The Global Fund
To Fight AIDS, Tuberculosis and Malaria

# Global Fund Information Note: Strategic Investments for HIV Programs

## Glossary of key terms

- **Above allocation amount (or above-indicative) request**: The request to the Global Fund that is over and above the allocation amount communicated by the Secretariat. This request is reviewed by the Technical Review Panel for technical soundness and strategic focus, which may be recommended for funding through any incentive funding available, and/or kept on the register of unfunded quality demand.
- **Allocated funding:** The amount allocated by the Global Fund to support an applicant's disease programs for the allocation period. The amount is determined using an allocation methodology based on disease burden and income levels, and is adjusted for qualitative factors. Both allocated and incentive funding are designed to encourage the submission of robust, ambitious requests based on national strategic plans or HIV investment cases.
- **Concept Note:** The concept note is the application to request new funds from the Global Fund for any one of the three diseases or cross-cutting health systems strengthening (HSS). Countries with high TB and HIV co-infection burdens as determined by WHO, are requested to submit a single TB and HIV concept note.[1]
- **Country bands:** Countries eligible for at least one disease component were placed in four country bands organized based on a combination of income and disease burden.[2]
- **Country dialogue:** A national process that builds upon existing, on-going mechanisms and dialogue in health and development in the country. It is not a Global Fund-specific process and includes key stakeholders beyond the Country Coordinating Mechanism (CCM) constituency including government, donors, partners and civil society.
- **Full expression[3] of demand**: The total amount of funding that is that has been costed by the country to implement a technically appropriate, focused, cost-effective and efficient response to the disease(s) and/or cross-cutting HSS.
- **Incentive funding**: A separate reserve of funding which will reward high impact, well-performing programs, and encourage ambitious but feasible requests making a particularly strong case for investment. Incentive funding is made available, on a competitive basis, to select applicants in Country Bands 1, 2 and 3.
- **Investment approach:** A process that countries can use to develop investment cases or strong national strategy plans, in order to reach the 2015 global AIDS targets and beyond, and to ensure optimized sustainable HIV responses; it catalyzes a rigorous

[1] Thirty-eight of the 41 countries that WHO considers as TB/HIV priority countries are requested to submit a single TB and HIV concept note. A list of these countries has been released by the Global Fund. See the Information note on joint TB and HIV programming.
[2] Band 1: Lower income, higher burden; Band 2: Lower income, lower burden; Band 3: Higher income, higher burden; Band 4: Higher income, lower burden.
[3] For Bands 1-3, 10 percent is subtracted from the initial allocation to Bands 1-3 to form a pool of incentive funding (US$950 million). Band 4 countries are unique because they do not have to compete for incentive funding.
No funding is subtracted from the Band 4 allocation amount for incentive funding. Disease components that are considered significantly "over-allocated" and regional applicants are not eligible to be awarded incentive funding.

examination of HIV responses in terms of effectiveness, efficiency, and sustainability with a long term outlook (typically 10+ years). Countries are encouraged to use it whenever rigorous examination of the HIV response is required including developing or reviewing national and sub-national strategic plans and investment cases.

- **Investment case**: a document that makes the case for optimized HIV investments. At its core is a description of returns on investment in a country's optimized HIV response over the long-term (typically 10+ years). It summarizes the state of the epidemic and the response, describes the prioritized interventions, populations, and geographic areas to be implemented to achieve the greatest impact over the long term and the resources required. It also outlines the main access, delivery, quality and efficiency issues to be addressed to improve HIV services and describes what will be done to address these issues. It includes an analysis of, and plan for, realistic and more sustainable financing of the HIV response, including increases in domestic financing where relevant.
- **National disease strategic plan (NSP)**: Disease-specific strategies that provide the overall strategic direction for a country over a period of time (usually five years). These strategies (also called plans in some countries) are further supported by implementation plans (annual, bi-annual or 3 year plans), and other operational documents, including a costed budget.
- **Unfunded quality demand**: Funding requested through a concept note which is considered technically sound[4] by the Technical Review Panel, but above the funding amount available (i.e. allocated funding and any additional incentive funding awarded), which is registered up to three years for possible funding by the Global Fund or other donors when, and if, new resources become available.

## 1. Introduction

The Global Fund funding model has been redesigned to bring the Global Fund Strategy of 'Investing for Impact' to life. Its **New Funding Model** (NFM) is intended to allow the Global Fund and the countries it supports to invest more strategically, to maximize available resources, to reward ambitious vision, and to make bigger impact against the three diseases. Launched initially with a transition period in 2013, the full roll out of the NFM started in March 2014.

The **purpose of this information note** is to provide guidance for Global Fund applicants to employ the **HIV strategic investment approach** in the development of Global Fund concept notes. Concept notes replace previous Global Fund proposal documents and are the principal mechanism to request and access Global Fund funding under the NFM. Applying strategic

[4] Within the context of Global Fund concept notes, "technically sound" refers to the criteria that the TRP uses when reviewing funding requests for technical soundness and strategic focus, as per TRP Terms of Reference. This includes soundness of approach, feasibility, potential for sustainable outcomes and value for money (Global Fund 2014: Resource Book for Applicants, p. 14). HIV NSPs and/or investment cases, which form the basis of concept notes, also need to be "technically sound" in the sense that they are aligned with international normative guidance.

investment thinking throughout the concept note design process is critical to target investments on the interventions and populations where they will have maximum impact.

Building on the strategic investment approach, this information note gives guidance to applicants in applying the investment approach tailored to their contexts, and in prioritizing cost-effective interventions to accelerate access to key services where coverage gaps exist and financing by the government or other donors remains insufficient.

All **applicants that are requesting funding for HIV** from the Global Fund are encouraged to use this information note. Given that concept notes are an output of an iterative and participatory multi-stakeholder **country dialogue**, this information note is particularly relevant during the country dialogue to facilitate a more focused and effective use of the resources available for HIV.

This information note should be **read in conjunction with guidance** provided by the Global Fund and partners. These include the Global Fund's "Concept Note Instructions", the "Resource Book for Applicants: Global Fund's New Funding Model", other related information notes (including for joint TB and HIV programming, and reproductive, maternal, newborn and child health [RMNCH]), and strategic investment and national planning guidance from technical partners, such as the UNAIDS/WHO "Resource Kit for High Impact Programming" that is currently being developed and scheduled for publication in June 2014.

## 2. Investment approach: Recommended process for developing robust national HIV strategies and/or investment cases

The **HIV strategic investment approach** was developed in 2011 by an international group of experts, including from UNAIDS (Joint United Nations Programme on HIV/AIDS), the Global Fund, the Bill & Melinda Gates Foundation, civil society organizations (CSOs), the World Bank, the World Health Organization, UNICEF and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) to increase the impact of HIV funding and to assist countries in planning and prioritizing different elements of an effective, efficient and sustainable AIDS response.[5]

The investment approach is a **process** that can be used by countries to focus efforts on reaching the 2015 global AIDS targets and beyond and to ensure an optimized and sustainable HIV response by applying a **long-term outlook** (typically 10+ years). It is underpinned by meticulous analysis of empirical evidence, a realistic appraisal of existing resources, and quantification of the returns of HIV investments. It shifts the focus from costs and expenditures to investments that deliver returns.

The investment approach incorporates a **human rights-based approach**[6] to HIV to address discriminatory practices and unjust distributions of power that impede progress in the HIV

[5] Schwartländer B. et al. (2011): Towards an improved investment approach for an effective response to HIV/AIDS. *Lancet*, 277:2031–2041. UNAIDS (2012): Investing for Results. Results for People. A people-centred investment tool towards ending AIDS.

[6] A human rights-based approach is a conceptual framework for the HIV response grounded in international human rights norms and principles both in terms of process (e.g. right to participation, equality and accountability) and outcome (e.g. rights to health, life and scientific progress).

response by strengthening the capacities of rights-holders to claim their rights and of duty-bearers to meet their obligations. It lays out **three categories of investments** essential to tackling the HIV response in any context: basic program activities that have high impact, critical enablers, and development synergies.

**Basic program activities are high impact interventions** that have a direct impact on HIV risk, transmission, morbidity and mortality. High impact interventions are essential to an adequate HIV response and should be delivered at scale according to the size and geographical location of the relevant population in need.

**Box 1: High impact HIV interventions**

High impact interventions directly reduce HIV transmission and keep people alive, healthy and productive. They are evidence based and evidence informed interventions, which when implemented together at scale, can change the course of epidemics.

- **Antiretroviral therapy for eligible people living with HIV** (including for preventing HIV transmission), and treating opportunistic infections.
- **Confidential HIV-testing and counselling** which includes countries choosing a strategic mix of acceptable HIV testing and counseling approaches.[7]
- **Prevention of mother to child transmission of HIV (PMTCT).[8]**
- **Behavior change programs**, including for people engaging in casual sex and young people.
- **Condom promotion and distribution.**
- **Male circumcision** (in countries with high HIV prevalence and low coverage rates of circumcision practiced for religious or cultural reasons.[9] WHO prequalified the first non-surgical adult circumcision device for use in low-resource settings in October 2013, providing an alternative to conventional surgical male circumcision.[10]
- **Integrated prevention and treatment responses focusing on key populations:** in many epidemics the key populations at higher risk of HIV infection are people who inject drugs[11], sex workers, men who have sex with men and transgender

[7] WHO (2012): Service delivery approaches to HIV testing and counselling (HTC): A strategic policy framework.
[8] PMTCT consists of four prongs including primary prevention to women and girls, preventing unwanted pregnancies in HIV positive women, antiretroviral treatment during pregnancy, at time of delivery and during breastfeeding and prevention, diagnosis and treatment to children and other family members.
[9] There are 16 UNAIDS priority countries for voluntary medical male circumcision; UNAIDS (2013): Report on the Global AIDS Epidemic.
[10] The device requires no sutures or injected local anaesthetic and may be placed and removed by trained mid-level health providers including nurses. WHO recommends use of this device in settings health providers are appropriately trained and surgical backup facilities and skills are available. It is hoped that WHO prequalified male circumcision devices will accelerate scale-up by providing men with an alternative and by relieving demands on the limited number of surgeons available in priority countries. WHO (2013): Guideline on the use of devices for adult male circumcision for HIV prevention.
[11] Global Fund (2014): Global Fund Information Note: Harm reduction for people who inject drugs.

people (particularly transgender women).[12] Other vulnerable populations may be important in specific settings (including adolescent girls, orphans, street children, people living in extreme poverty, people with disabilities, people in prisons and migrants).

- **Joint TB and HIV programming** in countries with high burden of co-infection with the two diseases: joint programming for HIV and TB will maximize the impact of Global Fund investments to make an even greater contribution towards the vision of a world free of the burden of HIV and tuberculosis. Enhanced joint HIV and TB programming will allow to better target resources, to scale-up services and to increase their effectiveness and efficiency, quality and sustainability.

**Practical Advice: Applicants are strongly advised to review the most recent technical and normative guidance related to these high impact interventions**.[13] Key guidance documents are listed at the end of this information note.

