve the needs of PLHIV better and reduce unnecessary burdens on the health system." IAS Society (2019). Differentiated Service Delivery
[10] WHO (2016). Framework on integrated, people-centered health services.
[11] Hatt, Laurel, Ben Johns, Catherine Connor, Megan Meline, Matt Kukla, and Kaelan Moat, June 2015.Impact of Health Systems Strengthening on Health. Bethesda, MD: Health Finance & Governance Project, Abt Associates.

[12] UNAIDS. Global AIDS Update (2018). Miles to Go: Closing Gaps, Breaking Barriers, Righting Injustices.
[13] Global Fund (2017). TRP: Report of the technical review panel on the funding requests submitted in the first and second windows of the 2017-2019 allocation period. The final report summarizing findings from all four windows will be available on the Global Fund website by the end of 2019.

HIV strategies, policies and programs and holds governments and other national stakeholders accountable to those populations.

5. *Sustainability* – The Global Fund defines sustainability as the ability of a health program or country to both maintain and scale-up service coverage to a level that will provide continuing control of a public health problem and support efforts for elimination, even after the removal of external funding by the Global Fund and other major external donors.[14] Sustainability is thus a process rather than a single terminal event. There are many dimensions to sustainability in the HIV response, such as financial, programmatic, systems-related, governance, human rights and political.[15] All countries should consider the long-term sustainability of their HIV programs as part of the overall sustainability of health services. The Global Fund requires applicants to embed sustainability considerations into program design, to have in place a robust, costed and prioritized national strategic plan (NSP) and a health financing strategy, with adequate funding for community and civil society-led efforts, and to track health and disease program spending.

3. Prioritized interventions across the HIV cascade

! The Global Fund continues to support the principle of country ownership in tandem with a greater focus on prioritizing interventions that have the best evidence of impact. To achieve HIV targets at both national and global levels the Global Fund and partners have identified a set of *prioritized interventions*.

To save lives and reduce the incidence of HIV, the Global Fund urges applicants to propose funding requests that:

- Balance both HIV treatment and HIV prevention.
- Prioritize interventions at sufficient coverage and scale to have an impact.
- Address populations with greatest HIV burden and barriers to accessing services.
- Rapid scale-up of new and innovative medicines and technologies, as recommended by the WHO and other normative agencies.

Applicants should provide a strong rationale when not including prioritized interventions in the funding request.[16] An example could be when and activity is already being funded through another source, either domestic or international. The Global Fund also recommends applicants consider *strongly encouraged interventions* in their funding request. These are not necessarily required but may be additionally requested.

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[14] Global Fund (2017). Guidance Note: Sustainability, Transition and Co-financing of programs supported by the Global Fund.
[15] A number of frameworks set out the different dimensions of sustainability. This example is adapted from Oberth, G., & Whiteside, A. (2016). What does sustainability mean in the HIV and AIDS response?.
[16] See Part 2 of Funding Request Application Form, which provides space to describe the rationale for the funding request and prioritization.

The interventions presented are closely linked to the [Global Fund strategy](#)[17] and reflect lessons learned during the previous allocation cycle.[18] They are also in line with WHO guidance and other partner minimum requirements.[19]

A list of prioritized and strongly encouraged interventions can be found below, and a summary of prioritized interventions in Box 3. The full list of interventions that the Global Fund supports can be found on the [Modular Framework](#).

Applicants can refer to Section 4.1 to review how a package of interventions takes into account contextual factors such as location/geographies and other country-specific epidemiological factors.

3.1   Prevention: Scale-up key HIV prevention services

New HIV infections among adolescents and adults have declined far too slowly.[20] This is despite robust evidence that combination HIV prevention programs are successful when implemented at scale and when effective HIV prevention tools are available.

> **!**   Given insufficient progress on reducing HIV incidence, applicants should pay particular attention to HIV prevention scale and quality, focusing their national HIV prevention responses on the five prevention pillars endorsed by the Global Prevention Coalition.[21]

The Global Fund expects applicants to include the following interventions in their funding requests:

1. *HIV prevention programming for key populations in all epidemic settings.* National and sub-national HIV transmission data should determine the focus of programmatic investments. Applicants are encouraged to identify and address populations with high HIV incidence, and populations or sub-populations including specific key populations where the greatest numbers of new infections are occurring. The Global Fund is prioritizing investments in:
    *   Scaled-up and comprehensive primary prevention programs for key populations, as described in WHO and partner guidance.[22]
    *   Programs designed to address coverage gaps and that substantially increase access to prevention, testing and treatment services for key populations.
    *   Prevention programs that integrate human rights interventions so beneficiaries have the knowledge and the means to prevent HIV, without fear of arrest, detention, criminalization, or breaches of privacy. These programs are most successfully provided by community-based and community-led organizations.[23]
    *   The development and expansion of civil society-led platforms for large scale prevention program delivery for key population-targeted HIV testing, treatment, adherence support and community mobilization activities.

> **📎**   The Global Fund [Addressing Sex Workers, Men who have Sex with Men, Transgender People, People who use Drugs and People in Prison and Other Closed Settings in the Context of the HIV Epidemic Technical Brief](#) and the Global Fund [Community Systems Strengthening Technical Brief](#) include more information.

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[17] The Global Fund's strategy includes efforts to maximize the impact of investments for HIV through differentiated approaches, increased alignment and sustainability of programs and recognizes the importance of strengthening systems for health for the achievement of disease outcomes. Global Fund (2017). [Global Fund Strategy 2017-2022 Investing to End Epidemics](#).
[18] Largely based on recommendations put forward by the Global Fund's Technical Review Panel (TRP). The Global Fund's TRP "is an independent, impartial team of experts appointed by the Strategy Committee (in accordance with the delegated authority from the Board) with the responsibility of providing rigorous, independent technical assessment of funding requests made to the Global Fund." Global Fund (2016). [Technical Review Panel Terms of Reference](#).
[19] 2019 minimum requirements of PEPFAR also are in line with WHO guidelines and recommendations.
[20] UNAIDS (2018). [HIV Prevention Score Card: The Big Picture](#).
[21] UNAIDS (2017). [HIV Prevention 2020 Road Map](#).
[22] WHO (2014). [Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations](#). Note WHO guidelines articulate comprehensiveness of programs for universally recognized key populations: men who have sex with men; people in prisons and other closes settings; people who inject drugs: sex workers; transgender people. Please see Annex for reference links to the HIV Key Populations Implementation tools, including MSMIT, SWIT, IDUIT and TRANSIT.
[23] Ibid.; see also UNAIDS (2017) [Strengthening HIV Primary Prevention](#)

2. *Combination HIV prevention for adolescent girls and young women, and for men and boys, in high-burden settings.*[24] Prevention programs that deliver a differentiated mix of interventions as a package in high burden settings is a Global Fund priority.

   Priority interventions include:
   - Provision of information, commodities and demand generation for HIV prevention and testing, including male and female condoms and pre-exposure prophylaxis (PrEP).
   - HIV prevention in and out of schools as part of comprehensive sexuality education, addressing harmful masculinity and other gender-based norms and human rights barriers, including gender-based violence.
   - Improving access to sexual and reproductive health (SRH) services and rights, including contraception as a priority for adolescent girls and boys, and for women and men.
   - Integration of HIV prevention services, such as male and female condom provision, PrEP and HIV testing, including partner testing in family planning clinics. (Also see below, under 3.1., bullet #6.)
   - Addressing specific HIV prevention needs of adolescent girls, of young women up to the age of 29 years, and of the male partners of these girls and women.

   Guidance on how to identify underlying determinants of HIV vulnerability, the type of programs that are effective, how to implement programs for AGYW, and how to improve these based on lessons learned, is provided by UNAIDS in 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. Also see Adolescent Girls and Young Women in High-HIV Burden Settings Technical Brief for more information.

3. *Voluntary medical male circumcision (VMMC) programs for men and boys in high burden settings where there is low coverage of medical male circumcision*, provided alongside other services such as HIV testing and STI diagnosis and treatment. VMMC services are a package of services defined by the WHO[25] and can lead to cost savings by reducing HIV acquisition. They provide opportunities to reach boys and men and are a gateway to other services. WHO recommends the use of surgical male circumcision or prequalified non-surgical adult circumcision devices together with tetanus immunization for use in low-resource settings, which can provide an alternative approach where the infrastructure and capacity to perform surgical circumcision may be insufficient.[26,27]

4. *Condom programming in settings with moderate to high HIV burden*. The Global Fund recognizes significant gaps in condom access and use in many countries. It also recognizes strong condom programs as essential to national HIV prevention efforts in moderate and high prevalence settings. For improved access to and use of condoms by priority populations, changes need to occur at multiple levels. At the systems level, better stewardship of national condom programs requires improved quantification of need [28] and understanding of existing use, strengthened procurement and supply systems, and a strong evidence base to understand market dynamics and factors influencing uptake and use.

