THE GLOBAL FUND

Resilient and Sustainable Systems for Health and Pandemic Response and Preparedness Information Note

Grant Cycle 8

Core Guidance

Date published: 15 December 2025

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Adapting GC8 to new realities on the path to self-reliance

The result of the Global Fund Eighth Replenishment, while still partial, reflects the increasingly challenging global health landscape that the partnership must now navigate. Whereas the Global Fund's unique model remains strong, it is clear that **the approach to Grant Cycle 8 (GC8) must evolve**. With less funding, the partnership will need to work smarter and collaborate even more effectively.

In GC8, most countries will receive reduced allocations. Those with higher economic capacity and lower disease burden will see a more significant reduction. However, all countries will need to make difficult but necessary decisions to selectively target investments to protect HIV, TB and malaria outcomes and sustain momentum, **and more rigorously use Global Fund investments** in a catalytic manner, in complementarity with domestic budgets and other funding.

The Global Fund will introduce significant changes and strategic shifts in GC8, including revamping its approach to co-financing, sharpening the focus on transition planning, supporting public financial management, integration, and other changes being discussed by its governance bodies. Country context will inform sustainability and transition pathways.

During this phase, countries can start preparing by planning how to:

- **Accelerate the path to self-reliance.** All countries will be expected to determine what changes are needed on the path to self-reliance and sustainability. Increasing domestic financing for health will be essential to advance sustainability progress across all portfolios. The Global Fund will continue to support to accelerate transitions from its investments effectively and responsibly with progressive take-up by governments, especially for human resources for health and commodities.
- **Rigorously prioritize investments and strengthen value for money.** Countries can expect a strong emphasis from the Global Fund on strategic prioritization of investments that advance equitable access to essential services for the most vulnerable populations and strengthen health and community systems. Optimization of investments and streamlined implementation arrangements to maximize value for money will be key. Community leadership and engagement will continue to be central to the partnership's approach.
- **Maximize health outcomes and sustainability through integration** of health systems and service delivery. Optimizing and sustaining HIV, TB and malaria outcomes requires integration to strengthen results, promote equitable access, and enhance efficiency and cost-effectiveness. This should be pursued based on countries' specific context and priorities. Other enablers include removal of barriers to human rights and gender equality, to reach most at-risk populations.
- **Consistently advance access to innovations.** Ensuring faster introduction and scale-up of innovations, whether in products, delivery platforms, or data systems, will be central to

achieving accelerated results across HIV, TB and malaria. But innovations must be integrated into people-centered service packages so those who can benefit the most can access them.

GC8 Information Notes: guiding prioritization

GC8 investment guidance more clearly outline areas of investment that are high priority and those the Global Fund is unlikely to fund or that require strong justification so countries can decide accordingly. The guidance emphasizes how to optimize investments and drive cost effectiveness to maximize results.

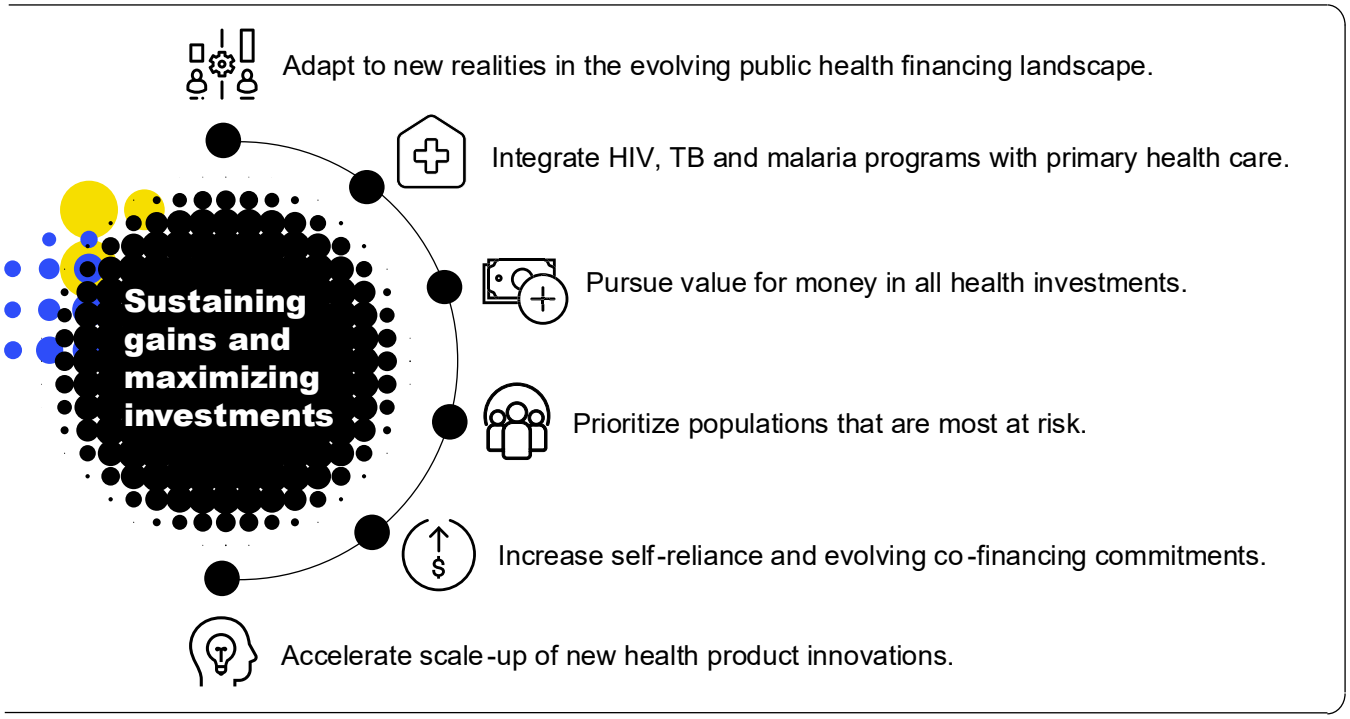
Countries should identify priorities for **integration of HIV, TB and malaria services** into primary health care and across health and community systems pillars. **Community, human rights and gender** considerations should be planned holistically and specific investments should enable equitable access to services.

Two other areas of attention include health product management for all essential medicines from all sources (including non-grant procurement) and **support for introduction and scale-up of innovations.**

Areas of focus to transition from Global Fund financing include: health worker remuneration, program management and maintenance and operating costs for equipment and infrastructure. Countries should **progressively use domestic financing for essential diagnostics and medicines** such as first-line treatment for HIV and TB, drugs for malaria in pregnancy and malaria rapid diagnostic tests.

What's new across all the investment guidance notes

GC8 strategic shifts: on the path to self-reliance



What's New in the RSSH-PPR Information Note for Grant Cycle 8

The RSSH-PPR GC8 information note contains the following new information:

- **There are ten areas of RSSH-PPR**, as per the GC8 Modular Framework Handbook. Investments are categorized into higher and lower priority areas, plus those that are out of scope. Optimization and efficiency considerations are also highlighted.
- **Focus on using data and evidence to drive prioritization, including use of maturity models** (forthcoming) to support prioritization decisions. A maturity model is a framework that enables countries to measure system maturity in a given area to identify key system gaps, facilitate national planning processes and prioritize funding accordingly. The Global Fund has worked with partners to develop maturity model assessment tools for Community Health Workers (CHWs), Laboratory Systems, Supply Chain Systems, Early Warning Surveillance and Response, and Community Responses and Systems Strengthening. Results from the WHO Global Digital Health Monitor and University of Oslo DHIS2 Maturity Profiles can guide investments in health information systems and digital health. See **here** for more information about the Global Fund's maturity models.
- **Focus on integration of HIV, TB and malaria services into primary health care, and integrated RSSH-PPR investments that support this**, including human resources for health, health product management, laboratory systems, health financing, public financial management and interoperable digital health information systems for all diseases, PHC and public health functions. Integration aims to improve accessibility, efficiency, effectiveness, and sustainability of HIV, TB and malaria services, and strengthen people-centered health services within the PHC system.[1] See the Global Fund's **Technical Brief on Integration** for more information.
- **Support stronger sustainability and value for money.** Strongly encourage countries to accelerate transition away from Global Fund support for human resources for health remuneration, including for CHWs, program management and maintenance, and operation costs for equipment and infrastructure, particularly in upper middle-income and lower middle-income countries. See the **Global Fund's Sustainability, Transition and Co-financing policy** for more information.
- **Improve strategies for community engagement** that address access barriers to interventions and enhance integration. Human rights and gender considerations have been added to the RSSH-PPR modules to encourage a more holistic systems approach to addressing these issues across disease programs.
- **Support pandemic preparedness and response** to maintain gains achieved under the COVID-19 Response Mechanism. Health and climate considerations included ensuring access to health services even when affected by extreme weather events. **Involve health security stakeholders with design and implementation** of RSSH-PPR investments to advance epidemic and pandemic preparedness and response.

- **Base investments in digital services and data systems on national digital strategies**, where possible. These should be developed in an integrated, holistic manner across disease-specific, PHC and health system strengthening domains. To ensure impact and efficiency, digital investments must also align with the country's national digital health (operational) roadmap, architecture, and maturity (e.g. the Global Digital Health Monitor). Where digital foundations such as policy, governance, infrastructure, or workforce are insufficient to support proposed digital activities across the funding request, countries are encouraged to consider support for these in their funding requests or other sources.
- **Leverage health system partnerships** including with Gavi, Global Financing Facility (GFF) and the World Bank, bi-laterals and other organizations. The Global Fund is part of the Lusaka agenda and is making robust efforts to establish stronger programmatic linkages and complementarity with Gavi, the Vaccine Alliance and the GFF. As part of country dialogue, countries can lead a joint review of the national funding landscape, including domestic resources, to identify opportunities for co-financing and advancing integrated approaches, for example, on CHW programs or to support more integrated data and surveillance systems.

Additional Considerations

Sustainability, transition and co-financing. The Global Fund's approach to sustainability emphasizes the capacity of health systems to maintain and scale up service coverage at levels sufficient to control public health threats of national and potentially global concern. It also supports countries to progress toward the long-term management and eventual elimination of the three diseases beyond reliance on Global Fund or other external financing. For further details, see the Global Fund's Sustainability, Transition and Co-Financing (STC) Policy and Sustainability, Transition and Co-Financing Guidance.

Challenging Operating Environments (COEs). In portfolios where the Global Fund's challenging operating environment policy can be applied, the Global Fund suggests that applicants consider a mix of humanitarian and systems strengthening investments that focus on building resilience when addressing responses to crises and/or emergencies. This will enable a continuum from emergency response to stronger and more sustainable systems for health.

Climate and health. RSSH investments directly and indirectly contribute to managing climate risks and increasing climate resilience of health systems under the current and future climate scenarios, including more robust supply chains, environmentally sustainable waste management and clean energy systems (including solarization), climate-informed health information and surveillance systems, and HRH. See the Technical Brief on Climate and Health.

Align RSSH digital investments in HRH, including CHWs, surveillance, health information and laboratory systems to strengthen digitalized disease surveillance and programmatic response monitoring systems.

Optimizing HIV, TB and Malaria outcomes: addressing human rights and gender-related barriers considerations

Effective HIV, TB and malaria responses rely on reaching the people who need it the most. Experience has long shown that specific programmatic approaches that effectively target different populations according to their needs considerably improve health outcomes.[2] Global Fund requirements on minimum standards are built into the Global Fund's Code of Conduct and grant agreements.

In addition, applicants are encouraged to design activities to consistently integrate these considerations and make HIV, TB and malaria services rights-based and gender-responsive. This requires targeted programmatic investments to reduce access barriers. This information note outlines cross-cutting areas of investment to prioritize. The Technical Brief on Reducing Human Rights and Gender-related Barriers to HIV, TB and Malaria Services provides further guidance on those specific to improving access to services for each of the three diseases.

Minimum standards and obligations include:

- **Safeguarding human rights standards** ensures the provision of people-centered services and prevents harm. These include: granting non-discriminatory access to services for all; employing only scientifically sound and approved medicines or medical practices; not employing methods that constitute torture or that are cruel, inhumane or degrading; respecting and protecting informed consent, confidentiality and the right to privacy concerning medical testing, treatment or health services rendered; and avoiding medical detention and involuntary isolation. All programming must also protect the safety and security of data, staff and clients.
- **Implementing protection from Sexual Exploitation, Abuse and Harassment (PSEAH).** Applicants should indicate in their funding requests how they are identifying and mitigating sexual exploitation, abuse and harassment risks to beneficiaries and service providers at facility and community levels to ensure that services are provided in a safe way. This is to prevent and respond to instances where service providers use their power to withhold the distribution or allocation of resources, such as treatment and prevention tools, and to demand sexual activities in exchange. Abuse or exploitation can also occur due to a lack of safeguards.

Integrating rights-based and gender-responsive approaches in HIV service delivery

- Availability of services is a first step. Access, uptake and retention in care require a focus on identifying and responding to specific barriers that are hindering equitable access for the most affected populations.
- Services need to be adapted to respond to the different needs and barriers experienced by women and girls, men and boys, trans and gender-diverse people.
- Services should be designed with and for the most affected and vulnerable populations, in a way that makes them rights-based, meaning available, accessible, acceptable and of good quality.

Specific Global Fund investment areas to prioritize as per the modular framework.

- Interventions such as training of health care workers against stigma and discrimination and strengthening mechanisms for accountability and redress, legal literacy, paralegal support and community-led monitoring of human rights violations.
- Tailored peer support interventions that support self-efficacy and autonomy for women and girls and health care-seeking behaviors for men and boys; and interventions to respond to gender-based violence and integrated post-rape care.

Health product considerations

This section guides program managers through key health product considerations for GC8, such as accelerating the introduction and scale-up of health products and unlocking budget efficiencies. See Global Fund Quality Assurance Policies, Guidelines on Health Product Procurement and Supply Management, GC8 Technical Brief on Procurement and Supply Management and other guidance.

