Grant Cycle 8 (GC8)
Prioritization Guidance: Tuberculosis

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Context & purpose of this GC8 guidance

The Global Fund Partnership is committed to its mission of advancing the end of HIV, TB and malaria as health threats while investing in resilient systems that improve health outcomes. Within a context of constrained financing, this requires optimizing the use of *all* available resources through rigorous programmatic prioritization.

With countries and communities in the lead, success requires a relentless focus on efficiency and effectiveness, on making tough trade-offs in the face of inescapable funding gaps, on tackling barriers to accessing life-saving services for those most at risk, and on acting at pace to innovate and adapt.

This prioritization guidance serves to equip national stakeholders in determining additive, high impact Global Fund investments in national responses.

*The six (6) **Strategic Shifts** for GC8, shared with the Board in February 2026. This guidance reinforces <u>all</u> shifts, with an emphasis on 3, 4 and 5*

What are some of the changes in the guidance?

Increased focus on prioritization. With constrained global health resourcing, this guidance was developed with technical partners to equip stakeholders in determining additive, prioritized investment from the Global Fund. This was further streamlined in line with the Strategic Shifts.

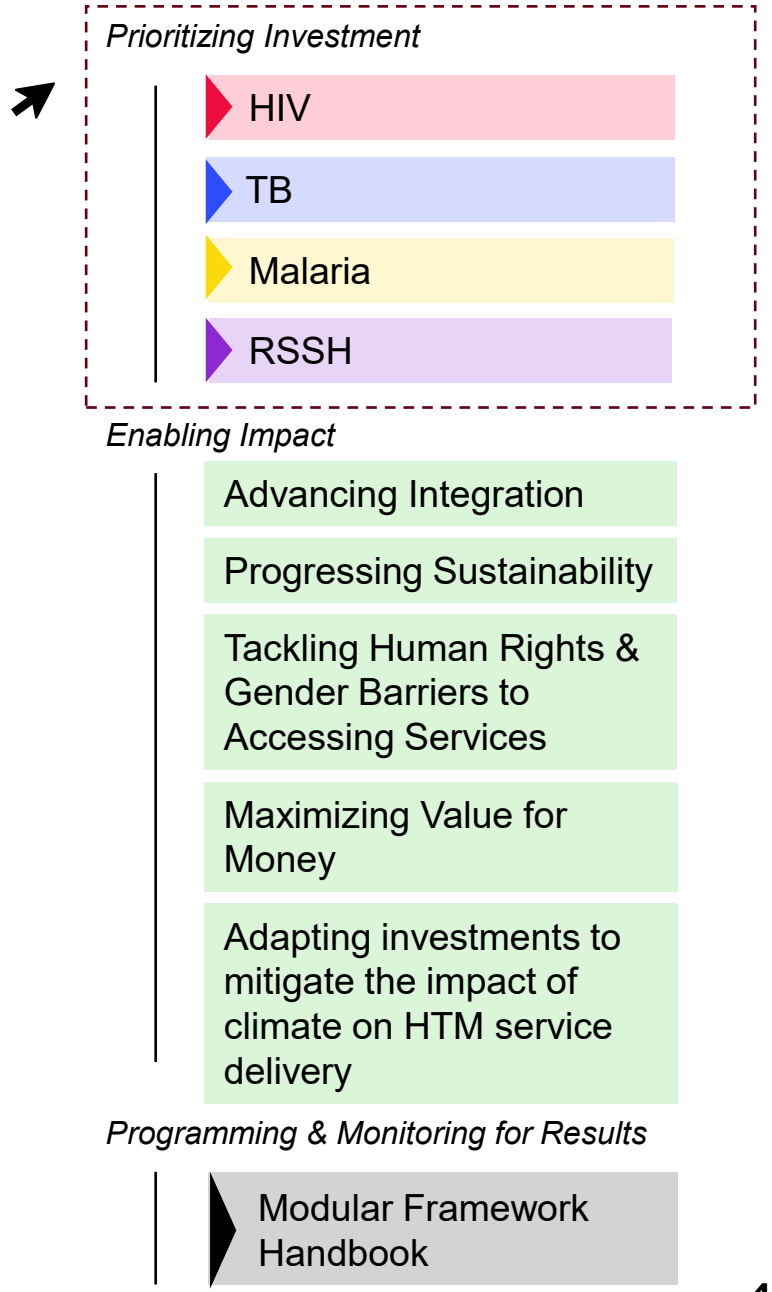
Reduced complexity. Stakeholders have repeatedly requested more concise materials, including slide decks to summarize key points in CCM meetings and cascade to diverse audiences during country dialogue.

