GC7 Programmatic Reprioritization Approach

"Protecting and enabling access to lifesaving services"

Date published: 5 June 2025

The information contained in this document is not meant to be prescriptive and any decisions made on changes to current grant activities require tailoring to country context.

Contents

Introduction

This document supports Country Coordinating Mechanisms (CCMs)[1] and Principal Recipients (PRs) in decision-making for reprioritization of interventions in Global Fund grants for Grant Cycle 7 (GC7), respecting the principle of country ownership and without losing sight of the Global Fund's mission to save lives.

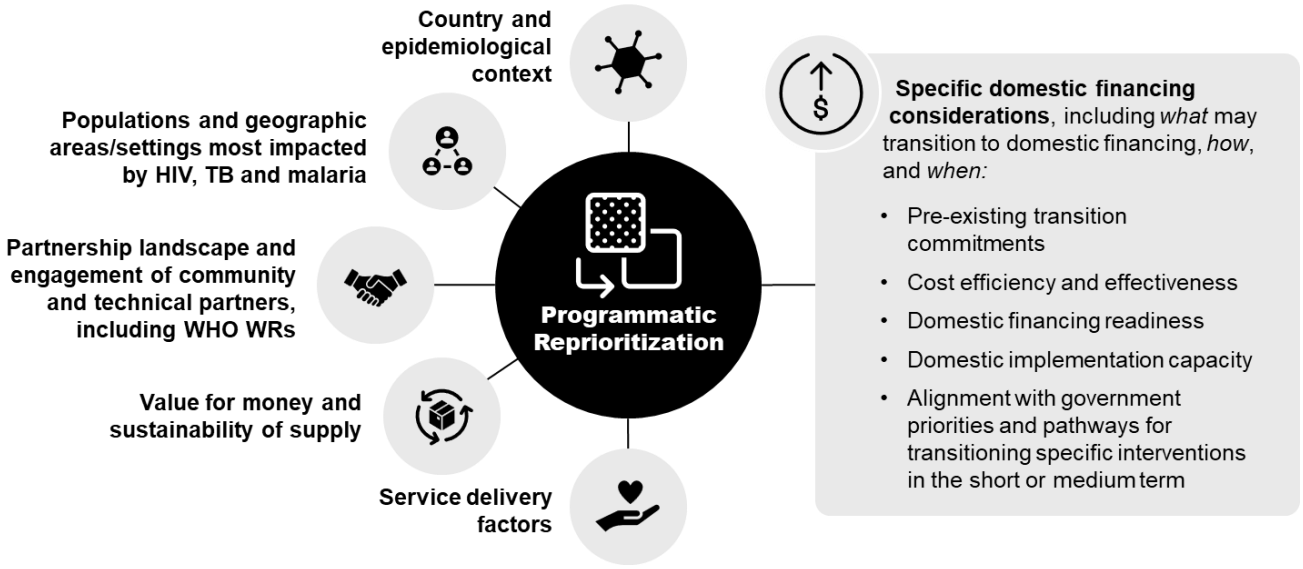
Any changes must be tailored to each unique grant and country context, considering programmatic interdependencies and all sources of funds. In preparation for Grant Cycle 8 (GC8), reprioritization decisions and grant revisions for GC7 must be taken considering integration, cost effectiveness and long-term sustainability of HIV, TB, malaria activities within countries' primary health care services and health and community systems. See section on "RSSH and integration" below.

Reprioritization is intended to impact GC7 grants only. Currently approved C19RM-related activities are expected to continue given the need to maintain the pace of execution within the C19RM implementation period. In cases where reprioritization discussions impact private sector contributions, catalytic investments such as matching funds or blended finance transactions, please consult with the Global Fund Country Team directly.

As a first step ahead of this reprioritization exercise, Global Fund Country Teams have been working with CCMs and Principal Recipients in the past months to defer and/or pause specific grant activities under current Grant Cycle 6 (GC6) and GC7 grants. The deferral/pause of these activities is aimed at maximizing available funding for critical lifesaving services, see section 3 in this document. Process guidance to start grant revisions will be issued separately.

[1] Throughout this document, references to "CCM" include any Regional Coordinating Mechanism (RCM), Regional Organization (RO) or other applicant, as applicable.

Figure 1: Programmatic Reprioritization decisions should consider country context and all sources of funding



How to use this document

This document is divided into module or intervention-specific sections for HIV, TB, malaria and RSSH, complemented by a section on health products and procurement. Each section proposes interventions to consider for prioritization and deprioritization, and suggests where to find efficiencies or optimize investments.

General Considerations

Equity, Human Rights, Gender and Community Systems

Key interventions to reduce equity, human rights, and gender-related barriers should be prioritized to ensure that the most affected populations can effectively access HIV, TB, and malaria services. Availability of services alone is considered insufficient as interventions must be designed to ensure that key, vulnerable and underserved populations can access and benefit from them, with sustained focus in engaging communities across the cascade of care. Countries must work to remove structural barriers across health and community systems such as stigma, discrimination and gender-based violence. These barriers are further heightened in many settings, as a result of funding cuts for health.

Maintaining and strengthening community systems is essential to reaching the most affected populations. This includes preserving community peer cadres and ensuring that community-led service delivery mechanisms are optimized, remain functional and well-

supported. This will require protecting investments that contribute to improved linkage and referral between formal and community health delivery platforms.

Integration into primary care services should be accompanied by efforts to make services accessible and acceptable to the most affected populations, including activities to strengthen competencies in delivering inclusive, respectful, stigma-free, gender-responsive and age-appropriate care. Additionally, community-led monitoring (CLM) and accountability mechanisms are critical to identifying and addressing rights violations and ensuring that health systems remain responsive to the needs of those most at risk. However, it is important to avoid support for standalone or trial CLM programs at this time as per the information in this document.

It is important that these areas of investment are not disproportionately reduced, given their immediate and long-term benefits in overcoming service access barriers. Prioritization decisions must be considered holistically at the country level and assessed for their cumulative impacts or unintended consequences on vulnerable populations, and their potential to worsen barriers in access to health care or health inequities.

For example, prioritization of interventions in pregnancy needs to consider any reductions in HIV testing at antenatal care (ANC) in high burden areas, and nutritional support for pregnant women with TB, alongside reductions in sexual and reproductive health services and the removal of social protection for adolescent girls and young women, as these are likely to combine to increase maternal mortality rates and significantly worsen existing gender inequalities.

RSSH and integration

The Global Fund continues to encourage countries to finance disease interventions in a more integrated and sustainable way, embedding equity, human rights and gender equality in each intervention, while prioritizing systems strengthening for maximum impact and resilience.

Prioritization of disease-specific activities should be considered together with RSSH prioritization areas including human resources for health (particularly CHWs), supply chain systems, community-based and led service delivery and monitoring, data systems (HIS, LMIS, laboratory, etc.), integrated laboratory systems and other health functions that support quality of and equitable access to disease-specific activities. Additional considerations to support sustainability are also included in the RSSH section.

Value for Money

The Global Fund requires all funding requests to exhibit good value for money, maximizing and sustaining quality and equitable health outputs, outcomes and impact for the level of

investment. This is demonstrated through the five dimensions of economy, effectiveness, efficiency, equity and sustainability. Applicants are encouraged to review the Value for Money Technical Brief to understand how to demonstrate good value for money.

Domestic financing

Within a country's funding landscape, it is imperative to consider the role that domestic financing plays in sustaining critical interventions that are essential to HIV, TB and malaria responses and RSSH, and what investments are best placed for transition to domestic financing in the short-, medium- and long-term. A context specific, intentional approach to domestic financing is needed to avoid programmatic disruption, sustain critical interventions and avoid increasing dependencies on Global Fund financing when possible. Prioritization discussions should consider opportunities for decreasing reliance on Global Fund financing for critical interventions, especially given potential longer-term pressure on Global Fund resourcing.

Transitioning specific investments to domestic financing is context-specific and influenced by several factors, including:

1. **Health financing landscape/funding landscape:** Who funds what currently, how this is shifting, and/or may shift?
2. **Fiscal space/economic situation:** What is the ability of countries to increase financing in the medium- to long-term for specific interventions/costs?
3. **Existing co-financing commitments made for GC7:** What has the country already formally committed to in GC7, what is the progress made toward meeting these commitments, and which of these could be built on?
4. **Which interventions are best placed to be transitioned to domestic financing:** What does the transition pathway look like for specific interventions?
5. **"Scaling" of relevant interventions:** How quickly can specific interventions be moved to domestic financing?

Grant targets

We do not recommend revising grant targets because of prioritization and grant re-investments to minimize disruptions and enable PRs focus on implementation rather than revisions to the performance framework.

Contingency planning for reduced funding scenarios: Deferral of GC6 and GC7 activities

This section was initially published in April 2025 to support Principal Recipients' decision-making when deferring cross-cutting grant activities under GC6 and GC7 grants. The deferred investments aim to preserve critical lifesaving services while pausing some areas of investment to maximize available funding. Deferral decisions must be tailored to each unique grant and country context, considering programmatic interdependencies.

Cross-cutting activities for immediate stop, scale back or pause

- **Infrastructure upgrades that have yet to substantially progress, or yet to convincingly demonstrate likelihood of successful completion before the end of GC7** (e.g., a warehousing, storage or waste management infrastructure that has not initiated construction). Specifically, if the construction has not started and there is no clear path to completing it on budget and on time and cheaper, lower risk alternatives exist.
- **Purchase of new vehicles, IT equipment, lab and other equipment**. Prioritize service, maintenance and warranty coverage to ensure precision of instruments and maximize the useful life of the equipment. Accelerate discussions with MoH to take-up financing of server maintenance, license fees where applicable, equipment warranties and warehouse storage costs.
- **Conference** attendance/study tours.
- **Off-site workshop-style standalone in-service training** (e.g., refresher training) on a single disease for HRH/CHW (any cadre, including peers).
- **Meeting costs** for policy development, coordination, validation, and dissemination—including venues, per diems, and refreshments. Countries should leverage existing Ministry of Health and district/village structures or use virtual platforms. Essential meetings that advance integration and sustainability (e.g., finalizing a CHW sustainability plan) can be supported, but must be demonstrably leaner in terms of travel-related costs (number of participants, meeting duration, etc.). Travel-related costs for KVPs to participate in technical forums and inform decision-making can be maintained to ensure inclusive and equitable processes. The goal is not to halt planning, but to economize while preserving meaningful engagement.
- **New surveys, studies, assessments and reviews** including malaria indicator surveys (MIS), demographic and health surveys (DHS), prevalence surveys (e.g., TB), HIV drug resistance surveys, integrated biological behavioral surveillance (IBBS), national data quality reviews (DQRs), Harmonized Health Facility Assessments (HHFAs), rapid impact assessments (RIA), operational research surveys and studies for KPI reporting that have not yet begun. Targeted ART data audits may remain useful in the short-term, however countries should opt moving to

integrated digital routine data quality assurance (eRDQA) activities for a more efficient and sustainable approach. Exception: tHFAs should continue for Board KPI reporting unless alternate feasible approaches to collect KPI data are identified.

- **Print materials and publication costs** except for data collection and reporting tools, such as hospital/lab/facility/CHW registers if not digitalized. Leverage digital platforms instead.
- **Behavior change programs/materials,** mass media campaigns (e.g., for HIV prevention) and launch events (e.g., malaria campaigns). Focus on virtual and IPC rather than print. Exceptions: essential identifiers for campaign distributors/community actors requiring identification (e.g., arm band/t-shirt/cap).
- **PPE** (Personal Protective Equipment) that is not essential for staff or patient protection (e.g., stop procuring masks for insecticide-treated nets (ITNs)/seasonal malaria chemoprevention (SMC) campaign staff). Maintain PPE for TB, especially drug-resistant TB (DRTB) patients and staff supporting them including CHWs.
- **Commemorative days,** generic mass media events and campaigns including related commodities (t-shirts, notebooks, pens).
- **Standalone advocacy efforts.** Exceptions: those that are proven effective in influencing policymakers or maintenance of essential services or linked to community-led monitoring (CLM) data use.
- **Single disease/service supervision.** Scale back while protecting service delivery needs e.g., planned monthly supervision can go to quarterly with virtual check-ins instead, where possible.
    - Reduce inputs e.g., reduce number of supervisors or number of supervision days by tailoring the focus of supervisions on outcomes that are lagging.
    - Deprioritize frequency of supervision of facilities/districts that consistently perform well. Focus on lower performing facilities.
    - Deprioritize supervision from the national level to decentralized level, including public facilities and CSOs. Prioritize sub-national level supervision instead e.g., district to PHC level and strengthening CSO linkages with local health system actors.
- **Operational costs.** Find efficiencies in programmatic management, PMU costs and in-country travel.

HIV

This section is organized by HIV module in the Global Fund GC7 Modular Framework and proposes prioritization, deprioritization, and efficiencies at the intervention level based on the following principles:

- **Priority 1.** Save lives by prioritizing interventions in HIV treatment and care including procurement of ARVs and service delivery (e.g., ART delivery, support for treatment continuation), and diagnosis and management of TB and advanced HIV disease (AHD).

- **Priority 2.** Identify people living with HIV not on ART and link them to treatment, care, and support. Refer others to HIV prevention. Support HIV testing for people with higher HIV risk through cost-effective approaches (such as network-based testing including index testing and partner services), testing people with higher mortality risks such as in TB clinics, testing in services for sexually transmitted infections (STI), services providing care to key populations (KP) and through provider-initiated testing and counseling (PITC). Support testing at antenatal care (ANC) services in high burden settings, and ARV prophylaxis and early infant diagnosis (EID) for HIV-exposed infants.

- **Priority 3.** Protect primary prevention through cost-effective approaches such as the provision of condoms and lubricants. Protect PrEP provision for current PrEP users and prioritize new initiations among those at highest risk of acquiring HIV. Protect harm reduction programs focusing on the continuation of lifesaving interventions such as opioid agonist treatment and safe injecting. Provide PEP to all those potentially exposed to HIV. Integrate HIV prevention into existing sexual and reproductive health (SRH)/STI/ family planning (FP) services.

Barriers to service access: Priority interventions and approaches to address barriers to services are integrated across these three priority areas. They focus on activities that engage communities and address inequities, human rights- and gender-related barriers to HIV services and include community service delivery.

Human resources for health (HRH): Cross-cutting HRH/community health worker (CHW) considerations (including on peer outreach workers) are also addressed in the RSSH HRH section.

Systems interventions: Consider health system interventions that are functional to service provision and quality, prioritizing integrated approaches that improve efficiency and sustainability wherever feasible.

Once prioritization has been considered at intervention level, cross-cutting recommendations are provided by cost input to further focus prioritized interventions. Of important note, all the tables below reflect choices in the context of the most constrained funding.

WHO will soon publish *Sustaining HIV, viral hepatitis and STI priority services in a changed funding landscape: An operational guidance*. This resource will provide more detailed and tailored guidance to countries that seek to adjust program activities to match available funds.

HIV treatment, care and support

Investments in HIV treatment are highest priority. The objective is to ensure that people living with HIV (PLHIV) can initiate and continue receiving ART and those newly diagnosed are promptly linked to services and initiated on treatment, care and support.

