Strategic Recommendations for EECA Countries:

High-Impact Interventions for GC8 Funding Requests

Alliance for Public Health

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This document was developed by Alliance for Public Health and provides EECA Country Coordinating Mechanisms (CCMs) with a set of practical, ready-to-use interventions that can be incorporated directly into Global Fund Funding Requests for Grant Cycle 8 (GC8). The recommendations are intentionally aligned with the GC8 strategic shifts – including a stronger focus on people-centered services, community leadership, digital transformation, and sustainable systems for health – to help CCMs prepare proposals that are both technically sound and strategically competitive.

GC8 places particular emphasis on:

- Integrated, person-centered prevention and care models, especially for key and vulnerable populations.
- Digital and data systems that improve program quality, efficiency, and accountability.
- Community-led monitoring and human rights interventions that address structural barriers to access.
- Sustainable financing and transition-ready systems, including domestic resource mobilization.
- Differentiated and innovative service delivery, such as telehealth and long-acting PrEP.

The interventions included in this document directly support these shifts. They reflect proven, scalable models already implemented across EECA countries and address persistent regional challenges, including fragmented data systems, limited reach of key population programs, low PrEP retention, underfunded human rights responses, and insufficient domestic financing mechanisms.

Each component is presented in a standardized, CCM-friendly format – problem statement, intervention description, expected results, and indicative budget – allowing CCMs to quickly assess relevance, feasibility, and value for money. The interventions can be incorporated into HIV, TB, RSSH, CRG, or prevention modules and adapted to national priorities and epidemiological contexts.

For CCMs, this document serves three strategic functions:

1. **Ensuring alignment with GC8 priorities**
   Each recommended intervention directly advances one or more GC8 strategic shifts, helping CCMs build proposals that respond to the Global Fund's updated expectations and investment logic.
2. **Strengthening evidence-based decision-making**
   The interventions are grounded in regional experience and demonstrate measurable impact, enabling CCMs to prioritize components that address real programmatic gaps.
3. **Supporting inclusive and transparent CCM deliberations**
   The standardized format allows government, civil society, and key population representatives to evaluate options on equal footing and make informed decisions about what to include in the Funding Request.

CCMs may select individual interventions or combine several into an integrated package. All components are modular, scalable, and adaptable, and can be implemented with varying levels of investment.

By using this document, EECA CCMs can ensure that their GC8 Funding Requests are strategically aligned, impactful, and fully responsive to the Global Fund's new strategic direction, while addressing the unique needs and challenges of the region.

The following interventions are suggested to be included in GC8 applications:

1. Budget Advocacy and Social Contracting for Sustainable HIV Financing
2. DHIS2-based National HIV Prevention, Care and Support Information System
3. Overcoming human rights barriers to accessing services through systematic monitoring and response – REAct (Rights – Evidence – Action)
4. PrEP: Introduction of Lweong-Acting (Lenacapavir and Upcoming Long-Acting Oral Agents (the pill, named MK 8527, Merck), and telePrEP
5. LADB: Long-Acting Depot Buprenorphine as an Opioid Agonist Therapy Option for People Who Inject Drugs
6. TWIIN – AI-based Digital Assistant for Service Access and Referrals

Intervention detailed outlines are provided below.

For more information on any of the listed solutions contact iSoS Project: filippovych@aph.org.ua

1. Budget Advocacy and Social Contracting for Sustainable HIV Financing

Module RSSH: **Health Financing Systems**

Intervention: **Social contracting**

PROBLEM STATEMENT / JUSTIFICATION

Across low- and middle-income countries, HIV responses are undergoing a structural transition due to the gradual decline of external donor funding. This shift requires governments to increasingly finance HIV prevention, treatment, and care services through domestic resources. However, in many settings, public financing mechanisms remain underdeveloped, fragmented, or not fully accessible for civil society organizations delivering essential services to key populations.

As a result, there is a risk of service disruption, particularly for community-based and prevention services that are often not fully integrated into national health financing systems. Strengthening domestic financing and institutionalizing social contracting mechanisms is therefore critical to ensure sustainability, continuity, and alignment of HIV responses with national priorities.

