THE GLOBAL FUND

Tuberculosis Information Note

Grant Cycle 8

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Core Guidance

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

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

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

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

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

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

GC8 Information Notes: guiding prioritization

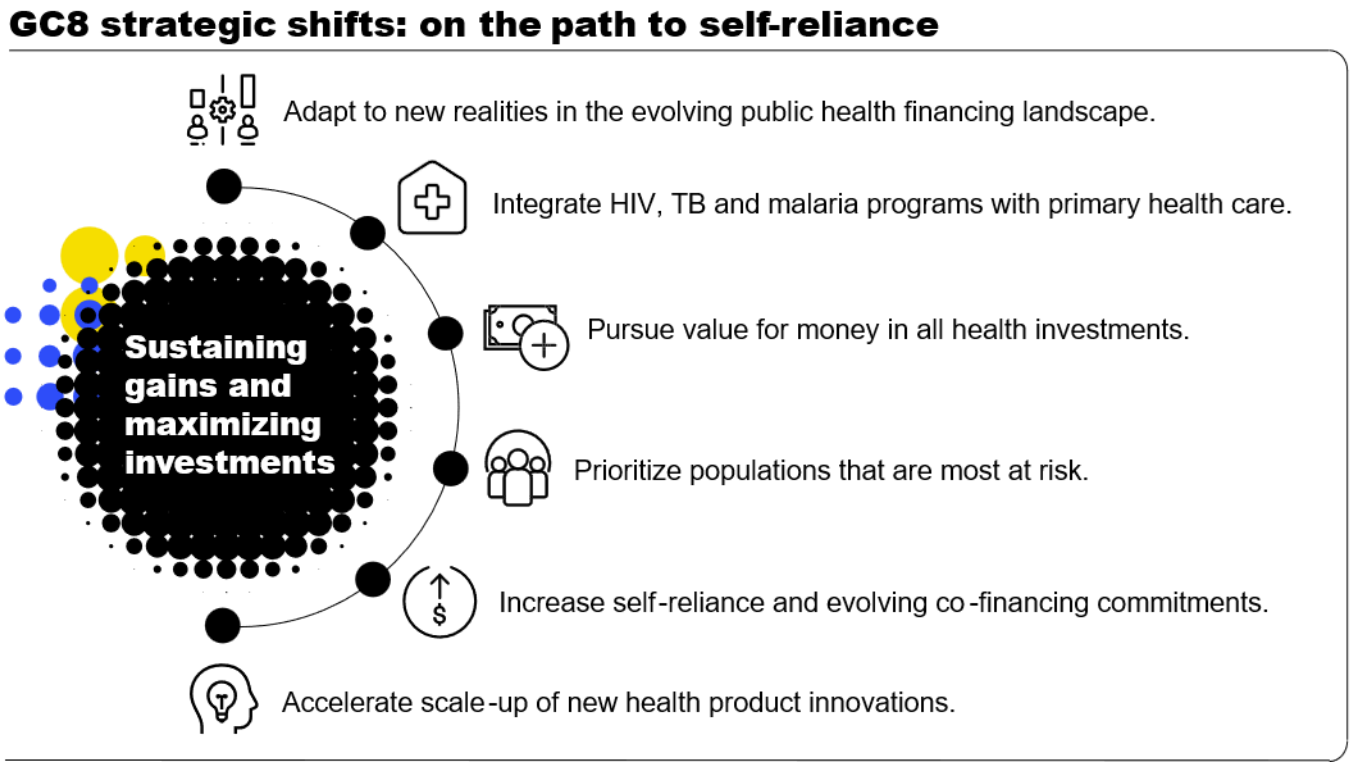
GC8 investment guidance more clearly outline areas of investment that are high priority and those the Global Fund is unlikely to fund or that require strong justification so countries can decide accordingly. The guidance emphasizes how to optimize investments and drive cost effectiveness to maximize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

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

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

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

What's new across all the investment guidance notes:



Key messages

- This information note guides applicants through interventions that are categorized as higher or lower priority for Global Fund investments. There is a third category of interventions that can be considered for optimization and efficiency.

- The document is aligned with the Grant Cycle 7 Programmatic Reprioritization Approach including programmatic efficiency and optimizations which are relevant in any or low and flat funding scenarios.

- TB program essentials introduced in GC7 are now included as priority interventions in relevant sections, summarized in the Annex.

- It includes new WHO recommendations on new DR-TB treatment regimen, the use of concurrent tests for TB diagnosis in people living with HIV and children, and preparations for introduction of near point of care TB tests once recommended by WHO

- Considerations of people in fragile and conflict- affected settings, people affected by extreme weather events and climate impacts on food security and livelihoods are included as key and vulnerable populations for TB.

In addition to optimizing disease investments and planning for sustainability in their Grant Cycle 8 funding requests, Applicants will need to consider the following **areas of investment that the Global Fund will no longer fund unless strong rationale is provided**:

- **Purchase of new vehicles, information technology and non-essential laboratory and other equipment** will require detailed information such as a list of existing equipment, how the needs for new assets were determined and plans for deployment. Consider rentals when this is more cost-efficient. Prioritize service, maintenance and warranty coverage to ensure precision of instruments and maximize the useful life of the equipment. Transition financing of server maintenance, license fees where applicable, equipment warranties and warehouse storage costs to domestic budgets, ideally within the grant period.
- **Infrastructure upgrades**, such as building or renovation of laboratories, warehouses, storage, shelters, and environmental controls for airborne infection prevention and control, will require strong justification. It should be part of an investment in the health system rather than a standalone disease component and ideally fully or partially co-funded with domestic budgets.
- **International conference attendance** and study tours. Explore virtual alternatives instead.
- **Commemorative days, generic mass media events and campaigns**, including related commodities (t-shirts, notebooks, pens) on World TB Day or other events that do not directly link to improved outcomes of TB patients.
- **Non-strategic training and meetings.** The objective is not to halt these but find more efficient ways to save time and resources and to prioritize trainings that are essential for quality of care. Where possible, organize training courses to cover more subjects, use existing meeting or

training rooms of government institutions or use virtual platforms and be leaner in terms of travel-related costs (e.g., number of participants, meeting duration and other costs).

Prioritize pre-service training over in-service. Where in-service training is part of a broader performance improvement package, models such as low-dose, high-frequency virtual learnings are preferred over one-off training in person.

- **Inefficient supervision and monitoring**. Explore cost-saving options, for example, reduce supervision frequency by moving from monthly to quarterly supervision with virtual check-ins instead, where possible; focus on low-performing facilities rather than all facilities; reduce the number of supervisors or number of supervision days by tailoring the focus of supervision on outcomes that are lagging.

  Where appropriate, integrated, supportive supervision should be prioritized over single-disease supervision, prioritizing the sub-national level (e.g., integrated supervision from district to primary health care facilities rather than from central to regional or provincial level). For more details, refer to the guidance on human resources for health in the Resilient and Sustainable Systems for Health and Pandemic Preparedness and Response Information Note.
- **Limit print materials and publication costs** except for routine data collection and reporting tools where they are not digitalized and leverage digital platforms instead.
- **Operational costs.** Find efficiencies in program management, program management unit costs and in-country travel.

Additional Considerations

Demonstrating Value for Money for effectiveness, efficiency, equity in the context of the HIV response, means for applicants to:

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

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

Climate and health. Resilient and sustainable systems for health (RSSH) investments directly and indirectly contribute to managing climate risks and increasing climate resilience of health systems under the current and future climate scenarios, including more robust supply chains, environmentally sustainable waste management and clean energy systems (including

solarization), climate-informed health information and surveillance systems, and HRH. See the Technical Brief on Climate and Health.

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

Health product considerations

Applicants are required to follow the Global Fund's quality assurance policies and guidelines on health product procurement and supply management when procuring health products using Global Fund grants. Health product procurement decisions should consider total implementation costs, not just product prices.

