THE GLOBAL FUND

Toolkit for Tuberculosis Program Essentials

February 2023

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1. Background

In the 2023-2025 funding cycle, otherwise known as Grant Cycle 7 or GC7, the Global Fund is introducing “Program Essentials”. These Program Essentials ensure that Global Fund investments support the scale-up of critical interventions that follow the latest recommendations for HIV, tuberculosis (TB) and malaria. The Program Essentials also serve as a tool to ensure equity in access for all populations, in particular for key and vulnerable groups.

Program Essentials are evidence-based interventions and approaches coming from the recommendations of technical partners such as the World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the Stop TB Partnership, Roll Back Malaria (RBM), each of whom provide more detailed information in their respective technical guidelines.

The Global Fund has also produced technical guidelines on Program Essentials in its TB Information Note as well as in the Technical Brief on Reducing Human Rights-related Barriers to TB Services. Additional information can also be found in the slides shown in Annex 3.

In December 2022, the approach described in this document was piloted in a high-burden country. From that experience were drawn the lessons learned which have served as the basis for this toolkit. The aim is to support countries to take action on the Program Essentials as part of the country’s funding request development process, most notably as part of the country dialogue.

This toolkit provides step-by-step guidance on incorporating Program Essentials into the funding request as well as on how to manage subsequent monitoring through routine TB program activities. In addition, this toolkit can be adapted to and integrated in other processes such as program reviews, epi-analysis, national strategic plan development and others.

The toolkit has three components. Though specific timings may vary by country and context, the estimated time for completion of all components is 7 to 10 days, broken down as follows:

1. TB Program Essentials baseline assessment – 3 days
2. Stakeholder engagement and consultation – 2 to 4 days
3. Analysis and synthesis of results – 2 to 3 days

The whole exercise should ideally be completed by an external consultant, who would complete the baseline assessment, lead the consultation with relevant stakeholders, and

analyze and synthetize the results. Depending on context, the exercise can also be completed by a designated member of the national TB program with support from the monitoring and evaluation (M&E) team, or by a technical partner with the support of the national TB program. Annex 1 provides draft terms of reference that can be used to select the external consultant.

2. TB Program Essential Baseline Assessment

The TB Program Essential Baseline Assessment is a critical activity; the results will be used to support discussion during stakeholder consultation. And it can be used by national TB programs as a tool to track progress on the implementation of Program Essentials.

The TB Program Essentials baseline assessment can be conducted separately or as part of other process such as epi-analysis or an update of the national strategic plan for TB.

The following table shows the list of TB Program Essentials, mapping each to appropriate indicators and available sources of information. Note that both the availability of data and the source(s) of information can vary from country to country.

Table 1. TB Program Essentials, Indicators, Sources

	Program Essential	Indicator	Source of information
1. TB Screening and Diagnostics	1.1 Systematic TB screening is provided for those at highest risk (key and vulnerable population), including through the use of chest X-rays, with or without computer-aided detection (currently recommended for people aged 15 and older).	% health facility attendees screened for TB in outpatient department (OPD) = **Numerator:** Number screened for TB= **Denominator:** Total OPD attendance =	Health management information system (HMIS) reports (weekly, monthly, quarterly), and/or case-based surveillance systems (where functional) National TB program focal point for TB case finding
	1.2 Multiyear plan to achieve universal use of rapid molecular assays as the initial test to diagnose TB for all people with presumptive	% total new and relapse TB cases tested with rapid diagnostics at time of diagnosis =	HMIS reports (weekly, monthly, quarterly), and/or case-based surveillance systems (where functional)

	TB, with implementation on track.	**Numerator:** Number of new and relapse TB cases tested using GeneXpert= **Denominator:** Total number of new and relapse TB cases notified =	WHO Country TB profile (2021), National TB reference laboratory (NTRL) diagnostics focal point
	1.3 All people with bacteriologically confirmed TB are tested for at least rifampicin resistance and for those with rifampicin-resistant TB (RR-TB) further tests are conducted to rule out resistance to other drugs.	% bacteriologically confirmed TB cases tested for RR = **Numerator:** Total bacteriologically positive TB cases tested for RR = **Denominator:** Total number of bacteriologically TB cases =	HMIS reports (weekly, monthly, quarterly), and/or case-based surveillance systems (where functional) WHO Country TB profile (2021), NTRL diagnostics focal point, national programmatic management of drug-resistant TB (PMDT) focal point
		% RR-TB cases further tested to rule out resistance to other drugs = **Numerator:** Total with RR-TB who got further tests to rule-out resistance to other drugs = **Denominator:** Total TB cases with RR-TB =	HMIS reports (weekly, monthly, quarterly), and/ or case-based surveillance systems (where functional) WHO Country TB profile (2021), NTRL diagnostics focal point, national PMDT focal point
	1.4 TB diagnostic network operates efficiently to increase access to testing and includes specimen transportation, maintenance of equipment, connectivity solutions, biosafety, quality	TB Diagnostic Network Standards, core capacities and components	TB DNA report (if available), NTRL diagnostics focal point

	assurance and supply system.		
2. TB treatment and care	2.1 Child-friendly formulations, all oral regimens for DR-TB, and 4-month regimen for non-severe, drug-sensitive TB (DS-TB) are used for TB treatment in children. OBS: As not necessarily all of the components on the Program Essential will be completed, this can be disaggregated if needed.	Availability of the required child formulations/ regimens at health facilities =	NTLP 2021 TB report and summary statistics provided by childhood TB focal point
	2.2 People with DR-TB receive shorter, all-oral regimens or individualized longer treatment regimens, as recommended by WHO.	Availability of the required DR-TB formulations/ regimens at health facilities =	WHO Country TB profile (2021), NTRL diagnostics focal point, national PMDT focal point
3. TB prevention	3.1 TB preventive treatment (TPT) (including shorter regimens) is available for all eligible people living with HIV (PLHIV) (adults and children)	% PLHIV in care who received TPT within the specified reporting period = **Numerator:** Total number of PLHIV in care who received/started TPT within the specified reporting period = **Denominator:** Total number of PLHIV in care in the specified reporting period = Where possible, provide information on the availability and use of shorter TPT regimens	HMIS reports (weekly, monthly, quarterly), and/ or case-based surveillance systems (where functional) WHO country Profile (2021) or AIDSInfo or summary statistics on TPT coverage among PLHIV by HIV/TB focal point at Ministry of Health