In addition to basic programs interventions, the investment approach emphasizes the vital need to invest in **critical enablers**, which are necessary to support the effectiveness and efficiency of basic program interventions and ensure they have the maximum impact. Critical enablers are used to support the design, access, uptake and expansion of basic program interventions. They make program access and success more likely and are essential for effectively overcoming obstacles to successfully implementing and scaling-up basic programs.[14] Critical enablers can be divided into two groups:

- **Social enablers** support people living with HIV or vulnerable to infection by creating favorable social and legal environments for access to services and that enable them to protect themselves. These include: community mobilization, stigma reduction, countering harmful gender norms and practices, women's empowerment related to HIV and violence prevention, protective HIV legal frameworks, law reform, legal services, human rights and legal literacy, and protection of women's property and inheritance rights. Programs that mobilize communities to know their rights and relevant laws in the context of HIV and to use these to make HIV-specific demands for HIV preventions and treatment are a major critical enabler (please refer to the section on Community-led service delivery and community systems strengthening below).
- **Program enablers** enable implementation and effectiveness of and demand for basic programs and interventions; program management, capacity-building and monitoring of service provision for community-based organizations and other service providers; training of health care workers on nondiscrimination, informed consent and

[12] Global Fund (2014): Global Fund Information Note: Addressing Sex Work, MSM and Transgender People in the Context of the HIV Epidemic.
[13] WHO (2013): Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection - Recommendations for a Public Health Approach.
[14] UNDP/UNAIDS (2012): Understanding and acting on critical enablers and development synergies for strategic investments.

confidentiality; treatment literacy; treatment adherence support; linking HIV and sexual and reproductive rights.

The investment approach also supports the need to invest in **development synergies**, with the understanding that investments in other sectors can have a positive effect on HIV outcomes. Rather than being implemented in isolation, AIDS programs should be linked to and aligned with wider health system, human rights and development efforts. This involves creating linkages between the HIV response, development and human rights work in other areas, such as health and employment systems, education, social protection, gender equality, the rights of the child, rule of law and access to justice.

The investment approach suggests a **four-step process** to prioritize the different components of a country's HIV response (Box 2).

**Box 2: Four key steps of the investment approach[15]**

- **Understand:** To maximize impact of HIV investments, a thorough understanding is required of the extent and dynamics of the national AIDS epidemic, based on the latest epidemiological evidence and the current response. This includes understanding of key locations and populations with the greatest HIV burden and the greatest unmet needs for HIV services, as well as structural obstacles to service uptake and reach.
- **Design**: Based on this evidence, countries have to decide on the combination of interventions to prioritize — considering the interventions' effectiveness in reducing their HIV epidemic and keeping people alive with a view to achieving the greatest impact.
- **Deliver:** To increase impact, the response needs to be delivered at scale, i.e. aimed at reaching all those in need. It is thus recommended that countries identify major inefficiencies in HIV programs, and strategies to address key bottlenecks to access, delivery and quality of HIV services. In this context, pursuing efficiency gains through the minimization of commodity procurement costs and cost-efficient delivery methods can be important. Particular attention will also be required to devise effective means for reaching key populations and vulnerable groups, including mothers and children.
- **Sustain**: The investment approach emphasizes that countries should address challenges related to a *sustainable* AIDS response, e.g. by synergizing health investments with investments in other development sectors that can have a positive effect on HIV programs and outcomes[16], integrating key services, and avoiding duplications. It also emphasizes the need for more sustainable financing of the HIV response through identifying new sources of domestic and external funding. Increased domestic funding is essential for achieving larger scale-up and sustainability.

[15] UNAIDS (2013): Making the case for investing in HIV more strategically: An investment case tool.
[16] For example, investments in prisoner health, education and social protection.

### *Using the investment approach to develop robust national HIV strategies and investment cases*

Countries are encouraged to use the **investment approach** whenever rigorous examination of the HIV response is required, especially in the development and review of their **national disease strategic plans (NSPs) and/or investment cases for HIV**. Robust NSPs and/or solid investment cases form the basis of Global Fund concept notes, the principal means to request funding under the NFM (please refer to section 3 below).

NSPs provide the overall strategic direction for a country over a period of time (usually five years). While many strategic plans are ambitious, robust NSPs are evidence-based, realistic, prioritized, costed, and reflect areas where impact can be maximized and efficiencies gained over the set time-frame (see Glossary). To develop robust NSPs and to determine if existing NSPs are robust, countries should refer to the International Health Partnership's **"Joint Assessment of National Health Strategies"** (JANS) tool and guidelines, which set out the 16 attributes for robust NSPs.[17] Attributes of robust NSPs include a sound situational analysis, comprehensive expenditure framework, and a review of the evaluation mechanisms for each program. Robust NSPs are country-owned and developed through an inclusive multi-stakeholder process. Key populations and other vulnerable populations, CSOs, as well as bilateral and multilateral partners, should be included in their development and implementation.

While there is significant overlap between robust NSPs and investment cases in the sense that investment cases are also evidence-based documents providing essential information on the epidemiological context, the current response, and other key areas, a sound investment case differs in that it explicitly quantifies the returns on HIV investments. Many NSPs often do not include such an assessment, but in an ideal case would do. **Investment cases have a longer-term perspective** (typically 10+ years), which is crucial, as returns of investments often occur beyond the 5-year horizon of a NSP.

When preparing their HIV NSPs and investment cases, countries should also take into account international commitments, such as those made at the UN General Assembly High Level Meeting (HLM) on AIDS in New York in 2011, to be reached by 2015. The commitments of the 2011 Political Declaration on HIV and AIDS include ten specific targets to reduce new HIV infections, eliminate new HIV infections among children, increase the number of people on HIV treatment and eliminate stigma and gender-related barriers to effective responses. Other global commitments and targets may also be reflected, including the Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive.[18]

### *Tools to assist in the preparation of robust NSPs and investment cases*

Various tools and guidance documents have been made available to countries by UNAIDS and other technical partners to support the creation and/or strengthening of HIV NSPs and

[17] IHP+ (2013): Joint Assessment of National Health Strategies and Plans – Combined Joint Assessment Tool and Guidelines. Please also refer to the Global Fund: "Resource Book for Applicants".
[18] UNAIDS (2011): Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive.

investment cases, provide support in developing strong national strategies within the frame of strategic investments, and help to address the most difficult allocation and prioritization choices required for impact.[19] This includes the **UNAIDS' HIV investment case tool and process guide** which countries are encouraged to use.[20]

In the development of NSPs and/or investment cases, countries should also consider applying specific **HIV resource allocation tools and models** to compare different intervention scenarios and to identify the optimal intervention packages that maximize impact. Examples of these tools include OneHealth, AIDs Epidemic Model, OPTimyze, and Socio-Technical Allocation of Resources (STAR). These tools are described in more detail in the **UNAIDS/WHO Resource Kit for High Impact Programming.** Different tools may be utilized according to the specific country needs and circumstances as they have different strengths and attributes. Some support countries in making strategic investment decisions by quantifying the costs and health impacts of a given intervention scenario, with the costing framework and rigorous epidemiological impact models built into the tools.[21] These tools also support countries to conduct fiscal sustainability analysis based on the projection of future funding needs. Others facilitate policy dialogues and decision making through analyzing the costs and benefits of intervention options enabling the incorporation of other factors, such as equity and feasibility.

## 3. Translating national HIV strategies and/or investment cases into Global Fund concept notes

Under the NFM, applicants request funding from the Global Fund by submitting a concept note, which details the applicant's proposed request for Global Fund resources for a three-year period.[22] Concept notes can be submitted for any one of the three diseases or cross-cutting health systems strengthening (HSS). Following a decision by the Global Fund Board,[23] countries with a high burden of TB-HIV co-infection are requested to submit a **single TB and HIV concept note** that presents integrated and joint programming for the two diseases (please refer to the section on joint TB and HIV programming below).[24]

A key principle of the NFM is that concept notes should be build upon **costed and prioritized NSPs and/or solid investment cases for HIV**, which are accompanied by recent program reviews (as discussed below). With regards to this principle, applicants have three options:

- **NSP**: Applicants can base their concept notes on robust, prioritized and fully costed NSPs. In the absence of a robust NSP, applicants should consider conducting a review process at the country level to strengthen their NSP.
- **NSP complemented by investment case**: Where NSPs are not robust enough to support the development of a strong concept note, applicants can strengthen the funding

[19] UNAIDS (2012): Investing for Results. Results for People. A people-centred investment tool towards ending AIDS.
[20] UNAIDS (2013): Making the case for investing in HIV more strategically: an investment case tool.
[21] Certain tools also provide optimal resource allocation across HIV programs for any given budget scenario.
[22] Grants will typically cover a three year implementation period, with the flexibility to structure longer or shorter grant implementation periods if needed.
[23] Global Fund Strategy, Investment, and Impact Committee (2013): Decisions and Recommendations to the Board; GF/30/11: GF/SIIC09/05: Implementing TB-HIV Collaboration Services.
[24] See Decision Point: GF/SIIC09/DP5.

request through an HIV investment case, which complements their NSP. This approach could facilitate a timely submission of funding requests to the Global Fund.

- **Investment case**: Applicants can also base their concept note on robust HIV investment cases alone, which by definition also contain the necessary information required for a strong concept note.

In the same way that strong NSPs and investment cases need to be based on an inclusive country dialogue that ensures the meaningful involvement of all stakeholders (including key populations), concept notes must also be developed through an inclusive country dialogue process (see Glossary).

In order to assess whether existing NSPs and/or investment cases are strong enough to serve as the basis for concept notes, the **Global Fund encourages countries to conduct joint reviews of their NSP and/or investment case**. Such reviews should be based on a credible, independent, multi-stakeholder process in order to ensure that the national response is still appropriate to the country disease context. The **JANS criteria** are recommended as a framework for assessment.[25] Governments are responsible for determining what reviews are needed and to commission these. CCMs are expected to contribute to reviews and to identify key populations, technical partners, CSOs and other key stakeholders that should be engaged in the review.

The reviews should be based on an assessment of data quality and analysis of existing data, including disaggregation by year, gender, age and geographic location. They should also make recommendations to strengthen the NSPs and/or investment cases in areas where weaknesses are found, and should explain how the programmatic and financial gaps should be addressed by the funding application, which should emphasize the new strategic directions that need to be taken.

**Practical Advice**: Ensuring the robustness of NSPs and investment cases is a key pillar of a strong concept note. Please refer to the Key Documents section for reference on JANS assessments.

### *What should a concept note look like?*

As part of their concept notes, Global Fund applicants have to describe their HIV NSP and/or investment case, and how it addresses the country disease context. This includes information on the following areas:

- Goals, objectives and priorities, placing emphasis on their on-going relevance and any planned or needed revisions over the lifetime of the funding request.

[25] IHP+ (2013): Joint Assessment of National Health Strategies and Plans – Combined Joint Assessment Tool and Guidelines.

- Stage of implementation of the NSP and/or investment case, with reference to any recent program reviews, impact evaluations and other relevant studies, and the country processes for reviewing and revising these strategic documents.[26]
- Summary of obstacles or limitations to the implementation of NSPs/investment cases.
- Scope and status of ongoing TB-HIV collaborative activities, including on how the two national programs have been involved in the concept note development.

As described in the following sections, applicants need to provide a range of other information, including on the country disease context and the funding landscape. Ideally, this information should be directly drawn from HIV NSPs and investment cases, as well as from recent program reviews. Applicants also are requested to attach the NSP and/or the national investment case for HIV to their concept note, if available, as well as any recent reviews.