Health products constitute a large proportion of Global Fund investments. Measures to improve efficiency include:

- Using standardized product specifications (e.g., fewer variations of products, including pack sizes, and stopping customizations) to maintain price advantages and simplify supply chains.
- Use reference pricing from the Global Fund's pooled procurement mechanism (PPM)/wambo.org in health product management tools to monitor price changes and assess grant impact.
- Stay updated on Global Fund lead-time guidance to enable timely order placement and avoid delays.
- Optimize procurement channels (e.g., PPM/wambo.org for core products) to access negotiated terms, prices, quality assured products and reliable supply especially for low-volume or pediatric items.

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

1. Prioritization for Global Fund Investments

This section lists which interventions are of high or low priority for Global Fund investments. It also includes considerations for finding efficiencies and optimizing investments. The Global Fund expects countries to take these into account in their Grant Cycle 8 funding requests, while acknowledging that activities require tailoring to unique country contexts, and to consider all sources of funds.

Related information is available in the GC7 Programmatic Reprioritization Approach and the TB Programmatic Efficiency and Optimizing TB Response, which include country examples.

1.1 Screening and Diagnosis of TB, Including Drug-resistant TB

Systematic screening for TB disease is necessary, including in people not reporting typical symptoms suggestive of TB, to find and successfully treat all people with TB early and minimize its transmission. Globally, TB treatment coverage reached 75% in 2023 but only 48% of people with TB were tested with molecular World Health Organization (WHO)-recommended rapid diagnostic tests (mWRD) at the time of diagnosis.[1] Increases in mWRD coverage and bacteriological confirmation (necessary to test for drug resistance) are critical to improve the treatment coverage for multidrug-resistant TB (MDR-TB) and rifampicin-resistant TB (RR-TB), which remained low at just 44% of cases treated in 2023.

Screening and diagnosis

Priorities for Global Fund investments

- Implement screening and diagnostic algorithms that are sensitive, accurate and efficient, such as chest x-ray with or without computer-aided detection (CAD) for TB screening, molecular WHO-recommended rapid diagnostic test (mWRD) as the initial test for TB and bacteriological confirmation of pulmonary TB patients.
- Prepare for appropriate introduction and scale-up of affordable new tools to support universal coverage of mWRD as the initial diagnostic test for TB during Grant Cycle 8, including near point-of-care tests and alternative sampling techniques recommended by WHO, in consultation with stakeholders including affected communities, and ensuring equitable access for all.
- Intensify screening and testing for TB in health facilities, including quality improvement activities, in both public and private facilities so all people presenting to health facilities with TB symptoms or at risk of TB are promptly identified, tested and linked to appropriate care.
- Integrate TB into essential health care packages and systems to improve access and sustain TB services. Primary health care services should include TB screening and treatment support (with referrals when needed) and pregnant women living in high TB burden areas should be routinely screened for TB as part of antenatal care.
- Implement targeted active case finding focused on key and vulnerable populations, and in areas where TB case notification is lower than expected, and implement population-wide screening among the general population in geographies with an estimated TB prevalence of 0.5% or higher.
- Interventions to find children and adolescents with TB should be part of overall case finding efforts, including contact investigations. Children should have access to mWRD testing for non-sputum-based samples and to chest x-ray to aid in diagnosis and identify children with non-severe TB who can benefit from the shorter four-month regimen.[2] TB programs need to collaborate with and build the capacity of providers engaged in child and adolescent care.
- Implement diagnostic scale-up, network strengthening and optimization in the overall context of integrated laboratory services. Workstreams related to network management should be designed together with leadership from the national TB program and national laboratory directorates.
- Understand the gaps that limit access to and use of high-quality diagnostic services to inform interventions that address these gaps. This may include: (i) ensuring TB laboratories have the necessary equipment, supplies and trained human resources; (ii) ensuring uninterrupted supplies and maintenance of equipment, biosafety and quality assurance of lab services; (iii) ensuring appropriate placement of equipment to ensure access while maintaining optimal utilization; (iv) using a sample referral system to cover sites where services are not available; (v) implementing affordable connectivity solutions to enable automated reporting by diagnostic devices.
- Promote decentralized diagnostic networks, sample transportation and storage, and integrated testing for TB with other diseases, including through multiplex diagnostic testing platforms as part of integrated laboratory system strengthening (see the RSSH and PPR Information Note), e.g., integrated sample referral system and shared use of molecular test devices for TB diagnosis, HIV early infant diagnosis and viral load monitoring for both HIV and hepatitis.
- Ensure rapid drug-susceptibility testing (DST) of all people diagnosed with TB to guide appropriate treatment and ensure rapid turnaround times for test results and treatment initiation, including through use of digital tools.

Screening and diagnosis

- Understand, design and implement interventions to close the gaps in the TB diagnosis cascade so that people presenting themselves with TB symptoms, or at risk of TB, at health facilities are promptly diagnosed and started on treatment. In addition, develop systems for the timely investigation and diagnosis of conditions with overlapping chronic respiratory symptoms to facilitate appropriate care.

Strengthen linkages between diagnosis and treatment to minimize pre-treatment loss-to-follow-up. All interventions should be people-centered, address human rights and gender-related barriers, support community and private sector engagement, and promote integrated approaches.

Lower priority for Global Fund investments

- Limit the use of sputum microscopy to monitoring treatment progress only. (mWRD tests, not sputum microscopy, should be used for TB diagnosis.)
- Stop active case finding interventions where the overall yield is lower than estimated population prevalence.
- Avoid activities such as mass media campaigns and high-profile and expensive events and forums that do not yield demand for care or result in increased case finding or improved treatment outcomes of TB patients.
- Please refer to the key messages for considerations on cross-cutting activities such as the purchase of equipment and optimizing travel-related costs and activities that are not a priority for Global Fund investments.

Optimization, efficiency and other considerations

- Consider mapping and targeting high-risk groups and geographic areas with high incidence ("hotspots") using available data, including a vulnerability index, keeping in mind the limitations of notification data alone. The population size and location of some TB risk groups can be partially estimated based on existing TB data, while other estimates may require data from additional sources, such as demographic and health surveys or living standards surveys, community sources and tools such as WHO's ScreenTB[3] and Stop TB Partnership's size estimation tool.[4]
- Consider options to optimize the use of test cartridges, such as pooling of sputum samples for mWRD tests and upfront use of x-rays (with CAD) for TB screening to reduce the number of mWRD cartridges needed, if screening costs are more affordable.
- To optimize resources, active case finding and other community-based activities should: integrate HIV, malaria and noncommunicable disease services in active case finding, when appropriate; integrate contact screening and TB preventive treatment (TPT) by linking the algorithms for TB screening and diagnosis with TPT initiation; integrate TB sample transportation with other programs; and use remunerated polyvalent community health workers (see the human resources for health guidance in the RSSH and PPR Information Note for more detail).
- Consider the concurrent use of molecular tests on respiratory specimens and stool for diagnosis of TB in children who are HIV-negative or of unknown status over single testing, per WHO rapid communication,[5] if adequate resources are available.
- Monitor cost and performance data of different screening strategies to guide the most cost-effective interventions. Where activities such as case finding or retention strategies involve relatively high costs (transport, health worker time or total test costs) and/or limited case finding, consider alternative models

Screening and diagnosis

that could improve targeting or lower-resource requirements. Important lessons from South-East Asia on optimizing active case finding has been published by WHO.[6]

Note: Specific interventions related to TB/HIV, key and vulnerable populations, private sector, and community systems and responses are in the relevant sections of this information note. Interventions related to RSSH, including the areas of governance, health financing, human resources for health, laboratory systems strengthening, health information management systems and health products management, are detailed in the RSSH and PPR Information Note.

