Guidance Note

Prioritization Framework for Supporting Health and Longevity Among People Living With HIV

Allocation Period 2023-2025

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THE GLOBAL FUND

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Contents

Introduction

UNAIDS estimated that in 2021, AIDS took a life every minute. Despite effective treatment for HIV and tools to prevent, diagnose and treat opportunistic infections, about 650,000 people living with HIV died of AIDS-related causes during the year.[1]

This guidance note is relevant to applicants preparing HIV and joint tuberculosis (TB)/HIV funding requests for the 2023-2025 allocation period. The note is designed to help applicants identify the most impactful co-infections and co-morbidities (COIM) priorities that will improve health and longevity among people living with HIV and priority populations.

Integrated delivery of these COIM priorities can also support access to and uptake of HIV services , and promote health equity. There is also a positive impact on HIV and overall health outcomes, and the quality of life of people living with HIV and of other priority populations across their life-course, The COIM priorities in this guidance note are among those outlined in the Policy on Global Fund's support for Co-infections and Co-morbidities (2015) and recommended in section 6 (*General care and managing common co-infections and co-morbidities*) of the WHO 2021 *Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach*.[2]

This note provides further details on support to interventions described in the Global Fund's HIV Information Note Section 3.2.3b (Support health and longevity among people living with HIV) and Section 3.2.5 (TB/HIV). It builds on integration principles described in the Global Fund's Resilient and Sustainable Systems for Health (RSSH) Information Note. Finally, this note reiterates relevant HIV and TB program essentials and provides country examples of investments in health and longevity for people living with HIV. This guidance note is designed to be read alongside:

- The **Policy on Global Fund's support for Co-infections and Co-morbidities** (2015), including the Framework for Financing COIM as approved by the Global Fund Board.**Error! Bookmark not defined.**
- **Core Information Notes:** HIV and RSSH.
- **Technical Briefs:** Harm Reduction for People Who Use Drugs: Priorities for Investment and Increased Impact.; HIV Programming for Adolescent Girls and Young Women in High-HIV Burden Settings; HIV Programming at Scale for and with Key Populations;and Prisons and Other Closed Settings: Priorities for Investment and Increased Impact.
- **Modular Framework Handbook,** which identifies the interventions that the Global Fund supports, associated budget and indicators against which progress is measured. This guidance note provides guidance on prioritization within that list.

[1] UNAIDS (2022). In Danger: UNAIDS Global AIDS Update 2022. https://www.unaids.org/en/resources/documents/2022/in-danger-global-aids-update
[2] WHO (2021). Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach. https://www.who.int/publications/i/item/9789240031593

This note is also aligned with the Global Fund Strategy (2023-2028),[3] the global health sector strategies on, respectively, HIV, viral hepatitis, and sexually transmitted infections for the period 2022-2030,[4] and the UNAIDS Global AIDS Strategy 2021-2026.[5] These strategies commit to promoting the introduction of new tools, diagnostics, therapeutics, and service delivery innovations. Integrated coordination of care and clinical service delivery to ensure services are people-centered and address individuals' holistic health needs are also prioritized.

[3] The Global Fund (2021). Fighting Pandemics and Building a Healthier and More Equitable World: Global Fund Strategy (2023-2028). https://www.theglobalfund.org/media/11612/strategy_globalfund2023-2028_narrative_en.pdf
[4] WHO (2022). Global health sector strategies on, respectively, HIV, viral hepatitis, and sexually transmitted infections for the period 2022-2030. https://www.who.int/publications/i/item/9789240053779.
[5] UNAIDS (2021) Global AIDS Strategy 2021-2026 - End Inequalities. End AIDS. https://www.unaids.org/en/resources/documents/2021/2021-2026-global-AIDS-strategy

1. Key Considerations for Prioritization

This guidance note articulates the opportunities and priorities for integrated investments to prevent, identify and manage advanced HIV disease, viral hepatitis, cervical and anal cancer, non-communicable diseases (NCDs), mental health conditions, and COVID-19 and other emerging pandemics. These are consistent with prioritized interventions described in the HIV Information Note, noting that TB is fully addressed in section 3.2.5 (*TB/HIV: addressing co-infection with TB and HIV)* and in the Global Fund's Tuberculosis Information Note.

Applicants requesting funding for COIM priorities described in this guidance note should ensure alignment with all principles set out in the **Framework for Financing Co-infections and Co-Morbidities of HIV/AIDS, Tuberculosis and Malaria (COIM)**.[6]