	Eligible household contacts of people with bacteriologically confirmed pulmonary TB who received TPT. OBS: there is only one Program Essential for prevention, but it has two components: one for PLHIV and another for household contacts (household contacts can be disaggregated also by age into <5 years of age and >5 years.)	**Numerator:** Total number of eligible household contacts of TB patients who started TPT = **Denominator:** Total number of household contacts of TB patients =	HMIS reports (weekly, monthly, quarterly), and/or case-based surveillance systems (where functional) WHO country profile (2021) Summary statistics on TPT by NTLP TPT Focal Point (2021)
4. TB/HIV	4.1 All PLHIV with active TB are started on ARV treatment early as per recommendations	**Numerator:** Total TB/HIV co-infected patients initiated on TB and antiretroviral therapy (ART) co-treatment = **Denominator:** Total number of patients with HIV/TB co-infection:	HMIS reports (weekly, monthly, quarterly), and/or case-based surveillance systems (where functional) Summary statistics provided by TB/HIV focal point, WHO TB country profile report (2021)
5. Cross-cutting areas	5.1 Establish, progressively scale-up, and maintain a comprehensive, real-time, digital case-based TB surveillance system	**Numerator:** Total number of TB Basic Management Units (BMUs)/health facilities with “functional” digital case-based surveillance systems in place = **Denominator:** Total number of TB BMUs/health facilities expected to report routine TB data in the country =	Report on rollout/scale-up of TB digital case-based surveillance system by HMIS/M&E focal point

	5.2 Prioritized interventions are informed by cascade analysis throughout the pathway of TB care, including for TPT.	TB care cascade analysis conducted in the last 12 months In addition, try to establish if the output of the cascade analysis was used for any strategic planning or prioritization	National Strategic Plan National TB program annual report Interview with national TB program manager Any other relevant national strategic planning document
	5.3 Engagement of private health care providers is on a scale commensurate with their role in the health care system.	**Numerator:** Total notified TB patients reported from the private sector **Denominator**: Total notified TB cases	National TB program annual report
	5.4 Decentralized, ambulatory, community- and home-based, people-centered services are provided across the continuum of TB care	% TB patients that receive TB care via decentralized, ambulatory, community- and home-based approach	National TB program annual report
	5.5 All TB programming must be human rights-based, gender-responsive and informed by and respond to analysis of inequities; and include stigma and discrimination reduction activities for people with TB and TB-affected populations; legal literacy and access to justice activities; as well as support for community mobilization and advocacy and community-led monitoring for social accountability.	Based on findings from assessments, reports/survey on gender, stigma, human rights-related barriers, programming to reduce human rights-related barriers, community-led monitoring, e.g., Community, Rights, Gender (CRG) assessment performed and informing TB programming (Y/N) TB programming is human rights-based (Y/N)	CRG assessment report Breaking Down Barriers Assessments Rapid assessments of information on human rights-related barriers to TB services Gender assessments TB patient cost survey report

	TB program is gender-responsive (Y/N)
	TB stigma assessment conducted (Y/N)
	TB program is informed by and responds to analysis of inequities (Y/N)
	TB program includes adequate stigma and discrimination activities for people with TB and TB-affected populations (Y/N)
	TB program includes legal literacy and access to justice activities (Y/N)
	TB programming includes support for community mobilization and advocacy and community-led monitoring for social accountability. (Y/N)

The results of the assessment will also be used to complete the Essential Data Table (EDT) that has to be submitted as part of the Global Fund funding request. Below is a sample EDT.

Table 2. Completed Essential Data Table

Key Area	Are all policies and guidelines in place to fully operationalize the Program Essential?	Status of implementation
TB screening and diagnosis		
Systematic TB screening is provided for those at highest risk (key and vulnerable populations), including using chest X-rays with or without computer-aided detection (currently recommended for people 15 years and older).	Yes	Implemented in some sites (<50%)
Multiyear plan to achieve universal use of rapid molecular assays as the initial test to diagnose TB for all people with presumptive TB, with implementation on track.	Yes	Implemented in some sites (<50%)
All people with bacteriologically confirmed TB are tested for at least RR and for those with RR-TB further tests are conducted to rule out resistance to other drugs.	Yes	Implemented in many sites (50%-05%)
TB diagnostic network operates efficiently to increase access to testing and includes specimen transportation, maintenance of equipment, connectivity solutions, biosafety, quality assurance and supply system	Yes	Implemented in some sites (<50%)
TB treatment and care		
Child-friendly formulations, all-oral regimens for DR-TB, and 4-month regimen for non-severe, DS-TB are used for TB treatment in children.	Yes	Implemented country-wide (>95%)
People with DR-TB receive shorter, all-oral regimens or individualized, longer treatment regimens as recommended by WHO and people-centered support to complete their treatment.	Yes	Implemented country-wide (>95%)
TB prevention		
TPT (including shorter regimens) is available for all eligible people living with HIV (adults and children) and for all eligible household contacts of people with bacteriologically confirmed pulmonary TB.	Yes	Implemented in some sites (<50%)