1.2 Treatment and Care for Drug-susceptible TB and Drug-resistant TB

Against the global target of a 90% treatment success rate, TB treatment success reached 88% among people with newly diagnosed and relapsed TB and 68% among people with drug-resistant TB (DR-TB) in 2023.[1] Treatment and care services should be designed and delivered considering the needs and preferences of people with TB rather than that of the health care system. Universal access to drug susceptibility testing and shorter, all-oral and patient-friendly treatment regimens, ensuring uninterrupted supply of medicines, managing adverse drug reactions and comorbidities, and the use of digital tools and psychosocial support are important elements to support people with TB to access and complete their treatment successfully. Digital adherence technologies and polyvalent community health workers can significantly reduce the pressure on health care facilities while meeting the needs and preferences of clients. Digital tools should be interoperable and in accordance with the country's national digital health strategy.

Treatment and care

Priorities for Global Fund investments

- The standard 6-month regimen (2HRZE/4HR) for drug-susceptible TB (DS-TB) remains the preferred option, as it offers advantages of lower cost and lower pill burden compared to the new four-month DS-TB regimen (2HPMZ/2HPM).
- For children with non-severe DS-TB, build capacity to assess eligibility to prioritize the use of the shorter and more patient-friendly four-month regimen (2HRZ(E)/2HR) using child-friendly drug formulations, including pediatric fixed-dose combination (FDC) tablets.[7]
- Following WHO's updated recommendation in 2025,[7] all patients with MDR-TB or RR-TB, including those with additional resistance to fluoroquinolones, should benefit from effective all-oral treatment regimens, either shorter or longer, implemented under programmatic conditions. While the BPaL/M regimens remain the treatment of choice for eligible patients, the new all oral BDLLfxC regimen can expand the use of the six-month regimens to additional patient groups who are not eligible for BPaL/M.

Treatment and care

- Decentralize services, integrating DR-TB with DS-TB testing and treatment services. Offer ambulatory care for DR-TB patients from the start of treatment, limiting hospitalization only to when medically or socially required. Laboratory tests, second-line drugs and clinical capacity should be accessible (directly or through sample transportation) close to the patients to avoid treatment initiation delays and loss to follow-up.
- Manage common co-existing conditions and co-morbidities by integrating care or supporting linkages to care during and after TB treatment, including care for post-TB sequelae, dispensing of TB drugs with other medications for chronic conditions, and counselling and social support to people with TB by trained community health workers, peers and community-led organizations.
- Address barriers to TB treatment adherence, including client costs (transport, time or other costs) and human rights, stigma and gender-related barriers.
- Implement active TB drug safety monitoring and management using clinical and laboratory tests for people on DR-TB treatment to detect, manage and report adverse drug reactions promptly.
- As a part of a patient's support package, consider the use of digital tools such as treatment adherence technologies, call centers and mobile apps to support patients for treatment adherence, counselling and reporting adverse drug reactions. Digital adherence technologies (DAT) such as video-supported treatment, medication sleeves/labels and smart pill boxes have been successfully used in countries to complement in-person counselling and directly observed treatment. The Global DAT Task Force technical brief provides an overview of the technologies and guidance to applicants on planning, budgeting and implementation considerations.[8]
- Prioritize investments to ensure uninterrupted availability of quality-assured anti-TB medicines and screening and diagnostics tools, including through capacity building and strong procurement and supply chain management systems.

Lower priority for Global Fund investments

- The four-month DS-TB regimen (2HPMZ/2HPM) for people aged ≥12 years will only be considered for few specific population groups, when the needs justify the additional costs over the standard six-month regimen, such as TB patients who are homeless or on the move.
- WHO has also recommended three new nine-month all-oral regimens (BLMZ, BLLfxCZ and BDLLfxZ) over currently recommended but longer (more than 18 months) regimens in patients with MDR-TB and RR-TB and in whom resistance to fluoroquinolones has been excluded. The nine-month regimen is of lower priority, in favor of the 6-month treatment (BPaL/M, BDLLfxC), which remains the treatment of choice for eligible DR-TB patients.
- To promote decentralization and integration of DR-TB with DS-TB care, vertical DR-TB clinical infrastructure will not be supported.
- The Global Fund will not invest in injection-based regimens for DR-TB, with the exception of treatment for the few who may present with complex drug resistance profiles.
- The Global Fund will not invest in operational research for modified DR-TB treatment regimens given the availability of several WHO-recommended treatment options that can be used under programmatic conditions.
- Please refer to the key messages for considerations on cross-cutting activities such as the purchase of equipment, optimizing travel-related costs and activities that are not a priority for Global Fund investments.

Treatment and care

Optimization, efficiency and other considerations

- Advocate and mobilize resources to provide financial, transportation, nutritional, psychological and mental health support for people with TB and their families, particularly through government social protection schemes and corporate social responsibility programs.

1.3 TB Prevention

Accelerating actions for TB prevention, along with early diagnosis and successful treatment, is critical to end TB. While progress has been made in the proportion of people living with HIV starting on TPT (56% in 2023), the proportion of household contacts of bacteriologically confirmed TB cases on preventive treatment was only 21%.[1] WHO recommendations on the use of shorter TPT regimens, the new class of antigen-based TB skin tests and increased awareness of airborne infection prevention and control (IPC) provide opportunities for TB prevention.[9]

TB prevention

Priorities for Global Fund investments

- Design and implement activities to promote TPT as part of routine activities across the TB care cascade. Contact investigation should integrate finding TB cases along with identifying people eligible for TPT. Active case finding and other community-based activities can integrate TPT by linking the algorithms for TB screening and diagnosis with TPT initiation and engagement of polyvalent community health workers via task shifting (see the guidance on human resources for health in the RSSH and PPR Information Note for details).
- In resource-limited situations, the highest priority groups for TPT are children under five years of age who are household contacts of bacteriologically confirmed pulmonary TB and people living with HIV (adults and children). This prioritization is based on the "strong" recommendation and "high" certainty in the estimates of effect of the WHO recommendation on TPT for these populations.[9] These two groups do not require TB infection testing to start TPT, while household contacts who are five years or older and found not to have TB disease after an appropriate clinical evaluation may also be given TPT. Other groups may be considered based on the country's epidemiological context and availability of resources.
- Update national guidelines to align with the latest recommendations to offer newer, shorter TPT combination therapies (3HP, 1HP, 3HR and 6Lfx for DR-TB),[9] using pediatric formulations and FDCs once they become available while continuing with 6H or 9H in the meantime.
- Monitor and address gaps in the TB prevention cascade so all those eligible for TPT are started on and complete their treatment. Involve community-led organizations to increase awareness and demand, and organize peer support networks to improve treatment adherence and completion.
- Develop and implement appropriate airborne IPC measures across all levels of the health care system, in congregate settings and at the community level. TB IPC programs should be part of the wider health system effort to prevent transmission of infection at the health facility and community level, designed and implemented as a part of RSSH interventions.

TB prevention

- Ensure that: administrative controls are in place and followed to protect health care workers and patients attending health facilities; environmental measures provide a safe working environment; and adequate personal protective equipment such as masks and respirators are available and properly used by patients and health care workers, including community health workers.
- Support associated activities for the introduction and roll-out of a new WHO-recommended TB vaccine when it becomes available, including assessment of feasibility and acceptability, demand forecasting, regulatory preparedness, policy updates and building linkages with national vaccine programs and local authorities to monitor adverse events.
- Where possible, prioritize antigen-based skin tests for TB infection testing, as they are significantly less expensive than interferon-gamma release assays and have higher specificity than the tuberculin skin test among BCG-vaccinated individuals.