> Transition must be smart. CSO and communities are the only channels to reach to the hardest-to-reach. Social contracting is the way to ensure government reaches to most vulnerable groups and takes over control of the epidemics

INTERVENTION

The intervention focuses on providing targeted technical assistance and policy support to governments and key stakeholders to strengthen domestic financing mechanisms for HIV services, including the introduction and scaling of social contracting.

Key areas of support include:

- Development and refinement of service delivery standards and costing methodologies (tariffs);
- Legal and regulatory support to enable public procurement and contracting of civil society providers;
- Budget advocacy and facilitation of multi-stakeholder dialogue between ministries, public institutions, and civil society;
- Capacity building for government and non-government actors to design, implement, and manage social contracting mechanisms;
- Analytical support to improve alignment between national HIV strategies and budget allocations.

This approach ensures that HIV services, particularly for key populations, are progressively integrated into national financing systems and supported through sustainable public funding.

EXPECTED RESULTS

Implementation of this intervention is expected to result in:

- Improved legal and regulatory frameworks enabling social contracting and public financing of HIV services;
- Introduction or strengthening of standardized service packages, including approved costing and tariff structures;
- Increased allocation of domestic funding for HIV prevention and key population programmes;
- Enhanced capacity of governments and civil society organizations to manage and implement contracting mechanisms;
- Strengthened coordination and dialogue between key stakeholders, leading to more transparent and efficient use of public resources;
- Improved sustainability and continuity of HIV services, with reduced reliance on external donor funding.

INDICATIVE BUDGET

This intervention represents a cost-effective investment in strengthening national health financing systems and ensuring the sustainability of HIV responses through increased domestic resource mobilization and efficient allocation.

The estimated indicative budget is approximately **150,000 USD**, depending on country context and scope of engagement.

Typical costs include:

- **Technical expertise and consultancy ~60,000 USD /one time (3.0 External professional services (EPS))**
  Development of service standards and tariffs, legal and regulatory support, costing methodologies, and policy analysis;
- **Advocacy and stakeholder engagement ~ 30,000 USD /one time (3.0 External professional services (EPS))**
  Ongoing budget advocacy efforts, coordination with ministries and national stakeholders, facilitation of policy dialogue;
- **Capacity building and trainings ~ 25,000 USD /one time (2.0 Travel-related costs (TRC))**
  Workshops, training sessions, and technical support for government and civil society actors;
- **International and national expert missions ~ 20,000 USD /one time (2.0 Travel-related costs (TRC))**
  In-country visits, technical missions, and peer exchange support;
- **Monitoring, analysis, and reporting ~ 10,000 USD /one time (3.0 External professional services (EPS))**
  Budget tracking, data analysis, and documentation of results;
  Administrative and coordination costs ~ 5,000 USD /year (11.0 Indirect and overhead costs/ 1.0 Human resources)

This streamlined investment allows for targeted, high-impact support to governments, enabling sustainable transition from donor-funded HIV programmes to domestically financed systems.

2. DHIS2-based National HIV Prevention, Care and Support Information System

Module RSSH: **Monitoring and Evaluation Systems**

Intervention: **Routine reporting & Administrative data sources**

PROBLEM STATEMENT / JUSTIFICATION

Many programs rely on fragmented systems (paper, Excel, parallel databases), leading to duplicated reporting, inconsistent data, and limited ability to track client pathways or program performance. Data is often collected but not effectively used, reducing its value for planning and decision-making.

This results in increased workload for staff, reduced data quality, and limited ability to respond quickly to program gaps. A unified system is needed to ensure data consistency, integration across actors, and real-time visibility of program performance.

> Digitalization is the key to integration, agility and relevance. We should know where the service is delivered, how efficient it is to be able to react and improve. Digital solutions allow to match responses of previously parallel systems. Digitalized, integrated healthcare systems are critical for relevance and sustainability.

