



# HIV service delivery prioritization in resource- constrained settings

18 August 2026



# Agenda - Part 1: The case for prioritization



## Welcome and opening remarks

- Maureen Syowai, CQUIN, ICAP at Columbia University



## Setting the scene: Why ongoing HIV service delivery prioritization matters now

- Anna Grimsrud, IAS



## Adaptive HIV program prioritization: Lessons from CQUIN countries

- Onyekachi Ukaejiofo, CQUIN, ICAP at Columbia University



## From priorities to action: Practical tools for informed programming

- Chantalle Okondo, Population Council Kenya



# Agenda - Part 2: From principles to practice: TIER-Plus



## **TIER-Plus: Supporting evidence-informed prioritization and trade-off analysis in HIV service planning**

- Brooke Nichols, Boston University



## **Country experience: Applying TIER-Plus to support programme prioritization in Mozambique**

- Irénio Gaspar, Ministry of Health, Mozambique



## **Country reflections: Early experiences**

- Clarence Mademutsa, ZNNP+, Zimbabwe
- Simon Sikwese, Pakachere, Malawi
- SuilANJI Sivile, Ministry of Health, Zambia



# Agenda - Part 3: Discussion



## **Moderated discussion and audience Q&A**

- Panelists: Presenters plus Alex de Nooy, Amsterdam University Medical Centre, the Netherlands
- Moderators: Anna Grimsrud and Onyekachi Ukaejiofo



## **Closing remarks**

- Ayesha Ismail, SSLN



# Setting the scene: Why ongoing HIV service delivery prioritization matters now

*HIV service delivery prioritization in resource-constrained settings*

Anna Grimsrud, IAS

18 August 2026

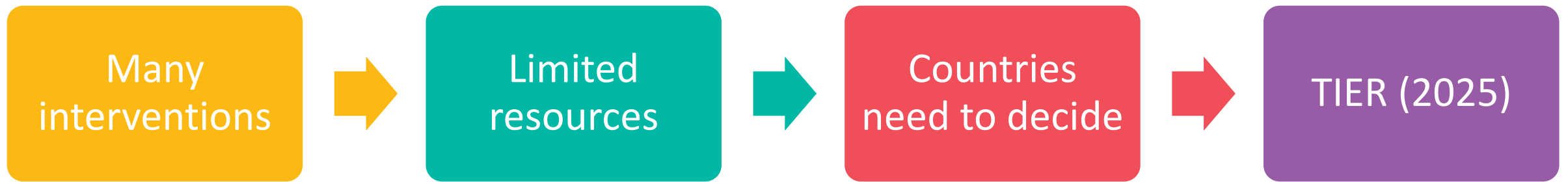


# What if this isn't the storm...

# ...what if it's the climate?



# Supporting countries to prioritize



Tool for  
Intervention  
Evaluation and  
Ranking

# Countries – and communities – used TIER

- Versions of the TIER were used by at least 21 countries



- **COMPASS partners adapted the TIER tool to develop a, “TIER-Community Prioritization Tool” for HIV, TB, Malaria, NCDs and pandemics**
  - For example, in Tanzania, circulated draft to community service organizations to determine the prioritization of the interventions and used their TIER to engage regarding prioritization with the Global Fund, PEPFAR and national government

Prioritization became a shared conversation rather than a technical exercise.

# “SHOW US THE IMPACT”

TIER could identify priorities.....but not quantify their impact.



From  
prioritization  
to potential  
impact

## Enter TIER-Plus

- Compare scenarios
- Estimate outcomes
- Understand trade-offs

Designed to be openly available – not just for select stakeholders.





# Adaptive HIV program prioritization: Lessons from CQUIN countries

Evidence-informed decisions in a changing funding landscape

Dr. Onyekachi Ukaejiofo, MD, MSc.

Regional Advisor, Clinical and Quality Management

ICAP/ CQUIN



# Why adaptive prioritization matters?

## 2025 FUNDING SHOCK

>50% Reduction in U.S. Government external funding  
~11% Average reduction in Global Fund awards (7–16% range)



## CHANGING FUNDING LANDSCAPE

Service disruptions + new bilateral funding mechanisms, including Government-to-Government MOUs under the U.S. America First Global Health Strategy



## COUNTRY RESPONSE

Prioritize → Adapt → Sustain  
CQUIN + countries + global partners: identifying a core package of essential HIV services

# CQUIN-Supported Prioritization Process in 2025

- **MOH-led** exercises that involved partners, recipients of care, donors, and ICAP/CQUIN teams through a mixture of **in-person** and **hybrid meetings**
- Countries **gathered documents in advance** and held **one-day prioritization meetings** to deliberate and assess interventions to be de/prioritized using a CQUIN-modified prioritization TIER tool.
- Country submissions were **validated** for accuracy and summarized through **multiple lenses** to support interpretation.