Lower priority for Global Fund investments

- In situations of limited funding, target groups for TB infection testing. TPT may be prioritized based on the strength of WHO recommendations and certainty in the estimates of effect for the specific population group, depending on the country's epidemiological and financial context.
- Based on the point above, an example of a lower priority would be TB infection testing of adolescent and adult household contacts of TB patients in high TB burden countries with ongoing transmission. Note that in this example, household contacts who are children aged five years and older, adolescents and adults can be given TPT if they are found not to have TB disease after an appropriate clinical evaluation.
- Deprioritize interferon-gamma release assays tests in favor of more affordable tests (refer to the last bullet point in the priority intervention list above).
- Please refer to the key messages for considerations on cross-cutting activities such as the purchase of equipment, optimizing travel-related costs and activities that are not a priority for Global Fund investments.

Optimization, efficiency and other considerations

- TB prevention activities, particularly contact investigation, TPT and IPC, should be designed and implemented as part of routine TB activities rather than standalone interventions. TB-related airborne IPC at health facilities should be part of the general health facility and system approach for IPC and should be considered as an important element of pandemic preparedness and pandemic response programming.
- Likewise, TPT can be integrated with active case finding and routine TB services.

1.4 TB/HIV

TB remains the leading cause of death among people living with HIV. Implementation of collaborative TB/HIV activities will reduce TB incidence and mortality in people living with HIV, contributing to global End TB and Ending AIDS by 2030 goals. To foster collaboration and ensure alignment, countries with high TB and HIV co-infection are required to submit joint TB/HIV funding requests that present integrated quality programming for the two diseases.

TB/HIV

Priorities for Global Fund investments

- Offer provider-initiated HIV testing and counseling to all people with TB and presumptive TB. Ensure early provision of antiretroviral therapy, cotrimoxazole and TB treatment for those with TB and HIV co-infection, with well-coordinated or integrated service delivery.
- Conduct systematic screening for TB disease among people living with HIV at each contact with a health care facility and integrate systematic TB screening in differentiated service delivery models. Wherever possible, screening algorithms could be adapted to fulfill new WHO recommendations to include chest x-ray (with or without CAD).
- TPT should be provided to all eligible people living with HIV. TB infection testing is not a requirement to start TPT among people living with HIV and should not be a barrier for TPT initiation (as is the case for children under five years). Countries should adopt shorter TPT regimens (3HP) and FDCs.
- Pregnant women living with HIV in whom TB disease has been excluded should receive TPT as part of a comprehensive package of HIV care, using a non-rifapentine-based TPT regimen recommended by WHO.[10]
- TPT should be integrated into differentiated service delivery models for HIV to reduce patient burden and improve retention (e.g., multi-month dispensing of ART, community adherence groups and other activities). Implementing differentiated service delivery should not become a reason for delaying or denying benefits of TPT to people living with HIV and TPT should not be a reason for patients to become ineligible for accessing differentiated service delivery.
- Intensify the collaboration between TB and HIV programs, integration of TB/HIV services, joint programming, implementation, supervision and monitoring. Multi-disease screening and diagnostic platforms and integrated sample transportation systems are good opportunities to strengthen collaboration and contribute to strengthening health systems.

Lower priority for Global Fund investments

- Procurement of C-reactive protein for TB screening.
- Please refer to the key messages for considerations on cross-cutting activities such as the purchase of equipment, optimizing travel-related costs and activities that are not a priority for Global Fund investments.

Optimization, efficiency and other considerations

- In high TB and HIV burden settings, TB/HIV services should be integrated (the “one-stop shop” model).
- Since 2024, the concurrent use of the low-complexity automated nucleic acid amplification test (LC-aNAAT) and the lateral flow urine lipoarabinomannan assay (LF-LAM) is recommended for early and timely diagnosis of TB among people living with HIV.[5] In resource-constrained settings where concurrent use of tests may not be possible for all people living with HIV, those with advanced HIV disease should be prioritized for concurrent tests.

1.5 Collaboration with Other Providers and Sectors

In countries with a large private health sector, the first point of care for a large proportion of people with or at risk of TB are health care providers outside the national TB programs. In addition, a significant proportion of people with TB do not seek health services because they are not aware, may not perceive themselves to be ill or have difficulty accessing services. To find all people with TB and improve service access and quality, TB programs need to work with private health care providers, community leaders and community-based and -led organizations while addressing access barriers, including to gender-sensitive and rights-based service delivery. Without the active engagement of partners who provide services to a significant portion of the population, achieving national TB targets will be difficult. TB also disproportionately affects the most vulnerable populations, who may present with other comorbidities, requiring collaboration with other health programs and social protection schemes.

Collaboration with other providers and sectors

Priorities for Global Fund investments

- Understand the size and role of private providers in the care-seeking behavior of the population and the provision of TB-related services. Private providers include: for-profit providers (e.g., private hospitals, general practitioners, private laboratories, informal providers and pharmacies); the not-for-profit sector (e.g., faith-based organizations, civil society); and other non-national TB program public care providers (e.g., military and police hospitals, medical schools).
- Develop policies and plans for engagement with private providers, aligned with the broader health system private sector strategy, prioritizing those who can contribute the most to early TB case notification and successful treatment. The scale of private provider engagement should be commensurate with their size and role in the provision of TB-related services.
- Design and implement models of private sector engagement that may be differentiated considering the type of provider and services provided (symptom screening and referrals, diagnosis, treatment and other components). Where appropriate, engage the services of intermediary agencies and consider innovative engagement models, including contracting, outsourcing and results- or performance-based payments. Build flexibility to adapt implementation models according to the requirements of each setting and in response to evolving understanding of provider and patient preferences.
- Include private sector facilities in sample transportation systems for TB patients to enhance the efficiency and reach of TB diagnostic services, particularly mWRDs. Providing logistical support to high-volume private sector facilities for sample transportation can significantly reduce delays in testing, turnaround times and treatment initiation.
- Ensure that engaged private providers have easy access to drugs from the National TB Program to minimize delays to treatment initiation, improve access and treatment outcome.
- Strengthen and incentivize reporting of TB data from private providers and integrate these data in the national TB program and health management information system. Minimize the recording and reporting burden on private providers through interoperability with the data systems they use and the creative use of call centers, WhatsApp and other tools. Monitor and report quality of care, outcomes and notifications among private patients.

Collaboration with other providers and sectors

- Strengthen the capacity of relevant national authorities, for example, private sector regulatory authorities, health insurance and national public health laboratories, to engage and monitor quality of services through the development of appropriate legislation and regulatory systems, inclusion of private laboratories in external quality assurance programs and national laboratory information systems, accreditation of private health facilities and engagement with professional associations.
- Strengthen collaboration with other health programs for effective integrated service delivery and/or referral linkages to address co-infection, comorbidities and active TB drug-safety monitoring and management. Besides HIV programs, this may include reproductive, maternal, newborn, child and adolescent health, mental health and non-communicable disease programs.
- Develop linkages to investigate and treat conditions other than TB with overlapping chronic respiratory symptoms or those that may be detected during chest x-ray screening.
- Design and implement collaborative activities to address co-existing and co-morbid conditions such undernutrition, diabetes, mental health disorders, tobacco use, substance use disorders, including alcohol and drug use, and post-TB disabilities.
- Support approaches to address catastrophic costs due to TB, in line with national policies. Advocate and collaborate with relevant ministries, departments and agencies to include TB services and support for people with TB as a part of universal health coverage packages and social protection schemes, particularly for the most vulnerable communities. Social support may include cash, food, nutrition supplements, health insurance coverage and other social benefits.

Lower priority for Global Fund investments

- Large incentives paid to health care providers (both public and private), per patient diagnosed and successfully treated may not be cost-effective or sustainable and are discouraged unless it is in line with integrated pay for performance programs at the primary health care level. Consider non-monetary incentives, including recognition, certification and digitalizing services to encourage engagement of private providers.
- Please refer to the key messages for considerations on cross-cutting activities such as the purchase of equipment, optimizing travel-related costs and activities that are not a priority for Global Fund investments.