HIV treatment, care and support			
Intervention	**Prioritize investments**	**Deprioritize investments**	**Additional considerations/efficiencies**
HIV treatment and differentiated service delivery - [adults (15 and above), children (under 15)]	Access to HIV treatment, including procurement of ARVs and service delivery (ART delivery, support for treatment continuation), for existing cohort and expansion to newly diagnosed people. Retention and re-engagement with care. Measures to maintain key and/or vulnerable populations (KVPs) on treatment (in context of poor treatment outcomes/loss to follow-up), including maintaining safety and security, peer-based support for treatment continuation and advocacy.		Safeguarding the current ART cohort is the top priority; scope of expansion of the cohort will depend on the overall availability of resources. Use resource-sparing dispensing and pick-up models where possible, e.g., quick pick-up points. Consider private pharmacy models as part of differentiated service delivery. Consider multi-month dispensing (at least 3 months and where feasible, six months), community ART delivery, optimized use of peers and community actors where feasible, adapted service delivery and adherence support models tailored to reach those most in need (including vulnerable adolescent girls and young women, youth and men).
Diagnosis and management of advanced disease (adults and children)	CD4 testing TB diagnostics for people with AHD (urinary LF-LAM and molecular tests). Cryptococcal antigen (CrAg) testing, and treatment for cryptococcal meningitis.	Cotrimoxazole continuation for those once stable on ART 1-2 years post immune recovery in line with WHO guidance.	Consider the use of telemedicine for the management of complex cases where possible.

HIV treatment, care and support			
Intervention	**Prioritize investments**	**Deprioritize investments**	**Additional considerations/efficiencies**
	Cotrimoxazole prophylaxis, with attention to subsequent discontinuation when appropriate. Testing and management of other OIs based on country context. e.g., Histoplasmosis. Lumbar puncture needles and blood cultures for diagnosis of serious bacterial infections.		
Integrated management of common co-infections and co-morbidities (adults and children)	Integrated hepatitis C testing and management as part of HIV care only in countries with high levels of coinfection. Treatment for already diagnosed hepatitis B cases. Support for existing programs to screen for cervical cancer and to deliver secondary prevention.	Active hepatitis B case finding and management among adults Development/implementation of new programs for cervical cancer screening Management of NCDs	Hep C services, if supported, should be delivered through integrated low-cost delivery models. Hep B testing and management could be supported in high prevalence settings among people at higher risk. Support through grants for NCD treatments may need to be deprioritized if core HIV services are threatened by funding constraints. Integrated screening (e.g., assessment of risk factors such as smoking and measurement of blood pressure) should continue, given the benefits and the little/no direct cost.
Treatment monitoring - drug resistance		HIV drug resistance surveys and surveillance can be deferred until resources are available.	
Treatment monitoring - viral load and antiretroviral (ARV) toxicity	Viral load, with potential modifications (see additional considerations column).		In some countries, contingency plans may include using VL less frequently or in a more targeted way than recommended by WHO – to economize in the context of severe budget constraints. Global Fund-supported programs

HIV treatment, care and support			
Intervention	**Prioritize investments**	**Deprioritize investments**	**Additional considerations/efficiencies**
			align with national guidelines in countries where this decision is made. We note that WHO guidance continues to support routine VL testing for patient monitoring.

TB/HIV

TB remains the leading cause of death in PLHIV, therefore key activities such as bidirectional screening and prompt treatment for both diseases should be prioritized as they are lifesaving measures. TB preventive treatment in PLHIV has also been proven to decrease morbidity and mortality and should be prioritized. Integrated service delivery models should be implemented wherever feasible.

TB/HIV			
Intervention	**Prioritize investments**	**Deprioritize investments**	**Additional considerations /efficiencies**
TB/HIV - Screening, testing and diagnosis	Screening: TB symptoms in every contact with health facility. TB screening using X-ray if the equipment is already available. Diagnosis: molecular diagnosis (e.g., GeneXpert, TrueNat) and LF-LAM for TB diagnosis HIV testing for those with TB.	Procurement of new x-ray machines. Procurement of C reactive protein for screening	LC-aNAATs (GeneXpert, True NAT) and LF-LAM should be used concurrently as diagnostic tests for PLHIV. However, in some countries, contingency plans may include using LF-LAM less frequently or in a more targeted way than recommended by WHO – to economize in the context of severe budget constraints.
TB/HIV - Treatment and care	Activities related to early initiation or continuation of ART for TB/HIV coinfected patients and provision of anti-TB treatment: linkage to HIV and TB services for those coinfected. Integration of services.		
TB/HIV - Prevention	TPT – among all eligible PLHIV	IGRA and skin tests.	Use of shorter TPT regimens recommended as they are cost effective, have fewer side effects and higher completion rate.

Elimination of Vertical Transmission (EVT)

HIV testing in ANC should prioritize high-burden geographies and individuals at highest risk of HIV, including pregnant women at antenatal care in high burden settings; along with pregnant women at increased risk of HIV (e.g., sex workers, partners of MSM, PWID). Integration opportunities for testing for other co-infections, especially hepatitis, TB and STIs, should be considered.

Elimination of Vertical Transmission (EVT)			
Intervention	**Prioritize investments**	**Deprioritize investments**	**Additional considerations/efficiencies**
Integrated testing of pregnant women for HIV, syphilis and hepatitis B	HIV-syphilis dual test as first test in EVT. Testing among women in KP groups and other women at high risk (including high risk AGYW in high incidence settings). Prioritize HIV testing at ANC in high burden settings[2]	Hepatitis B testing (see "Additional considerations")	In EVT, hepatitis B testing has a higher potential impact in some epidemiologic settings; deprioritization needs careful consideration given potential disruption to established integration efforts.
Prevention of incident HIV among pregnant and breastfeeding women	Provision of condoms Introduction/scale-up of PrEP in settings providing services to individuals who are pregnant/breastfeeding where incidence in the population is: (1) >3%; or (2) 1-3% **and** high-risk behavior is reported. Use lowest costing oral PrEP and lowest costing injectable PrEP options. Continued access to PrEP for those currently using PrEP. GBV screening and effective referral; and GBV first-line response services when already integrated in ANC services.	Introduction/scale-up of PrEP in settings providing services to individuals who are pregnant/breastfeeding where incidence is (1) >3%; or (2) 1-3% **and** high-risk behavior is not reported. PrEP ring procurements for new users, while supporting transition to other HIV prevention options which best meet the individual's needs. Diagnostics/services for PrEP initiation/continuation that are not part of WHO's suggested	Use rapid diagnostic tests (RDTs) and HIV self-tests (HIVST) for PrEP initiation and follow-up noting that HIVST is not recommended for initiation or continuation of injectable PrEP. Support task shifting/sharing for PrEP. Support referral networks for gender-based violence response and for survivor support services.

[2] Considerations for prevention and testing prioritization within this document that take into consideration incidence and prevalence thresholds were based on those suggested by UNAIDS in their Global AIDS Strategy 2021-2026, under prioritization of HIV prevention methods.

Elimination of Vertical Transmission (EVT)			
Intervention	**Prioritize investments**	**Deprioritize investments**	**Additional considerations/efficiencies**
		minimum service delivery package for PrEP.[3]	
Post-natal infant prophylaxis	Infant prophylaxis for all children exposed to HIV		
Early infant diagnosis and follow-up HIV testing for exposed infants	EID and follow-up testing for all children exposed to HIV	Investment in new POC equipment for EID/VL	Optimize existing diagnostic networks to continue ensuring EID
Retention support for pregnant and breastfeeding women (facility and community)	Retention support to continue ART, including community-based strategies.		Consider efficiencies within peer support/mentor mother models and opportunities to expand scope of peer work where feasible (e.g., in support of ART dispensation)

[3] https://www.who.int/publications/i/item/9789240097230

HIV Testing

Testing is crucial for both prevention and treatment pathways. Prioritize testing investments that use the best approaches for the local epidemic context and population needs and preferences. A careful examination of unit costs and cost-effectiveness of various delivery approaches can assist in identifying the most effective options in relation to available resources.

Differentiated HIV Testing Services			
Intervention	**Prioritize investments**	**Deprioritize investments**	**Additional considerations /efficiencies**
Facility-based, community-based and self-testing for key populations (KP) and adolescent girls and young women (AGYW) at high-risk and their male sexual partners	Testing for key populations Testing for AGYW and their male sexual partners: in areas where incidence is high (1-3%), and in areas where incidence is moderate (0.3-<1%) and AGYW report high risk behavior Index and social network testing		Engaging lay providers for HIV testing can be **cost-effective** as compared to delivery of HIV testing by health workers. It can help address gaps in human resources for health and significantly expand community reach for HIV testing and testing access for KVP Opportunities for cost-savings by shifting to low-cost HIV test kits and commodities. • Low-cost quality-assured options are available, with a focus on first test in the 3-test algorithm. • Shifting to HIV self-testing (including at facility level) could lead to savings if replacing provider testing. • See WHO's FAQ for additional efficiencies: https://cdn.who.int/media/docs/default-source/hq-hiv-hepatitis-and-stis-library/priorization_low_cost_faq_handout_may2025_final.pdf?sfvrsn=f49f2626_3
Facility-based, community-based, and self-testing for other populations	Testing in services for TB, for at-risk children, for people with an STI, and for others defined as at risk by provider (PITC). Index and social network testing		

HIV Prevention

Integrate HIV prevention programs for KPs and AGYW into mainstream services where competency exists and where protections against stigma and discrimination are in place.

HIV Prevention			
Intervention	**Prioritize investments**	**Deprioritize investments**	**Additional considerations/efficiencies**
Condom and lubricant programing for all KP, and for AGYW/MSP in moderate and high incidence settings[4]	Male condoms and lubricants Expand availability of condoms/lube/safe injecting equipment in informal sites (e.g., bars, brothels, vending machines) managed by local actors.	Female condoms (higher cost and limited use). However flexible approach recommended where demand for female condoms is clear, especially amongst sex workers.	Focus investment in high HIV incidence settings first, followed by moderate incidence settings. Consider a total market approach for sustainable condom markets.
PrEP programming for FSW (including AGYW selling sex)	Introduction/scale-up in settings where national adult (15-49) HIV prevalence is >3%. Use lowest costing oral PrEP and lowest costing injectable options. Continued access for those currently using PrEP.	Settings where national adult (15-49) prevalence is <3%. PrEP ring procurements for new users, while supporting transition to other HIV prevention options that best meet the individual's needs. Diagnostics/services for PrEP initiation/continuation that are not part of WHO's suggested minimum service delivery package for PrEP.[5]	People requesting PrEP should be able to initiate and continue PrEP without identifying with a specific population or revealing specific behaviors. Plans for introduction and scale-up of oral and injectable PrEP should continue for those populations/settings identified under "prioritize". This includes catalyzing introduction of lenacapavir (LEN) PrEP in specific portfolios as part of broader institutional planning efforts. Integrate PrEP/PEP into existing SRH/FP/STI/other health services and where feasible, community-based differentiated service delivery. Use rapid diagnostic tests (RDTs) and HIV self-tests (HIVST) for PrEP initiation and follow-up noting that HIVST is not recommended for initiation or continuation of injectable PrEP. Support task shifting/sharing for PrEP.

[4] For AGYW programming, moderate incidence settings are those with an incidence among AGYW 15-24 of 0.3 – <1.0%, and high incidence settings 1-3%.
[5] https://www.who.int/publications/i/item/9789240097230

HIV Prevention			
Intervention	**Prioritize investments**	**Deprioritize investments**	**Additional considerations/efficiencies**
PrEP programming for MSM and trans and gender-diverse people	Introduction/scale-up in settings where a proportion of populations are estimated to have incidence >3%.[6] Use lowest costing oral PrEP and lowest costing injectable options. Continued access for those currently using PrEP.	PrEP ring procurements for new users, while supporting transition to other HIV prevention options which best meet the individual's needs. Diagnostics/services for PrEP initiation/continuation that are not part of WHO's suggested minimum service delivery package for PrEP.[7]	
PrEP programming for PWID	Introduction/scale-up in settings with few/low reach of needle-syringe programs and low opioid substitution therapy coverage. Use lowest costing oral PrEP and lowest costing injectable options. Continued access for those currently using PrEP.	Settings where there is high reach of needle-syringe programs and high opioid substitution coverage. PrEP ring procurements for new users, while supporting transition to other HIV prevention options which best meet the individual's needs Diagnostics/services for PrEP initiation/continuation that are not part of WHO's suggested minimum service delivery package for PrEP.[8]	

[6] Incidence rates among a proportion of the population may be further assessed by adjusting the population size estimate to remove PLHIV and those not using condoms consistently. Where incidence data is limited, prevalence data combined with data on 95-95-95 progress can be used to support prioritization.
[7] https://www.who.int/publications/i/item/9789240097230
[8] https://www.who.int/publications/i/item/9789240097230

HIV Prevention			
Intervention	**Prioritize investments**	**Deprioritize investments**	**Additional considerations/efficiencies**
PrEP programming for prisoners and others in close settings	Introduction/scale-up in settings where national adult (15-49) HIV prevalence is >10%. Use lowest costing oral PrEP and lowest costing injectable options. Continued access for those currently using PrEP	Settings where national adult (15-49) prevalence is <10% PrEP ring procurements for new users, while supporting transition to other HIV prevention options that best meet the individual's needs. Diagnostics/services for PrEP initiation/continuation that are not part of WHO's suggested minimum service delivery package for PrEP.[9]	
PrEP programming for AGYW/MSP, and other vulnerable populations in high incidence settings	Introduction/scale-up in settings where incidence for the population is (1) >3%; or (2) 1-3% **and** high-risk behavior is reported. Use lowest costing oral PrEP and lowest costing injectable options. Continued access for those currently using PrEP.	Settings where incidence for the population is (1) >3%; or (2) 1-3% **and** high-risk behavior is reported. PrEP ring procurements for new users, while supporting transition to other HIV prevention options that best meet the individual's needs. Diagnostics/services for PrEP initiation/continuation that are not part of WHO's suggested	

[9] https://www.who.int/publications/i/item/9789240097230

HIV Prevention			
Intervention	**Prioritize investments**	**Deprioritize investments**	**Additional considerations/efficiencies**
		minimum service delivery package for PrEP.[10]	
HIV prevention communication, information, and demand creation for all KP, and for AGYW/MSP in moderate and high incidence settings	Combine interpersonal with online and m-health modalities, targeted towards priority populations.	Untargeted mass media campaigns	Communication/information/demand creation should be integrated as part of service delivery to ensure increasing uptake of evidence-based HIV prevention options (condoms, PrEP/PEP, harm reduction). Consider potential for demand creation activities that address multiple HIV prevention/testing options rather than single option campaigns. Consider mobilizing private sector marketing capacity to increase the reach of online and m-health communication/demand creation campaigns.
Community empowerment for all KP	Targeted outreach-based HIV prevention delivery focused on use of HIV prevention options Participation in technical working groups, national, provincial, and local decision-making fora Safety and security for implementers and beneficiaries of KVP programs	Community empowerment campaigns, surveys, trainings and meetings that require travel or transport costs & refunds	Consider online and m-health delivery. Consider including investments at the organizational level for safety and security implementers as part of Community System Strengthening module (refer to capacity development of CLOs/CBOs below for more information).
Social protection interventions for AGYW *in high HIV incidence settings with a high*	Structured interpersonal communication on HIV prevention and social norms (e.g., Stepping Stones and SASA!)	Direct education subsidies Direct cash incentive programs	Target investments in structured interpersonal communication towards AGYW in high HIV incidence settings with a high prevalence of HIV risk factors, Focus programs on increasing uptake of evidence-based HIV prevention options.