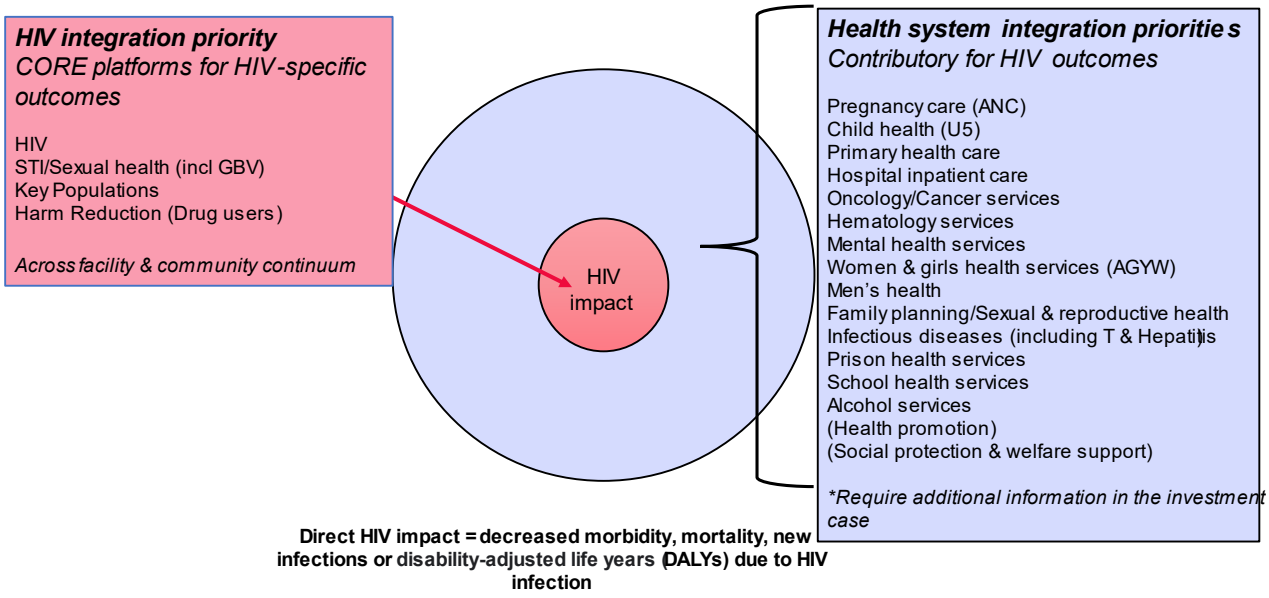
Below are additional key considerations:

- **Proposed investments are supported by a strong detailed investment case** informed by epidemiology, programmatic needs, potential HIV impact and cost-effectiveness of investments at national and subnational levels with an understanding of highest incidence locations, as well as program readiness and absorption capacity. Ideally the case should be complemented by existing costed national HIV and co-infections and co-morbidities strategic plans.
- **Proposed investments reflect integrated people-centered care that holistically addresses the needs of people living with HIV along their life course.** The Global Fund Strategy (2023-2028)[3] calls for resilient and sustainable systems for health that place people and communities, not diseases, at the center of the health system, to promote the achievement of universal health coverage. To facilitate this, applicants are encouraged to maximize investments in **integrated approaches, systems, and services**, such as multi-disease testing capacity, develop integrated and interoperable health information systems, and support differentiated service delivery approaches across disease areas, including multi-month dispensing of medications.
- **Proposed investments prioritize integration for key HIV service delivery platforms in HIV funding requests.** Across the seven COIM priorities (detailed below), applicants are encouraged to optimize intervention packages delivered in HIV platforms as an integration priority. This encompasses the facility and community continuum of HIV prevention, testing, treatment platforms, platforms serving key populations, adolescent girls and young women, and harm reduction platforms. In some epidemic settings the need to integrate co-infections and co-morbidities priorities into other platforms providing HIV services as part of wider packages of care. These other platforms may include maternal and neonatal health care, family planning, sexual health and sexual reproductive health, adolescent, and hematology

[6] The Global Fund (2015). Thirty-Third Board Meeting. Global Fund support for co- infections and co-morbidities. Page 12. https://www.theglobalfund.org/media/4167/bm33_11-co-infectionsandco-morbidities_report_en.pdf

services. Applicants can choose to invest in these platforms if and when integration of HIV and COIM priorities into these platforms will be critical to improve HIV-related health outcomes in their country context. Investments in non-HIV platforms require additional information to bring together the justification for these investments and the applicants' investments across the three diseases (HIV, TB and malaria) and RSSH. Figure 1 below depicts these service delivery platform considerations.

Figure 1. Service delivery platform considerations



- **Proposed investment align with relevant co-financing investments.** The Policy on Global Fund's support for Co-infections and Co-morbidities (2015) prioritizes co-financing investments through a country-led prioritization approach while also ensuring that Global Fund financing would not displace resources from other funding sources. Applicants are encouraged to describe the contributions of domestic and other resources to help quantify the level of unmet needs. Additionally, vaccines for human papillomavirus (HPV), hepatitis, malaria and others are not included in this guidance note as other partners (e.g. GAVI, the Vaccine Alliance) already provide direct support for implementing countries.

2. Co-infections and Co-morbidities Priorities to Support Health and Longevity for People Living with HIV

Priority 1: Advanced HIV disease

Management of advanced HIV disease (AHD) – A Global Fund Program Essential (see Box 1 below and Table 2 of the HIV Information Note)

The burden of morbidity and mortality associated with HIV infection has decreased over the past decade as access to and uptake of antiretroviral therapy (ART) has increased. Despite this progress, up to half of people living with HIV continue to present to care with advanced HIV disease.[7]

WHO defines advanced HIV disease for children five years and older, adolescents and adults as having a CD4 cell count of less than 200 cells/mm^3 or WHO clinical stage 3 or 4 disease. This includes both individuals presenting to care who are ART-naïve and those returning to care after interrupted treatment. People with AHD are at high risk of death, even after starting ART; this risk increases with decreasing CD4 cell count. The most common causes of severe illness and death are tuberculosis, severe bacterial infections and cryptococcal meningitis.[8]