INTERVENTION

DHIS2 is an open-source digital platform used globally to collect, manage, verify, and analyze health data in a single system. A tailored DHIS2-based solution for HIV programs developed by Alliance for Public Health enables implementers to replace fragmented tools with a centralized system for tracking services, clients, and results. The system is already being implemented and/or piloted across several countries in the EECA region.

It supports flexible program modules (HIV, TB, PrEP, STI), allowing adaptation to national program structures and reporting requirements. Some additional functionality developed recently to improve processes include

batch (journal) data entry for efficient input of large datasets, built-in data verification, integration with national and partner systems, and full cascade tracking from outreach to treatment and retention.

In practice, service providers (NGOs, clinics, outreach teams) enter data directly, while supervisors and national teams monitor quality and performance through dashboards and reports. Features such as batch data entry, automated validation, and real-time dashboards significantly reduce manual workload, minimize errors, and make data immediately usable for program management. This enables a shift from passive reporting to active, data-driven decision-making at all levels.

EXPECTED RESULTS

Implementation of DHIS2 leads to improved data quality, completeness, and timeliness, while significantly reducing duplication and reporting burden. Programs benefit from faster and more accurate data entry, standardized indicators aligned with Global Fund requirements, and the ability to track client pathways across services.

It also enables better identification of service gaps (e.g. drop-offs in the cascade), more precise targeting of interventions, and improved coordination between NGOs and national programs. Over time, this contributes to more efficient resource allocation and stronger program performance.

INDICATIVE BUDGET

DHIS2 is cost-efficient due to its open-source nature and scalability, allowing countries to build on existing infrastructure rather than develop new systems from scratch.

Typical costs include:

- Initial development/adaptation of the system tailored to the country ~ 30 000 USD/one time (9.0 Non-health equipment (NHE))
- Integration with other systems ~ 10,000 USD/one time (9.0 Non-health equipment (NHE))

Annual maintenance costs:

- Annual technical support and maintenance ~ 3,000 – 10,000 USD/year (3.0 External professional services (EPS))
- Coordination and data oversight ~ 6,000 USD /year (3.0 External professional services (EPS))
- Hosting (if required) ~ 1,000 USD/year (9.0 Non-health equipment (NHE))

Investments are primarily focused on adaptation, integration, and ongoing support, ensuring sustainability and long-term use.

3. Overcoming human rights barriers to accessing services through systematic monitoring and response REAct (Rights–Evidence–Action):

Module RSSH: **Reducing Human Rights-related Barriers to HIV, TB and Malaria Services**

Intervention: **Expanding Access to Quality and Discrimination-free Health Care**

PROBLEM STATEMENT / JUSTIFICATION

Human rights–related barriers, such as stigma, discrimination, violence, denial of services, and abusive law enforcement practices, continue to limit access to HIV and TB prevention, treatment, and care for key and vulnerable populations. These barriers reduce service uptake, adherence, and overall prevention and treatment efficiency.

In EECA countries, systems for documenting human rights violations and providing responses did exist, such as REAct system, which functioned effectively. However, due to reductions in funding for human rights and community programmes, this critically important work has become underfunded. This gap is particularly acute in contexts where civil society faces increasing political pressure, making community-led documentation and response mechanisms more essential than ever.

> Would you ever get tested for HIV if you know there is criminal persecution in case you are HIV-positive? A rhetoric question. If we want to end AIDS we must reduce human rights barriers to prevention, testing and treatment.

INTERVENTION

REAct (Rights–Evidence–Action) is a community-led human rights monitoring and response system that has been implemented in the EECA region since 2019 across 14 countries. The system is fully developed, piloted, and operational, with a proven implementation model that ensures effective functioning without the need for further development or

adaptation. REAct represents a ready-to-use, cost-efficient intervention that can be immediately integrated into national programmes, avoiding additional costs associated with designing or piloting new systems.

REAct enables trained community actors to:

- Systematically document human rights violations affecting access to HIV/TB services;
- Provide or refer clients to legal, health, psychosocial, and protection services;
- Aggregate and analyse data to inform program improvement, advocacy, and policy dialogue.