[10] https://www.who.int/publications/i/item/9789240097230

HIV Prevention			
Intervention	**Prioritize investments**	**Deprioritize investments**	**Additional considerations/efficiencies**
prevalence of HIV risk factors			Accelerate transition to government programs for social protection and education support based on stakeholder engagement and a transition plan. Transition away from social protection projects towards financing the strengthening of national social protection platforms. In non-priority locations, ensure careful phasing out to minimize harm.
Sexual and reproductive health services, including sexually transmitted infections (STIs), hepatitis, post-violence care for all KPs and for AGYW/MSP in moderate and high incidence settings	PEP for all potential exposures to HIV, including as part of integrated first-line gender-based violence response services. Integrated basic STI services and syndromic STI management. HCV testing/treatment in harm reduction services in countries with high levels of coinfection.	Any STI molecular (etiological) diagnosis investments (e.g., CT/NG x-pert). Adult hepatitis B screening	Integrate hepatitis C services through low-cost delivery models Hep B testing and management could be supported in high prevalence settings among people at higher risk. Support integration of HIV prevention with contraception/family planning information and services and pregnancy testing. Support referral networks for gender-based violence response and for survivor support services.
Removing human rights-related barriers to prevention for all KP, AGYW/MSP in moderate and high incidence settings	Human rights activities directly linked to improving access to services, e.g., addressing harmful policing practices, emergency legal support, safety and security measures.		Maintain existing CLM of human rights violations as part of CSS activities and ensure referrals for redress.
Needle and syringe programs for PWID	Safe injecting equipment that reflects user choices Wound care		Advise caution when procuring low-cost syringes – most cost-effective option is option that injectors will use (context dependent)

HIV Prevention			
Intervention	**Prioritize investments**	**Deprioritize investments**	**Additional considerations/efficiencies**
			Monitor cost of service delivery by limiting range of 'add-on' services, minimizing non-essential staff and extending reach of outreach, including using online/m-health approaches. Explore non-drop-in center (DIC)-based availability of safe injecting equipment, e.g., pharmacy-voucher schemes, vending machines
Opiate substitution treatment for PWID	Prevent interruption of supply and delivery.		Integrate services where possible. Advocate for take-home dosing for stable patients to reduce costs of service delivery including human resource costs; and for low threshold models (such as community pharmacies), where possible.
Overdose prevention and management for PWID	All activities directly related to service delivery.		
Harm reduction interventions for drug use for prisoners	All activities directly related to service delivery.		
Comprehensive sexuality education (CSE) for AGYW and adolescent boys and young men (ABYM)	High HIV incidence settings only, and if not funded through education sector. Development of curricula that include a clear link to increasing uptake of HIV prevention options.	CSE activities in settings with low and moderate HIV incidence among AGYW; activities with no clear link to HIV prevention options.	Advocate for domestic financing for CSE. Leverage existing evidence-based CSE programs developed/led by Ministries of Education.
Voluntary medical male circumcision	Integrate into mainstream sexual health or primary health care.	Stand-alone VMMC services	
Prevention program stewardship	Management and adaptation of service delivery, integration of HIV prevention into SRH/FP		Ensure sufficient attention/resources for condom program management, last mile supply and demand creation functions.

HIV Prevention			
Intervention	**Prioritize investments**	**Deprioritize investments**	**Additional considerations/efficiencies**
	and primary care, and to address critical supply needs (condoms and lubricants, PrEP/PEP, harm reduction commodities).		

Considerations for prioritizing HIV prevention service delivery:

Community outreach:

- Strengthen community outreach system for a continuum of HIV prevention, testing, treatment and support. Avoid single-issue/intervention outreach.
- Prioritize investment for CBOs/CLOs with significant reach.
- Ensure outreach is focused on HIV prevention/testing and linkage to care outcomes.
- Increase online and m-health service delivery.
- Shift CBO/CLO/outreach-related human resource costs to sustainable and standardized national salary scales. Where context does not permit an immediate shift without disruptions to outreach services, initiate planning for a shift to standardized national salary scales to start with GC8 funding cycle (refer to HRH/CHW section below for more information).

Leverage existing service delivery platforms:

- SRH/FP/STI services (government and CSO) are under-used as sites for HIV prevention/testing. Consider shift to SRH service platform as key delivery platform for HIV prevention and testing.
- Expand pharmacy-based delivery of HIV prevention commodities and other private sector delivery models such as direct-to-consumer models
- Review costs of mobile services and fixed sites (e.g., KP drop-in centres, KP safe spaces), assessing performance towards HIV targets.
- Focus investment on locations with high KP concentration.

Reducing Human Rights Related Barriers to HIV/TB Services

Human rights and gender-related barriers limit access to lifesaving HIV services, and essential interventions/activities need to be prioritized for the effectiveness and efficiency of prioritized HIV interventions.

Reducing Human Rights-Related Barriers to HIV/TB Services			
Intervention	**Prioritize investments**	**Deprioritize investments**	**Additional considerations/efficiencies**
Eliminating stigma and discrimination in all settings Ensuring nondiscriminatory provision of health care	Activities to reduce stigma and discrimination in (1) healthcare settings and (2) community settings for the purpose of reducing barriers to health services. Maintain existing multistakeholder mechanisms for coordination and oversight of implementation of human rights strategic plans and programming (including TWGs, steering committees).	Stigma and discrimination activities in other settings (unless a particular setting, such as justice, is more relevant in a particular country context)	Integrate non-discrimination, KP and gender competencies in relevant capacity building activities for healthcare providers.
Increasing access to justice	Maintain existing CLM of human rights violations and redress in health facilities. Maintain community-led interventions (e.g., Community Paralegals) to support access to justice, accountability and redress in context of human rights barriers to health services	Development of new institutional policies and reporting mechanisms	For longer-term sustainability, support integration of HIV access to justice activities within broader national human rights mechanisms and institutions, including accountability mechanisms for rights-based HIV services and reporting mechanisms for patients.
Community mobilization and advocacy for human rights	Maintain community capacity to deliver stigma and discrimination monitoring and reduction including in health care, community and justice settings.	Standalone awareness-raising events, commemorative days, and research studies	

As a second step, countries can examine **cost inputs** within prioritized interventions and consider the following to optimize costs:

Cost Input	Prioritize investments	Deprioritize investments	Additional considerations
Health products – Pharmaceutical products (HPPP)	Prioritize ARVs for treatment continuation and expansion – all ages, including in EVT. Prioritize ARVs for infant prophylaxis. Prioritize TB treatment for PLHIV, looking at low-cost delivery options (e.g., digital treatment adherence, family members and/or communities). Low-cost options for TB preventive therapy, treatment, and prophylaxis for cryptococcal meningitis, including lowest cost options for generic flucytosine. Commodities for histoplasmosis diagnosis and management, other OIs and Kaposi sarcoma. Prioritize methadone for OAMT (and buprenorphine where methadone not provided). Prioritize naloxone for overdose prevention for harm reduction programs.	PrEP ring for new users NCD treatment commodities, other non-essential commodities ARVs – Introduction of alternative higher cost regimens such as TAF, if higher than WHO recommended % of cohort – recognizing too will have other costs (e.g., training)	Careful attention needed to treatment commodities for cryptococcal meningitis, including flucytosine and amphotericin B. Nonavailability of which will result in death for those affected by disease which is universally fatal without treatment. Longstanding support has been provided to some countries to Kaposi sarcoma patients. New programming is not recommended but continue existing support. Detailed SO/health product considerations are provided below in the document.

Cost Input	Prioritize investments	Deprioritize investments	Additional considerations
Health Products - Non-Pharmaceuticals (HPNP)	Commodities for viral load (VL) testing - potential for rationalization (see additional consideration column). EVT – Dual tests for HIV/syphilis. TB molecular testing for PLHIV (e.g., GeneXpert,TrueNat) and urinary LF-LAM test. Lumbar puncture needles. Male condoms Safe injecting equipment for harm reduction programs	Routine hematology and biochemistry which is in excess of WHO essential requirements Female condoms. However flexible approach recommended where demand for female condoms is clear, especially amongst sex workers. Hep B testing in EVT (see additional considerations column) Adult hep B testing	In some countries, contingency plans may include using VL less frequently or in a more targeted way than recommended by WHO – to economize in the context of severe budget constraints. Global Fund-supported programs align with national guidelines in countries where this decision is made. We note that WHO guidance continues to support routine VL testing for patient monitoring. Carefully review any proposals to introduce new lab-based testing platforms, considering point of care alternatives. In EVT, hepatitis B testing has a higher potential impact in some epidemiologic settings; deprioritization needs careful consideration given potential disruption to established integration efforts.
Non-health equipment (NHP)	Those vital for delivery of prioritized interventions above.	Non-essential health equipment	
Procurement and supply-chain management costs (PSM)	Those vital for delivery of prioritized interventions above.		Prioritize last mile supply of key HIV prevention commodities listed above.
Human resources (HR) - salaries – HF and community-based staff	Those vital for delivery of and access to prioritized interventions above. EVT - Peer support/mentor mothers – continue where cost-effective. Consider opportunities for task shifting in support of ART delivery.		Priority HR functions for condom programs: program management incl total market approach, last mile supply and demand creation. Consider integrated teams of KP peer educators in health facilities providing

Cost Input	Prioritize investments	Deprioritize investments	Additional considerations
	Maintain peer outreach for HIV prevention, testing and referral to treatment. Ensure HR costs are consistent with national standards. See considerations under HR.		services to KPs (including paralegals, where feasible). Please refer to the RSSH/HRH section below for more considerations on integration relevant to HIV services.
Travel related costs - meeting/advocacy/TA related per diems/transport/other costs	Only those vital for delivery of and access to prioritized interventions.		
Travel related costs – training related per diems/transport/other costs	Only those vital for delivery of and access to prioritized interventions. On-job training	Out of service training Refresher trainings Travel for meetings	Pause all non-critical out-of-service training, using in-service where needed. Integrate and optimize, where possible. Transition training costs to government where possible. Please refer to the RSSH/HRH section in the document for more considerations on streamlining training budgets relevant to HIV services.
Travel related costs – Supervision related per diems/transport/other costs	Only those vital for delivery of and access to prioritized interventions above. Consider less frequent supervision activities.		On the job support/training can reduce the need for separate supervision. Please refer to the RSSH/HRH section in the document for more considerations on streamlining supervision budgets relevant to HIV services.
Travel-related costs - Surveys/data collection related per diems/transport/other costs		Deprioritize planned studies and operational research that are non-critical for program and prioritization planning.	Note that support for integration of HIV prevention outcome reporting (POMT) in routine monitoring of services continues to be

Cost Input	Prioritize investments	Deprioritize investments	Additional considerations
			prioritized (as per HIS and M&E content in the section below).
Communication material and publications (CMP)	Prioritize online and m-health interventions, and peer outreach-based approaches in priority locations/for priority populations.	Report printing, bus wraps, billboards, mugs, radio/TV spots, t-shirts, and other mass media approaches.	See comments above on HIV prevention communication and demand creation.

Tuberculosis

We recommend considering the following options for TB depending on country contexts and availability of funding from all sources:

- **Optimization and efficient** use of resources and tools in any funding scenario as there has been funding gap for TB responses in low and middle-income countries.
- **Prioritization** of investments in interventions and activities along the care cascade in low funding scenarios.
- **Deprioritization** of investments in interventions and activities depending on country contexts, funding gaps and funding availability from domestic and other sources.

Optimization and efficient use of resources and tools

TB programs have been operating under significant funding gaps for years. While advocating for more resources for TB including from domestic sources, through innovative and blended financing and external sources, there are opportunities to **gain efficiency** and address urgent gaps in TB funding, especially for critical health products, and sustain the momentum and gains. These could be done through **integration** (within TB and with other diseases and sectors) and **optimization** of the use of existing resources and tools, approaches and algorithms and accelerating transition to new tools when these are available along the cascade of care. Optimization is an important lever to address funding gaps and could be implemented in the short-, mid- or long-term. The options listed below are based on country examples on “how” efficiencies could be gained, and the use of tools optimized to sustain and accelerate TB response.

Please refer TB programmatic efficiency and optimization analysis for more information on optimization and efficiency, and country examples.

Enhancing efficiency in TB Programs	Integrating TB services with other programs/sectors and contribute to RSSH
Combine contact screening as well as TB screening in other high-risk groups with TB diagnosis, treatment and provision of TB prevention treatment (TPT).	Integrate disease screening (such as TB, HIV, diabetes, maternal and child health and nutrition) across health programs and strengthen referral networks for optimal management and comprehensive care.
Decentralize and integrate drug-resistant TB (DR-TB) and integrate with drug-susceptible TB (DS-TB) activities.	Strengthen and empower community health workers (CHWs) for disease detection, treatment adherence, and delivery of integrated health services across multiple conditions/diseases.
Invest in new low-cost and more sensitive and specific tools for screening, diagnosis and DST when these are available and recommended. Promote cost-effective, shorter treatment regimens for DR-TB, children with non-severe DS-TB and TPT.	Expand and integrate sample transport networks constructed on national/local platforms and systems for TB and other diseases.
Optimize resources by combining screening using digital chest X-rays with AI, sputum sample pooling, and WHO-recommended rapid molecular diagnostics (WRDs).	Promote multi-disease screening/testing platforms which could contribute to RSSH and pandemic preparedness and response.
Digitalize TB recording and reporting, enhance interoperability, strengthen surveillance system and data use.	Utilize digital and online platforms for training and community engagement
Scale up innovative and most efficient private provider engagement models in TB.	Leveraging digital solutions for integrated health surveillance and reporting

Prioritization of interventions and activities along cascade of care

After the optimization and programmatic efficiency exercise which could also be done throughout, consider prioritizing TB interventions and activities below depending on country contexts and availability of funding. The top priority interventions for TB are diagnosis and treatment of people with TB disease (including DR-TB and TB/HIV). This includes not only procurement and distribution of health products but also service provision, access and related programmatic interventions. The table below summarizes priority interventions and investments and options to consider during planning and implementation depending on country contexts and availability of resources from all sources.

Interventions	Priority investments	Considerations
Screening and Diagnosis (DS-TB, DR-TB, TB/HIV and TB infection)	• Continue supporting case finding in health facilities and intensified case finding mainly in high-volume health facilities; this includes where appropriate the use of TB champions or other CHWs in identifying people with TB symptoms. • Maintain essential screening and diagnostic services and access to WRDs and optimize their use. Rapidly transition to lower-cost WRDs when and where available. • Continue supporting sputum sample transportation systems, which are currently functional efficient in ensuring access to WRDs and drug susceptibility testing (DST). • TB/HIV activities such as HIV testing for people with TB and initiating ART for those with co-infection as well as TB screening and diagnosis for PLHIV. • Continue with provision of integrated service delivery for those with other diseases such as diabetes, undernutrition and other co-morbidities, including bi-directional screening/testing and collaborative activities. • Continue investing in private sector engagement in TB as one of the cost-effective approaches, especially in countries where most people with TB symptoms access services in the private sector. • Maintain community engagement to overcome stigma, build trust with service providers and improve service uptake, and secure sustained access to lifesaving TB care for KVPs.	• Review community-based ACF to identify where it is most critical for detecting TB cases, which populations it most effectively reaches, and where integration into existing community-based efforts can maximize impact and efficiency. • Where required redeploy equipment purchased for outreach screening campaigns for use in health facilities to avoid waste and address limited warranties/shelf life. • Wherever feasible, consider pooling respiratory samples to optimize cartridge costs (limited evidence available, requires *WHO review/approval*). Use digital X-rays (preferably with AI) for screening to reduce cartridges/chips needed. • Use alternative sample testing for specific groups, e.g., stool testing for children.