TB/HIV collaborative activities		
All people living with HIV with active TB are started on ARV treatment early as per recommendations.	Yes	Implemented country-wide (>95%)
Cross-cutting areas		
Establish, progressively scale-up, and maintain a comprehensive, real-time, digital case-based TB surveillance systems and ensure analysis and use of TB data for decision-making at all levels of TB services.	Yes	Implemented in some sites (<50%)
Prioritized interventions are informed by cascade analysis throughout the pathway of TB care, including for TPT	Yes	Implemented in many sites (50%-95%)
Engagement of private health care providers is on a scale commensurate with their role in the provision of TB services.	Yes	Implemented in some sites (<50%)
Decentralized, ambulatory, community- and home-based, people-centered services are provided across the continuum of TB care.	Yes	Implemented in many sites (50%-95%)
All TB programming must be human rights-based, gender-responsive and informed by and respond to analysis of inequities; and include stigma and discrimination reduction activities for people with TB and TB-affected populations; legal literacy and access to justice activities; as well as support for community mobilization and advocacy and community-led monitoring for social accountability.	Yes	Implemented in many sites (50%-95%)

3. Stakeholder Consultations

Stakeholder consultations on the TB Program Essentials can ideally be completed during a single dedicated workshop. TB stakeholder engagement can take place either within existing in-country technical working groups or as part of a separate gathering of stakeholders, depending on context. If it is not possible to organize a TB stakeholder consultation prior to the country dialogue, it can be included in that process, providing that a dedicated time is allotted for the Program Essentials exercise.

It is recommended that 1–2 days be allotted for the stakeholder consultation, with the following objectives that will feed into subsequent prioritization discussions during country dialogue:

- Introduce TB Program Essentials to in-country stakeholders
- Discuss the findings from the country's baseline assessment of the TB Program Essentials, with a view of obtaining additional input
- Share perspectives from partners and stakeholders on how to catalyze action on TB Program Essentials
- Identify information gaps which need to be addressed before the next funding cycle
- Set targets for each of the TB Program Essentials for the upcoming cycle.

Given the complex nature of the discussions, in-person participation is highly recommended. Participants should include at a minimum: Ministry of Health/national TB program staff (including some or all of the following: manager, TB screening, TB/HIV, childhood TB, multidrug-resistant TB (MDR-TB), Global Fund advisor, multisectoral accountability framework (MAF), M&E, the focal point for public-private mix, etc.), selected Country Coordinating Mechanism (CCM) members, funding and technical support agencies/partners: the United States Agency for International Development (USAID), the Centers for Disease Control (CDC), WHO, Clinton Health Access Initiative (CHAI), AIDS Commission, Stop TB Partnership, TB implementing partners, TB survivors and civil society.

Annex 2 presents a sample workshop agenda that can be adapted to local needs. To efficiently address the aforementioned objectives, workshop organizers are encouraged to create separate working groups that each focus on one of the five distinct categories of TB Program Essentials:

1. Screening and prevention
2. TB diagnosis
3. TB treatment and care + TB/HIV
4. Cross-cutting: digital and private sector + cascade analysis,
5. Cross-cutting: human rights, gender equality and equity; and decentralized, community- and home-based care.

Each working group should have participants with specific content expertise on the topic being discussed. If feasible, participants should receive the baseline assessment and the questions to guide the discussion prior to the workshop, with sufficient time to review.

Each group should think critically about how to approach the Program Essentials in their specific category. The following questions can be used to guide the discussion:

1. Given the current status (baseline assessment, national/international target), how would the country like to introduce/scale up in the next three years to reach the WHO/internationally recommended target for each of the Program Essentials?

2. Discuss the bottlenecks hindering the implementation/progressive scale-up and how to overcome them in the next funding cycle.

3. Based on the above, what are some of the gaps/analyses/technical assistance requests that would need to be undertaken ahead of the funding request development process?

4. How will the country ensure Program Essentials are equitably implemented to all relevant populations throughout the country?

5. How would the country incorporate the Program Essential into routine activities (e.g., in supervision, training, registers, standard operating procedures, updating guidelines?)

6. How can partners and other stakeholders support the implementation of the Program Essentials?

7. How will the TB Program Essentials be monitored?

Once discussions have taken place, each group should present their findings to the broader workshop and plenary discussions should follow. All information should be collated and used as an input to the country dialogue process.

4. Analysis and Synthesis of Results

Following completion of the baseline assessment, a completed EDT should be ready to submit as part of the country's funding request. This data, together with the input received in the stakeholder consultation, will enable the country to develop and complete a dashboard that clearly shows the baseline and targets for the upcoming funding cycle (Table 3).

Table 3. Sample TB Program Essentials Dashboard

Key Area	Indicator	Baseline	2023	2024	2025
TB screening and diagnosis					
Systematic TB screening is provided for those at highest risk (key and vulnerable populations), including using chest X-rays with or without computer-aided detection (currently recommended for people aged 15 years and older).	% health facility attendees screened for TB (OPD) = 59% **Numerator:** Number screened for TB=31,803,510 **Denominator:** Total OPD attendance = 53,936,660	59	75	90	90
Multiyear plan to achieve universal use of rapid molecular assays as the initial test to diagnose TB for all people with presumptive TB, with implementation on track.	% total new and relapse TB cases tested with rapid diagnostics at time of diagnosis = 69% **Numerator:** Number tested using GeneXpert= 51,611 **Denominator:** Total TB cases notified = 74,799	69	90	90	90
All people with bacteriologically confirmed TB are tested for at least RR and for those with RR-TB further tests are conducted to rule out resistance to other drugs.	A) % bacteriologically confirmed TB cases tested for rifampicin resistance = 75% **Numerator:** Total bacteriologically positive TB cases tested for RR = 31,416 **Denominator:** Total bacteriologically positive TB cases = 41,887 B) % RR-TB cases further tested to rule out resistance to other drugs = 65% **Numerator:** Total with RR-TB who got further	75	80	85	90