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[24] High burden settings are defined as settings with high HIV incidence rate of more than 0.3% (0.3 in 100 person/years). Reference: 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.
[25] WHO (2018) Manual for male circumcision under local anaesthesia and HIV prevention services for adolescent boys and men https://www.who.int/hiv/pub/malecircumcision/male-circumcision-guide-2018/en/
[26] WHO (2013). Status of active products undergoing the prequalification of male circumcision devices assessment procedure.
[27] WHO (2013) WHO prequalification of PrePex medical male circumcision device has the potential to help countries accelerate VMMC.
[28] For assistance with quantifying condom need, see UNAIDS tool "Condom Needs and Resource Requirement Estimation Tool https://hivpreventioncoalition.unaids.org/resource/condom-needs-and-resource-requirement-estimation-tool/

National condom programs also require efforts to develop a supportive environment, including national demand creation efforts, improved coordination and advocacy in support of a total market approach, and enabling policy and regulatory environments that support diversified markets to sustain condom access. At the community level, efforts need to include adequate male and female condom and lubricant procurement and supplies, peer-based distribution to priority populations, distribution of free commodities for those with greatest need especially in rural and isolated locations, behavior change communication to support effective condom use, demand creation activities and targeted social marketing. 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 power to use condoms correctly and consistently.

📎 For more information see UNAIDS/UNFPA Technical Note on Condom Programming(forthcoming September 2019).

5. *PrEP for people at increased risk[29] in all epidemic settings*, especially men who have sex with men (MSM), transgender women and sex workers, and AGYW in some settings in East and Southern Africa. The Global Fund notes the effectiveness of PrEP for population groups at increased risk.[,30] Accurately targeting of PrEP for people at increased HIV risk, such as MSM, is critical.[31] Countries should refer to normative guidance to determine the HIV incidence threshold for which providing PrEP is cost-effective as this threshold varies across geographies and populations. When determining whether or how cost-effective it would be to offer PrEP to a specific high-risk group for a specific location, countries are encouraged to consider PrEP implementation factors such as input prices, service delivery modality, service monitoring and adherence support interventions in the PrEP program design.[32] Populations being targeted for PrEP programs should be meaningfully involved in program design and delivery.

6. *Integration of family planning and sexual and reproductive health (SRH) services* into HIV care for all women in high prevalence areas. This includes sexually transmitted infection (STI) prevention and treatment, family planning and cervical cancer screening, to improve cost-effectiveness, uptake, access to and quality of care.[33]

3.2 Testing: Deliver a strategic mix of tailored HIV testing modalities and linkage to prevention or treatment services

Differentiated approaches to HIV testing services (HTS) [34], including innovative approaches, will need to be scaled-up in many settings to achieve global targets. [35] Applicants should demonstrate that their testing strategies are adapted to the epidemiological context and follow

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[29] 'Increased risk' is defined by WHO as either relating to a geographical area, a location, where HIV transmission is intensified, or to specific populations experiencing an incidence of greater than 3 per 100 person years.
[1] See WHO (2017). WHO implementation tool for pre-exposure prophylaxis of HIV infection.
[30] See WHO (2017). WHO implementation tool for pre-exposure prophylaxis of HIV infection.
[31] Gomez GB, et al. (2013). The cost and impact of scaling up pre-exposure prophylaxis for HIV prevention: a systematic review of cost-effectiveness modelling studies.
[32] WHO (2017). Implementation tool for pre-exposure prophylaxis of HIV infection. Module 9: Strategic planning.
[33] The results of the ECHO trial showed that HIV incidence was high in women seeking pregnancy prevention, emphasizing the need for strengthening HIV prevention services within family planning services.
[34] "HIV testing services include the full range of services that should be provided together with HIV testing: counselling (pre-test information and post-test counselling); linkage to appropriate HIV prevention, treatment and care services, and other clinical and support services; and coordination with laboratory services to support quality assurance and the delivery of correct results."
WHO (2019). HIV/AIDS: HIV testing services.
[35] UNAIDS (2019). Knowledge is power — Know your status, know your viral load.

the "5 Cs": consent, confidentiality, counselling, correct result, and connection/ immediate linkage.[36]

> **!** The Global Fund expects applicants to include the following programmatic activities in their funding requests:

1. *An HIV testing strategy based on routine and frequent review of HIV testing data (for example on yield; disease burden) to identify gaps in coverage by geography, specific age groups, sex and service delivery sites.* Such information should be used to inform decision-making about differentiated testing approaches,[37] linkage strategies and geographical prioritization of facility- or community-based testing.

2. *A strategic mix of differentiated approaches* that improve effectiveness of testing (especially among key populations in which testing coverage is low[38]), and efficiency of HIV testing services.[39] These approaches should be implemented in communities and facilities using various types of testing modalities including: self-testing and index testing with assisted partner notification, in line with the WHO forthcoming 'Consolidated guidelines on HIV testing services'.[40] Strategies should adequately address the needs of hard-to-reach groups that face barriers in accessing facility-based services such as young men, AGYW and key populations. In high burden settings prioritization of facility-based provider-initiated testing and counseling (PITC) is recommended for all accessing antenatal and postnatal, sexually transmitted infection (STI), and presumptive or active TB services. While the Global Fund prioritizes investments in HIV testing at ANC in high burden settings only, it continues to remain committed to the Super-Fast-Track Framework to end AIDS. The Global Fund encourages countries to invest available national resources to support achievement of national targets for HIV testing at ANC in areas not covered by the Global Fund.

3. *Linkage to services.* Interventions that link people across all ages, sex and risk categories to the services they need according to their test results. For example, strong linkages both to HIV treatment and care services for those found to be positive, and to comprehensive HIV prevention for those found to be negative and at increased risk of HIV.

4. In high prevalence settings, the use of *nucleic acid testing at birth* for HIV-exposed infants and HIV serological testing at around 9 months of age. The Global Fund expects the use of point-of-care (POC)[41] technologies for early infant diagnosis testing. Mapping and optimizing laboratory networks (such as through costing exercises) should be used to ensure appropriate placement of both conventional and POC technology. See the WHO Updated recommendations on first-line and second-line antiretroviral regiments and post-exposure prophylaxis and recommendations on early infant diagnosis of HIV for more information.

5. Scale-up of *innovative testing approaches*, such as self-testing (HIVST). This could include revision of relevant policies and regulations to enable implementation. Self-testing should be used as method to reach high-risk populations that do not access health services, such as young men, including male partners of antenatal care (ANC) clients, and key populations

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[36] WHO (2015). Consolidated guidelines on HIV testing services: 5Cs: consent, confidentiality, counselling, correct results and connection 2015.

[37] IAS (2018). Differentiated Service Delivery for HIV: A Decision Framework for HIV Testing Services.

[38] The TRP observed in the 2017-2019 allocation cycle that countries need to pay more attention to targeting higher-risk groups for HIV case-finding and to implementing innovative and hard- strategies that deliver high quality tests. Global Fund (2017). TRP: Report of the technical review panel on the funding requests submitted in the first and second windows of the 2017-2019 allocation period.

[39] HIV testing yield should be used to assess the efficiency of HIV testing services in finding people who are infected but do not know their status and linking them to treatment. For populations at high risk of HIV infection, the goal of HIV testing is also to link those who are HIV negative to HIV prevention services and not to maximize testing yield.

[40] Refer to the WHO website for the latest consolidated guidelines on testing services. Applicants can refer to the WHO (2016) Guidelines on HIV self-testing and partner notification until a more updated version is made available.

[41] According to the WHO, POC has no universal definition; the core components are "(1) testing is carried out at or near the person being tested, (2) the results are returned to the person being tested during the same visit and (3) the results of point-of-care testing can be used immediately for patient care and referral." WHO (2015). Improving the Quality of HIV-Related Point-of-Care Testing.

and contacts of key populations. Implementers that are planning, starting or scaling up HIVST should refer to the [WHO HIV self-testing strategic framework: a guide for planning, introducing and scaling up](#), which includes a six-step approach to differentiated HIV testing.[42]

6. Countries with suboptimal testing yield in facilities when compared to their HIV prevalence should consider *prioritization tools based on needs and available resources*, using geographic prioritization and screening tools. Screening tools need careful monitoring and evaluation. Risk-screening should only be deployed after validation and assessment of the costs of screening versus benefits of fewer people tested.

7. Validation and inclusion of *alternative/back up HIV rapid diagnostic tests* in national testing algorithms for all lines of testing (for each screening assay, i.e., Assay 0, Assay 1, Assay 2 and Assay 3), in line with the WHO guidelines,[43] to ensure supplier security. The WHO continues to recommend that an HIV-positive diagnosis be based on an algorithm of tests of two or three different HIV rapid tests. It is critical for countries to validate national testing algorithms when selecting products for a most accurate and reliable HIV diagnosis.

3.3 Treatment and retention: Provide a differentiated mix of interventions

! The Global Fund, PEPFAR and global partners recommend that all countries reflect timely transition plans to WHO's latest guidelines on the use of optimal antiretroviral regimens, most critically the "Treat All" recommendation.[44]

The Global Fund expects applicants to include the following programmatic interventions in their funding requests:

1. Scaled-up *DSD models that provide people-centered services* and offer an appropriate mix of interventions at both facility and community levels, including:
    i) Scaling up differentiated approaches with fidelity that address all age, sex and priority groups;
    ii) Rapid initiation of ART for people diagnosed with HIV including the offer of same-day initiation where there is no clinical contraindication;
    iii) For stable patients, adopting multi-month (3-6 months) scripting and standardized multi-month refills facilitated by improved capacity of respective procurement and supply management systems.