Interventions	Priority investments	Considerations
Treatment of DS-TB/DR-TB, TB/HIV and TB infection	• Ensure TB patients with all forms of TB receive appropriate treatment and support, with first-line anti-TB medicines procured through domestic financing and increasingly taking over procurement of second-line medicines as much as possible. • Use the newer, shorter, more effective regimens like 6-month BPaL/M (BDLLfx/C for children and pregnant women) for DR-TB, 3HP for TPT and 4-month DS-TB regimen for children and adolescents with non-severe TB are used for savings costs (commodities, programmatic and patients) and improve outcome. • For TB preventive treatment, focus on priority groups such as PLHIV and household contacts of patients with bacteriologically confirmed pulmonary TB (PTB+). • Continue supporting infection prevention activities, especially personal protective equipment such as appropriate masks for patients with DR-TB and respirators for staff, including CHWs who support them.	• Transition to shorter DR-TB regimens as these are more effective, patient-friendly and cost-effective. • Integrate DR-TB and DS-TB services and transition to people-centered treatment models supported through digital treatment adherence, family members and/or communities. • Consider using symptom-based screening among PLHIV and household contacts of patients with PTB+ (than IGRA/TST) to provide TPT as per the WHO recommendation. .
Data, monitoring, supervision, program reviews and training	• Maintain routine reporting system and surveillance strengthening activities to accurately monitor program performance, including referral from CHWs. • Conduct routine analysis and use data to identify gaps and for better targeted interventions. • Review and prioritize training that is critical for delivery of lifesaving interventions, including ensuring human rights and gender considerations are integrated. • Continue supporting routine program supervision and M&E activities, including integrated with other programs (e.g., HIV), where relevant and efficient.	• Use already available information for hotspot mapping and TB care cascade analyses guide targeted interventions and populations and optimize resource utilization. • Use routine surveillance data, epi-review and simple approaches/tools to inform planning and prioritization. • If required, support a streamlined process of epi and program reviews to inform NSP revision/development, based on available data and through remote support, in line with the new approach recently announced by WHO. • Leverage e-learning platforms and technologies to provide remote training, establishing mentoring networks and supervision to reduce costs related to transport, per diems, and time away from programmatic duties.

Deprioritization: Interventions and activities to consider deprioritizing from Global Fund funding

The lists of interventions and activities to consider deprioritizing depending on country contexts and availability of funding are highlighted below. We encourage considering alternative options/considerations highlighted below depending on country contexts and funding gaps and availability.

Interventions/activities	Deprioritize investments	Considerations
Screening and Diagnosis	• Procurement of new equipment.	• Prioritize use of microscopes for treatment follow up than for TB diagnosis. • Optimize the use of cartridges, e.g., sputum sample pooling, using X-rays (with AI) for screening for TB and triaging people seeking care, testing stool samples for children. • Replacement of faulty modules than procuring new machines and considering using local innovations for data linkage than costly licenses of connectivity solutions. • Introduce and use new affordable near point-of-care tests (when available).
Active Case Finding	• Mass chest camps or campaigns and unprioritized/untargeted active case finding.	• Consider mapping and targeting high-risk groups and geographic areas with high incidence (“hotspots”) using available data including vulnerability index.
Treatment	• Long and expensive treatment regimens while shorter, more effective and cheaper alternatives are available (long regimens for DR-TB or four-month regimen for adults with DS-TB).	• Accelerate transitioning to new shorter treatment regimens (e.g., six-month regimens for DR-TB, 3HP/1HP, 3HR for TPT, four-month DS-TB for children with non-severe form of the disease). Continue using six-month regimen for adults with DS-TB as a cost-effective option.
Enablers including nutritional and transport support	• Blanket nutritional and transport support	• Maintain/prioritize provision of nutritional and transport support to targeted groups such as patients with DR-TB and children with severe undernutrition.
Surveys	• New TB surveys, including prevalence surveys • Non-urgent and costly operational research projects	• Existing data could be used to update TB burden estimation, as needed. • Limit operational research to critical ones and use existing data and evidence to improve coverage and quality of TB services.

Program management, HRH/CHWs **New Constructions** **Technical assistance (TA)**	• Scale-up of TB-specific community workers, and paralegals. • Infrastructure upgrades that have yet to substantially progress, or yet to convincingly demonstrate likelihood of successful completion before the end of GC7.	• Maintain CHWs and TB champions currently engaged. Please refer to the RSSH/HRH section below for more considerations on integration of CHWs. • Critically review program management costs and salaries for all cadres of health care providers including CHWs. • Consider remote participation than travelling for international conferences, meetings and training • Reduce expenditure on in-country meetings, workshops, etc. • Review and prioritize TA to make this more targeted and efficient including through remote support.
Removing barriers	• New legal and policy frameworks to prevent punitive or coercive measures and improve rights-based TB services.	• Support integrating efforts on TB-related legal and policy frameworks and access to justice activities within broader national human rights mechanisms and institutions, including accountability mechanisms for rights-based TB services and reporting mechanisms for patients, and continue support to legal reforms that are progressing well.

Malaria

The first objective is to explore possible operational efficiencies in each of the core interventions, ensuring quality implementation and impact. Despite identifying savings, programs may find there are still insufficient resources across all available funding sources to cover planned interventions. In this case, the primary aim is to ensure the most impactful activities are maintained to minimize malaria mortality. Ensuring timely access to quality diagnosis and treatment for those who are ill should therefore remain a central pillar. Prevention interventions, such as vector control and seasonal malaria chemoprevention, should be next in the prioritization exercise based on subnational needs, partner contributions, and local transmission dynamics. Ideally a program should aim to achieve and maintain universal coverage of vector control, layering SMC in areas with very high seasonal transmission. However, acknowledging this may not be feasible in all appropriate settings, some variation in prevention strategies may be justified. Surveillance cuts across all interventions and should be streamlined with activities prioritized to ensure sufficient data for decision-making. It is important to note that the outlined approach is not intended to require addressing each element sequentially. Rather, a country should review all the potentially relevant strategies for efficiencies and prioritization and adopt the combination of interventions most relevant to their specific context, recognizing the order of priorities may differ according to the malaria transmission setting. However, the justification for a country's prioritization should be clear, including assurance that case management in the public sector is covered through all available resources (whether through Global Fund, the government and/or other partners).

Within these interventions, the essential components are those ensuring availability, acceptability and accessibility of quality services and monitoring their implementation. Prioritization of a subnationally tailored approach not only focuses interventions where they are needed most, but also ensures adaptation of implementation of those interventions to local contexts to maximize impact (e.g., targeting supervision, training and quality improvement to subnational needs). When prioritizing populations or geographic areas, special attention must be given to maintaining an equity lens, especially in challenging operating environment (COE) contexts where certain populations may have limited access to malaria services.

In elimination and pre-elimination contexts, the same overarching principles should apply when assessing how to prioritize the grants. In general, work is ongoing to ensure more domestic funding for essential elements such as case-management commodities, and the guidance will focus on adapting the methods of service delivery. These grants are already targeting specific vulnerable populations where malaria burden is highest. Note that at the end of each section there are specific recommendations for elimination settings.

Key Considerations:

- Work through interventions in the order shown.
- As prioritization takes place, consider the effects of each decision on previous decisions made.
- Case management and prevention need to be balanced.
- Scaled back prevention will lead to increasing cases and higher budgets for case management, balance the best use of these funds for prevention/ case management.
- Consider all sources of funds including potential new gaps due to changes in the donor landscape.
- The Global Fund and partners can assist with potential national/subnational trade-offs of the intervention mix.

Case management

Considerations for: Public facility-based treatment and integrated community case management
Ensuring sufficient ACT, RDTs and IVAS are available at **public facility and community** levels is top priority, as these are lifesaving commodities. If rectal artesunate has been rolled out in your country, maintain this as well. **Quantification and product selection** • **Re-evaluate your standard quantification and adjust as needed** based on current and projected burden. Projected burden may need to be adjusted, especially if reducing or delaying preventive interventions. • Note that you may need additional ACT/RDTs if implementing ANC1 surveillance (see Surveillance section). 1. If a PMI country, consider **what additional quantities could be needed if PMI stocks are discontinued.** 2. Evaluate whether stocks can be delivered through the **national supply chain system** (if not happening already). Does it require additional investments from Global Fund, if so, can they be transferred to the government (immediately or phased)? Can delivery of medicines and consumables be further optimized? 3. **RDT product selection:** Based on Global Fund reference prices, *Pf*-only 25 test kits are US$0.11 less than *Pf*-PAN RDTs and box kits (box of RDTs without individual buffer) are US$0.32 less than POCT tests (individual buffer provided for each RDT). The Global Fund is working with manufacturers to address the practical challenges (e.g., not enough buffer, etc.) for boxed kits. • **Global Fund-financing will procure *Pf*- only tests for *Pf* predominant countries and *Pf*/*Pv* tests when burden of *P. vivax* is significant**. • **ACT diversification and Multiple Firstline Therapies (MFT) plans as part of the strategy to address antimalarial drug resistance is a priority**, particularly for Sub-Saharan African countries. If a country has or has planned for an MFT strategy in GC7, it should be prioritized. For ACT selection to support MFT strategies, countries should prioritize AL-ASAQ in either WHO recommended simultaneous or rapid cycling approach as a transitional option (given their cost

neutrality) and consider AS-PY or DP only if AL and ASAQ are not suitable based on latest efficacy data or overlap with SMC, access support is available, prices improve, and supply becomes more sustainable. Please reach out to your Global Fund Country Team for more information on drug selection and approach for your specific country.

- **Maintaining the addition of single low dose primaquine** to ACT treatment as a gametocidal agent should continue as it is low-cost and contributes to transmission reduction in low transmission settings. It can also be considered in countries with artemisinin partial resistance or partner drug failure. G6PD testing is not required.
- In most settings **RDTs should be prioritized over procurement of microscopes and associated commodities**. In elimination contexts, maintaining a high level of quality microscopy will be important to ensure quality diagnosis and sustainability. Look at leveraging existing equipment and other disease programs for integrated support for microscopy in higher level health facilities.
- In countries where ***P. vivax*** is the predominant species, *Pf/Pv* RDTs should be used for diagnosis. Ensure sufficient stocks of antimalarials (chloroquine and/or ACTs) and primaquine are available. Where tafenoquine or high-dose seven-day primaquine is being implemented, maintain sufficient stocks of the drug and G6PD testing commodities. Discuss with your Global Fund Country Team how to move forward with the implementation of radical cure strategies using shorter regimens (primaquine seven-days and/or tafenoquine) if they have not been implemented, as they will require G6PD testing and initial rollout will be costly. Consider support from partner organizations for this rollout.

Quality of care

- **Training/supervision should:**
  - **Integrate within the primary health care** quality improvement package and malaria-specific training/supervision should be phased out (preferably immediately). Similarly, general training on equity, human rights and gender should be integrated and phased out as standalone trainings. Train multi-skilled supervisors/trainers to ensure that integration does not simply mean bringing together teams from different programs in the same place at the same time.
  - **Tailor subnationally** to address the specific needs based on evaluation of routine patient data to assess the performance of health facilities/CHWs (or at the lowest administrative unit possible based on data availability). For example, if the NMCP sees that the testing rate of one facility is 80%, while another averages 40%, this latter facility should be targeted for supervision and investigation. The same for facilities reporting high malaria mortality, low/no reporting, or treatment without testing.
  - **Maintain an HR training repository** to track training courses received and avoid receiving the same training multiple times.
  - **SBC should be embedded within service provision** at both facility and community levels (e.g., IPC), reinforcing messages of care seeking and prevention, and addressing harmful social and gender norms.

Access to care

- **Optimal deployment of CHWs** will vary depending on context of care seeking practices. It may be beneficial to closely review plans for maintenance and/or considerations of further subnational targeting; and review current scope of community case management support and CHWs, providing iCCM with Global Fund

resources (in the disease/RSSH/C19RM grants) and status of community platform supported by PMI or other funders (consider PEPFAR supported CHWs that provide care for malaria). Non-malaria iCCM commodities should continue where already implemented but plan for transition to government funding moving forward.

- Consider targeted outreach in remote/insecure areas and in sub-populations with limited access (e.g., urban poor, migrants, displaced populations).
- Community case management should be prioritized for at least U5s, but if already provided for all age groups, try to maintain the same scope.
- **Community referrals**: funding assisted referrals reduces expenditure on severe case management. Where possible, if referral system is considered functional, pre-referral treatment of complicated malaria should be continued.

Most countries have already **phased out private sector co-payment of commodities**. Depending on country context (% use of private sector), it may be beneficial to continue supporting private sector efforts to maintain access to quality care with a focus on ensuring reporting and monitoring of quality assurance of treatment rather than direct service delivery.

In elimination contexts passive case detection should be prioritized, as active and reactive case detection strategies are more costly and should be considered for pause. While RDTs will continue to be the main diagnostic method, especially for hard-to-reach populations, countries may want to maintain a high level of quality microscopy, that must be integrated with other disease activities. Special attention should be given to ensuring that cases diagnosed in the private sector are included. Prevention of re-establishment activities should be maintained, with attention to optimization of activities as with other interventions. Surveillance will need to be maintained to ensure monitoring of elimination and prevention of reintroduction.

Vector control

Considerations for: Indoor Residual Spraying

Countries are encouraged to work closely with Global Fund Country Teams if your program includes Global Fund or partner supported IRS, where funding may not be able to be maintained. If an IRS campaign is imminent, it should be prioritized given the serious risk of upsurges with its abrupt discontinuation. If IRS is not imminent, given budget constraints and potential issues of sustainability, seriously consider a switch to CFP-Dual AI ITNs. The targeted areas should be prioritized for CFP-Dual AI ITNs with their distribution coinciding with the planned timing of the next spray cycle (not the next ITN campaign cycle). In addition, case rates should monitored for upsurges and consideration given to an additional case management buffer.

Operational efficiencies

- Review the table ‘Adaptations for operational activities’ below to consider which campaign efficiencies can be adapted to IRS campaigns. However, there may be less opportunity to reduce IRS campaign costs in the short term, given the requirements for safeguarding environmental and human health and the importance of communications activities to ensure household acceptance of the intervention.

Product choice

- There may also be limited opportunity to change product given the need to procure in line with insecticide resistance management plans. It may be worth discussing with your Global Fund Country Team if there are useful price differences linked to formulations and packaging types.

Considerations for: Insecticide treated nets (ITNs) – Mass campaign and continuous distribution

Countries are in very different stages and situations–some have already completed a campaign, others have not–and of these some have placed orders and others have not. Some contexts may have particular challenges or needs (e.g., COE). Below are general recommendations to be applied depending on country context.