Optimization, efficiency and other considerations

- Engage businesses to adopt workplace TB programs, particularly in high-risk occupational sectors, such as mining and construction. This could include building awareness, diagnosis, treatment and prevention services for employees (including daily, casual workers), their families and communities. Businesses may also institute workplace policies to allow employees with TB/DR-TB to take paid medical leave and protect them from discrimination due to TB.

1.6 Key and Vulnerable Populations

Key and vulnerable population groups for TB vary by country but are all disproportionately affected by disease, poverty, stigma and discrimination, and human rights and gender-related barriers to accessing health services. In all countries, children represent a unique key and vulnerable population – disadvantaged by less sensitive TB diagnostics, without access to economic means and unable to self-advocate.

Many new cases of TB are attributable to five risk factors: undernutrition, alcohol use disorders, smoking (especially among men), HIV infection and diabetes.[1] There is considerable variation by country and sex in the relative importance and contribution of these risk factors, and this should guide how they are prioritized as part of national efforts to reduce the burden of TB disease.

Table 1: Key and Vulnerable Populations for TB

Grouping	Risk groups	
People who have increased risk of TB exposure due to where they live or work	• Prisoners, miners, sex workers, hospital visitors, health care workers and community health workers People who: • are household contacts and other close contacts • live or work in overcrowded environments such as urban slums or informal settlements, or camps for internally displaced people	• People in congregate settings such as nursing homes, hospitals, poorly ventilated spaces where people use drugs, military barracks • Children
People who have limited access to high quality TB services including prevention and care	People who: • identify as sexual and gender minorities, particularly in settings with discriminatory laws and policies • are homeless • live in hard-to-reach areas • live in fragile and conflict-affected settings • live in homes for the elderly • have mental or physical disabilities • face legal barriers to access care • use drugs or alcohol	• Migrant workers, women and adolescent girls in settings with gender disparities, men in settings where health care access is not tailored to their needs, children and adolescents, migrants, refugees or internally displaced people, including those displaced by extreme weather events and climate impacts on food security and livelihoods, nomadic populations, people with disabilities and illegal miners • Indigenous and First Nations Peoples • Sex workers • Poor and low-income people, including the rural poor

Grouping	Risk groups	
People at increased risk of TB because of biological or behavioral factors that compromise immune function	• Young children • Pregnant and postpartum women • Elderly People who: • are living with HIV • have diabetes or silicosis • are undernourished • use tobacco • use alcohol • inject drugs	• People with untreated fibrotic lesions (on chest x-ray) • People undergoing immunosuppressive therapy or with immune suppressing conditions, including transplant recipients, those undergoing anti-TNF alpha therapy, those with late-stage chronic kidney disease or those on dialysis • People in high TB burden settings who have a clinical risk factor, including people with previous TB, diabetes mellitus, people who smoke, people who are malnourished and those with chronic lung disease.

Source: Adapted from WHO (2025) Tuberculosis among populations at high risk and people in vulnerable situations: Policy brief. World Health Organization, 2025; and the Global Plan to End TB 2023-2030. Stop TB Partnership, 2022.

Key and vulnerable populations

Priorities for Global Fund investments

- Understand the size, location, barriers encountered and special needs of key and vulnerable populations in the country. Special considerations, policies and action plans may be needed to address the unique needs of the different key and vulnerable population groups. They should be empowered and deliberately and meaningfully engaged by policymakers and implementing organizations to contribute insights and oversight so their needs are considered and addressed.
- Remove barriers to TB services for key and vulnerable populations. This may entail engaging and targeting key and vulnerable populations for TB screening and diagnosis through mobile outreach and community-based or community-led services (e.g., prisoners, miners, people who inject drugs and mobile populations), special allowances for key and vulnerable populations to avail of services, linkage to social protection schemes (e.g., food, financial support, nutrition supplements, transport, labor protection) and programs to address stigma and discrimination and gender-based violence and to protect human rights and legal services.
- In countries with high cross-border movements of people, consider cross-border policies, legal frameworks and interventions to facilitate the continuum of TB care services. In addition to cross-border refugees and migrants, internally displaced populations are often located in hard-to-reach areas with high security threats. Reaching out to these population groups in complex emergencies requires tailored approaches, including working with humanitarian partners.

Key and vulnerable populations

- Special consideration is needed for those in fragile and conflict-affected settings. In portfolios where the Global Fund's challenging operating environment policy can be applied, the Global Fund suggests that applicants consider an appropriate mix of humanitarian and systems strengthening approaches.
- Train health care workers on infection prevention and control and ensure access to a safe working environment, including adequate supplies of personal protective equipment, regular screening for TB and support to complete treatment successfully. Advocate for health workers' labor rights to ensure that they are given adequate paid sick leave to recover and be fit for work before resuming duties
- Adopt new tools and innovations that address the needs of key and vulnerable populations. Children, migrant and mobile populations, and internally displaced people can benefit from the latest innovations for TB screening, diagnosis, treatment, digital tools and mobile outreach services described in relevant sections of this document.
- Support people in prisons and other closed settings to access TB services, including entry screening, periodic screening (preferably using x-rays with AI), and treatment. Services should be equivalent to those in the community and in health facilities. Advocate for less reliance on pretrial detention to reduce prison overcrowding and address barriers to linkage to care during transfers between detention centers and upon release.
- Provide targeted psychosocial, transport and nutritional support as part of an integrated social protection package for key and vulnerable populations (e.g., people in prisons, migrants, pregnant and lactating women, children, individuals with drug-resistant TB and those experiencing acute food insecurity due to climate shocks in national and local food systems) to facilitate access and adherence to TB services, and linkage to appropriate services after release from prisons.

Lower priority for Global Fund investments

- Please refer to the key messages for considerations on cross-cutting activities such as the purchase of equipment, optimizing travel-related costs and activities that are not a priority for Global Fund investments.

1.7 Community Systems and Responses

Community systems include the mechanisms, processes, organizations and networks through which communities engage, coordinate and respond to their health-related and broader social needs. They are essential to health systems and proven to improve the TB response by ensuring it is people-centered, equitable, cost-effective and accountable. They go beyond the reach of clinical facilities by identifying and responding to social and structural barriers to accessing TB care and supporting services. Capacitated and resilient community systems make community-based and community-led responses effective and impactful. These community responses contribute equally to the TB response, complementing and strengthening the work of the national TB program, the private sector and facility-based health service delivery. Interventions to support both community systems and community responses should be embedded within TB grants as an integral part of the overall TB response.

Community systems and responses

Priorities for Global Fund investments

As the foundation of a strong and sustainable community system to fight against the three diseases and other emerging health issues, Global Fund investments are critical to strengthen the institutional capacity and leadership of TB community-based and -led organizations and networks of TB survivors to:

- Facilitate their participation and engagement in the national and sub-national TB response, pandemic preparedness and response, primary health care governance and decision-making processes (including prioritizing feedback from TB survivors and key population networks during program design, agreements on service packages for health providers and community referral and linkage protocols, and participation in monitoring).
- Provide opportunities for technical knowledge and skill-building to deliver quality services, advocate for community priorities to be reflected in program design and build capacity for right-based monitoring of services.
- Support organizational assessments of community-led groups to identify areas for improvement and develop targeted capacity building plans (the use of Community Pulse[11] is recommended). For newly established TB survivors' networks, this can include the development of governance policies and structures to ensure compliance with national standards/procedures. For more mature networks this can include capacity strengthening on program monitoring and evaluation, resource mobilization and advocacy.
- Support community-based and -led provision of services primarily for TB screening (including demand creation), facilitating access to diagnosis (e.g., referrals, delivery of samples), treatment adherence through peers or community workers and TB literacy, livelihood support due to possible unemployment, psychosocial support and other care activities, supporting activities to reduce stigma, TB prevention and rehabilitation.
- Maintain and sustain community-led monitoring (CLM), which provides valuable information to the NTP and service providers from service user experiences on the availability, accessibility, acceptability and quality of TB care and support services. Key CLM funding should prioritize data collection, management, analysis, reporting and sharing, and advocacy with health service sites, government and communities and should ensure data are also used for monitoring outcomes (i.e., service improvements).
- Promote integrated services for TB with HIV and other services related to social protection, human rights and gender-based violence, especially for those affected by the two diseases. The priority should be supporting community-led and -based organizations to ensure that these services are serving both TB and HIV communities to a high-quality standard and respecting human rights, referring to guidance material published by partners.