*Country disease and health and community systems context*

Based on the latest epidemiological data, concept notes should describe the overall country context, including the current and evolving epidemiological situation, the health and community systems context, the actual national HIV response, and service delivery barriers. Information provided should include:

- Evidence on all specific populations that are key to the epidemic and response based on the epidemiological and social context. This includes those populations contributing the largest absolute number of new infections as well as those disproportionally affected by HIV. It is crucial to identify those that may have disproportionately low access to HIV prevention, treatment, and care and support services and the reasons why this is the case. The concept note should include steps taken to address these issues.
- Information on areas with high HIV burden/transmission, and any recent epidemiological changes (HIV incidence or prevalence). Absence of epidemiological data among particular key affected populations should also be identified and explained.
- Evidence on factors that may cause inequity in or barriers to access to services for HIV treatment and prevention, such as gender norms and legal practices and policy barriers, stigma and discrimination, and poverty. This analysis is essential as human rights and gender issues need to be critically addressed to ensure optimal delivery of HIV services.
- Discussion and data on systems-related constraints at the national, sub-national and community levels in reducing the HIV/AIDS burden. This includes constraints related to the involvement of communities and community based organizations in implementing programs.
- An assessment of the role of community sector organizations in the response to HIV and of the potential for further involvement as a strategy for scaling up and improving the impact of the response.

[26] If the NSP will come to an end in the next 18 months, an explanation of the process and timeline for the development of a new NSP, developed within the frame of a strategic investment approach, is required.

**Practical Advice**: Technical assistance is available to strengthen the capacity of NGO and community groups. Please refer also to the Global Fund information notes on Community Systems Strengthening, Human Rights, and Gender.

*Funding Landscape, Additionality and Sustainability*

Information is also required on the current and anticipated funding landscape of the national program over the entire grant duration. For each disease component, including cross-cutting program areas, applicants need to describe the program areas that currently receive support, and clearly identify the source of funding (i.e. domestic and/or donors or other partners). Program areas suffering from substantial financing gaps need to be clearly outlined along with planned actions to address these gaps; this helps to ensure that significant gaps are addressed through the funding request to the Global Fund.

Applicants also need to indicate how they intend to fulfill their shared responsibility to sustain and increase contributions of their national HIV response. Applicants should:

- Indicate whether the counterpart financing requirement has been met.[27] If not, a justification is needed that explains which actions are planned during implementation to fulfill the counterpart financing requirements.
- Describe whether and how the funding request will be complemented by additional funding commitments from the government. To incentivize additional co-investments, the Global Fund incorporated 'willingness-to-pay' as a qualitative factor for adjusting the allocated funding. The allocated funding amount communicated to countries includes a 15% allocation for willingness-to-pay that can be availed by applicant countries based on additional government commitments for the next phase.[28]
- Describe how the funding request can leverage other donor resources.

*Gap analysis and priority areas proposed for allocated funding and for funding above the allocation amount*

Building on the programmatic and financial analyses provided, applicants need to provide an analysis of the key programmatic gaps which forms the basis upon which the funding request is prioritized. For specifying and prioritizing the proposed interventions, applicants must use the **modular template** (please refer to the section on the modular template below).

Coverage data for key interventions and financial information are critical to identifying gaps, as is information on legal and gender barriers which hinder access to HIV information and services and so make people more vulnerable. Applicants need to describe how allocated funding

[27] The counterpart financing requirements of the Global Fund are set forth in the Policy on Eligibility Criteria, Counterpart Financing Requirements, and Prioritization.
[28] A country's willingness-to-pay commitments will be presented ahead of concept note development to encourage countries to demonstrate their future financial commitment to the three diseases. The actual level of government commitments required to avail the total willingness-to-pay adjustment will be agreed upon with the Secretariat during country dialogue and reviewed on an annual basis.

requested, as well as any existing Global Fund financing, will be invested (or reprogrammed) during the funding request period to address these gaps and to maximize impact. This involves describing the assumptions, methodology and sources used in estimating the programmatic gaps. Applicants also should provide the following information:

- The objectives and expected outcomes of the funding request, and how the outcomes have been estimated and will contribute to achieving maximal impact.
- The modules from the Modular Template (see below) prioritized in the funding request in addition to the rationale for their prioritization (by the selection of appropriate modules).
- For consolidated funding requests, applicants should explain how current interventions will be adapted, discontinued or extended to maximize impact.

In preparing their concept notes, applicants should indicate which HIV investments will be covered through their **allocated funding**, and what should be covered through the funding request above the allocated funding amount (a decision will then be made by the Global Fund which portion of this amount will be covered through **incentive funding** or considered as unfunded quality demand, see Glossary). **All funding** requested should be based on the applicant's previous analysis of the financial and programmatic gap and should be consistent with the priority areas for enhanced investment outlined in the NSP and/or investment case. In addition, applicants should consider the following key points:

- The funding request for **allocated funding** should be focused on core funding needs, i.e. ensuring that the **strategic elements of existing programs get carried forward and scaled up**. High impact interventions that are currently underfunded should be prioritized for Global Fund support. **Large financing gaps for high impact interventions**, such as PMTCT, may be addressed through the allocated funding budget. In establishing which interventions should be included in the allocated funding amount, priority should be considered for key population programming and other areas of programming that are typically neglected even though they have a high potential for impact.
- **Allocated funding requests must include a technically sound mix of interventions**. While applicants should consider the **importance of scaling up high impact interventions**, allocated **funding requests should also reflect the critical enablers** essential for optimizing basic program efforts.
- To encourage ambitious, high-quality expressions of full demand that go beyond the core funding range, the Global Fund has set aside a portion of funds for competition ('**incentive funding**').[29] Countries that base their **concept note on strong national strategic plans and/or solid investment cases** may qualify for this incentive funding. Other criteria for award of incentive funding include the ambition of the request (i.e. whether it reflects the full need), potential impact, strong performance and sustainability (including co-investment and national willingness-to-pay commitments).

[29] See Board decision point GF/B27/DP7 which states that "incentiviz[ing] high-impact, well-performing programs and the submission of robust, ambitious requests based on national strategic plans or investment cases," and "motivat[ing] full expressions of quality demand." See also the related decision points GF/B28/DP4 and GF/B31/DP10.

Countries should request incentive funding to further maximize the impact of the investments requested in their allocated funding.[30]

While investments should prioritize those interventions that are likely to have the largest impact and enable high impact programs to work, **efficiency** and **cost-effectiveness** are also important to improve value for money. Countries should allocate resources towards interventions that are cost-effective ("allocative efficiency"). Some of the resource allocation tools described in Section 2 also help to determine the most cost-effective HIV response. Efficiencies can also be reached through integrated programming, for instance through integrating HIV and TB or the integration of HIV programs with services and platforms benefitting the health of women and children.[31]

### *Technical Assistance for stronger concept notes*

To guide the planning and implementation of TA under the new funding model the Global Fund Secretariat, in collaboration with its technical partners, has developed the Technical Assistance Framework (Annex 1), which provides a thematic classification of the types of TA available to support various steps and processes associated with the NFM. This includes TA for the development and review of NSPs/investment cases, concept note development, the engagement of key affected populations, and support for grant implementation.

Identifying technical assistance needs is a critical step of finalizing concept note submission. Substantial technical assistance needs are expected to support country dialogues to shape funding requests that reflect both high-impact strategic investments and a full expression of demand. A wide range of bilateral and multilateral partners can provide support to countries in developing strong NSPs and/or investment cases and translate them into concept notes. Funding for technical assistance for pre-concept note and concept note stages can be obtained from the following sources:[32]

- Technical partners including UNAIDS and its co-sponsors, WHO, Stop TB and RBM.
- Bilateral partners including German BACKUP initiative, French 5% initiative and USG-funded agencies (including PEPFAR and GMS).
- Existing Global Fund grant funding: CCMs are encouraged to utilize existing TA budgets within existing grants including the reprogramming option of up to USD 150,000 per disease component. This funding can be used for strengthening/review of the NSPs, facilitation of in-country dialogue, and engagement of CSO/KAP/PLWD in country dialogue.

[30] Please refer to Footnote 2 that specifies the eligibility criteria for incentive funding.
[31] UNAIDS (2013): Efficient and Sustainable HIV Responses: Case studies on country progress.
[32] Further information on process can be found in Annex 2 of the Resource Book.

*Global Fund Special Initiatives budget*

The Global Fund Board approved several special initiatives to support the roll-out of the NFM.[33] One of these provides funding for technical assistance for stronger concept notes across the three diseases, HSS, and RMNCH. A second initiative focuses on integrating community, rights and gender components, as well as capacity building and strengthening the inclusion of civil society organizations and key populations in concept note development processes. The third initiative aims to support countries in strengthening country data systems to ensure improved data collection, monitoring and usage - better data is a prerequisite for better programming. The fourth initiative, which is aimed at maximizing the robustness of concept notes, addresses financial sustainability of Global Fund programs, supporting work to increase sustainability and to enhance value for money. Funds from these special initiatives are used to complement existing resources and may be requested to address critical unfunded technical assistance needs when other options have been thoroughly exhausted.

**Practical Advice:** As the applicant, the CCM has a central role in coordinating technical assistance for concept note development. Engage technical partners and Global Fund Country Teams in technical assistance planning and coordination as part of the country dialogue process.

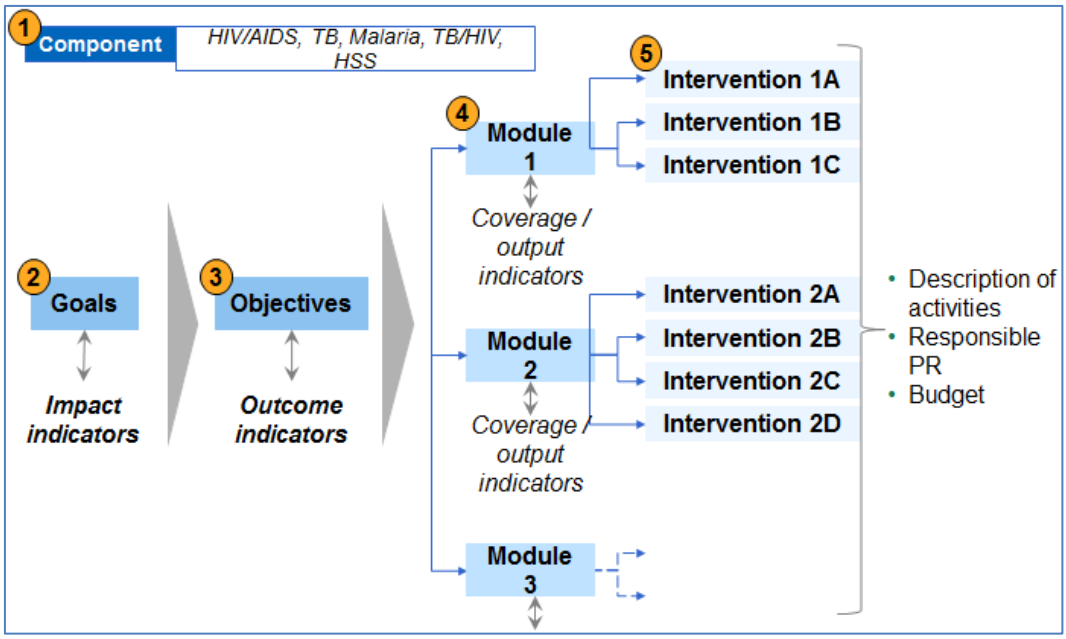
***Modular Template***

The **modular template** streamlines Global Fund grant programmatic planning, budgeting and reporting by replacing the performance framework and detailed budget and logical framework tools previously used. In Section 4 of the concept note, it is a requirement to refer to the modular template. In this section, applicants should present a disease-specific, high-level costed plan of interventions and activities linked to indicators.