	tests to rule out resistance to other drugs = 377 **Denominator:** Total TB cases with RR-TB = 508				
TB diagnostic network operates efficiently to increase access to testing and includes specimen transportation, maintenance of equipment, connectivity solutions, biosafety, quality assurance and supply system	Diagnostic coverage 58% Equipment, supplies 48% Biosafety 44% Quality Assurance 49% Workforce 60%	58	80	85	90
TB treatment and care					
Child-friendly formulations, all-oral regimens for DR-TB, and 4-month regimen for non-severe, DS-TB are used for TB treatment in children.	Availability of required child formulations/ regimens at health facilities = 100%	100	100	100	100
People with DR-TB receive shorter, all-oral regimens or individualized longer treatment regimens as recommended by WHO and people-centered support to complete their treatment.	Availability of required DR-TB formulations/ regimens at health facilities = 100%	100	100	100	100
TB prevention					
TPT (including shorter regimens) is available for all eligible PLHIV (adults and children) and for all eligible household contacts of people with bacteriologically confirmed pulmonary TB.	A) % PLHIV in care provided TPT= 85% **Numerator:** Total number of PLHIV in care provided TPT = 1,190,000 **Denominator:** Total number of PLHIV in care: 1,400,000 B) Eligible household contacts <5 of people with bacteriologically confirmed pulmonary TB	56	74	82	90

	who received TB preventive treatment = 45 %. C) Eligible household contacts <5 of people with bacteriologically confirmed pulmonary TB who received TB preventive treatment = 38%.				
TB/HIV collaborative activities					
All people living with HIV with active TB are started on ART early as per recommendations.	97% **Numerator:** Total TB/HIV co-infected patients initiated on TB and ART co-treatment = 22,963 **Denominator:** Total number of patients with HIV/TB co-infection: 23,661	97	100	100	100
Cross-cutting areas					
Establish, progressively scale-up and maintain a comprehensive, real-time, digital case-based TB surveillance systems and ensure analysis and use of TB data for decision-making at all levels of TB services.	24% **Numerator:** Total number of TB diagnostic and treatment units with DHIS2 installed = 400 **Denominator:** Total number of TB diagnostic and treatment units across the country = 1,700	24	60	90	90
Prioritized interventions are informed by cascade analysis throughout the pathway of TB care, including for TB preventive treatment	TB care cascade analysis performed in the past three years. Interventions informed by cascade analysis	100	100	100	100

Engagement of private health care providers is on a scale commensurate with their role in the provision of TB services.	22% **Numerator:** Total notified TB patients reported from the private sector = 16,156 **Denominator:** Total notified TB cases = 74,799	22	35	35	35
Decentralized, ambulatory, community- and home-based, people-centered services are provided across the continuum of TB care.	95% % TB patients that receive TB care via decentralized, ambulatory, community- and home-based approach	95	95	95	95
All TB programming must be human rights-based, gender-responsive and informed by and respond to analysis of inequities; and include stigma and discrimination reduction activities for people with TB and TB-affected populations; legal literacy and access to justice activities; as well as support for community mobilization and advocacy and community-led monitoring for social accountability.	CRG Assessment performed (Y/N) Yes TB programming is human-rights based [Human Rights Assessment performed in last three years] (Y/N) Yes TB program is gender-responsive (Y/N) yes TB stigma assessment conducted (Y/N) No TB program responsive to analysis of inequities [e.g., Access to support services] (Y/N) Yes Activities to reduce TB stigma and discrimination conducted (Y/N) No Community-led monitoring for accountability in place (Y/N) yes	100	100	100	100

4.1 Monitoring of TB Program Essentials

While the Program Essentials will be critical during country dialogue and funding request preparation, the dashboard and EDT can provide an important baseline to track progress of implementation of the Program Essentials. The Program Essentials can be embedded into regular TB program activities such as program reviews, supervision, training tools, M&E. Progress in implementation can be monitored on an annual basis or more frequently, depending on need.

Abbreviations and Acronyms

ART	Antiretroviral therapy (for HIV)
BMU	Basic management unit
CDC	Centers for Disease Control (U.S.)
CHAI	Clinton Health Access Initiative
CCM	Country Coordinating Mechanism
CRG	Community, rights, gender
DS-TB	Drug-sensitive TB
EDT	Essential Data Table
GC7	Grant Cycle 7 (2023-2025 funding cycle)
HMIS	Health management information system
M&E	Monitoring and evaluation
MAF	Multisectoral accountability framework
MDR-TB	Multidrug-resistant TB
NTRL	National tuberculosis reference laboratory
OPD	Outpatient department
PLHIV	People living with HIV/AIDS
PMDT	Programmatic management of drug-resistant tuberculosis
RBM	Roll Back Malaria
RR-TB	Rifampicin-resistant tuberculosis
TB	tuberculosis
TPT	Tuberculosis preventive treatment
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
WHO	World Health Organization

Annex 1 – Sample Terms of Reference for Consultancy

This is sample terms of reference as used by the Global Fund and is only meant to serve as an example, to be adapted by the country and the funding party.