2. *Safe and effective transition to [WHO's latest guidance on the use of optimal antiretroviral (ARV) drugs](#)*, including dolutegravir (DTG)-based regimens such as TLD (tenofovir, lamivudine, dolutegravir) and optimized ART regimens for pediatric populations.[45] Countries should outline in their applications how these regimens will be scaled up, including closing treatment gaps between adult and pediatric populations, while also taking a women-centered and human rights-based approach. For children, transition to latest WHO guidelines requires detailed forecasting of stock over time at country level to coordinate drug supply at the global level. The Global Fund will no longer support requests for nevirapine (NVP) for use in adults and will also gradually decrease funding for nevirapine-based drugs for use in children aligned with increasing global supply of alternative ARVs, particularly in countries with significant resistance to NVP.

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[42] Applicants should refer to the WHO's forthcoming HIVST M&E Module on how to monitor the scale-up of self-testing.
[43] Refer to the WHO [website](#) for the latest consolidated guidelines on testing services. Applicants can refer to the WHO (2015) [Consolidated Guidelines on HIV Testing](#) until a more updated version is made available.
[44] Consult the WHO [website](#) for the latest recommendations on ART.
[45] The July 2019 WHO guidelines provide further reassurance of DTG as the preferred antiretroviral (ARV) drug in first- and second-line regimens due to the declining estimate of neural tube defect risk and observed efficacy.

3. *A system for retaining patients effectively*, including systematic identification and tracing of those who are lost-to-follow-up. The foundation of these systems should be a mechanism to track all patients initiated on ART. Those not returning for scheduled visits, should be traced back to their communities and efforts should be made to bring them back into regular contact with health professionals who can provide differentiated adherence counseling support and clinical monitoring tailored for population groups, for example, key populations, adolescents, and pregnant women. This will include ensuring facilities offer friendly return to care services for clients who are re-engaging in care.

4. *Expansion of access to viral load testing for routine monitoring of all people on ART*, including key populations, children, adolescents, and pregnant women., Viral load testing should replace CD4 testing as the standard approach for monitoring people on ART. A baseline CD4 is indicated: at treatment initiation, at representation after interruption in care, and when identifying patients with advanced HIV disease. It is important for applicants to consider increased viral load access, including POC viral load testing, as part of their overarching laboratory system optimization and integration plans.

5. *Access to CD4 testing to identify everyone presenting with advanced HIV disease* (CD4</=200mm^3 or WHO Stage 3 or 4), offering a pathway and package that includes opportunistic infection screening, treatment and/or prophylaxis, such as TB and cryptococcal meningitis; rapid ART initiation, particularly for those PLHIV with low CD4 count (</=200 cells/mm^3); and adherence support.

6. In settings with high TB/HIV co-infection burden, *TB Preventive Treatment (TPT).* This includes the recently WHO-recommended combination of drugs for PLHIV without active TB, such as rifapentine combined with isoniazid for 12 weeks (3HP) and Isoniazid plus rifampicin (3RH), as part of national TPT scale-up plans (see Section 4.3 for more information).[46]

Systems to address HIV drug-resistance (HIVDR), including surveys every three years to understand acquired/pre-treatment drug resistance in adults and every 5 years in infants, especially in the 45 WHO focus countries, in alignment with the [WHO Global Action Plan on HIV Drug Resistance (2017-2021)](#) and as part of a public health approach to HIVDR.

The Global Fund strongly encourages applicants to include the following interventions in their funding requests:

1. *Integration of prevention of mother-to-child transmission (PMTCT) into ANC and post-natal care services* in high burden settings for improved service quality and access. Applicants are encouraged to review the [RSSH Information Note](#) to understand how further investments to strengthen sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) platforms are synergistic for PMTCT success.

2. *Scaling-up evidence-based community-level interventions*, including community ART dispensing and community-based and peer-led ART support groups. Several models have been developed to optimize HIV service delivery for stable patients. For example, within community ART groups (CAGs), group members rotate in collecting medications at the facility for all members.

3. The use of *multi-disease platforms/integrating diagnostic services for different diseases*. Countries with high-burden of TB/HIV co-infection should consider the optimal use of

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[46] Applicants in low TB/HIV burden countries are also encouraged to take responsibility for scale-up of simple TB interventions, such as providing PLHIV with latent TB infection with TPT. See WHO (2019). https://www.who.int/tb/publications/2019/guidelines-tuberculosis-infection-prevention-2019/en/for more details on preventative TB/HIV measures.

GeneXpert machines to meet the needs of viral load testing in HIV programs.[47] Systems should be in place to return test results in a timely manner and be utilized for clinical management.

4. *Aligning all investments with national laboratory strategic plans.* Applicants should have a strategic overview of the investments needed in laboratory services.[48] If applicants do not have a national laboratory strategic plan, Global Fund resources can be used to support its development. As countries consider the use of near POC instruments, a laboratory network optimization should be conducted, including mapping and costing exercises of the laboratory system, to establish the need and appropriate placement of both conventional and near POC instruments through reagent rental or all-inclusive approaches. This approach will improve service delivery, contribute to efficient management of resources by ensuring optimal use of technology.

    📎 See Global Fund Technical Brief on Strategic Support for Integrated Laboratory Services for more information.

3.4 Strategic Information: Invest in data for impact

HIV responses are still hindered by gaps in the availability of certain data, such as the size estimates of key populations, disaggregated gender and age data, and data on policy or legal barriers to accessing services.[49] Applicants are encouraged to enhance information flows through improved programmatic monitoring and reporting systems, including electronic medical records, District Health Information System 2 (DHIS2) and/or other locally implemented tools. Applicants should focus on strengthening and integrating the monitoring of interventions that are delivered outside health facilities, as routine monitoring systems for these interventions are often weaker than clinical systems. Monitoring, reporting, and evaluating Global Fund investments should be integrated into broader national systems rather than operating in a parallel manner (see also Global Fund Information Note on RSSH.[50]) Priority health information system (HIS) and digital health investments are also defined within the RSSH information note.

📎 This section outlines priority HIV-specific strategic information (SI) investments within HIV programs. All of these interventions are consistent with the WHO Consolidated SI Guidelines and Person-centered Monitoring and Case Surveillance Guidelines. For information on how to build systems to collect, analyze and use data across all levels of Global Fund program implementation, refer to the Global Fund Strategic Framework for Data Use for Action and Improvement at Country Level. In addition, the UNAIDS Global Monitoring 2019 provides guidance to national AIDS programs on the use of global indicators to measure and report on country responses. The WHO Consolidated Strategic Information Guidelines for HIV in the Health Sector (2015) provides information on how countries should monitor the health sector response to HIV.

Additional information on how to use the above- mentioned resources when developing a funding request is presented in Section 4.1.

The Global Fund expects applicants to include the following in their funding requests:

1. *Routine cascade data reviews:* Should be convened monthly, quarterly, semi-annually, or, at a minimum, annually. They should focus on geographically and socio-demographically disaggregated analyses of routinely available individual-level (like case surveillance) and/or aggregate program data, including prevention, testing, linkage to care or preventive

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[47] Applicants should explain in their funding requests how they will address the challenges of using both existing and new machines for viral load testing will be addressed (Global Fund (2019). TRP: Report on RSSH Investments in the 2017-2019 Funding Cycle. For more details on TB/HIV testing, treatment and care, see: WHO (2017 update). Guidelines for treatment of drug-susceptible tuberculosis and patient care   and the WHO (forthcoming) Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection.

[48] TRP (2017). TRP review of Global Fund Window 1 funding requests: Technical lessons learned for malaria, TB and HIV.

[49] Global Fund (2019). TRP: Report on RSSH Investments in the 2017-2019 Funding Cycle.

[50] [Placeholder for Global Fund RSSH Information Note.

interventions, initiation of and retention in treatment, and viral load testing. They should be implemented at all relevant levels of the health system, from central to facility level.

These reviews should include assessment of key treatment outcomes including retention, loss-to-follow-up and viral load suppression, in line with the WHO Cascade Data Use Manual to Identify Gaps in HIV and Health Services for Programme Improvement. To facilitate the cascade analysis, applicants should link case surveillance with patient monitoring (such as via database of people on ART and with unique identifier codes (UIC) to link patients to other health services). Annual cascade reviews should include updated epidemiologic and impact data (for example from Spectrum and/or population-based surveys). It is important that activities be country-owned and community-based (convened and overseen by the Ministry of Health), and include all relevant donor, technical and implementation partners. See Section 4.1 for information on the importance of cascade analyses.

2. *HIV case surveillance:* Patient monitoring should be invested in both enabling effective clinical management of patients and generating data for program monitoring, consistent with the WHO Consolidated guidelines on person-centered HIV patient monitoring and case surveillance, after a context-specific assessment of available digital tools and solutions and based on expert consultation. Applicants should address policy standards for implementation of unique health identification. This data should represent the most robust source of essential disaggregated data analysis for use in program improvement and tracking of treatment outcomes. It should be used alongside and, increasingly, in place of aggregate data for the routine cascade data review activities described above.