Drawing on strategic investment guidance, the HIV modular template outlines the main goals, objectives, modules, interventions, indicators and targets, costs and cost assumptions. It is organized around specific modules which are composed of interventions and linked to targets, indicators, and costs to strategically guide HIV investments in evidence based, effective and high impact interventions (Figure 1)

[33] See Board decision point GF/B31/DP06.

**Figure 1: Modular approach and structure of the modular template**




The HIV modular template includes the following modules:

- **Six prevention modules** that support prevention programming across populations groups in line with technical partner guidance.
- **One module each for 'PMTCT', 'Treatment, Care and Support' and 'TB/HIV'**;
- **Two cross-cutting modules**: 'Community systems strengthening', and human rights ("removing legal barriers to access") to ensure that critical enablers and development synergies are integrated alongside core programs.
- **Two supporting modules**: 'Health information systems/monitoring and evaluation' and 'program management'.

Disease specific HSS interventions have been embedded in the above modules. In addition, the template includes modules for six cross-cutting HSS areas from which applicants may include interventions in their HIV concept note. These six areas are procurement and supply chain management; health and community workforce; service delivery; financial management; policy and governance; and healthcare financing (please read the section on HSS below).

Applicants may choose to select all or any of the core modules and supportive modules. The tool allows applicants to capture the outputs of the strategic deliberations during the country

dialogue and to organize interventions.[34] Please see Table 1 in Annex 2 for the HIV core, cross-cutting, and supportive modules, including the interventions, and Table 2 in Annex 2 for the HIV coverage/output, outcome, and impact indicators.

## 4. Operationalizing key thematic and cross-cutting areas

There are a number of key issues that applicants should consider when preparing their HIV and/or TB and HIV concept notes. Although not an exhaustive list, particular attention is focused here on a number of critical thematic and cross-cutting areas often identified as needing strengthening by the technical review and grant advisory panels. Thematic areas include combination prevention, operationalizing WHO 2013 consolidated ARV guidelines, and joint TB-HIV programming. Consideration should also be given to the cross-cutting areas of Health Systems Strengthening, Gender, Community Systems Strengthening, human rights, reproductive, maternal, newborn and child health, and key populations.

### *Combination prevention*

Recent advancements in science and technical experience suggest that there are now enough interventions and programmatic knowledge to ensure that HIV epidemics can be controlled to no longer be a public health threat. This is envisioned in the HLM targets, the declaration of three zeros by member states and the blueprint for an AIDS free generation by PEPFAR. Despite numerous advances challenges remain in translating knowledge into policy and action towards population level effectiveness.

The concept of combination prevention is used to describe a pragmatic approach to public health control, which helps to ensure that prevention and treatment resources are used in a combined way to focus interventions to where the majority of new infections are occurring. The starting principle is that different countries have different micro-epidemics, with very different levels of transmission and risk groups, which change over time. Therefore, building on the principle of 'know your epidemic', countries should focus on high-transmission geographies, people at highest risk for HIV, and the package of interventions that are most likely to have the largest effect in each different setting. It is important to recognize that vulnerability and risk are not evenly distributed and effective interventions will vary depending on risk profile. Thus, as stated before, it is important to ensure that there is robust knowledge of the right interventions, provided to the right populations (the most important epidemiological drivers) in the micro-epidemic settings.

Applicants should consider using the conceptual framework of combination prevention to design complete programmatic interventions for concept notes.[35]

[34] Beyond the interventions or modules contained in the tool, countries can include additional ones specific to their context with a justification for why this specific activity/intervention is needed.
[35] Transformation of HIV from pandemic to low-endemic levels: a public health approach to combination prevention published online April 14, 2014 http://dx.doi.org/10.1016/S0140-6736 (13)62230-8.

### *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection, June 2013*

The Global Fund very much welcomes the "Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection" which were released by WHO in June 2013. These guidelines represent an important step towards achieving universal access to antiretroviral therapy (ART) for treating and preventing HIV, increasing the efficiency, impact and long-term sustainability of ART programs and realizing the ultimate goal of ending HIV epidemics as public health threats. The guidelines bring together clinical, service delivery and programmatic guidance for low- and middle- income countries across all age ranges. Major recommendations include:

- **Initiating ART earlier when the immune system is stronger:** treatment in adults living with HIV should start when their CD4 cell count falls to 500 cells/mm$^3$ or less (the previous WHO recommendation from 2010 was to offer treatment at 350 CD4 cells/mm$^3$ or less). Evidence indicates that earlier treatment prolongs life and results in fewer transmissions from an infected person to an uninfected person.
- **Providing ART,** irrespective of their CD4 count, **to all children** with HIV under 5 years of age, all **pregnant and breastfeeding women** with HIV, all TB patients and persons with Hepatitis B and chronic liver disease, and to all **HIV-positive partners** where one partner in the relationship is uninfected.
- Offering all adults starting to take ARV the same **daily fixed-dose combination pill** that combines three ARV drugs in a single pill.[36]
- Phasing in and using **viral load** (and, by implication, less use of CD4 for monitoring of ART) **as the preferred monitoring approach** to diagnose and confirm treatment failure. This recommendation requires significant investments (e.g. for infrastructure, quality assurance and human resources. The supplement to the 2013 guidelines provides guidance on developing a national strategy and implementation plan for viral load testing.

For countries which are in the process of adopting and transitioning to the 2013 guidelines, national HIV programme managers are encouraged to take into context national governance processes, HIV epidemiology, equity of access, health systems capacity and availability and sustainability of financial resources. Concept notes should show clear operational frameworks for scale up ensuring service quality and attention to the treatment cascade. Programmatic and operational considerations are included within the consolidated guidelines, and a short operational note highlighting key issues raised by the TRP in concept notes from early applicants will be shortly available.

[36] This regimen of tenofovir + lamivudine (or emtricitabine) + efavirenz (TDF + 3TC (or FTC) + EFV) was selected because it is simple, and less toxic.

### *Joint programming for TB and HIV*

To optimize investments in TB and HIV programs, and maximize synergies between TB and HIV programs for better health outcomes, **countries with high burden of co-infection with TB and HIV[37] are requested to submit a single TB and HIV concept note** that presents integrated and joint programming for the two diseases. These concept notes need to present prioritized, high impact interventions and activities for the TB and HIV programs (including collaborative TB/HIV activities) and a detailed description on how these two programs will work jointly to address the burden of co-infection with TB and HIV. Countries preparing single TB and HIV concept notes should also consider addressing common health system-related constraints, which interfere with the successful implementation of TB and HIV programs and other cross-cutting areas for joint TB and HIV programming. The Global Fund has made available a specific concept note template ("TB and HIV concept note") and accompanying instructions on its New Funding Model website.[38]

All other countries, particularly countries with concentrated and increasing HIV epidemics (e.g. in Central Asia and Eastern Europe) are also encouraged to consider joint planning and submission of a single concept note. In any case, all applicants should review the information note on joint tuberculosis and HIV programming (see below), which includes a list of collaborative TB-HIV activities, and ensure that TB-HIV collaborative activities are prioritized and integrated in their concept notes to promote efficient and effective use of resources and optimize existing opportunities to respond to each country's unique TB and HIV challenges.

Emphasis should be on gaining efficiency from synergized program management and consistent collaboration and coordination of TB and HIV services (e.g. through joint planning, joint budgeting, supervision and monitoring). This might entail undergoing adjustments in the management of the TB and HIV programs. At the same time, it should be ensured that program areas that are outlined in global and national strategies pertaining specifically to a TB and an HIV program are adequately included in the concept note; i.e. based on disease epidemiology, national priorities and the extent of the program response.

The submission of a single TB and HIV concept note should not be viewed as constraining either application, for the TB or HIV program. It rather provides the opportunity to maximize synergies and efficiencies, and strengthen programs for two diseases which are inextricably linked. Applicants should determine the scope and critical areas of joint programming with a flexible approach based on the country context.

For further details, please refer to the *Global Fund Information Note on Joint Tuberculosis and HIV Programming*, the *Information Note on Strategic Investments for TB*, **and the** *TB/HIV Technical Guidance Note from the UNAIDS/WHO "Resource Kit for High Impact Programming".*

[37] This decision applies to 38 of the 41 countries which WHO considers as the TB/HIV priority countries that have the highest estimated number of people living with HIV who develop TB. A list of these countries has been released by the Global Fund. See the Information note on joint TB and HIV programming.
[38] http://www.theglobalfund.org/en/fundingmodel/single/applicationmaterial/

### *Health Systems Strengthening*

Under the NFM, HSS investments are aimed at supporting **cross-cutting HSS interventions**, i.e. interventions that have a direct linkage to improving HIV, TB and/or malaria outcomes, but benefit more than one disease program, as well as improving broader health outcomes for women and children.[39] If eligible, countries can request cross-cutting HSS through one or more disease specific concept note(s); a single TB & HIV concept note; (iii) or a stand-alone concept note for cross-cutting HSS.[40]

Under the NFM the Global Fund is prioritizing five specific areas for cross-cutting HSS investments:

(i) Procurement and supply chain management: effective operationalization of procurement and supply management systems, as well as improvement of procurement and supply management infrastructure and development of tools
(ii) Health management information systems (HMIS) and monitoring and evaluation (M&E): routine reporting, analysis, review & transparency, surveys, administrative & financial data sources, and vital registration systems
(iii) Health and community workforce: Health & community worker capacity building, scaling up health & community workforces, and retention & distribution of health & community workforce
(iv) Service delivery: improving service organization & facilitate management, improving laboratory infrastructure[41] & systems, and improving service delivery infrastructure; and
(v) Financial management: including strengthening the performance, transparency, accountability of public financial management systems in the health sector.

These priority investment areas have been identified based on an analysis of the Global Fund's grant portfolio, which revealed a number of health system-related risks that directly affect successful implementation of HIV/AIDS, TB and malaria programs. Investments in procurement and supply chain management and HMIS/M&E are often highly important to facilitate an effective HIV response. Applicants should thus consider requesting funding for these areas. Specifically, applicants may request support for developing or reviewing HIV-relevant national pharmaceutical policies and operational plans. HMIS/M&E can be improved through routine reporting (e.g. longitudinal ART patient cohort monitoring over time) and surveys (e.g. measuring trends in HIV sero-prevalence).

The modular template includes six HSS modules that cover the major components of the health system (in addition to modules for removing legal barriers, program management, and HIS/M&E). These modules are in line the WHO Health Systems Framework. In addition to

[39] Global Fund: Concept Note Instructions for Health Systems Strengthening.
[40] The Global Fund seeks to encourage differentiated cross-cutting HSS investment by Band as follows: Band 1 countries: HSS investment strongly encouraged; Band 2 countries: HSS investment encouraged; Band 3 countries: HSS investment encouraged; Band 4 countries: HSS investment considered on an exceptional basis.
[41] If a country plans to improve their laboratory services by implementing the 2013 WHO ARV guidelines which recommend viral load as the preferred monitoring approach to diagnose and confirm ARV treatment failure, then applicants should consider to request funding in order to enable the shift to the recommended approach.

cross-cutting HSS, the Global Fund continues to support disease-specific HSS interventions that can be integrated into disease-specific concept notes and are embedded in each disease-specific module.

For further information, please refer to the *Information Note on Health Systems Strengthening for Global Fund Applicants*.