- All ITN deployments should be optimized using the below suggestions:
  - For all nets, review 'Product considerations' below – e.g., consider a smaller net size if appropriate.
  - For campaigns, review the 'Adaptations for operational activities' table below (bear in mind what is feasible in the time remaining before a deployment).
  - For continuous distribution channels for nets, review the 'Adaptations for operational activities' table to reflect on what may be relevant for these channels. Heavy emphasis should also be placed on integrating the respective ITN deliveries and associated support into the relevant in-country programs – e.g., maternal child health programs and EPI programs.
- Deployment strategies should be reviewed considering available budget:
  - Ideally, and for biggest impact on malaria burden and mortality, high coverage in high and moderate burden areas (considering malariogenic potential rather than just current burden) should be maintained, with access ensured via routine channels for biologically vulnerable groups in all at-risk areas. Pregnant women and children under five are the key vulnerable groups in most cases, though consider other locally relevant high-risk groups.
  - If maintaining high coverage in high and moderate risk areas is not possible, the top priority is to cover biologically vulnerable groups in all at-risk areas.
  - Different deployment strategies may be appropriate given the context of access and equity of access to various channels – no one channel will be sufficient. Channels can also be combined in different ways subnationally.
  - It is important to remember that while not all channels may directly provide nets to vulnerable groups, data has consistently shown that within a household, nets received from any channel are prioritized for those most vulnerable within the household when there are insufficient nets to cover all household members.
  - Consider the following when determining which channels to use and how to adapt them:
    - **Ensure routine channels are stocked in all at-risk areas.** ANC/EPI channels ensure access for pregnant women and infants and ensure some continued availability of nets between campaigns., These remain important channels. Consider prioritizing the most functional channels (e.g., ANC over EPI in some cases), and consider enhancing the security stock if the pipeline of routine nets is uncertain, which may be a particular concern in PMI countries. If ANC/EPI services are not accessible (e.g., some COE settings), alternative channels with frequent/routine touch points with vulnerable populations may be useful.
    - **Expand beyond routine channels as far as budget allows; routine channels alone will not achieve high coverage nor reach all U5s.**
    - Where not possible to aim for universal coverage, programs should still aim for as high coverage as possible in high and moderate areas by implementing lower coverage campaigns (targeting only U5 children, or all households at reduced coverage) or, using high throughput continuous channels such as annual school-based distribution.

        - For campaigns consider all the following:
            - Remove low burden areas and, where appropriate, urban areas. For many urban areas, given logistical challenges and better access to care, a campaign approach is not recommended. In these places ensure routine access to ITNs for vulnerable groups through ANC and EPI and continue efforts to strengthen case management. In urban areas where *An. stephensi* is a concern, discuss appropriate vector control response with your Global Fund Country Team. Peri-urban areas, or localized vulnerable groups (e.g., slum dwellers) may continue to need campaign distribution – however it is recommended to identify these areas using health system data and local knowledge and expertise, rather than by complex microstratification approaches which have proven challenging and costly and not recommended for grant funds. Discuss options to address these issues with your Global Fund Country Team.
            - Outside urban areas consider either an U5 campaign providing 1 net per U5 child (which has the benefit of ensuring high coverage in this main vulnerable group), or a lower coverage general campaign (which has the advantage of reaching all households, including those with under-fives) to all households by reducing quantities of nets per person or modifying target groups (e.g., one net per >1.8 people, or a fixed number per household).
            - Stagger timing of campaigns in subnational areas where available data confirm net retention beyond three years (i.e. show certain areas still have high access and use of effective nets).
    - **Alternative high-volume channels:** in parallel to the above campaign options, consider when alternative channels might be appropriate, given the local context and/or if the quantity of nets reduces so far as to make campaigns uneconomical. For example, annual school-based distributions are a strong alternative to campaigns as they can be adapted to the number of nets available, targets children missed by ANC/EPI delivery and can channel nets to households between campaigns to address net attrition.
    - Where even U5 or reduced coverage campaigns cannot be achieved in all high/moderate burden areas; first ensure routine access to vulnerable groups in all at -risk areas and then do whatever campaign/high throughput approaches are feasible in highest burden areas, noting that case rates in areas no longer protected will rise and case management plans should be adjusted appropriately.
- **Countries who have already ordered nets** will likely prefer to continue as closely as possible with existing plans for those nets but should optimize delivery costs and rationalize scope (e.g., remove low burden or urban areas where appropriate). They should also consider whether some of the quantities are needed for routine channels (now, or even to enhance security stocks if future routine supply is uncertain). If available campaign net quantities are reduced, consider the options mentioned above.
- **Countries who have not yet ordered nets** still have the opportunity to revise the initially planned quantities, as well as revisiting optimal channels of delivery considering the suggestions above to maximize impact. As noted above, ensure efficient channels to provide ITNs for vulnerable populations are prioritized; and if additional funding is available, optimize delivery costs and then determine how many nets can be afforded.

Other considerations

- If an ITN campaign will be co-funded with another partner beyond the government and PR (e.g., Against Malaria Foundation), it is important to understand their requirements for support and work on any adaptations jointly with all stakeholders. Leveraging grant funds to access non-grant supported net commodities is very valuable for the programs; enabling this partnership should be given serious consideration.

Product selection

- If pyrethroid resistance is known and PBO or CFP Dual AIs already planned or deployed, maintain the same product choice. Countries should consider converting any planned pyrethroid-only nets in these areas to CFP Dual AI if possible; the value for money is higher (even considering the higher unit cost and potential that fewer nets could be afforded). Please consult your Global Fund Country Team if there are questions.
- No ITN customization.
- Consider a smaller ITN size if appropriate – this can bring significant savings, and many countries achieve high use given access with the smaller size nets.

In elimination contexts, target vector control interventions at areas at risk of the continuation or resumption of transmission. Depending on feasibility and availability, IRS or ITNs are often the main method to reduce transmission in residual or new active foci.

Adaptations for operational activities (most relevant for campaigns, though adaptable to other channels)

Cost-saving adaptations for: Campaign design

- Single phased campaign (i.e. register and distribute at same time).
- Consider if macroplanning phase is needed.
- Reevaluate and optimize microplanning approach, potentially reducing scale of workshop to cover most essential content and participants. Draw down on existing available data – previous microplanning (including from activities beyond malaria), National Statistics Bureau data etc.
- Consider providing fixed number of nets per household (HH) – no registration.
- Evaluate number of HH/distributor and whether it is right-sized (especially if the campaign approach has been modified) - assess if similar impact can be achieved through fixed-point distribution.
- Integrate campaign delivery with local existing workforce, such as community health workers (note this may also support e-payments where systems for routine incentives are employed).
- Exclude urban areas (extra nets can be used to increase cap/routine distribution/cover non-traditional dwellings like orphanages, etc.) - see 'geographical area' bullet above.
- Identify options for campaign integration – including data/hardware/software sharing but also combining the campaign or providing the ITNs to your target community through programs with planned campaigns (e.g., measles, malaria vaccination or lymphatic filariasis campaign). At a minimum consider ITN/SMC joint campaigns with ITN distribution with first cycle SMC.
- No mop up campaigns.

Cost-saving adaptations for: Training
• Cut down on number of days of training or change how training is done (online, if appropriate – taking this opportunity to move to digitalized training and tools where feasible). • Scrutinize proposed participants to ensure focus on priority personnel. • Limit payment for training venues where there is potential for free/in kind use of space. • Consider combining with other planned training if appropriate – for example, where SMC campaigns are planned around the same time, even if campaign activities are not integrated.
Cost-saving adaptations for: Transport and Warehousing
• Scrutinize transport budgets – some grants have found opportunities for significant reductions. • Consider limiting national level warehousing and moving sooner to lower level, with lower volumes meaning more feasibility to use existing spaces. • Limit payment for warehousing where there is potential for free/in kind use of space. • Do not economize if there is a risk on commodity security and quality of health products.
Cost-saving adaptations for: Social and behavior change (SBC)
• No campaign launches. • No SBC in areas with historically high ITN use given access. • No hang up campaigns. • Retain low-cost SBC in areas with lower historical ITN use given access - e.g., interpersonal communications (including social media). No leaflets or mass media (e.g., radio/TV spots). • Retain announcements of campaign approach/timing/location but prioritize low-cost options in particular interpersonal communication (IPC). For example, town announcers such as criers, griots, and others (reducing to essential numbers), collaboration with key opinion leaders including religious gatherings (such as churches and mosques), political and social events, and sports activities – also consider social media, WhatsApp/SMS pushes or radio if necessary - but not TV spots. These communication activities might be categorized in the budget as SBC but should be considered as essential activities, particularly when campaign strategies have changed and maybe targeting only certain groups/communities. • Retain materials that act as identifiers for campaign distributors (e.g., arm band, badge, cap, but choose cheapest local option) – these also might be categorized in the budget as SBC but should be considered as essential activities.

Cost-saving adaptations for: Digitalization

• Look at your digitalization needs and prioritize the prioritize the essentials
• Encourage bring-your-own-device (BYOD) for digitalized campaigns.
• If starting digitalization for the first time:
  ○ Consider whether start-up costs (including HR) will be higher than conducting a non-digitalized campaign. If so, consider pausing on a move to digitalization until funding becomes clear (e.g., next grant cycle) as start-up investments may not be justified.
  ○ Check if any other programs in country are conducting digitalized activities, and if so, adopt their tools and app. As there are different benefits and challenges for each tool, there is not a recommended 'cheapest' tool. Choosing an open access platform over a proprietary one will likely minimize costs in the long term.
  Use publicly available training materials rather than developing them afresh.

Cost-saving adaptations for: Reporting/post campaign activities
• Deprioritize data validation workshops – these are also likely unnecessary for digitalized campaigns. • Eliminate annual workshops for review relying instead on continuous improvements based on supervision. • Consider virtual workshops. • Deprioritize post-campaign surveys and, where feasible, measure coverage through routine methodologies (ANC1 surveillance, LQAS, CLM).

Considerations for: Larval Source Management
• In most settings, LSM is a lower priority than other vector control, however considerations of the *An. stephensi* threat will need to be taken into account. Discuss any larval source management plans with your Global Fund Country Team to consider if appropriate to pause..

Chemoprevention

Considerations for: Seasonal Malaria Chemoprevention (SMC)
In recent years, programs have expanded geographically, expanded age groups as well as number of cycles of SMC. The Global Fund suggests the following prioritization for continuation of SMC: ○ **Prioritize children under five years of age** (group with highest mortality rate) as well as focusing on the geographic areas with the highest burden and with poor access to health services (including but not limited to insecure areas). ○ Deprioritize urban areas given access to care and the logistical challenges to operationalize campaigns. ○ Review data on duration of peak transmission season to **optimize number of cycles**. Where possible, use climate data to adjust timing and number of cycles. ○ Consider gaps that may arise due to potential shifts in donor funding (including PMI). There may be a need to shift geographic coverage based on burden analysis, etc. A program may want to make a trade off to reduce the number of SMC cycles to be able to cover additional populations. Please consult your Global Fund Country Team to help support such trade off decisions. As with vector control campaigns, the operational issues outlined in Tables 1 and adaptations for operational activities should be considered. In addition: • Explore existing touch points with the target population and opportunities for integration (ex. ITN campaign, vaccination campaign, child health days, other outreach activities). If a country is considering integrating the malaria vaccine with SMC, please contact your Global Fund Country Team. • Consider feasibility of use of existing CHWs to provide SMC (could be subnationally if CHW workforce insufficient to cover SMC targeted areas). • **Deprioritize** directly observed therapy for doses 2 and 3 of each cycle, which may help increase number of households a distributor can visit per day. Explore options of SMS message reminders for caretakers to administer subsequent doses.
Considerations for: Intermittent preventive therapy for pregnant women (IPTp)
Antenatal care (ANC) services should be fully integrated and the Maternal and Child Health (MCH) department managing those services – including malaria in pregnancy. The national malaria program should be involved in the technical working group and provide technical guidance to the MCH department if needed. Plans for this transition should be made as soon as possible, considering overall resourcing available for RMNCH (including through other Global Fund grants). Where routine nets are distributed through ANC/EPI channels efforts should be made to integrate into routine health system activities and transition to MCH/EPI management respectively. Note that **data systems and reporting by these departments will need to include these interventions.** Consider potential gaps due to changes in donor funding (particularly PMI) for IPTp as well as ANC platform strengthening.

- Procurement of SP should be transitioned to the government as soon as this is feasible and is already ongoing in multiple countries.
- Training/supervision should be integrated within the antenatal care quality improvement package under MCH, and malaria-specific training/supervision should be phased out (preferably immediately).
- Training/supervision should be subnationally tailored to address the specific needs based on the performance of health facilities/CHWs (or at the lowest administrative unit possible based on data availability). For example, if IPT-1 is 60% in one facility with ANC services while another has IPT-1 of 90%, support should be prioritized for the former.
- Community IPTp can increase coverage of this intervention and should be integrated within the CHW strategy.
- SBC should be embedded within service provision at both facility and community levels (e.g., IPC), including use of volunteer, low-cost groups like peer ANC/PNC groups.

Considerations for: Perennial malaria chemoprevention (PMC)

In areas where PMC roll-out has not started, priority should be given to other ongoing interventions.

PMC is provided mainly through the EPI platform and a similar approach to IPTp should be taken for PMC, where management, including supervision and training is transferred to EPI technical working group with support from NMCP as needed. Where routine nets are distributed through ANC/EPI channels efforts should be made to integrate into routine health system activities and transition to MCH/EPI management respectively. Note that data systems and reporting by these departments will need to include these interventions.

- The drug used for PMC is also SP and procurement should be transitioned to the government as soon as this is feasible.
- As PMC is a newer intervention, national malaria programs may need to be more heavily involved in the startup and subsequent roll out, but ideally, the EPI program is well placed to continue with the service with the malaria program being involved in the TWG and providing technical guidance.
- Note that PMC can be delivered through other channels other than EPI, and a similar approach should be taken, integrating into existing delivery systems to increase coverage in the second year of life (e.g., deployment through CHW).
- SBC should be embedded within service provision at both facility and community levels (e.g., IPC), including use of volunteer, low-cost groups like peer ANC/PNC groups.