To reduce morbidity and mortality among people with AHD, applicants are encouraged to prioritize the WHO AHD package of interventions to prevent, diagnose and treat major opportunistic infections, alongside efforts to ensure rapid access to and uptake of effective ART. Most co-infections are preventable or curable if diagnosed and managed early.[8]

Programs should take steps to ensure rapid access to and uptake of effective ART for all, considering specific measures to address the needs of people with AHD. Measures critical to prevent AHD include rapid ART initiation with optimized regimens for treatment-naive people, early identification of undiagnosed children with HIV, re-engagement for people who have disengaged from care, and rapid switching to effective alternative treatment for those not virologically suppressed. For those disengaged from care, identifying the reasons for disengagement is crucial for addressing it. See section 3.2.3 of HIV Information Note and the WHO recommendations[8] on management of advanced HIV for more information.

[7] WHO (2017). Guidelines for managing advanced HIV disease and rapid initiation of antiretroviral therapy. https://www.who.int/publications/i/item/9789241550062

[8] WHO (2021). Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach. https://www.who.int/publications/i/item/9789240031593

Box 1. HIV Program Essentials: HIV treatment and care[9]

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. HIV care includes management of advanced HIV.
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 co-morbidity and co-infections are available for management of HIV.

Applicants are encouraged to prioritize the support for all diagnostics and therapeutics necessary for implementing the AHD package of care. Prioritized interventions include:

i. CD4 cell count - a Global Fund priority intervention. CD4 cell count is critical to give an indication of the health of the immune system. It is the entry point for the AHD package of care and necessary for all people initiating ART, those not virologically suppressed, and those returning to care after having disengaged. Applicants are encouraged to quantify CD4 needs and assess testing network structure (including the appropriate mix of laboratory, point-of-care devices, and point-of-care Lateral Flow Assay) as well as geographic considerations that inform a strategic approach to configuring their CD4 network.[7] See section 4.7 of the RSSH Information Note on laboratory system strengthening.

ii. Tuberculosis. Applicants are encouraged to rapidly scale up point-of-care urinary TB LAM (Lateral flow assay, lipoarabinomannan) tests. Applicants are also encouraged to scale up TB preventive treatment (TPT) and ensure Cotrimoxazole use as part of the AHD package of care.[7] See section 3.2.5 of the HIV Information Note (TB/HIV) and the Tuberculosis Information Note for more details. Box 2 below describes the TB/HIV program essentials.

Box 2. HIV Program Essentials: TB/HIV9[9]

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

iii. Cryptococcal meningitis**.** Applicants are encouraged to prioritize interventions to prevent, diagnose and treat cryptococcal meningitis. Interventions include: (1) Cryptococcal Antigen (CrAg) screening; (2) the use of pre-emptive therapy with fluconazole as outlined in the WHO guidance (2022);[10] and (3) the introduction of the preferred induction regimens for the treatment of cryptococcal meningitis, using

[9] The full list of Program Essentials is included as Table 2 of the HIV Information Note. The Global Fund (2022). HIV Information Note. https://www.theglobalfund.org/media/4765/core_hiv_infonote_en.pdf

[10] WHO (2022). Guidelines for diagnosing, preventing and managing cryptococcal disease among adults, adolescents and children living with HIV. https://www.who.int/publications/i/item/9789240052178

flucytosine in combination with Amphotericin B.[10] Applicants are encouraged to utilize high dose liposomal amphotericin B for induction therapy, as recommended by the WHO respective guidance,[10] given its favorable safety profile compared to amphotericin B deoxycholate.

iv. Histoplasmosis and other regional endemic fungal infections associated with HIV. Diagnosis and treatment in endemic settings is in line with WHO AHD guidance (2017).[7]

v. Enhanced patient and community support. As outlined in the, activities for intensive treatment and support services for people with advanced HIV disease and unsuppressed viral load are strongly encouraged, which includes models supporting return to care, treatment literacy and psychosocial support.

Priority 2: Viral hepatitis

Viral hepatitis includes hepatitis B (HBV) and hepatitis C (HCV) and together they could account for almost two thirds of the global burden of cirrhosis.[11] In African and Asian countries, HBV is more common (although with some exceptions), and the combined prevalence of both viruses among patients with cirrhosis usually exceeds 50%.[11]

Because of this, as well as the advent of new and highly effective cures for HCV and an expanding array of preventive and therapeutic interventions for HBV, investments to reduce the impact of viral hepatitis within HIV programs are strategic and cost-effective.[12]

Hepatitis B Virus

Hepatitis B is a vaccine-preventable disease that is the leading cause of chronic liver disease worldwide. An estimated one in ten people with HIV (3.9 million) are thought to be infected with Hepatitis B Virus (HBV) and suffer heightened morbidity and mortality.[13] Global Fund investments can be used to support coordinated national hepatitis or bloodborne diseases strategy. Applicants are encouraged to prioritize the following targeted interventions, integrated within HIV service delivery platforms:

i. Testing: One of the HIV integration priorities (Figure 1) is to integrate HBV testing within HIV service delivery platforms as part of a comprehensive people-centered package in line with WHO guidance. This includes: (1) testing for adults and adolescents living with HIV, and their partners; (2) focused testing for key populations and their partners, mobile and migrant populations; and (3) routine testing in pregnant