Decreased duplication within existing materials. The Modular Framework Handbook includes eligible modules, interventions and activity descriptions. As requested by stakeholders, this guidance includes further information on how to prioritize in GC8.

Recognized maturity of national responses. With decades of experience across most countries & communities and readily available technical and normative guidance, the reconfiguration of GC8 investment guidance is in step with most countries' self-reliance and leadership.

How to use this guidance

- This Prioritization Guidance is based on **evidence-based normative and technical guidance** from across the partnership and includes relevant references.
- The guidance informs **country-led decision-making** on how to maximize the impact of Global Fund resources, used together with National Strategic Plans to ensure alignment with overall spending plans, including domestic resourcing and external funding from other sources.
- The guidance **complements** the Global Fund's Modular Framework Handbook, which describes the interventions eligible for Global Fund investments, and a separate cross-cutting guidance on "Enabling Impact".
- Each section of this guidance (HIV, TB, Malaria, RSSH), **lays out overall priorities for GC8** (expanded for HIV and TB as Program Essentials), and suggests the prioritization approach and considerations for each intervention, including higher priority activities, potential optimization and efficiency opportunities, and (in some cases) lower priority activities which may no longer be necessary.
- This document will be updated as necessary to reflect innovations and change in technical guidance.



Definitions: Key Populations and Key and Vulnerable Populations

For **HIV**, Key Populations (KP) are defined by UNAIDS as those particularly vulnerable to HIV and frequently lack adequate access to services. These five groups are gay men and other men who have sex with men, sex workers, transgender people, people who inject drugs and prisoners and other incarcerated people (definition). Key and Vulnerable Populations (KVP) include KP, adolescent girls and young women (AGYW) and other vulnerable populations (OVP) at risk.

For **TB**, KVP are defined by Stop TB Partnership as populations at high risk and people in vulnerable situations (definition).

For **malaria**, WHO defines populations vulnerable to malaria as those at increased risk of infection and severe disease, particularly children under five, pregnant women and girls, people with immunocompromising conditions such as HIV, non-immune populations such as travelers, mobile populations, and populations with limited access to prevention and treatment services including in humanitarian settings; vulnerable groups vary by context.

Limited financial resources and the setback caused by the COVID-19 epidemic leave the world off track to reach the Sustainable Development Goal 3 (SDG 3) target of ending TB by 2030.

However, the strong political leadership and the ongoing rollout and scale-up of innovations bring momentum to the start of GC8.

Prioritization of the highest impact interventions while working together with governments, civil society, the private sector, and community-based organizations will collectively advance the end of TB as a public health threat.

- ✓ **Outlines** areas of investment that are high priority and those that the Global Fund is unlikely to fund or that require strong justification from countries.
- ✓ **Emphasizes** how to optimize investments and drive cost effectiveness to maximize results.
- ✓ **Reinforces** that Global Fund investments should focus on evidence-based interventions and approaches recommended by TB technical partners that are critical for impact.

Program Essentials* provide a framework for prioritizing context specific interventions

Screening & Diagnosis

- Provide systematic TB screening for those at highest risk.
- Achieve universal use of WHO-recommended rapid molecular tests as the initial test for TB.
- Test all people with bacteriologically confirmed TB for at least rifampicin resistance.
- Improve efficiency through optimized TB screening and diagnostic network.