Note: The Global Fund does not finance malaria vaccine procurement or its direct roll-out as this is under Gavi's mandate. The Global Fund supports interventions that are complementary to the roll-out of the malaria vaccine. Refer to this document for potential support through the Global Fund: https://resources.theglobalfund.org/en/updates/2024-12-02-gavi-global-fund-malaria-vaccine-guidelines/

Surveillance and Monitoring and Evaluation

Considerations for: Data and use
The outline below includes streamlined activities to continue to strengthen data and data use for decision-making. Please consider potential gaps from shift in donor support (including PMI) to try to ensure essential elements are covered. **Well-structured and cleaned HIS data** • HIS systems and data quality assurance should be integrated, include basic malaria reporting, including suspected cases/fevers, cases tested, and cases treated, and cost shared across MOH departments. Please see the RSSH section for more information. • If the Global Fund support is planned to establish a national malaria data repository, this should be prioritized. If it is already established, transfer to domestic funding as soon as possible for upkeep. **Data in the absence of surveys** • As mentioned in above, large scale surveys supported by Global Fund resources (e.g., MIS/DHS) if not already underway, should be paused or revisit the scope (focus on intervention coverage) if alternative methods are not feasible. For surveys that are currently in process and planned Global Fund support cannot continue, every effort should be made to find alternative funding to finish the survey. In parallel, explore introduction of more cost effective, routine strategies to assess coverage, usage and prevalence. • ANC1 surveillance for routine monitoring of prevalence is a new strategy so will need resources to introduce the intervention. These will include recalculation of ACTs and RDTs needed at ANC care (and included in the overall quantification), possible register revisions (if new columns need to be added), changes to guidelines to allow for testing and treatment in pregnancy during the first ANC visit and orientation to ANC providers to test all women for malaria during their first visit. While upfront costs, such as commodity costs, and training, need to be considered, the costs for sustaining this surveillance without Global Fund resources are a consideration for introduction. Note that while ANC prevalence can be useful for trends and as a proxy of community prevalence, infections in pregnant women is often considerably lower than infections in children under five and will underestimate community level transmission and will need adjustment. • Monitoring of coverage, access and use outcomes should be done using cost-efficient methodologies such as targeted LQAS or other small-scale surveys where the number of households is reduced, and thresholds of use and access are established and focused on data needed for specific decisions. Nationwide LQAS is not recommended as a cost-efficient approach. **Data driven decision-making** • Malaria program reviews and mid-term reviews should be done with cost efficiency in mind, without extra funding for venues, virtual participation to limit travel while acknowledging some travel (e.g., for community participants) may still be needed and relying on established SNT partners for technical assistance. • Surveillance system investments should focus on the data needed for data-driven decision-making rather than reporting.

- Programmatic prioritization should include consideration of all malaria interventions, including malaria vaccines, LSM or other interventions that may have limited support or not be supported under Global Fund grants. This will ensure that sub-national allocation, or re-allocation, of these interventions is done holistically and focuses on saving as many lives as possible.
- Mature and effective community-led monitoring (CLM) interventions at primary healthcare should be maintained to monitor access and quality of service delivery and gender or human rights violations that need to be addressed.

Biologic threats monitoring

- TES – limit to every two years with consideration of **site selection optimization**. Please reach out to your Global Fund Country Team if PMI or PMI/Global Fund funds were planned for TES implementation. Countries are encouraged to consider the following:
    - **Ensure timely generation and sharing of high-quality TES data (both clinical efficacy and molecular):** Data from past and ongoing studies should be used to inform the selection of sentinel sites for subsequent studies, allowing for more efficient TES scheduling with a more targeted sentinel sites. This approach aims to optimize resource use while ensuring the generation of actionable evidence for decision-making.
    - **Concentrate TES on areas with suspected or confirmed artemisinin partial resistance (APR):** to confirm the clinical relevance of impact of K13 mutations. Continued monitoring in these areas is critical. The decision to relax TES in certain areas should also be informed by up-to-date TES data.
    - **Rely on molecular surveillance, if capacity exists:** markers of resistance are early warning signals, which should be included in the analysis used to inform polices and future surveillance needs.
    - **Use public health staff:** use NMP or local MoH, local research institute staff to run TES. Depending on capacity needs, consider engaging external consultants with TES experience to improve quality and reduce costs. WHO has a roster of consultants to provide TA support.
    - **Remote monitoring and leveraging digital tools:** Whenever possible, remote supervision models (e.g., digital where possible).
    - **More efficient ways to process TES samples:** Consider options to avoid delays in processing of TES samples results (including inter-country collaboration for sharing of lab resources, sharing of updated data to inform subsequent studies planning), and other operational efficiencies to cut down costs.
- HRP2/3 deletion monitoring: limit to once per three years. If results show prevalence of false-negative RDTs due to pfhrp2/3 higher than 3%, consult your Global Fund Country Team.
- Entomologic monitoring: insecticide resistance monitoring should be maintained to guide product choice, but other entomologic monitoring can be paused, though discuss with your Global Fund Country Team for areas where *An. stephensi* is a concern.

Outbreak detection and epidemic preparedness activities will be more important than ever, so ensure the malaria program has the capability of identifying and analyzing outbreaks and a response plan. If the integrated disease surveillance programs (or Health Cluster in COE contexts) currently are tracking malaria outbreaks, then analysis and response efforts should be integrated. In the event of **outbreaks**, the response should also be operationalized from a decentralized level if feasible, to reduce travel related costs and increase expediency. In areas where IDSR and outbreak reporting is nascent, consider targeted support to key facilities that could serve as early detection centers.

Changes from aggregate reporting systems to case-based reporting systems should be paused (except for elimination contexts). If activity is well underway, please consult your Malaria Team/RSSH/PMD.
In elimination contexts, case-based surveillance should be maintained, and the operationalization of case reporting and investigation should be decentralized.

Health Products and Procurement Considerations

Priority services and products will differ by disease program, but as a general consideration, health products will continue to be a significant proportion of investments.

Programs should focus grant procurement on lifesaving HIV, TB and malaria health products and consider financing and/or sourcing essential medicines and routine laboratory supplies through quality-assured local suppliers.

Maintaining a healthy and viable market for health products is critical to the sustainability of HIV, TB and malaria responses. Significant programmatic choices that result in volume reductions for essential products could damage supply security, leading to price increases or unavailability of these products.

The procurement implications of any reprioritization choices should be carefully considered and included within **forecasting and procurement plans.** Early indications of material changes to plans must be communicated as soon as possible to the Global Fund's Supply Operations department.

When making health product choices, **programs should consider the overall cost of implementation and service delivery rather than product cost alone** – for example, opting for a more costly product may be the preferred option when this reduces the cost of in-country delivery (e.g., multi-month dispensing of ARVs, long-acting formulations which reduce service delivery costs).

Broader considerations include:

- **Purchase orders and contracts already placed cannot be canceled:** Once the supplier signs and accepts the Contract/Purchase Order from the buyer, it becomes a legally binding agreement for both parties for the supplier to provide the buyer with the correct items at the agreed-upon price and within the specified time frame. Cancellation of purchase orders and contracts already issued may result in penalties up to the full cost of the contract. Additionally, there could be knock-on market and pricing implications impacting the whole portfolio.

- **Reference pricing:** For all procurement channels, **HPMTs should be updated with mandatory use of PPM or GDF reference pricing** for health products and associated services to enable rapid portfolio wide assessments of the implications of any price changes for the grants, especially actual or potential price increases. More information.

- **Market intelligence**: PRs should monitor any changes in Global Fund's advice on lead-times to enable procurement orders to be placed on time should lead-times for some products extend.

- **Optimize procurement channels for grant and domestic financing**: the use of PPM/Wambo and GDF is recommended where possible for core products. This can enable countries to benefit from negotiated terms, prices and quality-assured products from a diversified and sustainable supply base, through by optimizing the Global Fund's purchasing power to sustain access and pricing. It can also simplify orders especially for lower volume products, including for children's drugs, that may become scarce on the global market.

- **Standardize specifications of high-volume products.** With overall reduced volumes, concentrate demand on fewer variations of products to support efforts to maintain unit price efficiencies. Standardized specifications also help simplify global and national supply chains (e.g., storage, distribution).

Malaria

- Promote the standardization of specifications of pyrethroid and PBO ITNs around the standard sizes used to optimize the supply of dual AI ITNs:
    - 180x160x150
    - 180x190x150

TB

- Use of the four-month regimen for adults for DSTB (2HPMZ/2HPM) should be minimal, as it lacks an FDC, and the costs are currently considerably higher than the existing six-month regimens (6HRZE) which has an FDC formulation.
- The use of the new antigen-based Next Generation Skin Tests for confirming TB infection should be preferred to the IGRA tests which are considerably more expensive and PPD/TST which is not specific.

HIV:

- Consolidate TLD procurement around the 90-pack size as the optimal pack size as the reference price is lower and enables for different multi-month dispensing arrangements.
    - Note: 30 pack of TLD will be needed for HIV post-exposure prophylaxis.

- Consolidate pALD procurement around 180-pack size (rather than 90) as reference price is lower and allows larger flexibility across weight bands.

- Consolidate all condom procurement around a few choices meeting most user preferences, such as 53mm plain condoms.

- The Global Fund may advise of further standardizations in the coming weeks.

- **Lower-costing alternatives**: Adopt lower-costing, quality assured products where they exist. Consider policy adaptations and change management activities.
    - HIV professional use and HIV/syphilis dual tests: WHO's new guidance recommends adopt lower-costing A1 professional use tests with verification studies conducted concurrently or after the use introduction of the test
    - HIV self-tests (HIVSTs): consider lower costing blood-based tests available on the market and newer products as they launch to market
    - CD4: consider use of affordable lateral-flow-assays (LFAs); CD4 networks should not rely exclusive on LFAs thus inform procurement based on overall CD4 network mappings and quantifications
    - HIV oral PrEP: adopt and procure lower costing generic TDF/3TC for oral PrEP in place of higher-costing TDF/FTC.

- **Product preferences:** in product areas where choice is offered, only procure and offer products that meet the needs of users to avoid expiries and wastage. Ensure product quantification and procurement reflects user preferences and needs. Sample product areas include:
    - Sterile needles and syringes for harm reduction
    - Condoms and lubricants.
    - HIV PrEP

- **Stop customization**: For example, on labels and leaflets to optimize flexibility to be more responsive to urgent needs and to be able to reallocate products to another country. This includes customized labels for ITNs and condoms.

- **Update quantifications:** Be sure to adjust quantification for potential increased or reduced consumption for some of the interventions. In addition to regular considerations of stock on hand and historical consumption, consider where increased or reduced consumption and how quantification is projected in the near term such as:
    - Revised product eligibility; changes in anticipated coverage; and reduced frequency of testing.
    - Challenges with distribution networks including sample transportation; and distribution of products to health facilities.
    - Care in order quantities for products with short shelf-life (i.e., <12 months) including some laboratory reagents and controls.
    - Consolidate demand of reagents and consumable needs across different programs/pathogens and optimize platform testing utilization and utilization of reagents and consumables.

- **Transition off sub-optimal regimens:** Promote accelerated transition off regimens where volumes are globally low and better products exist. Forced transitions due to unavailability of product should be avoided. Consider any policy adaptations and change management activities to effectively implement health product changes. This includes optimization of pediatric and second-line ART and transition to shorter TB regimens. Disease specific information and more details are included in respective sections.

- **Equipment:** Since purchase of new vehicles, IT equipment, lab and other equipment is generally not prioritized, it is important to prioritize service, maintenance and warranty coverage of existing equipment to ensure precision of instruments and maximize the useful life of the equipment. Accelerate discussions with MoH to take-up financing of server maintenance, license fees where applicable, equipment warranties and warehouse storage costs.

- **Innovation:** Programs should still consider the place of new, optimal health products as they become available, where they offer opportunity to improve health outcomes and cost-effectiveness or savings. Examples include malaria first-line therapy diversification, pipeline near point of care TB diagnostics, long-acting HIV prevention innovations including injectable PrEP and long-acting depot buprenorphine.

RSSH

Health and community systems investments that underpin and without which create gaps in the delivery of lifesaving HIV, TB, and malaria services proposed above are lifesaving investments to prioritize. Such investments vary significantly by country, so critical review of lifesaving systems investments for each thematic area would be critical. In general, the priority should be given to RSSH investments that directly enable **integrated** HIV/TB/malaria service provision, including enabling access, equity and quality, and that accelerate the transition towards sustainable country platforms/systems. The following thematic areas directly contribute to the delivery of lifesaving HIV, TB, and malaria services.

- **Human resources for health and community health workers** that provide HIV, TB, and malaria services, including community-based and community-led delivery where cost-effective, aligned with integrated service delivery models and national HRH and community health strategies.

- **Supply chain (health product management systems)**, including logistics information systems, in-country storage and distribution of identified priority health products procured by Global Fund grants.

- **Laboratory systems**, providing quality assured HIV, TB, and malaria diagnostic services and integrated lab systems including specimen transport and result return.

- Core **health information systems (HIS), surveillance, monitoring and evaluation** functions, including staff, digital HIS maintenance, integrated routine data quality assurance, and optimized data analysis and use activities at district/health facility levels.

- **Community Systems Strengthening** to strengthen community linkages, service delivery and monitoring quality, equity and accessibility of lifesaving services.

While addressing key gaps in delivery of prioritized HIV, TB and malaria services, it is also critical to support countries to **build more sustainable systems by integrating HIV, TB, and malaria work into primary health care** where possible, and through greater allocative efficiency, for example through targeted policy reforms that support integration (e.g., task-shifting, integration of HIV/TB/malaria into essential

PHC packages etc.) and through stronger health financing systems (e.g., financial integration of HIV/TB/malaria into health financing schemes; public financial management reforms, resource tracking). It is also critical to continue to prioritize specific sustainability and transition planning related exercises and activities designed to support short-, medium-, and long-term dependencies on external financing.

Human Resources for Health (HRH) including Community Health Workers (CHWs)

Human Resources for Health (HRH) including Community Health Workers (CHWs)		
Consider Prioritizing	**Consider Deprioritizing**	**Consider promoting (through policy engagement and investments) for sustainability and integration**
Priority should be on **optimizing the performance of HRH/CHW while advancing on integration and sustainability**. There are likely to be context-specific tradeoffs and short-term risks to consider, however advancing and accelerating sustainability and integration is key. As a general principle, it is also essential to strike a balance between community and facility-based support to protect both access and quality of integrated services (i.e., avoid prioritizing only community health workers, or only quality improvement). The recommendation is to prioritize based on: (2) status of advancement; (2) likely impact and strategic relevance for integrated, people-centered quality services; and (3) lean and efficient approaches for training and supervision. • Maintain support for **remuneration and equipment/job aids, including digital data collection tools for HRH/CHW** that provide integrated lifesaving services (including HIV/TB/malaria/RMNCAH services) at community, primary health care (PHC) level and high-volume facilities, inclusive of peers and paralegals, laboratory workforce and public health functions.	Based on country context, consider deprioritizing single-disease/vertical HRH/CHWs activities. • **Recruitment, remuneration and deployment and preservice training for new HRH/CHWs**, especially single disease/vertical HRH/CHW, including single disease M&E officers. Context considerations can apply to HRH/CHW needs for campaigns, ensuring that planning processes strive for lean resourcing, and integrated planning with other campaigns (inc. not Global Fund funded) and outreach services (e.g., leverage mobile brigades, where cost effective). Existing CHW platforms, where coverage is high and they are mature can be leveraged for both community engagement, demand-creation & post-campaign follow up. **Deprioritize pre-service training for new CHW** for single disease/vertical CHWs (e.g., peers). Focus instead of requalification of existing peers as polyvalent CHWs providing integrated services to key and vulnerable	Accelerate or start activities enabling sustainability and integration: **Policy and planning, including workforce deployment** • Develop/update costed HRH/CHW strategies. • Develop HRH compacts/sustainability plans for HRH/CHWs. Domestic co-financing commitments for PHC workforce including CHWs, and plans for progressive transition away from disease specific HRH/CHW investment toward an integrated and sustainable polyvalent HRH/CHW workforce. • Formalization of CHW role, including enabling legal framework • Task sharing reform to enable service integration. Including better linkage of CHWs within integrated service delivery models • Paralegals and other legal redress mechanisms are important separate, complementary components focused on improving access to justice where human rights barriers affect access to health. Depending on context, there may be