[11] Alberts CJ, Clifford GM, Georges D, Negro F, Lesi OA, Hutin YJ, de Martel C. Worldwide prevalence of hepatitis B virus and hepatitis C virus among patients with cirrhosis at country, region, and global levels: a systematic review. Lancet Gastroenterol Hepatol. 2022 Aug;7(8):724-735. doi: 10.1016/S2468-1253(22)00050-4. Epub 2022 May 14. PMID: 35576953; PMCID: PMC9259503.
[12] Hecht R, Hiebert L, Spearman WC, Sonderup MW, Guthrie T, Hallett TB, Nayagam S, Razavi H, Soe-Lin S, Vilakazi-Nhlapo K, Pillay Y, Resch S. The investment case for hepatitis B and C in South Africa: adaptation and innovation in policy analysis for disease program scale-up. Health Policy Plan. 2018 May 1;33(4):528-538. doi: 10.1093/heapol/czy018. PMID: 29529282; PMCID: PMC5894072.
[13] Utsumi T, Lusida MI. Viral hepatitis and human immunodeficiency virus co-infections in Asia. World J Virol. 2015 May 12;4(2):96-104. doi: 10.5501/wjv.v4.i2.96. PMID: 25964874; PMCID: PMC4419124.

women for HBV (alongside HIV and syphilis as part of triple elimination efforts)[14] Applicants are encouraged to consider point-of-care diagnostics, molecular testing platforms with quantitative capabilities that can help to support integrated management, as well as self-testing options, when available. These activities are defined in the respective WHO guidance and outlined in the Global Fund Modular Framework.

ii. Prevention:

a. The Global Fund can support integrated HBV vaccination delivery within HIV platforms for people living with HIV , and all key and vulnerable populations as part of a comprehensive prevention that also includes condoms, lubricants, and appropriate behavior change. It can also be supported as part of comprehensive post sexual violence care. This includes the cost of referrals and delivery but excludes vaccine costs.

b. Elimination of Vertical HIV Transmission: In line with the HIV Information Note, applicants are encouraged to prioritize integrated approaches to eliminate mother-to-child transmission of HIV, syphilis, and hepatitis B (triple elimination), as part of a comprehensive national strategic plan.[14]

As part of triple elimination efforts, the Global Fund supports integrated service delivery investments to support countries in moving to hepatitis B birth dosing, as part of a wider national expanded immunization strategy. To better contribute to infant and perinatal vaccination, countries are required to develop a strong investment case that is aligned with national hepatitis elimination, expanded immunization and maternal, child neonatal health care strategies. Global Fund support excludes the vaccine costs.

iii. Pretreatment assessment and treatment: Hepatitis B treatment is an integration priority in HIV platforms. In line with the WHO-recommended algorithm for diagnosis, treatment and monitoring and acknowledging that all HIV patients with HBV co-infection should be on Tenofovir-containing ARV to mitigate the higher risk of progression to liver cirrhosis and cancer.[2] It is also critical to highlight needs for pregnant and breast-feeding women as part of the elimination of vertical transmission strategies and for key populations in prevention platforms.

iv. Advanced care for chronic HBV disease: If applicants are considering investments in long-term hepatitis B treatment, additional information is required as part of the detailed costed investment case and will be considered on a case-by-case basis.

[14] Elimination of mother-to-child transmission of HIV, syphilis and hepatitis B. https://www.who.int/initiatives/triple-elimination-initiative-of-mother-to-child-transmission-of-hiv-syphilis-and-hepatitis-b. Accessed 14 January 2023.

Hepatitis C virus

Estimates suggest that 58 million people are chronically infected with Hepatitis C Virus (HCV) and about 1.5 million new infections occur each year.[15] Globally, more than 2 million people with HIV are estimated to be co-infected with HCV, with almost 60% of those co-infections thought to be among people who inject drugs.[16] Hepatitis C can now be treated successfully by taking medicines for several weeks, especially if infection is diagnosed in the early stages. Countries may wish to prioritize the following interventions for HCV, integrated within HIV services where there is a clear investment case informed by local epidemiology:

i. Testing: One of the HIV integration priorities (Figure1) is to incorporate HCV testing within HIV service delivery platforms as part of a comprehensive people-centered package in line with WHO guidance. This includes testing for adults and adolescents living with HIV, and their partners, as defined by WHO and outlined in the Global Fund Modular Framework and includes targeted testing for key populations and their partners, mobile and migrant populations, noting the critical focus on people who inject drugs.

   To support integrated management, applicants are encouraged to consider point-of-care diagnostics, molecular testing platforms with quantitative capabilities and self-testing options.

   Prevention: Although no HCV vaccine currently exists, HCV prevention is a critical intervention as part of all prevention packages for key populations and is included in the comprehensive harm reduction interventions and services for people who inject drugs alongside provision of condoms and lubricants, behavior change.

ii. Confirmation of viremia, assessment and treatment: Hepatitis C treatment is an integration priority in HIV platforms in line with WHO-recommended algorithm for diagnosis, treatment and monitoring.[17] This expands the eligibility of HIV funding, especially for people who inject drugs accessing HIV services, where treatment can be provided irrespective of their HIV status. Although hepatitis C treatment costs have reduced in recent years, considerable variation exists, and diagnostic costs can exceed those of treatment in some settings. Procurement practices in line with the Global Fund's value for money framework should be prioritized (see RSSH Information Note Section 4.6).

iii. Advanced care for chronic HCV disease: For applicants considering investments in long-term treatment of chronic hepatitis C disease , additional information is required as part of the detailed costed investment case and will be considered on a case-by-case basis.