Title	Early engagement of countries for successful implementation of TB Program Essentials
Introduction	A baseline assessment followed by stakeholder workshops to discuss the operationalization of Program Essentials in the context of XXXX, to be conducted in XXXXXX. Gaps in successful implementation of Program Essentials will be discussed and recommendations for improvement before country dialogue for GC7 will be identified.
Background	Program Essentials are key evidence-based interventions and approaches which are critical to enable TB programs to expand and scale up the latest recommendations to reach End TB goals. Program Essentials are being introduced for the first time as part of the new Global Fund Strategy 2023-2028 and will be implemented in the upcoming 2023-2025 grant cycle. They represent a summary which best aligns with the key priority interventions of the Global Fund and are considered critical to accelerate the TB response to meet countries and global TB targets. Program Essentials are aligned with technical recommendations from WHO, Stop TB, the Global Fund Technical Review Panel and other partners and have been discussed with all stakeholders. Applicants to the Global Fund are expected to implement Program Essentials throughout the grant cycle: during country dialogue, funding request development, grant-making, implementation and performance monitoring
Scope / Objective	The overall objective is to establish a baseline for the Program Essentials and to identify the best country-level engagement for successful operationalization of the Program Essentials.

Tasks

Task	Task activity description
1-Baseline assessment of Program Essential for XXXXX	Gather the information available regarding the implementation of Program Essentials in XXXX and create a baseline assessment Program Essential country profile (EDT table completed) for XXXXX.
2- Identify best approaches/methods for successful operationalization of the Program Essentials 3- Identify potential country-level bottlenecks in operationalization of Program Essentials and provide recommendations on how to address them.	Engage TB stakeholders and gather their opinions, expectations and recommendations, identify approaches/methods for successful operationalization of the Program Essentials and identify potential country-level bottlenecks in operationalization of Program Essentials and provide recommendations on how to address them. A two-day workshop with participants from the following stakeholders will be conducted: National TB program manager and other key staff • Members of the CCM • Principal Recipients of Global Fund grants • USAID • CDC • Implementing partners • WHO • Civil society organizations working in TB Points that should be discussed (but are not restricted): 1. Discuss the bottlenecks hindering the scale-up and how to overcome them in the next funding cycle. 2. Based on the above, what are some of the gaps/analyses/technical assistance needs to

		be undertaken ahead of the funding request development? 3. How will the country ensure Program Essentials are equitably implemented for all relevant populations throughout the country? 4. How would the country incorporate the Program Essential into routine activities (e.g., in supervision, training, registers, SOPs, updating guidelines?) 5. How can partners and other stakeholders support the implementation of the Program Essentials? 6. How are you planning to monitor the TB Program Essentials? Recommendations for improvement for successful implementation of Program Essentials for XXXX in GC7
	Stakeholders meeting	Facilitation of workshop with relevant stakeholders to review the findings and recommendations.

Deliverables

1. Baseline assessment (Program Essential country profile, EDT table completed) for XXXX

2. Report on best approaches/methods for the operationalization of Program Essentials (throughout the cycle) and list of potential operationalization bottlenecks and how to resolve them (both in Word and in PowerPoint).

3. Recommendations on area of improvements for XXXX to prepare for GC7

4. Dashboard with targets for the upcoming funding cycle

Experience

- Master's in Public Health or related area

Skills

- Relevant experience in monitoring and evaluation
- Minimum 10 years' experience in implementation of TB projects.
- Excellent competence in the elaboration of critical analysis. identification of solutions and preparation of reports in English/Spanish/French (country language).

	• Experience in the region and work with national TB programs and other stakeholders. • Knowledge of the latest WHO TB guidance, Global Fund Information Note, Technical brief on reducing human rights-related barriers to TB services; and “Undertaking a Rapid assessment of information on human rights-related barriers to HIV and TB services. Guidance and tools. • Communication skills, with strong experience in facilitating workshops.
Place of Performance	XXXX.
Period of Performance	10 days (Can be changed depending on the data collection needs)

Annex 2 – Sample Workshop Agenda

The following outlines what a stakeholder consultation workshop could look like. Feel free to adapt to the country and funding party's needs.

Day 1		
Time	**Item**	**Responsible party**
09:00 am – 09:10 am	Welcome	MoH/National TB Program
09:10 am – 09:20 am	Introduction of participants	XXXXX
09:20 am – 09:30 am	Objectives of the workshop	Consultants
09:30 am – 09:50 am	Role of Program Essentials Why Program Essentials?	Global Fund or consultant.
09:50 am – 10:10 am	Questions	
10:10 am – 10:55 am	Findings on the baseline assessments (gaps)	Consultants
10:55 am – 11:30 am Break		
11:30 am – 12:00 pm	Discussion on the findings of the baseline assessments	ALL
12:00 pm – 13:30 pm	Gaps in successful implementation of the Program Essentials	
13:30 pm – 14: 30 pm Lunch		
14:30 pm – 17:00 pm	Group work on the gaps for the implementation of Program Essentials and possible mitigation plans	
Day 2		
09:00 am – 10:15 am	Continuation of group work	
10:15 am – 10:45 am Break		
10:30 am – 13:00	Group presentations	
13:00 pm – 14: 00 pm Lunch		
14:00 am – 15:00 pm	Group presentations	
15:00 pm – 16 :30 pm	Next steps for grant implementation	
16: 30 pm	Closure	

Annex 3 – Slides

Global Fund Program Essentials

Guidance for Allocation Period 2023-2025 (Grant Cycle 7)

Structure of this document

What are Program Essentials?

How will Program Essentials be used throughout the grant life-cycle?

