



Information Note

HIV Information Note

Allocation Period 2023-2025

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1. Executive Summary

This information note provides guidance to applicants preparing funding requests for HIV and joint tuberculosis (TB)/HIV programs for the 2023-2025 allocation period. To accelerate progress in preventing, diagnosing, and treating HIV, this note describes a strategic investment approach, defines the program essentials that all applicants are expected to address, and identifies the prioritized interventions to have an impact. This information note also provides several country examples of good practices for investments in HIV.

Together this partnership has made tremendous progress in fighting AIDS over the last twenty years: the number of new HIV infections globally has declined from 3.2 million in 1996 to 1.5 million in 2021 and the expansion of treatment has led to a 52% reduction in deaths from AIDS-related causes since 2010.¹

However, these results did not achieve targets set in 2016 for a 75% decline in both new HIV infections and AIDS-related deaths between 2010 and 2020.² In addition, the COVID-19 pandemic severely impacted access to services in 2020 and 2021, resulting in declines in HIV prevention and testing service coverage,³ even as HIV treatment proved more resilient. In this context, meeting the global 2025 targets and the global goal of ending AIDS by 2030 requires urgent and transformative action.

In the 2023-2025 allocation period, there are new opportunities to leverage advances in HIV prevention and treatment and to adopt precision public health approaches. There is also a need for continued attention to addressing inequities and human rights- and gender-related barriers to services, to support integration between HIV services and related areas of health and to strengthen the health systems that support a wider range of services.

To guide its investments, the Global Fund has developed an ambitious new Strategy⁴ to get progress back on track against HIV, TB and malaria and contribute to the target of achieving universal health coverage. The Global Fund will put a greater focus on equity, sustainability, program quality and innovation. This new Strategy guides the Global Fund to take determined action to tackle human rights- and gender-related barriers and leverage the fight against the three diseases to build more inclusive, resilient and sustainable systems for health better able to deliver health and well-being and to prevent, identify and respond to pandemics. Key Performance Indicators for the Global Fund will also be updated to reflect the new strategy.⁵

The **goal of ending AIDS** is supported by **five objectives** in the new Global Fund Strategy that provide a framework for considering Global Fund investments (Figure 1):

¹ UNAIDS (2022). [In Danger: UNAIDS Global AIDS Update 2022](#).

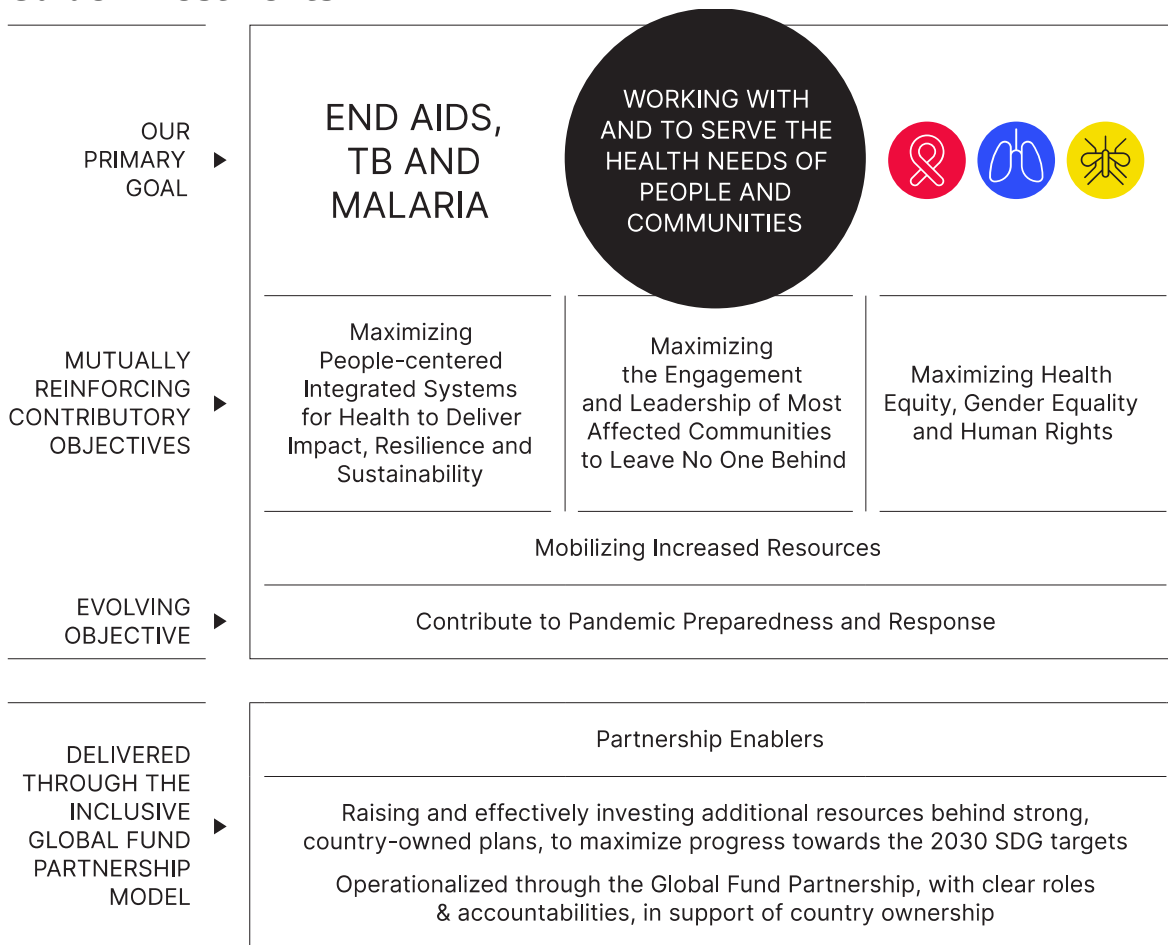
² Mahy, M.I. et al. [Progress towards 2020 global HIV impact and treatment targets](#). J Int AIDS Soc. 2021 Sep; 24(Suppl 5): e25779.

³ The Global Fund (2022). [Results Report 2021](#).

⁴ The Global Fund (2021). [Fighting Pandemics and Building a Healthier and More Equitable World: Global Fund Strategy \(2023-2028\)](#).

⁵ The Key Performance Indicator Framework will be available in 2023 on the Global Fund website.

Figure 1. Applying the Global Fund 2023-2028 Strategic Objectives to Guide Investments



Applicants should consult the resources listed below when developing their HIV funding request. Countries with a high TB and HIV coinfection burden are required to submit joint TB/HIV funding requests that present integrated quality programming for the two diseases.

- [Applicant's Handbook](#): how to develop a funding request.
- [Funding Request Instructions](#): to complete the Application Form.
- [Modular Framework](#): identifies the interventions that the Global Fund supports, associated budget and indicators against which progress is measured.
- [Information Notes & Technical Briefs](#)
- [Sustainability and Transition Guidance](#) (Annex II – HIV and Sustainability).

2. Investment Approach

Global Fund investments should contribute to country-owned responses. Therefore, requests should be aligned with national priorities set out in national strategic documents, specifically HIV National Strategic Plans which should be harmonized with national health sector strategies.

This section outlines four stages of a strategic investment approach: *understand, design, deliver, and sustain*.¹ Recommendations from the 2020-2022 Technical Review Panel (TRP) Lessons Learned Report² are also reflected here.

2.1. Understand: continue to know your epidemic and its updated resource needs

The Global Fund encourages countries to expand the collection and analysis of key HIV and sexual health data. Increased granularity of quality data is key to understand HIV epidemic dynamics along with program priorities and outcomes to support strong funding requests. The following are recommended:

a) Analyze the current and evolving epidemiological context

Data should be collected in line with World Health Organization (WHO) recommendations on HIV strategic information.³ Applicants should collect and analyze data that is disaggregated by geography, by population (key and vulnerable), by sex/gender and age. Data and information should be compiled and analyzed on sexual and drug use risk practices, social context and rights-related barriers relevant to the local context. These analyses should be considered together with current and trend analyses of HIV and TB incidence, morbidity and mortality.

Geospatial data can be used to map the geographic distribution of disease, associated risk factors, and service availability for HIV prevention and treatment. It can help to analyze risks for disease, epidemic trends over space and time, and disease hotspots.

Size estimation and mapping of key and vulnerable populations is essential to ensure that programs are sufficiently targeted and can achieve adequate coverage for HIV impact. Collecting data on key populations can pose significant personal and privacy-related risks to key populations and young people. Accordingly, data should be collected in ways that *do no harm*, that is, data collection and storage that protects privacy and confidentiality, ensures informed consent, and minimizes all security risks.

b) Perform HIV cascade data analysis

Information should be collected and analyzed across the HIV prevention and treatment cascades. See the WHO⁴ and Global HIV Prevention Coalition⁵ guidance for information on how applicants should undertake these analyses. See also [Section 3.2.6](#).

¹ UNAIDS (2012). [Investing for results. Results for people](#); and UNAIDS (2013). [Smart investments](#).

² The Global Fund (2021). [2020 Technical Review Panel Lessons Learned](#).

³ WHO (2022). [Consolidated Guidelines on Person-Centred HIV Strategic Information: Strengthening Routine Data for Impact](#).

⁴ WHO (2018). [Cascade Data Use Manual to Identify Gaps in HIV and Health Services for Programme Improvement](#).

⁵ Global HIV Prevention Coalition/UNAIDS (2021). [Creating HIV prevention cascades](#).

c) Understand and update unit cost estimates

A good understanding of the cost estimates of core interventions and program areas by inputs (such as personnel, medicines and travel) enhances investment efficiency. Unit costs, especially if collected sub-nationally across service providers and provider types, and over time, can highlight where program efficiencies are possible (e.g., program management, transportation, commodities, human resources).

Unit costs of interventions also serve as important inputs for allocative efficiency analyses to inform the mix of optimal interventions within given resources for maximum impact. For example, applicants can compare costs against expected HIV program impact (death, infection or cases averted) across interventions, and prioritize those most likely to have impact within budget constraints. See also [Section 2.3.b.](#)

Applicants are encouraged to refer to the following resources: Checklist and reference list for developing and reviewing a national strategic plan for HIV;¹ the Reference Case for Estimating the Costs of Global Health Services and Interventions;² and the Global Fund HIV, Human Rights, and Gender Equality Technical Brief³ to estimate the associated costs for HIV-related human rights programs. Further information on budget considerations for trusted access platforms for key population programs is provided in Global HIV Prevention Coalition guidance.⁴

d) Analyze the partner landscape

Understanding the current domestic and partner funding landscape is critical to a coordinated and fully funded HIV response and enables the leveraging of multisectoral partnerships to improve the impact of programs. Applicants are recommended to strengthen their analysis of the funding landscape with solid data sources from sound resource tracking, costing, and budgeting. Applicants are requested in their applications to note how the Global Fund, the President's Emergency Plan for AIDS Relief (PEPFAR) and other funding sources are complementary to one another and to domestic resources. See also the [Resilient and Sustainable Systems for Health \(RSSH\) Information Note](#) Section 3 on the importance of including RSSH funding landscape in this analysis.

2.2. Design: prioritize an optimal mix of interventions and service delivery platforms

a) Prioritize programs, services and platforms that maximize use and impact

Applicants are encouraged to optimize intervention packages that prioritize high impact interventions for people with the greatest needs, and to ensure services and programs are delivered in ways that lead to maximum uptake, use and impact. The design should further differentiate service delivery - building on and further expanding existing services to ensure that the mix and organization of service delivery can reach those who are most in need of them.

¹ UNAIDS (2020). [Checklist and reference list for developing and reviewing a national strategic plan for HIV.](#)

² Global Health Costs Consortium (2017). [Reference Case for Estimating the Costs of Global Health Services and Interventions.](#)

³ The Global Fund (2022). [HIV, Human Rights and Gender Equality Technical Brief.](#)

⁴ Global HIV Prevention Coalition/UNAIDS (2020). [Key population trusted access platforms: Considerations in planning and budgeting for a key population platform to deliver scaled, quality HIV prevention and treatment services and for addressing critical enablers.](#)

Design must be mindful of costs.¹ HIV resource allocation tools and models exist to compare different intervention scenarios and to identify optimal intervention packages that maximize impact with available resources. Examples of these tools include: the AIDS Impact Model (AIM) and Goals Model (both are included in the Spectrum suite),² AIDS Epidemic Model (AEM), Optima-HIV³ and the Global Fund Technical Brief on value for money.⁴

b) Involve stakeholders in program design

The design of people-centered programs must be inclusive, engaging service users and involving partners such as community-based and community-led organizations, nongovernmental organizations and private sector organizations delivering services.⁵ Inclusive design helps to ensure that services respond to clients' needs and preferences in humane and holistic ways and break down barriers to access. All programs should be rights-based, gender-responsive and informed by and respond to an analysis of equity.

2.3. Deliver: ensure high quality and efficient service delivery for optimal scale-up

Delivering quality programs requires continual program monitoring and realignment to demonstrate results. This includes adaptation to emerging changes (such as changes in the operating environment, new delivery modalities, tools, products and technologies) that offer the potential for greater impact. It includes adapting and differentiating service delivery models to ensure that more people have services and options provided where they are needed. It also includes ensuring that standards related to human rights and protection from sexual exploitation, abuse and harassment are met by all programs.

a) Accelerate adoption and scale-up of novel health products, technologies and service delivery innovations

New health products, tools, and technologies for HIV prevention, diagnosis and care that are either recently approved by the WHO or are in the approval pipeline, offer potential for accelerated impact. They should be considered and planned for in funding requests. Deploying new products for HIV prevention can yield significant results. Service delivery innovations can expand access and improve choice. Long-acting drug delivery is an impactful innovation in drug administration for both treatment and prevention. Diagnostics and monitoring tools have advanced significantly but are still under-used.⁶ Importantly, some but not all HIV innovations will enter the market at higher costs. For innovations with higher product costs, national HIV programs should holistically assess the impacts of new products, going beyond straightforward commodity cost calculations and accounting for the impact on the broader health system. For innovations entering the market at relatively lower costs, budget efficiencies, whether from the commodity costs or health system, can likely be realized and re-directed toward other priority HIV programmatic areas.

¹ The Global Fund (2021). [2020 Technical Review Panel Lessons Learned](#).