Human Resources for Health (HRH) including Community Health Workers (CHWs)		
Consider Prioritizing	**Consider Deprioritizing**	**Consider promoting (through policy engagement and investments) for sustainability and integration**
• Where contexts allow without disruption to lifesaving services, shift single disease/vertical HRH/CHW toward integrated services (in alignment with national service packages and national HRH and community health strategies). • Efficiency can also be gained by reviewing and optimizing deployment. • Depending on contexts, co-financing commitments should be negotiated, coupled with accelerated work on sustainability and transition. • Maintain support to **pre-service training 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. Actively champion requalification of vertical peers into polyvalent CHWs as part of integrated CHW pre-service training roll out. • **Pre-service education of HRH (non-CHW) can be considered in the following circumstances (otherwise deprioritize**): ○ Contributes to PHC workforce development priorities (e.g., nursing, midwifery training programs), depending on status of advancement/PR track record, alignment to national HRH strategies or HRH investment plans. ○ Has a demonstrable added value to service delivery integration, quality or innovation (e.g., transition to blended learning, curricula revision to integrate HIV/TB/malaria competences into PHC workforce,	populations while balancing equity and human rights considerations. • **Off-site refresher/standalone in-service training** (for any topic area) for HRH/CHW (any cadre). Focus instead on continuous quality improvement, clinical mentoring, virtual/blended options. Any protocol/single issue update should be delivered through digital or mobile platforms, or where not available, on-the-job supervision. - Single topic **CHW training** for elements not included in pre-service education packages. Training should prioritize roll out of pre-service integrated package, including requalification of single disease / vertical CHWs into polyvalent ones through the integrated curriculum. **CHW equipment** not in line with national working kit for CHWs (focus also on optimal targeting of equipment distribution for CHWs) • **Hotel-based workshops/meetings for any policy and strategic planning, dissemination, validation purpose**. Prioritize in-house and virtual meetings instead. Focus on protecting critical planning for integration and sustainability but with lean approaches	opportunities for efficiencies and improved integration of legal support services across diseases. **Financing and remuneration** . Shift single disease/vertical HRH/CHW toward integrated services (in alignment with national packages and national HRH and community health strategies). Harmonization of pay scales for HRH/CHWs (including peers) with national pay scales. Where context does not permit an immediate shift toward national integrated service packages and national pay scales without disruptions to services, initiate planning and policy level discussions to prepare for these shifts to start with the GC8 funding cycle. . Resource mapping and expenditure tracking for HRH/CHW, including strengthening national processes to do the tracking, including to quantify salary discrepancies, duplications and inefficiencies in HRH/CHW funding. **Training capacity building and supervision** • Outline and fast track the inclusion of disease specific functions and competences and gender and human rights competencies in pre-service training programs for relevant PHC cadres including CHWs, supervision and

Human Resources for Health (HRH) including Community Health Workers (CHWs)		
Consider Prioritizing	**Consider Deprioritizing**	**Consider promoting (through policy engagement and investments) for sustainability and integration**
including stigma-free, rights-based gender-responsive, KP competent care) • Maintain **HRH analytics, policy and planning activities**, if they have a specific focus on integration and alignment of workforce to PHC implementation, task sharing reform and/or transition planning or they can be catalytic of such processes (e.g., health labor market analysis support can be maintained, if it can help de-verticalize workforce planning and integrate CHWs into workforce investment cases). Focus on the cross-cutting principle on efficiency of meetings and aim for lean HRH planning processes. • Maintain support to **continuous quality improvement for integrated services** at PHC or high-volume facilities (e.g., Cross-disciplinary QI teams regularly using data for continuous improvement). Focus on selected indicators across HIV/TB/malaria programs where performance has been suboptimal and on ensuring stigma-free, rights-based and gender-responsive care. This approach should be preferred over training and supervision. Consider quality across the referral system as relevant to the aim for improvement (i.e., multidisciplinary quality improvement teams involving both HRH and CHWs, do not only focus on facility-based staff or CHWs in isolation). For CHW competency maintenance, focus should be on strengthening national CHW supervision system, integration of CHWs in quality improvement approaches and virtual learning where CHWs are digitalized.	• **Single disease/service supervision for HRH/CHW**, such as supervision that is not integrated supportive supervision. For integrated supervision, consider cross-cutting guidance on streamlining inputs and integration. • **Pre-service education for HRH**, excluding CHWs if: (1) activity does not contribute to PHC workforce development or HRH plan, or has limited added value to service delivery integration or innovation (i.e., Funding to HRH production that is part of a Compact or is about strengthening blended learning can be retained); (2) activity is infrastructure (e.g., training facilities) that have not substantially progressed; and/or (3) activity has not started. • **HRH information systems maintenance**, unless there is good status of advancement, or risk/impact of cancellation of support is high. Development of new systems should be deprioritized (with exception of CHW masters lists and their transition into Human Resources for Health Information System (HRHIS) • Other quality of care activities, unless directly benefitting the service delivery level.	data collection systems, as well as equipment lists. • Redesign training approaches to enable shift to quality improvement complemented (as appropriate) by blended learning/clinical mentoring instead of in-service training. • Joint planning for training and supervision across HIV/TB/malaria grants, integrating approaches at different levels of the system with a view to shift away from silo training and supervisions to continuous and targeted quality improvement instead. • Integration of HIV/TB/malaria elements into integrated supervision systems at PHC level.

Health Product Management Systems

Health Product Management Systems		
Consider Prioritizing	**Consider Deprioritizing**	**Consider promoting (through policy engagement and investments) for sustainability and integration**
The recommended approach that countries should adopt for the prioritization of supply chain investments should be driven primarily by interventions and costs that are lifesaving in nature and ensure equitable access to health products, while accelerating efficiency, integration and sustainability of health product management systems. This includes: • **Maintain procurement and supply management (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:** The Global Fund grants should continue to finance PSM costs, including those that support outsourcing of the aforementioned services, where pertinent. Procurement and supply management (PSM) costs may cover activities related to management of health products starting from selection of products until delivery to beneficiaries, use and reporting. These costs are not included in the RSSH section of the Modular Framework, but a key priority to retain because of their lifesaving nature. • Beyond paying for PSM costs, **identify efficiency opportunities in downstream PSM costs being paid in grants 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 in 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 here will	Given the specific country context, level of political buy-in, co-financing investment, consider deprioritizing siloed/disease specific supply chain investments including in areas such as information systems and infrastructure. Ensure that these are integrated across all programmatic areas. Other considerations and areas of investment to deprioritize include: • **Infrastructure upgrades that have yet to substantially progress,** or yet to convincingly demonstrate likelihood of successful completion before the end of GC7. (e.g., a warehousing, storage or waste management infrastructure that has not initiated construction). Specifically, if the construction has not started and there is no clear path to completing it on budget and on time and cheaper, lower risk alternatives exist. Furthermore, consider de-prioritization if project-related procurement of contracting firm	Countries should take into account their overall supply chain maturity to prioritize the investments required to identify priority areas required to ensure sustainability of their supply chain, which will be enabled by cost-efficient and integrated supply chains that guarantee continuous availability of health products to people. • **Aligned national supply chain strategies that accelerate and embed supply chain sustainability** across all core areas (i.e., financing, digitalization, governance, policies, resource optimization, public private partnership models, etc.). These could be reflected in revised national strategic plans. • A focus, under the stewardship of countries and in coordination with core partners, on **designing and implementing more integrated supply chains**. This will involve accelerated streamlining of disparate supply chain functions, consolidation and standardization of core processes to generate economies of scale where appliable and minimized duplication of effort of core functions that have procurement and supply chain responsibilities along the entire value chain. These efforts will yield efficiency gains and cost reductions as well to ensure greater supply chain sustainability. • **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,

Health Product Management Systems		
Consider Prioritizing	**Consider Deprioritizing**	**Consider promoting (through policy engagement and investments) for sustainability and integration**
be on ensuring value 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 data systems, storage and distribution services. • **Accelerated deployment of interoperable, disease agnostic information systems**, such as an electronic logistics management information system (eLMIS), warehouse management systems (WMS), enterprise resource planning (ERP) systems and digital transport management systems (TMS). This may also include grant investments in integrated, health product agnostic information systems to ensure verification and traceability of health products. These systems will be critical in guaranteeing end to end visibility, generating operational data to support core supply chain functions including integrated planning and early detection of supply gaps (e.g., on-shelf availability, stocked according to plan) and further support comprehensive supply chain analysis for performance and risk management. Costs associated with configuration, hosting, licensing, maintenance and workforce development for the use of the system should be prioritized. These investments should also extend to include all platforms and related activities to strengthen analytics, data-use, data quality, forecasting, and demand-planning. In some countries, this may require increased upfront investments but will subsequently yield longer-term savings. • **Development and/or revisions of National Strategic Plans (NSPs)**, including digital health strategies (where needed).	or if designs are yet to be completed. • For **equipment procurement**, including that for waste management, particularly where site operational readiness is at high-risk, review on a case-by-case basis to identify if any orders in the pipeline can be reversed or cancelled. • **Deprioritize funding residential workshops** for supply chain- related activities (e.g., development of guidelines, quantification exercises, strategic plans, tools and program reviews). Identify alternative options that do not require per diems, etc.) • **Single disease specific supply chain supervision** for data quality, product availability or other supervision areas that are not integrated. For integrated supervision, consider cross-cutting guidance on streamlining inputs and integration.	and health benefit package designs to ensure both financial sustainability and maximum population coverage.

Health Product Management Systems		
Consider Prioritizing	**Consider Deprioritizing**	**Consider promoting (through policy engagement and investments) for sustainability and integration**
These can use data from recent supply chain assessments, including any supply chain maturity assessments that feed or support strategic planning. • **Coordinated, comprehensive national supply chain governance** to provide accountability, stewardship, leadership and oversight over the entire supply chain system performance and ensure effective performance management and execution of all policy and planning related activities. • **Sustainability of already existing (completed or near complete) waste management and warehouse equipment and infrastructure**, such as warranty and maintenance, operations costs, and operational capacity building (to be complemented with co-financing); for after the C19RM end-date, in cases where use of domestic resources will not be feasible.		

Integrated Laboratory Systems Strengthening

Integrated Laboratory Systems Strengthening		
Consider Prioritizing	**Consider Deprioritizing**	**Consider promoting (through policy engagement and investments) for sustainability and integration**
Countries can further shift toward integrated laboratory systems, shifting from disease specific ones. Priorities will be on key components of the integrated laboratory systems such as specimen referral systems (SRS), laboratory information systems (LIS), and/or laboratory	Consider deprioritizing siloed/disease-specific laboratory systems investments, infrastructure, and stalled equipment investments, such as:	• Promote **regional initiatives** including **peer-to-peer learning** that enhance implementation of integrated laboratory systems

Integrated Laboratory Systems Strengthening		
Consider Prioritizing	**Consider Deprioritizing**	**Consider promoting (through policy engagement and investments) for sustainability and integration**
quality management system (LQMS), based on country context/need. This may include activities that: • Strengthen **integrated SRS** and communication of test results. • **Enable participation in integrated proficiency testing schemes** (i.e., HIV/TB/malaria diagnostics), leveraging on ISO 17043 certified regional/national schemes. • Support **interoperability of LIS** with other data systems. • Utilization of **existing diagnostic network optimization data** to improve entire laboratory network functions • **Maintain equipment contracts and warranties** for existing equipment. • **Replace modules for Xperts** instead of procuring new equipment.	• All previously funded siloed **(disease-specific) SRS or LIS** should be reprogrammed to prioritize integrated SRS and LIS through a phased approach. • Infrastructure upgrades that have yet to substantially progress, or yet to convincingly demonstrate likelihood of successful completion before the end of GC7.Infrastructure upgrades that have not started, or yet to convincingly demonstrate likelihood of successful completion before the end of GC7. • Disease/equipment specific diagnostic network optimization (DNO). • Review new equipment procurement on a case-by-case basis and **deprioritize based on lack of site operational readiness.** • Disease specific site supervision and mentoring of lower-level laboratories from central level • **Hotel based meetings/**workshops for development/validation of lab guidelines/tools/SOPs – these can consider other no cost options e.g., MOH lab/partner boardrooms	• Leverage **existing country-capabilities** e.g., “home grown “ and/or open-source integrated LIS to expand coverage of LIS for improved patient management • Support the roll out of the Lab maturity model (LMM) in collaboration with regional partners (Africa CDC and WHO-AFRO) to assess the maturity of laboratory systems towards equitable healthcare access, the integration of diagnostic services, and other key health system (including disease specific targets) objectives. Advocate for including LMM assessment as an integral part of the Global fund grant cycle. Support the establishment of a global dashboard summarizing levels of laboratory system maturity in various countries. Support the adoption of LMM in other regions outside of Africa.

Health Information Systems (HIS) and Monitoring and Evaluation (M&E)

Health Information Systems (HIS) and M&E		
Consider Prioritizing	**Consider Deprioritizing**	**Consider promoting (through policy engagement and investments) for sustainability and integration**
Prioritize interventions to maintain essential surveillance, HIS and M&E functions, including staff, digital HIS maintenance, integrated routine data quality assurance, and optimized data analysis and use activities at district and health facility levels, with a focus on high-volume sites and priority districts/health facilities, etc.) **Cross-cutting (in order by indicative priority):** • **Maintain M&E core staff** across HIV/TB/malaria programs and HIS directorates, including at subnational levels. Consider integrating functions/personnel whenever possible, in line with HRH and surveillance prioritization information in this document. • Ensure availability of **paper-based data collection and reporting tools** for all sectors (public, private community) in hybrid systems (paper/digital). The revision of data collection and reporting tools in GC7 should be supported only if critical; countries should assess if the revision can be postponed to GC8. • Ensure the **maintenance of national digital HIS** (e.g., DHIS2 and other): - Digital HIS core team staffing and essential training (reduce frequency and improve methodology, explore virtual modality); helpdesk; hardware maintenance; software license/fees; hosting fees; internet data fees; - TA for priority high level expertise updates; e.g., software version updates.	Consider de-prioritizing: (1) vertical data processes that can be optimized through integrated ones; (2) resource-intensive assessments and surveys; (3) printing strategy documents, guidelines and bulletins; and (4) costly data related national workshops. More specifically, countries should consider: • Pausing **new digital decentralization in hybrid (paper/digital) systems** (not applicable in near fully digital systems).When planning the development of a new patient-level system (Tracker or EMR), **avoid** opting for **disease-specific systems** and aim for integrated systems. • Discontinuing funding **residential workshops** for data related activities (e.g., development of guidelines, strategies, tools, TWG meetings at national level to monitor implementation, etc.). Find alternative methods (e.g., virtual validation meetings, meeting options not requiring per diems, etc.) • Discontinuing **disease specific data audits, routine data quality assessments (RDQA)**	Countries should take into account their HIS maturity, digital HIS and DHIS2 maturity to guide critical investments. The M&E System profile can further guide the CT in their discussions on prioritization. To identify medium- to long-term efficiencies, and to continue building functional and sustainable national health information systems that generate key and quality data, it is necessary to embrace novel approaches that will initially incur a cost but will subsequently generate longer-term savings. These may include: • **eRDQA for data quality assurance** – stop periodic resource intensive national/diseases specific data audits, and comprehensive surveillance system assessments in favor of digital routine data quality assessments (eRDQA). • **Virtual trainings** – these need to be developed first, some may already exist, e.g. health facility/district monitoring meetings in CIV/Mali, RHIS online curriculum, etc. Explore cross-country use of existing virtual HIS training materials.