Prevention

- Ensure availability of TB preventive treatment for all eligible people living with HIV & children under 5 years who are household contacts of people with bacteriologically confirmed pulmonary TB.

Treatment & Care

- Use child-friendly formulations and a 4-month regimen for children with non-severe forms of TB.
- Prioritize shorter, all oral regimens for people with DR-TB, with BPaLM as the treatment of choice for eligible patients.

TB/HIV

- Start all people living with HIV with TB disease on antiretroviral treatment early
- Concurrently use LC-aNAAT and LF-LAM tests for the diagnosis of TB disease among people living with HIV.

Cross Cutting

- Use data-driven decision-making, enabled by the rapid generation, analysis and use of high-quality data.

Cross Cutting

- Introduce and scale new, cost-saving innovations such as the near point-of-care molecular TB tests, use of tongue swabs and sputum sample pooling.
- Integrate TB in primary health care services and within the broader health systems.
- Engage private health care providers on a scale commensurate with their role in the health care system.
- Provide decentralized, ambulatory, community-based and–led, people-centered services.
- Use analyses of disparities in accessing TB services and include stigma and discrimination reduction for those living with TB; legal literacy & access to justice; community mobilization and monitoring for and by people with TB and TB-affected populations to promote people-centered health outcomes.

*Program essentials are derived from normative guidance and are considered critical to accelerate the TB response to meet the Global Fund strategy and End TB targets.
See WHO guidelines for further expansions and details.

Prioritization approach & considerations

Interventions	Prioritization considerations
TB screening and diagnosis *and* DR-TB diagnosis / drug susceptibility testing (DST)	**Areas prioritized for GF investment** • Adopt **sensitive & efficient TB screening & diagnostic tools and algorithms**, including chest x-ray for TB screening, computer-aided detection (CAD) for x-ray reading, molecular WHO-recommended rapid diagnostic test (mWRD) as initial test for TB diagnosis. • Introduce and scale cost-saving innovations like the n**ear point-of-care (NPOC) tests, use of tongue swab**s **& sputum sample pooling.** • Integrate TB into basic health care packages and systems. **Include TB services within primary health care,** including screening for TB as a part of antenatal care. • Implement **targeted active case finding** focused on KVP, and in geographical locations with high TB burden. • Strengthen diagnosis of **TB in children & adolescents**. Support diagnosis with access to non-sputum-based samples & chest X-ray. • Address gaps that limit access to and use of **diagnostic services,** including functional equipment, adequate supplies and trained human resources; biosafety and quality assurance; optimized equipment placement to balance access and utilization; sample referral system; and connectivity solutions for test reports. • Promote decentralized diagnostic networks, **integrated sample transportation** and use of **multiplex diagnostic platforms** for multiple diseases (e.g., TB, HIV, Hepatitis). • Ensure rapid **drug-susceptibility testing** (DST) for people diagnosed with TB to guide proper treatment. • Strengthen linkages between diagnosis and treatment to **minimize pre-treatment loss-to-follow-up.** **Opportunities to increase optimization & efficiency** • Map and target high-risk groups and geographic areas with high TB incidence **("hotspots") for active case finding**. In addition to notification data, use other data such as the vulnerability index, demographic and health surveys and tools developed by partners. • **Integrate** active case finding and other community-based activities with HIV, malaria and non-communicable disease services as appropriate; link TB screening and diagnosis algorithm with contact screening and TB preventive treatment (TPT) initiation; integrate TB sample transport with other programs; and use remunerated polyvalent community health workers. • **Monitor cost and performance data** across screening and **case-finding strategies** to guide selection of the most cost-effective interventions. Adapt high-cost or low-yield approaches by testing alternative models that improve targeting or reduce resource needs. **Activities of lower priority (context dependent)** • Limit the use of **sputum microscopy for treatment monitoring only**, using mRDs for the diagnosis of TB. • **Deprioritize untargeted active case finding** and mass chest camps among the general population. • Deprioritize mass media campaigns and high-profile, high-cost events or forums.