² Avenir Health website. [Spectrum](#) (accessed 5 July 2022).

³ Optima Model website. [Optima: helping decision-makers choose the best public health investments](#) (accessed 5 July 2022).

⁴ The Global Fund (2019). [Value for money Technical Brief](#).

⁵ The Global Fund (2022). [Community Engagement: Opportunities throughout the Grant Life Cycle](#).

⁶ The Global Fund (2021). [2020 Technical Review Panel Lessons Learned](#).

Anticipating and planning for transitions to new products or developments in service delivery may include, for example:

- a cost-effectiveness analysis to enable the planning of sequencing and scaling up new products or technologies, considering price trends, fiscal space and possible delivery models;
- demand-creation interventions to ensure equitable access to these new products and tools;
- the development of policy, regulatory and programmatic enablers; and
- plans for removal of products that are no longer compliant with best practice as recommended in guidelines.

[Section 4.1](#) provides a country example in new product introduction. See also the [RSSH Information Note](#) Section 4.6 (Health Product Management Systems) for considerations about achieving equitable access to quality-assured existing and new health products.

The Global Fund, in the 2023-2025 implementation period, will focus on introduction and scale-up of the following products and technologies (Table 1). These products add to the range of existing proven-effective products (such as condoms) that the Global Fund will continue to support.¹

¹ The Global Fund website. [Health Product Procurement](#) (accessed 8 July 2022).

Table 1. Products and technologies for introduction and scale-up in Global Fund-supported programs¹

Product Area	Objective	Products
Diagnostics/ screening <i>HIV</i>	Improve case finding, accelerate self-care and prevention	<ul style="list-style-type: none"> • HIV self-testing² • Early infant diagnosis (EID), including at point of care
Diagnostics/ screening <i>Coinfections and comorbidities</i>	Accelerate rapid diagnosis of important coinfections and comorbidities	<ul style="list-style-type: none"> • Diagnostics for advanced HIV disease, especially fungal and next generation lateral flow urine lipoarabinomannan assay (LF-LAM) • Dual HIV/Syphilis rapid diagnostic tests (RDT) • Multi-disease RDTs: sexually transmitted infections (STI)/HIV/Hepatitis • Multi-disease molecular testing: TB/Hepatitis/HIV/drug resistance • Human papillomavirus (HPV) nucleic acid amplification tests (NAATs) for screening • Hepatitis C self-tests
Prevention <i>HIV</i>	Expand choice, accelerate self-care, enable people-centered services	<ul style="list-style-type: none"> • Pre-exposure prophylaxis (PrEP) – dapivirine vaginal ring and long-acting injectable cabotegravir • Long-acting opioid substitution therapy (OST)
Management <i>HIV treatment and care</i>	Achieve early and sustained viral suppression	<ul style="list-style-type: none"> • Dolutegravir-based regimens, including 10mg dolutegravir for children • Point of care (POC) technologies for viral load measurement, including early infant diagnosis (EID) • Point of care CD4 count testing (Visitect)
Prevention and management <i>Coinfections and comorbidities</i>	Optimize HIV management to reduce morbidity and mortality	<ul style="list-style-type: none"> • TB preventive therapy: 3HP (weekly isoniazid and rifapentine for 3 months) • Hepatitis B and C antiviral drugs • Liposomal amphotericin B (single high dose) for Cryptococcal infection
Devices/ technology	Accelerate differentiation and digital and virtual service delivery for people-centered services	<ul style="list-style-type: none"> • Use of virtual interventions, including the use of both telephone and internet-based platforms to reach and engage clients in HIV testing, prevention, and treatment.
	Enhance public health surveillance and response	<ul style="list-style-type: none"> • Rapid survey tools • Geo-mapping (mapping using geospatial data)

b) Maximize efficiencies and systems integration, and ensure people-centered health services

HIV-specific investments in health systems enhance HIV program quality and service delivery, ensuring a continuum of prevention, testing, treatment and care. Investments in laboratory systems, integrated HIV service delivery platforms and human resources for health (HRH) are referred to in the respective prioritized interventions described in [Section 3.2](#).

The [RSSH Information Note](#) addresses investments in broader health and community systems that increase the quality, sustainability and resilience of HIV programs. These investments include effective program management, especially through effective

¹ For details on the specific products listed see [Section 3.2](#) on prioritized interventions and the WHO technical guidance referenced there. All products listed will be added to the Global Fund [Health Product Procurement](#) list once they are WHO-recommended.

² The cost of self-tests is decreasing. A new partnership including MedAccess, the Clinton Health Access Initiative and Wondfo has agreed to make Wondfo's HIV self-test available for US\$1, making it the lowest priced WHO prequalified self-test for HIV on the market. <https://www.clintonhealthaccess.org/news/new-agreement-secures-historic-us1-price-for-hiv-self-test/>

monitoring and evaluation (RSSH Section 4.4), Human Resources for Health and Quality of Care (RSSH Section 4.5), and quality management (RSSH Section 6.1/Annex 1). See also the Global Fund Laboratory Systems Strengthening¹ and Community Systems Strengthening² Technical Briefs. Tools to support cross-programmatic efficiency analyses are available³ that highlight opportunities for efficiency and/or equity gains that are possible with improved program integration.⁴

c) Ensure standards are met for all Global Fund-supported programs and services

All grant agreements signed by the Global Fund are expected to meet the following five human rights standards:

- i. provide non-discriminatory access to services for all, including people in detention;
- ii. employ only scientifically sound and approved medicines or medical practices;
- iii. do not employ methods that constitute torture or cruel, inhuman or degrading treatment;
- iv. respect and protect informed consent, confidentiality and the right to privacy concerning medical testing, treatment or health services rendered; and
- v. avoid medical detention and involuntary isolation, which are to be used only as a last resort.

Global Fund grant recipients are required to advise the Global Fund of risks to these human rights standards. The Global Fund's independent Office of the Inspector General has established a mechanism to investigate complaints regarding the standards.⁵

Applicants are also expected to consider the Protection from Sexual Exploitation, Abuse and Harassment (PSEAH),⁶ as well as child protection in the planning and design of program interventions. Program-related risks of sexual exploitation, abuse and harassment to beneficiaries, community workers and others, as relevant, should be identified in the proposed interventions, which should also include necessary mitigation measures to ensure that services are provided to, and accessed by, beneficiaries in a safe way. It is also recommended to include PSEAH in community awareness activities like outreach strategies, communication campaigns, trainings or other activities that target grant beneficiaries. See the Global Fund Guidance Note on PSEAH.⁷

d) Programming in Challenging Operating Environments

Programs in Challenging Operating Environments (COE) require a differentiated approach to increase health impact, blending development and humanitarian approaches. The Global Fund COE Policy allows flexibilities to maximize coverage and access to services in these settings.⁸ Central to this policy are partnerships to protect and enhance service delivery and

¹ The Global Fund (2022). [Laboratory Systems Strengthening Technical Brief](#).

² The Global Fund (2022). [Community Systems Strengthening Technical Brief](#).

³ WHO (2022). [Cross programmatic efficiency analysis](#).

⁴ WHO Global Health Observatory website. [Health Equity Assessment Toolkit](#) (accessed 5 July 2022).

⁵ The Global Fund (2015). [The Global Fund Human Rights Complaints Procedure Responding to Community Concerns](#).

⁶ The Global Fund (2021). [Operational Framework on the Protection from Sexual Exploitation and Abuse, Sexual Harassment, and Related Abuse of Power](#).

⁷ The Global Fund (2022). [Protection from Sexual Exploitation, Abuse and Harassment Guidance Note](#).

⁸ The Global Fund 35th Board Meeting (2016). [The Challenging Operating Environments Policy](#).

improve in-country coordination to reach the populations in need, leveraging technical assistance and the comparative advantages of partners.

For further considerations consult the Inter-Agency Standing Committee guidance on addressing HIV in emergency and humanitarian settings,^{1,2} and the Global Fund Technical Brief on human rights and gender in COE.³

2.4. Sustain: strengthen the sustainability of national disease responses and health systems

The Global Fund encourages all countries to incorporate sustainability considerations in national planning, grant design, co-financing commitments, and grant implementation, regardless of where a country is on the development continuum or their proximity to transition from Global Fund financing. See the Global Fund guidance note on these topics.⁴

¹ Inter-Agency Standing Committee (2010). [Guidelines: Addressing HIV in Humanitarian Settings](#).

² Inter-Agency Standing Committee (2003). [Guidelines: HIV/AIDS Interventions in Emergency Settings](#).

³ The Global Fund (2022). [Human Rights and Gender Programming in Challenging Operating Environments Technical Brief](#).

⁴ The Global Fund (2022). [Sustainability, Transition and Co-Financing Guidance Note](#).

3. Priorities for HIV Investments

The Global Fund continues to support the principle of country ownership in tandem with a greater focus on evidence-based and rights-based interventions that demonstrate impact. Broadly, the Global Fund expects applicants to propose funding requests that:

- Demonstrate an intensified focus on HIV prevention, especially HIV prevention-related outcomes.
- Prioritize interventions that can be delivered at sufficient scale and quality to have significant impact.
- Prioritize people living with HIV across their life-course and key and vulnerable populations with the highest risk of HIV infection. Address human rights- and gender-related barriers to service access and continuation.
- Align with guidance from WHO, UNAIDS and other technical agencies.
- Maintain support for proven-effective products, technologies and service delivery approaches
- Support the rapid adoption and scale-up of new products, technologies and service delivery approaches, as recommended in global strategies, policies and technical guidance from the WHO, UNAIDS and other technical agencies.
- Deliver integrated people-centered health services.
- Support an enabling environment for HIV and related services and programs with supportive laws and policies.

To achieve HIV targets at both national and global levels, this information note documents a set of **program essentials** identified by the Global Fund and partners to be addressed in funding requests for HIV programs. This information note also identifies **prioritized interventions** for consideration in funding requests.

Both program essentials and prioritized interventions are closely linked to global HIV strategies, are aligned with technical guidelines from partners and reflect lessons learned during the previous allocation cycle.¹

Applicants should provide a strong rationale for the interventions proposed in the funding request, but particularly those that are not among the program essentials or prioritized interventions described in Sections 3.1 - 3.2.² For example, if an intervention is already funded through another source.

3.1 HIV Program Essentials

HIV program essentials are key evidence-based interventions and approaches to address the ambitious goals set out in the UNAIDS Global AIDS Strategy 2021-2026,³ the 2022-2030 WHO Global Health Sector Strategies on HIV, viral hepatitis, and sexually transmitted

¹ The Global Fund (2021). [2020 Technical Review Panel Lessons Learned](#).

² See Part 2 of Funding Request Application Form, which provides space to describe the rationale for the funding request and prioritization.

³ UNAIDS (2021). [Global AIDS Strategy 2021-2026 — End Inequalities. End AIDS](#).

infections¹ and the 2023-2028 Global Fund Strategy.² The program essentials presented below (Table 2) are supported by HIV technical partners and respond to their respective HIV technical guidelines. They are critical to ensure equity in access to high-impact interventions for those who need them most.

In the funding requests for the 2023-2025 allocation period, applicants are now required to outline how advanced the country is in the implementation of each of the program essentials.

In situations where the introduction and acceleration of program essentials have been prioritized in funding requests, the Global Fund will support countries throughout the grant life cycle towards their achievement and sustainability.

Relevant program essentials should be reinforced by demand creation activities to inform, increase uptake and support adherence.

¹ WHO (2022). [Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022-2030](#).

² The Global Fund (2021). [Fighting Pandemics and Building a Healthier and More Equitable World: Global Fund Strategy \(2023-2028\)](#).

Table 2. HIV Program Essentials

Note that **all** programming must be human rights-based, gender-responsive and informed by and respond to an analysis of inequities.

HIV primary prevention	<ol style="list-style-type: none"> 1. Condoms and lubricants are available for all people at increased risk of HIV infection. 2. Pre-exposure prophylaxis (PrEP) is available to all people at increased risk of HIV infection, and post-exposure prophylaxis (PEP) is available for those eligible. 3. Harm reduction services are available for people who use drugs. 4. Voluntary medical male circumcision (VMMC) is available for adolescent boys (15+ years) and men in WHO/UNAIDS VMMC priority countries.
HIV testing and diagnosis	<ol style="list-style-type: none"> 5. HIV testing services include HIV self-testing, safe ethical index testing and social network-based testing. 6. A three-test algorithm is followed for rapid diagnostic test-based diagnosis of HIV . 7. Rapid diagnostic tests are conducted by trained and supervised lay providers in addition to health professionals.
Elimination of vertical transmission	<ol style="list-style-type: none"> 8. Antiretroviral therapy (ART) is available for pregnant and breastfeeding women living with HIV to ensure viral suppression. 9. HIV testing, including early infant diagnosis (EID) is available for all HIV-exposed infants.
HIV treatment and care	<ol style="list-style-type: none"> 10. Rapid ART initiation follows a confirmed HIV diagnosis for all people irrespective of age, sex or gender. 11. HIV treatment uses WHO recommended regimens. 12. Management of advanced HIV disease is available. 13. Support is available to retain people across the treatment cascade including return to care. 14. CD4 and viral load testing, and diagnosis of common comorbidity and coinfections are available for management of HIV.
TB/HIV	<ol style="list-style-type: none"> 15. People living with HIV with active tuberculosis (TB) are started on ART early. 16. TB preventive therapy is available for all eligible people living with HIV, including children and adolescents.
Differentiated service delivery (DSD)	<ol style="list-style-type: none"> 17. HIV services (prevention, testing, treatment and care) are available in health facilities, including sexual and reproductive health services, and outside health facilities including through community, outreach, pharmacy and digital platforms. 18. Multi-month dispensing is available for ART and other HIV commodities.
Human rights	<ol style="list-style-type: none"> 19. HIV programs for key and vulnerable populations integrate interventions to reduce human rights- and gender-related barriers. 20. Stigma and discrimination reduction activities for people living with HIV and key populations are undertaken in health care and other settings. 21. Legal literacy and access to justice activities are accessible to people living with HIV and key populations. 22. Support is provided to efforts, including community-led efforts, to analyze and reform criminal and other harmful laws, policies and practices that hinder effective HIV responses.