Health Information Systems (HIS) and M&E		
Consider Prioritizing	**Consider Deprioritizing**	**Consider promoting (through policy engagement and investments) for sustainability and integration**
• Prioritize system interoperability and/or integration (e.g., CHIS; private sector, LIS, LMIS, IDSR, etc.) where digital HIS maturity level is medium/high and in countries with patient-level systems. • Trainings should be **limited to essential data-related processes** (data collection, quality assurance, analysis and use), delivered on site/on-the-job or virtually, where possible. See also Surveillance section. • Support **configuration of data quality functionalities in** digital **HMIS** software (e.g., the DHIS2 Data Quality Toolkit). • Implement **integrated eRDQA** (digital data quality supervisions) in high volume sites; frequency can be adapted to available funding, e.g., every six months/ annually instead of quarterly. • Support routine **data analysis and use monitoring meetings** at all levels, with a focus **on district and health facility levels**, to identify gaps, monitor trends and better target interventions. Reduce frequency, if necessary, improve methodology (transform data validation meetings into monitoring meetings that analyze data quality, program performance and define action taking). Explore virtual meetings at national and regional levels, favor in-person meetings at district and health facility levels. • **Support case-based /patient level data systems only if already introduced**: e.g., Electronic Medical Record (EMR)/ DHIS2 Tracker implementation and support. • **Maintain existing data repositories** and continue those that are in the process of being set up. Do not plan to set up new	using excel format. Favor **integrated** and **digital** approaches. • Stopping or **reducing printing** of guidelines, reports, bulletins etc. Disseminate and use electronic versions. • Refraining from **new standalone surveillance system assessments**. Focus on implementation of results from past assessments. • Refraining from implementing new surveys/studies or assessments, decide on a case-by-case basis. - **HIV**: no new population-based and other surveys (DHS, PHIA, stigma index survey) and specific assessments; slow down/deprioritize integrated biological behavioral surveillance (IBBS) in particular if done in GC6, and transition to simplified methods (such as Prevention Outcomes Monitoring Toolkit: BBS lite, Rapid Coverage Survey, Polling Booth Survey and ANC sentinel surveillance, and sentinel surveillance plus among key populations). - **TB:** No new TB prevalence surveys. - **Malaria:** No new Malaria Indicator Surveys, revisit the scope of those in the pipeline - focus on intervention coverage;	• **Improved methodology for data monitoring meetings** – transform data validation into data analysis and use meetings at district/health facility level. Use existing material developed during Data SI. Use TA to support introduction. Use virtual modalities for associated training and potentially mentoring – it will result in improved data quality, program implementation/targeting, efficiencies and impact. • **Continued system digitalization and integration** – will contribute to better quality data (timeliness / accuracy) for decision making for targeted program implementation and ultimately savings on paper-based tools and logistics. • **Seek further integration of pandemic and HIV/TB/malaria surveillance systems with HIS** • Avoid residential workshops, but this requires common approach among donors and sectors/high level governance/leadership.

Health Information Systems (HIS) and M&E		
Consider Prioritizing	**Consider Deprioritizing**	**Consider promoting (through policy engagement and investments) for sustainability and integration**
ones but ensure basic data triangulation happens during data analyses. See also Surveillance section. • Adapt **efficient methodology for program/system reviews** – look at cost-saving options, greater focus on desk review including rapid surveillance assessments, virtual validation meetings, and less field level visits. • Critical ongoing surveys and assessments should be supported to completion, depending on their implementation stage. **HIV:** • Support system security to ensure privacy and confidentiality. • Support patient monitoring, including initiation, re-entry, loss to follow-up. • Support monitoring ARVs dispensing for ART, PrEP and PEP. • Support monitoring of lab tests, VL, CD4 and HIV testing. • Support patient level (e.g., EMR, DHIS2 Tracker, etc.) and aggregated digital data systems (e.g., DHIS2 HMIS). • Support integration of prevention outcome monitoring (POMT) in routine monitoring of services. **TB:** • Prioritize TB routine surveillance system strengthening activities (case-based and aggregate level reporting). • Accelerate transitioning to real-time reporting according to country context.	no new comprehensive surveillance system assessments. • **Cross-cutting:** No new HHFAs/national DQRs. **For tHFA for KPI reporting**, consider consolidation with existing surveys (e.g., GFF FASTR) where available; also consider potential use of routine systems where KPI information can be feasibly integrated.	

Health Information Systems (HIS) and M&E		
Consider Prioritizing	**Consider Deprioritizing**	**Consider promoting (through policy engagement and investments) for sustainability and integration**
Malaria: • Continue support for strengthening routine malaria surveillance, including at public, private and community service delivery points and incorporating epidemic monitoring and response. Private sector surveillance system strengthening should focus on countries where strong support to private sector case management exists. • Maintain support for targeted surveillance around biological threats, which may include entomological assessments (especially on invasive vector species), insecticide resistance monitoring, therapeutic efficacy studies, HRP2/3 deletion surveys. • Maintain support for surveys that are in the pipeline. Support introduction of ANC1-based surveillance as an alternative to MIS.		

Community Systems Strengthening

Community Systems Strengthening		
Consider Prioritizing	**Consider Deprioritizing**	**Consider promoting (through policy engagement and investments) for sustainability and integration**
Protect investments that contribute to improved linkage, referral and human rights support between formal and community health delivery platforms leveraging community partners to deliver, including:	Deprioritize community-led research, advocacy, and CLM initiatives that are not directly linked to data use for quality improvement or the removal of service barriers, including standalone pilots and parallel structures without clear pathways to action. **Standalone CLM pilots** not linked to	Integrate CLM platforms into national quality assurance/improvement systems or fund activities that link CLM to national and/or district level social accountability mechanisms to avoid operating in siloes (e.g., citizen charters, grievance mechanisms

Community Systems Strengthening		
Consider Prioritizing	**Consider Deprioritizing**	**Consider promoting (through policy engagement and investments) for sustainability and integration**
○ Maintain existing *or* mature CLM programs that provide real-time data on accessibility and quality of lifesaving services, including commodities and diagnostics. These are low cost, generating critical feedback on responsiveness and utilization. TA and advice are available in Secretariat to support prioritized site selection (coverage) and duration of implementation (costing). • Ensure CLM programs have approved access to facilities and already trained and deployed monitors and data collection and analysis frameworks for quality improvement. Continue investing in capacity development of community-led and –based organizations supporting delivery of lifesaving services. These CLOs and CBOs are essential for reaching key and vulnerable populations. • Maintain peer cadres, including mentor mothers, with remuneration and supervision for delivery of quality lifesaving services (see HRH/CHW Section). • Invest in peers that deliver Integrated services (HIV/TB/malaria, human rights, NCDs) to key and vulnerable communities (context specific). • See HRH/CHW Section on training and supervision.	program improvement cycles and/or **parallel structures for monitoring without a clear pathway to change.** Deprioritize CLM-focused research especially in countries where the CLM program is new or has not yet completed more than two data collection cycles Refrain from investing in **additional feedback mechanisms** outside of existing engagement platforms to provide community feedback on quality of services and meaningful engagement in decision making and governance. Deprioritize research activities led by or implemented by community partners if not directly linked to supporting quality service delivery.	parliamentary oversight) linked to epidemiological prioritization and geographic scope. Implementing integrated CLM mechanisms across topics (e.g., noncommunicable diseases, HIV/TB/malaria, PPR, gender and human rights, social protection, mental health and human rights) at point of care instead of vertical CLM mechanisms that has the potential for duplication (several vertical mechanisms approaching the same client for feedback on the already integrated services they received). Use existing data systems (HMIS, eLMIS) to streamline community feedback, solutions and reporting – institutionalizing client feedback on service quality, equity and access Where possible, invest in enabling legal and policy environments that fast tracks capacity development of community partners to set them up for social contracting or delivery of services through other finance streams (donor, domestic, private, social income generation approaches). These efforts should take a systems-wide approach and select mature community organizations (led and -based) to deliver quality services, strengthening both technical and institutional capacities with clear outcomes to ensure sustainability. Safety and security of implementers should include investments at organizational level as part of

Community Systems Strengthening		
Consider Prioritizing	**Consider Deprioritizing**	**Consider promoting (through policy engagement and investments) for sustainability and integration**
		community system strengthening (refer to capacity development of CLOs/CBOs below for more information).

Health Financing Systems

Health Financing Systems		
Consider Prioritizing	**Consider Deprioritizing**	**Consider promoting (through policy engagement and investments) for sustainability and integration**
Priority should be on continuing financing of existing grant activities that specifically **support sustainability and transition planning at the country level, address health financing challenges, and/or directly strengthen health financing systems**. These remain critical given the changes in the external financing landscape and the need to support a gradual transition away from external financing. Such activities include: • Support for **transition plans, sustainability plans, transition assessments, and/or other planning exercises** that directly support country level transition and sustainability planning • **Health financing strategies** for improving domestic revenue mobilization, collection and financing of the health sector. • **Interventions that specifically support funding pooling and integration of beneficiaries and HIV/TB/malaria services into PHC/benefits packages**	Consider deprioritizing activities that do not have a direct impact on core health financing and/or sustainability objectives: • **Activities that are complementary to** those of other development partners who are no longer able to fulfill their commitments, especially when such activities would have limited impact if implemented in isolation. • Activities **not directly linked to improved health outcomes or critical systems functions.** • Within PFM activities:	Accelerate or start activities that could support greater sustainability and integration, including: • Opportunities to support **country level planning exercises** designed specifically to support transition away from reliance on Global Fund and external financing. • Activities that could support **pooling of Global Fund grants with health insurance and health financing schemes** for inclusion of people living with HIV/TB/malaria and HIV/TB/malaria services. • Activities that would **support sustainable financing / payment options for HRH / CHW and social contracting**. See HRH/CHW section for detail.

Health Financing Systems		
Consider Prioritizing	**Consider Deprioritizing**	**Consider promoting (through policy engagement and investments) for sustainability and integration**
• Activities that specifically support **resource tracking investments** and/or the **capacity of country stakeholders to generate and use health financing data** to support the transition away from external financing • Investments that contribute to **blended finance mechanisms** designed to support improved resource mobilization • Activities designed to strengthen **public financial management** (PFM) and support the mainstreaming of Global Fund grants into country PFM systems in the short to medium term[1]. Specifically, these include: i. PFM activities that have been legally contracted for or where there exists a legal obligation to deliver goods and/or services iii. Strategic PFM activities that add value to demonstrating sustainability and transition and which have been leveraged to demonstrate "additionality" with other donor funding. iv. PFM activities that encompass **co-funding PFM initiatives** with other development partners as part of pre-agreed co-funding arrangements. v. PFM activities that are **central to PR transition to the use of country systems for grant financial management** and are critical for KPI reporting or linked to delivery on Objectives and Key Results (OKR). These include but are not limited to the provision of digital PFM payment solutions supporting sub-national/last mile	**PFM-related capacity assessments found to be duplicative of the efforts of other development partners** and where such assessments could be leveraged by the Global Fund to inform its PFM interventions **PFM capacity-building training activities falling outside the scope of those contained in the "consider prioritizing"** section and which do not produce measurable or time-sensitive/clear outputs PFM budget not yet identified in specific activities	• PFM activities that fall outside the scope defined in the "consider prioritizing" section but which are impactful with execution targeted or aimed for in the long-term. These are strategic and highly sustainable PFM investments characterized with a longer-term[2] lead time for execution and delivery. These include the following: ○ PFM activities tied to ERP or integrated financial management information systems introduction or optimization including associated work on chart of accounts mapping with the Global Fund's costing dimension to enhance expenditure tracking and reporting ○ Activities supporting professionalization or certification of health sector finance professionals including strengthening the ethical & regulatory environment ○ Activities tied to institutional strengthening of PFM actors such as internal audit, external audit/supreme audit institutions (SAIs) and public sector financial controlling functions that are critical to supporting efforts to mainstream grant fiduciary oversight (for e.g., transitioning out of a fiscal agent).

Health Financing Systems		
Consider Prioritizing	**Consider Deprioritizing**	**Consider promoting (through policy engagement and investments) for sustainability and integration**
service delivery, SAI & internal audit assessments and capacitation and activities that support Global Fund grants being on national budget. vi. **Strategic country-level PFM engagement** organized by the Global fund to accelerate the use of country system for health delivery.		○ Activities designed to support adequate and effective domestic health budget formulation and execution

Surveillance Systems Strengthening

Surveillance Systems Strengthening	
Consider Prioritizing	**Consider Deprioritizing**
Note: Non- HIV/TB/malaria surveillance activities are nearly exclusively reflected in C19RM budgets. In the context of GC7 contingency planning it is *not* expected that countries will seek to newly prioritize limited GC7 funding for non- HIV/TB/malaria surveillance. Thus, as with medical O2, the select activities below represent a limited set of specific, essential Surveillance needs that could be considered as overall priorities even in sharply constrained environments especially as national disease programs accelerate integration of public health functions. • Maintain and complete activities funded under C19RM. • Support pre- and/or in-service education of new polyvalent CHWs on event-based surveillance, in line with national government program curricula. • Strengthen sub-national maintenance of integrated national digital HIS systems (e.g., DHIS2) including indicator-based notifiable disease surveillance modules e.g., IDSR. • Support frontline field epidemiology training on routine program monitoring and surveillance data analysis and use with a focus on district and health facility levels, to identify gaps, monitor trends and better target investigation and response activities. • Expand existing integrated disease surveillance data repositories within public health emergency operations centers to strengthen HIV, TB, and malaria focus on tracking continuity of essential services, outbreaks, etc.	• Stop or significantly reduce the development of new surveillance systems and modules. • Stop or reduce hotel-based training for surveillance and find alternative methods, including virtual or hybrid trainings, supportive supervision and continuous quality improvement. • Discontinue funding residential workshops for data related activities. Find alternative methods (e.g., virtual validation meetings, meeting options not requiring per diems, etc.). • Reduce purchases of laptops, mobile phones, and other IT equipment unless they serve integrated functions critical to operations. • Stop or reduce printing of guidelines, reports, bulletins etc. • Disseminate and use electronic versions. • Do not plan to set up new data repositories but ensure basic data triangulation happens during surveillance data analyses.

Medical Oxygen & Respiratory Care

Medical Oxygen & Respiratory Care	
Consider Prioritizing	**Consider Deprioritizing**
Note: O2 are entirely reflected in C19RM budgets. In the context of GC7 contingency planning it is *not* advised that countries seek to newly prioritize limited GC7 funding for O2.	• **General expansion of PSA plant/bulk O2 infrastructure**. • **Liquid O2** capacity and distribution systems (LOX).

Medical Oxygen & Respiratory Care	
Consider Prioritizing	**Consider Deprioritizing**
Thus, as with surveillance, the select activities below represent a limited set of specific, essential O2 needs that could be considered as overall priorities even in sharply constrained environments. • **Sustainability of existing PSA plant supply infrastructure**, such as warranty and maintenance; operational capacity building (to be complemented with co-financing) in health facilities serving large populations of people living with HIV, TB, and/or malaria; for after the C19RM end-date where use of domestic resources will not be feasible.	• Medical O2 delivery equipment. • Building **O2 associated infrastructure and generators.**