[15] Accelerating access to hepatitis C diagnostics and treatment: overcoming barriers in low- and middle-income countries. Global progress report 2020. World Health Organization 2021. https://www.who.int/publications-detail-redirect/9789240019003. Accessed 15 September 2022.
[16] Platt L, Easterbrook P, Gower G, et al. (2016). Prevalence and burden of HCV co-infection in people living with HIV: a global systematic review and meta-analysis. Lancet Infect Dis. Jul;16(7):797-808.
[17] Updated recommendations on simplified service delivery and diagnostics for hepatitis C infection: policy brief. World Health Organization 2022. https://www.who.int/publications/i/item/9789240052697. Accessed 15 September 2022.

Priority 3: Cervical cancer

People living with HIV are at increased risk of cervical cancer. HIV-associated cervical cancer places a substantial disease burden in countries in East and Southern Africa with a high HIV burden[18] that may increase as women with HIV live longer.[18] Applicants may wish to prioritize the following integrated, cervical cancer interventions. This should be funded as part of a coordinated national HIV and cancer strategy.

i. Screening and diagnosis: Cervical cancer screening within HIV platforms is an HIV integration priority for all women living with HIV, transgender, non-binary and intersex people, as well as those accessing HIV services who meet WHO eligibility criteria for screening.[19] Applicants are encouraged to adopt the WHO-recommended "screen, triage and treat" approach, using HPV DNA testing as the preferred first test where possible. Applicants are encouraged to integrate cervical screening with HIV prevention, treatment and comprehensive sexual and reproductive health (SRH) services, which can increase access to and uptake of services delivered via the same platform.[18]

ii. Human papillomavirus (HPV) vaccination: HPV vaccination is an integration priority in HIV platforms for women living with HIV, transgender, non-binary and intersex people, key and vulnerable populations and their partners, and specifically girls aged 9-14 years before becoming sexually active in line with WHO eligibility criteria.[19] The Global Fund-supported interventions need to be aligned with national cervical cancer and expanded immunization strategies. Global Fund support excludes the costs of HPV vaccines.

iii. Secondary preventative treatment is supported as part of an integrated package of care within HIV service delivery platforms as soon as possible within six months of diagnosis and in line with WHO's treatment algorithm and monitoring guidance.[20]

iv. Advanced and invasive cancer treatment: Integrated referral for advanced and invasive cervical cancer treatment is encouraged.

Support for wider cancer prevention and treatment platforms is a secondary integration priority and requires additional information in the investment case. Applicants are encouraged to identify other investments, stakeholders and co-financing opportunities.

Priority 4: Anal cancer

The incidence of anal cancer is the fourth most common cancer among people living with HIV.[21] Research has shown that people living with HIV have more types of HPV, are less likely to naturally clear the virus and experience more rapid progression to

[18] StelzleD, Tanaka LF, Lee KK, et al. (2021). Estimates of the global burden of cervical cancer associated with HIV. The Lancet Global Health, Volume 9, Issue 2, e161 - e169. https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(20)30459-9/fulltext
[19] WHO (2021). WHO guideline for screening and treatment of cervical pre-cancer lesions for cervical cancer prevention, second edition. https://www.who.int/publications/i/item/9789240030824
[20] White HL, Meglioli A, Chowdhury R, Nuccio O. (2017). Integrating cervical cancer screening and preventive treatment with family planning and HIV-related services. Int J Gynecol Obstet, 138: 41-46. https://doi.org/10.1002/ijgo.12194

cancer.[21] Furthermore, the incidence of anal dysplasia caused by the HPV is increasing in men and can be a precursor to the development of anal cancer.[22]

i. Screening and diagnosis: Anal cancer screening within HIV platforms is an HIV integration priority for all people living with HIV and for key and vulnerable populations. Applicants are encouraged to align screening and diagnosis interventions with the most recent global guidance and their national health strategies.

ii. Treatment and advanced cancer care: Integrated referral for advanced and invasive anal cancer treatment is an HIV integration priority. Additional information is required as part of the detailed costed investment case and will be considered on a case-by-case basis.

Priority 5: Non-communicable diseases associated with ageing

Up to a quarter of all people with HIV are over age 50.[23] Associated with the aging cohort is a large and growing burden of NCDs. Where NCD integration is proposed, countries are encouraged to align services with epidemiological contexts and the WHO package of essential NCD disease interventions for primary health care,[24] focusing on cardiovascular and chronic respiratory diseases, diabetes, and early diagnosis of cancer.

i. Early detection for NCDs is an HIV integration priority. Applicants are encouraged to integrate early detection for NCDs as part of integrated packages delivered within HIV platforms as an integration priority aligned with WHO consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach.[2]

ii. Primary and secondary prevention of NCDs: Applicants are encouraged to provide behavioral advice and support as a part of integrated packages delivered within HIV platforms, addressing modifiable disease risk factors including blood pressure, smoking, obesity, unhealthy diet and lack of physical activity, as recommended by the WHO guidance.[2]

iii. Treatment: Integration of nationally available and procured treatment within HIV service delivery platforms is supported by the Global Fund. Where there is a strong investment case to address gaps in NCD management for people living with HIV, it will be considered on a case-by-case basis. Applicants are encouraged to align NCD follow-up visits with those for HIV care and integrate multimonth dispensing of NCD medicines with ART.