Prioritization approach & considerations

Interventions	Prioritization considerations
TB treatment, care and support *and* DR-TB treatment, care and support	**Areas prioritized for GF investment** • Prioritize the standard six-month regimen (2HRZE/4HR) for **drug-susceptible TB (DS-TB)** given its lower cost and pill burden compared with 2HPMZ/2HPM. • Prioritize the four-month regimen (2HRZ(E)/2HR) **for children with non-severe DS-TB**, using pediatric formulations and fixed-dose combination tablets. • **For DR-TB patients,** prioritize the all-oral shorter regimens with BPaLM as the treatment of choice, using the BDLLfxC regimen for patients not eligible for BPaLM. • **Offer decentralized ambulatory DR-TB** services by ensuring laboratory services (through sample transport if needed), second-line medicines, and clinical capacity are accessible close to patients. • Address **barriers to access TB services** to support treatment uptake and adherence, particularly among DR-TB patients, including human rights, stigma and gender-related barriers. • Implement **active TB drug-safety monitoring and management (aDSM)** for people on DR-TB treatment. **Opportunities to increase optimization & efficiency** • Consider **digital tools** like digital adherence technologies, call centers, and mobile applications to support treatment adherence where appropriate. Also, for counseling and adverse-event reporting, prioritizing DR-TB patients. • Advocate and mobilize resources to provide financial, transportation and nutritional support for people with TB and their families, through government **social protection scheme**s and corporate social responsibility programs. • **Integrate** management of common **co-existing conditions and co-morbidities**. **Activities of lower priority (context dependent)** • Limit the use of the **four-month DS-TB regimen (2HPMZ/2HPM**) to specific populations where programmatic needs justify the additional costs compared with the standard six-month regimen. • Use the **nine-month all-oral DR-TB regimens (BLMZ, BLLfxCZ, BDLLfxZ)** only when six-month regimens are not suitable, recognizing their lower priority compared to the shorter treatment options. • **Limit use of injection-based regimens** for DR-TB for patients with complex resistance profiles requiring such treatment.

Prioritization approach & considerations

Interventions	Prioritization considerations
Screening/testing for TB infection *and* Preventive treatment *and* Infection Prevention Control (IPC)	**Areas prioritized for GF investment** • Deliver TB preventive treatment (TPT) as a **routine component** of TB services. **Integrate TPT** into contact investigation and embed it within active case finding by aligning TB diagnostic algorithms with TPT initiation. • **Prioritize TPT for the highest-risk groups** in resource-constrained settings, including children under 5 years who are household contacts of TB patients and all PLHIV. Initiate TPT in these groups without TB infection testing. • Prioritize the use of **shorter TPT regimens** - 3HP, 1HP, 3HR, and 6Lfx for DR-TB, over 6H or 9H regimens. • Address **provider hesitancy** to prescribe TPT and the **acceptability of TPT**. Engage community-led organizations to raise awareness, demand and support for treatment completion. • Develop and implement **airborne infection prevention and control (IPC**) measures across all levels of the health systems and in community settings, including measures to **protect health care workers, community health workers and patients.** • Prepare for the introduction and roll-out of a **new TB vaccine** - linkage with immunization programs, assessing feasibility and acceptability, forecasting demand, strengthening regulatory and policy readiness. • Use **antigen-based skin tests** for TB infection testing when indicated. **Opportunities to increase optimization & efficiency** • **Integrate TPT delivery** with active case finding and routine TB services to maximize efficiency and coverage. • **Embed airborne TB IPC** in health facilities within the broader facility- and system-wide IPC approach. • Consider other groups for TPT based on epidemiological context and available resources. **Activities of lower priority (context dependent)** • Limit use of TB infection testing among **adolescent and adult household contacts**; in high-TB-burden settings with ongoing transmission, it is of lower priority. • **Deprioritize interferon-gamma release assays** and **tuberculin skin tests.**