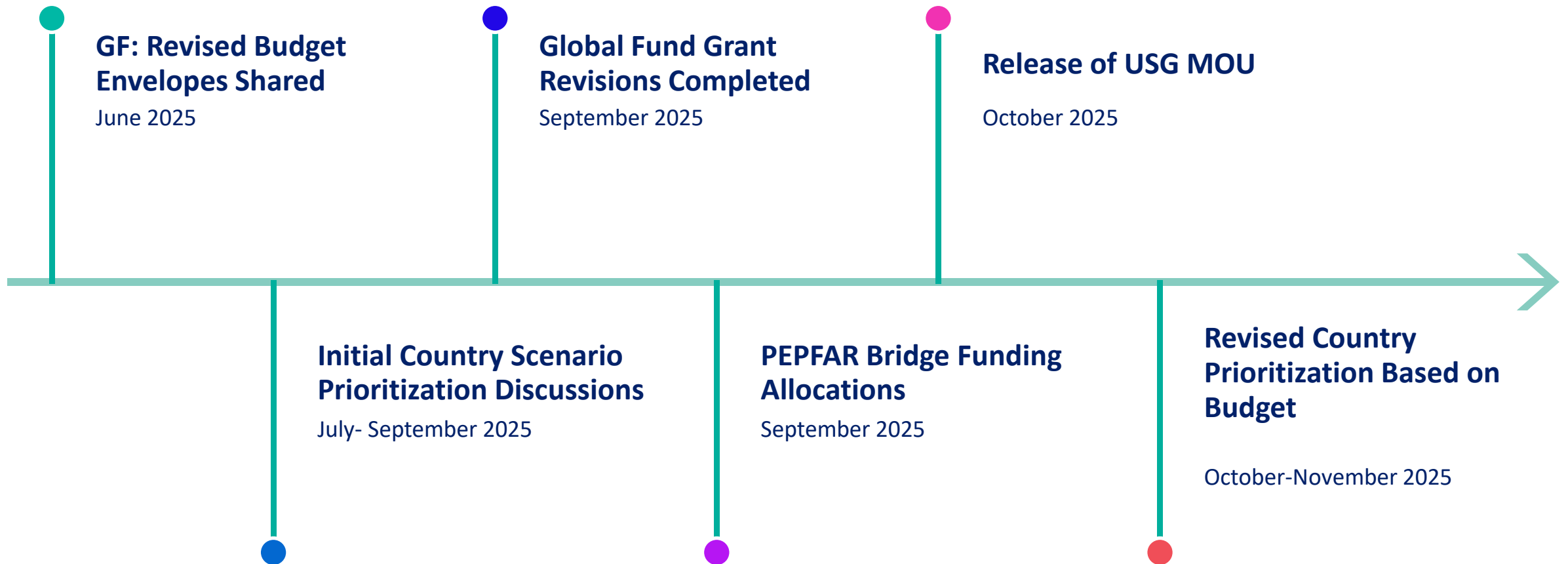
## CQUIN Modified TIER Tool

|                                    | HIV TREATMENT SERVICES                                                                                                                                                                                                                        | With 0% external funding (vs. current year)          |                                        |                |            |                   |
|------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|----------------------------------------|----------------|------------|-------------------|
| Component                          | Intervention                                                                                                                                                                                                                                  | Keep or drop                                         | Planned Funding Source (if continuing) |                |            |                   |
|                                    |                                                                                                                                                                                                                                               |                                                      | % funded by PEPFAR/USG                 | % funded by GF | % domestic | % funded by other |
| ART continuity                     | Provide uninterrupted ART treatment to ALL people who are already on ART, all populations and all regimens                                                                                                                                    | Keep (no change)                                     |                                        |                |            |                   |
|                                    | Provide a minimum of 3MMD for all, unless clinically unwell (including re-engaging clients) with 6MMD preferred for those established on ART (for all over 5-years of age)                                                                    | Keep (no change)                                     |                                        |                |            |                   |
|                                    | Conduct an annual quality clinical review if established on ART and virally suppressed with longest scripting period allowed 6-12 months                                                                                                      | Not applicable                                       |                                        |                |            |                   |
|                                    | Enroll eligible clients in less-intensive DSD models                                                                                                                                                                                          | Keep (no change)                                     |                                        |                |            |                   |
|                                    | Sustain individual DSD models based at facilities                                                                                                                                                                                             | Keep (no change)                                     |                                        |                |            |                   |
|                                    | Sustain individual DSD models for key populations not based at facilities                                                                                                                                                                     | Keep (no change)                                     |                                        |                |            |                   |
|                                    | Sustain group DSD models managed by clients                                                                                                                                                                                                   | Not applicable                                       |                                        |                |            |                   |
|                                    | Sustain group DSD models for adolescents managed by healthcare workers                                                                                                                                                                        | Not applicable                                       |                                        |                |            |                   |
|                                    | Sustain individual DSD models not based at facilities                                                                                                                                                                                         | Drop                                                 |                                        |                |            |                   |
|                                    | Sustain group DSD models managed by healthcare workers                                                                                                                                                                                        | Keep (no change)                                     |                                        |                |            |                   |
|                                    | Actively support transfer all clients from facilities that are closing to preferred public sector facility with same day continuation of ART, minimum 3MMD, offer less-intensive DSD model without required transfer documentation            | Not applicable                                       |                                        |                |            |                   |
| Continuity OI prophylaxis          | Provide cotrimoxazole prophylaxis to adults Stage 3 and 4 or CD4 <350. Note recommendation when to stop                                                                                                                                       | Keep (no change)                                     |                                        |                |            |                   |
|                                    | Provide cotrimoxazole to adults in settings where malaria and/or severe bacterial infections are highly prevalent; co-trimoxazole prophylaxis should be initiated regardless of CD4 cell count or WHO stage; Note recommendation when to stop | Keep (no change)                                     |                                        |                |            |                   |
|                                    | Provide cotrimoxazole to patients living with HIV and TB                                                                                                                                                                                      | Keep (no change)                                     |                                        |                |            |                   |
|                                    | Provide cotrimoxazole to children living with HIV; Note recommendation on when to stop                                                                                                                                                        | Keep (no change)                                     |                                        |                |            |                   |
|                                    | Provide cotrimoxazole to HIV exposed infants; Note recommendation when to stop                                                                                                                                                                | Keep (no change)                                     |                                        |                |            |                   |
|                                    | Provide secondary fluconazole prophylaxis (maintenance); Note recommendation on when to stop                                                                                                                                                  | Keep (no change)                                     |                                        |                |            |                   |
| ART initiation (and re-initiation) | Initiate children under 5 years                                                                                                                                                                                                               | Keep (no change)                                     |                                        |                |            |                   |
|                                    | Initiate pregnant and breastfeeding women                                                                                                                                                                                                     | Keep (no change)                                     |                                        |                |            |                   |
|                                    | Initiate those with clinical signs and symptoms of HIV/AIDS or CD4<200 if known (AHD)                                                                                                                                                         | Keep (no change)                                     |                                        |                |            |                   |
|                                    | Initiate all people testing positive for HIV (new and re-engaging) and transferring                                                                                                                                                           | Keep (no change)                                     |                                        |                |            |                   |
|                                    | Initiate all people testing positive for HIV - stage 3 or 4 or if CD4 known or baseline CD4 (CD4 nadir) below 200/350/500                                                                                                                     | Keep (no change)                                     |                                        |                |            |                   |
|                                    | Initiate all people testing positive for HIV - stage 1 or 2 or if CD4 known or baseline CD4 (CD4 nadir) above 200/350/500                                                                                                                     | Keep (no change)                                     |                                        |                |            |                   |
| Viral load monitoring              | Provide VL testing for those presenting with signs and symptoms of treatment failure                                                                                                                                                          | Keep (but modify, provide details in "notes" column) |                                        |                |            |                   |
|                                    | load after 3 months                                                                                                                                                                                                                           | Keep (but modify, provide details in "notes" column) |                                        |                |            |                   |
|                                    | Provide first viral load for anyone with no previous VL                                                                                                                                                                                       | Not applicable                                       |                                        |                |            |                   |
|                                    | the last 3 months) or after 3 months on ART                                                                                                                                                                                                   | Not applicable                                       |                                        |                |            |                   |
|                                    | For all pregnant women: Provide VL testing at 34-36 weeks of pregnancy (or latest delivery)                                                                                                                                                   | Keep (but modify, provide details in "notes" column) |                                        |                |            |                   |

From funding disruption → to evidence-informed prioritization → to resilient HIV programs



# Prioritization Activity Timeline



## Example of Prioritization Output: HIV Prevention

|  |                  |
|--|------------------|
|  | Keep (No Change) |
|  | Keep (Modify)    |
|  | Drop             |
|  | Not applicable   |
|  | Missing Data     |

### By Country: Jul-Sep 2025 (N=14)

[illegible]

### By Country: Oct-Nov 2025 (N=21)

[illegible]

Prioritization exercise results by service and country. More details are available [here](#):

[cquin.icap.columbia.edu/wp-content/uploads/2026/02/Session-1](https://cquin.icap.columbia.edu/wp-content/uploads/2026/02/Session-1) CQUIN-9th-Annual-Meeting 17-Nov-2025

# Cross-Cutting Findings: Prevention

- Facility-based infant prophylaxis (especially for high-risk infants in the first 6 weeks) and PEP remained consistently high-priority.
- PrEP initiation and continuation for key populations and pregnant/breastfeeding women stayed prioritized; virtual PrEP refills and some out-of-facility DSD models saw a slight downgrade in October–November.
- Community-based condom distribution (especially for general populations) was deprioritized, while facility-based condom availability remained more stable.
- Harm-reduction interventions for people who inject drugs (OAMT, needle/syringe distribution) continued to rank low.

# Cross-Cutting Findings: Testing

- Facility-based testing at ANC, TB, STI, and malnutrition clinics, plus testing for HIV-exposed infants and symptomatic individuals, remained strong priorities.
- Virtual and community-based HIV self-testing (HIVST) platforms and collection points were deprioritized in October–November.
- Provider-assisted and passive partner notification/index testing stayed prioritized, particularly for newly diagnosed people and key populations.

# Cross-Cutting Findings: Treatment

- Uninterrupted ART, initiation for all populations (including children, pregnant women, and people with advanced HIV disease), and viral-load monitoring for treatment failure were universally top priorities.
- Facility-based individual DSD models retained high prioritization; group models and out-of-facility options showed more variability and some de-prioritization later in the period.
- Opportunistic infection prophylaxis and the AHD package (cotrimoxazole, fluconazole, CD4, LAM/CrAg) remained moderately prioritized.
- Integration of NCD and family-planning services continued to show variability and generally limited prioritization.

# How are CQUIN countries approaching prioritization?

## 1. Data-driven prioritization:

Using epidemiological, program and outcome data to identify where resources can have greatest impact.

## 2. Programme optimization:

Reviewing differentiated service delivery models, testing, treatment, retention and other program components to identify efficiencies.

## 3. Scenario-based decision-making:

Assessing different funding/resource scenarios and their implications for program coverage and outcomes.

## 4. Continuous review and adaptation:

Using monitoring data and changing circumstances to revisit priorities rather than relying solely on annual planning cycles

**Common principle:** Prioritization is strongest when evidence, programme realities and available resources are considered together.