### *Integration of Reproductive, Maternal, Newborn and Child Health services*

The Global Fund Strategic Framework 2012-2016 aims to have a greater impact on HIV/AIDS, TB and malaria by financing synergistic reproductive, maternal, newborn and child health (RMNCH) programming, maximizing existing flexibilities for integration. Disease-specific programming, including for HIV, should be planned, budgeted and implemented to achieve maximum impact on RMNCH interventions. Funding requests should include efforts to promote the integration and enhancement of RMNCH interventions. Evidence-based and technically sound integrated programming will be given favorable consideration during the concept note review process, and the country dialogue should be used to discuss health more comprehensively and to develop bi-directional synergies between disease-specific interventions funded by the Global Fund and RMNCH.

Beneficiaries seeking HIV/AIDS services and those seeking RMNCH services often have common needs, and applicants should proactively identify opportunities to link those high-impact RMNCH interventions that improve the health of women and children affected by HIV/AIDS. Examples of integration of RMNCH services include the provision of comprehensive care, addressing co-infections and preventing mother-to-child transmission, and comprehensive approaches to ensure HIV free survival of children born to HIV positive women including early infant diagnosis and treatment.

The Global Fund also recognizes other highly synergistic RMNCH interventions that not only address HIV, TB, and malaria, but go beyond the three diseases. These interventions represent excellent opportunities to advance the health of women and children with minimum additional investments, and should be discussed during the country dialogue with the potential for donor synergies. These include screening and treatment of syphilis in pregnancy, family planning, promotion and support of breastfeeding, and child nutrition.

Existing RMNCH service delivery platforms, such as antenatal care clinics, may be leveraged and/or strengthened to deliver HIV/AIDS service to maximize the impact of Global Fund investments. The modular template for HIV/AIDS can assist applicants in selecting RMNCH related interventions. It includes relevant RMNCH interventions and indicators.

For **further guidance** on how RMNCH interventions can be integrated into HIV/AIDS grants, please refer to the Global Fund Information Note on *Maximizing the Impact on Reproductive, Maternal, Newborn and Child Health*, and the WHO Technical Guidance Note on *Strengthening Inclusion of Reproductive Health and Maternal, Newborn and Child Health in proposals to the Global Fund and other Partners*.

**Practical Advice:** The Global Fund and UNICEF signed a *Memorandum of Understanding* to better coordinate efforts aimed at reducing the burden of HIV, TB and malaria and improving the health of mothers, newborns, and children. Countries are encouraged to work with the Global Fund UNICEF, and other partners working in RMNCH to better align HIV, TB and malaria programming with broader maternal, newborn and child health efforts.

### *Community-led service delivery and community systems strengthening*

Community-based organizations have a unique ability to identify, understand and respond quickly to the needs of communities and individuals who are vulnerable as a result of social and structural factors, and who are affected by inequitable access to health and other basic services.[42] As such, community action on health is an important complement to clinical or facility-based health services.

The involvement of community-based organizations in program activities is of particular importance for ensuring that HIV programs reach excluded and marginalized populations whose health and human rights are compromised. Many of the most effective HIV responses for key affected populations are delivered in community-based settings, often by peers. However, these communities often lack the resources they need to be effective partners in national HIV responses. When deciding how the different high impact interventions for HIV will be delivered, applicants are encouraged to use community and civil society-led service provision as a means of scaling up provision and ensuring services reach excluded groups.

As well as encouraging community-led service provision, the Global Fund also encourages applicants to include community system strengthening (CSS) components in concept notes. CSS is an approach that promotes the development of informed, capable and coordinated communities, and community-based organizations, groups and structures. When applying for resources for community systems strengthening, applicants are encouraged to focus on system weaknesses that affect access to services by key affected populations. Such interventions may include capacity building, supplies and infrastructure, core funding for networks and organizations of key affected populations, partnership building for organizations that represent or work with sexual minority groups, as well as partnership building between networks of people living with HIV and AIDS, and networks of key affected populations.

CSS interventions can be integrated into disease-specific modules. The modular template for HIV, which is based on the *CSS framework*, includes a CSS module which is made up of four interventions: i) community-level monitoring systems to hold accountable those responsible for delivering health services, ii) advocacy to resolve barriers to access and in favor of sustainable financing; iii) support for coordination and collaboration between community and formal health sectors, and with broader development and human rights actors; and iv) institutional capacity

[42] Strong community systems play an important role in facilitating community participation in the design, implementation and evaluation of programs and services, advocacy, creation of demand for good-quality health services and equitable access, addressing broader determinants of health and promoting meaningful community engagement in health-related governance, oversight and accountability.

building of the community sector (NGOs, community groups and organizations and networks) to enable the sector to be more effective.

Guidance on how to apply for CSS funding using the modular template is provided in the *Community Systems Strengthening* information note. Applicants should also refer to the UNAIDS guidance tool.[43]

### *Human Rights and Gender Equality*

Discrimination, stigmatization and criminalization of groups most affected by and vulnerable to HIV can drastically diminish the impact of HIV programs. They can block access to HIV prevention and treatment programs, thereby contributing to the transmission of HIV and can increase the impact of HIV. Recognizing the importance of addressing HIV-related human rights issues, the Global Fund Strategy 2012-2016 aims **to integrate human rights considerations including gender equality throughout the grant cycle**, increase investments in this area, and ensure that human rights are not infringed upon in any of the supported programs.[44]

It is thus encouraged that applicants engage in frank and in-depth discussion about human rights and gender issues throughout the country dialogue, and during the NSP or HIV investment case development process. A human rights-based approach to HIV, which is grounded in international human rights norms and principles, should be used as a conceptual framework for the HIV response. As highlighted in Section 2 above, implementing a human rights based approach is key to addressing discriminatory practices and unjust distributions of power that impede progress in the HIV response by strengthening the capacities of rights-holders to claim their rights and of duty-bearers to meet their obligations.

Gender inequalities and harmful gender norms require special attention because they pose significant threats to the successful implementation of high impact HIV interventions and increase vulnerability to HIV particularly among women and girls, including those who are not perceived to be adhering to traditional gender identities or roles (e.g. transgender women) The Global Fund has recognized the relevance of addressing sexuality and gender issues in its Gender Equality Strategy and the Sexual Orientation and Gender Identities (SOGI) Strategy.[45] People of all sexes (male, female and transgender) and of all ages should equally be reached by, involved in, and benefit from resources contributed by the Global Fund. HIV-related vulnerabilities of people who are marginalized due to real or perceived sexual orientation, gender identity or consensual sexual behaviors should be addressed. When preparing an HIV funding request, gender sensitive and/or transformative[46] interventions should seek to address these immediate

[43] UNAIDS (2011): Supporting community-based responses to AIDS, tuberculosis and malaria. A guidance tool for including community systems strengthening in proposals for the Global Fund to Fight AIDS, Tuberculosis and Malaria.
[44] See also: UNAIDS (2008), Guidance Note: Addressing HIV-Related Law at National Level.
[45] Global Fund (2009): Global Fund Core Gender Equality Strategy.
[46] Gender-sensitive approaches recognize and respond to the different needs and constraints of individuals based on their gender differences. They attempt to redress existing and immediate gender inequalities without action on the larger contextual issues that lie at the root of these inequalities. Gender transformative approaches seek to build

and long-term concerns related to health, social protection and human rights. Countries should also consider conducting a gender analysis[47] of the epidemiological and behavioral data in the country, generated using an equity perspective (if such an analysis is not already available). This allows countries to describe and analyze needs, challenges, gaps and opportunities to reach women, girls, men, boys, and transgender persons.

Overall, Global Fund applicants are strongly encouraged to incorporate gender and human rights related issues in their HIV funding requests as a function of each country's particular epidemic and response gaps. In particular, and in accordance with states' obligations under international human rights standards, applicants are encouraged to identify priority areas where measurable progress can be made to eliminate barriers to service access and ensure meaningful participation of people living with and affected by HIV. Barriers may include, but are not limited to, discrimination, gender inequities and gender-based violence, criminalization of KAPs, and restrictions on civil society to register organizations, share information and express opinions on policy.

Countries should also explore where development synergies may already exist that promote gender equality, and strengthen rule of law, accountability, access to justice, and human rights standards. For example, in a country that already has programs in existence that train judges in human rights standards, it would be advisable to add HIV components and the participation of affected communities to such training programs rather than to create a new program.

More detailed guidance is provided in the *Human Rights for HIV, TB, Malaria and HSS Grants*, *Addressing Gender Inequalities and Strengthening Responses for Women and Girls* information notes, and in the Global Fund's *Core Gender Equality Strategy*.

### *Key populations*

Key populations are central to responses to HIV, TB and malaria, and the Global Fund recognizes the critical inputs made by key populations, placing a high value on developing an inclusive working relationship with them. In the context of HIV, key populations include gay, bisexual and other men who have sex with men; women, men and transgender people who inject drugs, and/or who are sex workers; as well as all transgender people. In every nation that reliably collects and accurately reports surveillance data, these groups have higher HIV risk, mortality and/or morbidity when compared to the general population. Access to, or uptake of, relevant services is significantly lower for these sub-populations than for other groups, and they are often criminalized and marginalized, making them even more vulnerable. Young key populations and key affected women often have compounded vulnerability related to laws and social norms.

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equitable social norms and structures in addition to individual gender-equitable behavior, transforming gender roles and creating more gender-equitable relationships.

[47] UNAIDS' gender assessment tool assists countries to assess their HIV epidemic, context and response from a gender perspective, helping them to make their HIV responses gender transformative and (as such) more effective. UNAIDS (2014): UNAIDS Gender assessment tool: Towards a gender-transformative HIV response. Available at: http://www.unaids.org/en/resources/documents/2014/name,93584,en.asp.

In addition to people who experience enhanced risk and vulnerability, all people living with HIV are also "key populations". Stigma and discrimination toward people living with HIV is well documented and is a major impediment to improving health outcomes, accompanied by internalized stigma which amplifies risk and vulnerability, and enhances the barriers to effective action. Stigmatization, discrimination, disenfranchisement and criminalization of key populations impede country efforts to reach their respective goals and targets, and this is damaging to national responses.

Countries seeking new grants are expected to focus national responses toward key populations by:

1. Improving the collection and use of accurate data on key populations.
2. Strengthening the participation of key populations throughout the country dialogue, concept note development and grant-making and implementation processes.
3. Ensuring at country level that sufficient funding is allocated to key populations – in order to respond to their needs, and because this is key to achieving the highest possible impact.
4. Improving expertise and quality of programming for key populations (including through increased provision of focused technical support).

Promoting and protecting the human rights of key populations by ensuring their active involvement, by removing legal barriers, and by ensuring programs adopt rights-based approaches. More information on key populations is provided in different Global Fund information notes, including the *Addressing Sex Work, MSM and Transgender People in the Context of the HIV Epidemic*, and the *Harm reduction for people who inject drugs*.

**Key Documents**

## Global Fund – Strategic Investment Guidance & Information Notes

Global Fund Information Note: Addressing Sex Work, MSM and Transgender People in the Context of the HIV Epidemic (February 2014).

Global Fund Information Note: Addressing Gender Inequalities and Strengthening Responses for Women and Girls (February 2014).

Global Fund Information Note: Community Systems Strengthening (February 2014).

Global Fund Information Note: Harm reduction for people who inject drugs (February 2014).

Global Fund Information Note: Health Systems Strengthening for Global Fund Applicants (March 2014).

Global Fund Information Note: Human Rights for HIV, TB, Malaria and HSS Grants (February 2014).

Global Fund Information Note: Joint TB and HIV programming and single TB and HIV concept note (April 2014).

Global Fund Information Note: Maximizing the Impact on Reproductive, Maternal, Newborn and Child Health (RMNCH) (April 2014).