During funding request development and grant-making, countries should assess opportunities to introduce and scale available health products in their contexts, and monitor market developments once the products become eligible for Global Fund procurement.

For all procurement channels, program managers should use: **reference pricing** from the Global Fund's Pooled Procurement Mechanism (PPM) for health products and associated services; monitor any market availability changes through the Global Fund's advice on lead times to enable procurement orders to be placed on time should lead times for some products be extended; **end customization** (labels, condoms) to support manufacturing efficiency and control costs to help mitigate pressures on pricing; **prioritize service, maintenance and warranty coverage** of existing equipment to maximize investments and the useful life of equipment; **optimize procurement channels for grants and domestic financing** through the use of the Global Fund's PPM/wambo.org, to benefit from negotiated terms, prices and quality-assured products.

1. Health Sector Governance and Integrated People-centered Services

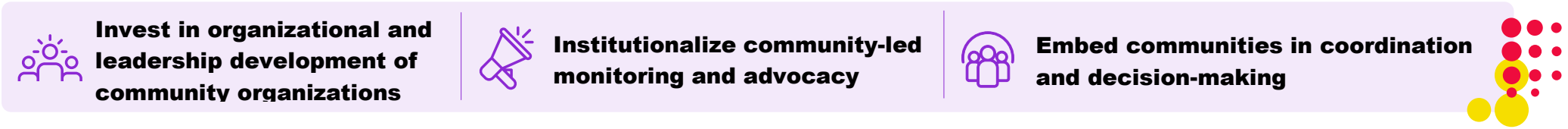
Effective planning, leadership and governance of the national health sector supports improvement of health system performance, scale up of integrated service delivery and achievement of universal health coverage (UHC). Engaging with the private sector facilitates more effective service provision and health system functions.

Health Sector Governance and Integrated People-centered Services	
Key Priorities	**Main approaches**
1. Strengthening national health sector strategy, policy and regulations, including for private sector engagement	**Priorities for Global Fund investments** • **Prioritize planning, implementation and review of national health strategies** such as integrated strategies and plans for service delivery. This includes integrated essential health services packages, and key health system functions like supply chain management, laboratory, surveillance and human resources for health, informed by evidence-based discussions and analysis. Strategies include pandemic preparedness and climate and health related policies, plans and regulatory frameworks developed in consultation with multi-sectoral stakeholders. They also include national policy and regulatory frameworks, and mechanisms to meaningfully engage relevant stakeholders, including communities, civil society and the private sector, in policy dialogue and implementation. • **Strengthen the management capacity and coordination functions** of the Ministry of Health (MOH) (e.g. Department of Planning), national public health institutes (NPHI), and other relevant functions and organizations (e.g. Health Insurance Institutes, Ministries of Local planning, etc.) that coordinate and monitor priority health programs including HIV, TB, malaria and health systems investments.

Health Sector Governance and Integrated People-centered Services	
Key Priorities	**Main approaches**
	• **Use data and evidence to inform strategies, policies and regulations**, and to strengthen capacity for better planning, leadership and governance at the national and sub-national levels. • **Engage private sector entities** to leverage their resources in service provision and other health system functions through the application of equitable, market-based approaches and financing (contracting, outsourcing, establishing public-private partnerships). Support can be used to strengthen regulation of the private sector (e.g. certification, licensing, accreditation, franchising and social marketing), to create fair enforcement mechanisms, and to improve information exchange by including private sector health information into national reporting systems.
2. Planning, management, and delivery of integrated people centered services	**Priorities for Global Fund investments** • **Strengthen governance and leadership for integrated service delivery and systems**. This includes joint planning and coordination, co-implementation arrangements, cross- or intra-sectoral reviews and assessments, and support for decentralized decision-making, resource allocation and capacity-building for local health authorities to implement integrated services. Where feasible, consolidate planning, budgeting, budget execution and coordination across various programs and parts of the health system and sources of finance, and support governments to mobilize domestic resources and align and leverage external funding for integrated delivery. Ensure country stewardship and differentiated approaches, based on country context, epidemiology, progress and maturity of integrated services and systems, and a strong focus on outcomes and equity. MOH senior leadership should lead the process, in partnership with relevant stakeholders including civil society and partners e.g., Gavi, World Bank and WHO. • **Focus on integrating HIV, TB and malaria programs into PHC platforms** based on service user, patient pathways and life-course specific service packages, while also strengthening PHC platforms. Improve client experiences (including in humanitarian contexts) to ensure access to all necessary services at the PHC level such as reproductive, maternal, adolescent and child health services that can include HIV, TB and malaria prevention and care services. To facilitate a path to sustainability, it is important to include HIV, TB and malaria services into essential health service packages that are financed through domestic financing, for example by health insurance schemes, as explained under the Health Financing section. Integration opportunities include:

Health Sector Governance and Integrated People-centered Services	
Key Priorities	**Main approaches**
	○ Integration of HIV, TB and malaria diagnosis, treatment and referral within PHC service delivery platforms (e.g. in- and outpatient facilities, outreach and community-based services) according to epidemiological context. ○ Converging human resources for health (HRH) investments to enable more integrated service delivery through more integrated training, supervision, and quality assurance with differentiated approaches adjusted for performance. ○ Integration of malaria campaigns (chemoprevention or insecticide-treated nets (ITN) distribution) with other public health campaigns (nutrition screening, vitamin A supplementation, neglected tropical diseases mass drug administration or immunization). ○ In challenging operating environments and/or specific sub-national areas affected by conflict and/or climate related displacement, focus on providing integrated, cross-programmatic packages. ○ Activities should be categorized under the relevant modules as needed (health sector governance, HRH, malaria). • **Focus on strengthening health system functions to improve access, efficiency and quality of integrated services delivered through primary care.** These include supply chain management, HRH, laboratory, data and surveillance systems, covered in more detail under the relevant modules below. **Optimization and efficiency considerations** • Integration should aim to improve health outcomes, equity and the overall user/community experience as well as efficiency and decrease costs through reducing duplication. This requires more coordinated HRH development, service planning, costing and management across funding sources and health departments and programs to enable potential efficiencies, noting that initial costs may increase as systems are developed or adapted for more integrated approaches.

2. Community Systems Strengthening



Services designed with and implemented through community-led (CLOs) and community-based organizations (CBOs) of people living with and affected by the three diseases build trust, increase relevance, and expand access. In the context of RSSH, community systems interventions are about strengthening governance of community organizations so they can deliver services in a sustainable manner. As described below, countries can assess the maturity model of their community systems through tools that help identify the most strategic investment areas for improved sustainability and integration. Applicants should demonstrate how community and government systems work together, with clearly defined roles and responsibilities, national standards and protocols, monitoring and evaluation (M&E), referral and linkage agreements between community and health facilities, and reporting mechanisms that capture the contributions of communities to national health responses.

Community Systems Strengthening	
Key Priorities	**Main approaches**
1. Organizational and Leadership Development	**Priorities for Global Fund investments** • **Prioritize the establishment, strengthening, and sustainability of CLOs and CBOs**, particularly those led by key populations, women, youth, and people living with or affected by HIV, TB, and malaria. Investments in capacity development should focus on strengthening long-term resilience of community institutions and supporting collaborative relationships between community and formal health systems; in addition to improving the quality and scale of community-led service delivery. • **Assess the maturity and development needs of these organizations** using tools such as the CRSS Maturity Framework forthcoming) and Community Pulse. Tailor capacity and leadership-development responding to context, operational roles, and

Community Systems Strengthening	
Key Priorities	**Main approaches**
	maturity of institutionalization to ensure investments are strategic, sustainable and resilient in the context of increasing health impacts of extreme weather events and other climate hazards. • **Support legal registration of CLOs and CBOs as part of a broader package of institutional capacity strengthening**, including governance, financial management, sustainability planning, internal policies, leadership development, organizing and social dialogue, program management, monitoring, evaluation, learning, and reporting. This should also uphold duty of care for staff and communities and ensure compliance with the five minimum human rights standards. • **Where appropriate, invest in enabling legal and policy environments at all levels** that accelerate the capacity development of community organizations and position them for social contracting or financing through domestic, private, or income-generating streams. Investments should take a system-wide approach, strengthening both technical and institutional capacities with clear outcomes for sustainability. • **Consider the safety and security of implementers** at the organizational level as a key part of community systems strengthening. **Low priority and requiring strong justification if proposed** • Deprioritize one-off trainings and capacity development activities that do not contribute to more effective community responses and engagement and to working relationships. **Optimization and efficiency considerations** • Invest in approaches that strengthen existing structures, networks, and national frameworks rather than creating parallel systems, especially repeat capacity assessments or development of curricula. • Encourage joint capacity-building initiatives (e.g. multi-CLO/CBO accessing shared support and development to maximize efficiency and sustainability. • Ensure that organizational and leadership development of community organizations directly supports their active engagement in service design, delivery, and oversight and integration with national programs.

Community Systems Strengthening	
Key Priorities	**Main approaches**
2. Community-led monitoring (CLM) and Advocacy	**Priorities for Global Fund investments** • **Position CLM mechanisms and processes as a core element of community systems interventions**. CLM data should complement national health management information and One Health-PPR surveillance systems, inform quality improvement plans, and national and community health strategies, generate actionable evidence of barriers to the availability, accessibility, acceptability and quality (AAAQ) of services, and be acted on to increase service uptake and better health outcomes. • **Support CLM programs across all stages of the CLM cycle**, including strengthening the technical and implementation capacity of CLOs, CBOs and CSOs to effectively implement and manage — from defining issues and indicators, to routine community-led data collection, quality assurance, analysis, advocacy, monitoring and documenting outcomes and impact — ensuring government and stakeholder commitment to act on findings, especially where they affect key and vulnerable populations. • **Ensure partnerships between CLM implementers, service delivery sites, and decision-makers** to implement solutions to barriers identified by communities, and track whether changes lead to improved service uptake and health outcomes. • **Support the institutionalization of CLM platforms into sub-national and national quality assurance and accountability mechanisms** (e.g., health management information systems, electronic community health information systems (eCHIS), electronic medical records, electronic logistics management systems, One Health-PPR, citizen charters, grievance systems, parliamentary oversight), so that community feedback is systematically captured and acted upon. • **Maintain or scale up existing CLM programs that provide low-cost, routine data on AAAQ of services** including human rights and gender-related barriers, commodities and diagnostics and impacts of extreme weather events and other climate shocks. Ensure that CLM monitors have facility access and use standardized frameworks for collection, analysis, and feedback without compromising the CLM principles of being community-led and independent. • **Support monitoring, evaluation, accountability and learning of CLM programs** beyond direct service improvements in areas such as community leadership, engagement, protection from sexual exploitation, abuse and harassment (PSEAH), capacity and skills, and partnerships to be able to understand the broader impact of CLM for a sustainable community system. • Support development and implementation of sustainability plans for CLM platforms that include clear transition strategies and multiple financing options (public, private and philanthropy).

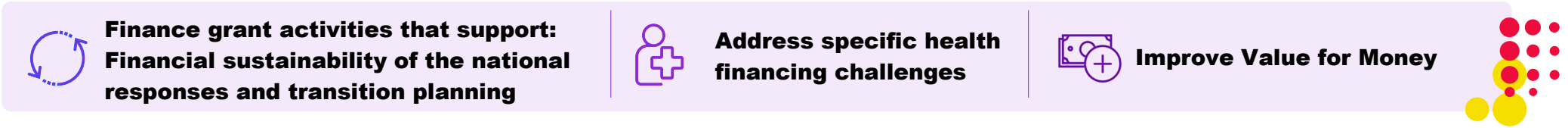
Community Systems Strengthening	
Key Priorities	**Main approaches**

	• Uphold the principles of transparency, accountability, and independence in all CLM programs:
	  ○ **Transparency** – CLM stakeholders, including affected communities, health service sites and providers, sub-national and national health officials, are aware of issues monitored and have access to CLM findings in an understandable form.
	  ○ **Accountability** – CLM is focused on results – findings must lead to corrective action and follow-up. Affected communities are regularly updated on the results of CLM activities and verify that services have improved.
	  ○ **Independence** – CLM is community-led, owned and -driven, but collaborative with government and donors to support issues selection and implementation of solutions to identified barriers.
	
	Low priority and requiring strong justification if proposed
	
	• Standalone or pilot CLM programs not linked to program improvement cycles or lacking a clear pathway to change.
	• CLM initiatives that have not yet secured stakeholder commitment or defined priority issues for monitoring.
	• Parallel community-led research or feedback platforms not linked to national quality or accountability systems.
	• CLM-focused research in early-stage programs (i.e., before two full data collection cycles are completed), unless directly linked to improving service delivery.
	
	Optimization and efficiency considerations
	
	• Invest in supporting greater coordination or harmonization across multiple standalone CLM programs for better data use.
	• Support integration of additional health priorities into CLM programs for comprehensive monitoring and to reduce vertical mechanisms and strengthen accountability across the health system. This could include monitoring AAAQ of services for multiple disease or health issues such as HIV, TB, malaria, PPR, sexual and reproductive health, maternal and newborn child health, human rights, gender and equity, noncommunicable diseases (NCDs), mental health, and/or climate change.
	• Prioritize coverage and duration of CLM based on epidemiological intelligence, needs and cost-effectiveness, using Secretariat guidance for site selection and costing and also the open access planning tools listed in the annexes of the Value for Money Technical Brief.
	• Leverage digital tools to facilitate CLM data collection, analysis, management and reporting while ensuring data safety and security.