Prioritization approach & considerations

Interventions	Prioritization considerations
TB/HIV - Collaborative interventions *and* TB/HIV - Screening, testing and diagnosis *and* TB/HIV - Treatment and care *and* TB/HIV - Prevention *(includes TB/HIV Program Essentials)*	**Areas prioritized for GF investment** • Offer provider-initiated **HIV testing** and counselling to all people with TB and presumptive TB, and ensure early initiation of **antiretroviral therapy, cotrimoxazole and TB treatmen**t for those with TB/HIV co-infection through well-coordinated or integrated service delivery. • **Screen people living with HIV for TB** at every health-care contact, integrate TB screening into differentiated service delivery models. • Use molecular WHO-recommended rapid diagnostic test (mWRD) as the initial test for TB diagnosis. (e.g., GeneXpert, TrueNat, LF-LAM,NPOC). • Provide **TPT to all eligible people living with HIV** without requiring TB infection testing, preferentially using shorter TPT regimens. • **Integrate TPT** into differentiated HIV service delivery models to reduce patient burden and improve retention, including through multi-month ART dispensing, community adherence groups and related approaches. • **Strengthen TB/HIV collaboration** through integrated service delivery, joint planning, implementation, supervision and monitoring. Leverage multi-disease diagnostic platforms and integrate sample transportation. **Opportunities to increase optimization & efficiency** • Integrate TB, HIV and other services. • Consider the use of concurrent low-complexity automated nucleic acid amplification testing (LC-aNAAT) and lateral flow urine lipoarabinomannan (LF-LAM) assays for early TB diagnosis among people living with HIV, in line with WHO recommendations. • Prioritize people with advanced HIV disease where concurrent testing cannot be provided to all. **Activities of lower priority (context dependent)** • Limit use of C-reactive protein for TB screening.

Prioritization approach & considerations

Interventions	Prioritization considerations
Private provider engagement in TB/DR-TB care *and* Linkage to social protection for KVP affected by TB *and* Collaboration with other programs/sectors	**Areas prioritized for GF investment** • Engage private providers based on an assessment of their size and role in providing TB services. **Prioritize** those most likely to **contribute to TB case notification** and treatment success. • Implement **differentiated models of engagement** based on the type of private provider and the services they offer. Leverage intermediary agencies where suitable, **apply innovative approaches** such as contracting, outsourcing and performance-based payments. • Support high-volume **private facilities to offer mWRD testing,** while making provision for certain private providers to **access TB medicines** through the NTP so patients can remain in care. • Strengthen and **incentivize shifting TB data reporting from private providers** to the NTP and **reduce reporting burden** through interoperable systems and the use of digital tools, • Strengthen the capacity of relevant national authorities to **regulate, engage and monitor the quality** of TB services through legislation, regulatory frameworks, and accreditation of private health facilities. • Strengthen collaboration between TB and other health programs to support **integrated service delivery and referral linkages for co-infection and co-morbidities management**, including undernutrition, HIV, diabetes, mental health disorders, tobacco use, and substance use disorders. **Opportunities to increase optimization & efficiency** • Advocate for and collaborate with relevant ministries and agencies to i**nclude TB services and patient support within national health insurance and social protection schemes**, prioritizing the most vulnerable populations. • Engage high-risk occupational sectors such as mining and construction, to **implement workplace TB programs** that include awareness generation, onsite TB services and policies that ensure paid medical leave and protect employees at risk of TB from discrimination. **Activities of lower priority (context dependent)** • **Avoid large per-patient financial incentives** to health care providers (public or private) for TB diagnosis and treatment outcomes, as these are not sustainable.