Global Fund Information Note: TB Strategic Investment (February 2014).

Global Fund Information Note: Programming of laboratory investments with a focus on viral load testing" June 2014). [forthcoming]

## Further selected Global Fund documents

Global Fund: Core Gender Equality Strategy (2009).

Global Fund: Resource Book for Applicants: The Global Fund's New Funding Model (February 2014).

Global Fund: Standard Concept Note Instructions (10 March 2014).

Global Fund: Instructions: Single TB and HIV concept note (19 March 2014).

## UNAIDS key planning and guiding documents and tools

UNAIDS (online, updated regularly): HIV Prevention Toolkit.

UNAIDS: Making the case for investing in HIV more strategically: an investment case tool (August 2013) [PowerPoint].

UNAIDS: Making the case for investing in HIV more strategically: a process guide (August 2013) [PowerPoint].

UNAIDS: Smart Investments (2013).

UNAIDS: Investing for Results. Results for People. A people-centred investment tool towards ending AIDS (2012).

UNAIDS: Promising practices in community engagement for elimination of new HIV infections

among children by 2015 and keeping their mothers alive (2012).

UNAIDS: Global Fund HIV Proposal Development for Key Population Proposals and for the Targeted Pool in Round 11 Toolkit (2011).

UNAIDS: Human Rights Costing Tool & The User Guide for the HIV-Related Human Rights Costing Tool (2012).

UNAIDS: Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive (2011).

UNAIDS: Supporting community-based responses to AIDS, tuberculosis and malaria. A guidance tool for including community systems strengthening in proposals for the Global Fund to Fight AIDS, Tuberculosis and Malaria (2011).

UNAIDS: Guidance Note: Addressing HIV-Related Law at National Level (2008).

**WHO guidelines and key documents**

WHO: March 2014 Supplement to the Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection – Recommendations for a Public Health Approach (2014).

WHO: Opportunities for Reproductive, Maternal, Newborn and Child Health (RMNCH) in the Global Fund New Funding Model (2014).

WHO: Guide to conducting programme reviews for the health sector response to HIV/AIDS - Guidance (2013).

WHO: Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection (June 2013).

WHO: Guide to Conducting Programme Reviews for the Health Sector Response to HIV/AIDS (October 2013).

WHO: Guideline on the Use of Devices for Adult Male Circumcision for HIV Prevention (October 2013).

WHO/UNAIDS/AVAC/FHI: Clearinghouse on Male Circumcision for HIV Prevention.

WHO: Guidance on Couples HIV Testing and Counselling including Antiretroviral Therapy for Treatment and Prevention in Serodiscordant Couples (2012).

WHO: Planning Guide for the Health Sector Response to HIV/AIDS (2011).

WHO: Service delivery approaches to HIV testing and counseling (HTC): A strategic policy framework (2012).

**Other key documents**

IHP+: Joint Assessment of National Health Strategies and Plans – Combined Joint Assessment Tool and Guidelines (2013).

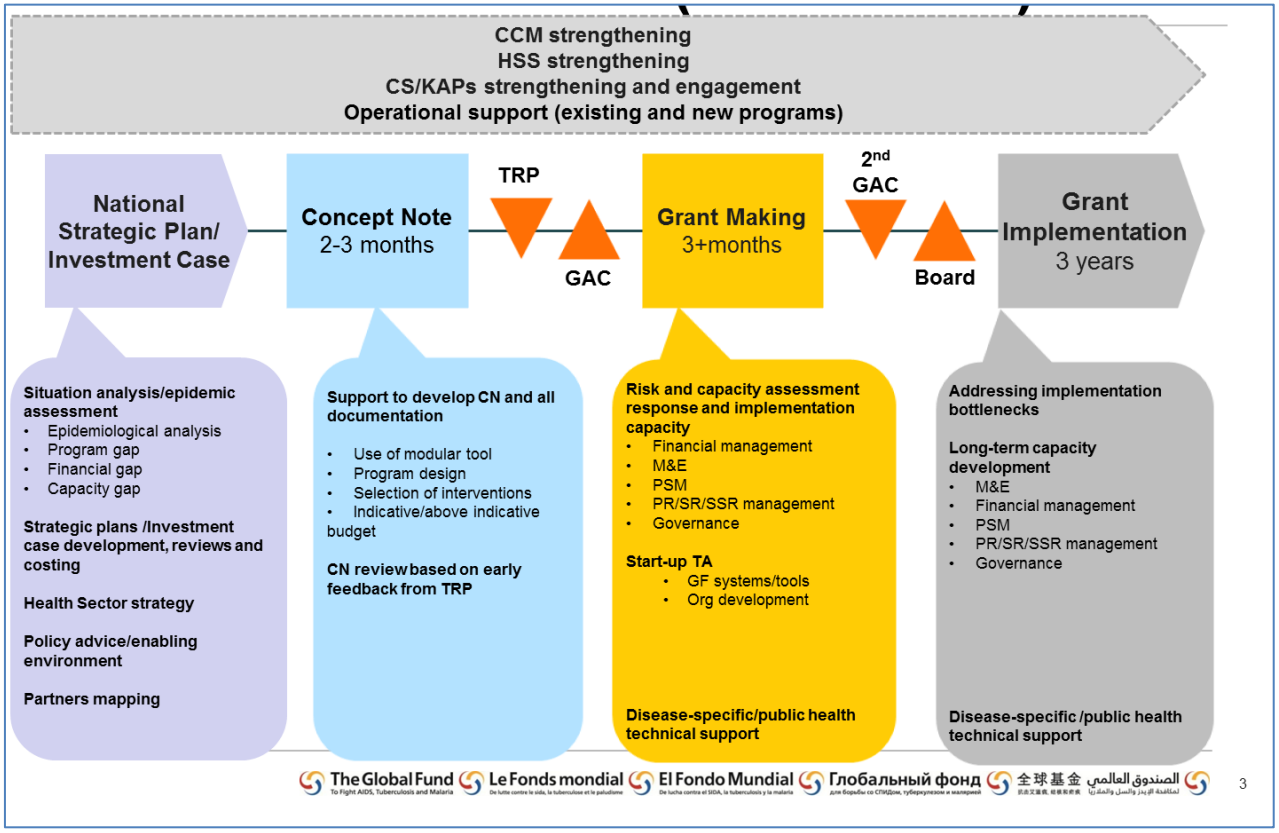
UNAIDS/WHO: Resource Kit for High Impact Programming (June 2014). [forthcoming]

UNICEF: Options B and B+: Key Considerations for Countries to Implement an Equity-focused Approach. Eliminating New HIV Infections Among Children and Keeping Mothers Living with

HIV Alive and Well (2012).

UNDP/UNAIDS: Understanding and acting on critical enablers and development synergies for strategic investments (2012).

## Annex 1: A framework for technical assistance throughout the grant life cycle



## Annex 2: HIV Modular Template

### Table 1: HIV modules and interventions (excluding cross-cutting HSS modules)

| Module | Intervention | Scope and description of intervention package |
|---|---|---|
| Prevention programs for general population | Behavioral change as part of programs for general population | Designing, developing and implementing behavioural change programs: including planning, human resources, training, IEC material, targeted mass media campaigns, outreach and peer education. Include programs tailored for different needs of men, women and girls in the general population, to support male and female condoms, gender norms, testing and counselling and Male Circumcision. This includes workplace policies and programs. Exclude programs for Key and vulnerable populations and Youth. |
| | Condoms as part of programs for general population | Promotion and distribution of female and male condoms for HIV prevention including links to Behaviour Change programs. Exclude condoms included as part of PMTCT Prong 2. Exclude programs for Key and vulnerable populations and Youth. |
| | Male circumcision | Promotion and provision of medical male circumcision for adults, adolescents and youth including links to Behaviour Change programs, HIV testing and counselling and STI diagnosis and treatment. |
| | HIV testing and counseling as part of programs for general population | Designing, developing and implementing provider and client-initiated testing, community-based HIV Testing and Counselling, including outreach, home-based and targeted campaigns. Include all HIV testing and counselling programs targeting general populations.<br>Exclude programs for Key and vulnerable populations. |
| | Diagnosis and treatment of STIs as part of programs for general population | Designing, developing and implementing Syndromic and Clinical management programs of sexually transmitted infections. Exclude programs for Key and vulnerable populations. |
| | Blood safety | Designing, developing and implementing interventions to assure blood safety and apply universal precautions |
| | Orphan and vulnerable children (OVC) package | Designing and implementing programs aimed to strengthen the capacity of families to protect and care for OVC by prolonging the lives of parents and providing economic, psychosocial, addressing young girls vulnerabilities and other support including community-based responses and access to essential services including education, health care, birth registration and others. |
| | RMNCH linkages and gender-based violence (GBV) | Designing, developing and implementing gender responsive, women and girls focused HIV services including prevention and responses to gender-based violence, HIV service integration into RMNCH services, promotion of sexual and reproductive health |
| | Other interventions for general population - Please specify | |

| | | |
|---|---|---|
| Prevention programs for MSM and TGs | Behavioral change as part of programs for MSM and TGs | Designing, developing and implementing behavioural change programs such as individual-level, community-level behavioural interventions, targeted internet-based strategies, social marketing-based strategies, sex venue-based outreach strategies. SOGI strategy.<br>Exclude programs for general population, youth, and other Key Populations. |
| | Condoms as part of programs for MSM and TGs | Promotion and distribution of female and male condoms and condom-compatible lubricants for HIV prevention Links to Behaviour Change programs. |
| | HIV testing and counseling as part of programs for MSM and TGs | Designing, developing and implementing provider and client-initiated testing, community-based HIV testing and counselling including outreach, mobile services and partner's testing and targeted campaign, links to care and treatment. Exclude HIV testing and counselling programs for general population, youth, and other Key Populations. |
| | Diagnosis and treatment of STIs as part of programs for MSM and TGs | Designing, developing and implementing Syndromic and Clinical management programs of sexually transmitted infections |
| | Diagnosis and treatment of viral hepatitis as part of programs for MSM and TGs | Designing, developing and implementing Viral Hepatitis programs targeting PWID including human resources and training , links to Behaviour Change programs, HIV testing and counselling, care and treatment. Exclude programs for general population and other KPs. |
| | Other interventions for MSM and TGs - Please specify | |
| Prevention programs for sex workers and their clients | Behavioral change as part of programs for sex workers and their clients | Designing, developing and implementing behavioural change programs such as individual-level, community-level behavioural interventions, targeted internet-based strategies, social marketing-based strategies, sex venue-based outreach strategies: including planning, human resources, training material, outreach and peer education. Exclude programs for general population, youth, and other Key Populations. |
| | Condoms as part of programs for sex workers and their clients | Promotion and distribution of female and male condoms for HIV prevention - this includes demand creation, training and distribution. Links to behaviour change programs. |
| | HIV testing and counseling as part of programs for sex workers and their clients | Designing, developing and implementing provider and client-initiated testing, community-based HIV testing and counselling including outreach, mobile services and partner's testing and targeted campaign. Links to care and treatment. Exclude programs for general population, youth, and other Key Populations. |
| | Diagnosis and treatment of STIs as part of programs for sex workers and their clients | Designing, developing and implementing Syndromic and Clinical management programs of sexually transmitted infections including links to Reproductive Health services. |
| | Harm reduction as part of programs for sex workers and their clients | Designing, developing and implementing gender responsive, sex workers friendly services including prevention and responses to gender-based violence, RMNCH services, and promotion of sexual and reproductive health. Exclude programs for general population and other Key Populations. |