REAct is fully consistent with Global Fund technical guidance on CRG, CLM, and people-centered service delivery. It provides a ready-to-use, evidence-based mechanism to translate Global Fund principles on human rights and community leadership into measurable programme results—without the need for new system development or piloting.

1. Removing Human Rights-Related Barriers

REAct directly operationalises the Global Fund's CRG framework by enabling community-led identification, documentation, and response to human rights barriers that impede access to HIV and TB services—such as stigma and discrimination, denial of care, violence, and abusive law enforcement practices.

REAct delivers exactly these functions through a structured, community-led monitoring and response mechanism, supporting the scale-up of comprehensive human rights programmes and increasing the effectiveness of Global Fund grants.

2. Community-Led Monitoring (CLM)

The Global Fund defines **community-led monitoring (CLM)** as a core intervention to improve quality, accessibility, and equity of services by generating real-time, community-owned data and linking it to decision-making.

REAct is fully aligned with **CLM guidance** as it:

- is led and implemented by community-based organisations;
- systematically collects qualitative and quantitative data on barriers to care;
- links monitoring results to case response, service improvement, and accountability mechanisms;
- produces actionable evidence for programme management and advocacy.

REAct therefore meets the Global Fund's recommended criteria for mature, high-value CLM interventions that should be maintained and scaled within national grants.

3. Integrated Service Delivery and Person-Centred Care

The Global Fund Strategy (2023–2028) emphasizes people-centered, integrated service delivery, particularly for key and vulnerable populations facing multiple and intersecting barriers.

REAct supports this approach by:

- placing the individual client at the centre of the intervention (person-based, not case-based);
- integrating legal, health, psychosocial, and protection referrals into HIV/TB service pathways;
- strengthening linkages between community systems and formal health services;
- enabling adaptive programme management through systematic use of community-generated evidence.

By embedding human rights response within service delivery, REAct enhances continuity of care, trust in services, and long-term sustainability of Global Fund investments.

EXPECTED RESULTS

Implementation of REAct within Global Fund–supported programmes is expected to:

- Improve early identification and resolution of human rights barriers at individual level;
- Increase access, retention, and adherence to HIV/TB services among key populations;
- Generate high-quality, community-owned evidence to strengthen grant performance, adaptive management, and advocacy;
- Contribute to more enabling legal, policy, and service environments, improving the sustainability of Global Fund investments.

INDICATIVE BUDGET

REAct is a **cost-efficient intervention** that can be integrated within existing CRG, CLM, or service delivery modules. Indicative cost components include, with overall costs varying depending on the scale of implementation and the existing infrastructure and systems in place within the country.

- Training of community monitors (REActors) (on-line) ~1,000 – 2,000 USD / year (3.0 External professional services (EPS)/ 2.0 Travel-related costs (TRC))
- REActors' (case managers) fee for documentation and provision of services ~USD 100 – 300 / per person / per month (3.0 External professional services (EPS)) *(Various approaches can be used to calculate remuneration for these services, including monthly rates or part-time engagements. While we recommend a payment-per-case model (based on documented or successfully responded cases), monthly payments are also common in practice. It is important to adopt the model that works best within the specific context of your country)*.
- System setup and maintenance (access management, servers, IT technical assistance) –~ 5000 USD / per year (9.0 Non-health equipment (NHE)/(3.0 External professional services (EPS))
- Case response and referral costs (legal aid, psychosocial support, emergency assistance) – vary depending on existing services in the country.
- Data analysis, reporting, advocacy and coordination with national stakeholders ~ 5,000 - 10,000 USD / year (3.0 External professional services (EPS))

4. PrEP: long-acting and telePrEP

4.1. Introduction of Long-Acting PrEP (Lenacapavir and Upcoming Long-Acting Oral Agents (the pill, named MK 8527, Merck)

Module: **HIV Prevention**

Intervention: **Pre-exposure prophylaxis (PrEP) and postexposure prophylaxis (PEP) programming**

PROBLEM STATEMENT / JUSTIFICATION

Across EECA and Balkan countries, PrEP scale-up remains limited not because of lack of clinical guidance, but because of structural barriers that prevent sustained use. Daily oral PrEP requires continuous adherence, repeated clinic visits, laboratory monitoring, and regular interaction with formal healthcare settings. For many key populations — including MSM, transgender people, migrants, sex workers, and people living outside capitals — these requirements represent significant barriers.