Prioritization approach & considerations

Interventions	Prioritization considerations
Community-based TB/DR-TB care	**Areas prioritized for GF investment** • Facilitate meaningful participation and engagement of TB communities in national and sub-national TB responses, PPR and PHC governance; and prioritize structured feedback from TB survivors and key population networks. • Support community-based and community-led service delivery: TB screening and demand creation; access to diagnosis (referrals and sample transport); treatment adherence support through peers or CHWs; ensuring TB literacy; providing psychosocial support; reducing stigma of a positive TB diagnosis; prevention and rehabilitation. • Conduct organizational assessments, including Community Pulse, to identify capacity gaps and develop targeted capacity-building plans. Strengthen governance of emerging TB survivor networks and build capacity of established networks in monitoring and evaluation, resource mobilization and advocacy. • Sustain CLM as a core accountability mechanism generating actionable data on availability, accessibility, acceptability, and quality of TB services, including tracking stigma & discrimination for those infected by TB; confidentiality breaches, unlawful user fees, and TB-related exclusion from work or education. Prioritize investments in the full data cycle — collection, management, analysis, reporting, sharing, and advocacy — and ensure findings drive service improvements and outcome monitoring. Where feasible, integrate CLM across disease areas and RSSH to maximize efficiency and impact of CLM investments. • Invest in mechanisms enabling contracting or purchasing of services from TB networks and community organizations by the government or the private sector to improve financial sustainability and continuity of community TB responses. **Activities of lower priority (context dependent)** • Strengthen collaboration and coordination to support learning and exchange of best practices through existing platforms and mechanisms, improving efficiency and long-term sustainability. • Use of community-led research as a primary investment area for identifying best practices and service delivery gaps, including participatory research design and dissemination, is a lower priority, except where it is clearly justified and linked to programmatic decision-making.

Prioritization approach & considerations

Interventions	Prioritization considerations
KVP - Children and adolescents *and* KVP - People in prisons/jails/detention centers *and* KVP - Others	**Areas prioritized for GF investment** • Use available data and community-generated evidence to understand the specific TB burden, barriers and service gaps facing KVP and develop tailored policies and action plans in partnership with affected communities. • Remove barriers to TB services for KVP through targeted screening and diagnosis using mobile outreach and community-based or community-led approaches; improve privacy and safety in TB facilities, offer flexible hours, and employ outreach services to reach higher-risk populations, including men in high-risk occupation settings. Link patients to social protection (food, financial support, transport, labor protection) and address legal barriers to accessing testing, treatment and care services, including legal services. • Ensure comprehensive TB services in prisons and other closed settings: entry and periodic screening (preferably chest X-ray with AI/CAD), diagnosis and treatment equivalent to community standards. Strengthen care linkage during transfers and upon release, focus on reducing pre-trial detention to address overcrowding and reduce the risk of TB transmission. • Apply tailored approaches for refugees, migrants, and internally displaced populations, including cross-border policies and service continuity arrangements. Work with humanitarian partners in complex emergency, fragile and conflict-affected settings. To facilitate continuity of health services. • Provide integrated psychosocial, transport, and nutritional support for KVP — including people in prisons, migrants, pregnant and lactating women, children and people with DR-TB — to support access, adherence and continuity of care. • Deploy innovations in TB screening, diagnosis, treatment, digital adherence support and mobile outreach targeted to the needs of underserved KVP groups.

Prioritization approach & considerations

Interventions	Prioritization considerations
Cross-cutting	**Areas prioritized for GF investment** • Address TB-related stigma and discrimination using stigma-measurement tools and training on patient health rights for health workers, community health workers, employers, law enforcement, journalists, and community and religious leaders. Include mental health support, engage people with TB throughout and track progress through community-led monitoring. • Ensure people-centered TB services by training health workers on non-discrimination, TB vulnerabilities among women and at-risk groups, informed consent, confidentiality and privacy. Sustain through supportive supervision and accountability mechanisms. • Provide peer-led, community-based legal and paralegal support and information on TB-related rights, particularly for groups at risk of exclusion, involuntary isolation or denial of TB services. • Work to remove legal, regulatory and policy barriers to TB services — including involuntary isolation policies — and expand access to social protection and TB-related disability benefits. Prioritize community-led approaches and engage judicial actors and parliamentarians to strengthen awareness and accountability. **Opportunities to increase optimization & efficiency** • Promote multi-sectoral coordination across relevant ministries and institutions to strengthen complementarity and accountability in TB service delivery, and build capacity among TB providers and community health workers to reduce discrimination and improve TB service responsiveness. **Activities of lower priority (context dependent)** • Limit standalone training on human rights and gender-related barriers to TB services, except where it is part of targeted capacity-building for TB survivors and key TB-affected populations.