# Key Lessons Learned

## Turning Point

Countries are treating this as a strategic shift, not a temporary disruption

## Treatment First

ART and essential care remain protected.

## Domestic Financing

Domestic funding will grow, but gaps will remain.

## TA is Evolving

More focus on financing, systems and government-led models.

## Sustainability

Sustainability and government ownership are now central to planning.

## Equity Matters

Safeguards are needed to prevent wider gaps for underserved groups

# Looking Ahead

- **Protect core treatment services as a non-negotiable priority:** Ring-fence resources for uninterrupted ART, rapid ART initiation, viral-load monitoring, and the advanced HIV disease (AHD) package.
- **Continue to conduct structured prioritization using improved TIER tools:** Use tools such as the IAS TIER Plus to rank interventions under current funding envelopes and involve multi-stakeholders in the exercise.
- **Strengthen the foundational enablers in parallel:** Data visibility and quality, commodity security, and HRH transition will be essential to implement prioritized services.
- **CQUIN will provide on-demand, need-based technical support** to countries reassessing and re-prioritizing HIV services, helping them apply data-driven approaches, strengthen decision-making, and embed prioritization within routine program systems.

# From Priorities to Action: Practical Tools for Informed Programming

Insight 2 Implementation, Chantalle Okondo

18th August 2026



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## Session Objectives

- Strengthen evidence-informed HIV prevention planning and monitoring through South-to-South learning and collaboration.





# Introduction to Insight 2 Implementation (i2i)



# Through i2i, the evidence to action of the SSLN, we support countries to translate global and regional evidence into impact

## As i2i we ...

1.

Collaborate with country stakeholders **to identify and prioritise** their prevention evidence gaps and understand the barriers and enablers of applying evidence to strengthen programmes and policies



2.

**Consolidate and synthesise** existing regional HIV prevention evidence into clear, practical, and user-friendly knowledge products and disseminate it to country stakeholders.



3.

Support country stakeholders to ensure that the evidence from our **knowledge products is used** to strengthen prevention policies and programmes.





# Introduction to the HIV-DDM

# HIV Data Decision Maker

A resource created to empower HIV program stakeholders with the tools, data, and insights they need to make informed decisions that drive impactful interventions.

- During country stakeholder workshops, we realised that despite the existence of numerous helpful datasets and guides, there was a need for a centralised resource hub in the HIV prevention space.
- To address this, i2i gathered data and toolkits shared during the stakeholder workshops and scoped for further relevant documents, to develop the HIV DDM

## Purpose of the Tool

- ★ The HIV DDM is designed to serve as a go-to hub for exploring key datasets, practical tools, and best practices for planning, monitoring, and evaluating HIV programs.
- ★ It's a PowerPoint slide deck that follows a flow chart type structure. The main goal of the HIV DDM is to equip users to:

1

Navigate diverse data resources tailored to programme needs

2

Understand when and how to collect and use data

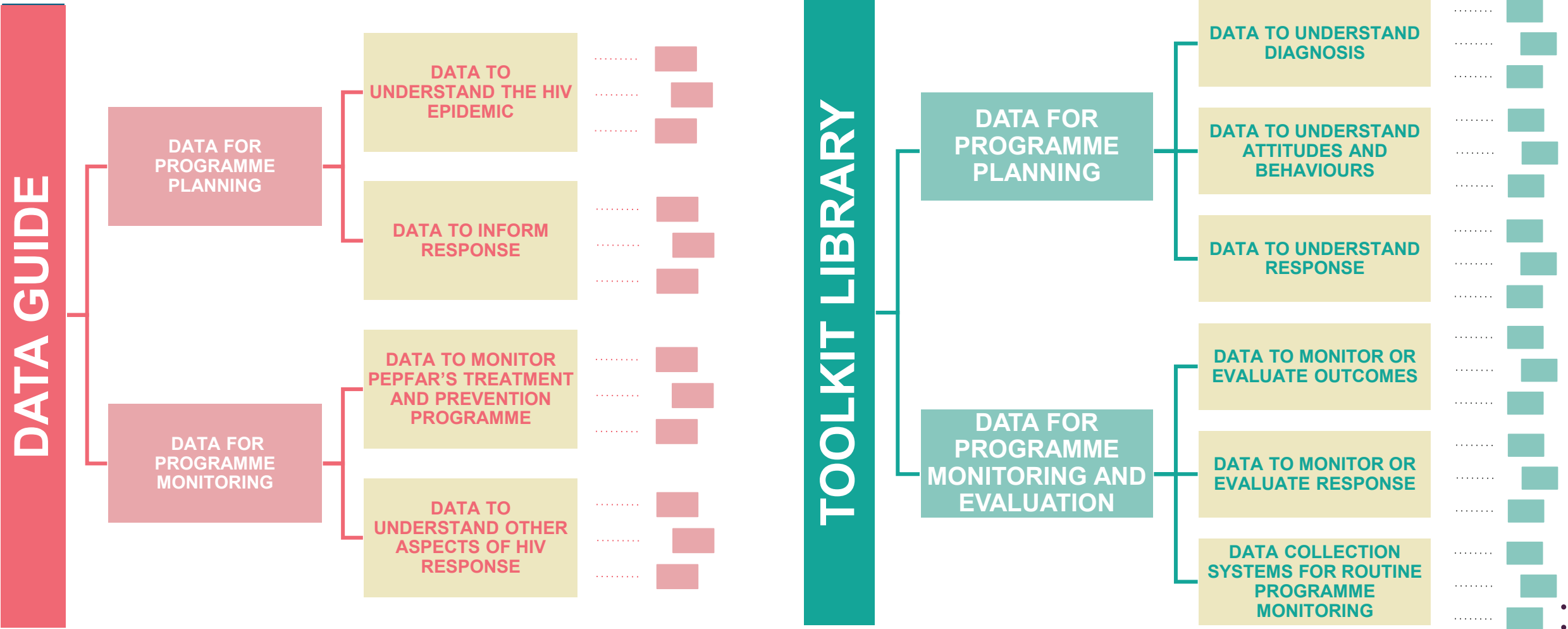
3

Assess the real-world impact of HIV interventions

# OVERVIEW OF THE TOOL

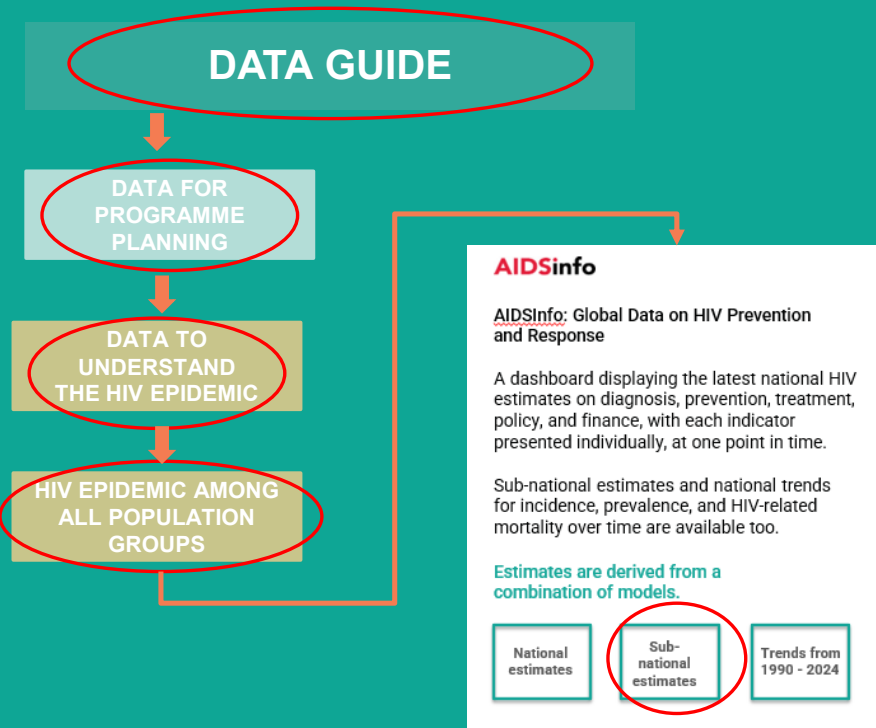
The tool has two components:

- 1. A **data guide** to help you explore existing data resources, and a
- 2. A **toolkit library** to help you find guidance on how to collect new data.