Community Systems Strengthening	
Key Priorities	**Main approaches**
	• Formalize use of CLM data during health sector and program reviews, strategy development, technical working groups, coordination committees and other decision-making platforms to strengthen accountability and embed CLM data in sub-national and national processes for sustainability. **Out of scope** • CLM activities that are not linked to national objectives and targets or consistently fail to demonstrate evidence of CLM data use linked to corrective action. • Generic community-led research or advocacy initiatives not tied to improving service quality or accountability.
3. **Community Coordination and Engagement in Decision Making**	**Priorities for Global Fund investments** • **Support community-led structures and networks** to organize, coordinate, and participate in decision-making mechanisms and processes at national and subnational levels to improve health responses and equitable access and quality of services as well as resilience of health services to climate hazards, linking to health sector planning and budgeting cycles. • **Provide resources for communities to meaningfully engage**, including consulting their constituencies, convening dialogues, preparing position papers or briefing notes, and generating evidence (e.g., from CLM and other sources). This should inform governance and oversight of processes as well as the development, revision, and implementation of national guidelines (e.g., on integration, and operational service delivery guidelines). • **Strengthen linkages between community coordination platforms and formal decision-making bodies** (e.g., country coordinating mechanisms (CCMs), Local Health Boards, UHC and other technical working groups and *fora*), ensuring communities systematically contribute to priority-setting, budgeting, and M&E. • **Invest in the institutional and technical capacity of community platforms and coalitions** to participate in health governance while reinforcing their ability to operate within broader civic space and health systems landscape. • **Promote mechanisms that aggregate and amplify feedback from marginalized and under-served populations** (e.g., key population-led groups, women, youth, rural communities) ensuring their collective voice informs national and subnational *fora*. **Low priority and requiring justification if proposed**

Community Systems Strengthening	
Key Priorities	**Main approaches**
	• One-off dialogue events or consultations without clear linkages to decision-making processes or outcomes. **Optimization and efficiency considerations** • Build on existing governance and accountability structures (CCMs, Local Health Boards, UHC platforms) to avoid duplication or setting up platforms that require external financing. • Support collective representation through coalitions or networks to reduce fragmentation and ensure diverse community voices are included. • Promote effective and efficient use of CLM and other community-generated evidence by linking findings directly to governance and oversight structures. **Out of scope** • Parallel platforms or networks that do not connect to national or subnational health governance systems.

3. Health Financing Systems



Strengthening health financing systems enables support for increased domestic resource mobilization, pooling and purchasing to sustain progress against HIV, TB and malaria and advancing towards UHC. Support to health financing systems also enhance and support more integrated

approaches to service delivery. With official development assistance (ODA) declining, countries must increase domestic resource mobilization and financing to protect gains and maintain momentum; while ensuring that this shift does not transfer the burden to households through out-of-pocket payments, which remain a major barrier to equitable access and financial protection. Countries need to support gradual, planned, effective transitions away from external financing. The Global Fund's approach to sustainability and transitions outlined in the Global Fund Guidance on Sustainability, Transition and Co-Financing.

Health Financing Systems	
Key Priorities	**Main approaches**
1. National Transition Planning, Health Financing Strategies for Domestic and External Resource Mobilization	**Priorities for Global Fund Investments** • **Health financing strategies** to improve domestic revenue mobilization, pooling, purchasing and financing of the health sector. • **Country level planning exercises and implementation to support transition** away from reliance on Global Fund and external financing and sustainability. This includes support for transition plans such as those for health products and equipment, sustainability plans, transition assessments, and/or other planning exercises. It includes activities to support resource tracking of investments (i.e. costing of national strategies and operational plans, resource mapping that tracks expenditure to costed priorities, and developing an investment case with clear domestic and external commitments by service level, service type and geographic area) and/or the capacity of country stakeholders to generate and use health financing data to support transition. • **Leveraging additional resources (financial and technical) from other development partners, such as multilateral development banks through innovative financing mechanisms** (including blended finance) and their effective use to catalyze or scale up integrated disease services coverage and/or health sector reforms to address systemic bottlenecks for sustainability of Global Fund-supported programs. • **Advocacy** at multiple levels, including community and civil society advocacy, to hold governments accountable for co-financing commitments and increasing domestic resource mobilization. **Optimization and efficiency considerations** • Health financing and domestic resource mobilization activities should consider all sources of health financing and incentivize greater integration of HIV, TB and malaria services and/or systems into the national health system.

Health Financing Systems	
Key Priorities	**Main approaches**
2. Pooling and Purchasing Arrangements and Health Financing Schemes	**Priorities for Global Fund investments** • **Interventions that support more sustainable and strategic purchasing** of value for money health services, including pooling of funding and strengthening and/or development of health financing schemes (e.g. health insurance) to enhance access particularly for key and vulnerable populations, and integration of HIV, TB and malaria services into PHC/benefits packages. This includes reforms looking at enhancing resource mobilization for health insurance schemes (e.g. through design of levies, sin taxes, innovative financing, etc.); enhancing their design (costing of benefit package; review of appropriate tariffs at each level for population-based payments or fee for services; improvements of guarantees against moral hazards and encouraging quality delivery) as well as processes to strengthen universal access (e.g. through community-led registration and mechanisms to rapidly collect and integrate community feedback). • **Sustainable financing / payment options for HRH, including CHWs,** depending on accompanying HRH investments. • **Contracting** with CSOs (preferably strengthening local/national actors for sustainability) and CBOs for advocacy, social and behavioral change communication (SBCC) and health service delivery, including interventions that specifically support key and vulnerable populations and community led responses. Both these and interventions to improve strategic purchasing of health services can make strong contributions to maximizing impact from limited health resources, by supporting targeting of resources and shifting towards more output-based forms of financing services. • **Promote optimization and efficiency** in health financing and domestic resource mobilization across all funding sources. Grant-supported efforts should facilitate, and not hinder, the integration of HIV, TB and malaria services into national systems, including the PHC system. Where possible, strengthen partnerships and explore synergies and efficiencies across donor-funded programs (e.g. Gavi, GFF/World Bank, private funders, etc.) as they may be funding similar activities (e.g., M&E, reporting, planning).
3. Strengthening Health Finance Data Systems, Public Financial Management and	**Priorities for Global Fund investments** • **Strengthen health finance systems to generate costing, financing and expenditure data** to improve the monitoring of health and disease financing, financial planning, execution against budgetary allocations, alignment of external funders with national plans, and link to performance monitoring to improve value for money of external and domestic investments.

Health Financing Systems	
Key Priorities	**Main approaches**
Routine Financial Management Systems	• **Use planning and optimization tools and processes**, including those set out in the annex of the Value for Money Technical Brief to establish priorities and conduct planning based on value for money considerations. This can include developing and using unit cost data to make management choices; the use of intervention cost-effectiveness ratios to drive purchasing decisions. • **Strengthen public financial management (PFM) systems** to improve effective domestic health budget formulation and execution, including: strengthening regular resource mapping efforts and ensure they inform realistic costing of the national health strategy and budget; deployment of strategic purchasing strategies, reforms and process that allow countries to more readily compare their spending versus outcomes obtained at each level of the health system; strengthening district and health facilities' capabilities on financial management to align to greater levels of financial autonomy; and support the transition to a "one M&E, one budget, one plan approach" with regular reviews of the health sectors' performance. • **Support the mainstreaming of Global Fund and other external grants into country PFM systems**, mainstreaming grant fiduciary delivery and oversight while enabling the transitioning out of fiscal agents. Investments should contribute to sustainability and transition, demonstrate "additionality" with domestic and other donor funding, and leverage joint PFM financing frameworks and coordination platforms at country level. This includes supporting PFM maturity assessments and action planning, provided they don't duplicate existing assessments, including those performed by other development partners. • **Support digital PFM payment and other solutions** leveraging financial digital public infrastructure to strengthen sub-national, last-mile service delivery, internal audit assessments, and the inclusion of Global Fund and other external grants in the national budget. To enhance efficiency and equity, support enterprise resource planning, integrated financial management information systems, and introduction, optimization and mapping the Global Fund's costing dimensions to enhance budget allocation, expenditure tracking and reporting. Support professionalization or certification of health sector finance professionals and strengthening the regulatory environment. • **Support strengthening of routine financial management systems** that are used by Prinicipal Recipients to manage Global Fund's investments, while continuing to strengthen national PFM systems.

4. Health Product Management Systems

Development or revision of policies and procedures

Training qualified staff who can lead, plan and execute efficient and green procurement

Strengthen national supply chain systems

Investments should be adapted to country context and system maturity level, including country preparedness and readiness to introduce new health products and innovative health service solutions. Countries can conduct supply chain maturity assessments (forthcoming) to identify priority investment areas to build cost-efficient, integrated and sustainable supply chains that guarantee continuous availability of quality health products.

Health Product Management Systems	
Key Priorities	**Main approaches**
1. **Policy, Strategy, and Governance**	**Priorities for Global Fund investments** • **Support coordinated, comprehensive national procurement, supply chain management and regulatory governance** that provides accountability, leadership and stewardship across the entire health product management cycle, ensuring effective performance management and execution of all policy, planning and implementation activities. • **Create a holistic, costed national strategic plan for health product management systems**, including quantification and forecasting, procurement, in-country supply chains, quality assurance, and waste management, supported by required governance and human resources and endorsed by relevant national authorities and stakeholders. Based on these plans, coordinate and leverage other investments from the government, Gavi, GFF, multilateral development banks including the World Bank and Asian Development Bank, and other bilateral donors and partners supporting the country. • **Prioritize development or revision of supply chain strategic plans**, including digital health strategies where needed. Use data from recent supply chain assessments, including maturity assessments, to inform strategic planning. Prioritize aligned national supply chain strategies that accelerate and embed supply chain sustainability across core areas such as digitalization,

Health Product Management Systems	
Key Priorities	**Main approaches**
	financing, governance, policies, reporting, resource optimization, and models for partnership with the private sector where appropriate, and reflect these within revised national strategic plans. • **Implement more integrated supply chains** under the stewardship of countries and in coordination with core partners. This includes accelerated streamlining of disparate disease specific functions, consolidation and standardization of core processes to generate economies of scale where applicable, and minimization of duplication across functions with procurement and supply chain responsibilities along the value chain. These efforts should yield efficiency gains, cost reductions, and greater supply chain sustainability. • **Invest in Central Medical Stores governance**, audits and information, including financial reviews, business plans, operational models, key performance indicators, and financial dashboards to provide insights into current performance, future financial sustainability and evolving value for money measures.
2. Planning and Procurement Capacity	**Priorities for Global Fund investments** • **Timely quantification and forecasting (at least bi- or annually), supply planning and procurement** to acquire quality-assured health products at the lowest possible sustainable cost and ensuring its continuous availability. As timely and efficient procurements are central, countries should also prioritize strengthening their national procurement systems and capacities, including relevant human resources and processes. • **Standardize specifications of high-volume products.** With overall reduced volumes, concentrate demand on fewer variations of products including pack sizes to support efforts to maintain unit price efficiencies. Standardized specifications also help simplify global and national supply chains (e.g., storage, distribution). • **Prioritize acquisition of diagnostic platforms and other health equipment through all-inclusive pricing arrangements as cost-effective models that** support sustainability and functionality (extended service and maintenance) of health equipment. • **Increase domestic financing and procurement channel usage for low-value, low-quantity non-core health products** (e.g. essential medicines, lab supplies and consumables). This is especially applicable for Focused countries. **Low priority and requiring justification if proposed**

Health Product Management Systems	
Key Priorities	**Main approaches**
	• Deprioritize funding for residential workshops for procurement and supply management (PSM) -related activities (e.g., development of guidelines, quantification exercises, strategic plans, tools and program reviews). Identify alternative options that do not require per diem and other costs. **Optimization and efficiency considerations:** • **Optimize the procurement and use of health products.** Large efficiencies can be realized by switching to WHO-recommended, more effective, lower-costing products such as optimal HIV prevention and treatments as well as lower-costing, quality-assured, and WHO recommended health products of equivalent effectiveness, such as rapid diagnostic tests.[3] Additionally National programs should budget latest reference prices of the Global Fund's Pooled Procurement Mechanism[4] (PPM) in line with the Global Fund's Guidelines for Grant Budgeting.[5] • **Timely quantification and forecasting (at least bi- or annually), supply planning and procurement** to acquire quality-assured health products at the lowest possible sustainable cost and ensuring its continuous availability. As timely and efficient procurements are central, countries should also prioritize strengthening their national procurement systems and capacities, including relevant human resources and processes. • **Standardize specifications of high-volume products.** With overall reduced volumes, concentrate demand on fewer variations of products including pack sizes to support efforts to maintain unit price efficiencies. Standardized specifications also help simplify global and national supply chains (e.g., storage, distribution). • **Prioritize acquisition of diagnostic platforms and other health equipment through all-inclusive pricing arrangements as cost-effective models that** support sustainability and functionality (extended service and maintenance) of health equipment. • **Increase domestic financing and procurement channel usage for low-value, low-quantity non-core health products** (e.g. essential medicines, lab supplies and consumables). This is especially applicable for Focused countries. **Low priority and requiring justification if proposed**

Health Product Management Systems	
Key Priorities	**Main approaches**
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Health Product Management Systems	
Key Priorities	**Main approaches**
	quality-assured, and WHO recommended health products of equivalent effectiveness, such as rapid diagnostic tests.[7] Additionally National programs should budget latest reference prices of the Global Fund's Pooled Procurement Mechanism[8] (PPM) in line with the Global Fund's Guidelines for Grant Budgeting.[9] • **Optimize procurement channels for grant and domestic financing** by partnering with PPM/Wambo to benefit from negotiated terms, prices and quality-assured health products from a diversified and sustainable supply base, through optimizing the Global Fund's purchasing power to sustain access and pricing.
3. Storage and Distribution Capacity, Design, Operations & Outsourcing	**Priorities for Global Fund investments** • **Use information and evidence.** Findings from maturity assessments, interventions in national strategies and recent supply chain system design and operational assessments should inform investments to enable the most effective use of existing capacity. They should also be used to determine if additional capacity is needed and, if so, how much and where, and possible financing. These assessments should determine what activities should be outsourced or insourced, and if sufficient processes and people are in place to manage all aspects of the supply chain systems, including for required coordination, governance, monitoring and supportive supervision. • **Maintain and optimize PSM costs** to ensure comprehensive and effective freight, quality assurance, warehousing and storage and in-country distribution services of priority identified health products, procured via Global Fund grants. Continue to support outsourcing of services, as pertinent. PSM costs may cover activities related to the management of health products starting from selection of products until delivery to beneficiaries, rational use and reporting. These costs should represent value for money, while noting their importance to retain given of their lifesaving nature**.** • **Strengthen distribution capacity and innovations to deliver people centered services** including to the community level and "last mile." To enhance the efficiency, effectiveness and sustainability, evaluate supply chain aspects (e.g., costs, inventory norms, distribution frequency, smart product segmentation, route and fleet optimization, network design, product flows, layers in the supply chain, integration of parallel supply chains, and waste minimization) and opportunities for operations improvements (e.g., warehouse management, inventory management, fleet tracking and management). Leverage vendor managed services (VMS) to streamline the distribution of high-volume health products, ensuring optimal inventory control, maximizing storage