Prioritization approach & considerations

Prioritization considerations

Areas prioritized for GF investment

- Deploy a **real-time, digital case-based TB surveillance** or electronic medical record system, that can track individual TB cases across the care continuum and is interoperable with other systems. Strengthen existing routine aggregate data systems in parallel.
- **Disaggregate TB data** at least by age and sex, and by KVP groups where possible, to better understand disease burden and service delivery gaps and to inform differentiated responses.
- **Integrate** private-sector, community health services, and community-led monitoring and reporting in the TB information system.
- Build in-**country capacity and conduct** timely data generation, reporting and surveillance; targeted supportive supervision; programmatic and epidemiological reviews; **data analysis and use for prioritization and improvements** at all levels – national, sub-national and facility levels.

Opportunities to increase optimization & efficiency

- Transition from periodic drug-resistance surveys toward robust, **continuous drug-resistance surveillance** based on routine drug-susceptibility testing (DST).
- Rationalize the **frequency of repeat** surveys. Avoid overly frequent surveys or assessments (e.g., biannual KAP surveys) when quick changes are not expected and the results will not be used to inform programmatic decisions.
- Consider **conducting TB inventory studies**, including record-linkage exercises to directly measure under-reporting, only in countries that meet the standard pre-requisites and methodological assumptions for this approach.

Activities of lower priority (context dependent)

- **Deprioritize** TB prevalence surveys, household cost surveys, knowledge, attitudes and practices surveys, and operational research to only exceptional circumstances.
- **Use exceptional survey investments only where they leverage existing resources** through joint funding with domestic and/or other donor sources and demonstrate clear cost efficiency.

This guidance was developed with expertise and input across the technical partnership.

The prioritization recommendations draw from deep technical resources linked here as well *(non-exhaustive)*

1. World Health Organization (2026). WHO recommends near point-of-care tests, tongue swabs, and sputum pooling for TB diagnosis. https://www.who.int/news/item/09-03-2026-who-recommends-near-point-of-care-tests--tongue-swabs--and-sputum-pooling-for-tb-diagnosis
2. World Health Organization (2024). WHO consolidated guidelines on tuberculosis Module 1: prevention - tuberculosis preventive treatment, second edition. https://www.who.int/publications/i/item/9789240096196
3. WHO operational handbook on tuberculosis (2022). Module 2: Screening - Systematic screening for tuberculosis disease, https://www.who.int/publications/b/57554
4. World Health Organization (2025). WHO consolidated guidelines on tuberculosis. Module 3: diagnosis, https://iris.who.int/server/api/core/bitstreams/ae20e43e-17fd-4951-b475-3e36e166e7ae/content
5. World Health Organization (2022). WHO consolidated guidelines on tuberculosis. Module 4: treatment and care, https://www.who.int/publications/i/item/9789240048126
6. World Health Organization (2023). ScreenTB - a web-based tool to help countries prioritize action for TB screening, https://www.who.int/news/item/16-10-2023-screentb-help-countries-prioritize-action-for-tb-screening-and-prevention
7. Stop TB Partnership (2023). Tuberculosis KVP size estimation tool, https://www.stoptb.org/sites/default/files/imported/document/tb-kvp_population_size_estimation_tool-v3_002.pdf.
8. The Global Fund. TB Quarterly Update. https://www.theglobalfund.org/en/tuberculosis/tb-quarterly-update/
9. The Global Fund (2026). Grant Cyle 8 investment guidance. https://resources.theglobalfund.org/en/technical-guidance/