Australian Government
Department of Foreign Affairs and Trade

Investment Concept

Australian Support for Pacific HIV Action (ASPHA)	
Start date: July 2026	**End date:** June 2031
Total proposed DFAT funding: AUD 48 million	**Total proposed funding from all donor/s:** TBC
Initial Risk: medium	**Value:** medium
Proposed design pathway: ADAPT design-implement, partner-led	
Quality Assurance: Virtual peer review of concept; independent appraisal and peer review of forthcoming design	
Policy Approval: Delegate at Post: N/a	**Delegate in Canberra:** FAS Global Health Division (GHD)

A. DEVELOPMENT CONTEXT (WHAT IS THE PROBLEM?)

HIV IN THE PACIFIC: SITUATIONAL UPDATE

A rapidly escalating human immunodeficiency virus (HIV) epidemic in Fiji threatens to overwhelm Fiji's health system, create serious economic and social impacts, and initiate or worsen HIV outbreaks elsewhere in the Pacific. Rising rates of HIV will create a major, long-term burden on the region. This is compounded by increasing rates of co-infections, particularly tuberculosis (TB) and blood-borne viruses (BBVs) such as viral hepatitis. Sexually transmitted infections (STIs) are endemic across the Pacific and are associated with an increased risk of acquiring HIV.

Fiji

Fiji's HIV epidemic is growing at an alarming pace. In 2024, Fiji recorded its highest-ever annual total of new HIV diagnoses (1,583 cases), up nearly threefold since 2023 and nine-fold since 2018. The Government of Fiji formally declared an HIV outbreak in January 2025.

According to the most recent UNAIDS data, in 2024, 36% of Fijians living with HIV were aware of their HIV status and 24% were receiving treatment. Data from the first half of 2024 reported that approximately 50% of new HIV infections, where mode of transmission was known, were acquired through the sharing of needles/syringes and other drug paraphernalia during injecting drug use. Other at-risk groups include men who have sex with men and female sex workers, with the latter group testing as high as 40% HIV positivity in preliminary results from a recent survey in Suva.

Other Pacific Island countries (PICs)

The reported incidence of HIV in other PICs has, to date, been low. However, these countries share multiple risk factors making the spread of HIV more likely. These factors include low HIV literacy; low rates of HIV testing; high rates of other STIs; low rates of condom use; limited access to pre- and post-exposure prophylaxis and other harm-reduction measures such as needle and syringe programs and challenging environments for people living with HIV and key populations.

Papua New Guinea

While HIV prevalence has been high in Papua New Guinea (PNG) for the last two decades, it has seen a sharp resurgence in recent years with the number of reported cases steadily increasing. There were an estimated 11,000 new HIV infections in 2024, with significant increases in the rate of vertical (parent to infant) transmission. At least 120,000 people are currently living with HIV. Less than half of those living with HIV are on treatment, and co-infection with TB (including cases of drug-resistant TB) and critical health system gaps are contributing to persistent, high HIV-related mortality.

On 26 June 2025, the PNG Minister for Health declared the increase in cases to be a 'National HIV Crisis'. A sizeable funding gap (approximately AUD 70 million per year) remains to fully implement the National HIV Strategy.

A more detailed situational update on HIV in the Pacific is provided at Annex 1.

Global HIV financing is contracting at the same time as the Pacific's needs are growing. Global health organisations are under significant fiscal pressure at a time of global funding uncertainty. The global funding environment means the region will be increasingly reliant on domestic financing and bilateral support to sustain prevention, testing, treatment, and technical coordination functions.

SUMMARY OF PROPOSED INVESTMENT

Australian Support for Pacific HIV Action (ASPHA) is a major new DFAT investment designed to encourage and support Pacific governments to implement effective and sustainable HIV programs in response to growing threats to the region's health systems, societies and economies.

ASPHA will strengthen government and community-led responses through a package of technical assistance, community-based prevention and support initiatives, health commodity procurement, and human resources support, tailored to country needs and ambition.

A rapid response phase in 2025-26 will address urgent needs in Fiji and fund rapid HIV and TB assessments in other PICs on request. The broader initiative, starting in 2026-27, will support nationally-led HIV response efforts, with Australian support intended to encourage partner government co-investment. ASPHA will draw on a minimum of AUD 48 million over six years including rapid-response activities (with potential additional contributions from Pacific bilateral and regional programs).

Fiji will be a major focus due to the rapid growth of its HIV outbreak and potential to cause or exacerbate outbreaks elsewhere in the Pacific. Other PICs will receive support focused on prevention, surveillance, and system strengthening. In PNG, ASPHA will provide some targeted support, complementing Australia's investments through the bilateral health program.