3.2 Prioritized Interventions for Global Fund-supported HIV Services

This section describes priority intervention for seven program areas:

1. [HIV primary prevention](#)
2. [HIV testing](#)
3. [HIV treatment](#)
4. [Elimination of vertical transmission of HIV, syphilis and hepatitis B](#)
5. [TB/HIV coinfection](#)
6. [HIV strategic information](#)
7. [Human rights](#)

3.2.1 HIV Prevention: improve access to and use of precision combination HIV prevention for people at increased risk of HIV infection

The prevention landscape is rapidly changing – and modernization of prevention systems and approaches is critical. The UNAIDS Global AIDS Strategy 2021-2026 commits to ensure that 95% of people at risk of HIV infection have access to and use appropriate, prioritized, person-centered and effective combination HIV prevention options.¹ The Global Fund Strategy prioritizes substantial reductions in HIV incidence through accelerated access to and use of precision combination HIV prevention, tailored to individual risks and local contexts (Box 1).

To make these changes – for more people at increased risk of HIV infection to have HIV prevention options in their hands, and the knowledge and power to use them – requires an intensified focus on scale and coverage, on a highly targeted approach, on stronger systems to deliver HIV prevention, and on specific HIV prevention-related results.

Box 1. The Global Fund HIV Primary Prevention Results Framework ([Section 6.1/Annex](#)) is aligned with the Global HIV Prevention Coalition’s five key pillars for HIV primary prevention.² **The theory of change** linked to this Results Framework ([Section 6.2/Annex](#)) illustrates how **a range of behavioral, biomedical and structural prevention interventions contribute to HIV prevention outcomes and demonstrates that biomedical interventions have a direct pathway to HIV prevention outcomes** compared to behavioral and structural interventions, and as such are prioritized interventions.

However, increasing access to and use of HIV prevention interventions for people at increased risk of HIV infection requires **additional activities to address the social and behavioral factors that increase risk and vulnerability**. These factors include stigma, discrimination and

¹ UNAIDS (2021). [Global AIDS Strategy 2021-2026 — End Inequalities. End AIDS.](#)

² Global HIV Prevention Coalition/UNAIDS (2022). [HIV Prevention 2025 – Road Map: Getting on track to end AIDS as a public health threat by 2030.](#)

criminalization, all of which increase vulnerability to HIV infection and impede access to and use of HIV prevention options. Recommended activities include behavioral and structural interventions to reduce HIV vulnerability and improve access to and use of HIV prevention options, especially for key populations in all epidemic settings, and for adolescent girls and young women and men in locations with high HIV incidence.¹

a) Expand coverage of combination HIV prevention for key populations and their sexual partners in all epidemic settings

The [Modular Framework](#) lists all interventions eligible for funding for relevant key populations: sex workers (SW) of all genders, gay men and other men who have sex with men (MSM), transgender people (TG), people who use drugs (PUD) especially people who inject drugs (PWID), and people in prisons and other closed settings (Box 2).² This framework includes interventions for cohorts of young people within key populations, and for the sexual partners of key populations. To maximize impact, applicants are encouraged to prioritize the following interventions and approaches in their funding requests if not funded by other sources:

- i. Provision of *male and female condoms and lubricants* for all key populations ([Program Essential 1](#)), along with efforts to modernize and expand condom programs such as condom demand creation and strengthened last mile supply systems. The Global HIV Prevention Coalition provides guidance on condom program planning in its *Condom Planning Package* resource.³
- ii. *Provision of PEP and PrEP* ([Program Essential 2](#)) as recommended by WHO. With respect to PrEP, the Global Fund supports all PrEP modalities recommended by WHO including long-acting formulations, such as the dapivirine vaginal ring and injectable cabotegravir, and other formulations once the formulations are recommended by WHO.⁴ WHO makes recommendations to inform PrEP implementation as part of their 2021 consolidated guidelines,⁵ and released additional technical guidance on PrEP in July 2022.⁶ The UNAIDS Global AIDS Strategy 2021-2026 also provides differentiated targets for PrEP.⁷
- iii. *Sexual and reproductive health/sexually transmitted infections (STI) interventions* provided as part of HIV prevention services, and HIV prevention interventions provided as part of sexual and reproductive health (SRH) service delivery. See [RSSH Information Note](#) Section 3.2 on designing and Section 3.3. on delivering and monitoring integrated services. Interventions include:
 - contraceptives/family planning;
 - screening, prevention, testing and treatment of syphilis (dual test), gonorrhea, chlamydia, hepatitis B and C (HBV and HCV);

¹ UNAIDS currently uses the following incidence categories: moderate (0.3-1.0%), high (1.0-3.0%) and very high (>3.0%), and this Information Note aligns to these categories. UNAIDS (2021). [Global AIDS Strategy 2021-2026 — End Inequalities. End AIDS.](#)

² The term People who Use Drugs (PUD) includes people who inject drugs (PWID) and the HIV/HCV risks associated with the sharing of injecting equipment. The term also includes people who use non-opiate and non-injected drugs whose drug use might be associated with increased sexual risk practices.

³ Global HIV Prevention Coalition/UNAIDS (2020). [Condom Planning Package, Version 1.](#)

⁴ WHO (2022). [Guidelines on long-acting injectable cabotegravir for HIV prevention.](#)

⁵ WHO (2021). [Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach.](#)

⁶ WHO (2022). [Differentiated and simplified PrEP for HIV prevention: Update to WHO implementation guidance.](#)

⁷ UNAIDS (2021). [Global AIDS Strategy 2021-2026 — End Inequalities. End AIDS.](#)

- screening, prevention and referral for human papillomavirus (HPV), cervical and anal cancer (see [Section 3.2.3b](#) and Global Fund Guidance Note¹); and
- post-violence care, including PEP and psychosocial support.

Gender-affirming care can be included for transgender people, as part of HIV prevention.

- iv. For people who inject drugs, provision of *harm reduction services*. These include needle and syringe programs, Opioid Substitution Therapy (OST),² overdose prevention and response (including provision and training on the use of naloxone), and HCV screening, prevention, diagnosis and treatment (see [Section 3.2.3b](#) and Global Fund Guidance Note³). ([Program Essential 3](#)) People using stimulant drugs (including MSM, SW, TG) can be at increased sexual risk for HIV and should be prioritized for needle and syringe programs (if stimulant drugs are injected), along with PrEP, SRH services and STI prevention and mental health support. Provision of gender-sensitive harm reduction services and linkages to sexual and reproductive health services for women and transgender people who use drugs is emphasized.
- v. Priority interventions for people in *prisons and other closed settings* include condoms and lubricants and PrEP, and for PWID in prison and detention, services such as needle and syringe programs and OST. HIV/HCV screening and prevention is also prioritized (see [Section 3.2.3b](#) and Global Fund Guidance Note⁴). Prisoners and detainees should have access to post-violence mental health support, PEP, and linkages to medical-legal support.
- vi. Provision of HIV prevention commodities and services to key populations should be underpinned by *health communication interventions* to provide information, to promote safer sexual and drug using practices and to increase demand for HIV prevention options.⁵
- vii. Provision of biomedical and behavioral interventions should be supported by *structural interventions or social enablers* such as:
 - community mobilization and advocacy;
 - interventions to address harmful gender norms;
 - violence prevention (gender- and sexuality-based);
 - interventions to eliminate stigma (including self-stigma) and discrimination;
 - legal advice, legal literacy and access to justice programs; and
 - advocacy for supportive laws and policies and for supportive law enforcement practices.⁶
- viii. Activities to assess, prevent and respond to *security-related risks* faced by key populations.⁷ These risks can undermine program reach and cause harm to key populations and those delivering services to them.

¹ The Global Fund (2022). [Prioritization Framework for Supporting Health and Longevity among People Living with HIV](#).

² OST is also referred to as Opioid Agonist Maintenance Treatment (OAMT).

³ The Global Fund (2022). [Prioritization Framework for Supporting Health and Longevity among People Living with HIV](#).

⁴ Ibid.

⁵ In the Global Fund's updated [Modular Framework](#) "Behavior Change Communication" has been re-named as "HIV Prevention communication, information and demand creation".

⁶ The Global Fund (2022). [HIV, Human Rights and Gender Equality Technical Brief](#).

⁷ Frontline AIDS (formerly International HIV Alliance) (2018). [Safety and Security Toolkit](#); and FHI360 (2021) [Implementer and Data Security](#) (suite of tools, accessed 7 July 2022).

Box 2. *Key populations* refer to sex workers of all genders, 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 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.¹

The Global Fund recommends the use of the 2022 consolidated WHO guidance for key populations² to provide further details on components of the combination HIV prevention package. In addition, the Global Fund has Technical Briefs on HIV prevention and care for people who use drugs³ and on programming at scale.⁴

b) Expand coverage of combination HIV prevention for adolescent girls and young women (AGYW) and male sexual partners in settings with high HIV incidence⁵

To prevent HIV among the greatest number of AGYW at risk of HIV infection, increased attention to HIV prevention outcomes for AGYW is emphasized through a balance of biomedical, behavioral and structural interventions. In high HIV incidence settings, interventions that address both the HIV infection risks and vulnerabilities of AGYW along with interventions that target their male sexual partners, are emphasized. HIV prevention for AGYW should be tailored to the diverse and multifaceted identities, vulnerabilities and needs of AGYW. In some cases, these identities, vulnerabilities and needs will overlap with those of key populations, for example young women involved in commercial or transactional sex.

Investments should focus on interventions that increase access to and use of HIV prevention options in settings with high HIV incidence. To maximize impact, applicants are encouraged to prioritize the following interventions and approaches in their funding requests if not funded by other sources:

- i. For both AGYW and male sexual partners in settings with high HIV incidence, *provision of male and female condoms and lubricants* along with efforts to modernize and expand condom programs such as condom demand creation and strengthened last mile supply systems. ([Program Essential 1](#)) The Global HIV Prevention Coalition provides guidance on condom program planning in its *Condom Planning Package* resource.⁶

¹ UNAIDS (2015). [UNAIDS Terminology Guidelines](#) (adapted).

² WHO (2022). [Consolidated Guidelines on HIV, Viral Hepatitis and STI Prevention, Diagnosis, Treatment and Care for Key Populations](#).

³ The Global Fund (2022). [Harm Reduction for People Who Use Drugs: Priorities for Investment and Increased Impact](#).

⁴ The Global Fund (2022). [Programming at Scale with Sex Workers, Men who have Sex with Men, Transgender People, People who Inject Drugs, and People in Prison and other Closed Settings \(2023-2025\)](#).

⁵ UNAIDS currently uses the following incidence categories: moderate (0.3-<1.0%), high (1.0-3.0%) and very high (>3.0%), and this Information Note aligns to these categories. UNAIDS (2021). [Global AIDS Strategy 2021-2026 — End Inequalities. End AIDS](#).

⁶ Global HIV Prevention Coalition/UNAIDS (2020). [Condom Planning Package, Version 1](#).

- ii. Provision of *PEP and PrEP* (oral, injectable or vaginal ring), as recommended by WHO. ([Program Essential 2](#)) With respect to PrEP, the Global Fund supports all PrEP modalities recommended by WHO including long-acting formulations such as the dapivirine vaginal ring and injectable cabotegravir and other formulations once the formulations are recommended by WHO.¹ WHO makes recommendations to inform PrEP implementation as part of their 2021 consolidated guidelines,² and released additional technical guidance on PrEP in July 2022.³ The UNAIDS Global AIDS Strategy 2021-2026 also provides differentiated targets for PrEP.⁴
- iii. *Sexual and reproductive health/sexually transmitted infections (STI) interventions* provided as part of HIV prevention services and HIV prevention interventions provided as part of SRH service delivery. See [RSSH Information Note](#) Section 3.2 on designing and Section 3.3 on delivering and monitoring integrated services. Interventions include:
 - contraceptives/family planning;
 - screening, prevention, testing and treatment of syphilis (dual test), gonorrhoea, chlamydia, hepatitis B and C (HBV and HCV);
 - screening, prevention, vaccination and referral for human papillomavirus (HPV);
 - screening, prevention and referral for cervical and anal cancer (see [Section 3.2.3b](#) and Global Fund Guidance Note⁵); and
 - post-violence care including PEP and psychosocial support.
- iv. Provision of counselling and support on *HIV prevention, sexual and reproductive health and rights and family planning*. Pregnant AGYW should be linked to ante-natal care (ANC) and post-natal care (PNC) services that are adolescent-friendly and that address HIV prevention and HIV treatment needs along with ANC and PNC care needs.
- v. Provision of *voluntary medical male circumcision (VMMC)* for adolescent boys (15+ years) and men in WHO/UNAIDS VMMC priority countries. See WHO recommendations on VMMC.⁶ ([Program Essential 4](#))
- vi. For both AGYW and their male sexual partners, provision of prevention commodities and services should be combined with *risk assessment and reduction counselling and referral* to other support services. This includes *health communication interventions* that provide information and create demand for the use of and adherence to the range of HIV prevention options outlined above.⁷
- vii. Biomedical and behavioral interventions should be *supported by structural interventions or social enablers* to increase access to services and reduce HIV vulnerability for AGYW, e.g., community mobilization and advocacy, interventions to address harmful gender norms and prevent violence (gender- and sexuality-based), interventions to address stigma and discrimination and to improve access to justice,

¹ WHO (2022). [Long acting injectable cabotegravir for HIV prevention](#).

² WHO (2021). [Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach](#).

³ WHO (2022). [Differentiated and simplified PrEP for HIV prevention: Update to WHO implementation guidance](#).

⁴ UNAIDS (2021). [Global AIDS Strategy 2021-2026 — End Inequalities. End AIDS](#).

⁵ The Global Fund (2022). [Prioritization Framework for Supporting Health and Longevity among People Living with HIV](#).

⁶ WHO (2020). [Preventing HIV through safe voluntary medical male circumcision for adolescent boys and men in generalized HIV epidemics: recommendations and key considerations](#).

⁷ 'Behavior Change Communication' has been re-named as 'HIV Prevention communication, information and demand creation' in the Global Fund's updated [Modular Framework](#).

and advocacy for supportive laws and policies and for supportive law enforcement practices.¹

- viii. In some settings with high to very high incidence,² Global Fund supports *targeted HIV prevention campaigns* and accelerated implementation of comprehensive sexuality education (CSE)³ for AGYW and adolescent boys.
- ix. In settings with very high incidence,⁴ the Global Fund supports *social protection* interventions that aim to keep girls in school, cash transfers and other interventions that address socioeconomic vulnerability.