The Global Fund strongly encourages applicants to include the following in their funding requests:

1. *Biobehavioral surveys (BBS) and population size estimates (PSE)* among key populations: Such techniques should be done in all relevant geographic settings according to guidelines, see the WHO Biobehavioral Survey Guidelines for Populations at risk for HIV and HIV sentinel surveillance. Refer to the HIV surveillance options for key and vulnerable populations in Global Fund grants. Interventions should also be informed by the local context, such as funding availability and quality of routine program data. Data collection efforts should include activities for population size estimation, or such interventions should be funded separately.

2. *Data Quality Assessments (DQA)* should be undertaken periodically to assess and strengthen reporting of priority national aggregate indicators (such as number of PLHIV currently on antiretroviral therapy from patient-level health information system (HIS) data sources). Such assessments should be conducted in line with the WHO Data quality assessment of national and partner HIV treatment and patient monitoring data and systems implementation tool.

3. *Early Warning Drug Resistance Indicators* as part of routine data or surveys. The information should be used to inform ART scale up plans. See Section 3.3 and the WHO Consolidated guidelines on person-centered HIV patient monitoring and case surveillance and Global report on early indicators of HIV drug resistance for more information.

3.5   Human Rights: Remove human rights-related barriers to services

Prevention and treatment interventions must reach all those affected. Applicants must put in place programs to remove human rights-related barriers to HIV services. Barriers are: i)

stigma and discrimination based on HIV, gender, sexual orientation, social and/or legal status; ii) punitive practices, policies and laws; and iii) gender inequality and/or violence against women living with HIV.

Applicants are expected to: i) use existing data or conduct assessments of human rights-related barriers to services to identify the barriers and who is affected by them; ii) determine the right combination of the interventions described below that are most likely to remove these barriers and indicate how these should be integrated into prevention and treatment strategies and iii) cost, budget and implement at scale.

Governments and technical partners have recognized the following program areas as essential in removing barriers to services:

1. *Stigma and discrimination reduction;*
2. *Training for health care providers on human rights and medical ethics;*
3. *Sensitization of lawmakers and law enforcement agents;*
4. *Reducing discrimination against women in the context of HIV;*
5. *Legal literacy ("know your rights");*
6. *Legal services; and*
7. *Monitoring and reforming laws, regulations and policies relating to HIV and TB.*

Please refer to the Global Fund Technical Brief on HIV, Human Rights and Gender Equality, Frequently Asked Questions for the 2020-2022 Funding Cycle and the UNAIDS User Guide for the HIV-Related Human Rights Costing Tool. Applicants can use the GNP+, ICW and UNAIDS PLHIV Stigma Index to assess stigma, including self-stigma and discrimination in various settings and how it impacts individuals and communities. Other Global Fund priorities regarding human rights are laid out in Section 4.3.

Box 3: Summary of prioritized interventions

PROGRAM/ INVESTMENT AREAS	PROGRAMMATIC PRIORITIES
HIV prevention	• HIV prevention programs addressing KPs in all epidemic settings. • HIV prevention programs addressing AGYW and men in high burden settings. • VMMC for adolescent boys and men in high burden settings. • Comprehensive condom programming. • PrEP programs for populations with substantial HIV risk. • Integration of family planning and SRH services into HIV care for all women in high prevalence areas.
HIV testing	• HIV testing strategies based on routine and frequent review of HIV testing data. • A strategic mix of differentiated testing approaches, including self-tests, that improve testing coverage, testing yield and efficiency of HIV testing services. • Linkage strategies designed to ensure clients – differentiated by age, sex and risk - are linked to appropriate prevention and treatment services.
HIV treatment & care	• Scaled-up DSD models that offer a mix of interventions at both facility and community levels. • Rapid initiation for all people diagnosed with HIV and strong mechanisms to retain people across the cascade. • Introduction at scale of optimal ARV regimens in line with WHO recommendations. • Advanced HIV disease pathways. • Optimized VL testing at scale as preferred treatment monitoring • Monitoring of drug resistance through WHO-recommended surveys. • TB preventive treatment (TPT) at scale in countries with high burden of TB/HIV co-infection.
HIV strategic information	• Routine review of data tracking people along the HIV prevention, testing and treatment cascade. • HIV case surveillance.
Human rights	• The UNAIDS "7 key programs to reduce stigma and discrimination and increase access to justice", scaled up and integrated into prevention and treatment programs.

4. Investment Approach

Strategic investments are critical when preparing a Global Fund funding request. This section frames four stages of a strategic investment approach: *understand, design, deliver, and sustain.*[51]

Global Fund investments should contribute to country-owned responses, therefore requests should be aligned with national priorities set forward in national strategic documents (see Box 4), specifically HIV National Strategic Plans (NSPs) which should be harmonized with the national health sector strategy.

Box 4: Conduct an update of national strategic documents

HIV investment cases, NSPs and other relevant disease-specific and health systems documents outline the parameters for a strong national strategic HIV, HIV/TB and health systems strengthening response. Countries should consider updating their national strategic documents and HIV investment scenario modelling during the funding request design process when:

- The most effective strategies are not yet included and targets need aligning with Fast-Track goals.
- Epidemiological and response data needs an update;
- New policies, guidelines, service delivery models and technologies and the associated unit cost changes have been introduced;
- An update is needed on information regarding social and legal barriers to services and the programmatic response to remove these barriers;
- Networks of key populations and community-based organizations are supported in a sustainable way to be empowered, engaged and mobilized around their needs. Applicants are encouraged to use the UNAIDS/WHO Guidance Notes for country programming for strengthening of HIV NSPs and investment cases.

4.1 Understand: Continue to know your epidemic and its updated resource needs

The Global Fund encourages countries to expand the collection and analysis of data. Increased granularity of quality data is key to analyze sub-epidemics and program outcomes (Box 5), in support of strong funding requests.[52]

Specifically, applicants are required to:

1. *Analyze the current and evolving epidemiological situation*

Data should be collected in line with the WHO Consolidated Strategic Information Guidelines for HIV in the Health Sector, which focus on routine analysis and use of facility data for program improvement (rather than standalone epidemiological and impact analyses).[53] Applicants should collect and analyze disaggregated data, by geographies at sub-national level, key population, gender and age group, and data on HIV and TB incidence, morbidity and mortality, which is necessary for linking epidemiological trends to program efforts.

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[51] Adapted from UNAIDS' four stages of developing a context specific, outcome-driven country owned investment package. See UNAIDS (2012). Investing for results. Results for people and UNAIDS (2013). Smart investments.
[52] Global Fund Funding Request Instructions.
[53] An update of this document is forthcoming. Consult the WHO HIV/AIDS Publications on HIV webpage.

Understanding the HIV situation also includes estimating the size of populations that have disproportionally low access to services and identifying facilitators and barriers to service uptake. Reliable mapping and size estimation of key populations is essential to ensure that programs reach and cover an adequate proportion of them with relevant services. 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 in place throughout the process. Applicants should avoid overreliance on modelling and use multiple sources of available data, including program and epidemiological data

Box 5: TRP findings on the use of data

The TRP observed that disaggregated data for both key and general populations are still infrequently used for prioritization. Furthermore, many funding requests did not consider epidemiological and qualitative data for HIV prevention programs. The TRP noted that attention needs to be placed on ensuring funding requests have discussion of HIV prevention efforts for young women and girls, and young people at higher risk of HIV. Source: Aidspan (2018). TRP identifies lessons learned from Window 4 funding requests.

to tailor HIV responses to specific needs and gaps within countries.[54] The Global Fund encourages applicants to dedicate financing, Global Fund and/or others', to collect prevalence, behavioral and programmatic data, and to estimate the population size for different key population groups, using locally appropriate and sustainable approaches. See Section 3.4 for select prioritized interventions.

2. *Perform HIV prevent-test-treat-retain cascade analysis*

Information should be collected across the HIV cascade. Cascade analyses entail identifying where programs fail to reach and retain PLHIV and other vulnerable populations. They are also used to help to monitor viral load suppression and support treatment adherence and retention in care; determine the magnitude of the losses and gaps along the continuum; and identify and analyze the causes of the gaps. See Section 3.4 above for essential information on how applicants should go about performing their cascade analyses.

Applicants should refer to the WHO HIV test-treat-retain cascade analysis: guide and tools 2017, 2nd ed. on how to conduct the cascade analysis. Applicants should also refer to the WHO Consolidated guidelines on person-centered HIV monitoring and case surveillance for guidance on how to monitor systems for patients and all cases of HIV as part of public health surveillance, as well as the forthcoming UNAIDS Prevention Cascade Analysis Tool.[55]

3. *Understand key service delivery barriers including health and community systems constraints, human rights- and gender-related barriers*

Applicants are encouraged to take a systems approach to understanding the barriers to service delivery. They should systematically map out and develop an understanding of the key health systems barriers that are impeding the delivery of HIV services. These barriers could include: health workforce shortages, weak referral systems, fragmented laboratory systems, constraints related to the involvement of communities, and constraints for community-based organizations as implementers of programs and services. Communities should be meaningfully engaged in the information-gathering and decision-making processes. Applicants are encouraged to refer to the Global Fund RSSH Information Note for additional information.