ASPHA's primary focus is on HIV prevention, testing, treatment and care. However, in some cases it will be appropriate to support integrated responses with common co-infections such as TB, STIs and BBVs. Where scope and funding allow, and at the request of national governments, ASPHA funding may support standalone activities for these illnesses, based on national needs.

The proposed design approach for ASPHA, outlined in Section F, is for this Investment Concept Note (ICN) and consultations to inform a call for proposals process to select delivery partners. Selected partners will develop partner-led designs and DFAT will draft an overarching Investment Design Summary (IDS) for the ASPHA investment as a whole.

B. STRATEGIC INTENT AND RATIONALE (WHY SHOULD AUSTRALIA INVEST?)

POLICY OBJECTIVES

DFAT's policy objectives for ASPHA are as follows:

- **Stabilise the HIV epidemic in Fiji:** support Fiji to bring its rapidly escalating HIV outbreak under control.
- **Support other PICs to build strong evidence-based and sustainable HIV programs:** support selected countries to strengthen national HIV programs to prevent and respond to rises in HIV cases.
- **Reinforce Australia's role as the development partner of choice in the region**: demonstrate visible, high-impact Australian leadership on a pressing but sensitive regional health issue, reinforcing Australia's reputation as a reliable, responsive and effective partner, and strengthening bilateral relationships with Pacific governments.
- **Prevent broader socio-economic and labour market disruptions linked to uncontrolled HIV transmission**: mitigate the extent of the impact of Fiji's HIV epidemic on other sectors, including tourism, education, and labour mobility by intervening early and effectively.
- **Enhance regional and domestic health security for Australia**: strengthen Pacific health systems to detect, prevent, and respond to communicable disease threats, reducing the risk of HIV transmission into Australia and reinforcing regional health resilience as part of Australia's broader Indo-Pacific health security agenda.

ASPHA aligns with Australia's International Development Policy, the Pacific Regional Development Partnership Plan (DPP) 2025-2029 and bilateral DPPs by directly supporting better health outcomes and strengthening health systems in the Pacific and mitigating a significant risk to broader development objectives.

ASPHA will align closely with Australia's development principles by embedding partnership, effectiveness, value for money, and accountability into its core design and implementation. **Partnership** will be central, with national governments leading the process—determining priorities, shaping support, and co-financing interventions to ensure ownership and sustainability. To ensure **effectiveness**, ASPHA will focus exclusively on globally recognised, evidence-based HIV interventions, while tailoring them through in-country consultations to reflect local contexts and needs. To maximise **value for money**, the initiative will utilise pooled procurement mechanisms for health commodities, improve efficiency through multi-country or regional approaches and encourage partner government co-financing. **Accountability** will be upheld through a robust results framework featuring clear indicators and targets, with transparent public reporting and a mid-term assessment to inform continuous improvement.

ODA eligibility

The Official Development Assistance (ODA) Eligibility Flowchart has been followed for this investment and confirms the proposed new investment is **ODA eligible** as it promotes development and welfare in ODA-eligible countries. A formal ODA eligibility assessment is not required for this new investment.

Where ASPHA's Pacific regional elements potentially interact with Pacific countries that are not ODA-eligible (such as Cook Islands) or graduating from ODA, Global Health Division (GHD) will work closely with the Office of the Pacific (OTP) and Development Policy Division (DPD) to ensure that funds are programmed and expensed in line with ODA requirements.

Lessons from previous DFAT and other donor engagement

DFAT has implemented several HIV programs in the Indo-Pacific region over the past two decades, including the HIV Consortium (2008-2012), the Australian HIV/AIDS Partnership Initiative (2004-2007), the Regional HIV Capacity Building Program (RHCBP) (2012-2015, AUD 10 million) and the PNG HIV Response (1995-2010, AUD 250 million).

GHD has reviewed independent evaluations and consulted DFAT staff involved in their implementation to document key lessons and critical shortcomings. ASPHA will draw on lessons learned from past programming to improve impact and value for money. This will include clearer design, strong monitoring and evaluation and governance and increased engagement with key populations to prioritise local leadership and integration with broader health systems.

C. PROPOSED OUTCOMES AND INVESTMENT OPTIONS (WHAT?)

PROPOSED INVESTMENT APPROACH

ASPHA will have a core budget of AUD 48 million over six years from 2025-26. ASPHA will be designed to allow DFAT to respond flexibly to evolving country needs, including the capacity to scale up rapidly where there is additional funding from bilateral and regional programs and demand. The ASHPA program logic and monitoring, evaluation and learning (MEL) framework will be adaptive and revised if additional funding becomes available.