These priorities are aligned with Global HIV Prevention Coalition guidance on HIV prevention planning and decision-making for AGYW and their male partners.⁵ This guidance is designed to support applicants to determine what combination of interventions to prioritize (what, by whom, where) based on local context and HIV incidence.

For additional information, the [Modular Framework](#) lists all interventions and approaches eligible for funding.

c) Expand Service Delivery Platforms for HIV Prevention

To reduce HIV incidence and close coverage gaps in HIV prevention, people who are most at risk of HIV infection should have increased access to HIV prevention options, provided where and when they are needed. Services should be provided from a range of service delivery platforms, including community-based and community-led service delivery platforms, and differentiated to address the needs and preferences of relevant sub-populations. Scale and sustainability are key considerations to the design and planning of HIV prevention service delivery platforms. Applicants are encouraged to prioritize expansion of the range of service delivery platforms to increase access where gaps exist. This can include:

- i. A combination of public sector (health facility), community-based and community-led, and private sector delivery systems. ([Program Essential 17](#))
- ii. Expanded platforms for community-based and peer outreach-based HIV prevention programs and services. Considerations for planning large scale “trusted access platforms” for key population programs are described in the Global HIV Prevention Coalition publication.⁶ ([Program Essential 17](#))
- iii. Integrated models for improved HIV prevention and sexual health outcomes for key populations and their sexual/injecting partners, and AGYW and their male partners.

¹ The Global Fund (2022). [HIV, Human Rights and Gender Equality Technical Brief](#).

² UNAIDS currently uses the following incidence categories: moderate (0.3-<1.0%), high (1.0-3.0%) and very high (>3.0%), and this Information Note aligns to these categories. UNAIDS (2021). [Global AIDS Strategy 2021-2026 — End Inequalities. End AIDS](#). However, note that in the [Decision-making Aide for Investments into HIV Prevention Programmes among Adolescent Girls and Young Women](#) [UNAIDS (2020)], the older categories are used: high (now moderate), very high (now high) and extremely high (now very high). UNAIDS is expected to update the Decision-making Aide in 2022 to align with the new categories.

³ UNESCO (2018). [International technical guidance on sexuality education: An evidence-informed approach](#).

⁴ UNAIDS currently uses the following incidence categories: moderate (0.3-<1.0%), high (1.0-3.0%) and very high (>3.0%), and this Information Note aligns to these categories. UNAIDS (2021). [Global AIDS Strategy 2021-2026 — End Inequalities. End AIDS](#). However, note that in the [Decision-making Aide for Investments into HIV Prevention Programmes among Adolescent Girls and Young Women](#) [UNAIDS (2020)], the older categories are used: high (now moderate), very high (now high) and extremely high (now very high). UNAIDS is expected to update the Decision-making Aide in 2022 to align with the new categories.

⁵ Global HIV Prevention Coalition/UNAIDS (2020). [Decision-making Aide for Investments into HIV Prevention Programmes among Adolescent Girls and Young Women](#). UNAIDS is expected to update the Decision-making Aide in 2022.

⁶ Global HIV Prevention Coalition/UNAIDS (2020). [Key population trusted access platforms: Considerations in planning and budgeting for a key population platform to deliver scaled, quality HIV prevention and treatment services and for addressing critical enablers](#).

For example, increased availability of HIV prevention and testing in SRH/STI/family planning service delivery platforms.

- iv. Virtual platforms (mobile phone and internet-based) to extend outreach beyond physical spaces, expand service delivery and mitigate stigma.¹ ([Program Essential 17](#))
- v. Pharmacies (community/private) and other easy access points (e.g., kiosks, shops), schools. ([Program Essential 17](#))
- vi. Multi-month scripting, dispensing and distribution of key HIV prevention commodities. ([Program Essential 18](#))

For additional information, the [Modular Framework](#) lists all interventions and approaches eligible for funding. Applicants are also encouraged to review the [RSSH Information Note](#) Section 4.3 (Community Systems and Responses) and Section 4.5 (Human Resources for Health and Quality of Care) for additional information on the necessary health systems investments to expand the range of service delivery platforms.

d) Expand and integrate human rights interventions into HIV prevention

The Global Fund emphasizes the integration of human rights interventions into HIV prevention programs to address human rights- and gender-related barriers to HIV prevention, especially for marginalized and criminalized populations. ([Program Essential 19](#))

Examples of integration include:

- i. training of peer and community-based HIV prevention service providers to work as peer paralegals to provide information on HIV and human rights;
- ii. community-based and community-led monitoring of HIV prevention services;
- iii. legal counselling, advice and support provided in HIV prevention services, and advocacy for access to HIV prevention and for supportive laws and policies.

For additional examples of integrated HIV prevention and human rights interventions, see the Global Fund Technical Brief.²

e) Strengthen HIV prevention systems and program stewardship

The Global Fund supports investment in national planning, coordination and management systems to strengthen HIV prevention responses and outcomes. The Global Fund refers to the key considerations set out in the Global HIV Prevention Coalition's HIV prevention road map "HIV Prevention 2025"³ to direct attention and investment towards people with the greatest HIV prevention needs and in locations with the highest HIV incidence.

HIV prevention program stewardship investments include:

¹ UNAIDS (2022). [Virtual HIV Interventions: A Budgeting and Programming Aid](#).

² The Global Fund (2022). [HIV, Human Rights and Gender Equality Technical Brief](#).

³ Global HIV Prevention Coalition/UNAIDS (2022). [HIV Prevention 2025 – Road Map: Getting on track to end AIDS as a public health threat by 2030](#).

- i. activities to support program planning, design and delivery such as target-setting, costing and operational planning;
- ii. technical working groups and national and sub-national coordination and review mechanisms;
- iii. last mile supply and distribution systems for prevention commodities;
- iv. HIV prevention product introduction and scale-up and strengthening of total market approaches;¹
- v. capacity development, including human resources to support prevention program management and delivery (including in community-based and community-led service delivery);
- vi. integration of HIV prevention and SRH communication, health promotion and service delivery; and
- vii. monitoring of prevention outcomes, performance reviews and use of data for micro-planning and problem solving.

Ensuring coverage for priority populations and settings relies on the availability of data on HIV transmission dynamics, sexual and drug-using practices and factors that increase individual risks and vulnerabilities, including factors related to setting, race or ethnicity, occupation, sex or gender identity, religion, education, socioeconomic status, and social capital. The Global Fund supports investment in social science research to identify social factors influencing HIV vulnerability and risk, and implementation science research to evaluate the effectiveness of interventions to address sexual and drug-use-related risk practices.

The planning, implementation and management of HIV prevention programs requires regular analysis of quantitative and qualitative data to adapt and meet the changing HIV prevention needs of key and vulnerable populations. Unique identification codes, which protect privacy and confidentiality, should be developed to enable unduplicated reporting of program results.

Community-led monitoring provides valuable data on the quality, accessibility, acceptability and affordability of HIV prevention/sexual health commodities, services, and programs.²

For additional information, the [Modular Framework](#) lists all interventions and approaches eligible for funding.

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

Differentiated models of HIV testing services, including innovative approaches, need to be scaled up in many settings to achieve global targets. Applicants should demonstrate that their testing strategies are adapted to the epidemiological context and follow the “5 Cs”: consent, confidentiality, counselling, correct result, and connection/immediate

¹ Global HIV Prevention Coalition/UNAIDS (2020). [Condom Planning Package, Version 1](#).

² The Global Fund (2022). [Community Systems Strengthening Technical Brief](#).

linkage. Efforts should focus on finding and supporting people living with HIV, and HIV-negative persons at high risk of acquiring HIV who do not know their status.

To maximize impact, applicants are encouraged to prioritize the following interventions and approaches in their funding requests, if not funded by other sources:

- i. An HIV testing *strategy based on routine and frequent review of HIV testing data* (HIV testing coverage, volume and positivity) to identify gaps in coverage by geography, specific age groups, sex/gender and service delivery sites. Such information should be collected, analyzed and used to inform decision-making about differentiated testing approaches, linkage strategies, testing frequency and geographical prioritization of HIV testing services.
- ii. A strategic mix of *differentiated HIV testing services* that includes facility-based testing, community-based testing, HIV self-testing, as well as social network-based and safe ethical index (partner) testing. ([Program Essential 5](#); [Program Essential 17](#)) Strategies should address the needs of priority populations that face barriers in accessing facility-based services, such as AGYW and male sexual partners in high HIV incidence settings, and key populations for whom social network and self-testing may be particularly useful. In high-HIV-burden settings,¹ prioritization of facility-based provider-initiated testing and counselling (PITC) is recommended for all those accessing ANC and PNC, STI, sexual health and presumptive or active TB services. While the Global Fund remains committed to the 2021-2026 Global AIDS Strategy target of 95% of pregnant women tested for HIV, it prioritizes investments in HIV testing at ANC in settings with a high burden of HIV, and among pregnant women at increased risk of HIV in settings with a low burden. Countries should invest available domestic or other resources to support achievement of national targets for HIV testing at ANC in geographic areas and populations not covered by Global Fund resources. Integration opportunities for testing for other coinfections, especially hepatitis and STI, should be explored.
- iii. A *three-test strategy*, which reduces the risk of false positive results by requiring three consecutive reactive test results to receive an HIV-positive diagnosis. A three-test strategy is recommended for all countries where HIV positivity within the national HIV testing program has fallen below 5%.² ([Program Essential 6](#)) Most countries are at or will soon be at this 5% cut-off.³ Countries should plan a verification study when reviewing algorithms.⁴ See WHO HIV testing guidelines for further recommendations.⁵
- iv. The inclusion of *HIV self-testing* as part of the strategic mix of HIV testing services. ([Program Essential 5](#)) Self-testing expands HIV testing services among people at risk of HIV who may not otherwise test, (i.e., those afraid of stigmatizing practices at

¹ WHO (2021). [Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach.](#)

² Ibid.

³ Giguere K. et al (2021) [Trends in knowledge of HIV status and efficiency of HIV testing services in sub-Saharan Africa, 2000-20: a modelling study using survey and HIV testing programme data.](#) Lancet HIV 2021; 8: e284–93

⁴ WHO (2021). [Toolkit to optimize HIV testing algorithms.](#)

⁵ WHO (2021). [Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach.](#)

mainstream services, those at ongoing risk who need to test frequently, those undergoing index testing). Self-testing can also be used to optimize HIV testing in facility, such as a screening tool. Delivery approaches include community- and facility-based, online order, secondary distribution¹ and sales through retail outlets, pharmacies, and vending machines. Further, the Global Fund supports the use of self-testing in alignment with WHO recommendations and guidance for starting, continuing, and restarting PrEP.² See [Section 4.3](#) for a country example in HIV self-testing.

- v. *The use of dual HIV/syphilis rapid diagnostic tests* as first test in HIV testing algorithms for pregnant women (to contribute to the elimination of mother-to-child transmission of HIV and syphilis) and services targeting key populations. The recent price reductions of this test should encourage countries to introduce dual HIV/syphilis testing and review their testing algorithm simultaneously.
- vi. HIV testing programs should aim for *high testing coverage* for people at increased risk of HIV infection, such as key populations in all settings, and AGYW and their male sexual partners in high HIV incidence settings. Monitoring HIV positivity among those tested is important to ensure the following:
 - testing is focused on those who are most affected and are less likely to access testing;
 - assessing the effectiveness of prevention programs; and
 - determining the ideal frequency of HIV testing adapted to local HIV incidence in targeted populations.

Employing peers to conduct HIV testing, distribute HIV self-tests and act as navigators for referral can increase coverage in programs for key populations, AGYW and their male sexual partners.

- vii. *The review/modification of policies on parental consent* for HIV testing (and self-testing) for adolescents. Countries should examine their age-of-consent policies to remove age-related barriers to HIV services and to empower providers to act in the best interest of the adolescent, whilst recognizing the evolving capacities of adolescents to assent. ([Program Essential 22](#))
- viii. *Early infant diagnosis* (EID) for children exposed to HIV and linkage to care. Increasing access is crucial to reduce mortality among children living with HIV. ([Program Essential 9](#)) Countries should map and optimize laboratory networks to ensure appropriate placement of both conventional and point of care (POC) technologies. Access to POC should be prioritized for early infant diagnosis.^{3,4} In

¹ An example of secondary distribution is a test distributed to someone who then redistributes it to someone else such as a peer or sexual partner.

² WHO (2022). [Differentiated and simplified PrEP for HIV prevention: Update to WHO implementation guidance](#).

³ WHO (2021). [Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach](#).

⁴ WHO (2018). [HIV diagnosis and ARV use in HIV-exposed infants: a programmatic update](#). Also WHO (2021). [Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach](#).

addition to the WHO recommendations, see information on laboratory systems and service integration in the [RSSH Information Note](#) Section 4.7.

- ix. Safe, ethical and voluntary *index testing* should be offered to all people living with HIV, prioritizing newly diagnosed people living with HIV and those who are not virally suppressed. ([Program Essential 5](#)) Social network-based HIV testing approaches can be considered as an approach for reaching the sexual or drug-injecting partners and social contacts of members of key populations.
- x. *The integration of point of care CD4 testing* in HIV testing services. To reduce mortality and accelerate advanced HIV diagnosis, applicants are encouraged to prioritize integrating POC CD4 in HIV testing services, particularly in settings with high prevalence of advanced HIV disease ($CD4 \leq 200 \text{mm}^3$) among newly diagnosed people living with HIV. See [Section 3.2.3](#) and the WHO recommendations on management of advanced HIV¹ for more information.
- xi. *Linkage to services*. Interventions should link people across all ages, sex/gender and risk categories to the services they need according to their test results. That is, linkages both to HIV treatment and care for those found to be HIV positive, and to comprehensive HIV prevention for those found to be negative and at increased risk of HIV. See the [RSSH Information Note](#) Section 6.2/Annex 2 on investing in the health system to strengthen referral systems. See also [Section 4.4](#) in this note for a country example of addressing linkage loss.
- xii. *Task shifting*. Lay workers and peers can safely perform HIV testing and are therefore important in increasing access to HIV testing, particularly among key and vulnerable populations.
- xiii. *The use of virtual interventions*, including the use of both telephone and internet-based platforms to reach and engage clients in HIV testing. Virtual interventions also can be used to simplify scheduling of appointments and/or ordering of commodities, facilitate community monitoring, and scale up the diffusion of essential information. Many existing virtual approaches have been leveraged to mitigate the impact of COVID-19 to provide access to HIV services, including testing, and can include self-assessment of risk before testing.² See also the [RSSH Information Note](#) Section 4.9 on digital health.