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| | Other interventions for sex workers and their clients - Please specify | |
| Prevention programs for people who inject drugs (PWID) and their partners | Behavioural change as part of programs for PWID and their partners | Designing, developing and implementing behavioural change programs such as individual-level, community-level behavioural interventions, targeted internet-based strategies, social marketing-based strategies, sex venue-based outreach strategies: including planning, human resources, training material, outreach and peer education. Exclude programs for general population, youth, and other Key Populations. |
| | Condoms as part of programs for PWID and their partners | Promotion and distribution male and female condoms - this includes demand creation, training and distribution. Links to Behaviour Change programs. |
| | HIV testing and Counselling as part of programs for PWID and their partners | Designing, developing and implementing provider and client-initiated testing, community-based HTC including outreach, mobile services and partner's testing and targeted campaign. Links to care and treatment. Exclude programs for general population, youth, and other Key Populations. |
| | Diagnosis and treatment of STIs as part of programs for PWID and their partners | Designing, developing and implementing Syndromic and Clinical management programs of sexually transmitted infections |
| | Needle and Syringe programs as part of programs for PWID and their partners | Designing, developing and implementing Needle & Syringe programs including human resources and training , links to behaviour change programs, HIV testing and counselling, care and treatment. |
| | Opioid substitution therapy and other drug dependence treatment as part of programs for PWIDs and their partners | Designing, developing and implementing OST programs including human resources and training , links to Behaviour Change programs, HIV testing and counselling, care and treatment. |
| | Diagnosis and treatment of viral hepatitis as part of programs for PWIDs and their partners | Designing, developing and implementing Viral Hepatitis programs targeting PWID including human resources and training , links to Behaviour Change programs, HIV testing and counselling, care and treatment. Exclude programs for general population and other Key Populations. |
| | Other interventions for IDUs and their partners - Please specify | |
| Prevention programs for other vulnerable populations (please specify) | Behavioral change as part of programs for other vulnerable populations | Designing, developing and implementing behavioural change programs such as individual-level, community-level behavioural interventions, targeted internet-based strategies, social marketing-based strategies, sex venue-based outreach strategies: including planning, human resources, training material, outreach and peer education. Exclude programs for general population, youth, and other Key Populations. |
| | Condoms as part of programs for other vulnerable populations | Promotion and distribution of female and male condoms for HIV prevention - this includes demand creation, training and distribution. Links to Behaviour Change programs. |

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| | HIV testing and counseling as part of programs for other vulnerable populations | Designing, developing and implementing HIV testing and counselling: provider-initiated, client-initiated and community-based including mobile services and partner's testing. This includes demand creation, training, human resources and links to care and treatment. |
| | Diagnosis and treatment of STIs as part of programs for other vulnerable populations | Designing, developing and implementing Syndromic and Clinical management programs of sexually transmitted infections |
| | Other interventions for other vulnerable populations - Please specify | |
| Prevention programs for adolescents and youth, in and out of school | Behavioral change as part of programs for adolescent and youth | Designing, developing and implementing behavioural change programs such as individual-level, community-level behavioural interventions, targeted internet-based strategies, social marketing-based strategies, sex venue-based outreach strategies: including planning, human resources, training material, outreach and peer education. Exclude programs for general population, youth, and other Key Populations. |
| | Condoms part of programs for adolescent and youth | Promotion and distribution of condoms for sexually active young people this includes demand creation, training and distribution; Links to Behaviour Change programs. |
| | HIV testing and counseling as part of programs for adolescent and youth | Designing, developing and implementing youth-friendly HIV testing and counselling programs including provider-initiated, client-initiated and community-based HIV testing and counselling including mobile services and partner's testing. This includes demand creation, training, human resources and links to care and treatment. |
| | RMNCH linkages and gender-based violence (GBV) as part of programs for adolescent and youth | Designing, developing and implementing gender responsive, adolescents and youth friendly services including prevention and responses to violence against children, youth-friendly RMNCH services, and promotion of sexual and reproductive health. Exclude programs for general population and other Key Populations. |
| | Young Key Population interventions as part of programs for adolescent and youth | Designing and implementing other specific interventions for young key populations e.g. interventions aimed at young MSM and harm reduction for young people who are injecting drug users. |
| | Other interventions for adolescent and youth | |
| PMTCT | Prong 1: Primary prevention of HIV infection among women of childbearing age | Designing, developing and implementing programs aimed at primary prevention of HIV among women of reproductive age within services related to reproductive health such as antenatal care, postpartum/natal care and other health and HIV service delivery points, including working with community structures. |
| | Prong 2: Preventing unintended pregnancies among women living with HIV | Designing, developing and implementing reproductive health programs targeting women living with HIV including linkages and referrals. |

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| | Prong 3: Preventing vertical HIV transmission | Designing, developing and implementing programs aimed at preventing vertical transmission this includes HIV testing and counselling, ARVs, interventions along the continuum pregnancy, delivery and breastfeeding. Please include provisions for option A and B. |
| | Prong 4: Treatment, care and support to mothers living with HIV and their children and families | Designing, developing and implementing programs aimed to provide HIV care, treatment and support for women found to be positive and their families including Early Infant Diagnosis (EID) |
| | Other interventions for PMTCT- Please specify | |
| Treatment, care and support | Pre-ART care | Designing, developing and implementing comprehensive pre-ART interventions including confirmation of HIV infection status, staging of the disease, baseline clinical assessment and monitoring before treatment initiation including treatment preparedness. |
| | Antiretroviral Therapy (ART) | Designing, developing and implementing ART programs for all populations with the exception of prophylaxis under options A and B which are included in the PMTCT module. This includes, first , second and third-line for both adults and children, Treatment as Prevention and provisions for expansion to option B+ as well as Pre and Post-exposure prophylaxis (PrEP and PEP). This includes links and referrals to care and support. |
| | Treatment monitoring | This includes Clinical and laboratory monitoring at treatment initiation and during ART. |
| | Treatment adherence | Designing, developing and implementing a comprehensive treatment adherence strategy both at the programmatic/facility level and at the community level. |
| | Prevention, diagnosis and treatment of opportunistic infections | Designing, developing and implementing diagnosis and treatment programs of OIs, including vaccination, diagnosis and treatment of viral hepatitis- excluding TB. |
| | Counseling and psycho-social support | Designing, developing and implementing a comprehensive support program including psychosocial support; optimizing nutrition and income generation etc. |
| | Out-patient care | This includes other outpatient health services. |
| | In-patient care | This includes inpatient care including palliative care. |
| | Other interventions for treatment - Please specify | |

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| TB/HIV | TB/HIV collaborative interventions | This intervention refers to implementation of the 12 elements of TB/HIV collaborative activities that are aligned with the HIV program. These include- setting up and strengthening a coordinating body for collaborative TB/HIV activities functional at all levels, joint TB and HIV planning to integrate the delivery of TB and HIV services; HIV testing of TB patients and early initiation of ART and CPT for co-infected patients; It also includes screening of PLHIV for TB and rapid molecular tools for TB diagnosis among PLHIV with presumptive TB; IPT, infection control measures. It includes procurement of consumables and drugs which are not covered by the HIV program. |
| | Engaging all care providers | This includes engaging public and private providers, traditional healers in TB/HIV control activities (diagnosis, treatment and follow-up of patients). Public-private (PPM) refers to private providers which are not included in the NTP (including private not for-profit and for-profit private clinics, hospitals). Public-public mix refers to public providers which are collaborating with NTP but not included in the NTP |
| | Community TB care delivery | Capacity building for community-level service delivery. This includes training and capacity-building of TB service providers, TB patients, community-based interventions and outreach services for TB patients. |
| | Key Affected Populations | This include Active case finding among Key Affected Populations and high risk groups such as prisoners, displaced people, migrants and ethnic minorities/indigenous populations, miners, children, urban poor, elderly and adapting models of TB/HIV care for high risk groups such as people who inject drugs. This includes adapting services to the needs of specific groups to make services people-centered and improve accessibility, appropriateness, and availability; adapt diagnostic and treatment structures to meet needs of key populations, e.g. through community-based TB care and prevention, mobile outreach to remote areas, community-based sputum collection, sputum transport arrangements, etc. |
| | Collaborative activities with other programs and sectors* | This intervention includes collaboration with other service providers for patients with co-morbidities including Reproductive Maternal Neonatal and Child Health (RMNCH), diabetes co-morbidities and collaborative activities for TB /HIV prevention and care with other sectors beyond health |
| | Other | |
| Health information systems and M&E | Routine reporting | Establishment/maintenance/strengthening of national HMIS system including DHIS 2; Other systems or sentinel sites for routine data collection, recording and reporting of outpatients, in-patients and deaths– including public, private and community reporting; any related web-based/electronic system to support data reporting from all levels of health system; training; reporting forms and tools with appropriate disaggregation of indicators; Health facility assessment including quality of services; data quality assessment and validation including any specific supervisory visits related to data collection and reporting. For example, these could include:<br>HIV: Sentinel surveillance (ANC and Key Populations); HIV testing and treatment; Longitudinal |

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| | | ART patient cohort monitoring over time, ideally nation-wide or in representative sentinel sites: patient adherence & survival (tracking loss-to-follow-up); Data collection and reporting from other service providers (communities and civil society); Reporting on distribution of commodities such as- condoms, needles and syringes, IEC material, etc.; Routine reporting of TB/HIV collaborative activities and infection control measures; etc.<br>TB: Routine R & R/ e-TB register; Data collection and reporting from other care providers (PPM, communities and civil society); Routine reporting of TB/HIV collaborative activities and infection control measures; Surveillance systems Standards & Benchmarks checklist applied (case and death notification and vital registration systems); Inventory (e.g. capture-recapture) studies assessing completeness of case/death reporting, including from private sector; etc.<br>Malaria: Routine systems for reporting on microscopy and RDT tests and anti-malaria treatment; reporting on stock-outs; data collection and reporting from other care providers (private, communities and civil society); reporting on ITN/LLIN distribution, IRS; etc. |
| | Analysis, review and transparency | Analysis, interpretation and use of data and evidence generated through integrated program reviews, evaluation of whole or a specific component of the program; development and sharing of periodic reports through websites/publications; reviews and evaluations of national health strategies; Operations research- e.g. specific to any of the components of HIV, TB, and Malaria control programs; Model-based (EPP/Spectrum) estimations. |
| | Surveys | Surveys/studies related to assessment of morbidity, mortality, service coverage and behavioral surveys/studies in general population or identified risk groups- e.g. DHS; health and morbidity surveys to assess out-of-pocket expenditures or burden; etc. For example, these could include:<br>HIV: Surveys measuring trends in HIV sero-prevalence; risk behaviour and KAP surveys, e.g. Integrated Bio Behavioural Surveys (IBBS) in MARPs in low-level and concentrated epidemics; Modes of Transmission studies; Population based surveys, for example, DHS or other nationally representative household surveys); Designing and establishing HIVDR surveillance.<br>TB: Surveys related to measuring TB burden, drug resistance, etc; population based surveys, for example, DHS, patient cost surveys; Special surveys to assess access barriers and specific needs of different key populations.<br>Malaria: Household surveys (e.g. DHS, MICS and MIS) to monitor anemia/ parasitemia prevalence, under-5 mortality and ITN/IRS/IPT/treatment coverage, etc. |
| | Administrative and finance data sources | Includes establishing systems for periodic (annual) reporting on key health administrative and service availability statistics, such as- Health workforce, inventory of health care providers and institutions; National Health Accounts and sub-accounts; setting up of financial reporting/ accounting systems; annual review of health sector and/or disease program budget and expenditures by funding source; Expenditure studies-e.g. NASA or other spending assessments. |
| | Vital registration system | Establishing/ strengthening and scale up of Vital registration information system including Sample Vital Registration systems, strengthening reporting of hospital morbidity and mortality statistics, cause of death, establishment of SMS system of reporting; training of community health workers on reporting vital events, drug stock-outs etc. |
| | Other | |