Health Product Management Systems	
Key Priorities	**Main approaches**
	efficiency, and reducing network congestion for a more resilient and cost-effective supply chain. Consider how to mitigate physical climate risks, and promote energy efficiency, clean energy, and resilience to climate shocks. • **Expand access to quality-assured health products through private sector pharmacies and other alternative delivery channels** by designing these channels as reimbursable through health insurance schemes - including analyses of how product and service costs should contribute to premium structures, co-pays, and health benefit package designs to ensure financial sustainability, equity and population coverage. • **Refer to the Global Fund Guidance on Procurement and Supply Chain Management** for further guidance on supply chain design and operations, and outsourcing including contract and performance management. **Low priority and requiring justification if proposed** • Consider deprioritizing siloed/disease specific supply chain investments, including information systems and infrastructure depending on specific country context, level of political buy-in, and co-financing investment. **Optimization and efficiency considerations:** • Beyond paying for PSM costs, identify efficiency opportunities in downstream PSM costs to ensure value for money and continued application of cost-effective measures. Depending on the country-specific context and services being paid for under the grant, efforts should be made to identify efficiencies, including instances where certain functions are outsourced to ensure cost-effective services are being provided. Prioritize routine contract and performance management related activities to facilitate this. The overall focus is ensuring value for money in storage and distribution costs being paid in grants. • Prioritize operations improvement interventions including integration across existing facilities and assets, such as inventory management processes, route optimization and fleet management depending on the country context. Grant interventions should be prioritized to generate efficiency across core supply chain functions including storage and distribution services.
4. Regulatory and Quality	**Priorities for Global Fund investments** • **Strengthen national regulatory systems** to benefit the three disease programs and beyond with an integrated approach to cover Essential Medicines Lists/Diagnostics Lists development and updates, timely registration to facilitate new health products

Health Product Management Systems	
Key Priorities	**Main approaches**
Assurance Support	introduction, quality testing and post-market surveillance, effective vigilance and other quality assurance system strengthening activities for health products (for example, triangulation between logistics and health information systems). Deliver and implement regulations that protect the public while enabling timely access to and innovation of quality products. This includes regulatory system strengthening and market surveillance of quality, safety and efficacy. • **Reinforce existing quality assurance systems and develop a quality assurance plan** within the masterplan/framework established for implementing national medicine/health product policy. It should outline all the different components under the quality assurance policy, specify approaches and activities, main actors involved (e.g., government agencies, laboratories, PRs and others), responsibilities of key actors, estimated budget and proposed implementation timeframe. The quality assurance plan should also be used to allow coordination of both domestic and donor financing support, including from the Global Fund. Additional guidance is provided in the Technical Brief on Support to Effective Regulatory Systems for Procurement and Supply Management of Health products. • **Strengthen national policies to more effectively manage the dispensing and use of antibiotics** as per WHO's "Access, Watch, Reserve" (AWaRe) classification of antibiotics. • **Request support for key actions or best practice that can be taken to reduce the time to introduce and/or remove products** no longer considered safe or best practice. This can include policy, regulatory and programmatic enablers like developing or updating national medicines/diagnostics/medical devices policy, Essential Medicines List, Essential Diagnostics List, Standard Treatment Guidelines. • **Investment decisions should be primarily based on existing and robust situation analysis**. The use of tools that have demonstrated their efficacy should be encouraged such as the WHO Global Benchmarking Tool, including for medical devices, regulatory systems assessments, and the Model Quality Assurance Systems assessment tool for procurement agencies. In-country existing plans such as Institutional Development Plan for Regulatory Systems Strengthening developed following such assessments should be considered during the design of the plan shared with Global Fund and regularly updated. **Low priority and requiring justification if proposed** • Consider deprioritizing siloed/disease specific vigilance investments. • Consider postponing quality control testing laboratory infrastructure upgrades.

Health Product Management Systems	
Key Priorities	**Main approaches**
	Optimization and efficiency considerations • Consider implementation of reliance principles in national regulatory authorities' practices (legal framework, procedure), and regional, continental and international framework and initiatives. • Consider integrating country Regulatory Authorities IT business needs in any new or revised country information systems. **Out of scope** • Post-shipment quality control testing activities of approved products if not justified by conditions having potential impact on their quality, safety and/or efficacy/performance.
5. Supply Chain Information Systems	**Priorities for Global Fund investments** • **Accelerate deployment of interoperable disease agnostic supply chain information systems,** such as an electronic logistics management information system (eLMIS), warehouse management systems (WMS), enterprise resource planning systems, digital transport management systems, and systems to ensure verification and traceability of health products. This supports end-to-end visibility and generates operational data for core supply chain functions including integrated planning and early detection of supply gaps (e.g., on-shelf availability, stocked according to plan). It also further supports comprehensive supply chain analysis for performance and risk management and continuous improvement of value for money. A Supply Chain Digitalization Roadmap should be used in conjunction with standardized approaches to health product information systems • **Prioritize costs associated with configuration, hosting, licensing, maintenance and workforce development**. Applicants should consider all other government and donor investments in this area (landscape analysis) and actively look for complementarity and efficiencies in investments, from design to operations. Investments should include all platforms and related activities to strengthen analytics, data-use, data quality, forecasting, and demand-planning. • **Consider implementation of supply chain information systems to permit traceability and fulfillment of reporting requirements,** such as physical stock counts and consumption reports. Support includes actions to minimize waste (e.g., eLMIS, WMS, reporting and analytics, master data/national product catalogs, procurement/order/requisition management, track and

Health Product Management Systems	
Key Priorities	**Main approaches**
	trace, mobile solutions, innovations, and others). The aim is to provide end-to-end visibility through interoperability and production of high-quality data to be used for data-driven decision-making, ensuring availability, quality and lower costs. **Low priority and requiring strong justification if proposed** • Single disease specific supply chain supervision for data quality, product availability or other supervision areas that are not integrated. **Optimization and efficiency considerations** • Maintain a single, authoritative set of national master data and a national product catalog to drive consistency across platforms and enable end-to-end visibility through interoperable data exchange. • In some countries, investment in supply chain information systems as outlined above may require increased upfront investments but will subsequently yield longer-term savings.
6. Waste Management and climate resilient and environmentally sustainable health facilities	**Priorities for Global Fund investments** • **Focus on sustainability of already existing health care waste management equipment and infrastructure**, such as warranty and maintenance, operations costs, and operational capacity building (to be complemented with co-financing) including public private partnerships, in cases where use of domestic resources will not be feasible. • **Use national assessments to steer health care waste management improvements**. Prioritize interventions that reduce lifecycle environmental impact across segregation, collection, decontamination, recycling, and final disposal. Emphasize prevention and resource efficiency (avoidance, separation at source, reuse, recycling, resource recovery) over disposal; deploy context-appropriate, innovative, and emissions-controlled technologies where needed. Focus support on standards, standard operating procedures (SOPs), workforce training, performance monitoring, and demonstration models that national systems and partners can scale. • **Evaluate and strengthen health care waste infrastructure and data flows.** Assess segregation, collection, treatment, recycling, and disposal capacity (e.g., transfer stations, autoclaves, landfills, specialized facilities). Estimate volumes with standardized Waste Tracking Tools and implement routine reporting. Foster partnerships for recycling, reverse logistics, and

Health Product Management Systems	
Key Priorities	**Main approaches**
	circular-economy solutions, prioritizing initiatives that establish governance, market linkages, and capacity to mobilize additional public–private investment and scale costed approaches. Consider support for operating facility costs (e.g., human resources, transport fees), environmental and social impacts and outsourcing of waste handling to private sector actors. The Stockholm Convention, highlights that incineration is a major cause of air pollution, and viable alternatives to incineration exist for the majority of waste in all contexts. Further guidance is provided in the Avoidance, Reduction and Safe Management of Health Care Waste Technical Brief. • **Consider developing and strengthening comprehensive, sustainable procurement and infrastructure** (i.e., low-emissions and climate-resilient). Conduct climate risk assessments of health infrastructures and inventories to identify vulnerabilities to climate-related shocks and extreme weather events, along with investments in clean and renewable energy solutions (e.g. solar photovoltaics, etc.), to ensure climate-resilient and environmentally sustainable operations of health facilities and warehouses. **Low priority and requiring justification if proposed** • Equipment procurement for waste management, particularly where sites are not ready to operate such equipment.

5. Human Resources for Health including Community Health Workers

Strengthening the PHC workforce for sustainability of the HIV, TB and malaria responses

HRH-CHW investments that align with and enable integrated service delivery models

Sustain both access and quality of services across the continuum of care

HRH includes all occupations engaged in the continuum of health promotion, disease prevention, treatment, rehabilitation and palliative care at PHC level, as defined by countries' health systems. HRH does not include staff whose primary role is managing Global Fund grants; these are referred to as program management staff. Prioritize investments in clinical cadres such as nurses, midwives, doctors, and pharmacists operating at PHC level, laboratory technicians, public health workforce and CHWs, and those deployed as part of rapid response teams. Also prioritize professional, polyvalent CHWs (CHWs providing integrated services in line with nationally defined essential packages, including HIV, TB and malaria) whose scope of work is recognized by national community health strategies and that promote the integration of CHWs into national health systems.

Applicants should strike a balance between community-based, facility-based and outreach interventions, including referrals and counter-referrals. Investments should also be informed by the epidemiological and socio-cultural context, integrated service delivery priorities and local cost-effectiveness considerations**.** Considering the health workforce is often predominantly female, particular emphasis should be placed on integrating gender dimensions in HRH-CHW programming. Joint planning, resource alignment and coordination with GAVI, GFF/World Bank and other partners improves efficiency of proposed interventions.

Human Resources for Health (HRH) including Community Health Workers (CHWs)	
Key Priorities	**Main approaches**
1.HRH planning and governance for integration and sustainability	**Priorities for Global Fund investments** • **Focus on HRH analytics, policy and planning** to enhance sustainability and align workforce to PHC strengthening priorities. Support health labor market and fiscal space analyses, or others with a clear use case for HRH strategic planning and deployment. Support development and implementation of integrated and costed HRH strategic plans, progressively enabling a shift from disease-specific HRH support to more sustainable workforce investments. HRH planning should also consider emergency policy measures and deployment strategies to strengthen the capacity to respond to public health emergencies arising from climate-related shocks and extreme weather events. • **Develop HRH Compacts/investment plans for HRH/CHWs**, including domestic co-financing commitments for PHC workforce, and plans for progressive transition away from disease specific investment toward an integrated and sustainable polyvalent HRH/CHW workforce. Definition of such compacts and sustainability plans should be inclusive of the community workforce.

Human Resources for Health (HRH) including Community Health Workers (CHWs)	
Key Priorities	**Main approaches**
	• **Align HRH-CHW investments for service integration priorities with national packages of essential health services**, and national HRH and community health strategies. This should include policy dialogue for harmonization of pay scales for HRH/CHWs (including peers) with national pay scales / costed service delivery packages. Where context does not permit an immediate shift without disruptions to services, initiate planning and policy level discussions to prepare for these shifts with a defined roadmap and timeline. See also health financing section on social contracting of CSOs. • **Support development of national legal frameworks**, certification/accreditation systems, payment mechanisms and master lists for CHWs aligned to national labor laws and national HRH and community health strategies. • **Support operationalization of task sharing reform** to strengthen integrated PHC teams aligned with essential health service packages. For example, scope of practice / curriculum reform and updated regulatory / legal framework that enables nurse- or midwifery-led care or expanded service provision by CHWs aligned with integrated service models and tailored to contexts e.g. in emergency and humanitarian settings, with aligned investments in capacity building, clinical mentoring and quality improvement for new service delivery packages or models. • **Support more evidence-based HRH deployment and remuneration.** Investment should be focused on PHC workforce and must be aligned with national HRH and community health strategic plans aimed at redressing HRH density or skills gaps or enabling rapid responses for climate-related events and PPR. The number and type of supported HRH-CHWs (all types) should be detailed (see Budgeting Guidelines) and justified. Use of HRH analytics such as Workload Indicators of Staffing Needs (WISN)[10] assessments is encouraged to support optimal deployment considerations, in line with integrated service delivery priorities. Where direct remuneration is supported, sustainability and transition considerations will apply depending on country income status and contextual considerations (such as being classified as COE). Co-financing commitments may need to be aligned to support gradual transition to government systems. See the Global Fund's STC policy for further details. • **Support resource mapping and expenditure tracking for HRH/CHW**, including strengthening national processes to conduct tracking to quantify salary discrepancies, duplications and inefficiencies in HRH/CHW funding. Support should be catalytic to gradual domestic resource mobilization and aligned to government-led HRH investment plans. Co-financing commitments or transition roadmaps need to accompany direct remuneration support and aligning to interventions (also see the health financing section).