For additional information, the [Modular Framework](#) lists all interventions and approaches eligible for funding.

3.2.3 HIV Treatment: ART, treatment continuity and maintaining health

There is an urgent need for treatment acceleration and optimization. While great progress has been made – reaching 28 million of the 38 million people living with HIV with lifesaving ART³ – gaps remain along the treatment cascade. Challenges to treatment programs

¹ WHO (2021). [Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach](#).

² The Global Fund (2021). [Information Note: Mitigation of COVID-19 Effects on HIV, TB and Malaria Services and Programs](#).

³ UNAIDS (2022). [Fact Sheet – Latest global and regional statistics on the status of the AIDS epidemic](#).

include gaps between testing and rapid ART initiation, late presentation to care, and the cyclical cascade of treatment interruption and return to care.¹

These gaps are particularly acute among children, adolescents, key populations and men more broadly. The reasons underlying the gaps include human rights- and gender-related barriers but vary for each population and warrant specific analyses. Additional attention should be paid to identifying and removing structural barriers, including out-of-pocket expenditures; stigma and discrimination in communities, in the workplace and health care settings; arrest or police harassment of key populations; and other factors contributing to inequitable services and outcomes.

a) Accelerate and optimize ART

To maximize impact, applicants are encouraged to prioritize the following interventions and approaches in their funding requests, if not funded by other sources:

- i. *Rapid ART initiation* (within 7 days of diagnosis) for all populations, including children, following a confirmed HIV diagnosis and clinical assessment and on the same day for people who are ready to start. ([Program Essential 10](#))
- ii. A *CD4 test* in line with WHO recommendations,⁴⁰ including at initial clinical assessment, to identify those with advanced HIV disease (including those re-entering care) and as clinically indicated. See also [Section 3.2.2x](#). ([Program Essential 14](#))
- iii. *Optimal ARV regimens*. Current regimen recommendations for children older than 4 weeks and weighing >3kg,² adolescents and adults are dolutegravir-based (abacavir-lamivudine-dolutegravir in children, tenofovir-lamivudine-dolutegravir [TLD] in adolescents and adults).³ ([Program Essential 11](#)) In their funding requests, applicants should outline how optimal ARV regimens will be scaled up both in adults and children, while also ensuring that all people living with HIV have equal access to improved treatment options, including pregnant women whose recommended regimen is dolutegravir-based and critical in the prevention of mother-to-child transmission of HIV. In addition, the Global Fund supports second-line optimization efforts in line with WHO recommendations, such as proactive drug substitutions from costly protease inhibitors (PIs) to superior and more affordable DTG-based regimens as well as continued PI optimization efforts as newer generic adult and pediatric products become available on the market for use after DTG-based regimen failure in first line. Simplified regimen selection is encouraged in line with WHO guidelines. Transition to the latest WHO guidelines requires detailed forecasting of stock over time at the country level to coordinate drug supply at the global level, particularly for paediatric regimens.

¹ Ehrenkranz P, Rosen S, Boule A, Eaton JW, Ford N, Fox MP, et al. (2021) [The revolving door of HIV care: Revising the service delivery cascade to achieve the UNAIDS 95-95-95 goals](#). PLoS Med 18(5): e1003651.

² WHO (2021). [The 2021 optimal formulary and limited-use list for antiretroviral drugs for children](#).

³ WHO (2021). [Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach](#).

- iv. *Increased access to routine viral load testing for treatment monitoring in facility and community service delivery settings.* Improve viral load access, including at point of care, at facility and community settings as part of overarching laboratory system optimization and integration plans. ([Program Essential 14](#)) Countries with a high burden of TB/HIV coinfection¹ are encouraged to prioritize the optimal use of multi-disease platforms (such as GeneXpert) and multi-use machines to undertake HIV viral load testing. Systems should be in place to return test results in a timely manner and for results to be utilized for clinical management. Monitor the flow of results and turnaround time (i.e., average/median time taken from the time of sample collection to the return of the result to the client) to progressively shorten it through quality-improvement efforts.² Investments should be aligned with national laboratory strategic plans. If applicants do not have a national laboratory strategic plan, Global Fund resources can be used to support its development. See information on laboratory systems strengthening in the [RSSH Information Note](#) Section 4.7. See also a country example in increasing viral load access in [Section 4.6](#) in this note.
- v. *Support continuity of treatment and return to care.* Ensure that support systems identify those lost to follow-up and support prompt relinkage and return to care, including for those imprisoned or released from prisons and other closed settings. ([Program Essential 13](#)) Ensure resources are available for interventions to improve treatment literacy so that individuals understand the importance of knowing one’s viral load and that virologic suppression is for one’s own health and to prevent onward HIV transmission in line with the “undetectable=untransmittable” (U=U) concept.³ Information systems, preferably electronic, to monitor and track people from the initiation of ART – with appropriate confidentiality protections – should be supported and used by health providers to immediately identify clients who miss appointments and recruit them back to care. See [Section 3.2.6](#) on strategic information. Tailored support services are needed for children, adolescents, key populations and men more broadly to ensure services are friendly, welcoming, and adapted to the needs of the specific population. For example, adherence counselling, peer navigators and support groups for key populations and adolescents may support retention in care, as well as virtual interventions, such as SMS reminders (see also the [Deliver Differentiated Services for HIV treatment and care](#) section below). Community and peer engagement can also promote demand for services, provide treatment literacy and patients’ rights education, mitigate the impact of stigma (including self-stigma), and address human rights- and gender-related barriers to ART and other clinical care critical for health and well-being of all people living with HIV. Community-led monitoring approaches are also encouraged. See the [RSSH Information Note](#) Section 4.3 on community-led monitoring.
- vi. *Quality assurance and improvement.* Ensure routine monitoring of quality-of-care measures, and the development of targeted interventions to improve program

¹ WHO (2021). [WHO global lists of high burden countries for tuberculosis \(TB\), TB/HIV and multidrug/rifampicin-resistant TB \(MDR/RR-TB\), 2021–2025.](#)

² WHO (2021). [Module for assessing and strengthening the quality of viral load testing data within HIV programmes.](#)

³ UNAIDS (2018). [Undetectable=Untransmittable: Public Health and HIV Viral Load Suppression.](#)

quality in line with a quality management and quality assurance plan.¹ See the [RSSH Information Note](#) Sections 4.5 and 6.1/Annex 1 on improving quality of care.

- vii. Support for *ARV toxicity monitoring systems* within routine information systems.² A combination of approaches to monitor antiretroviral drug toxicity and promote patient safety, which includes active and routine toxicity monitoring in all populations, including adults, adolescents and children, and surveillance of safety in pregnancy.³
- viii. Interventions to ensure *people-centered and rights-based HIV services* at health facilities. These interventions should be scaled up to reduce discrimination in provision of HIV treatment. Such interventions include:
 - pre- and in-service training of health care providers on patient rights, non-discrimination, duty to treat, informed consent and confidentiality, violence prevention and treatment;
 - support to community-led monitoring of the provision of treatment and drug supply chains;
 - the integration of paralegals into health facilities; and
 - the development and distribution of patients' rights materials and of institutional policies and accountability mechanisms for health care facilities.

See the Global Fund Technical Brief on HIV, human rights and gender equality.⁴ ([Program Essential 19](#))

For additional information, the [Modular Framework](#) lists all interventions and approaches eligible for funding.

b) Support health and longevity among people living with HIV

To reduce mortality and maintain health among people living with HIV, applicants should propose investments in integrated services delivered within HIV service delivery platforms. Proposals must be based on clear evidence of epidemiological and programmatic need in the local context. Interventions should be integrated within existing service delivery platforms to help achieve efficiency as well as to support the delivery of person-centered care. Applicants are encouraged to prioritize the following interventions and approaches in their funding requests, if not funded by other sources:

- i. Provision of a package of care that reduces mortality in individuals with advanced HIV disease in adults and children as per WHO recommendations.⁵ ([Program Essential 12](#))

¹ WHO (2019). [Maintaining and improving quality of care within HIV clinical services](#).

² WHO (2021). [Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach](#).

³ WHO (2020). [Surveillance of antiretroviral toxicity](#).

⁴ The Global Fund (2022). [HIV, Human Rights and Gender Equality Technical Brief](#).

⁵ WHO (2021). [Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach](#).

- ii. Integrated diagnosis and treatment interventions that reduce mortality and morbidity in the growing population of people on ART by addressing diagnosis and treatment of a subset of non-communicable disease (NCD) comorbidities, specifically risk factors of cardiovascular disease, hypertension, diabetes, obesity, and mental health conditions. Applicants should evaluate programmatic data to identify the needs of people on ART to ensure appropriate integration in treatment programs, as well as referral and linkage where appropriate.
- iii. Integrated diagnosis and treatment interventions to maintain health in people living with HIV by addressing diagnosis and treatment of a subset of coinfections and comorbidities including STI, cervical cancer and viral hepatitis (HBV and HCV). Countries should support the scale up of vaccination for Human Papilloma Virus (HPV) and HBV as recommended by the WHO within their respective national vaccination strategies, particularly in Sexual and Reproductive Health services, for pregnant and breastfeeding women and their babies and in programs addressing drug users. In low-and middle-income countries with insufficient resources other global mechanisms exist to support scale up of routine vaccination programs. Applicants should evaluate programmatic data to identify the needs of priority subpopulations, specifically pregnant and breastfeeding women, adolescent girls and young men, and key populations including people who use or inject drugs.

Guidance on prioritization and integration of these investments within existing HIV service delivery platforms is included in the Global Fund Guidance Note¹ and a country example is included in [Section 4.8](#) of this information note. The note provides additional guidance on integrating these services into other platforms based on a detailed and strong investment case in support of improving the health and longevity of people living with HIV, key and vulnerable populations.

For additional information, the [Modular Framework](#) lists all interventions and approaches eligible for funding.

c) Deliver differentiated services for HIV treatment and care

Differentiated service delivery models of HIV care are recommended by WHO to increase ART retention and improve clinical outcomes. Expanding alliances between the people in care and the health and community systems can facilitate services to address people's needs over the course of their lives. Self-care should be increasingly incorporated into service models. These models should leverage existing partnerships, community and stakeholder engagement to ensure sustainability.

To maximize impact, applicants are encouraged to prioritize the following interventions and approaches in their funding requests, if not funded by other sources:

- i. *Scaled up differentiated service delivery treatment models² both in facilities and communities*, tailored to specific needs of all people living with HIV, including children

¹ The Global Fund (2022). [Prioritization Framework for Supporting Health and Longevity among People Living with HIV](#).

² All interventions listed here are described in WHO (2021). [Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach](#).

and adolescents, pregnant and breastfeeding women, men and key populations. ([Program Essential 17](#)) Approaches to increasing access to HIV testing and treatment for key populations include provision of community-based and community-led services for key populations with involvement of peers, and engagement of peer navigators to link those who test HIV positive to treatment.

- ii. *Treatment offered as close to point of HIV testing as possible*, both in facilities and communities, to enable linkage to rapid ART initiation. Community ART initiation and task-shifting per WHO guidance¹ is encouraged, in particular for adolescents and key populations.
- iii. *Models focusing on patients who are doing well on treatment* (patients established on ART). Facility-based models include extended ART clinic hours, fast-track clinics, appointment spacing and facility-based group support models, such as ART clubs. Community-led models include community ART distribution points, decentralized drug distribution, drop-in-centers, out-of-facility pick-up points and community and peer-led ART groups. ([Program Essential 17](#))
- iv. For patients established on ART, adoption and scale-up of *multi-month dispensing* (MMD) of ARVs (three to six months). ([Program Essential 18](#)) This intervention has implications for procurement and supply management systems, and Global Fund investments can be used to strengthen these systems to enable MMD. See [RSSH Information Note](#) Section 4.6 on health product management.
- v. *Community and peer engagement*. Such engagement can promote demand for services, provide education on treatment literacy and patients' rights, mitigate the impact of stigma (including self-stigma), and address human rights and gender-related barriers to ART and other clinical care. See also Global Fund resources on engaging and strengthening community systems.²
- vi. *The use of virtual interventions*, including the use of both telephone and internet-based platforms to reach and engage clients in HIV treatment. They can also be used to simplify making of appointments and/or ordering of commodities, facilitate community monitoring and scale up adherence support and the diffusion of essential information. See also the [RSSH Information Note](#) Section 4.9 on digital health.
- vii. More intensive treatment and support service delivery models for *people with advanced disease or unsuppressed viral load*. Groups who typically need close follow-up include children, adolescents, pregnant women, key populations, and those with psychosocial barriers to adherence and retention.
- viii. *Enablers for coordination and oversight of DSD* at the national level. Enablers include a DSD national coordinator and performance dashboards for work planning, prioritization, and monitoring implementation.

¹ WHO (2021). [Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach](#).

² The Global Fund (2022). [Community Systems Strengthening Technical Brief](#).

See WHO,¹ ICAP Global Health² and International AIDS society³ for further guidance on DSD for treatment. See also [Section 4.3](#) and [Section 4.5](#) in this note for country examples of differentiated service adaptations that were implemented and scaled to ensure service continuity in the COVID-19 pandemic context.

For additional information, the [Modular Framework](#) lists all interventions and approaches eligible for funding.