As a result, many countries report low retention after 3 – 6 months of PrEP use, even where initial uptake is promising. This significantly reduces the overall preventive impact of PrEP programs.

Long-acting PrEP options, particularly Lenacapavir (injectable, twice per year), and new long-acting oral agents currently in Phase III trials (expected market availability around 2027), offer a fundamentally different service delivery model. These options remove the need for daily pill-taking and drastically reduce the frequency of contact with health facilities.

For countries with:

- centralized HIV services,
- mobile and hard-to-reach populations,
- low long-term PrEP retention,

long-acting PrEP should be considered not as a clinical innovation, but as a **programmatic solution** to persistent implementation challenges.

INTERVENTION

Countries are recommended to include a **pilot implementation of long-acting PrEP for 150–300 clients** as part of their funding request.

The intervention should include:

- Establishment of a national technical working group to adapt clinical protocols and develop SOPs for long-acting PrEP delivery.
- Preparation of 2–4 friendly sites (AIDS centers, infectious disease clinics, or trusted community clinics) with trained clinicians able to administer injections and monitor clients.
- Client recruitment through NGOs, outreach programs, telePrEP platforms, and community referral systems.
- Service model requiring only two visits per year for injection, with digital follow-up and adherence support through telePrEP or digital tools.
- Integration of long-acting PrEP indicators into DHIS2 or national monitoring systems to track retention, safety, and client satisfaction.

EXPECTED RESULTS

- Retention rates in PrEP programs exceeding 85%.
- Engagement of clients who previously declined or discontinued oral PrEP.
- Reduced burden on clinics due to infrequent visits.
- Strong evidence base for national scale-up.
- Lower long-term cost per retained PrEP client.

INDICATIVE BUDGET

Approximately 45,000–75,000 USD covering coordination, training, communication, monitoring integration, service delivery support, and procurement of long-acting PrEP medicines.

- Commodities (long-acting PrEP procurement) ~ 25,000 – 30,000 USD/ one time (4.0 Health products)
- Service delivery & NGO support ~ 28,000 – 32,000 USD/ year (3.0 External professional services (EPS)/ 2.0 Travel-related costs (TRC))
- Program coordination & capacity building ~ 10,000 – 15,000 USD/ year (3.0 External professional services (EPS)/ 2.0 Travel-related costs (TRC))
- Promotion and marketing ~ 8,000 – 10,000 USD/year (3.0 External professional services (EPS)/ 10.0 Communication material and publications (CMP))

4.2. TelePrEP and Pharmacy-Based PrEP Access Model

PROBLEM STATEMENT / JUSTIFICATION

In many EECA and Balkan countries, PrEP is formally available but practically inaccessible for large segments of key populations. Major barriers include stigma in healthcare settings, geographic distance from AIDS centers, inconvenient clinic hours, and fear of disclosure.

Experience from the region (e.g., Tajikistan, Kazakhstan, Ukraine, Serbia) shows that telePrEP combined with pharmacy-based access transforms PrEP from a clinic-centered intervention into a low-threshold prevention service.

This model is particularly relevant in settings where:

- services are centralized in capital cities,
- community trust in state facilities is low,
- NGOs play a strong role in outreach and client support,
- digital literacy and mobile phone access are widespread.

> We satisfy most of our needs online – ask, order, request delivery. Telemedicine has proven efficient for migrants, internally displaced persons, reducing costs for patient visits to health care facilities in EECA. Bright examples of telePrEP showcase that this modality should be made available for the groups mainly digital or on the move.