Human Resources for Health (HRH) including Community Health Workers (CHWs)	
Key Priorities	**Main approaches**
	Low priority and requiring very strong justification if proposed • Recruitment, remuneration and deployment for new single disease HRH/CHW, including single disease M&E officers. Context considerations can apply to HRH/CHW needs for campaigns. However, campaign planning processes should strive for lean resourcing and integrated planning with other campaigns, and include integrated outreach services (e.g., mobile brigades) and existing CHW platforms as feasible. **Optimization and efficiency considerations** • Improve the efficiency of meeting costs by using virtual options wherever possible. Limit frequency, duration, and number of participants for in-person meetings/workshops. • For remuneration and deployment of all cadres, including CHWs, ensure harmonization of remuneration to government-led packages, prioritize deployment to underserved areas, using HRH density data, and optimize deployment to ensure fully functional referral systems over expansion of coverage to ensure quality of services. **Out of scope** • Support to HRH remuneration for government positions in upper middle-income countries, unless they are classified as COE. • Support to HRH Information systems development or maintenance. • Support to one-off HRH analyses de-linked from HRH planning processes. • Payment schemes or incentive models that are not harmonized with government remuneration structures.
2. Optimizing approaches to HRH-CHW capacity building and quality improvement	**Priorities for Global Fund investments** • **Prioritize pre-service training** over in-service training. Pre-service education of HRH (non-CHW) activities can be considered if: a) it contributes to PHC workforce development priorities (e.g., nursing, midwifery training programs); b) is aligned with national HRH strategies; and/or c) has a demonstrable added value to service delivery integration, quality or innovation (e.g. acceleration of e-learning or curricula revision to integrate HIV,TB and malaria competences into PHC workforce, including stigma-free, rights-based, gender-responsive, key population competent, care free of any sexual exploitation, abuse and harassment); d) preservice trainings are competency-based and aligned with global standards.

Human Resources for Health (HRH) including Community Health Workers (CHWs)	
Key Priorities	**Main approaches**

for integrated services	• **Redesign performance improvement interventions for greater effectiveness and integration**:
	  ○ **Support to HRH performance improvement** should adhere to the 70:20:10 principle for adult learning, ie. 70% of adult learning comes from practice and problem solving on the job; 20% from learning from peers and supervisors, 10% from trainings or seminars. The approach to HRH-CHW capacity building should therefore prioritize structured quality improvement (QI) approaches (e.g. QI teams using plan-do-study-act cycles for continuous problem-solving and collaborative learning), over in-service training, complemented by blended learning/clinical mentoring as appropriate. Note the percentages are descriptive of relative priority, not a prescription for how much funding should be assigned to different training approaches.
	  ○ **QI investments should be driven by an assessment of service delivery quality and performance gaps**, as well as integration priorities. For example, strengthening coverage and quality of four ante-natal care visits can enhance access to HIV testing, support early retention in HIV care and treatment, improve viral suppression and increase uptake of intermittent preventive treatment in pregnancy/use of preventive measures e.g. ITNs for malaria. Prioritize continuous QI for integrated services at PHC level, high-volume facilities and/or low performing sites. Wherever possible, the approach should align to national quality of care strategies, leverage national or regional QI coaching / mentoring programs, and be guided by local health service managers (e.g. district health management teams, working with the community), focusing on selected indicators across HIV, TB and malaria and other priority PHC areas where performance has been suboptimal.
	• **Continuous professional development programs and models such as low dose high frequency virtual learnings[11] are preferred** over one-off, in-person training where training is part of a broader performance improvement package. Approaches should seize opportunities for introducing and scaling up innovation though digital solutions. This can apply to CHWs as well: where CHW digital systems are being introduced and scaled for monitoring, this investment can be leveraged for continuous learning (e.g. through in-app learning as part of eCHIS platforms) through structured blended approaches, replacing *ad-hoc* refresher trainings, especially in settings with a relatively mature CHW program.
	• **Accelerate or start activities that enable sustainable and integrated HRH-CHW capacity building**. For example, identification of priority topics / competences across HIV, TB and malaria and sexual, reproductive, maternal, child and adolescent health to strengthen pre-service training programs on; joint design and planning of training and supervision investments across disease programs to promote integrated quality improvement approaches and blended learning programs instead of single disease trainings.

Human Resources for Health (HRH) including Community Health Workers (CHWs)	
Key Priorities	**Main approaches**
	Capacity building approaches should be developed in partnership with national training / academic institutions and professional bodies and prioritize alignment with established and accredited continuous professional development programs. • **Integrated approaches to supportive supervision/clinical mentoring/QI coaching should be prioritized over single disease supervision**, prioritizing the sub-national level (e.g. integrated supervision from district to PHC facilities rather than from central to regional/provincial level). Integrated supervision should be data driven and focused on group-problem solving and continuous HRH-CHW capacity building. Capacity building of supervisors, where necessary to enable better problem solving through supervisions, should prioritize leadership and management training with structured curricula and predominantly virtual approaches to peer learning. • **Quality of care efforts can be integrated with continuous quality improvement interventions at facility and community level**. These should enable stigma-free, rights-based and gender-responsive care, through a systematic approach of barrier identification, use of community data and engagement of community actors in service shaping. **Low priority and requiring strong justification if proposed** • Off-site (e.g. hotel based) refresher/standalone in-service training (for any topic area) for HRH/CHW (any cadre). Any protocol/single issue update should be delivered through digital or mobile platforms or, where these are not available, through circulars and integrated supervisions. • Production and dissemination of job aids, de-linked from a package of quality improvement interventions and supportive supervision. • Single disease/service supervision. **Optimization and efficiency considerations** • Prioritize joint planning of training and supervisions (and where applicable, joint management of travel and supervision budgets across grants) to enable integration across programs and more efficient delivery: for example, where the same cadre requires training for a range of issues, combine where feasible. • Consider optimal frequency and targeting. For example, deprioritize frequency of supervision of facilities/districts that consistently perform well. Focus on lower performing facilities/districts, driven by service delivery needs. Consider elements that can be replaced by virtual check-ins with districts or facilities, depending on context.

Human Resources for Health (HRH) including Community Health Workers (CHWs)	
Key Priorities	**Main approaches**
	• Reduce inputs by decreasing the number of supervisors or number of supervision days, and tailoring the focus of supervisions on outcomes that are lagging. Better use of routine monitoring data can help focus supervision content. **Out of scope** • Capital investments in training institutions. • Equipment purchase for training institutions that is not directly linked to roll out of priority pre-service training programs. • Quality of care assessments and studies de-linked from continuous QI strategies.
3. Consolidating investments in polyvalent community health workers programs	**Priorities for Global Fund investments** • **Strengthen CHW program maturity and sustainability, and support service integration at PHC level**. Support the use of the CHW Systems Maturity Model (forthcoming) within national review processes. Strengthen the maturity of integrated CHW programs aligned to the costed national HRH and community health strategies and system maturity assessments. Investments should demonstrate complementarity with other domestic and external resources, aligned with a long-term financing plan, where in place. Ensure all elements that deliver effective programming are addressed (pre-service training, remuneration, equipment and commodities, digital data systems supervision, referral linkages) to ensure accessibility, acceptability, good quality, integration, institutionalization and sustainability. • **Prioritize addressing bottlenecks that have hampered effective and efficient implementation based on maturity model assessment learnings**. For example, where timely remuneration of CHWs has been an issue, consider specific approaches for improving financial flows. • **Develop and implement sustainability plans to gradually transition or integrate disease specific CHWs (including peers) with national community health programs and HRH plans.** This may include definition of strategies that will strengthen polyvalent CHW capacity to deliver HIV, TB and malaria specific community interventions; identifying and addressing barriers that hinder recruitment of disease specific CHWs into polyvalent CHW programs; improving alignment of differentiated service delivery models with community health strategies; recognizing the role of disease specific peers in community service delivery particularly around high volume sites / urban / peri-urban areas and for marginalized groups; and advancing social contracting reform. The pace and model of transition will be context specific and may start from a subset of peer cadres (e.g. mentor mothers, patient navigators, directly observed therapy

Human Resources for Health (HRH) including Community Health Workers (CHWs)	
Key Priorities	**Main approaches**
	short course (DOTS) supporters etc.) depending on program feasibility and contextual priorities, including changes in the country funding landscape. Definition of such sustainability plans should be developed with and inclusive of community actors and civil society. See also RSSH Community Systems Strengthening guidance on strengthening community networks and the health financing section for CSO social contracting. • **Continue to integrate CHWs into multi-professional PHC teams.** Strengthen focus on definition and tracking of key service outcomes and use of data for quality CHW supervision and ongoing capacity strengthening by relevant facility-based staff especially midwives; better integration of CHWs for demand generation linked to integrated outreach services; greater emphasis on community follow up in pregnancy and post discharge, for example strengthening quality of CHW pre and postnatal home visits for maternal and newborn health, including e.g., high risk pregnant women screening and referral , breastfeeding support as part of Prevention of Mother To Child Transmission (PMTCT), family planning, immunization and referral for complications • **Take advantage of country-led opportunities for revisions of CHW scope of work** to enable service integration, integrate public health functions (e.g., community event-based surveillance) and scale up self-care approaches (for example, HIV self-testing or integration of family planning interventions including self-injection at community level following national policies). Demonstrate alignment of commodity investments to enable such community level service provision (including alignment of other external financing, if relevant products are not eligible for Global Fund support). • **Support pre-service training and deployment of new polyvalent CHWs** in line with national community health strategies provided that at least one of the following is in place: (1) financing from domestic or other resources for deployment and remuneration; or (2) a credible sustainability approach in the form of a compact/sustainability plan. Actively champion re-qualification of vertical peers into polyvalent CHWs as part of integrated CHW pre-service training roll out, identifying and addressing gender and human rights barriers to health services to this transition (e.g. through integration of competences for stigma-free, rights-based, gender-responsive, key population competent health services and care) and involving community and civil society in this dialogue. Programs are encouraged to review efficiency of training approaches and consider institutionalizing CHW training provision through national training institutions or CSO contracting to build a sustainable CHW trainers' cohort and ensure regular quality review of pre-service training. • **Strengthen national CHW supervision systems**, ensuring that CHW supervision is embedded within the broader PHC integrated supportive supervision system, ideally led by local facility staff such as nurses, where workloads permit, or other designated staff attached to the health facility (e.g., promoted former CHWs), using national integrated digital tools and building on eCHIS, where

Human Resources for Health (HRH) including Community Health Workers (CHWs)	
Key Priorities	**Main approaches**
	functional. Priority should be given to low-performing areas and QI coaching / continuous capacity-building tailored to CHW needs based on available data. CHW supervision should also take advantage of routine facility visits (e.g., restocking) for group problem-solving. • **Ensure appropriate equipment and commodities**. Ensure alignment with national approved packages (i.e. commodity and equipment lists), and any changes in service scope, based on evolving integration priorities or task sharing reforms. Focus on efficiency of inputs and optimal alignment between CHW training, equipping and commodity distribution plans. • **Align CHW digitalization with national community health strategies and national health information systems / digital health strategies.** Focus on community data monitoring and continued use of data for CHW service improvement, through integrated supportive supervision and on the job coaching by CHW supervisors using integrated digital tools and building on eCHIS. **Low priority and requiring very strong justification if proposed** • Single topic CHW training for elements not included in pre-service education packages. Instead, training should prioritize the roll out of pre-service integrated package, including requalification of single disease / vertical CHWs into polyvalent ones through the integrated curriculum. **Optimization and efficiency considerations** • Integrate CHWs within national HRH planning and PHC deployment plans, including use of WISN assessments[12] or geospatial approaches to optimize the distribution of CHWs as part of PHC teams. • Harmonization of remuneration packages for CHWs (all types). • Leverage investments in eCHIS for continuous learning, ongoing supervision, digital security and rights, quality improvement and target, especially in settings with stronger program maturity. **Out of Scope:** • Introduction of new CHW digital applications or platforms not endorsed by the MOH and/or not integrated into national community health information systems.

Human Resources for Health (HRH) including Community Health Workers (CHWs)	
Key Priorities	**Main approaches**
	• Procurement of CHW kits or commodities that are not part of the nationally approved essential package or service integration priorities.

6. Integrated Laboratory Systems Strengthening

Focus on integrated laboratory systems to decentralize patient-centered diagnostics services, respond to disease threats and meet International Health Regulations

Investment priorities include: specimen referral systems (SRS), laboratory information systems (LIS), and/or laboratory quality management system (LQMS)

Integration of diagnostics services refers to the disease-agnostic consolidation and coordination of existing resources (e.g., facilities, multi-disease testing analyzers/equipment and personnel) and supportive processes, such as specimen referral, test reporting, inventory management, quality management and post-market surveillance. Countries should also consider supporting interoperability of LIS with other data systems, and utilization of existing diagnostic network optimization (DNO) data to improve laboratory network functions. Equipment maintenance and warranties for existing equipment should be prioritized over buying new equipment, for example, replacing modules for GeneXperts.

Laboratory Systems Strengthening	
Key Priorities/ Critical Approaches	**Main approaches**
1. Leadership, coordination and governance of national laboratory services	**Priorities for Global Fund investments** • **Consolidate leadership and coordination of laboratory systems and supportive services.** The national laboratory directorate should develop and maintain robust monitoring and evaluation mechanisms to progress implementation of the National Laboratory Strategic Plan (NLSP). This includes metrics on system and service timeliness, diagnostic coverage and access to diagnostic services across disease programs. Leverage opportunities to share and optimize resources through integration of supportive services. • **Support the roll-out of the Laboratory Maturity Model (LMM)** (forthcoming) to assess the maturity of laboratory systems in advancing equitable health care access, integrating diagnostic services, and achieving key health system objectives, including disease specific targets. • **Reinforce the laboratory workforce at central and operational level** through training and/or certification programs in various aspects of laboratory medicine, biomedical engineering, bioinformatics, genomics, biosafety, biosecurity and participation in the Global Laboratory Leadership Program.[13] • **Promote and participate in regional and country peer-to-peer learning initiatives** to implement best practices, adopt proven innovations and sustain integrated laboratory systems. **Low priority and requiring justification if proposed** • Establishing laboratory system dashboards or data repositories without adequate coordination with the laboratory directorate or equivalent coordinating body. • Participating in leadership courses that do not lead to a formally recognized certification. • Organizing hotel-based meetings for document development or validation (NLSP, SOPs, policies). Consider low/no cost venues instead. **Optimization and efficiency considerations** • Consider cost sharing between disease programs and laboratory directorates for the development of policies, use of data and management of assets concerning diagnostics and service delivery.