3.2.4 Eliminating vertical transmission of HIV, syphilis, and hepatitis B

The Global Fund supports the recommendation of the “triple elimination initiative” to use an integrated approach to eliminate vertical transmission of HIV, syphilis, and hepatitis B.⁴ National governments should ensure that ante-natal and post-natal care is comprehensive for pregnant and breastfeeding women and their infants. To maximize impact, applicants are encouraged to prioritize the following interventions and approaches in their funding requests, if not funded by other sources:

- i. *Integrated HIV testing and rapid ART initiation* among pregnant and breastfeeding women, including adolescents and key populations at facility and community service delivery points. ([Program Essential 8](#)) This includes HIV testing at the first ANC visit (particularly in settings with a high burden of HIV), retesting according to national protocols and prompt linkage to ART with optimal ARV regimens as per WHO recommendations.⁵ See also [Section 3.2.2v](#) on the need to transition to dual HIV and syphilis testing.
- ii. *Treatment continuity and retention of the mother-infant pair throughout the breastfeeding period.* ([Program Essential 8](#)) Interventions should include facility-linked adherence support services through community health workers and community-led support services, such as peer-to-peer support and treatment literacy efforts. Adolescent girls and young women, including key populations, may need focused support and services that are sensitive to their needs. Information systems that monitor care provided to the mother-infant cohort should be integrated with existing systems, where possible. Routine use of monitoring data to identify and re-engage those who have left care is critical for the health of the mother and child.
- iii. *Prevention of new HIV infections among pregnant and breastfeeding women.* Interventions should include the provision of male and female condoms and lubricants, PrEP, PEP, gender-based violence prevention and post-violence care, STI services, HIV self-testing and engagement of partners (including the offer of partner testing), with focus on settings with a high burden of HIV. Primary HIV prevention services should be available for women of reproductive age in high burden settings. See also [Section 3.2.1](#) on HIV prevention.

¹ WHO (2021) [Updated recommendations on service delivery for the treatment and care of people living with HIV](#).

² ICAP Global Health website, [Differentiated service delivery \(DSD\) approach](#). (accessed 5 July 2022)

³ International AIDS Society website, [Differentiated Service Delivery](#). (accessed 5 July 2022)

⁴ WHO website, [Triple Elimination Initiative of mother-to-child transmission of HIV, syphilis and hepatitis B](#). (accessed 5 July 2022)

⁵ WHO (2021). [Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach](#).

- iv. *Infant prophylaxis.* Interventions should include provision of ARVs to infants exposed to HIV to prevent vertical transmission of HIV, according to national protocols and in line with latest WHO guidance on optimal ARV regimens.¹ For infants with high-risk exposure,² provide enhanced prophylaxis regimens in line with latest evidence-informed global guidance.
- v. *Early infant diagnosis and follow-up HIV testing for infants through the breastfeeding period and linkage to paediatric HIV treatment.* ([Program Essential 9](#)) Interventions should include access to testing including through use of POC devices including multi-disease platforms and systems to ensure timely return of results and rapid linkage to ART initiation. See the [RSSH Information Note](#) Section 4.7 on laboratory systems strengthening, and [Section 3.2.2viii](#) in this note. Follow-up HIV testing of the exposed infant should follow the national algorithms on final testing after breastfeeding cessation.³
- vi. *Integrated service delivery with SRH and maternal, neonatal and child health.* Interventions include:
 - HIV, syphilis and hepatitis B testing at first ANC visit per national protocols; and
 - linkage to appropriate and prompt treatment, within sexual and reproductive health service delivery platforms, reflecting a comprehensive approach to a pregnant woman's most important health needs.

See the [RSSH Information Note](#) Section 3.2 on designing and Section 3.3. on delivering and monitoring integrated services. See also [Section 3.2.3b](#) in this note, and Global Fund Guidance Note⁴ related to hepatitis B testing and treatment.

For additional information on strengthening the ANC/PNC platform to improve service quality and demand for services, see [RSSH Information Note](#) Section 3.2. For additional information, the [Modular Framework](#) lists all interventions and approaches eligible for funding.

3.2.5 TB/HIV: addressing coinfection with TB and HIV

To foster collaboration and ensure alignment, countries with a high burden of TB/HIV coinfection are required to submit joint TB/HIV funding requests that present integrated quality programming for the two diseases.⁵

To maximize impact, applicants are encouraged to prioritize the following interventions and approaches in their funding requests, if not funded by other sources:

- i. HIV testing for all people with TB.

¹ WHO (2021). [The 2021 optimal formulary and limited-use list for antiretroviral drugs for children.](#)

² According to WHO guidance a high-risk infant is one whose mother was first identified as HIV-infected at delivery, started ART late in pregnancy, or had a VL>1000 within four weeks of delivery. WHO (2021). [Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach.](#)

³ WHO (2021). [Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach.](#)

⁴ The Global Fund (2022). [Prioritization Framework for Supporting Health and Longevity among People Living with HIV.](#)

⁵ The Global Fund website, [Funding Model.](#) (accessed 5 July 2022)

- ii. ART initiated as soon as possible within two weeks of initiating TB treatment, regardless of CD4 cell count for people diagnosed with HIV. ([Program Essential 15](#))
- iii. Cotrimoxazole preventive treatment and TB treatment for people living with HIV with active TB.
- iv. Systematic screening for TB disease among people living with HIV at each contact with facility and community health services and integrated in DSD models. Screening algorithms should be adapted to meet new WHO recommendations.¹
- v. For TB diagnosis, WHO-recommended rapid molecular assays should be used as the first diagnostic test.² In countries with a high burden of TB/HIV coinfection,³ LF-LAM tests can assist in diagnosing TB in selected groups of HIV-infected patients with presumed TB. This is crucial for urgent cases where a rapid TB diagnosis is necessary for the patient's survival.
- vi. Tuberculosis preventive treatment (TPT) for all eligible people living with HIV. ([Program Essential 16](#)) Countries are encouraged to adopt shorter TPT regimens⁴ and move to fixed-dose combinations as they become available.⁵ TPT should be integrated in DSD models.
- vii. Where services are provided in prisons, systematic screening for TB disease.

Integration of TB/HIV services and joint programming, implementation, supervision, and monitoring should be considered.

For additional information, the [Modular Framework](#) lists all interventions and approaches eligible for funding.

3.2.6 Strategic information: invest in data for impact

HIV responses are still hindered by gaps in the availability of key data, which include:

- incident infections;
- STI surveillance;
- size estimates of key populations and subgroups of AGYW and male sexual partners at increased risk of HIV infection;
- disaggregated gender and age data;
- secure data systems to support person-centered monitoring and HIV case surveillance;

¹ WHO (2021). [WHO operational handbook on tuberculosis. Module 2: Screening.](#)

² WHO (2021). [WHO consolidated guidelines on tuberculosis. Module 3: Diagnosis - Rapid diagnostics for tuberculosis detection 2021 update.](#)

³ WHO (2021). [WHO global lists of high burden countries for tuberculosis \(TB\), TB/HIV and multidrug/rifampicin-resistant TB \(MDR/RR-TB\), 2021–2025.](#)

⁴ Shorter TPT regimens include: weekly isoniazid and rifapentine for three months (3HP); daily isoniazid and rifapentine for one month (1HP); and daily regimen of isoniazid and rifampicin for three months (3RH).

⁵ WHO (2020). [WHO consolidated guidelines on tuberculosis. Module 1: Prevention - Tuberculosis preventive treatment.](#)

- HIV prevention program outcome monitoring; and
- qualitative data on social factors influencing HIV vulnerability and access to services.^{1,2}

Using recommended population-level HIV epidemic modelling software (e.g., Spectrum³ and Naomi⁴ models), countries are encouraged to routinely create and use nationally endorsed estimates of people living with HIV and HIV-negative population groups at increased risk of HIV infection. These data should be disaggregated by age, sex, administrative unit and risk profile, to inform investment priorities and ensure inequalities are addressed so that no one is left behind.

Applicants are encouraged to enhance information flows through improved program monitoring and reporting systems, including electronic medical records, District Health Information System 2 (DHIS2) and/or other locally implemented tools. In addition, applicants are encouraged to support initiatives to improve interoperability of data systems to increase data sharing and use and to strengthen routine data systems to allow longitudinal monitoring of individuals over time to facilitate service delivery and measurement of outcomes, in line with WHO guidelines.⁵ Regular data use and visualization for course-correction (e.g., at least quarterly, but often monthly or even weekly) has been a core component of successful ART programs and is encouraged.⁶

Monitoring, reporting and evaluating performance related to Global Fund investments should be integrated into national systems rather than operating in parallel. See the Global Fund's [RSSH Information Note](#) Section 4.4 on M&E systems and Section 6.4/Annex 4 on essential M&E investments. As community and national health data systems are integrated, the data privacy needs of priority populations are emphasized. ARV toxicity monitoring and adverse event reporting may be included within routine monitoring and reporting systems in line with national monitoring systems. This includes surveillance of safety in pregnancy, as well as active and routine ARV toxicity monitoring in all populations of all ages (see also [Section 3.2.3a.vii](#)).

To maximize impact, applicants are encouraged to prioritize the following strategic information investments in their funding requests, if not funded by other sources:

- i. *Routine cascade data reviews*: Cascade analyses identify gaps across the HIV prevention-testing-treatment-viral load spectrum of services. They help to identify where programs fail to reach and retain people who need HIV prevention and treatment. They are also used to determine the magnitude of needs and gaps along the continuum, to identify and analyze these gaps. They should be undertaken regularly and at least annually and focus on geographic and socio-demographic

¹ WHO (2022). [Consolidated Guidelines on Person-Centred HIV Strategic Information: Strengthening Routine Data for Impact](#).

² Hakim AJ, et al. [Gaps and opportunities: measuring the key population cascade through surveys and services to guide the HIV response](#). J Int AIDS Soc 2018 Jul;21 Suppl 5(Suppl 5):e25119.

³ Avenir Health (2019): [Spectrum](#).

⁴ Eaton JW et al (2021). [Naomi: a new modelling tool for estimating HIV epidemic indicators at the district level in sub-Saharan Africa](#). J Int AIDS Soc 2021,24(S5):e25788.

⁵ WHO (2022). [Consolidated Guidelines on Person-Centred HIV Strategic Information: Strengthening Routine Data for Impact](#).

⁶ Jahun I, Said I, El-Imam I, Ehoche A, Dalhatu I, Yakubu A, et al. (2021) [Optimizing community linkage to care and antiretroviral therapy initiation: lessons from the Nigeria HIV/AIDS indicator and impact survey \(NAIS\) and their adaptation in Nigeria ART Surge](#). PLoS ONE 16(9): e0257476.

disaggregated analyses of routinely available individual-level data (e.g., case surveillance data) and aggregate program data (e.g., HIV prevention, testing, linkage to HIV prevention or care interventions, initiation of ART, viral load testing and viral load suppression). Cascade data reviews should be implemented at all relevant levels of the health system, from central to facility level, and include services based in the community, and those in prisons and other closed settings. The reviews should consider both quantitative and qualitative data, in collaboration with in-country partners and in line with WHO guidance.¹ A country example in [Section 4.5](#) highlights the benefits of frequent joint data reviews.

- ii. *HIV case surveillance*: HIV case surveillance and patient monitoring enable effective clinical management of patients and generate data for program monitoring, consistent with the WHO recommendations.² Case surveillance systems should respond to an assessment of available digital tools and solutions and be based on expert consultation.³ Applicants should address policy and legal standards during the design and implementation of unique health identifiers, as outlined in the WHO guidance.⁴ This data should be the most robust source of essential disaggregated data used to improve programs and track outcomes. The individual-level data should be used alongside and, increasingly, in place of, aggregate data for the routine cascade data review activities described above. HIV case surveillance systems should be interoperable with other relevant data systems, which may include: laboratory for CD4 count and viral load; HIV testing for HIV test date; HIV treatment events over time (e.g., missed appointments); and civil registration and vital statistics for true mortality estimates.
- iii. *Detailed HIV expenditure analysis*: Data for analyses are obtained through National AIDS Spending Assessments (NASA) for the description and measurement of HIV financing flows and expenditures. NASA provides comprehensive HIV program expenditure analysis, including interventions delivered beyond the health sector, such as prevention, social support and structural interventions. To ensure complementarity with Global Fund grant expenditures on TB and malaria, applicants are encouraged to combine analyses from the National Health Accounts and the annual UNAIDS Global AIDS Monitoring data at a recommended frequency of two years. Expenditure analysis data should be analyzed per source of funding (domestic, public, private, international financing entity per recent NASA guidelines), financing agent (e.g., Ministry of Health, Ministry of Education, local government, health insurance, donors, community organization), beneficiary populations that receive services (disaggregated by type of key population, general population, etc.), per intervention, and per HIV prevention pillars. The NASAs primarily support country information needs, such as allocative efficiency, sufficiency, sustainability, and the data also serve the purpose of regional or global monitoring.⁵

¹ WHO (2018). [Cascade Data Use Manual to Identify Gaps in HIV and Health Services for Programme Improvement](#).

² WHO (2022). [Consolidated Guidelines on Person-Centred HIV Strategic Information: Strengthening Routine Data for Impact](#).

³ WHO (2022). [Digital Adaptation Kit for HIV: Operational Requirements for Implementing WHO Recommendations in Digital Systems](#).

⁴ WHO (2022). [Consolidated Guidelines on Person-Centred HIV Strategic Information: Strengthening Routine Data for Impact](#)

⁵ UNAIDS (2009). [National AIDS Spending Assessment \(NASA\): classification and definitions](#).

- iv. *Bio-behavioral surveys (BBS) and population size estimates (PSE)* among key and vulnerable populations. Such techniques should be implemented in all geographic settings according to guidelines and are key data for determining investment priorities. See WHO recommendations¹ and Global Fund guidance² related to HIV surveillance. For men who have sex with men, countries should revise their estimates that are less than 1% of the total adult male population before setting targets.³ In the rare situation where resources or policy environment do not allow a BBS, a community-led participatory needs assessment may be conducted to inform key population size estimates and service design.
- v. *Monitoring HIV Prevention Programs.* Increased attention to the monitoring of HIV prevention program coverage and outcomes is emphasized in line with the Global Fund's HIV Primary Prevention Results Framework ([Section 6.1/Annex](#)) and *Measurement Guidance for Global Fund-supported HIV Prevention Programs*.⁴ HIV prevention outcome monitoring should be integrated as part of the routine monitoring of Global Fund-supported HIV prevention programs to track access, use and outcomes of HIV prevention programs.
- See [Section 4.2](#) for a country example of HIV prevention outcome monitoring.
- vi. *Data Quality Assessments (DQA):* DQAs should be undertaken periodically to assess and strengthen reporting of priority national aggregate indicators from patient-level health information system data sources (e.g., number of people living with HIV currently on ART and quality and coverage of viral load testing and suppression data).⁵ Such assessments should be conducted in line with WHO implementation guidance,⁶ jointly with partners when appropriate, and overseen by the Ministry of Health.
- vii. *HIV Drug Resistance (HIVDR) Surveillance:* WHO recommends periodic HIVDR surveys⁷ to understand acquired and pre-treatment drug resistance in adults and infants, especially in the 45 WHO HIVDR focus countries.⁸ Early warning drug resistance indicator surveillance should be conducted as part of routine data or surveys. Surveillance of drug resistance in people acquiring HIV while taking PrEP is an increasing priority.⁹ In 2021 WHO released a laboratory-based approach using remnant viral load samples.¹⁰ Results of HIVDR surveillance can be used to inform ART scale-up and optimization plans. For more information, refer to WHO recommendations and resources.^{11,12}

¹ WHO (2017). [Biobehavioural Survey Guidelines for Populations at risk for HIV](#).