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| Removing legal barriers to access | Legal and policy environment assessment and law reform | Assess the legal and policy environment and share outcomes with those living with or directly affected by the disease. In consultation with them and with human rights experts, develop a measurable, time-bound plan to reform laws and policies, in order to remove barriers to accessing health services. PLEASE SEE THE GLOBAL FUND HUMAN RIGHTS GUIDANCE FOR MORE DETAILS. |
| | Legal aid services and legal literacy | Provide training for people living with and affected by the disease in their legal rights. Provide access to justice through community paralegals or legal aid programs. |
| | Training on rights for officials, health workers and police | Provide training for health officials, health workers and police who must implement rights-based laws and policies. |
| | Community-based monitoring of legal rights | Community-based organizations establish and implement mechanisms for ongoing monitoring of laws, policies and their implementation to document barriers to an effective response to the disease. This can include monitoring of individual cases for purposes of sharing with ombudsmen, for litigation, for research reports, and submission to UN human rights mechanisms. |
| | Policy advocacy on legal rights | Community-based organizations and networks of women and key populations implement a time-bound, measurable advocacy plan to advocate for either a) law and policy reform, b) better implementation of existing laws and policies, or c) to create and utilize platforms for social accountability, aimed at removing human rights barriers to accessing health services. |
| | Other | |
| Community systems strengthening | Community-based monitoring for accountability | Community-based organizations establish and implement mechanisms for ongoing monitoring of health policies and performance and quality of all services, activities, interventions and other factors that are relevant to the disease, including prevention, care and support services, financing of programs, and of issues and challenges in the environment, (such as discrimination and gender-based inequalities), that constitute barriers to an effective response to the disease and to an enabling environment. |
| | Advocacy for social accountability | Communities and affected populations conduct consensus, dialogue and advocacy at local and national levels aimed at holding to account responses to the disease, including health services, disease specific programs as well as broader issues such as discrimination, gender inequality and sustainable financing, and aimed at social transformation. |
| | Social mobilization, building community linkages, collaboration and coordination | Community action, establishment of community organizations and creation of networking and effective linkages with other actors and broader movements such as human rights and women's movements.<br>Strong informal and formal relationships between communities, community actors and other stakeholders enable them to work in complementary and mutually reinforcing ways, maximizing the use of resources and avoiding unnecessary duplication and competition. |
| | Institutional capacity building, planning and leadership development in the community sector | Capacity building of community sector groups, organizations and networks in a range of areas necessary for them to fulfil their roles in service provision, social mobilization, monitoring and advocacy. Includes support in planning, institutional and organizational development, systems development, human resources, leadership, and community sector organizing.<br>Provision of stable, predictable financial resources for communities and appropriate management |

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| | | of financial resources by community groups, organizations and networks.<br>Provision of technical, material and financial support to the community sector as required to enable them to fulfil roles in service provision, social mobilization, monitoring and advocacy. |
| | Other | |
| Program management | Policy, planning, coordination and management | For the three diseases, it could include- national program activities at the administrative level outside the point of health care delivery, such as development of national strategic plans and annual operational plans and budgets; oversight, technical assistance and supervision from national to subnational levels; human resource- planning/ staffing and overheads, operational costs; coordination with district and local authorities; quarterly meetings, training, and office/IT equipment; partnering process including advocacy and public awareness and communication carried out by partners and the national program; mobilizing leaders to support implementation and sustainability of the program. etc.<br>In addition for TB, it could include cross sector policy and planning on TB social determinants and protection (e.g. justice, housing, labour, poverty and social welfare); involvement of Key Affected populations in planning.<br>For HSS, it could include- activities at the local, district, regional and national levels aimed at integrated planning, programming, budgeting and financing health and disease control programs, integrating national disease strategies and budgets into broader health sector strategy, development of comprehensive national strategic plans, health sector budget and annual operational plan; oversight, technical assistance and supervision from national to subnational levels. |
| | Grant management | Includes specific Global Fund grant management related activities at the PMU/PR/SR level. These could include- development and submission of grant documents; oversight and technical assistance related to Global Fund grant implementation and management and specific Global Fund requirements; improvement of financial management; supervision from PR to SR level (applicable when the national disease control program is not the PR); human resource planning/ staffing and overheads, operational costs; coordination with national program, district and local authorities; quarterly meetings, training, and office/IT equipment at PR/SR level; mobilizing leaders to support implementation and sustainability of the program; Financial monitoring and audits. |
| | Supporting procurement and supply management | This includes interventions supporting the PSM capacity for the disease program. For example- capacity building on PSM, Renovating and equipping warehouses |
| | Other | |

**Table 2: List of indicators included in the HIV Modular Template**

| Impact indicator | Outcome indicator | Coverage/Output indicator |
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| HIV I-1: Percentage of young people aged 15–24 who are living with HIV (disaggregated by sex) | HIV O-1: Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy (disaggregated by age <15, 15+, sex, with 24 and 36 month data) | GP-1: Number of women and men aged 15+ who received an HIV test and know their results (disaggregated by sex and HIV test result) |
| HIV I-2: HIV incidence among 15-49 age group (disaggregated by sex) | HIV O-2: Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months (disaggregated by 15-19 and 20-24 age groups) | GP-2: Percentage of individuals from targeted population reached through community outreach with standardized HIV prevention interventions |
| HIV I-3a: Percentage of antenatal care attendees who were positive for syphilis | HIV O-3: Percentage of women and men aged 15-49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse (disaggregated by 15-19 and 20-24 age groups) | GP-3: Proportion of new individuals who test positive for HIV, enrolled in care (pre-ART or ART) services |
| HIV I-3b: Percentage of men who have sex with men with active syphilis | HIV O-4a: Percentage of men reporting the use of a condom the last time they had anal sex with a male partner | GP-4: Percentage of antenatal care attendees tested for syphilis |
| HIV I-3c: Percentage of sex workers with active syphilis | HIV O-4b: Percentage of transgender people who sell sex reporting the use of a condom with their most recent client | GP-5: Number of male circumcisions performed according to national standards |
| HIV I-4: AIDS related mortality per 100,000 population (disaggregated by sex; age <15, 15+) | HIV O-5: Percentage of sex workers reporting the use of a condom with their most recent client (disaggregated by sex male, female, transgender) | GP-6: Percentage of orphaned and vulnerable children aged 0–17 years whose households received free basic external support in caring for the child according to national guidelines |
| HIV I-5: New HIV infections among children | HIV O-6: Percentage of people who inject drugs reporting the use of sterile injecting equipment the last time they injected (disaggregated by sex) | |
| HIV I-6: Modelled lives saved based on latest epidemiological data | HIV O-7: Percentage of other vulnerable populations who report the use of a condom at last sexual intercourse | |
| HIV I-7: Modelled infections averted based on latest epidemiological data | HIV O-8: Current school attendance rate among orphans and non-orphans (disaggregated by sex) | |
| HIV I-8: Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months | HSS O-1: Percentage of women attending antenatal care | KP-1a: Percentage of MSM reached with HIV prevention programs - defined package of services |
| HIV I-9a: Percentage of men who | HSS O-2: Percentage of births attended by skilled | KP-1b: Percentage of TG reached with HIV prevention |

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| have sex with men who are living with HIV<br>HIV I-9b: Percentage of transgender people who are living with HIV<br>HIV I-10: Percentage of sex workers who are living with HIV<br>HIV I-11: Percentage of people who inject drugs who are living with HIV<br>HIV I-12: Percentage of other vulnerable populations (specify) who are living with HIV | health professional<br>HSS O-3: Ratio of household out-of-pocket payments for health to total expenditure on health<br>HSS O-5: Specific services readiness score for health facilities | programs - defined package of services<br>KP-2a: Percentage of MSM reached with HIV prevention programs - individual and/or smaller group level interventions<br>KP-2b: Percentage of TG reached with HIV prevention programs - individual and/or smaller group level interventions<br>KP-3a: Percentage of MSM that have received an HIV test during the reporting period and know their results<br>KP-3b: Percentage of TG that have received an HIV test during the reporting period and know their results |
| TB/HIV I-1: TB/HIV mortality rate<br>HSS I-1: Under 5 mortality rate per 1000 live births<br>HSS I-2: Neonatal mortality rate<br>HSS I-3: Maternal mortality ratio | | KP-1c: Percentage of sex workers reached with HIV prevention programs - defined package of services<br>KP-2c: Percentage of sex workers reached with HIV prevention programs - individual and/or smaller group level interventions<br>KP-3c: Percentage of sex workers that have received an HIV test during the reporting period and know their results |
| | | KP-1d: Percentage of PWID reached with HIV prevention programs - defined package of services<br>KP-2d: Percentage of PWID reached with HIV prevention programs - individual and/or smaller group level interventions<br>KP-3d: Percentage of PWID that have received an HIV test during the reporting period and know their results<br>KP-4: Number of needles and syringes distributed per person who injects drugs per year by needle and syringe programs<br>KP-5: Percentage of individuals receiving Opioid Substitution Therapy who received treatment for at least 6 months |
| | | KP-1e: Percentage of other vulnerable populations reached with HIV prevention programs - defined package of services<br>KP-2e: Percentage of other vulnerable populations reached with HIV prevention programs - individual and/or smaller group level interventions<br>KP-3e: Percentage of other vulnerable populations that have received an HIV test during the reporting period and know their results |
| | | YP-1: Percentage of young people aged 10–24 years reached by life skills–based HIV education in schools |

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| | | PMTCT-1: Percentage of pregnant women who know their HIV status (disaggregated by HIV status)<br>PMTCT-2: Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission (disaggregated by type of regimen)<br>PMTCT-3: Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth |
| | | TCS-1: Percentage of adults and children currently receiving antiretroviral therapy among all adults and children living with HIV (disaggregated by sex and age <15, 15+)<br>TCS-2: Percentage of people living with HIV that initiated ART with CD4 count of <200 cells/mm$^3$<br>TCS-3: Percentage of adults and children that initiated ART, with an undetectable viral load at 12 months (<1000 copies/ml)<br>TCS-4: Percentage of health facilities dispensing antiretroviral therapy that experienced a stock-out of at least one required antiretroviral drug in the last 12 month<br>TCS-5: Proportion of undernourished PLHIV that received therapeutic or supplementary food at any point during the reporting period |
| | | TB/HIV-1: Percentage of TB patients who had an HIV test result recorded in the TB register<br>TB/HIV-2: Percentage of HIV-positive registered TB patients given anti-retroviral therapy during TB treatment<br>TB/HIV-3: Percentage of HIV-positive patients who were screened for TB in HIV care or treatment settings<br>TB/HIV-4: Percentage of new HIV-positive patients starting IPT during the reporting period |
| | | M&E-1: Percentage of HMIS or other routine reporting units submitting timely reports according to national guidelines<br>M&E-3: Percentage of deaths registered (as reported by civil or sample registration systems, hospitals, community-based reporting systems) among the total deaths for the same period and geographical region |