The Global Fund has made a strategic commitment so investments address human rights and gender-related barriers. Applicants should develop an in-depth understanding of the nature and extent of the human rights- and gender-related barriers to HIV services and implement and take to scale programs that address and remove these barriers (see Section 3.5). The Global Fund HIV, Human Rights, Gender Equality Technical Brief provides more detailed information.

The UNAIDS Gender Assessment Tool (GAT) for national HIV responses and Stop TB GAT for national HIV/TB responses can be used to assist countries in assessing the HIV/TB epidemic, context and response from a gender perspective and to make responses gender

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[54] Global Fund (2017). TRP: Report of the technical review panel on the funding requests submitted in the first and second windows of the 2017-2019 allocation period.
[55] The publication will be available on the UNAIDS website once it is published.

transformative, equitable and rights based. In all settings, applicants should assess the level of safety- and security-related risks of individuals and organizations engaging in the delivery of programs for key populations and develop measures to mitigate those risks.[56]

Under the Global Fund's *Breaking Down Barriers* initiative, twenty countries[57] benefitted from formal assessments of the full range of human rights-related barriers to health services and have begun to put in place plans and programs for comprehensive responses to address them. Almost all countries have gathered other data on such barriers (for example, through legal environment and gender assessments and measurements of stigma in communities, health facilities and among police). Applicants can use the GNP+, ICW and UNAIDS PLHIV Stigma Index to assess stigma, including self-stigma and discrimination in various settings and how it impacts individuals and communities.

4. *Ensure unit cost estimates are up to date and of sound quality*

A good understanding of cost estimates of core interventions and program areas by cost inputs (such as personnel, medicines and travel) can help countries better understand where program inefficiency may lie and more robustly assess resource needs for the HIV response.

The information also serves as a necessary input for allocative efficiency analyses (see Section 4.2) to inform resource allocation decisions. For example, applicants can benchmark cost against expected program impact (infection or cases averted) across interventions and prioritize the most impactful ones. Applicants are encouraged to refer to the UNAIDS User Guide for the HIV-Related Human Rights Costing Tool to estimate the associated costs for HIV-related human rights programs.

5. *Analyze the partner landscape*

The Global Fund remains committed to country-led programs that foster partnerships among all relevant stakeholders and across all sectors of society, including governments, civil society, key populations, multilateral and bilateral agencies, including PEPFAR, and the private sector.[58] An understanding of the current funding situation and partner landscape is critical to accelerate progress to a coordinated and fully-funded HIV response.

Applicants should work to align service delivery modalities, streamline strategic information and data collection, work towards comprehensive coverage and scale up, and ensure the technical assistance needs included in their request complement the technical support and capacity building support provided by other actors.

Applicants are requested to provide an update on any changes in domestic or international funding that might have significant impact on the program's effectiveness and sustainability.[59] Section 4.4 describes tools that have been developed to facilitate this.

4.2   Design: Develop a mix of interventions that maximizes impact

When designing an evidence-based, cost-effective mix of interventions, key considerations must include prioritized, technically sound interventions (Section 3), the prevailing epidemic situation, costs involved (Section 4.1), sustainability and equity (Section 4.4), such as accessibility of services for key populations, with attention on addressing human rights- and gender-related barriers.

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[56] For more information on how to go about this assessment, refer to: Frontline AIDS (formerly HIV Alliance) (2018). Safety and Security Toolkit.
[57] Benin, Botswana, Cameroon, Democratic Republic of Congo (province-level), Cote d'Ivoire, Ghana, Honduras, Indonesia (selected cities), Jamaica, Kenya, Kyrgyzstan, Nepal, Mozambique, Philippines, Senegal, Sierra Leone, South Africa, Tunisia, Uganda and Ukraine.
[58] These values are core to the Global Fund's country coordination mechanism. Global Fund (2018). Country Coordinating Mechanism Policy Including Principles and Requirements.
[59] Global Fund Applicant Instructions

1. *Tools to identify the optimal package of interventions*

Applicants are encouraged to apply specific HIV resource allocation tools and models to compare different intervention scenarios and to identify an optimal intervention package that maximizes impact with available resources. Examples of these tools include: the AIDS Impact Model (AIM) and Goals Model (embedded in the Spectrum suite),[60] AIDS Epidemic Model (AEM), Optima-HIV[61] and STAR (Socio-Technical Allocation of Resources),[62] and WHO-CHOosing Interventions that are Cost-Effective (CHOICE).[63] Some of these tools can be used to incorporate a costing framework and rigorous epidemiological impact models that can help countries in making strategic investment decisions by quantifying the costs and health impacts of their investment scenarios. These tools can also support countries to conduct fiscal sustainability analyses based on projections of future funding; facilitate policy dialogues and decision making by analyzing the costs and benefits of intervention options; and enable the incorporation of other factors, such as equity and feasibility.

When applying these tools, applicants should choose strategic programmatic objectives, targets and a reasonable time horizon for the analysis, strengthen data inputs, articulate key questions including tradeoffs to be made and translate the analysis appropriately into policy. Applicants are recommended to refer to the Global Fund Technical Brief on Value for Money for information on how to approach value for money more comprehensively.

2. *Increase accessibility of services for key populations*

The Global Fund has specific policies and eligibility requirements to ensure adequate focus on key populations in funding requests.[64] As countries move closer to transitioning out or away from Global Fund support, it is expected that governments increasingly assume responsibility for financing critical programs such as interventions for key populations.[65]

Key populations should be involved in the application design process and in program implementation and monitoring to: articulate their main concerns and prioritize their needs; ensure their inclusion in the development of national strategies, policies and costed plans; better articulate specific roles, in line with technical guidance and broad evidence, in differentiated services programs for HIV prevention, testing, treatment and care.[66]

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

The Global Fund has established a procedure so its independent Office of the Inspector General (OIG) can investigate complaints alleging these standards are not met.[67] The Global Fund will not fund compulsory treatment programs, including those that aim to change sexual orientation or gender identity, to "rehabilitate" sex workers, or drug detention centers. The Global Fund may finance scientifically sound medical services in compulsory treatment programs or facilities in exceptional circumstances.[68]

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[60] Avenir Health (2019): Spectrum.
[61] Optima Model (2019): Optima.
[62] The Health Foundation (2019): Star: A tool for commissioners.
[63] WHO (2019): WHO-CHOICE.
[64] Global Fund (2019): Key populations.
[65] The Global Fund Sustainability, Transition and Co-financing Policy
[66] 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 and strengthens local accountability. More information on implementing comprehensive programs with key populations is provided in the Global Fund Information Note on Addressing Sex Work, MSM and Transgender People and People in Closed Settings in the Context of the HIV Epidemic and Global Fund Technical Brief on Harm Reduction for People who use drugs and the implementation guidance of technical partners.
[67] Global Fund (2018). Global Fund Human Rights Complaints Mechanism.
[68] Global Fund (2015). Thirty-Third Board Meeting: Community, Rights and Gender Report.

For more information on the OIG human rights standards/complaints process, refer to the [Global Fund Human Rights Complaints Mechanism](#).

4.3 Deliver: Ensure high quality and efficient service delivery for optimal scale-up

! The Global Fund continues to emphasize the improvement of quality and efficiency of program implementation, in line with global evidence on the importance of quality of care.[69]

Box 6: The Global Fund's approach to improving the quality and efficiency of program implementation

1. Technical efficiency of service delivery, including DSD models;
2. Efficiency of management, including planning, quality improvement, quality assurance, quality control, monitoring, evaluation and information flows;
3. Efficiency in program financing and financial flows;
4. Institutional efficiency and systems integration, including through integrated, people-centered health services.

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1. *Improve the technical efficiency of service delivery, including through differentiated service delivery (DSD) models*

DSD is a client-centered approach to provide tailored services by population, clinical characteristics and context. It aims to address the needs of identified populations through ongoing, real-time use of data for decision making, driving efficiencies in programming.

Development of appropriate DSD models requires a situational analysis that assesses the data, the country policies and existing DSD models in the country. Countries should consider whether existing service delivery models can be adapted or if new DSD models need to be built. Both adapting and building new models requires considering the building blocks of service delivery, specifically the optimal service frequency ("when"), service location ("where"), service provider ("who") and the service package ("what") for each component of the service provided.

Several resources are available for applicants to develop and scale DSD models. The *HIV Key Populations Implementation tools* provide additional information on how to deliver differentiated services to key populations: the Men who have Sex with Men Implementation Tool (MSMIT),[70] Sex Workers Implementation Tool (SWIT),[71] Injecting Drug Users Implementation Tool (IDUIT),[72] and Transgender Implementation Tool (TRANSIT).[73] The IAS [website](#) offers various approaches and decision frameworks.[74] More detailed information can also be found in the Global Fund [Implementation Quality Technical Brief](#).