FAQs

Additional opportunities to learn about Program Essentials

Introduction to Program Essentials

What are they?	How were they selected?
Program Essentials are **key evidence-based interventions and approaches** to address the ambitious goals set out in **the HIV, TB, and Malaria global strategies.** When part of national programs, **Program Essentials will support countries to achieve their national targets.** They can be funded by either The Global Fund or other sources.	Elements **recommended by technical partners** (WHO, UNAIDS, Stop TB, RBM) and further described in their respective technical guidelines **Critical interventions needed to achieve outcomes and impact** set out in global strategies (WHO, UNAIDS, Stop TB, RBM and the Global Fund) **Crucial to ensure equity in access** to highly impactful interventions

Structure of this document

What are Program Essentials?

How will Program Essentials be used throughout the grant life-cycle?

FAQs

Additional opportunities to learn about Program Essentials

How Will Program Essentials Be Used in Grant Cycle 7?

Overall objective

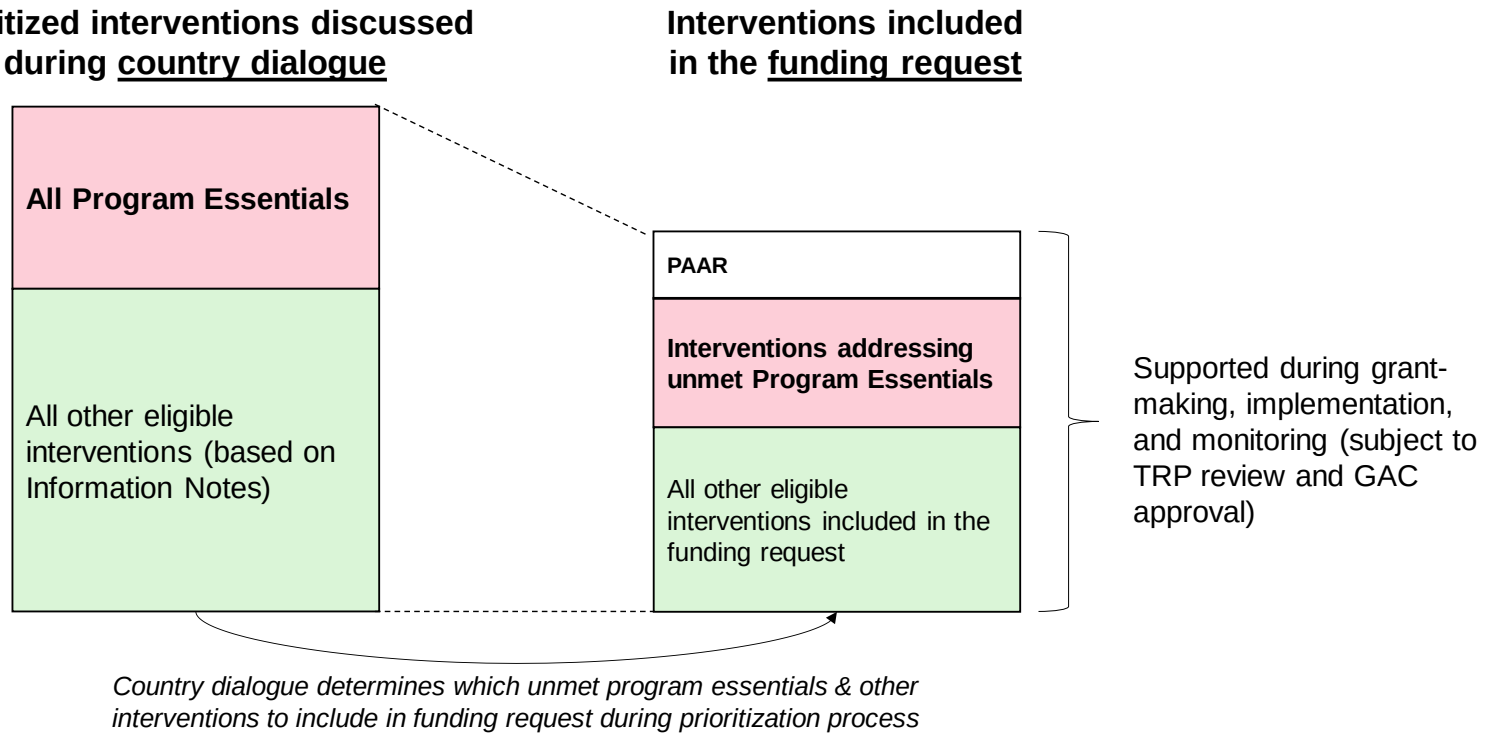
To achieve global goals for HIV, TB and malaria using the Global Fund strategy and its **Program Essentials as enablers**, whether through Global Fund grants or other means

How will Program Essentials be used to meet this objective in the new funding period?

1. Countries will be asked to **outline their "level of advancement"** toward achieving the Program Essentials and identify any gaps (see Essential Data Table).
2. Countries will **determine which actions to address unmet Program Essentials** should be included in their funding request, guided by country and disease context.
3. Where countries have **prioritized the introduction and acceleration of Program Essentials in funding requests**, the Global Fund – subject to TRP / GAC review – will support countries in achieving and sustaining them.
4. The Global Fund **will assess progress against the Program Essentials** through existing indicators (as relevant) and monitoring processes.