[21] Palefsky J et al (2022). *Treatment of anal high-grade squamous intraepithelial lesions to prevent anal cancer.* Conference on Retroviruses and Opportunistic Infections, abstract 106LB, 2022
[22] Goldstone SE, Enyinna CS, Davis TW (2009). Detection of oncogenic human papillomavirus and other predictors of anal high-grade dysplasia in men who have sex with men with abnormal cytology. Dis Colon Rectum. 2009 Jan;52(1):31-9. doi: 10.1007/DCR.0b013e31819736aa. PMID: 19273953.
[23] UNAIDS (2021). Data 2021. https://www.unaids.org/en/resources/documents/2021/2021_unaids_data
[24] WHO (2020). WHO package of essential noncommunicable (PEN) disease interventions for primary health care. https://www.who.int/publications/i/item/who-package-of-essential-noncommunicable-(pen)-disease-interventions-for-primary-health-care

Priority 6: Mental health

It is estimated that 970 million people live with mental health conditions.[25] Mental health conditions are disproportionately common among key populations and people living with HIV. Some mental health conditions are associated with increased risk of HIV and are sometimes associated with increased AIDS-related mortality.[2] Mental health conditions can delay access to and outcomes of HIV prevention, testing and linkage to care, and reduce adherence to and retention in HIV treatment and care. At the same time, treatment for depression can improve HIV prevention, treatment adherence and outcomes, especially when combined with adherence skills training.[26]

Mental health is an HIV integration priority that should be built in across HIV platforms. Applicants are encouraged to consider integrateing context-specific interventions/services in all their diversity, which may include screening, diagnosis and treatment for mental, various neurological or substance use conditions.[2, 27]

Applicants are encouraged to integrate multimonth dispensing of ART and medicines to treat mental health conditions, where possible also integrating mental health treatment and follow-up appointments with those for HIV services. For those conditions that cannot be managed in primary care, referral and linkages to higher levels of care is supported, although the provision of this specialist care will be considered on a case-by-case basis. For more information, refer to the RSSH Information Note.

Applicants are encouraged to align investments in mental health and psychosocial support. Psychosocial support should also be provided to improve outcomes across the prevention, testing and treatment cascades. Although this may be provided by the same practitioners managing mental health conditions, the aim and nature of the support offered is different: to support individuals at risk for HIV remain HIV-negative, to address stigma and to improve ART retention and adherence.

Priority 7: Coronavirus disease and other emerging pandemics

The COVID-19 pandemic continues to impact access to and uptake of HIV services in some countries and resulted in declines in HIV prevention and testing services while 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.

The scope of investments in COVID-19 is outlined in the C19RM Information Note: Mitigation of COVID-19 Effects on HIV, TB and Malaria Services and Programs (2021). The highest priority is protecting access to and uptake of essential HIV services and to maintain or strengthen interventions to remove human rights- and gender-related barriers to accessing

[25] World Health Organization (2022). *Mental disorders.* https://www.who.int/news-room/fact-sheets/detail/mental-disorders
[26] Bigna JJ, Tounouga DN, Kenne AM, et al. (2019). Epidemiology of depressive disorders in people living with HIV in Africa: a systematic review and meta-analysis: burden of depression in HIV in Africa. Gen Hosp Psychiatry.57:13–22.
[27] World Health Organization (2022). Integration of Mental Health and HIV Interventions: Key Considerations. https://www.who.int/publications/i/item/9789240043176

HIV services. Further guidance on funding related to COVID-19 and interventions that mitigate the impact of COVID-19 on HIV, TB and malaria services, is available on the Global Fund's website.

On 10 June 2022, WHO released new guidelines on Clinical Management and Infection Prevention and Control for Monkeypox (Mpox).[28] Global Fund financing can be used to fund activities and interventions that prevent, detect and/or respond to mpox outbreaks in Global Fund-eligible countries. Please refer to the Technical Brief on Global Fund Support to Prevent, Detect and Respond to Mpox for further details.

[28] The World Health Organization (2022). Clinical management and infection prevention and control for monkeypox: Interim rapid response guidance. https://www.who.int/publications/i/item/WHO-MPX-Clinical-and-IPC-2022.1