Applicants should consider and scale up DSD models for prevention.[75] Applicants should pay special attention to leveraging the comparative advantage of community systems to reach populations whose access to services is often limited. Community-based programs can help to reach, connect and retain people along the HIV prevention and treatment continuum, especially those most marginalized and most affected by HIV.[76] Community organizations, networks and

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[69] See, for example, Kruk, et al. (2018). [High-quality health systems in the Sustainable Development Goals era: time for a revolution](#).
[70] UNFPA, et al. (2015). [Implementing comprehensive HIV and STI Programmes with men who have sex with men: practical guidance for collaborative interventions.](#)
[71] UNDP, et al. (2017). [Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Intervention](#).
[72] INPUD, et al. (2017). [Implementing Comprehensive HIV and HCV Programmes with People Who Inject Drugs](#).
[73] UNFPA, et al. (2016). [Implementing Comprehensive HIV and STI Programmes with Transgender People: Practical Guidance for Collaborative Interventions](#).
[74] IAS (2017). [Differentiated Service Delivery for HIV: A Decision Framework for Antiretroviral Therapy](#); IAS (2018). [Differentiated Service Delivery for HIV: A Decision Framework for HIV Testing Services;](#) IAS (2019). [Differentiated Service Delivery for HIV: A Decision Framework for Differentiated Antiretroviral Therapy Delivery for Key Populations.](#) The IAS website also offers information on ['Services for female sex workers and men who have sex with men'](#)
[75] Aidspan (2017). [TRP review of Global Fund Window 1 funding requests: Technical lessons for malaria, TB and HIV](#).
[76] Global Fund (2019). [TRP: Report on RSSH Investments in the 2017-2019 Funding Cycle](#).

consortia are often effective delivery platforms for a range of programs, such as those that reduce human rights, gender and other barriers; create demand for commodities or services; foster community mobilization; strengthen referral pathways; and support adherence.

Community-led advocacy supports services and programs that meet the needs of communities. Advocacy also supports investments that are efficiently, effectively and equitably used to increase impact as well as contribute to wider health, rights and well-being.

Applicants are strongly encouraged to promote and facilitate investment in community-based organizations as key actors in an overall system to deliver HIV programs and services. Community organizations and systems require investments in capacity building and in management systems including routine monitoring and data systems, to deliver HIV programs efficiently and at scale. Community systems strengthening (CSS) investments can support institutional and organizational capacity development, including governance, financial management, sustainability planning, policy development, leadership development, program management, monitoring systems and data use, evaluation and learning, building and sustaining partnerships, and community organizing and advocacy.

Community-based monitoring (CBM) supports efforts to improve accessibility, responsiveness and quality of services. Applicants are encouraged to explore the potential of allocating funds to CBM, to increase community engagement through collaborative approaches to identifying and addressing bottlenecks and gaps in service provision, providing feedback using short, local feedback loops. CBM can focus on general health services, disease specific or intervention specific (such as monitoring of HIV treatment access or of human rights barriers for key populations). Examples of CBM tools that applicants should consider include scorecards, complaints mechanisms, stock out alert systems, treatment observatories, and monitoring of human rights and gender barriers to services.

For more information, refer to the Global Fund's webpage on Community Response Systems. The WHO guideline on health policy and system support to optimize community health worker programmes provides evidence on what is required to facilitate the proper integration of community health workers in health systems and communities.

2. *Improve the efficiency of management*

Applicants should consider improving the efficiency of the management of their programs, including planning, routine monitoring, evaluation, information flows, quality assurance and quality improvement practices, and the management of human resources for health (HRH); the latter include workforce planning, capacity building, leadership and management development, incentives, rewards and recognition. Typically, this requires a balance of strengthening the capacity of key actors, using routine monitoring data for problem-solving on a regular basis, and simplifying practices, standards, procedures and tools to make responsibilities easier to fulfill.[77,78]

Details on routine monitoring, evaluation and information flows are captured in Section 3.4. Improving planning processes can yield significant gains in efficiency directing resources to highest-priority areas and populations, and by aligning and avoiding duplication of efforts by key stakeholders. CCMs have key roles to play so planning processes are based on quality, up-to-date data and involve a representative set of stakeholders.

Applicants should secure the availability, accessibility, and quality of the health workforce and the services they provide. Countries could, for instance, request funding for pre-service training and refresher courses on delivering integrated and non-discriminatory health services. Moving from vertically organized staff (for example HIV-specific community health workers) to

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[77] Homan R et al.(2018). Leveraging existing program data for routine efficiency measurement in Zambia. Gates open research. 2018;2.

[78] Kandasami S et al. (2019). Can changes in service delivery models improve program quality and efficiency? A closer look at HIV programs in Kenya and Uganda. JAIDS Journal of Acquired Immune Deficiency Syndromes published ahead of print at: https://journals.lww.com/jaids/Abstract/publishahead/Can_changes_in_service_delivery_models_improve.96387.aspx

multipurpose health workers—both at the facility and community levels—is more efficient and will ease health workforce distribution across the country and increase access to services.[79] This includes supporting the motivation and presence of health workers, through HR management in resource limited settings and reinforcement of management skills of leadership through innovative practices. The Global Fund's Strategic Support for Human Resources for Health Technical Brief provides more information on improving HRH.

3. *Develop efficiencies in program financing and financial flows*

National financial systems that can accurately track resources, capture cost estimates and link investments to health outcomes are an important element of a systematic approach to improving program quality and effectiveness. A common approach to tracking resources for health is the development of health accounts using the System of Health Accounts (SHA) 2011 methodology.[80] In addition, some countries have conducted National AIDS Spending Assessments, for a deeper dive into HIV spending that provide much more granular expenditure data on the program. This granularity of data is particularly useful for efficiency and sustainability dialogues. However, when done in isolation (without SHA), these deep dives into disease expenditures do not capture broader health spending. PEPFAR, the Global Fund and UNAIDS have developed a harmonized budget framework which is aligned with the upcoming NASA 2019 framework. Countries are encouraged to implement NASA 2019 and seek technical assistance through UNAIDS if necessary.

Applicants should note in their applications how the Global Fund, PEPFAR and other funding sources are complementary to each other. To support countries with an overview of the complementarity of financing from key funding sources, the Global Fund, PEPFAR and the Bill and Melinda Gates Foundation have collaborated to produce harmonized budget profiles for a comprehensive view of the investment landscape and to better synchronize investments. Country specific profiles will be shared with respective countries.

4. *Maximize institutional efficiencies and systems integration, including through integrated, people-centered health services*

With early diagnosis and initiation of effective ART, PLHIV are expected to have a normal lifespan. HIV care is therefore increasingly following a chronic disease model. Services for HIV should be embedded within broader health systems. Applicants should improve efficiency and quality by integrating HIV services within national efforts for the delivery of integrated, people-centered health services.[81] Applicants are recommended to review in detail the Global Fund Information Note on RSSH.

Primary health care facilities and community health systems are particularly important areas for countries to explore the possibilities for greater integration. Another opportunity for integrating services is to strengthen the antenatal platform to enable the delivery of a package of services, including PMTCT, for pregnant women.

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[79] WHO (2018). WHO guideline on health policy and system support to optimize community health worker programmes.
[80] See the WHO Health Accounts webpage.
[81] Integrated health services are health services that are "managed and delivered so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services, coordinated across the different levels and sites of care within and beyond the health sector, and according to their needs throughout the life course". To complement this, people-centered care is "an approach to care that consciously adopts individuals', careers', families' and communities' perspectives as participants in, and beneficiaries of, trusted health systems that are organized around the comprehensive needs of people rather than individual diseases, and respects social preferences." WHO (2016). Framework on integrated, people-centered health services.

For example, Kenya has worked to strengthen service integration around antenatal and postnatal care. Focal areas of investments have included PMTCT, fee waivers for skilled-care deliveries and emergency obstetric equipment. Investments have contributed to national progress, including a 27 percent increase in HIV testing for pregnant women (2007 to 2012), a key initial step to a comprehensive and efficient service cascade.[82] Please refer to the Global Fund [Strengthening Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health (SRMNCAH) in Funding Requests to the Global Fund Technical Brief](#) for more information on activities to improve SRMNCAH.

Another way to improve the efficiency of service delivery is through investments in the integration of HRH in both facility and community services.

In **Zambia**, the Global Fund has invested in integrated HIV, TB and cervical cancer services, including the training of HRH in antiretroviral therapy centers to conduct cervical cancer screening. The integration of these services makes sense because prevalence of both HIV and invasive cervical cancer is very high, making it important to reduce cervical cancer-related mortality and morbidity among women with HIV.

Benin has a national CHW strategy, and the Global Fund is supporting it by funding the recruitment, training and salaries of CHWs to expand and scale up integrated community health services, in accordance with the country's strategic priorities for HIV/AIDS, TB, malaria, hepatitis and reproductive, maternal, newborn and child health. The CHW role is being expanded to include TB case detection and HIV prevention, follow-up and support, which are being added to the CHW integrated training curriculum. The government has made a commitment to contribute to CHW salaries from funds available at the local government level.