² The Global Fund (2017). [Guidance Note: HIV surveillance options for key and vulnerable populations in Global Fund grants](#).

³ WHO and UNAIDS (2020). [Recommended population size estimates of men who have sex with men](#).

⁴ The Global Fund (2022). *Measurement Guidance for Global Fund-supported HIV Prevention Programs*. (forthcoming)

⁵ WHO (2020). [Module for assessing and strengthening the quality of viral load testing data within HIV programmes and patient monitoring systems](#).

⁶ WHO (2018). [Data quality assessment of national and partner HIV treatment and patient monitoring data and systems: implementation tool](#).

⁷ WHO (2021). [HIV drug resistance strategy: 2021 update](#).

⁸ WHO (2021). [HIV drug resistance report 2021](#).

⁹ WHO (2021). [HIV drug resistance strategy: 2021 update](#).

¹⁰ WHO (2021). [HIV Drug Resistance: Laboratory-based survey of acquired HIV drug resistance using remnant viral load specimens](#).

¹¹ WHO (2022). [Consolidated Guidelines on Person-Centred HIV Strategic Information: Strengthening Routine Data for Impact](#).

¹² WHO (2021). [HIV drug resistance report 2021](#).

- viii. *People Living with HIV Stigma Index*¹ and legal, gender and human rights assessments related to HIV: Many countries have completed these assessments that provide critical information on the human rights- and gender-related barriers to HIV prevention and treatment. Applicants are encouraged to refer to the findings of existing assessments to inform HIV prevention and treatment program planning and to update program plans and make the data publicly available, as necessary.
- ix. Community-led monitoring is a critical source of country-level data that can provide valuable information on the quality, accessibility, acceptability and affordability of HIV services and on the barriers that key and vulnerable populations face when accessing them. Integrating community-generated data into national routine program monitoring systems has the potential to address barriers and improve the quality of services. Applicants are also encouraged to review the [RSSH Information Note](#) Section 4.3 (Community Systems and Responses) for additional information.

For information on how to build systems to collect, analyze and use data across all levels of programs supported by the Global Fund, refer to the Global Fund monitoring frameworks² and UNAIDS guidance to national AIDS programs.³ For additional information, the [Modular Framework](#) lists all interventions and approaches eligible for funding.

3.2.7 Human rights: remove human rights- and gender-related barriers to services

The Global Fund Strategy 2023-2028⁴ urges all Global Fund stakeholders to continue scaling up programs that remove human rights- and gender-related barriers to HIV services. These programs should also have an increased focus on ending stigma and discrimination, realizing gender equality, work towards removing punitive laws, policies and practices, and equitably distribute services based on the needs of key and vulnerable populations. Such action is necessary for impact, as well as to meet global targets on human rights and gender equality.⁵

The [Modular Framework](#) lists all interventions eligible for funding that aim to remove human rights- and gender-related barriers to HIV services. This framework draws on an internationally recognized set of programs,⁶ including interventions for specific key populations, as well as cross-cutting activities to support all groups to reduce barriers to access. To maximize impact, applicants are encouraged to prioritize the following interventions and approaches in their funding requests, if not funded by other sources:

- i. *Eliminate stigma and discrimination in all settings*: In alignment with WHO's guidance, countries should work towards eliminating HIV-related stigma and discrimination for

¹ Global network of people living with HIV (2022). [People living with HIV stigma index](#).

² The Global Fund website. [Monitoring & Evaluation](#) (accessed 5 July 2022)

³ UNAIDS (2021). [Global AIDS Monitoring Framework 2022-2026: Framework for monitoring the 2021 Political Declaration on AIDS](#).

⁴ The Global Fund (2021) [Fighting Pandemics and Building a Healthier and More Equitable World: Global Fund Strategy \(2023-2028\)](#).

⁵ The global targets on human rights and gender equality are: *Less than 10% of countries have punitive legal and policy environments that deny or limit access to services; less than 10% of people living with HIV and key populations experience stigma and discrimination; and less than 10% of women, girls, people living with HIV and key populations experience gender inequality and violence*. UNAIDS (2021). [Global AIDS Strategy 2021-2026 — End Inequalities. End AIDS](#).

⁶UNAIDS (2012). [Key programmes to reduce stigma and discrimination and increase access to justice in national HIV responses](#).

people living with HIV and key populations.¹ Stigma and discrimination should be addressed in several sectors, including: health care (see below); at the individual, household, and community levels; in the workplace; in education; in emergency and humanitarian settings; and in the justice sector (see below).² Activities to reduce HIV-related stigma and discrimination broadly fall into two types of interventions: (1) those that measure stigma and discrimination; and (2) those that reduce them. Tools that routinely measure and monitor stigma and discrimination include the People Living with HIV Stigma Index,³ specific indicators in the Global AIDS Monitoring framework⁴ and the Integrated HIV Bio-behavioral Surveillance module on stigma and discrimination as experienced by key populations.⁵ Examples of activities to reduce stigma and discrimination include community dialogues, edu-tainment,⁶ trainings to sensitize leaders on HIV-related stigma and discrimination, workplace and education anti-discrimination policies and incorporation of the needs of people living with HIV and other key populations in national emergency plans. ([Program Essential 20](#))

- ii. *Ensure non-discriminatory provision of health care:* WHO notes the importance of people-centered care, including sensitization of workers to provide services that respect confidentiality and non-discrimination.⁷ Trainings should include both pre- and in-service sensitization sessions that not only cover service providers but also administrative staff. Other activities include integration of paralegals within health facilities and development of institutional policies and accountability mechanisms. ([Program Essential 20](#))
- iii. *Improve legal literacy (“know-your rights”):* Programs on legal literacy enable people to know their rights – including the relevant policies and laws related to HIV – and draw on them to develop concrete HIV-related demands. Examples of legal literacy activities include the creation of community-level “know-your-rights” trainings for people living with HIV and other key populations, and integration of legal literacy information into peer education or treatment literacy efforts. Development and dissemination of patient rights materials also contribute to improving legal literacy. ([Program Essential 21](#))
- iv. *Increase access to justice:* Access to legal services can assist people to address structural factors that affect their health, their health-seeking behavior and their general wellbeing. For example, access to legal services can be critical for people who are criminalized, such as sex workers or people who use drugs. Legal services may also be used to challenge discriminatory laws and policies. Other sample activities include providing legal information, referral and representation through the development of pro bono legal networks, expanding peer paralegal programs and

¹ See critical enabler recommendations from WHO (2021). [Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach](#).

² UNAIDS (2018). [Global Partnership for Action to Eliminate all Forms of HIV-Related Stigma and Discrimination](#).

³ Global Network of People Living with HIV (GNP+) website. [The People Living with HIV Stigma Index](#) (accessed 7 July 2022)

⁴ UNAIDS (2021). [Global AIDS Monitoring 2022: Indicators and questions for monitoring progress on the 2021 Political Declaration on HIV and AIDS](#).

⁵ WHO (2017). [Biobehavioural Survey Guidelines for Populations at risk for HIV](#). See Section II: Questionnaire Module *Shame, Stigma, Harassment & Discrimination*.

⁶ Entertainment education or 'edu-tainment' uses entertainment media to convey key messages for public health behaviour change. The World Bank website, [Entertainment Education](#) (accessed 7 July 2022)

⁷ WHO (2021). [Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach](#).

supporting mechanisms for alternative dispute resolution. See a country example in [Section 4.7. \(Program Essential 21\)](#)

- v. *Ensure rights-based law enforcement practices*: Law enforcement officers, including police, judges, prosecutors and prison staff, are key to supporting individuals to access HIV services and to protecting people from discrimination and violence. However, officers may not understand how HIV is transmitted, the many forms that vulnerability to HIV may take, and may be sources of stigma and discrimination themselves. Activities to ensure rights-based law enforcement may include:
- sensitization trainings for officers (in both pre- and in-service trainings);
 - supporting community-led monitoring of police and prison practices; and
 - establishing joint working groups between key populations and local police.
- vi. *Improve laws, regulations and policies relating to HIV and HIV/TB*: WHO calls for countries to review and revise laws and policies to ensure that they support increased access to services for people living with HIV and other key populations. This encompasses working towards the decriminalization of drug use, sex work, same-sex activity and nonconforming gender identities.¹ Activities that can improve the legal and policy environment include legal environment assessments and follow-up action plans for reform, as well as advocacy for law reform and sensitization sessions for parliamentarians. ([Program Essential 22](#))
- vii. *Reduce HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity*: The Global Fund strongly encourages programs to account for specific gender-related risks and vulnerabilities for women and girls – otherwise known as “gender-responsive programming”. Where possible, programs should aim to be gender transformative by actively seeking to build equitable social norms and structures and support individual gender-equitable behavior. Examples of activities that address harmful gender norms include implementation of HIV and TB gender assessments with concrete follow-up plans, ([Program Essential 19](#)) reviewing and reforming laws and practices related to age of consent, spousal consent and domestic violence to align with public health and human rights norms, ([Program Essential 22](#)) as well as meaningful engagement and leadership of women and girls.
- viii. *Community mobilization and advocacy for human rights*: WHO and UNAIDS have recognized the importance of community mobilization as a critical enabler within effective HIV responses.² Aligned with this, the Global Fund encourages a stronger leadership role for communities living with, and affected by, HIV. Examples of activities in this program area include: community-led advocacy for law and policy reform, particularly decriminalization; community-led monitoring of HIV- and TB-related law and policy reform and implementation; and community-led outreach campaigns to address harmful gender norms and stereotypes and other gender and human rights-related barriers.

¹ WHO (2021). [Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach](#).

² Ibid, and UNAIDS (2021). [Global AIDS Update 2021: Confronting Inequalities](#).

To track country progress towards sustainable funding and support for programs to reduce human rights- and gender-related barriers, countries are encouraged to report their domestic expenditure on such interventions under the Global AIDS Monitoring framework.¹ For further information on human rights interventions see detailed activity descriptions in the [Modular Framework](#) and further information in the Global Fund Technical Brief.²

¹ UNAIDS (2021). [Global AIDS Monitoring Framework 2022-2026: Framework for monitoring the 2021 Political Declaration on AIDS](#).

² The Global Fund (2022). [HIV, Human Rights and Gender Equality Technical Brief](#).

4. Country Examples

4.1. New product introduction in South Africa

The South African Health Products Regulatory Authority (SAHPRA) approved the dapivirine vaginal ring for use as PrEP. Stakeholders are now developing clinical guidelines to begin implementation and respond to questions about implementation outside of clinical trials. Quick adoption of WHO-approved HIV prevention products increases the HIV prevention options for people who want and need to have PrEP at their disposal to prevent HIV acquisition. The development of guidelines aligning with WHO recommendations is key to support program quality and product access.

4.2. Using surveys to clarify the outcomes of HIV prevention programs in Kenya

In the period 2010-2020, there was a 49% decrease in new HIV infections among adults 15+ years of age in Kenya. To continue this trend, HIV prevention services needed to increasingly focus on key populations that are at increased risk of HIV infection.

Global Fund investments in Kenya's HIV prevention budget have been increasing significantly over time, supporting a range of HIV interventions targeting key populations. The largest investments have been allocated to condom and lubricant programs, behavior change interventions, community empowerment and needle and syringe programs.

Monitoring Prevention Outcomes: The Kenya National AIDS and STI Control Programme conducted polling booth surveys in 2014, 2015, and 2017 to measure outcomes from the HIV prevention program for key populations.¹ The outcome indicators that are most directly related to a reduction in new HIV infections showed good results (Table 3). In addition, the country has set up a robust monitoring system with standard data collection and reporting tools. Program data are analyzed every quarter to assess program progress.

Conclusion: Polling booth surveys can generate regular data on the outcome of prevention interventions.

Table 3. Prevention outcomes based on polling booth surveys, 2014-2017, Kenya

Outcome indicator	2014	2015	2017
FSW condom use at last sex with a client (90% target)	88%	92%	92%
MSM condom use at last anal sex (90% target)	77%	80%	79%
PWID using safe injecting equipment during last injection (95% target)	88%	89%	88%

¹ Polling booth surveys enable respondents to provide information anonymously through a ballot box. See National AIDS & STI Control Programme, Kenya Ministry of Health. 2018. [Third National Behavioural Assessment of Key Populations in Kenya: Polling Booth Survey Report](#).

4.3. Tailoring HIV self-testing delivery platforms from pilot to scale-up in Liberia

In Liberia, COVID-19 restrictions in 2020, including travel limitations, social distancing and curfews, significantly disrupted HIV service delivery to key populations. HIV testing among sex workers and men who have sex with men was particularly impacted, decreasing by 63% in the first half of 2020, compared to the previous six-month period (from over 14,000 tested to about 5,200).

To address these service disruptions, the National AIDS Control Program and Population Services International in Liberia used grant savings to fund adaptation measures – in particular, a 3-month pilot project on HIV self-testing among female sex workers, men who have sex with men, and transgender women. In addition, grant flexibilities allowed the purchase and distribution of face masks and sanitizing materials to protect clients and workers at service delivery sites. As a result, during the three-month pilot from September to December 2020, over 8,700 individuals tested, and almost 300 individuals were found to be positive and referred to care.