Laboratory Systems Strengthening	
Key Priorities/ Critical Approaches	**Main approaches**
	• Reinforce systems for the routine, accurate and collaborative reporting of laboratory key performance indicators from existing national data systems. **Out of scope** • Duplicating laboratory system evaluations using alternative unvalidated tools. Prioritize adoption of LMM instead. • Per diems for routine activities, salaries and/or incentives for laboratory personnel.
2. Best practices for the management of laboratory systems and networks	**Priorities for Global Fund investments** • **Institutionalize Quality Management Systems (QMS)** at all tiers of the laboratory network through national laboratory quality programs aligned with ISO 15189. Key activities include: quality assurance activities (e.g. SLIPTA, SLMTA, LQMS or LQSI); increased availability of and participation in ISO 17043 accredited External Quality Assessment (EQA) Schemes for all essential diagnostics; accreditation of clinical and public health laboratories; and strengthening national quality infrastructure such as calibration centers and accreditation bodies. • **Advance digitalization and interoperability of laboratory data with other health information systems** to enhance clinical and public health decision-making. Adopt data standards in line with the WHO Digital Implementation Investment Guide.[14] Strengthen integrated LIS to enable the real-time collection, aggregation and analysis of laboratory data (test results and laboratory network performance). Ensure adequate intelligence on the national laboratory system to facilitate the use of test results, monitor network performance to inform decision-making and enforce regulation around diagnostics. Leverage and integrate existing in-country capabilities (e.g., home grown and/or open-source systems developed through vertical disease programs). Design LIS interventions to improve turnaround time for test results, enhance oversight of laboratory network functions (e.g. monitoring in-vitro diagnostics consumption to forecast needs), connect laboratory instruments (to monitor functionality) and ensure interoperability with other health information data systems (e.g. DHIS2) to strengthen public health intelligence. • **Establish, strengthen or further distribute integrated SRS** to improve access to diagnostics services, enable better patient outcomes and inform outbreak response. Support the establishment of SRS through a geographic information system (GIS) -

Laboratory Systems Strengthening	
Key Priorities/ Critical Approaches	**Main approaches**
	based analysis (e.g. from network optimization exercises) to inform the configuration of the transport network (designation of hubs and spokes) to meet the needs of both routine care and outbreak response. Inclusion of private sector facilities is strongly encouraged. Strengthen SRS by training MOH staff on geospatial analysis; building workforce capacity for safe packaging, handling, transport and tracking; contracting of specialized transport agencies; courier certification; providing additional transport logistics services; digitization of processes; coordinating operations and transition plans towards self-sufficiency. • **Support laboratory-based surveillance as a critical component of disease surveillance**, outbreak detection, pandemic preparedness and response plans and antimicrobial resistance (AMR) containment strategies. This includes implementation, expansion or optimized use of molecular technologies, such as next-generation sequencing (NGS), wastewater-based surveillance; scaling-up of AMR surveillance; and strengthening of laboratory system capacity to perform bacteriology, mycology and antibiotic susceptibility testing of WHO Global Antimicrobial Resistance and Use Surveillance System (GLASS) pathogens in line with the latest WHO recommendations.[15] It also includes relevant One-health laboratory-based surveillance strategies for controlling emerging pathogens, including zoonoses and environmental infectious threats. Support interventions to achieve the IHR 7-1-7 targets and AMR containment. • **Strengthen laboratory supply chains by establishing resources or procedures supporting All Inclusive Pricing (AIP) Service Level Agreements (SLA)** and other contracting mechanisms to improve maintenance and servicing of diagnostic equipment. Strengthen staff expertise in managing and overseeing service and maintenance contracts for diagnostic or laboratory equipment within national laboratory directorate. Enhance inter-ministerial partnership to improve cost efficiencies and competitive pricing for laboratory commodities and reagents; pooled procurement mechanisms; forecasting and quantification of testing demand; streamlining processes of introduction of novel types of in vitro diagnostics (IVDs) and near point of care (NPOC) platforms. • **Strengthen infrastructure, equipment management systems, and biosafety/biosecurity** to comply with international requirements; improve connections to back-up power supply, internet connectivity, and information communication technology. Additional interventions include supporting calibration and preventive maintenance of key instruments through building the capacity of biomedical technicians, supply chain or inventory officers; establishing hands-on training on equipment maintenance; and supporting the coordinated and safe removal of equipment at end-of-life.

Laboratory Systems Strengthening	
Key Priorities/ Critical Approaches	**Main approaches**
	• For all laboratory systems strengthening interventions, countries are to strengthen public-private partnerships and inclusion of private sector facilities within network planning exercises, particularly in urban areas. **Low priority and requiring strong justification if proposed** Deprioritize siloed/disease-specific laboratory systems investments, infrastructure, and stalled equipment investments, such as: • Re-orient disease-specific SRS or LIS to prioritize integrated SRS and LIS, using a phased approach. Discontinue disease-specific referral systems. • Construction or upgrade of laboratory facilities that have yet to substantially progress, or yet to convincingly demonstrate likelihood of successful completion. • Procurement of mobile biosafety level 3 (BSL-3) laboratories. • DNO driven by disease or equipment-specific objectives, or DNO exercises with no plans to institutionalize the collection, update and access of GIS data by MOH. • Procurement of new equipment to be reviewed on a case-by-case basis and deprioritized based on lack of site operational readiness or lack of sustainability plans (e.g. the procurement of new NGS instruments). **Optimization and efficiency considerations** • Conduct thorough costing exercises to inform the transition of Global Fund-supported activities to MOH, including overall cost for equipment, tests, warranty and maintenance contracts. • Integrate M&E into national systems or use national data systems to monitor implementation and outcome of activities. • Decentralize supervision, training and management of the network whenever possible. • Consider no cost options instead of hotel-based meetings/workshops for development/validation of laboratory guidelines/tools/SOPs.

7. Medical Oxygen and Respiratory Care

Definitions. Oxygen and respiratory care systems consist of the equipment and processes to produce, store and distribute oxygen to the points of care within facilities. The systems also involve the people that deliver oxygen safely and effectively to patients providing quality health services and care. Oxygen equipment also requires maintenance and repairs.

Investments in oxygen and respiratory care prevent mortality from respiratory pandemics, severe forms of HIV, TB and malaria and many common conditions that affect the most vulnerable newborns, children, and pregnant women, in acute trauma, sepsis, surgery, anesthesia and chronic non communicable diseases. As such, these investments should be institutionalized within national health system strengthening and UHC frameworks, ensuring long-term integration and sustainability beyond emergency responses. Oxygen is included in the WHO Model Lists of Essential Medicines.[16]

During the COVID-19 pandemic, many countries around the world demonstrated inadequate oxygen capacity and subsequently made significant investments in complex equipment and infrastructure that have strengthened their oxygen ecosystem, including through: liquid oxygen tanks, pressure-swing adsorption (PSA) plants, medical gas piping systems, and distribution and delivery equipment such as medical oxygen cylinders, ventilators and pulse oximeters. These critical patient care investments will need to be operated and maintained to deliver maximum impact through their use life.

Medical Oxygen & Respiratory Care	
Key Priorities/ Critical Approaches	**Main approaches**
Focus on optimization and sustainability of existing PSA plant supply infrastructure	**Priorities for Global Fund investments** • **Align with national strategies or roadmaps** and coordinate with national technical working group or oxygen desks to prioritize domestic investments, alternative donor funding or innovative financing (public-private partnership/cost recovery where appropriate) to: • **Strengthen national service ecosystems** to cover extended warranties and maintenance, support operational budgets and capacity building of biomedical and clinical staff. • **Use digital asset management tools** to improve maintenance response and reduce reliance on external support. • **Consider a systems approach** such as establishment of a national oxygen and respiratory care technical working group to integrate related interventions into health services through coordination of policy, data collection, standardization and stakeholder alignment. This system's approach should emphasize institutional capacity and workforce retention, including structured in-country training programs, mentorship networks and career pathways for biomedical engineers and clinical staff to ensure sustained local expertise in oxygen and respiratory care, and strengthening procurement, supply chain management, governance, and M&E. Surge oxygen services should be considered for humanitarian contexts, conflicts or natural disasters. A National Oxygen Sustainability Plan or roadmap that sets out long-term operations, maintenance, financing, training, and monitoring mechanisms to realize the impact of the country's oxygen investments is a useful resource for all stakeholders. • **Prioritize Global Fund support only if the above sources of funds are not available and the health facilities are serving large populations of people living with HIV, TB and/or malaria**. After the C19RM end-date, consider grant funding with a clear transition and sustainability plan to domestic funding. **Low priority and requiring (very strong) justification if proposed** • Auxiliary oxygen infrastructure and energy back-up such as dedicated electricity generators. • Medical oxygen delivery and monitoring equipment. **Optimization and efficiency considerations** • Integrate distribution and quality assurance systems for medical oxygen into existing supply chain systems.

Medical Oxygen & Respiratory Care	
Key Priorities/ Critical Approaches	**Main approaches**
	• Integrate oxygen indicators (production, distribution, consumption, downtime) into the national health management information system. • Integrate support for human resources to operate and maintain oxygen systems such as biomedical engineering and plant operations with ongoing capacity building of technical staff and clinical providers. • Where relevant, consider the use of existing or planned alternative energy sources such as solar energy systems to reduce energy and fuel costs. **Out of scope** • General expansion of PSA plants and bulk oxygen infrastructure. • Liquid oxygen infrastructure.

8. Health Information Systems and Strategic Data

National health sectors and disease programs require strong data systems that can support different needs. This includes patient/client care, program monitoring, impact assessment, early warning surveillance and rapid response, and evidence-based decision-making for targeted and efficient use of resources. Applicants should thoroughly assess the maturity of their health information systems (HIS) and surveillance systems,

including data standards, integration and interoperability, to identify priority data and data system improvements. Results from the WHO Global Digital Health Monitor and DHIS2 Maturity Profiles[17] can guide investments in health information systems and digital health. Most of these interventions are included under the Monitoring and Evaluation Systems Module in the modular framework. Related activities are also included in the Health Product Management, Health Financing and Laboratory Systems modules.

Health Information Systems and Strategic Data	
Key Priorities	**Main approaches**

1. Cross-cutting data and data system investments	**Priorities for Global Fund investments**
	• **Data governance, leadership and management should be strengthened** by creating and reinforcing data planning and coordination structures, regulations, policies, strategies, work plans and standards to maintain effective, integrated data systems at all levels. In routine HIS, the focus should be on generating and improving data quality, analysis and use to inform planning, target responses and monitor equity, including at subnational levels.
	• **Maintain core staff supporting data and data systems (HIS, surveillance, M&E, information and communication technology [ICT])** across HIV/TB/malaria programs and other relevant directorates, including at subnational levels. Integrate functions and personnel whenever possible, in line with HRH and surveillance prioritization information in this document.
	• **Limit training to essential data-related processes** (e.g., data collection, quality assurance, analysis and use; health facility/district monitoring meetings; health informatics), delivered on-site, on-the-job or online using existing training materials, where possible.
	• **Ensure availability of appropriate data collection and reporting tools in hybrid systems** (paper/digital) for all sectors (public, private, community).
	• **Maintain national, digital HIS**
	  ○ Service and maintenance fees.
	  ○ Digital HIS core team staffing and capacity building, per above (reduce frequency, improve training methodology, explore virtual modality); helpdesk; hardware maintenance; software license/platform fees; local or cloud-based hosting solutions; internet data fees.
	  ○ Technical assistance for priority high level expertise, e.g., data standards adoption, cybersecurity, software version updates, artificial intelligence (AI).

Health Information Systems and Strategic Data	
Key Priorities	**Main approaches**

	• **Support digital transformation strategies**
	  ○ **Strengthen the national digital enterprise architecture**, compliant with relevant national **data standards**, e.g. Health Level 7 Fast Healthcare Interoperability Resources (HL7 FHIR), leveraging established health and multi-sectoral governance structures and mandates, and including data sharing agreements.
	  ○ **Prioritize integration and/or interoperability of digital HIS** (e.g. health management information systems (HMIS), community health information systems (CHIS), laboratory information systems (LIS), logistics management information systems(LMIS), notifiable disease surveillance and response (e.g. integrated disease surveillance and response (IDSR), human resource information systems (HRIS), climate/environment, and financial administrative, grant, and program management systems) according to digital HIS maturity level.
	  ○ **Support integrated case-based /patient-level data systems,** e.g. Electronic Medical Record (EMR) implementation and support.
	  ○ **Support implementation and maintenance of security solutions to keep data safe during collection, in transit, and in storage, to ensure privacy and confidentiality of health information and digital rights.**
	• **Support data quality improvement**
	  ○ Implement integrated, digital, electronic routine data quality assessments (eRDQA) in high volume sites. Frequency can be adapted to available funding, e.g. every six months/ annually instead of quarterly.
	  ○ Support configuration of data quality functionalities in digital HIS software (e.g. DHIS2 Data Quality Toolkit).
	• **Support routine data analysis and use monitoring meetings at all levels**, including district, health facility, and community, to identify gaps, monitor trends and better target interventions.
	• **Maintain existing data repositories and continue those that are in the process of being set up,** while optimizing data use functions. Also see below disease-specific and multi-source integrated disease surveillance data repositories.
	• **Adapt efficient methodologies for program/system reviews**. Review cost-saving options by reducing field-level visits and increasing desk reviews, including rapid surveillance assessments and virtual validation meetings.

Health Information Systems and Strategic Data	
Key Priorities	**Main approaches**

	• **Support critical surveys and assessments** to fill crucial data gaps and enable targeted, tailored program implementation. These may include surveys that address highest priority gaps in epidemiology, service access, or system capacity to address strategic and operational issues. Typically, it includes co-financing from governmental and other development partners.
	