INTERVENTION

Countries are recommended to include a **telePrEP and pharmacy access component** in their funding requests, with the following elements:

- Development or adaptation of a digital platform allowing anonymous contact with a clinician, online counseling, and electronic prescription/ referral to start or continue taking PrEP.
- Partnership with approximately 10 pharmacies where clients can obtain PrEP without visiting an AIDS center.
- Distribution of HIV self-testing kits through NGOs and pharmacies as part of the PrEP initiation pathway.
- Strong involvement of NGOs in online client support, follow-up, and adherence counseling.

- Digital promotion and targeted online campaigns to increase awareness and demand.
- Integration of telePrEP clients into DHIS2 or national monitoring systems.

EXPECTED RESULTS

- 30–50% increase in new PrEP clients who would not otherwise access clinic-based services.
- Significant decentralization of PrEP without opening new clinical sites.
- Reduced stigma and increased confidentiality for users.
- Scalable national model with relatively low operational cost.
- Improved linkage between testing, counseling, and PrEP initiation.

INDICATIVE BUDGET (ANNUAL)

Approximately 40,000–50,000 USD covering platform coordination, NGO support, promotion, digital marketing, monitoring integration, and platform maintenance.

- Platform coordination and maintenance ~10,000 – 15,000 USD/year (3.0 External professional services (EPS)/ (9.0 Non-health equipment (NHE))
- Promotion and digital marketing ~ 8,000 – 10,000 USD/year (3.0 External professional services (EPS)/10.0 Communication material and publications (CMP))
- NGO support and service delivery ~ 15,000 – 20,000 USD/year (3.0 External professional services (EPS)/ (9.0 Non-health equipment (NHE))
- Partner coordination, pharmacy onboarding, basic trainings ~ 5,000 – 7,000 USD/one time (3.0 External professional services (EPS)/ 2.0 Travel-related costs (TRC))

5. LADB: Long-Acting Depot Buprenorphine as an Opioid Agonist Therapy Option for People Who Inject Drugs

Module: **HIV Prevention**

Intervention: **Opioid agonist therapy for people who inject drugs**

PROBLEM STATEMENT / JUSTIFICATION

Opioid use disorder (OUD) remains a significant public health challenge across many countries in Eastern Europe and Central Asia, contributing to elevated rates of HIV transmission, overdose mortality, and poor treatment retention. Despite the proven effectiveness of opioid agonist therapy (OAT), access to and continuity of treatment remain limited due to structural barriers, stigma, daily dosing requirements, and service delivery constraints.

Long-acting depot buprenorphine (LADB) represents an evidence-based clinically effective and programmatically transformative advancement in OAT. By providing sustained therapeutic drug levels through monthly (or extended interval) injections, it significantly reduces the need for daily clinic attendance, improves adherence, and enhances patient autonomy while maintaining high treatment efficacy. It has been demonstrating promising results in a number of low- and middle-income countries such as Egypt, Kyrgyzstan, Ukraine, etc. with positive feedback from both OAT providers and PWID.

Procurement and implementation of LADB will strengthen harm reduction and HIV prevention programming. This investment is justified by the following considerations:

- Improved Treatment Retention and Outcomes: Evidence demonstrates that long-acting buprenorphine significantly increases retention in OAT compared to daily oral formulations, reducing relapse risk and improving long-term recovery outcomes.
- HIV and Hepatitis C Prevention Impact: Expanding access to sustained OAT directly reduces injection frequency and associated HIV/HCV transmission risk among people who inject drugs, aligning with Global Fund strategic priorities.

- Reduced Structural Barriers: Depot formulations minimize barriers related to daily pharmacy attendance, stigma, travel costs, and punitive policing environments that often disrupt continuity of care.
- Health System Efficiency: Reduced clinic burden allows healthcare providers to allocate resources more effectively while maintaining high-quality patient monitoring and support.
- Alignment with Global and Regional Strategies: This intervention aligns with WHO recommendations on OUD treatment diversification and supports regional HIV elimination targets in Eastern Europe and Central Asia.

> Daily visits to clinics are impossible for opioid dependent patients that live far away from OAT sites. Long-acting monthly injections are life-changing for these patients – they give their lives, families and jobs back; they also take extra burden away from doctors and societies.