3. Country Examples

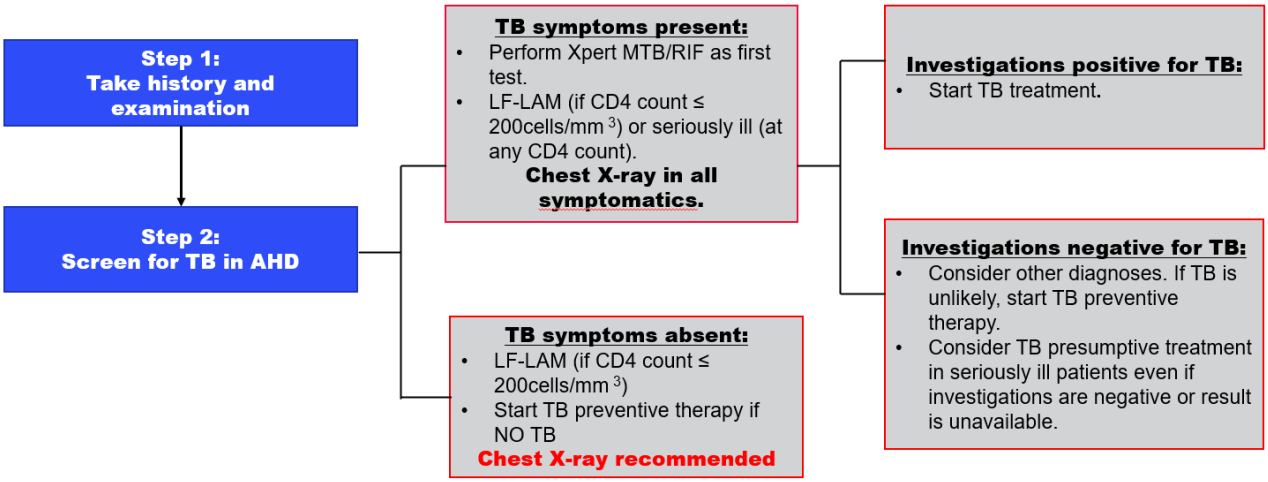
Zambia

Expanding access to and uptake of the advanced HIV disease package of care

Zambia's national HIV strategy (2017-2021) aims to reduce HIV mortality by 75%. With programmatic results in 2021-2022 of 18,000 annual deaths compared the target of less than 5,000, the national program identified gaps in ART retention rates, advance HIV disease (AHD) services, TB case identification and provision of TPT among the main barriers. In Zambia in 2016 approximately 17.7% of people newly diagnosed with HIV and aged 15-59 years had a CD4 count of less than 200 cell/mm^2. It is estimated that 5,000 cryptococcal meningitis cases present annually in Zambia and that approximately 13,000 TB/HIV mortalities are due to AHD.[29]

Zambia adopted the WHO AHD recommendations in 2019 and expanded the WHO-defined package for adults, adolescents and children older than five years. The national program strategy designed clear guidelines and standard operating procedures that included screening and treatment pathways.

Figure 2. Snapshot of AHD pathway and TB diagnosis in Zambia



Zambia added the CXR screening in all AHD cases.

[29] Ministry of Health Zambia (2021). Guidelines For Management Of Advanced HIV Disease In Zambia. https://www.moh.gov.zm/wp-content/uploads/filebase/guidelines/Guidelines-for-Management-of-Advanced-HIV-Disease-in-Zambia.pdf

Furthermore, the program formed a technical working group and adopted a dashboard to monitor the implementation of the AHD package implementation in the country. The program also established centers of excellence in a hub-spoke model, and used mentorship and AHD differentiated service delivery models to support expansion of the package. The pilot sites reached 1,169 people living with HIV as of August 2022, of which 896 patients were diagnosed with AHD. Lessons learned include: (1) using a hub and spoke model to scale up AHD management and (2) ensuring CD4 availability in high-volume sites.

Rwanda

Leveraging HIV investments to catalyze hepatitis integration

Rwanda's viral hepatitis program started in 2011 with a national assessment to understand the burden of hepatitis in Rwanda. Prioritizing the screening of high-risk populations – beginning with people living with HIV, followed by prisoners, healthcare workers, pregnant women and later the general population – Rwanda estimated a national HCV prevalence of 4%. Understanding the HCV burden among people living with HIV paved the way for Rwanda to successfully advocate for Global Fund investments to procure HCV antibody rapid tests and confirmatory viral load diagnostics, as well as Direct Acting Antivirals for HCV-co-infected people living with HIV.

The integration of Rwanda's viral hepatitis program within its robust HIV program, supported by Global Fund, and the adoption of a simplified public health approach to HCV testing and treatment, facilitated the decentralization and task sharing of HCV services, utilizing trained health providers from within the HIV program. Similarly, the viral hepatitis program utilized the HIV diagnostics infrastructure for sample transportation and laboratory functions.

This momentum led to a political commitment of Rwanda in 2018 to eliminate HCV within five years. This commitment combined with the already-established integration of the program within HIV, enabled the government to negotiate the lowest-ever price for WHO Pre-Qualified Direct Acting Antivirals at US$ 60 per person course. In addition, through pooling of volumes, Rwanda secured a 60% reduction in the price of viral load cartridges for both HIV and HCV viral load tests.

The catalytic impact of Global Fund investments contributed to Rwanda's success in micro-eliminating HCV among people living with HIV in 2019. To date, all people living with HIV have benefited and continue to benefit from continuous screening of HBV and HCV. The program continues to leverage Global Fund support to procure diagnostic and treatment commodities which has contributed to the screening of over 6 million Rwandans and treatment of over 60,000 patients.

As Rwanda approaches HCV elimination, further effort and resources are needed to prepare for WHO elimination validation and scoping for the elimination of HBV, focusing on HBV vertical transmission as part of an integrated approach for triple elimination of HIV, syphilis and HBV.

Sub-Saharan African countries

Co-financing integrated cervical cancer screening and treatment into HIV care settings for women living with HIV through Go Further partnership[30]

The Go Further public-private partnership is an example of innovative co-financing of a COIM priority through Global Fund partners, a key consideration for prioritization as described in section 2 of this guidance note.