# THE HIV DDM SUPPORTS EVIDENCE USE

## HIV Data Decision Maker



The DDM helps users move from:

**Data** → **Information** → **Evidence** → **Action**

## Getting the Most from the DDM

- **Step 1:** Start with your programme question.
- **Step 2:** Select either:
  - **Data Guide** (to find data)
  - **Toolkit Library** (to find guidance)
- **Step 3:** Follow the thematic navigation pathway.
- **Step 4:** Use the Home button to return to the main menu.
- **Step 5:** Explore linked resources for additional detail.



# Introduction to the Tobi Chatbot

# Meet Tobi



Hi there! I'm Tobi, your SSLN & I2I chatbot. Data, insights, impact — just ask me!

You can access Tobi below

[Tobi Chatbot](#)  
[Chatbot Demo](#)

- **AI-powered chatbot** designed to answer HIV programme-related questions in real time.
- **Delivers accurate and relevant information** sourced from a curated knowledge base.
- **Uses officially endorsed documents, reports, and handbooks** to ensure reliability and consistency.
- **Complements the DDM** by connecting global guidances to country specific data and helps you to weed through complex databases of tools.

# Data Sources & Governance

To ensure reliability and safety, Tobi's knowledge base will be restricted to:

01

**UNAIDS** technical guidance documents

04

**NSPs** (National Strategic Plans)

02

**WHO** consolidated HIV guidelines

05

**HIV M&E** guides (e.g. PHIA reports, DHS guidance)

03

**PEPFAR MER** indicators and **EHE** data tools

06

**Peer-reviewed literature** from vetted repositories

# How to use Tobi





# Reflections

Kindly reflect on your overall data needs as a country:

1

**Are there upcoming opportunities in your country to engage in data-related exercises?**

(e.g., an upcoming IBBS survey, programme review, or any other initiative focused on data analytics)?

2

**Are there any HIV-programme related resources in your country that you would like to be part of Tobi's knowledge base?**

(e.g. planning, strategies and guidelines)

3

**What are your current data challenges or needs in your country where SSLN-i2i could support?**

(e.g., access to data, analysis capacity, interpretation, or packaging for decision-makers)

Stay connected! Visit the  
SSLN-i2i website to  
explore more of our  
knowledge products:  
[https://www.hivinterchange  
.com/i2i/insight-2-  
implementation](https://www.hivinterchange.com/i2i/insight-2-implementation)

[HIV DDM Explainer Page](#)

[Tobi Chatbot](#)



For any questions related to HIV DDM & Tobi

Please contact:

Lekoeste Mahao - [lekoetsem@genesis-analytics.com](mailto:lekoetsem@genesis-analytics.com) ;

Obakeng Mojela - [obakengm@genesis-analytics.com](mailto:obakengm@genesis-analytics.com)

# Thank You



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# TIER-Plus: Supporting evidence-informed prioritization and trade-off analysis in HIV service planning

*HIV service delivery prioritization in resource-constrained settings*

Brooke Nichols, Boston University

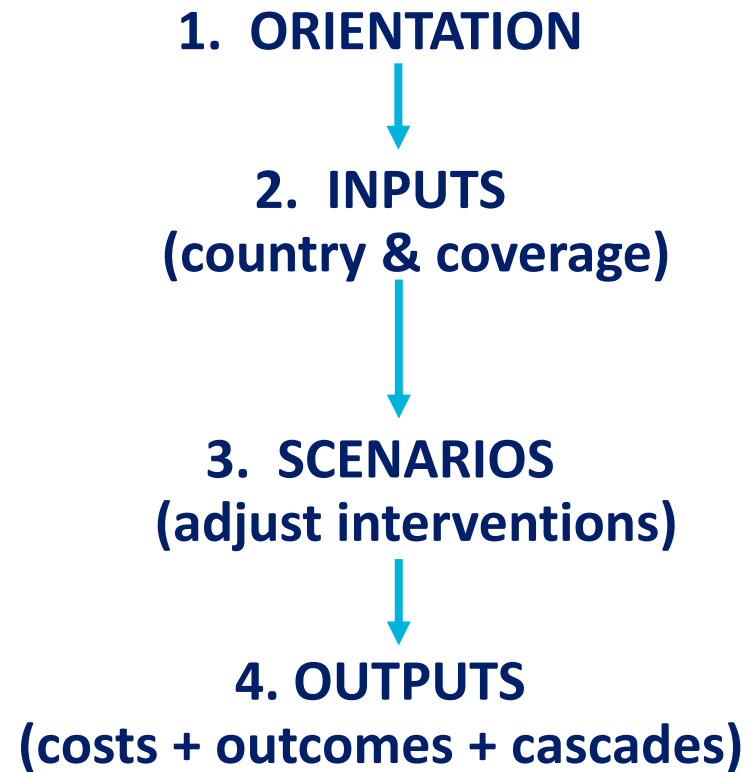
18 August 2026



# Who is TIER-Plus for?



# Let's take a look



98

 [dsd@iasociety.org](mailto:dsd@iasociety.org)

Watch on  YouTube

TIER-Plus is a planning tool for national HIV programme stakeholders to support annual budget allocation and resource



# What goes in (inputs 1)

- a. Select the country
- b. Confirm (or edit) epidemic parameters (greyed out cannot be modified)

Select Regional Profile:  
Zambia

Epidemic Parameters  
(Start of Year)

Total Population:  
21,913,874

HIV Prevalence among people  
aged 15+ (%):  
10,7

New HIV Acquisitions/Year:  
30,400

% of PLHIV Diagnosed:  
95,3

% Diagnosed on ART:  
98

% on ART Suppressed:  
97,5



## IAS TIER-Plus - HIV Intervention Impact Calculator

Select Regional Profile:

Zambia

Epidemic Parameters  
(Start of Year)

Total Population:

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[Share feedback](#) [dsd@iasociety.org](mailto:dsd@iasociety.org)

User Guide

Baseline Coverage

Scenarios

Results Comparison

Parameters

### TIER-Plus — User Guide

*A decision-support tool for trade-off analysis in HIV service planning*

The screenshot displays the TIER-Plus User Guide interface. It features a navigation bar with tabs: User Guide, Baseline Coverage (highlighted), Scenarios, Results Comparison, and Parameters. The main content area is titled 'TIER Plus Tutorial' and 'IAS - the International AIDS Society'. Below the title, there are several input fields for parameters, organized into sections: 'Epidemic Parameters (Start of Year)', 'Total Population', 'HIV Prevalence among people aged 15+ (%)', 'New HIV Acquisitions/Year', '% of PLHIV Diagnosed', '% Diagnosed on ART', '% on ART Suppressed', and 'AIDS Deaths/Year (expected)'. A central video player is visible, showing a red play button. To the right of the video player, there are two columns of input fields for 'Scenario 1' and 'Scenario 2'. At the bottom of the video player, there is a 'Watch on YouTube' button.

### What is TIER-Plus

TIER-Plus is a planning tool for national HIV programme stakeholders to support annual budget allocation and resource

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# What goes in (inputs 2)

## c. Baseline interventions (coverage)

- For prevention
- For testing and diagnosis
- For treatment monitoring and quality
- For retention and adherence support
- For advanced HIV disease

### Important note!

Default data is provided → Users can customize if better national data are available.