In the context of HIV funding requests, RSSH support should be formulated to ensure the efficiency of the health system as a whole: to remove duplications, overlaps or misalignments across core health system functions (financing, governance and service delivery) that constrain the level of effective coverage achievable by the health system. RSSH support should be specifically used to alleviate service delivery constraints faced not only by HIV programs but by the three diseases, increasing the efficiency of the programs and allowing for national health system strengthening.

Countries with high co-infection burden of TB and HIV[83] are required to submit joint TB/HIV funding requests that present integrated and joint programming for the two diseases. These funding requests need to present prioritized, high impact interventions including collaborative TB/HIV activities. This should include regular screening of PLHIV for TB, HIV testing of TB symptomatic people and TB patients, provision of ART, co-trimoxazole and TB medicines for co-infected patients and provision of TPT (including the recently recommended shorter combination regimens such as 3HP and 3RH for PLHIV without active TB). There are different opportunities to strengthen collaboration between the two programs, including multi-disease platforms such as GeneXpert which could be utilized for TB diagnosis and HIV viral load determination, and the use of lateral flow urine lipoarabinomannan assay (LF-LAM) for the diagnosis and screening of active tuberculosis in people living with HIV. Further expansion should be based on mapping for optimal deployment and use of respective technologies.

Joint funding requests should also provide a detailed description on how the two programs will work to address the burden of TB and HIV and the burden of TB/HIV co-infection. Emphasis should be placed on gaining efficiency through synergized program management and consistent in-country collaboration between the disease programs during the preparation of funding requests,

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[82] SEEK Development (2013; unpublished). Thematic Review of Global Fund's Contribution to Millennium Development Goals 4 and 5.
[83] See Footnote 4 in Section 2 for country list.

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. Countries 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. Opportunities for TB/HIV integration such as addressing TB prevention gap among PLHIV can be bridged by providing TB TPT through community-based differentiated adherence and ART care.

The epidemiology of the local TB and HIV epidemic, maturity and capacity of programs, diverse health infrastructures and management, and barriers to care and client needs should determine the scope and critical areas of joint programming with a flexible approach. One of the models to provide integrated services to TB and HIV patients includes "one-stop-shop" – although there is no "one-size-fits-all" approach.

Mozambique,[84] for example, uses a "one-stop-shop model" to provide integrated service delivery, with TB and HIV services available jointly at most facilities. As a result, 96 percent of TB patients know their HIV status and 94 percent of co-infected patients who were identified to have TB were initiated on ART in 2016.[85]

For further details, please refer to the Global Fund TB Information Note, the WHO End TB Strategy, Stop TB Key Population Brief: People Living With HIV and the WHO consolidated guidelines on Integrating collaborative TB and HIV services within a comprehensive package of care for people who inject drugs.

5. *Tailoring the response to challenging operating environments*

Programs in challenging operating environments (COEs) merit special mention, as the context may change the approach to implementation.[86] In particular, there are situations in which disease-specific delivery platforms may be more suitable than integrated, such as a short-term measure in fragile states and for the management of some emergencies. Applicants should refer to the Information Note on RSSH and the Global Fund Human Rights and Gender Programming in Challenging Operating Environments Guidance Brief for more details on COEs, including a list of eligible COEs and more country examples.

Tailored intervention and differentiated program management approaches to COEs are crucial to achieve results and impact. The Global Fund allows flexibilities to maximize coverage and access to services in COEs.[87] , the Global Fund's COEs Policy embraces the principle of "health for all" and the vision of the SDGs "to leave no one behind". Central to this policy are partnerships to enhance service delivery and improve in-country coordination to reach the populations in need, leveraging technical assistance and the comparative advantages of partners.

An example of the Global Fund's COE policy in practice can be found in the Somalia portfolio. Decades of civil war left Somalia with a dysfunctional health system. The country faces further challenges with displaced populations stemming from widespread violence, recurrent droughts and floods. In this fragile context, the Global Fund allowed flexibilities both in programmatic and processes aspects: budgetary adjustments, supply of health products as per constant shifts of situations, tailored grant work plan, adaptable performance framework and extended deadlines for data collection and reporting. The program has been successful in reducing HIV incidence by 23 percent and AIDS related deaths by 39 percent between 2010-2017. Other Global Fund performance indicators, such as the in-country financial absorption, have increased.

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[84] Mozambique has an incidence of HIV+TB of 221/100000. WHO (2018). Global Tuberculosis Report.
[85] Aidspan (2019). Mozambique's TB/HIV funding request to the Global Fund builds on achievements of current gaps, TRP says.
[86] The challenges of COEs may also impact the "understand" and "design" stages, the most significant impact is around program implementation, which is why COEs are covered in this section. As a general principle, the approaches outlined above in Sections 4.1 and 4.2 should be employed in COEs.
[87] Global Fund financing in COEs is generally provided through country allocations. Country allocations may be reprogrammed to respond to crises, including at the sub-national and regional level. An ad-hoc COE classification can be granted in case of emergency situations to enable rapid responses to cater to needs of key populations.

4.4 Sustain: Strengthen the sustainability of national disease responses and health systems

As outlined in the Global Fund Sustainability, Transition and Co-Financing (STC) policy sustainability is a process and not a single terminal event. It has several different facets, such as financial, programmatic, systems related, governance, human rights and political.[88] External financing can either enhance or detract from the sustainability of national disease responses and health systems. Insufficient domestic financing is a significant threat to the sustainability of HIV programs. The causes can be: revenue mobilized by the government is small, allocation to the health sector within the total government budget is minor, not a high allocation to HIV from the health budget, or inefficiencies in the overall system or service delivery limit the effectiveness of available funding, even when increased. Addressing these requires political commitment and collaboration across various sectors of national governments, particularly with ministries of finance.

Countries should consider all aspects of sustainability as they strengthen national planning. While not exhaustive, examples of various focus areas may include:

- Financial: domestic financing for interventions for key populations and for treatment scale-up, strengthening efficiency to decrease long term costs;
- Programmatic: program quality, DSD, integration of services into primary care;
- Systems related: formal health systems should work effectively with civil society organizations, and health reforms (including those related to social health insurance) strengthen access and financial protection for PLHIV, improve data systems and sustainable access to and use of data;
- Governance: continued engagement of people affected by HIV and key populations in decision-making processes related to HIV;
- Human rights: addressing barriers to access to services and employing effective interventions to reduce stigma and discrimination;
- Political: efforts to strengthen political will to increase overall sustainability of national disease responses.

All countries—not only those approaching transition from external financing—should consider elements related to sustainability in their funding requests, grant and program implementation. This should be done within the context of overall sustainability of health services, considering the country's national health financing and/or health sector strategy. Greater consideration of sustainability can help strengthen health systems in a manner that supports HIV outcomes, increase long-term domestic financing in line with national strategic plan goals, strengthen the overall efficiency of service delivery, prepare early for eventual transition from external financing, and gradually facilitate more country-ownership of the national disease response.

There is no single approach to address sustainability of HIV programs and country and regional context will play a strong role in determining the most appropriate and impactful focus areas. The following elements and principles are particularly important for countries to consider while conducting national planning and preparing funding requests.

1. *Country-owned and led*
A founding principle of the Global Fund is that programs are country-owned and led. The practical translation of this is seen through involvement and inclusion of stakeholders at all levels: national,

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[88] A number of frameworks set out the different dimensions of sustainability. This example is adapted from Oberth, G., & Whiteside, A. (2016). What does sustainability mean in the HIV and AIDS response?.

provincial and district. Inclusive HIV programming has been shown to be more effective in reaching those in need and addressing critical issues compared to where key stakeholders are not involved.[89]

2. *Plan for sustainability from the start*

Countries should consider sustainability as early as possible, including when developing or evolving programs and services. Too often, successful pilots do not consider the factors related to scaling-up and the transition to domestic financing and management, including unit costs, human resources and the balance of domestic versus external resources. For example, the introduction of new, innovative or high-tech services may prove efficacious, but translating these into effective, sustainable service provision may prove challenging, particularly if programs do not consider long term sustainability from the start. Building on existing services and developing and adapting them ensures that new innovations can be sustainably integrated into health and community systems. Approaches and programs should not operate in a standalone manner but should be assimilated into national strategies, practices and standard procedures.

3. *Bottom-up led, top-down supported*

Too often, the approach to management and programming in the health system is top-down. Ideas, solutions and instructions flow from the top downward, seeking to solve challenges in reaching targets. However, the real, experiential understanding of the challenges and what will work or not is at the ground level, where the system interfaces with its constituents and the challenges. DSD is a key approach for driving efficiencies in programming based on ongoing, real-time use of data for decision-making. Involving communities in the development of services takes time but evidence suggests that participatory approaches including "human-centered design" may improve services. Giving people the services that they want and need rather than one-size-fits-all service delivery is more effective and potentially more efficient and will ultimately lead to services that are more sustainable.