Lower priority for Global Fund investments

- Avoid parallel coordination platforms and instead invest in collaboration and coordination to support learning and sharing of best practices through existing platforms and mechanisms, for efficiency and sustainability.
- Deprioritize community-led research to provide a better understanding of best practices in TB service delivery for specific populations and the barriers and gaps (including social and structural) that impede effective delivery of people-centered TB services. This includes supporting identification of research topics, participatory research design and implementation, dissemination of research findings and partnerships with research institutions.

Community systems and responses

- Please refer to the key messages for considerations on cross-cutting activities such as the purchase of equipment, optimizing travel-related costs and activities that are not a priority for Global Fund investments.

Optimization, efficiency and other considerations

- Invest in pathways that enable contracting or purchasing of services through TB networks and organizations by government or private sector to improve the sustainability of their operations needed to maintain, improve and scale up TB community responses.
- CLM programs can be integrated and cover more than TB. Where feasible, prioritize investments in CLM programs that are integrated with HIV, malaria, pandemic preparedness and response, water, sanitation and hygiene, and human rights.

1.8 Reducing Equity, Human Rights and Gender-related Barriers to TB Services

Health inequities and human rights- and gender-related barriers increase vulnerability to contracting TB and undermine access to TB services, contributing to poorer, inequitable health outcomes. TB-related stigma is often linked to the stigma of poverty or other social status as well as misinformation. People in prisons and other closed settings face a high risk of developing TB but may be excluded from TB services; health care workers often lack occupational health support; and involuntary isolation of people with TB may occur, in violation of minimum human rights standards.[12] Social and structural determinants of health, such as poverty, malnutrition, overcrowded housing and limited access to quality health care, further drive TB vulnerability.

Women, men, trans and gender-diverse communities experience differences in their exposure and vulnerability to TB and distinct barriers to TB services because of their sex and gender. Adult men account for the majority of TB cases (55%, compared to 33% among adult women) and therefore represent a higher proportion of people not yet diagnosed (72%), while women are more susceptible to TB during pregnancy and to certain forms of TB and experience distinct consequences, such as intimate partner violence and a higher burden of care. Identifying and responding to the ways in which gender increases vulnerability, creates barriers to services and impacts retention in treatment can improve the effectiveness of TB programs. Interventions to reduce key human rights- and gender-related barriers to TB services should be embedded within TB and TB/HIV funding requests as an integral part of the national TB program.

While planning and designing program interventions, and in accordance with the principle of 'Do No Harm', it is important that applicants consider their obligations under the Code of Conduct for Recipients of Global Fund Resources to safeguard Global Fund human rights standards, to mitigate any program-related risks of sexual exploitation, abuse and harassment, and to keep children safe.

Reducing equity-, human rights- and gender-related barriers to TB services

Priorities for Global Fund investments

- Address TB-related stigma and discrimination using stigma measurement tools, training and other resources on patient rights and gender equality developed for health care workers, community health workers, communities, employers, law enforcement officers, journalists and social and religious leaders. Involve people with TB and affected populations and include mental health support. CLM should track TB-related stigma and discrimination and the progress made to reduce them.
- Ensure people-centered, rights-based and gender-responsive TB services through training and ongoing support for health care workers on non-discrimination, impacts of gender on TB vulnerability and gender-responsive care, informed consent, confidentiality and privacy, medical ethics, protection from sexual exploitation, abuse and harassment, and other rights of people affected by TB. Ensure sustained supportive supervision, mentoring and accountability mechanisms.
- Ensure people-centered and rights-based law enforcement practices through pre-service and in-service training and other engagements with police, with meaningful participation of people with TB and affected populations. Provide legal literacy ("Know your rights") for affected populations, particularly marginalized people at risk of exclusion from services or involuntary isolation.
- Increase access to justice for people with TB and affected populations through legal/paralegal assistance, ideally peer-led and community-based, to address breaches of confidentiality and privacy, unfair dismissal or exclusion from work and education, stigma and discrimination, gender-based violence, sexual exploitation, abuse and harassment, and compulsory treatment or involuntary isolation.
- Monitor and reform policies and laws regulating the TB response through advocacy, especially community-led, to reform normative acts that hinder access to TB services (including policies on involuntary isolation) and expand access to social protection and TB-associated disability services. Engage judiciary and parliamentarians to raise awareness.
- Include community mobilization and support to TB survivor-led groups to strengthen community accountability, including CLM of stigma, discrimination, breaches of medical confidentiality, unlawful imposition of user fees and unfair exclusion from work and education.
- Develop and implement policies, protocols and training for health workers to identify and provide support to TB patients experiencing intimate partner violence, rape or sexual exploitation, abuse or harassment, including through referral networks for prevention and response services and sexual and reproductive health services.
- Engage men and adolescent boys through peer education programs and community-wide campaigns to support them to change harmful behaviors related to masculine norms, to increase health care utilization, improve treatment adherence and reduce TB risk behaviors (smoking and alcohol use).
- Implement community education and mobilization to transform harmful gender norms, practices and behaviors that increase TB risk or barriers to diagnosis and treatment for women and trans and gender-diverse people.

Reducing equity-, human rights- and gender-related barriers to TB services

- Adapt TB facilities and services to reduce gender-related barriers, such as enhanced privacy in consultation rooms for confidentiality, safety and security, flexible operating hours or mobile services/outreach to reach men in high-risk settings.

Lower priority for Global Fund investments

- Isolated pilot projects on equity, human rights and gender that are not designed to inform broader TB programming, policy reform or integration into national strategies.
- Standalone training on human rights, gender and TB, unless for targeted capacity building of TB survivors and key TB-affected populations and part of broader empowerment, leadership or community systems strengthening efforts.
- Please refer to the key messages for considerations on cross-cutting activities such as the purchase of equipment, optimizing travel-related costs and activities that are not a priority for Global Fund investments.

Optimization, efficiency and other considerations

- Use findings from integrated equity, human rights and gender assessments, and disaggregated data to prioritize vulnerable populations and tailor approaches.
- Promote multisectoral coordination with gender ministries or human rights institutions to streamline budgeting, increase integration and complementarity of services and enhance accountability (e.g., integrate TB-related legal and policy frameworks and access to justice activities in national human rights institutions and reporting mechanisms for patients).
- Integrate human rights and gender competencies in relevant TB provider training and capacity building, and include TB providers and community health workers in broader human rights and gender capacity-building efforts.

1.9 Strategic Information

The Global Fund promotes data-driven decision-making, enabled by the rapid generation, analysis and use of high-quality disaggregated data. The RSSH and PPR Information Note covers detailed guidance on essential health management information system (HMIS) and monitoring and evaluation (M&E) investments and provides links to additional tools and resources. Applicants should do a thorough assessment of their M&E systems, identify data and system needs and request funding to fill the critical gaps. Digital solutions should be in accordance with the national digital health strategy, leverage national digital public infrastructure, align with a national health information exchange where available and adopt Health Level Seven International (HL7)'s fast health care interoperability resources (FHIR)[13] as an interoperability standard.