The qualitative assessment of the pilot showed that the acceptance of saliva-based HIV test kits was higher among key populations than the blood-based tests. The report also recommended actions to improve support for and monitoring of linkage to care and treatment (e.g., referral vouchers, transport for peer educators).

4.4. Addressing ART linkage loss in India

In India, data showing linkage loss – loss of patients between testing HIV-positive in a testing center and initiating ART – prompted a response in 19 states and focused on 100 centers reporting high loss. The Vihaan program of Alliance India assigned a peer navigator to each of the centers. The peer navigators set out to track “lost” cases, and provide these individuals with treatment preparedness counselling, referral and eventual accompaniment to ART services. As a result, 76% of clients testing positive between October 2021 and March 2022 were successfully initiated on ART. This compares to 54% in the previous six months. Those successfully initiated on ART are also followed for six months to support retention as they are established on ART.

4.5. Improving ART coverage in Nigeria

In Nigeria, the proportion of adults and children living with HIV who receive ART has been steadily increasing – from 58% in 2017 to about 95% in 2021. Despite numerous COVID-19 waves, Nigeria was able to continue to adapt its national program through strategic mitigation approaches tailored to the country context. These approaches include:

- intensifying community-based testing;
- expanding ARV distribution through community refill sites and pharmacies; and
- expanding availability of ARV multi-month dispensing of 3-6 months for those established on ART.

By the end of 2021, 98% of those on ART were receiving three or six months of ARVs at a time.

Nigeria was able to better target surge efforts because of good use of data for planning and delivery, including estimates of disease burden and service coverage at national and state levels from the Nigeria HIV/AIDS Indicator and Impact Survey (NAIIS). In addition, strong stakeholder alignment specifically between the Government of Nigeria, PEPFAR and Global Fund enhanced synergies and efficiencies. These efforts resulted in a substantial increase in the number of people on ART even during waves of COVID-19 – from 1.15 million at the end of 2019, to 1.49 million at the end of 2020, to close to 1.8 million at the end of 2021.

4.6. Increasing access to viral load testing in Kenya

The Kenya National AIDS and STI Control Program and the National HIV Reference Lab have successfully expanded the national viral load testing program, increasing access to viral load testing from ~600,000 tests in 2015 to almost 1.5 million in 2019. Several factors have been associated with this success, which include:

- **Policies aligned with WHO guidelines.**
- **Strong government coordination and a system-wide approach** by the National AIDS and STI Control Program and the National HIV Reference Lab, supporting comprehensive planning and management at all levels.
- **Data-driven approach and routine evaluation of progress.** An electronic data management system for patient monitoring provides data through a national dashboard. Viral load coverage and suppression information is thus readily available to support routine data reviews and quality improvement activities at the site level. The system also enables real-time tracking of specimen turnaround times – from sample collection to laboratory receipt and processing – and rapid identification of bottlenecks.
- **Diagnostic network optimization** to increase access to testing, improve network efficiencies, and generate greater public health impact.
- **Effective commodity management and reagent rental agreements.**
- **Site-level management** including optimization of human resources/training, data reviews and quality improvement approach.
- **Demand creation activities**, including treatment literacy.

4.7. Breaking down human rights barriers through community paralegals in Mozambique

Scaled-up assistance of community paralegals has demonstrated successes in reducing HIV-related human rights-related barriers. In collaboration with Namati, Project Viva, the Global Fund-supported community legal empowerment program in Mozambique, has trained nearly 400 community paralegals on human rights, gender and HIV. These paralegals have helped people living with HIV, women, adolescent girls and key populations reduce their HIV-related vulnerabilities. In the Tete district for example, community paralegals helped secure the release of 45 sex workers who were detained by a community safety council for the possession of used condoms. In the Zambezia, Manica and Tete provinces, paralegals and legal literacy sessions have resulted in the removal of girls from early marriages and protecting them from other rights violations. Addressing human rights and gender-related barriers empowers key and vulnerable populations and helps them out of situations that increase their risk of HIV.

4.8. Integrating mental health into HIV/TB and COVID-19 interventions in Zimbabwe

The Global Fund supports the integration of mental health with care for other comorbidities, including infectious diseases such as HIV and TB. Integrating care can yield reciprocal benefits:¹ mental health care improves adherence to HIV and TB treatments, and integration with HIV/TB treatment programs could provide needed staff to support people living with mental health conditions, all the while expanding access to mental health care as a more holistic service for people living with HIV/TB. The 2020-2022 funding request from Zimbabwe included mental health in the HIV/TB and COVID-19 interventions. Specific activities included:

- provisions for training and supervision of health professionals on mental health;
- supporting community health workers to screen people who may be experiencing mental health problems; and
- strengthening peer psychosocial support for young people.

Acknowledging that a lack of psychosocial support is a barrier to ARV initiation, the funding request also included mental health services and psychosocial counselling as part of the minimum comprehensive HIV prevention package for gay men and other men who have sex with men.

¹ United for Global Mental Health website. [Bending the Curve: The Impact of Integrating Mental Health Services on HIV and TB outcomes](#) (accessed 5 July 2022).

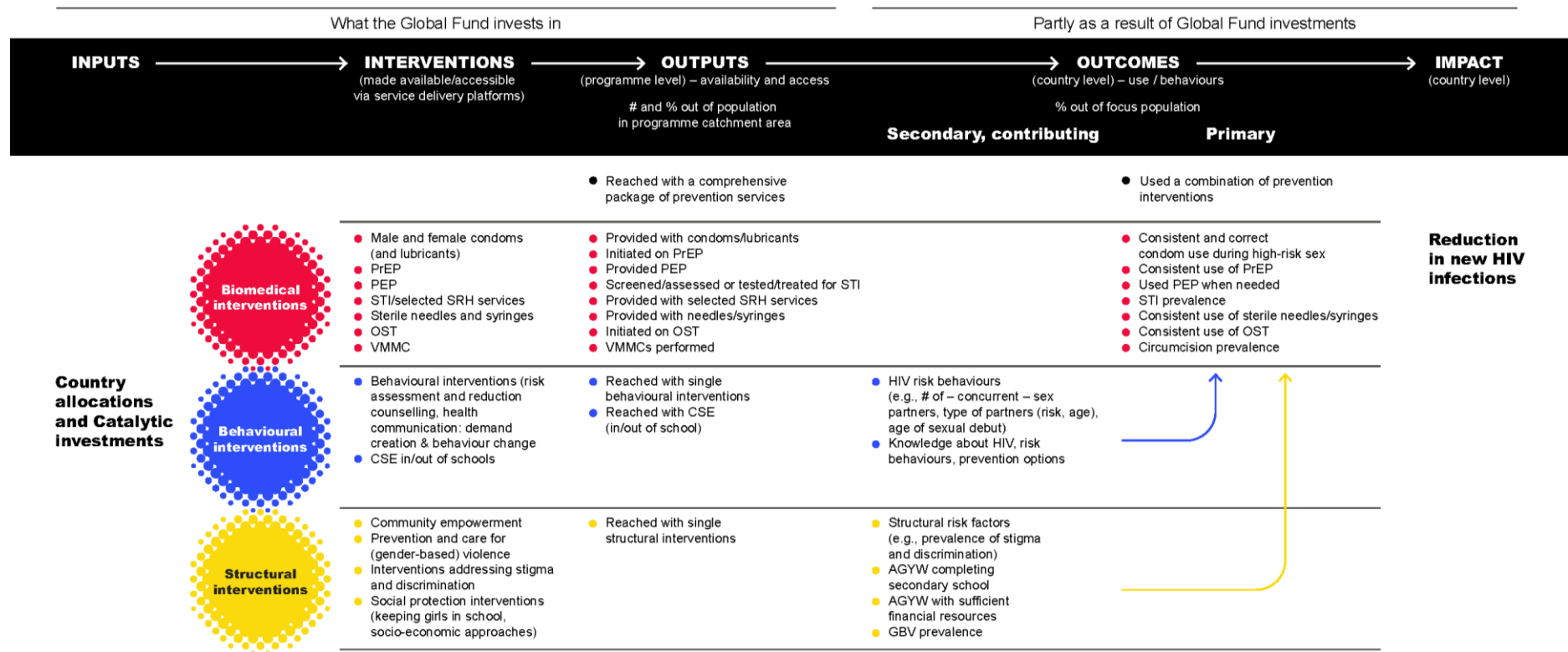
5. List of Abbreviations

1HP	Daily isoniazid and rifapentine for one month
3HP	Weekly isoniazid and rifapentine for three months
3RH	Daily isoniazid and rifampicin for three months
AEM	AIDS Epidemic Model
AGYW	Adolescent Girls and Young Women
AIM	AIDS Impact Model
ANC	Antenatal Care
ART	Antiretroviral Therapy
BBS	Biobehavioral Surveys
COE	Challenging Operating Environment
CSE	Comprehensive Sexuality Education
DHIS2	District Health Information System 2
DSD	Differentiated Service Delivery
DTG	Dolutegravir
DQA	Data Quality Assessments
EID	Early Infant Diagnosis
FSW	Female Sex Worker
HBV	Hepatitis B
HCV	Hepatitis C
HIVDR	HIV Drug-Resistance
HPV	Human Papillomavirus
INH	Isoniazid
LF-LAM	Lateral Flow Urine Lipoarabinomannan Assay
MMD	Multi-month Dispensing
MSM	Gay Men and Other Men Who Have Sex with Men
NAAT	Nucleic Acid Amplification Test
NASA	National AIDS Spending Assessments
NCD	Non-Communicable Disease
OAMT	Opioid Agonist Maintenance Treatment
OST	Opioid Substitution Therapy
PEP	Post-Exposure Prophylaxis
PEPFAR	The President's Emergency Plan for AIDS Relief

PITC	Provider-Initiated Testing and Counselling
PNC	Post-Natal Care
POC	Point of Care
PrEP	Pre-Exposure Prophylaxis
PSEAH	Protection from Sexual Exploitation, Abuse and Harassment
PSE	Population Size Estimates
PUD	People who Use Drugs
PWID	People who Inject Drugs
RDT	Rapid Diagnostic Test
RPT	Rifapentine
SW	Sex Worker
TB	Tuberculosis
TG	Transgender People
TPT	Tuberculosis Preventive Therapy
TRP	Technical Review Panel (Global Fund)
RSSH	Resilient and Sustainable Systems for Health
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
U=U	Undetectable = Untransmittable
UNAIDS	The Joint United Nations Programme on HIV/AIDS
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization

6. Annexes

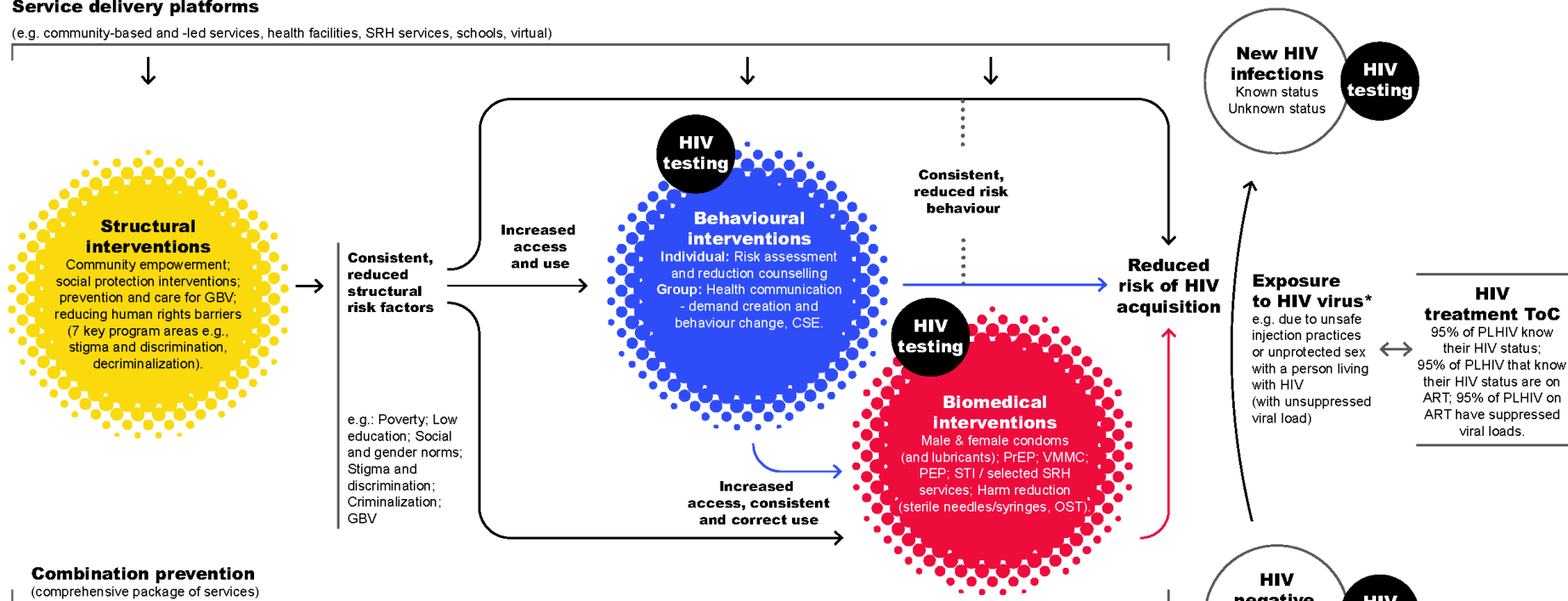
6.1 The Global Fund HIV Primary Prevention Results Framework



6.2 Theory of Change Underlying the Global Fund Investment in HIV Primary Prevention

Service delivery platforms

(e.g. community-based and -led services, health facilities, SRH services, schools, virtual)



CSE: comprehensive sexuality education; GBV: gender-based violence; OST: opioid substitution therapy; PrEP: pre-exposure prophylaxis; STI: sexually transmitted infection, SRH: sexual and reproductive health; VMMC: voluntary medical male circumcision

*Sexual behaviours associated with an increased risk of exposure, if unprotected, e.g.: Multiple (concurrent) partners; Partner status unknown; Partner with high-risk behaviour; Anal sex; Commercial / transactional sex; Early sexual debut; Age discordant relationships; Sex under the influence of alcohol and/or drugs