4. *Find ways to develop integrated platforms*

Disease-specific programs have often been effective at delivering precise and targeted interventions, allowing for rapid scale up. Over time, consideration should be given to how better integrate and align these services with primary health care services and other integrated platforms (see also Section 4.3). Ensuring long term sustainability will often be linked to integration of disease-specific interventions into the broader process of demand and supply for health services overall, while helping to strengthen the system itself in the process. This becomes of increased importance as a country's epidemic progresses.[90]

5. *Continuous quality improvement process*

Sustainability requires an iterative approach of testing and learning for a process of continuous improvement throughout its execution. Measurement to inform performance management is at the heart of sustainability and it should be used during implementation to quickly learn from both failures and successes, so that course-corrections can be rapidly made.

Many countries have established national HIV Quality Improvement initiatives to address quality assurance and quality improvement. The WHO HIV quality working group has recently produced a brief, Maintaining and Improving Quality of Care within HIV Clinical Services. Further details of this and other areas of quality are available in the Global Fund Implementation quality technical brief and the WHO Handbook for national quality policy and strategy.

The Global Fund's STC policy outlines the core principles of enhancing sustainability and provides a framework to support countries to strengthen sustainability, increase domestic financing, better prepare for transition from Global Fund financing and increasingly address specific sustainability and transition challenges.

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[89] The Global Fund (2016). Involvement of Key Populations and People Living with the Diseases Achieving Inclusiveness of Country Coordinating Mechanisms
[90] For example, as the epidemic progresses, the increased life expectancy of PLHIV on effective therapies means that non-communicable disease become more frequent and must be addressed within integrated platforms.

The Global Fund's [Sustainability, Transition and Co-Financing Guidance Note](#) now includes an HIV Annex that provides additional HIV specific considerations that may serve as a useful resource to support stakeholder dialogues and considerations on sustainability. In addition, the [PEPFAR Sustainability Index and Dashboard](#) can be used to facilitate an overall assessment of sustainability, in Global Fund supported countries where these have been completed.

Annex

A. List of Abbreviations

AGYW	Adolescent Girls and Young Women
AEM	AIDS Epidemic Model
AIM	AIDS Impact Model
ANC	Antenatal Care
ART	Antiretroviral therapy
BBS	Biobehavioral surveys
CBM	Community-Based Monitoring
CHOICE	WHO-CHOosing Interventions that are Cost-Effective
COE	Challenging Operating Environment
CSS	Community Systems Strengthening
DSD	Differentiated Service Delivery
DTG	Dolutegravir
DQA	Data Quality Assessments
GNP+	Global Network of People Living with HIV
HIVDR	HIV Drug-Resistance
HIVST	HIV Self-Testing
HRH	Human Resources for Health
HTS	HIV Testing Services
ICW	International Community of Women Living with HIV
KPs	Key Populations
NSP	National Strategic Plan
NVP	Nevirapine
OIG	Office of the Inspector General
PITC	Provider-Initiated Testing and Counseling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
POC	Point of Care
PrEP	Pre-Exposure Prophylaxis
PSE	Population size estimates
RSSH	Resilient and Sustainable Systems for Health

STAR	Socio-Technical Allocation of Resources
STI	Sexually Transmitted Infection
SRH	Sexual and Reproductive Health
SRMNCAH	Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health
STC	Sustainability, Transition and Co-financing
TLD	Tenofovir Disoproxil Fumarate, Lamivudine and Dolutegravir
TPT	TB Preventive Treatment
TRP	Technical Review Panel
UHC	Universal Health Coverage
UNAIDS	Joint United Nations Programme on HIV/AIDS
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization

B. Key References

Key Global Fund resources

- Global Fund Applicant's Handbook
- Global Fund COEs Policy Global Fund Community Systems Technical Brief
- Global Fund FAQ on 'Scaling up programs to remove human-rights barriers to health services'
- Global Fund Funding Request Instructions
- Global Fund Guidance Note on Self-Testing
- Global Fund Human Rights Complaints Mechanism
- Global Fund Modular Framework Handbook
- Global Fund RSSH Information Note
- Global Fund Strategic Framework for Data Use for Action and Improvement at Country Level
- Global Fund Strategy 2017-2022 Investing to End Epidemics
- Global Fund's Sustainability, Transition and Co-Financing Guidance Note
- Global Fund TB Information Note
- Global Fund Technical Brief on Harm Reduction for People who use drugs
- Global Fund Technical Brief on HIV, Human Rights and Gender Equality
- Global Fund Technical Brief on HIV and key populations
- Global Fund Technical Brief on Implementation Quality
- Global Fund Technical Brief on TB and Human Rights
- Global Fund Technical Brief on Strengthening sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) interventions in funding requests to the Global Fund
- Global Fund Value for Money Technical Brief
- Global Fund Technical Brief on Strengthening Community Systems and Responses

Partner institutions' planning, guidance documents and tools

- Frontline AIDS (formerly HIV Alliance) Safety and Security Toolkit.
- GNP+, ICW and UNAIDS PLHIV Stigma Index
- IAS Differentiated Care for HIV: A Decision Framework for Differentiated Antiretroviral Therapy Delivery – For Children, adolescents and pregnant and breastfeeding women
- IAS Differentiated Service Delivery for HIV: A Decision Framework for Differentiated Antiretroviral Therapy Delivery for Key Populations
- IAS Differentiated Service Delivery for HIV: A Decision Framework for HIV Testing Services.
- IATT Technical Briefs on Young Key Populations.
- INPUD, et al. Implementing Comprehensive HIV and HCV Programmes with People Who Inject Drugs.
- PEPFAR Sustainability Index and Dashboard
- Stop TB GAT
- Stop TB Key Population Brief: People Living With HIV
- UNAIDS (forthcoming September 2019) Prevention Cascade Analysis Tool]
- UNAIDS The Privacy, Confidentiality and Security Assessment Tool User Manuel
- UNAIDS Fast-Track and human rights: Advancing human rights in efforts to accelerate the response to HIV
- UNAIDS 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.

- UNAIDS GAT
- UNAIDS User Guide for the HIV-Related Human Rights Costing Tool
- UNAIDS Strengthening HIV Primary Prevention
- UNAIDS/UNFPA (forthcoming September 2019). Technical Note on Condom Programming
- UNAIDS/WHO Guidance Notes for country programming
- UNAIDS 2016-2021 Strategy: On the Fast-Track to end AIDS.
- UNAIDS Do no harm: health, human rights and people who use drugs
- UNAIDS HIV prevention among adolescent girls and young women
- UNAIDS Stronger together: from health and community systems to systems for health
- UNDP, et al. Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Intervention.
- UNFPA et al. Implementing comprehensive HIV and STI Programmes with men who have sex with men: practical guidance for collaborative interventions.
- UNFPA, et al. Implementing Comprehensive HIV and STI Programmes with Transgender People: Practical Guidance for Collaborative Interventions.
- WHO Biobehavioral Survey Guidelines for Populations at risk for HIV
- WHO Cascade Data Use Manual to Identify Gaps in HIV and Health Services for Programme Improvement
- WHO Considerations for Adoption and Use of Multi-disease Testing Devices in Integrated Laboratory Networks.
- WHO Consolidated guidelines on 'Integrating collaborative TB and HIV services within a comprehensive package of care for people who inject drugs'
- WHO Consolidated guidelines on drug-resistant tuberculosis treatment 2019 update
- WHO Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations.
- WHO Consolidated guidelines on person-centered HIV monitoring and case surveillance
- WHO Consolidated guidelines on person-centered HIV patient monitoring and case surveillance
- WHO Consolidated Strategic Information Guidelines for HIV in the Health Sector
- WHO Consultation on HIV differentiated service delivery models for specific populations and settings: Pregnant and breastfeeding women, children, adolescents and key populations
- WHO Data quality assessment of national and partner HIV treatment and patient monitoring data and systems implementation tool
- WHO forthcoming Consolidated guidelines on HIV testing services[91]
- WHO forthcoming HIV ST M&E Module
- WHO Framework on integrated, people-centered health services
- WHO Global Action Plan on HIV Drug Resistance (2017-2021)
- WHO Global health sector strategy on HIV, 2016-2021
- WHO Global report on early indicators of HIV drug resistance
- WHO Guide for the Stepwise Laboratory Improvement Process Towards Accreditation in the African Region
- WHO Guideline on health policy and system support to optimize community health worker programmes
- WHO Guidelines on tuberculosis infection prevention and control 2019 update

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[91] Existing guidelines at time of publication: WHO (2015) Consolidated guidelines on HIV testing services

- WHO [Guidelines for treatment of drug-susceptible tuberculosis and patient care](#) 2017 update
- WHO Handbook for national quality policy and strategy
- WHO HIV Self-testing strategic framework: a guide for planning, introducing and scaling up
- WHO Implementation tool for pre-exposure prophylaxis of HIV infection
- WHO Prequalification of PrePex medical male circumcision device has potential to help countries accelerate key HIV prevention program
- WHO The Maputo declaration on strengthening of laboratory systems
- WHO Updated recommendations on first-line and second-line antiretroviral regiments and post-exposure prophylaxis and recommendations on early infant diagnosis of HIV
- WHO Policy Brief. Update of recommendations on first- and second-line antiretroviral regimens (July 2019)
- WHO guideline on health policy and system support to optimize community health worker programmes
- WHO/UNAIDS Guidelines for HIV mortality measurement
- WHO Maintaining and improving quality of care within HIV clinical services