INTERVENTION

Integration of LADB courses within existing OAT delivery systems, prioritizing high-risk populations including PWID with unstable housing, those with poor adherence to daily medications, and individuals released from incarceration. Implementation would include:

- Clinical training for providers on depot buprenorphine administration
- Patient selection based on clinical eligibility and informed consent
- LADB administration
- Monitoring systems for safety, retention, and HIV risk outcomes
- Integration with existing harm reduction and HIV services

EXPECTED OUTCOMES

Funding this intervention is expected to yield:

- Increased retention in opioid agonist therapy
- Reduction in opioid injection frequency
- Decreased HIV and HCV transmission risk
- Improved quality of life and treatment satisfaction among clients
- Strengthened continuity of care in underserved populations

INDICATIVE BUDGET

- Long-acting medication procurement ~ 1200-2400 USD per patient per year (depending on tender competition and volume) (4.0 Health products)
- Service delivery & NGO support ~ 28,000 – 32,000 USD/ year (3.0 External professional services (EPS)/ 2.0 Travel-related costs (TRC))
- Program coordination & capacity building ~ 10,000 – 15,000 USD/year (3.0 External professional services (EPS)/ 2.0 Travel-related costs (TRC))
- Promotion and marketing ~ 8,000 – 10,000 USD/year (3.0 External professional services (EPS)/ 10.0 Communication material and publications (CMP))

6. TWIIN – AI-based Digital Assistant for Service Access and Referrals

Module: **HIV Prevention**

Intervention: **Sexual health education for HIV prevention for adolescents and young people**

PROBLEM STATEMENT / JUSTIFICATION

A significant proportion of target populations do not access services due to stigma, lack of information, geographic barriers, or limited interaction with traditional service providers. At the same time, outreach and engagement models are resource-intensive and difficult to scale.

There is a need for scalable solutions that can increase reach, improve access to services, and convert demand into actual service uptake.

> A specially trained chat GPT for HIV will make as much a transformation in AIDS response as AI made in our daily lives. Virtual outreach worker can consult, refer, be empathic and intelligent. He/she/they should become a force in HIV prevention and response.

INTERVENTION

TWIIN is an AI-based digital assistant that serves as a 24/7 digital entry point into services, helping users access information and connect directly to providers.

Through chat or voice interaction, TWIIN provides verified, program-approved information, guides users through available options, and generates direct referrals to specific NGOs, clinics, and testing services, helping convert user engagement into actual service uptake. It allows users to seek support anonymously, which is critical for sensitive and stigmatized topics.

The system can be fully localized to national context, including language, service directories, and program priorities, and can be integrated with outreach and communication activities to expand reach. The solution has also been successfully used in crisis and low-access settings, including during wartime conditions.

EXPECTED RESULTS

TWIIN increases access to services by reaching populations not engaged through traditional channels and converting information-seeking behavior into service uptake through referrals.

Implementation has demonstrated strong user engagement and demand, with over 180 000 users reached, more than 25 000 engaged in conversations, and over 50 000 consultations initiated. It also reduces pressure on staff by handling basic inquiries and service navigation digitally, while ensuring continuity of access in low-resource and emergency settings.

INDICATIVE BUDGET

TWIIN is a cost-efficient way to expand outreach and service access at scale.

Typical costs include:

Initial setup

- Content adaptation and localization ~5 000 – 15 000 USD/one time (3.0 External professional services (EPS))
- System setup and deployment ~10 000 – 25 000 USD/one time (3.0 External professional services (EPS)/ (9.0 Non-health equipment (NHE))

Annual maintenance costs

- Annual licensing and support ~ 5 000 – 20 000 USD/year (9.0 Non-health equipment (NHE))
- Annual content management and coordination (part-time LoE) ~ 6 000 – 10 000 USD/year (3.0 External professional services (EPS)/10.0 Communication material and publications (CMP))
- Outreach and communication activities/Digital promotion (depends on specific country promo plan) ~12 000 – 30 000 USD/year (3.0 External professional services (EPS)/ 10.0 Communication material and publications (CMP))

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