	Optimization and efficiency considerations
	
	• Consider the maturity of (digital) HIS, where appropriate, to guide critical investments.
	• Embrace novel approaches to supporting HIS that may lead to medium- to long-term efficiencies. These may initially incur cost but will likely generate longer-term savings; can include data digitization and AI-enabled analytics.
	  ○ For AI solutions, reference national AI and digital strategies, and global ethics and governance guidelines.[18]
	• Ensure periodic revisions of national indicators and data collection tools. Collected data and existing registries must be critically scrutinized and reduced to minimum. Respect the principles of one-time data collection, ensuring data is used for decision-making and data collection imposes minimal burden on the health workforce, including at community level.
	• Continue digitalizing and integrating systems to improve data quality (timeliness and accuracy) for decision-making and reduce costs of paper-based tools and logistics, taking into account digital system maturity.
	• Identify more efficient approaches for essential data functions, such as supportive supervision, data quality assessments (DQAs), and continuous quality improvement (CQI) and:
	  ○ Reduce frequency, if necessary, and improve methodology (e.g. transform data validation meetings into monitoring meetings that analyze data quality, program performance and define action taking).
	  ○ Employ virtual modes at national, regional, and district levels, and in-person modes at health facility and community levels.
	• Strengthen HIV/TB/malaria surveillance within routine HIS, e.g. HIV sentinel surveillance among pregnant women based on routine antenatal care (ANC)-PMTCT-based data, using established normative methods to integrate disease-specific surveillance into national health information and surveillance systems.

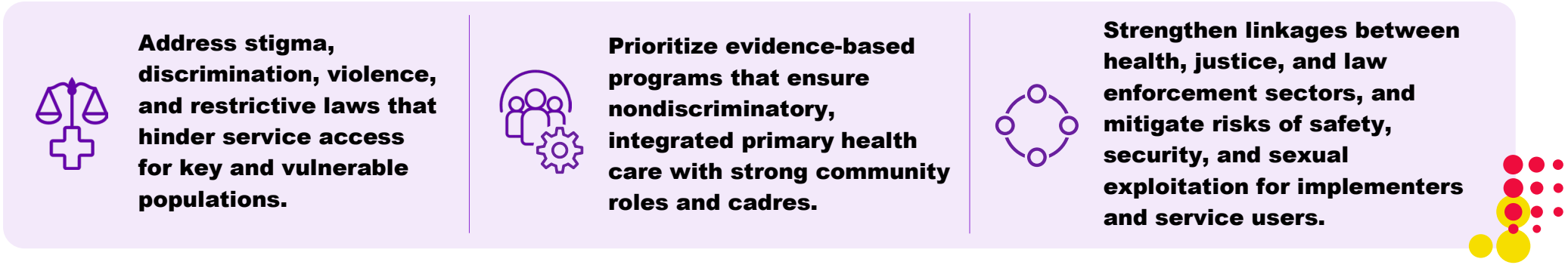
2. Disease-specific data and data	**Priorities for Global Fund investments** **HIV:** • Patient monitoring, including antiretroviral therapy (ART)/ pre-exposure prophylaxis (PrEP) initiation, re-entry, loss to follow-up.

Health Information Systems and Strategic Data	
Key Priorities	**Main approaches**
system investments	• Monitoring antiretrovirals (ARVs) dispensing for ART, PrEP and post-exposure prophylaxis (PEP). • Monitoring of lab tests, viral load, cluster of differentiation 4 (CD4) and HIV testing. • Simplified methods (bio-behavioral survey "(BBS) lite, HIV Sentinel Surveillance plus) to track biobehavioral trend among key and vulnerable populations. • Integration of prevention outcome monitoring (POMT) in routine monitoring of services. **TB:** • TB routine surveillance system strengthening activities (case-based and aggregate level reporting), including for key and vulnerable populations that are displaced due to extreme weather events and other climate shocks. • System enhancements to enable TB data disaggregation by health system level (community, primary, secondary, etc.) and, where appropriate, between public and private providers (in line with the TB PPM Dashboard). • Accelerate transitioning to real-time reporting according to country context. **Malaria:** • Targeted surveillance around biological threats, which may include entomological assessments (especially on invasive vector species), insecticide resistance monitoring, therapeutic efficacy studies and histidine rich protein 2 and 3 (HRP2/3) deletion surveys. • Integration of climate considerations into malaria surveillance systems, including strengthening data repositories that link malaria, GIS, climate, spatial, land use, land cover, and disaster data. Also see public health emergency operations center (PHEOC)-based data hubs, below. • Critical surveys and/or explore introduction of ANC1-based surveillance as an alternative to malaria indicator survey (MIS). • Strengthen malaria data reporting for outbreak preparedness and response in epidemic-prone settings and within community and private sector settings where malaria case management is strongly supported.

Health Information Systems and Strategic Data	
Key Priorities	**Main approaches**
3. Integrated multi-pathogen and collaborative surveillance	**Priorities for Global Fund investments** • **Prioritize epidemic-prone disease, early warning and collaborative surveillance** even in constrained financing environments, as national disease programs and public health institutes accelerate integration and consolidation of essential public health functions to improve efficiency and sustainability. • **Support integrated curriculum development and/or pre- and/or in-service training of polyvalent CHWs on community event-based surveillance (CEBS),** in line with national program curricula and via effective coordination between Community Health and Surveillance Departments. • **Develop integrated guidelines for supportive supervision and data quality assurance of CEBS data** linked to related Community Health and established indicator-based surveillance functions and broader continuous quality improvement of early detection and rapid response functions through application of early action reviews and 7-1-7 timeliness metrics. • **Adopt or strengthen Epidemic Intelligence from Open Sources (EIOS).** • **Support frontline field epidemiology training** on routine program monitoring and surveillance data collection, analysis and use with focus on district and health facility levels, to identify program gaps, analyze trends, and target response activities including through application of 7-1-7 timeliness metrics. • **Strengthen sub-national operation and maintenance of integrated national digital HIS systems** including indicator-based notifiable disease surveillance e.g., IDSR modules and/or digital tools for CEBS. • **Expand existing multi-source disease surveillance data repositories within PHEOCs** to provide critical epidemic intelligence, such as One Health-based environmental risk monitoring for climate-sensitive pathogens, climate-informed early warning systems, and tracking essential services and response needs during health emergencies. • **Advance IHR implementation** based on Joint External Evaluations (JEE) and National Action Plans for Health Security (NAPHS) capacity and operational gaps, underscoring PRET and collaborative surveillance. • **Support transitional training on notifiable disease surveillance** e.g. IDSR, including surveillance, HIS and clinical staff from within disease programs and PHC (including sub-national and health facility levels, as appropriate) to strengthen integrated functions within evolving decentralized governance structures and/or national public health institutes.

Health Information Systems and Strategic Data	
Key Priorities	**Main approaches**
	Optimization and efficiency considerations • Surveillance, workforce, and laboratory capacity-building should be planned holistically and in collaboration with all relevant stakeholders. For example, indicator-based IDSR training can include staff from different levels (national, sub-national, facility) and functions (clinical, laboratory, surveillance). Relevant governance units should be involved in planning and implementation to ensure coordination and efficiency. • Digital surveillance systems and infrastructure (e.g., data lakes, hubs) should be developed in consultation with national or decentralized bodies responsible for health information systems, digital health, information and communication technology (ICT), and related strategic planning. • Genomic, waste-water-based, and other lab-based surveillance e.g. AMR should be considered within the lab systems strengthening module and positioned within overall collaborative and One Health surveillance strategies and operations.

9. Reducing Human Rights-related Barriers to HIV, TB and Malaria Services



An effective response to the three diseases relies on reaching the people who need it the most. Experience has long shown that specific programmatic approaches that effectively target different populations according to their needs considerably improve health outcomes.[19] Addressing

human-related barriers that limit access to services for the people who need it the most supports an effective response to HIV, TB and malaria. Stigma, discrimination, violence and restrictions on civil society exclude key and vulnerable populations even where services exist, undermining quality of care and health outcomes. Applicants should integrate rights-based and gender-responsive approaches by investing in programs that remove access barriers, meet minimum human rights standards, and promote nondiscriminatory, people-centered PHC, including strong community roles. The technical brief on Reducing human rights and gender-related barriers to HIV, TB and malaria services further expands on areas of investment to prioritize listed below. Global Fund requirements on minimum standards are built into the Global Fund's Code of Conduct and grant agreements.

Reducing Human Rights-related Barriers to HIV, TB and Malaria Services	
Key Priorities/ Critical Approaches	**Main approaches**
1. Expanding access to quality and discrimination-free health care	**Priorities for Global Fund investments** • **Ensure non-discriminatory provision of health care,** by making health systems and services welcoming, inclusive, caring and supportive for all, through: ○ Integration of human rights considerations in pre-service and in-service trainings of health care providers, and activities to strengthen competencies and accountability among health care administrators, ancillary staff, and health care regulators. Trainings should focus on medical ethics, patients' rights, nondiscrimination, gender equality, disability and social inclusion, cultural competence, duty to treat, informed consent and confidentiality, PSEAH, violence prevention and treatment, as well as assessments of attitudes of health care providers, including pre- and post-intervention assessments. ○ Development of institutional policies and accountability mechanisms, including performance evaluation processes for stigma, discrimination and other abuses, and reporting mechanisms for patients. ○ Integration of human rights considerations and cadres in health care provision, such as community mediators to support in navigating access to health care or paralegals to support when rights are violated. • **Eliminate HIV and TB-related stigma and discrimination in all settings,** by assessing and addressing lived experiences and gaps in responses and implementing evidence-informed programs, such as: ○ Periodically measure stigma and discrimination with and for affected populations where incidence and prevalence are high. Disaggregate data by population, age and gender.[20]

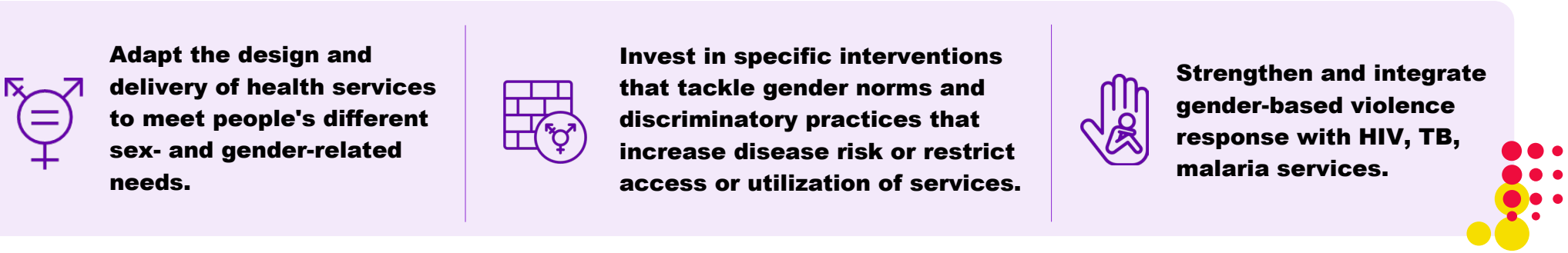
Reducing Human Rights-related Barriers to HIV, TB and Malaria Services	
Key Priorities/ Critical Approaches	**Main approaches**
	○ Address stigma and discrimination in individual, household and community settings given their demonstrated impact on access and adherence to health services continuum. This can be achieved by increasing individual-level counselling to mitigate internalized stigma; sensitizing and engaging community leaders through community dialogues and activities to shift norms that drive stigma and discrimination; engaging families and households in anti-stigma and anti-discrimination activities. ○ In portfolios where the Global Fund's challenging operating environments (COEs) policy applies and other high-risk contexts, focus on addressing stigma and discrimination in emergency and humanitarian settings. This includes revising national emergency plans to incorporate the needs of people living with HIV, those affected by TB and malaria and other key populations, and supporting CLOs to adapt quickly to the needs of their communities in emergencies. **Low priority and requiring justification** • Activities focusing on addressing stigma and discrimination in education settings. This includes training and providing institutional support for educators and administrators on identifying and addressing stigma and discrimination, such as those affecting young key and vulnerable populations, through school policies, school dialogues and procedures to handle conflict/bullying. • Activities focusing on stigma and discrimination in workplace settings. This includes providing training to workers on their rights within the workplace, tools and services for redress, implementing and enforcing workplace policies that promote a healthy and stigma-free environment **Optimization and efficiency considerations** • Leverage national human rights mechanisms and actors, such national human rights institutions for increased efficiency and optimization of human rights investments across the three diseases. • Integrate programs to address human rights barriers to HIV, TB and malaria services into broader efforts, such as community-led advocacy for legal and policy reforms on age-of-consent and third-party consent requirements, and sexual and reproductive health and rights to enhance accessibility to services and their optimal quality.

Reducing Human Rights-related Barriers to HIV, TB and Malaria Services	
Key Priorities/ Critical Approaches	**Main approaches**
	• Integration of interventions to remove human rights-related barriers as part of the package for the introduction of innovative tools for prevention and treatment.
2. Improving the legal and policy environment	**Priorities for Global Fund investments** • **Strengthen laws, regulations and policies to enable access to health care and effective HIV, TB and malaria responses** by: supporting decriminalization of key and vulnerable populations; addressing legal impediments to community-led service provisions and civil society registration, funding and operations; reforming laws and policies on mandatory testing, disclosure and treatment, or registration of people who use drugs; addressing age of consent barriers for adolescents accessing services; reforming laws and policies on addressing gender-based violence (GBV) and those allowing sterilization without full and informed consent; addressing travel restrictions that limit access to HIV, TB and malaria services; advancing digital rights and upholding access to scientific innovation. • **Ensure rights-based law enforcement practices to safeguard access to health services** through: rights-based public health approach to law enforcement policies; trainings for law enforcement officers (police, judges, prison staff) on public health, human rights and gender equality; assessments of attitudes of police, prosecutors, judges, prison staff, including pre- and post-intervention assessments; and joint activities between police personnel and representatives of key and vulnerable populations. **Consider deprioritizing unless essential based on country context** • Develop new disease-specific legal and policy frameworks, institutional policies and reporting mechanisms, where existing ones can be strengthened. Avoid conducting sensitization events that are not clearly linked with broader efforts to improve legal and policy environment or enforcement. **Optimization and efficiency considerations** • Respect patient rights, including informed consent, confidentiality and protection of personal data, as well as human rights principles such as meaningful community engagement and non-discrimination for efficiency and effectiveness.