## Testing & Diagnosis

Testing: facility-based (general) (tests performed) ⓘ

Testing: network testing (tests

## Prevention

Total oral PrEP (all groups):

Total lenacapavir (all groups):

Enter the national totals delivered. Capped at t

VMMC (annual people) ⓘ

Condom distribution (condoms distributed) ⓘ

## Treatment Monitoring & Quality

Routine VL monitoring (% of people on ART) ⓘ

## Advanced HIV Disease Package

MMI

clier

CD4 testing (all new initiations) (% of new ART initiations) ⓘ

MMI

clier

96

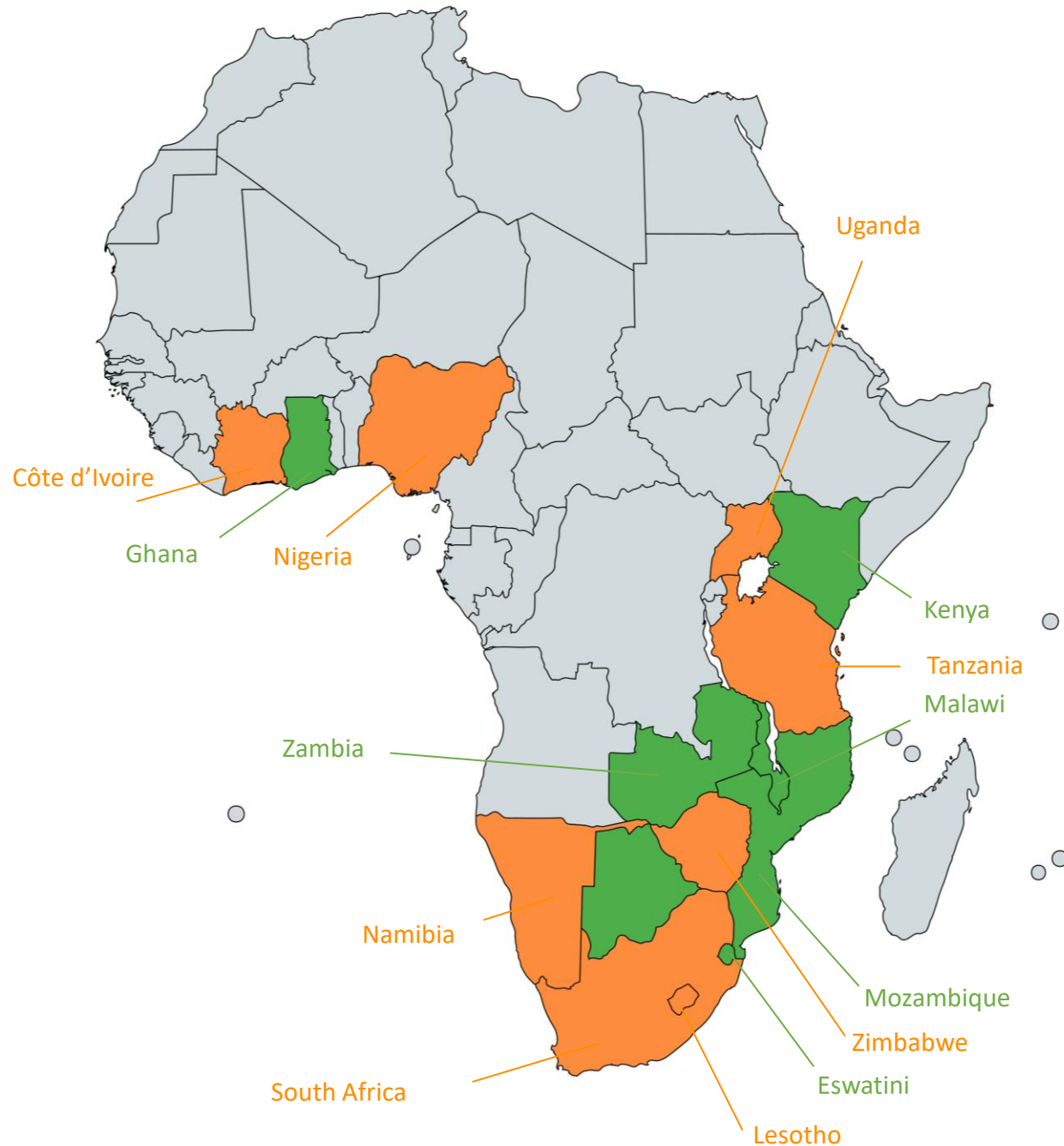
Full AHD package (LAM, CrAg, fluconazole) (% of AHD-diagnosed new initiations) ⓘ

MMI

clier

# Countries represented in TIER-Plus

- Baseline data values reviewed and updated by in-country teams
- Baseline data values from publicly available resources and literature



# IAS TIER-Plus - HIV Intervention Impact Calculator



Select Regional Profile:

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Baseline Coverage

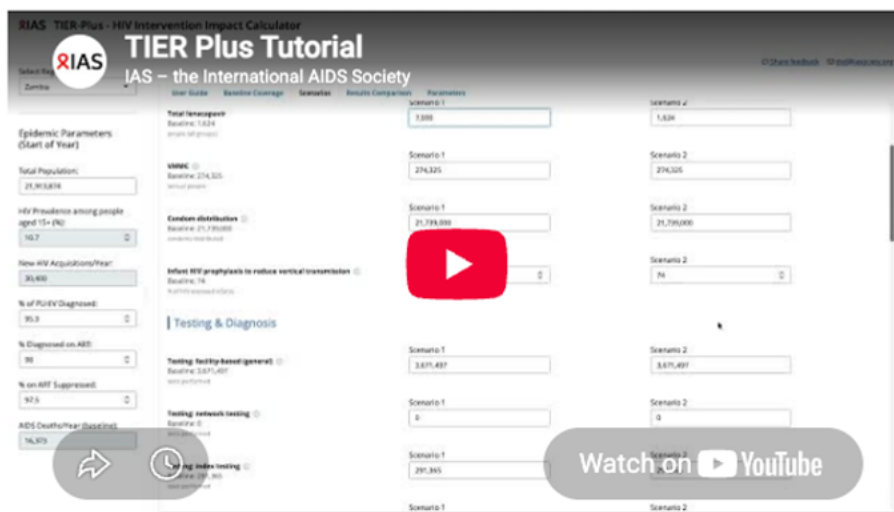
Scenarios

Results Comparison

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## TIER-Plus — User Guide

*A decision-support tool for trade-off analysis in HIV service planning*



## What is TIER-Plus

TIER-Plus is a planning tool for national HIV programme stakeholders to support annual budget allocation and resource

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# Then it's time to play – or build scenarios

Adapt the coverage of different interventions (populate different scenarios for comparison)

Add more interventions, and/or take some away



With this information, more and less of different interventions, TIER-Plus can then compare the impact on costs and outcomes

For example:

- Scenario 1: Reducing condoms while increasing lenacapavir
- Scenario 2: halve community testing

## Prevention

**Total lenacapavir**  
Baseline: 1,624  
people (all groups)

Scenario 1

40,000

Scenario 2

1,624

**VMMC** ⓘ  
Baseline: 274,325  
annual people

Scenario 1

274,325

Scenario 2

274,325

**Condom distribution** ⓘ  
Baseline: 21,739,000  
condoms distributed

Scenario 1

17,391,200

Scenario 2

21,739,000

## Testing & Diagnosis

**Testing: facility-based (general)** ⓘ  
Baseline: 3,671,497  
tests performed

Scenario 1

3,671,497

Scenario 2

3,671,497

**Testing: network testing** ⓘ  
Baseline: 0  
tests performed

Scenario 1

0

Scenario 2

0

**Testing: index testing** ⓘ  
Baseline: 291,365  
tests performed

Scenario 1

291,365

Scenario 2

291,365

**Testing: community-based** ⓘ  
Baseline: 516,869  
tests performed

Scenario 1

516,869

Scenario 2

258,435

# IAS TIER-Plus - HIV Intervention Impact Calculator



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# What TIER-Plus produces (outputs) 1/3