Illustrative

Program Essentials should be incorporated in the routine country dialogue / prioritization process



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Program Essentials will play a critical role in the grant life-cycle, vary by country and disease

Grant life-cycle	Steps to address Program Essentials	Applicable countries
Country dialogue	Program Essentials offer a platform for discussion among key country stakeholders; applicants actively review them during country dialogue, assess country progress against them, and identify implications for their programs	All countries
Funding request	Applicants outline their level of advancement in achieving the Program Essentials in either the Essential Data Tables (HIV & TB) or the funding request narrative (Malaria)	All countries
	Applicants incorporate actions to address unmet Program Essentials in their funding request (or PAAR), where identified through the country dialogue & the country's prioritization process	All countries
	Applicants describe any plans to address Program Essentials that are not considered addressed in the funding request narrative	HI & Core only
	As a part of their review, the TRP will consider an applicant's level of advancement toward fulfilling Program Essentials	All countries
Grant-making	Where grants fund interventions to address the Program Essentials, PRs embed them into the relevant grant-making documents (i.e., detailed budget, performance framework, implementation mapping)	All countries
	GAC reviews incorporation of Program Essentials in the grant-making documents	All countries
Implementation and tracking	Where interventions are included in the grants that address Program Essentials, their progress will be reviewed via relevant indicators in the portfolio review process, and routine portfolio update	All countries

Example: countries to complete Program Essentials fields in the HIV and TB Essential Data Tables

HIV program essentials key area	Are all policies and guidelines in place to fully operationalize the program essential? *(choose an option from drop-down list)*	Implementation Status *(choose an option from drop-down list)*
HIV primary prevention		
1. Condoms and lubricants are available for all people at increased risk of HIV infection.	Yes	Implemented in many sites (50%-95%)
2. Pre-exposure prophylaxis (PrEP) is available to all people at increased risk of HIV infection, and post-exposure prophylaxis (PEP) is available for those eligible.	No	Implementation not started
3. Harm reduction services are available for people who use drugs.	Yes	Implemented in some sites (<50%)
4. Voluntary medical male circumcision (VMMC) is available for adolescent boys (15+ years) and men in high HIV incidence settings.	No	N/A (not a high incidence setting)

Illustrative example shown above – countries can leverage this information to assess current advancement towards Program Essentials and facilitate discussions during country dialogue on meeting the Program Essentials

Note: for HIV / TB only, <u>not</u> Malaria

Structure of this document

What are Program Essentials?

How will Program Essentials be used throughout the grant life-cycle?

FAQs

Additional opportunities to learn about Program Essentials

Frequently asked questions on Program Essentials

Must countries use Global Fund grants to address or make progress towards achieving Program Essentials?

No. Actions targeted at the Program Essentials could also be directly funded by the country's national disease programs or by other partners / entities. The decision on whether Program Essentials will be included in Global Fund Funding Request should be made during the prioritization process (refer to HIV, TB, Malaria and RSSH Information notes for the respective lists of prioritized interventions).

What happens if a country's disease program does not fulfill the Program Essentials?

Program Essentials offer a platform for discussion with national programs and other country stakeholders on critical elements recommended by technical partners. While some of the Program Essentials may not be addressed initially, applicants are expected to make progress toward fulfilling them over time. As a part of their review, the TRP will consider an applicant's level of advancement toward fulfilling Program Essentials.

How should countries use Program Essentials during country dialogue?

Countries will review the Program Essentials and assess their level of advancement toward each of them. This is an opportunity for country stakeholders, including technical partners, to review country policies and the need to further align them with global technical recommendations. During the prioritization process, countries should consider including actions in their funding request to address any unmet Program Essentials, guided by their particular country and disease context.

Will progress against Program Essentials be tracked throughout the grant life-cycle?

Where interventions are included in the grants that address Program Essentials, their progress will be reviewed via relevant indicators in the portfolio review process, and routine portfolio update

Are there also Program Essentials for RSSH?

No. In view of the differing challenges and priorities for The Global Fund's RSSH investments, the RSSH team has developed a set of 'Critical Approaches' that are conceptually and operationally distinct from Program Essentials. More information about 'Critical Approaches' can be found in the RSSH Information Note.

Structure of this document

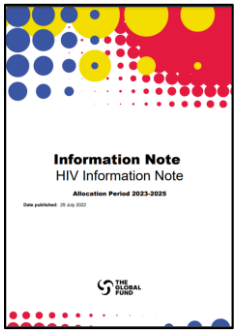
What are Program Essentials?

How will Program Essentials be used throughout the grant life-cycle?

FAQs

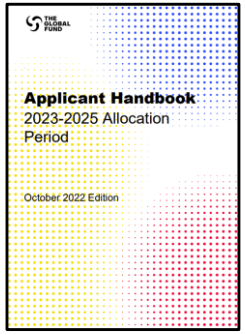
Additional opportunities to learn about Program Essentials

Relevant resources for Program Essentials

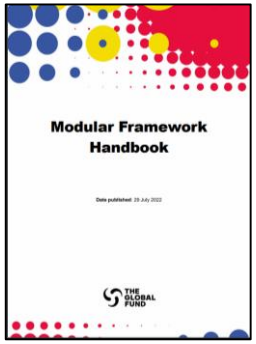


Information notes
List of Program Essentials and more detailed expectations by disease area

HIV / TB / Malaria



Applicant handbook
Explains the key steps in the funding request process where Program Essentials must be considered



Modular framework
Details the list of interventions and indicators that may be used to address and track Program Essentials

Link

Information sessions
Secretariat will cover Program Essentials in a webinar on the changes to the Information Notes

November 24

Translations are in process for all Global Fund materials.