A partnership between the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), the George W. Bush Institute, UNAIDS, Merck and Roche, Go Further aims to reduce new cervical cancer cases by 95% among women living with HIV in sub-Saharan African countries with high rates of HIV and cervical cancer. Women living with HIV are six times more likely to develop cervical cancer at a younger age, experience its more rapid progression to invasive cervical cancer and recurrence even after the treatment than women without HIV.[31]

In 12 sub-Saharan African countries with the highest HIV burden globally (Botswana, Eswatini, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Tanzania, Uganda, Zambia, Zimbabwe), Go Further has been supporting the integration and scaling up of secondary cervical cancer prevention. This has been done in HIV care settings through cervical cancer/HPV screening, diagnosis and treatment among women living with HIV, including by transitioning from older (visual inspection with acetic acid [VIA] for cervical cancer screening and cryotherapy for precancerous lesions) to newer and better performing WHO-recommended screening and treatment technologies (HPV DNA testing for cervical cancer screening using both provider- and self-collected cervical samples and thermal ablation for precancerous lesions).

Go Further partners with governments, policy makers, program implementers, service providers, communities, including women living with HIV, and the pharmaceutical industry to provide a comprehensive approach to cervical cancer control, with each partner bringing unique areas of expertise to strengthen the collaborative efforts.

With PEPFAR funding and technical support, nearly 4.5 million screenings for cervical cancer have been completed over the last four years in the 12 high-burden countries. Over 3.7 million women living with HIV (82% of all the women living with HIV screened) have been screened for cervical cancer for the first time. Nearly 170,000 women living with HIV with precancerous lesions have received cervical cancer treatment, and all those with suspicious invasive cervical cancer were referred to secondary or tertiary cancer care. Over the last

[30] This example of integrated cervical cancer screening and treatment in HIV settings for women living with HIV in sub-Saharan Africa is funded through Go Further, PEPFAR, UNAIDS, Merck and Roche partnership (and not through Global Fund grant funding).
[31] Cervical cancer. Key facts. World Health organization, 2022. https://www.who.int/news-room/fact-sheets/detail/cervical-cancer#:~:text=Of%20the%20estimated%20342%20000,attributable%20to%20HIV%20(2)

four years, the percentage of precancerous lesions treated has increased (up to over 60% in 2022), getting closer to the global 90% treatment target for cervical cancer elimination.[32]

Uganda

Co-financing innovative context-specific group support psychotherapy for depression that improves HIV viral suppression among people living with HIV[33]

Group Support Psychotherapy (GSP) for depression is a context-specific tailored approach to addressing the mental health treatment gap at scale, given its remarkable cost-effectiveness, efficacy and high deployment speed.

SEEK-GSP which stands for Social, Emotional, and Economic empowerment through Knowledge of GSP[34] is an innovative mental health program that trains lay health workers to recognize and respond to depression by delivering group support psychotherapy. GSP treats depression by enhancing emotional and social support networks, the ability to practice positive coping skills, and income-generating skills. 99% of treated individuals are free from depression after 6 to 24 months of treatment. A great advantage of GSP is that it does not require ongoing input from expert mental health practitioners; instead, existing primary healthcare workers in rural health centers have been trained to deliver GSP sessions. In turn, they have been able to train lay health workers, who identify individuals with depression and treat them in the villages with GSP –in this way SEEK-GSP empowers local communities to take control of their own mental health needs.

This reduction in depression increased self-reported ≥ 95% ART adherence by 22% among GSP recipients compared to only 7% in the control group.[34] Nakimuli-Mpungu etal (2022) hypothesized that GSP may lead to a sustained greater reduction in depression when compared with group HIV education (GHE), which would lead to improved ART adherence and viral suppression.

[32] Go Further (2022). Program-Wide Highlights. https://gwbcenter.imgix.net/Publications/Resources/Go_Further_Highlights/July2022/GoFurther_GlobalHighlights_FY22Q2_18_JULY_2022.pdf

[33] This co-financing project was not funded by the Global Fund, per the publication the SEEK-GSP study is funded by Grand Challenges Canada (grant no. 0770-05) and the MQ Mental Health Fellowship Award (grant no. MQ15FIP100024).

[34] Nakimuli-Mpungu, Etheldreda PhD; Smith, Colin M. MD; Wamala, Kizito MSc; Okello, James PhD; Birungi, Josephine MPH; Etukoit, Micheal MPH; Mojtabai, Ramin PhD; Nachega, Jean B. PhD; Harari, Ofir PhD; Musisi, Seggane FRCP (C); Mills, Edward J. PhD. Long-Term Effect of Group Support Psychotherapy on Depression and HIV Treatment Outcomes: Secondary Analysis of a Cluster Randomized Trial in Uganda. Psychosomatic Medicine 84(8):p 914-923, October 2022. | DOI: 10.1097/PSY.0000000000001128

Abbreviations and Acronyms

AHD	Advanced HIV disease
ART	Antiretroviral therapy
COIM	Co-infections and co-morbidities
COVID-19	Coronavirus disease
GSP	Group Support Psychotherapy
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HPV	Human Papillomavirus
NCD	Non-communicable disease
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
RSSH	Resilient and sustainable systems for health
TB	Tuberculosis
TPT	TB preventive treatment