→ Two scenarios compared to the baseline

*1-year outputs*

## a. Progress towards 95-95-95s

| Baseline                                   | Scenario 1                                          | Scenario 2                                            |
|--------------------------------------------|-----------------------------------------------------|-------------------------------------------------------|
| 1st 95: % of PLHIV diagnosed <b>95.6%</b>  | 1st 95: % of PLHIV diagnosed <b>95.6%</b><br>(0pp)  | 1st 95: % of PLHIV diagnosed <b>95.3%</b><br>(-0.3pp) |
| 2nd 95: % of diagnosed on ART <b>97.8%</b> | 2nd 95: % of diagnosed on ART <b>97.8%</b><br>(0pp) | 2nd 95: % of diagnosed on ART <b>97.8%</b><br>(0pp)   |
| 3rd 95: % on ART suppressed <b>98.1%</b>   | 3rd 95: % on ART suppressed <b>98.1%</b><br>(0pp)   | 3rd 95: % on ART suppressed <b>98.1%</b><br>(0pp)     |

## b. Key epidemiological outcomes

| Baseline                              | Scenario 1                                  | Scenario 2                                   |
|---------------------------------------|---------------------------------------------|----------------------------------------------|
| New Adult Acquisitions: <b>30,400</b> | New Adult Acquisitions: <b>30,357</b> (-43) | New Adult Acquisitions: <b>31,115</b> (+715) |
| New Infant Acquisitions: <b>2,004</b> | New Infant Acquisitions: <b>2,004</b> (0)   | New Infant Acquisitions: <b>2,004</b> (0)    |
| HIV-Related Deaths: <b>16,340</b>     | HIV-Related Deaths: <b>16,340</b> (0)       | HIV-Related Deaths: <b>16,405</b> (+65)      |

# What TIER-Plus produces (outputs) 2/3

## c. Health outcomes (relative to baseline)

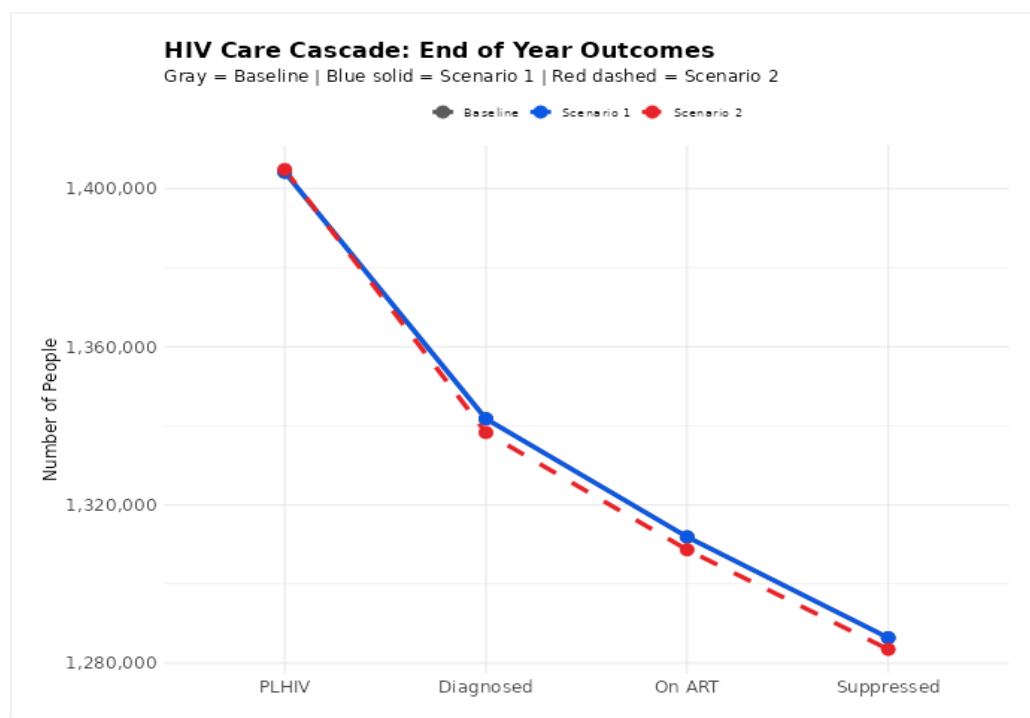
| Scenario 1                                 | Scenario 2                                  |
|--------------------------------------------|---------------------------------------------|
| Change in Acquisitions: <b>-43 (-0.1%)</b> | Change in Acquisitions: <b>+715 (+2.4%)</b> |
| Change in Deaths: <b>0 (+0.0%)</b>         | Change in Deaths: <b>+65 (+0.4%)</b>        |
| Change in Suppressed: <b>0 (+0.0%)</b>     | Change in Suppressed: <b>-2,925 (-0.2%)</b> |

## d. Cost analysis

| Baseline                                 | Scenario 1                               | Scenario 2                               |
|------------------------------------------|------------------------------------------|------------------------------------------|
| Intervention <b>\$76,404,822</b>         | Intervention <b>\$77,712,800</b>         | Intervention <b>\$75,752,464</b>         |
| Costs:                                   | Costs: <b>(+\$1,307,978)</b>             | Costs: <b>(-\$652,358)</b>               |
| ART Provision: <b>\$168,042,006</b>      | ART Provision: <b>\$168,042,006</b>      | ART Provision: <b>\$167,554,409</b>      |
|                                          |                                          | Provision: <b>(-\$487,597)</b>           |
| Total Program Cost: <b>\$244,446,828</b> | Total Program Cost: <b>\$245,754,806</b> | Total Program Cost: <b>\$243,306,873</b> |
|                                          | Program Cost: <b>(+\$1,307,978)</b>      | Program Cost: <b>(-\$1,139,955)</b>      |

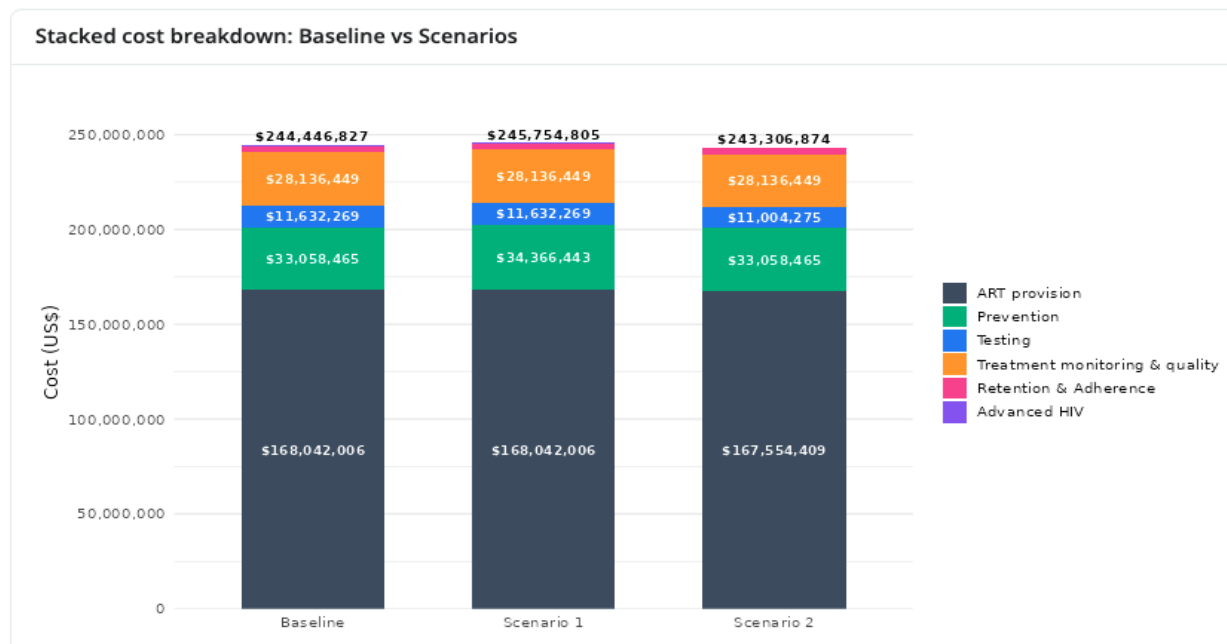
# What TIER-Plus produces (outputs) 3/3

## e. Impact on HIV care cascade



## f. Cost breakdown

### Cost by Programme Area (US\$)



## IAS TIER-Plus - HIV Intervention Impact Calculator

Select Regional Profile:

Zambia

Epidemic Parameters  
(Start of Year)

Total Population:

21,913,874

HIV Prevalence among people  
aged 15+ (%):

10,7

New HIV Acquisitions/Year:

30,400

% of PLHIV Diagnosed:

95,3

% Diagnosed on ART:

98

[Share feedback](#) [dsd@iasociety.org](mailto:dsd@iasociety.org)

User Guide

Baseline Coverage

Scenarios

Results Comparison

Parameters

### TIER-Plus — User Guide

*A decision-support tool for trade-off analysis in HIV service planning*

The screenshot displays the TIER-Plus User Guide interface. It features a navigation bar with tabs: User Guide, Baseline Coverage, Scenarios, Results Comparison, and Parameters. The main content area is titled 'TIER Plus Tutorial' and includes a video player with a red play button. Below the video, there are several input fields for parameters, organized into two columns. The left column includes fields for 'Total Population', 'HIV Prevalence among people aged 15+ (%)', 'New HIV Acquisitions/Year', '% of PLHIV Diagnosed', '% Diagnosed on ART', and '% on ART Suppressed'. The right column includes fields for 'Scenario 1' and 'Scenario 2' for various parameters. A 'Watch on YouTube' button is visible at the bottom right of the video player.

### What is TIER-Plus

TIER-Plus is a planning tool for national HIV programme stakeholders to support annual budget allocation and resource

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# What if you want to adjust the assumptions?

[User Guide](#)[Baseline Coverage](#)[Scenarios](#)[Results Comparison](#)[Parameters](#)

## Effectiveness and unit cost assumptions

**Note:** Values below represent those used as the defaults for the modelling results, informed by literature or country data where available. If these differ from your expectations, you can override them for this country session. Selecting a different country will reset these values to the defaults. This can also be done using the reset button at the bottom of the tab.

Percentage-point gain in viral suppression among established ART clients (on ART >1 year). Applied only where annual clinical visits are switched on in a scenario.

### Unit costs (USD)

#### Prevention

Oral PrEP, cost of a full 12 months per person

FSW [i](#)

MSM [i](#)

AGYW [i](#)

General population [i](#)

Lenacapavir, per person initiating

FSW [i](#)

MSM [i](#)

AGYW [i](#)

General population [i](#)

Other prevention, per unit delivered

VMMC [i](#)

Condoms (per condom) [i](#)

Infant prophylaxis [i](#)

# What TIER-Plus **can** and **cannot** do

## What TIER-Plus **can** do

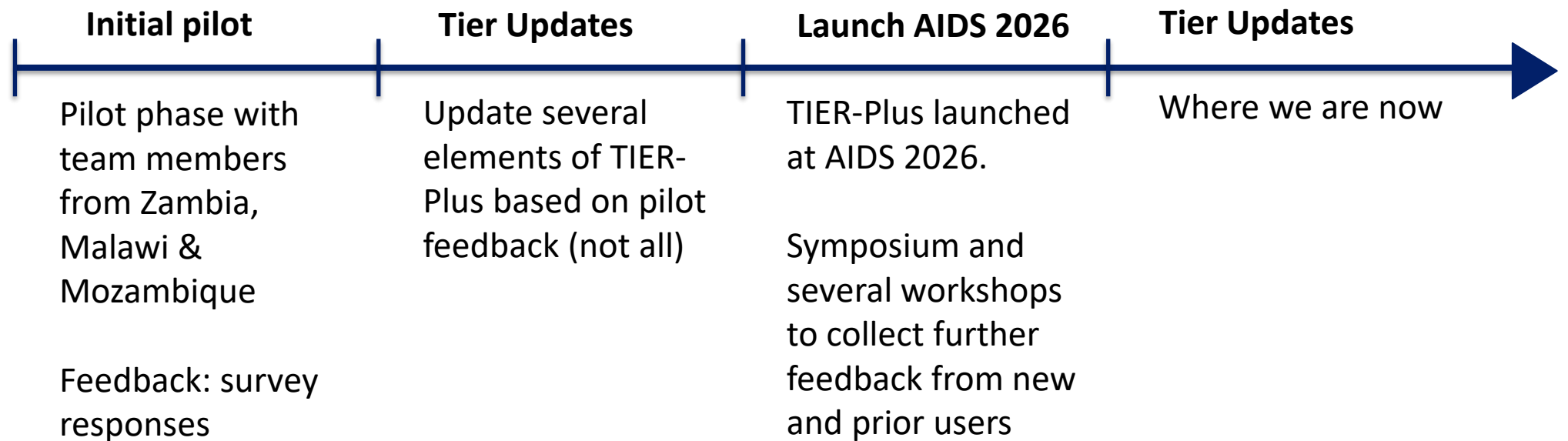
-  Support decision making conversations at a national level
-  Look at the impact across the cascade of multiple interventions
-  Give an understanding of relative impact of different interventions on both outcomes and cost

## What TIER-Plus **cannot** do

-  Provide exact cost estimates for budgeting
-  Give long-term estimates on epidemic impact
-  Replace intervention-specific planning (use DMPPT, PrEP-it, etc.)

## INTEGRATION

# TIER-Plus pilot, launch and feedback collection (so far)



# The piloting phase

The piloting phase had resulted in several meaningful changes before the AIDS 2026 launch:

✓ PrEP targeting by sub-population

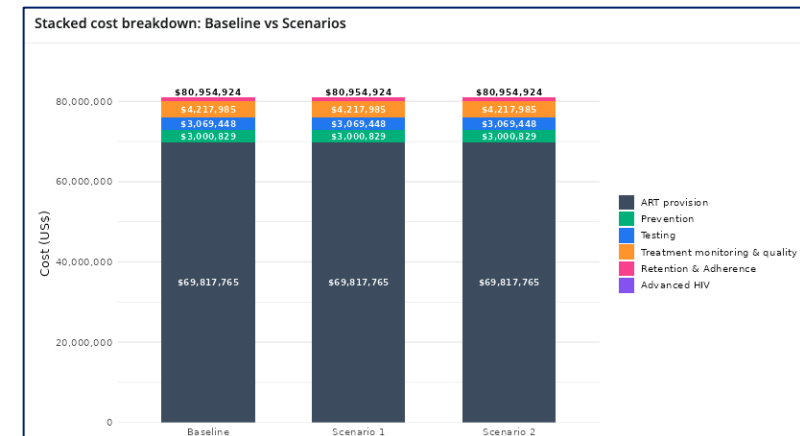
✓ Inclusion of 6-monthly clinical visits vs 12-monthly clinical visits

✓ Output including cost breakdown by category of costs

✓ Users able to update cost and effectiveness parameters

|                                                                                                  |                                                  |
|--------------------------------------------------------------------------------------------------|--------------------------------------------------|
| <b>Oral PrEP (FSW)</b> ⓘ<br>Baseline: 919<br>people receiving or initiating PrEP this year       | Scenario 1<br><input type="text" value="919"/>   |
| <b>Oral PrEP (MSM)</b> ⓘ<br>Baseline: 350<br>people receiving or initiating PrEP this year       | Scenario 1<br><input type="text" value="350"/>   |
| <b>Oral PrEP (AGYW)</b> ⓘ<br>Baseline: 1,731<br>people receiving or initiating PrEP this year    | Scenario 1<br><input type="text" value="1,731"/> |
| <b>Oral PrEP (General)</b> ⓘ<br>Baseline: 3,630<br>people receiving or initiating PrEP this year | Scenario 1<br><input type="text" value="3,630"/> |

|                                                                                              |                                                                                         |
|----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|
| <b>Frequency of clinical visits for stable clients</b> ⓘ<br>Baseline: 0<br>standard practice | Scenario 1<br><input checked="" type="radio"/> 6 months <input type="radio"/> 12 months |
|----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|



|                                                        |                                           |                                            |                                                          |
|--------------------------------------------------------|-------------------------------------------|--------------------------------------------|----------------------------------------------------------|
| <b>Oral PrEP</b>                                       |                                           |                                            |                                                          |
| Effectiveness (%) ⓘ<br><input type="text" value="74"/> |                                           |                                            |                                                          |
| Average duration on PrEP, by group (months)            |                                           |                                            |                                                          |
| FSW ⓘ<br><input type="text" value="2.4"/>              | MSM ⓘ<br><input type="text" value="4.2"/> | AGYW ⓘ<br><input type="text" value="2.4"/> | General population ⓘ<br><input type="text" value="2.4"/> |

# Feedback from pilot phase and AIDS sessions generated many other suggestions/additions

## Feedback/ Potential next steps

Adding additional countries

PrEP targeting to pregnant and breastfeeding women

Include a third scenario option

Greater capabilities to upload and share setting between sessions and team members

Expanded documentation on assumptions and sources of data – particularly for cost and effectiveness parameters

Expanded list of community interventions and impact

Additional cost breakdown by type – HR, commodities, demand creation

Subnational models

Including adoption of new technologies and policies e.g frequency of routine viral loads

Projections to 3-years

# TIER-Plus is a living tool

We need and want your feedback to make TIER-plus as useful as possible!