Appendix: HIV, TB, and Malaria Program Essentials

HIV Program Essentials (I/II)

Note that all programming must be human rights-based, gender-responsive and informed by and respond to an analysis of inequities

HIV primary prevention	1. Condoms and lubricants are available for all people at increased risk of HIV infection 2. Pre-exposure prophylaxis (PrEP) is available to all people at increased risk of HIV infection, and post-exposure prophylaxis (PEP) is available for those eligible. 3. Harm reduction services are available for people who use drugs 4. Voluntary medical male circumcision (VMMC) is available for adolescent boys (15+ years) and men in WHO/UNAIDS VMMC priority countries
HIV testing & diagnosis	5. HIV testing services include HIV self-testing, safe ethical index testing and social network-based testing 6. A three-test algorithm is followed for rapid diagnostic test-based diagnosis of HIV 7. Rapid diagnostic tests are conducted by trained and supervised lay providers in addition to health professionals
Elimination of vertical transmission	8. Antiretroviral treatment (ART) is available for pregnant and breastfeeding women living with HIV to ensure viral suppression 9. HIV testing including early infant diagnosis (EID) is available for all HIV-exposed infants
HIV treatment & care	10. Rapid ART initiation follows a confirmed HIV diagnosis for all people irrespective of age, sex or gender 11. HIV treatment uses WHO-recommended regimens 12. Management of advanced HIV disease is available 13. Support is available to retain people across the treatment cascade including return to care 14. CD4 and viral load testing, and diagnosis of common comorbidity and coinfections are available for management of HIV

HIV Program Essentials (II/II)

TB/HIV	15. People living with HIV with active tuberculosis (TB) are started on ART early 16. TB preventive therapy is available for all eligible people living with HIV including children and adolescents
Differentiated service delivery (DSD)	17. HIV services (prevention, testing, treatment and care) are available in health facilities, including sexual and reproductive health services, and outside health facilities including through community, outreach, pharmacy and digital platforms 18. Multi-month dispensing is available for ART and other HIV commodities
Human Rights	19. HIV programs for key and vulnerable populations integrate interventions to reduce human rights- and gender-related barriers. 20. Stigma and discrimination reduction activities for people living with HIV and key populations are undertaken in health care and other settings. 21. Legal literacy and access to justice activities are accessible to people living with HIV and key populations. 22. Support is provided to efforts, including community-led efforts, to analyze and reform criminal and other harmful laws, policies and practices that hinder effective HIV responses.

TB Program Essentials (I/II)

1. TB Screening and Diagnosis	1.1 Systematic TB screening is provided for those at highest risk (key and vulnerable population), including through the use of Chest X-rays, with or without computer aided detection (currently recommended for people aged 15 years and older). 1.2 Multiyear plan to achieve universal use of rapid molecular assays as the initial test to diagnose TB for all people with presumptive TB, with implementation on track. 1.3 All people with bacteriologically confirmed TB are tested for at least rifampicin resistance and for those with RR-TB further tests are conducted to rule out resistance to other drugs. 1.4 TB diagnostic network operates efficiently to increase access to testing and includes specimen transportation, maintenance of equipment, connectivity solutions, biosafety, quality assurance and supply system.
2. TB Treatment and Care	2.1 Child friendly formulations, all oral regimens for DR-TB, and 4-month regimen for non-severe, DS- TB are used for TB treatment in children. 2.2 People with DR-TB receive shorter, all oral regimens or individualized longer treatment regimens as recommended by WHO.
3. TB Prevention	3.1 TB preventive treatment (including shorter regimens) is available for all eligible PLHIV (adults and children) and for all eligible household contacts of people with bacteriologically confirmed pulmonary TB.

TB Program Essentials (II/II)

4. TB/HIV	4.1 All people living with HIV with active TB are started on ARV treatment early as per recommendations.
5. Cross-cutting Areas	5.1 Establish, progressively scale-up and maintain a comprehensive, real-time, digital case-based TB surveillance systems. 5.2 Prioritized interventions are informed by cascade analysis throughout the pathway of TB care, including for TB preventive treatment. 5.3 Engagement of private healthcare providers is on a scale commensurate with their role in the healthcare system. 5.4 Decentralized, ambulatory, community- and home-based, people-centered services are provided across the continuum of TB care 5.5 All TB programming must be human rights-based, gender-responsive and informed by and respond to analysis of inequities; and include stigma and discrimination reduction activities for people with TB and TB-affected populations; legal literacy and access to justice activities; as well as support for community mobilization and advocacy and community-led monitoring for social accountability.

Malaria Program Essentials (I/II)

Objective	Program Essentials
(a) Implement malaria interventions, tailored to sub-national level using granular data and capacitating decision-making and action.	•Support in-country capacity for sub-national tailoring and evidence-based prioritization of tailored malaria interventions. •Build capacity for quality data generation, analysis & use at national and sub-national levels. •Ensure sub-nationally tailored planning considers factors beyond malaria epidemiology such as health systems, access to services, equity, human rights, gender equality (EHRGE), cultural, geographic, climatic, etc. •Ensure quality of all commodities and monitor effectiveness. •Deliver all interventions in a timely, people-centered manner[3].
(b) Ensure optimal vector control coverage.	•Promote evidence-based prioritization for product selection, implementation modality and timing, and frequency of delivery with a focus on ensuring sustained high coverage among the highest risk populations. •Expand entomological surveillance. •Address barriers hampering the rapid scale-up of new products. •Evolve indicators to improve the tracking of effective vector control coverage.

Malaria Program Essentials (II/II)

Objective	Program Essentials
(c) Expand equitable access to quality, early diagnosis, and treatment of malaria through health facilities, at the public sector and community level, and in the private sector.	•Understand and address key barriers to access. •Engage private sector providers to drive parasitological testing before treatment. •Expand community platforms where access is low. •Improve and evolve surveillance and data collection tools and processes to enable continuous quality improvement (CQI) and accurate surveillance. •Use of quality of care (QoC) stratification to tailor support to case management across sectors. •Strengthening coordination and linkages between public, private and community systems for service provision.
(d) Optimize chemoprevention.	•Support data driven intervention selection and implementation modality. •Support flexibility on implementation strategies including integration within primary healthcare (PHC) as relevant.
(e) Drive toward elimination and facilitate prevention of re-establishment.	•Enhance and optimize vector control and case management. •Increase the sensitivity and specificity of surveillance. •Accelerate transmission reduction.