Strategic information

Priorities for Global Fund investments

- Establish, progressively scale up and maintain a single comprehensive, real-time, digital case-based TB surveillance system or electronic medical record system, ideally with a national unique patient ID, that is interoperable and able to monitor individual TB cases throughout the care continuum, based on country context and digital readiness. Existing routine aggregate data systems should also be strengthened.
- Disaggregate data at least by age, sex and key and vulnerable populations groups, where possible, to allow for better understanding of the disease burden and gaps in service delivery to inform differentiated responses. Use of a national case-based digital surveillance or national electronic medical record system will facilitate recording, analysis and use of disaggregated data.
- Integrate private sector, community health services and CLM data reporting and quality assurance in the national TB program information system.
- Build in-country capacity and support for: (i) timely data generation, reporting, surveillance, targeted supportive supervision, routine and periodic data analysis and use by local health staff of their own data (e.g., routine care cascade analysis); (ii) informing prioritization, planning and implementation at national, sub-national and health facility levels; (iii) using hotspot mapping and geospatial analysis for more targeted case finding.
- Implement comprehensive Tuberculosis Care Cascade Analysis, patient pathway analysis, program and epidemiological reviews, including cohort analysis, and country-led and independent evaluations. Use the results to design and monitor interventions to improve TB services.
- Strengthen national digital data governance, ensuring that different health information systems are interoperable and integrated into one national health information system and that private sector data are integrated into national systems securely, respecting confidentiality and data protection standards.
- Strengthen public financial management systems to generate financial data and use it to inform costing, budgeting, prioritization of interventions for planning and resource tracking to monitor program implementation, thereby improving the value for money of investments.

Lower priority for Global Fund investments

- While some surveys may be considered based on country-specific context and established criteria, TB prevalence surveys, household cost surveys (formerly called patient cost surveys), knowledge, attitudes and practices surveys and operational research should only be considered in exceptional situations.
- The Global Fund will only consider these exceptional requests if the investment leverages existing resources through joint funding with domestic and/or other donor resources, and cost efficiency is demonstrated.
- Please refer the key messages for considerations on cross-cutting activities such as the purchase of equipment, optimizing travel-related costs and activities that are not a priority for Global Fund investments.

Optimization, efficiency and other considerations

- Ideally, countries should transition from relying on periodic drug resistance surveys to establish robust, continuous surveillance systems based on routine drug susceptibility testing, which also improves access to mWRDs.

Strategic information

- Drug resistance surveys can, however, be considered in countries where routine DST coverage is below the recommended WHO threshold, i.e., the routine DST coverage for rifampicin among new and previously treated cases of bacteriological confirmed pulmonary TB through continuous surveillance is less than 80% and the testing coverage for isoniazid and other second-line TB drugs (among patients with rifampicin and isoniazid resistance) is suboptimal.
- Frequency of repeat surveys should be rational, based on WHO guidance where available. The practice in some countries of conducting overly frequent surveys and assessments (e.g., bi-annually), with results that do not differ much from previous reports and are not used to guide program interventions, is not a good investment of limited resources.
- The conduct of inventory studies to provide a direct measure of the level of underreporting of people diagnosed with TB with an associated record linkage exercise can be considered in countries that meet the standard prerequisites and assumptions for this activity.

1.10 New Products and Innovations

The Global Fund Strategy focuses on accelerating equitable deployment of and access to innovations, working with partners to take an end-to-end view to rapidly address bottlenecks to deployment and scale-up, ensuring access to those most in need. To achieve this, it is important to implement and scale up innovative tools and models of care for TB in a timely manner. Table 2 highlights potential new products supporting TB care during the 2026-2028 funding cycle.

Along with new products, non-product innovations in TB care are foreseen, including in specimen collection and processing, integrated services and quality improvement throughout the care cascade, integrated treatment decision algorithms, digital community-led monitoring and innovative financing.

Applicants are encouraged to include the most recent impactful innovations and tools in their funding requests. Prioritization of the new product or innovation should be guided by due consideration of value for money (see Value for Money Technical Brief), feasibility and sustainability given the country's context. By working with partners, the Global Fund can support countries with preparedness, demand estimation, transition planning and scale-up of new guidelines, innovations in care and new products throughout the grant cycle.

Table 2: Potential new products in TB care during the 2026-2028 funding cycle.

	Screening	Diagnosis	Treatment	Prevention
Objective	• Systematic screening of high-risk groups	• Early diagnosis of all people with any form of TB (DS-TB and DR-TB)	• Prompt initiation of and adherence to appropriate treatment for all people with DS-TB and DR-TB	• Prevention and treatment of TB infection
Innovative tools for inclusion in funding request	• Digital chest x-ray with or without CAD software; addition of CAD to existing x-ray systems. • TB antigen-based skin tests	• Near point-of-care rapid molecular diagnostic tests (WHO guidance expected in early 2026) • Alternative sampling techniques, including tongue swabs • Next-generation LF-LAM technologies	• Additional all-oral DR-TB regimens • Pediatric FDCs and formulations for all forms of TB treatment • Digital adherence technologies	
Potential new products within the grant period	• CAD software appropriate for children	• Urinary point-of-care tests • Multi-disease molecular diagnostic platforms		• Pediatric formulations and FDCs of isoniazid and rifapentine regimens

2. Best Practices: Optimizing the Use of Available Resources

TB programs have been operating under significant funding gaps for years. While advocating for more resources for TB, there are opportunities to enhance value for money to help address urgent gaps in TB funding, especially for critical health products, and sustain the momentum and gains.

Optimizing the impact of available resources can be achieved by addressing several major aspects of value for money (see Value for Money Technical Brief). Has the program made explicit choices and trade-offs amongst the most cost-effective interventions? Are those interventions being implemented in the most efficient way for the context by adopting efficient service models, better targeting and efficient management? Are input costs of selected interventions being reduced while maintaining their quality? Has equity been adequately considered?

Levers to optimize performance and maximize co-benefits can include: making difficult, evidence-based choices amongst many priorities; integration (within TB and with other diseases and sectors, including noncommunicable diseases); more effective use of existing resources and tools, approaches and algorithms; targeting interventions to contexts with higher yield; addressing those bottlenecks in cascades where any extra resources or efficiencies can provide the largest extra improvement in overall results; reducing procurement inefficiencies and prices for quality health products; and accelerating transition to new tools when these are available along the cascade of care. Optimization could be implemented in the short-, mid- or long-term. Some country examples are presented in the tables below. Please refer to Programmatic Efficiency and Optimizing TB Response for more information on optimization and efficiency and country examples.

2.1 Country Examples: Cost-effective and Cost-saving Interventions

Country	Interventions	Methodology	Impact
Multi-country (Bangladesh, Nigeria, Viet Nam, Zambia, 2024	Expanding molecular diagnostic coverage for TB by combining computer-aided chest radiography and sputum specimen pooling	• Data was obtained from community- and health care facility-based active case finding in the four countries. • AI scores used in the model were based on CAD4TB version 7 (Zambia) and qXR (other countries). • Four screening and testing approaches were modeled, incorporating AI-aided chest x-ray interpretation and pooled vs individual sample testing.	• In each country, the optimal screening and testing approach was to use AI to rule out testing in deciles with low AI scores and to guide pooled vs individual testing in persons with moderate and high AI scores, respectively. • This approach yielded cumulative savings in GeneXpert tests over baseline ranging from 50.8% in Zambia to 57.5% in Nigeria and 61.5% in Bangladesh and Viet Nam.
Global, 2022	Lifesaving, cost-saving: Innovative simplified regimens for drug-resistant tuberculosis	• Conventional DR-TB regimens required 5-7 drugs and up to 14,000 pills over 18+ months. • Shorter 9-11-month regimens had limited uptake, with > 40% of patients not completing therapy due to its complexity and length. • New six-month, all-oral regimens (BPaLM/BPaL) achieve ~90% success rates in MDR/RR-TB and pre-XDR-TB. • These new regimens simplify treatment and reduce pill burden to 3-4 pills per day.	• When using BPaLM/BPaL regimens, the potential savings can be estimated at: – ~40% compared to shorter treatment regimens (US$1,000–$2,000 savings per patient) – ~75% compared to conventional treatment regimens (US$4,000–$6,000 savings per patient) • Potential global savings could reach US$740 million annually, enabling treatment for