Reducing Human Rights-related Barriers to HIV, TB and Malaria Services	
Key Priorities/ Critical Approaches	**Main approaches**
	• Optimize capacity building by integrating non-discrimination, key population and gender competencies in relevant capacity building activities for health care providers through the HRH module (see GC8 Modular Framework Handbook).

3. Improved legal empowerment and access to justice	**Priorities for Global Fund investments**
	• **Enable people living with and affected by HIV, TB and malaria to know their rights and the relevant policies and laws, and advocate for access to quality health care,** through legal literacy ("Know Your Rights") community-level campaigns and sensitization, digital platforms and tools to counter misinformation and disinformation, strengthened integration into key and vulnerable populations programming as well as their safety and security, and GBV and sexual and reproductive health programming, including crises response mechanisms.
	• **Increase access to justice to enable key and vulnerable populations address legal issues affecting their health** and support consistent engagement in prevention, testing and treatment, through:
	  ○ Peer paralegals for key and vulnerable populations.
	  ○ Scaling up legal services provision and representation, including through partnerships with national legal aid mechanisms, pro bono legal services, linking paralegals with attorneys who can provide guidance and support.
	  ○ Support to health-related redress mechanisms, such as complaints mechanisms, alternative dispute resolution and hotlines and other rapid response mechanisms.
	  ○ Support strategic litigation to reform harmful laws and policies affecting access to health services and HIV, TB and malaria outcomes.
	Consider deprioritizing unless essential based on country context
	• Replacing lawyers within each separate organization with alterative arrangements, such as retainers.

10. Reducing gender-related vulnerabilities and barriers to HIV, TB and malaria services



To strengthen HIV, TB and malaria outcomes, it is important to address the underlying factors that contribute to gender disparities, including harmful gender norms, inequalities in power and control over resources, gender-based violence, and discriminatory practices. In designing activities to respond to underlying gender-related vulnerabilities and barriers, it is important to recognize that women, girls, men, boys, and gender-diverse communities have different health service needs and these may change depending on the context they are in, characteristics such as key population status, age, race, disability, or ethnicity, as well as socioeconomic, environmental, cultural and political determinants of health, and the way that these factors intersect. Migration or education status may, for example, increase gender-related barriers to malaria prevention interventions and case management and result in poorer outcomes for some women and girls, compared to their non-migrant or more educated peers. Adolescent girls and young women (AGYW) may feel less comfortable and safe seeking out health services compared to their older peers due to stigma from health care providers or other age-related barriers, such as parental consent requirements. These factors can also increase risk of sexual exploitation, abuse and harassment of particularly vulnerable groups as they access services. Integrated equity, gender and human rights assessments can help to identify gender-related vulnerabilities and barriers faced by specific groups, as well as the strategies that will be most effective in addressing them.

Reducing gender-related vulnerabilities and barriers to HIV, TB and malaria services	
Key Priorities	**Main approaches**
1. Transforming harmful gender norms and reducing gender discrimination	**Priorities for Global Fund investments** • **Prioritize evidence-based, gender norm change activities** in areas where gender-related disparities in HIV, TB and malaria outcomes are greatest or where gender-related vulnerabilities and barriers impact overall progress (e.g., in regions where HIV incidence among AGYW is high, TB among men or pregnant/breastfeeding women is high, or where women's lack of health decision-making power impacts their ability to seek malaria prophylaxis, uptake PMTCT services or treatment for themselves or their children, in areas where women's access to health care is disrupted and health risks increased due to violence, conflict, extreme weather events or climate-induced displacements or food insecurity). • **Reinforce multi-component and multi-level programs, such as single-sex or mixed sex group education** through social marketing and community mobilization activities, over a longer period that are more effective than standalone interventions. Simultaneously invest in gender-responsive service delivery to increase impact (e.g. through reducing gender-based stigma and discrimination in health facilities and addressing gender-related norms and barriers to access in the design and delivery of services, including improving quality of care, instituting flexible hours or mobile services, or increasing confidentiality and safety). • **Prioritize integrating gender norm-change activities** into HIV, TB and malaria services at health facilities or through community-level outreach by trained community health or peer workers, including couples counseling, group education, and peer-based interventions. • **Prioritize support for community-led organizations to implement social empowerment programs** (for example, safe space programs and mentoring, facilitating access to financial services and training), along with community-level awareness, mobilization and advocacy activities to increase health decision-making power and agency among women, girls, trans and gender-diverse communities. • **Prioritize group education programs that reduce both women and men's risk and vulnerability to HIV, TB and malaria, reinforced by social marketing messaging** to address gender norms and behaviors that hinder disease responses. **Low priority and requiring justification if proposed** • Avoid one-off community education and awareness-raising sessions. **Optimization and efficiency considerations**

Reducing gender-related vulnerabilities and barriers to HIV, TB and malaria services	
Key Priorities	**Main approaches**
	• Use data and evidence (e.g., from equity, gender, and human rights assessments) to optimize access to services by those who need them most but are hindered by gender-related vulnerabilities and barriers. • Work in partnership with women's rights and community-led organizations to design, implement and monitor programs to ensure that they are relevant and acceptable to communities that are most affected by HIV, TB and malaria. • Develop multisectoral coordination and collaboration to address gender-related vulnerabilities and barriers to services. Programs are more likely to be successful if accompanied by interventions to remove structural drivers of gender inequalities, such as legal and policy reform or interventions to increase access to education, livelihoods, and social protection. • Support blended financing and co-investments with other funders (e.g. contributing to social protection initiatives to facilitate access to or support for vulnerable groups of AGYW or pregnant/breastfeeding women with TB) to support more integrated approaches and increase scale and impact on both gender equality and health outcomes. • Integrate gender norm-change, gender-based violence, and gender-responsive service delivery interventions into primary health care and health and community systems strengthening interventions to reduce barriers to services and increase impact.
2. Preventing and responding to violence against women and girls in all their diversity	**Priorities for Global Fund investments** • **Prioritize post-rape care, intimate partner violence clinical care and medical management**, immediate support for survivors of violence, including case management, psychosocial support and safe spaces particularly in settings where HIV incidence among women, adolescent girls, trans and gender-diverse communities is high as well as in conflict and humanitarian settings. • **Prioritize integration of gender-based violence (GBV) services within sexual and reproductive health services primary health care settings**. Consider GBV services as an entry point for identifying priority populations in need of HIV PEP/PrEP. • **Prioritize integration of GBV screening, train and support health and community health workers to provide first-line support** to survivors of violence (e.g. LIVES Protocol), strengthening referral networks for case management and support services for survivors, and interface with community-led and community-based organizations. • **Prioritize awareness-raising, sensitization and demand creation activities,** along with training for law enforcement and other duty bearers on survivor-centered gender-based violence prevention and response in settings where minimum GBV response services are in place. Integrate GBV awareness and sensitization interventions into existing health outreach campaigns implemented by CHWs and community-led and community-based organizations.

Reducing gender-related vulnerabilities and barriers to HIV, TB and malaria services	
Key Priorities	**Main approaches**
	• **Support evidence-based prevention interventions with clear linkages to HIV, TB and malaria services and GBV clinical care and case management** in settings where GBV risks are highest as part of coordinated national or sub-national responses to GBV. Consider scaling through women's rights/women-led, key-population-led and other community-led organizations. • **Structured group education programs**, such as SASA! and Stepping Stones, are priority in settings where HIV incidence among AGYW is high. These group education programs should target adolescent girls and boys, young women and men and have strong feedback loops and community engagement components to gain support, generate demand for services, and increase sustainability. **Low priority and requiring justification if proposed** • Standalone cash transfers (except for immediate relief for survivors in emergency situations) and livelihood training programs. Economic empowerment is important for both preventing gender-based violence and increasing the resilience of survivors. However, funding requests should focus on facilitating access to national social protection services and training opportunities through referrals or assistance rather than establishing standalone initiatives as part of HIV, TB or malaria programs. Where standalone livelihood support or other social protection programs were previously supported through Global Fund grants, programs should be responsibly transitioned to national programs or carefully phased out to minimize potential harm to beneficiaries. Responsible transition can include support to strengthen the gender-responsiveness of national programs.

Acronyms

RSSH	Resilient and sustainable systems for health
PPR	Pandemic preparedness and response
CHW	Community health worker
WHO	World health organization
GFF	Global Financing Facility
UHC	Universal health coverage
NPHI	National public health institutes
MOH	Ministry of health
PHC	Primary health care
HRH	Human resources for health
ITN	Insecticide-treated nets
CLO	Community-led organization
CBO	Community-based organization
CRSS	Community responses and systems strengthening
M&E	Monitoring and evaluation
AAAQ	Availability, accessibility, acceptability and quality
PSEAH	Protection from sexual exploitation, abuse and harassment
NCD	Noncommunicable disease
CCM	Country coordinating mechanism
ODA	Official development assistance
STC	Sustainability, transition and co-financing
SBCC	Social and behavioral change communication
PFM	Public financial management
PPM	Pooled procurement mechanism
PSM	Procurement and supply management
SOP	Standard operating procedure
QI	Quality improvement
PMTCT	Prevention of mother to child transmission
eCHIS	Electronic community health information systems
IHR	International health regulations
SRS	Specimen referral systems
LIS	Laboratory information systems
LQMS	Laboratory quality management system
LMM	Laboratory maturity model
GIS	Geographic information system
AMR	Antimicrobial resistance
SLA	Service level agreement
DNO	Diagnostic network optimization
NGS	Next-generation sequencing
PSA	Pressure-swing adsorption
HIS	Health information systems
AI	Artificial intelligence
PHEOC	Public health emergency operations center
IDSR	Integrated disease surveillance and response
GBV	Gender-based violence
AGYW	Adolescent girls and young women
PEP	Post-exposure prophylaxis
PrEP	Pre-exposure prophylaxis

[1] "Services organization and integration," WHO, https://www.who.int/teams/integrated-health-services/clinical-services-and-systems/service-organizations-and-integration
[2] See also: WHO (2022) Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations, https://www.who.int/publications/i/item/9789240052390; WHO (2019) Consolidated guideline on sexual and reproductive health and rights of women living with HIV – Guideline, https://www.who.int/publications/i/item/9789241549998; 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; and World Health Assembly, 69 (2016). Framework on integrated, people-centred health services: report by the Secretariat. World Health Organization, https://apps.who.int/gb/ebwha/pdf_files/wha69/a69_39-en.pdf
[3] Hiebert L, Resch S, Schutte C, et al. Tanzania HIV Investment Case (IC) 2.0: Using modeling to explore optimization under severe resource constraints. Journal of Global Health Reports. 2022;5:e2021106. doi:10.29392/001c.30063
[4] https://www.theglobalfund.org/en/sourcing-management/health-products/
[5] https://resources.theglobalfund.org/media/13810/cr_budgeting-global-fund-grants_guidelines_en.pdf
[6] Hiebert L, Resch S, Schutte C, et al. Tanzania HIV Investment Case (IC) 2.0: Using modeling to explore optimization under severe resource constraints. Journal of Global Health Reports. 2022;5:e2021106. doi:10.29392/001c.30063
[7] Hiebert L, Resch S, Schutte C, et al. Tanzania HIV Investment Case (IC) 2.0: Using modeling to explore optimization under severe resource constraints. Journal of Global Health Reports. 2022;5:e2021106. doi:10.29392/001c.30063
[8] https://www.theglobalfund.org/en/sourcing-management/health-products/
[9] https://resources.theglobalfund.org/media/13810/cr_budgeting-global-fund-grants_guidelines_en.pdf
[10] WHO (2023), Workload Indicators of Staffing Needs, https://www.who.int/tools/wisn
[11] See: Madeleine Mukeshimana, MD; Rosine Bigirimana; Richard Kalisa, MD, PhD; Assumpta Kayinamura Mwali, MD; and Samson Radeny, PhD; "Enhancing Provider Competencies through the Low-dose, High-frequency Training Approach, *IntraHealth International*, May,22, https://www.intrahealth.org/sites/default/files/attachment-files/tb4enhancingprovidercompetenciesrev-5-22hr-d.pdf
[12] WHO (2023), Workload Indicators of Staffing Needs, https://www.who.int/tools/wisn
[13] Global Laboratory Leadership Programme (GLLP), https://www.who.int/initiatives/global-laboratory-leadership-programme
[14] WHO (2020) Digital Implementation Investment Guide (DIIG): Integrating Digital Interventions into Health Programmes, https://www.who.int/publications/i/item/9789240010567
[15] WHO (2025) Guidance note on the inclusion of activities for AMR surveillance and laboratory strengthening into Global Fund proposals, https://www.who.int/publications/m/item/guidance-note-on-the-inclusion-of-activities-for-amr-surveillance-and-laboratory-strengthening-into-global-fund-proposals
[16] WHO, Model Lists of Essential Medicines, https://www.who.int/groups/expert-committee-on-selection-and-use-of-essential-medicines/essential-medicines-lists
[17] WHO Global Digital Health Monitor and DHIS2 Maturity Profiles, https://digitalhealthmonitor.org/ and https://dhis2.org/maturity-profile/
[18] WHO (2025) Ethics and governance of artificial intelligence for health: Guidance on large multi-modal models, https://www.who.int/publications/i/item/9789240084759
[19] See also: WHO (2022) Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations, https://www.who.int/publications/i/item/9789240052390; WHO (2019) Consolidated guideline on sexual and reproductive health and rights of women living with HIV – Guideline, https://www.who.int/publications/i/item/9789241549998; 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; and World Health Assembly, 69 (2016). Framework on integrated, people-centred health services: report by the Secretariat. World Health Organization, https://apps.who.int/gb/ebwha/pdf_files/wha69/a69_39-en.pdf
[20] Using tools such as the People Living with HIV Stigma Index, the Integrated HIV Bio-behavioral Surveillance module on stigma and discrimination as experienced by key populations, TB stigma assessment tool