What else would you like to see?

Please explore and provide feedback!





# Using TIER-Plus to Inform HIV Programme Prioritization: Experience from Mozambique

Lessons for evidence-informed planning in a changing funding landscape

Irénio Gaspar, Ministry of Health, Mozambique



# Mozambique context (1)

Mozambique HIV estimates, 2025

| Population estimate                            | Total     | % of total PLHIV | Confidence interval |
|------------------------------------------------|-----------|------------------|---------------------|
| <b>No. of PLHIV</b>                            | 2,470,000 | –                | 2.26–2.72 million   |
| <b>Adults aged 15+ living with HIV</b>         | 2,300,000 | 93%              | 2.11–2.58 million   |
| Men aged 15+ living with HIV                   | 800,000   | 32%              | 723,000–885,000     |
| Women aged 15+ living with HIV                 | 1,520,000 | 62%              | 1.38–1.68 million   |
| Pregnant women living with HIV                 | 120,000   | –                | 103,000–135,000     |
| <b>Young people aged 15–24 living with HIV</b> | 285,000   | 12%              | 171,000–367,000     |
| <b>Children aged 0–14 living with HIV</b>      | 157,000   | 6%               | 136,000–180,000     |
| <b>New infections</b>                          | 77,000    | –                | 57,000–96,000       |
| New infections per day                         | 211       | –                |                     |
| New infections among adults                    | 65,000    | –                | 48,000–84,000       |
| New infections among children                  | 12,000    | –                | 9,000–17,000        |
| <b>Vertical transmission rate</b>              | 9.8%      | –                | 7.8%–12.7%          |
| <b>HIV/AIDS-related deaths</b>                 | 38,000    | 2%               | 32,000–46,000       |

Source: 2025 Estimates, Spectrum v6.43

AIDS 2026 • Rio de Janeiro, Brazil

## Why prioritization matters now

- Mozambique manages one of the world's largest HIV programmes, with 2.07 million people on ART and 83.8% ART coverage.
- The HIV response remains heavily dependent on external financing, particularly from the U.S. Government (USG) and the Global Fund, in an increasingly constrained funding environment.
- As the country transitions towards government-led, integrated, and sustainable service delivery, the Ministry of Health must balance HIV investments with broader health priorities.
- Evidence-informed prioritization is critical to maximize health impact, improve efficiency, and protect equity.

# Mozambique context (2)

## Key Challenge: Large national HIV program with diverse service delivery needs

- Sustaining lifelong treatment while protecting prevention, community services, commodities, health workers, data and quality of care.
- Persistent geographic and population inequalities, alongside major gaps among children, adolescents, men and pregnant women.
- Limited granular cost and impact data to support difficult choices under reduced funding ceilings.

## Why join TIER-Plus validation?

- **Respond to increasing pressure to optimize resources:** Participate in testing a transparent, evidence-informed approach to compare interventions and investment scenarios.
- **Support program sustainability amid funding changes:** Generate timely insights on how prioritization decisions may affect program costs, outcomes, and epidemic control.
- **Strengthen evidence-based planning and decision-making:** Apply the tool using Mozambique's data to ensure country realities and priorities inform its further refinement.

# Prioritization Approaches Used to Date

Mozambique used TIER-Plus as a complementary resource to support existing national prioritization processes by helping to:

## Protect essential services

- Prioritize high-impact HIV services during funding constraints.

## Target investments

- Focus resources where epidemiological and program data indicate the greatest need.

## Compare funding scenarios

- Assess the implications of different resource allocation options.

## Support transition planning

- Inform integration, sustainability, and government-led service delivery.

## Strengthen the evidence base

- Generate evidence to support strategic planning and resource allocation.

Stakeholders engaged: MoH • Provinces • Donors • Partners • Civil Society • PLHIV Networks

# Current Prioritization Questions

|                   |                                                                                |
|-------------------|--------------------------------------------------------------------------------|
| <b>Protect</b>    | Which services must be protected under severe funding reductions?              |
| <b>Focus</b>      | Which populations and geographies should be prioritized?                       |
| <b>Simplify</b>   | What can be integrated, simplified, transitioned or discontinued?              |
| <b>Reorganize</b> | How should community services and human resources be configured?               |
| <b>Transition</b> | How can partner-supported activities move to sustainable Government ownership? |

**Objective: maximize impact, equity and sustainability with available resources.**



# Experience Using TIER-Plus

## What worked

- **Supported iterative prioritization**  
Compared investment scenarios to inform program optimization as funding evolved
- **Strengthened evidence-informed decisions**  
Estimated potential health impact to identify higher-value investments.
- **Facilitated transparent dialogue**  
Provided a common evidence base for discussions across government, donors, partners and civil society.
- **Supported strategic planning**  
Contributed to resource allocation and transition planning towards a more sustainable HIV response.

## What needs improvement

- **Improve data traceability**  
Clearly display data sources, unit costs, and update dates.
- **Strengthen country customization**  
Enhance calibration to better reflect national epidemiology and programme context.

## Lessons Learned

- Prioritization works best when country-led.
- Modelling complements program experience.
- Stakeholder engagement builds trust.
- Data quality remains critical.
- Transparent processes improve acceptance of difficult decisions.

**TIER-Plus has strong potential to support evidence-informed prioritization when it is transparent, country-adapted, and embedded within a country-led planning process**

# Strengths and Limitations

## Strengths

- **Rapid scenario comparison**
  - Supports early-stage prioritization and brainstorming.
- **Real-time implications**
  - Shows potential cost and epidemiological effects.
- **Strategic application**
  - Can inform planning, resource allocation and donor transition.

## Data and feasibility considerations

- **Reliable, current data**
  - Requires updated coverage, unit cost and outcome data.
- **Subnational precision**
  - Limited disaggregation can reduce the accuracy of results.
- **Implementation reality**
  - Workforce needs and delivery capacity are not fully captured.

# Ongoing Opportunities and Feedback

- **It is important to keep TIER-Plus simple and practical.**
  - While there are adjustments and additions that could strengthen the tool, it will be critical to retain its simplicity and ease of use.
- **Use TIER-Plus to support ongoing prioritization and implementation.**
  - Even with Mozambique's MOU signed and the GC8 planning completed, TIER-Plus remains useful as the funding is operationalized and priorities evolve.
- **Opportunities to expand the utility of TIER-Plus if it could be used:**
  - At the sub-national level
  - Over a longer time horizon (beyond one year)
  - To assess future policies, interventions and products
- **Opportunities for ongoing feedback and improvements.**
  - Feedback from Mozambique has already been taken on board by the IAS modelling team e.g., around improving model transparency, making assumptions and input–output relationships more explicit

# Next Steps

## 1 Validate

Finalize feedback and retest with updated national coverage, cost and epidemiological data.

## 2 Apply

Explore country use for prioritization, strategy, resource allocation and donor transition.

## 3 Improve

Clarify assumptions, costs, metadata, calibration and implementation feasibility.

**TIER-Plus should inform, not replace, country-led decisions.**



# Thank you