Country	Interventions	Methodology	Impact
			~400,000 additional MDR/RR-TB patients or ~3.1 million DS-TB patients.
Ethiopia, 2010	Cost and cost-effectiveness of TB treatment by health extension workers (HEW) in Southern Ethiopia	• A community-randomized trial compared treatment by HEWs in health posts vs general health workers at health facilities. • Costs were analyzed from a societal perspective in 2007 in US$ using standard methods.	• Community-based treatment by HEWs cost only 39% of what treatment by general health workers cost for similar outcomes.
Nepal, 2018	The performance and yield of tuberculosis testing algorithms using microscopy, chest x-ray, and Xpert MTB/RIF	• Consecutively recruited TB-symptomatic patients offered smear microscopy, chest x-ray and Xpert MTB/RIF tests. • Six hypothetical algorithms were tested and compared based on yield, Bac+ cases missed, and tests conducted.	• Among 929 patients, Bac+ prevalence was 17.3% (n = 161). Smear microscopy detected 121 (75.2% of Bac+). • Depending on the radiologists' interpretation of chest x-ray, Xpert MTB/RIF testing could be reduced by 31%-60%.
Cameroon, 2022	A cost–benefit algorithm for rapid diagnosis of TB and RR detection during mass screening campaign	• TB mass screening campaigns were executed: 34 prisons and 3 refugee camps. • TB-LAMP was used as the initial test. • TB-LAMP-positive cases were further tested with Xpert to determine RIF resistance. • Turnaround time and cost-benefit analysis were conducted on the combined use of TB-LAMP and Xpert MTB/RIF compared to Xpert MTB/RIF alone.	The combined use of TB-LAMP followed by Xpert MTB/RIF test resulted in: • 73.23% reduction in turnaround time in prisons. • 74.92% reduction in turnaround time in refugee camps. The dual testing approach is also cost benefit from year two onwards.

2.2 Country Examples: Integrated Service Delivery

Country	Interventions	Methodology	Impact
South Africa, 2023	Routine TB screening with contact tracing and preventive treatment	• A deterministic mathematical model was used to evaluate age-based routine screening (from 0 to 5 years) with and without contact tracing and preventive treatment. • Screening included symptom history, tuberculin skin testing, chest x-rays and GeneXpert for confirmation.	• This combined strategy was cost effective (incremental cost-effectiveness ratio US$9050 per DALY; 95% CI: 2890–22 920). • Pediatric TB deaths were significantly reduced in high-incidence areas.
Philippines	Integrated transportation system for TB and HIV services	• 400 Specimen Transport Riders (STRiders), were deployed in 17 regions across the country. • Annual sample volume grew from 284,000 in 2021 to over 500,000 samples in 2023. • Delivered >100,000 TB drug packs and around 6,000 HIV drug packs to patients during 2021-2023.	• Timely diagnosis and treatment. • Reduced turnaround time of test results. • Reduced the catastrophic cost of TB-affected households by 42%.
Ethiopia, 2023	Patient centered drug-resistant TB treatment	• Used data from the STREAM trial (2017-2020) to develop a discrete event simulation model. • Applied patient cost data to model the clinical pathways of 1000 patients. • Calculated costs for a nine-month MDR-TB treatment in 2021.	• Patient-centered and hybrid models of care cost less than the standard of care by US$219 and US$276, respectively. • Patient-centered and hybrid strategies should be considered for routine care of MDR-TB patients.
Zimbabwe, 2016	Integrated specimen transportation for TB, HIV and other	• 63 districts with a network of over 2,000 health facilities, supported by 280 riders. • System supports a wide range of specimens, including TB sputum testing, early infant diagnosis, CD4 count and others.	• Reduced costs by 44% per sample and 35% per facility. • Early infant diagnosis turnaround time reduced by 24 days. • An 8-day turnaround time was achieved for CD4 and TB sputum testing.

Annex 1: Global Fund TB Program Essentials

Program essentials to guide Global Fund investments, derived from WHO recommendations and other international guidance, are listed in the table below. They represent a summary of what best aligns with the key priority interventions of the Global Fund and are considered critical to accelerate the TB response to meet global TB targets. The optimal ways of addressing these essentials should be determined based on the country's context.

TB screening and diagnosis
PE1_SCREEN: Systematic TB screening is provided for those at highest risk (key and vulnerable populations), preferably using chest x-rays, with or without computer-aided detection.
PE2_WRD: Multiyear plan to achieve universal use of molecular WHO-recommended rapid diagnostic tests, including near point-of-care tests, as the initial test to diagnose TB for all people with presumptive TB, with implementation on track.
PE3_DST: All people with bacteriologically confirmed TB are tested for at least rifampicin resistance; those with rifampicin resistance are further tested to rule out resistance to other drugs.
PE4_DXNETWORK: TB diagnostic network operates efficiently to increase access to testing and includes specimen transportation, maintenance of equipment, connectivity solutions, biosafety, quality assurance and supply system.
TB treatment and care
PE5_PED: Child-friendly formulations and a four-month regimen for non-severe, DS-TB are used for TB treatment in children.
PE6_DRTB: People with DR-TB receive shorter, all oral regimens or individualized longer treatment regimens as recommended by WHO, with BPaLM regimen as the treatment of choice for eligible patients.
TB prevention
PE7_TPT: TB preventive treatment (including shorter regimens) is available for all eligible people living with HIV (adults and children) and for all eligible household contacts of people with bacteriologically confirmed pulmonary TB.
TB/HIV
PE8_TBHIV: All people living with HIV with TB disease are started on antiretroviral treatment early as per recommendations.
PE9_TBHIV: TB/HIV services follow recommendations for concurrent use of LC-aNAAT and LF-LAM tests for the diagnosis of TB disease among people living with HIV in line with WHO guidance.
Cross-cutting areas
PE10_M&E/SURVEILLANCE: Establish, progressively scale up and maintain a single, comprehensive, real-time, digital, case-based TB surveillance system and conduct TB care cascade analyses to identify gaps, inform decision making and prioritize interventions.
PE11_PSE: Engagement of private health care providers is on a scale commensurate with their role in the health care system.
PE12_CSR: Decentralized, ambulatory, community-based and -led, home-based, people-centered services are provided across the continuum of TB care.

PE13_HRG: All TB programming must be human rights-based, gender-responsive and informed by and respond to analysis of inequities and include stigma and discrimination reduction activities for people with TB and TB-affected populations, legal literacy and access to justice activities, and support for community mobilization and advocacy and community-led monitoring for social accountability.

Annex 2: List of Abbreviations

ART	**Antiretroviral therapy**
BPaLM	Bedaquiline, pretomanid, linezolid and moxifloxacin, a four-drug combination regimen for drug-resistant TB
CAD	Computer-aided detection
CLM	Community-led monitoring
DAT	Digital adherence technologies
DR-TB	Drug-resistant tuberculosis
DST	Drug susceptibility testing
DS-TB	Drug-susceptible tuberculosis
FDC	Fixed-dose combination
HMIS	Health management information system
IPC	Infection prevention and control
LC-aNAAT	Low-complexity automated nucleic acid amplification test
LF-LAM	Lateral flow urine lipoarabinomannan assay
mWRD	Molecular WHO-recommended rapid diagnostic tests
M&E	Monitoring and evaluation
MDR-TB	Multidrug-resistant tuberculosis
RR-TB	Rifampicin-resistant tuberculosis
RSSH	Resilient and sustainable systems for health
TB	Tuberculosis
TB-LAMP	Tuberculosis loop-mediated isothermal amplification
TPT	Tuberculosis preventive treatment
WHO	World Health Organization

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