The investment will adopt a differentiated strategy tailored to each context:

- In Fiji, funding will support implementation of the National HIV Outbreak Response Plan and related national strategic plans that will follow. This includes, but is not limited to, the procurement of health commodities and the related systems to deliver those commodities, surge human resource support to the new HIV/sexual and reproductive health (SRH) Unit, implementation of needle and syringe programs and the provision of technical assistance across prevention, diagnostics, treatment and surveillance.
- In the broader Pacific, the program will help to identify and then support individual country needs. Initial investments will include country-level assessments of national HIV and TB programs and response planning. Ongoing programming will be based on results from rapid assessments and consultation with countries on their prioritised approach. Support may include technical assistance, testing and prevention services, and limited health commodity support. A regional approach will be used where appropriate—for example, in surveillance system strengthening, clinical guideline development, and training of health workforce—to promote standardisation, cost-efficiency, and South–South collaboration.
- In PNG, where the scale of the outbreak and funding gaps for HIV are larger, investments will be more targeted. ASPHA will complement Australia's growing bilateral investments in HIV by providing targeted, additive support to existing partnerships. This may include topping up funding to bilateral initiatives in consultation with Port Moresby post. It would not include significant commodity procurement. This approach ensures alignment with Australia's broader health engagement in PNG, while contributing to high-impact areas within the national HIV response. PNG would also be included in activities related to regional dialogue and exchange where possible.

ASPHA aims to deliver both immediate impact and build longer-term sustainability in nationally-led HIV programs.

A comprehensive mid-term review of progress will assess progress, system readiness and evolving country needs. This will inform program implementation and consideration of subsequent Australian support to prevent and respond to HIV and related co-infections in the Pacific.

Rapid Response Phase – 2025-26

To address urgent needs ahead of full program design, a rapid response phase will be initiated in late 2025, with an estimated budget of up to AUD 6 million. In this phase, Australia will offer rapid needs assessments to all ODA-eligible Pacific Island Countries (PICs) to identify gaps in national HIV and TB programs and develop prioritised responses. In Fiji, support will focus on immediate unfunded priorities, including procurement of essential health commodities and critical human resource positions within the national HIV/SRH Unit. Indicative activities planned for the rapid response phase are detailed in Annex 3.

An Adaptive Design and Procurement (ADAPT) pathway has been approved to enable early implementation ahead of full program design. Funding will be drawn from existing GHD and bilateral streams, with Suva Post indicating a likely commitment of an additional AUD 2.5 million in FY 2025–26.

Main Program Implementation – 2026-27 to 2030-31

Main program implementation is structured around two key dimensions: interventions and delivery modalities. The *interventions* represent the types of activities that may be funded—such as prevention, testing and linkage to care, treatment and retention, community-led responses, health system strengthening, and efforts to address structural barriers. These are the *what* of the investment: the areas where support may be directed based on country needs and priorities. In contrast, the *modalities* refer to how these interventions will be delivered—through health commodity procurement, technical assistance, and human and administrative support. These modalities are the mechanisms through which Australia's investment will be operationalised. The final scope of interventions and modalities will be determined through rapid assessments, consultations with national stakeholders, and alignment with national HIV and TB plans and will be articulated in partner-led designs.

The program may fund interventions across eight core areas:

- Prevention for key populations: the program may support a range of HIV prevention strategies, including condom and pre-exposure prophylaxis (PrEP) programming, community-led outreach, awareness campaigns, peer navigation services and harm reduction for people who inject drugs.
- Elimination of Vertical Transmission: funding may focus on integrated testing and prevention services for pregnant and breastfeeding women to prevent transmission of HIV (and syphilis and Hepatitis B), along with early infant diagnosis and follow-up care for infants.
- HIV and STI Testing: support may be provided for facility-based, community-based, and self-testing approaches, particularly for key populations.
- Treatment, Care and Support: the program may invest in differentiated HIV treatment services for adults and children, monitoring of treatment outcomes, and management of co-infections and advanced disease. The investment may also support antiretroviral therapy (ART) adherence programs, strategies to reduce loss to follow-up and differentiated service delivery models.
- TB/HIV Co-Infection: funding may support integrated screening, treatment, and prevention services for individuals with TB/HIV co-infection.
- TB Diagnosis, Treatment and Prevention: support may include TB screening and diagnosis, treatment and care for drug-sensitive and drug-resistant TB, and preventive interventions.

- Reducing Human Rights-Related Barriers to HIV/TB Services: investments may address stigma, discrimination, gender-based violence, and legal barriers that hinder access to HIV and TB services including activities such as legal literacy, policy reform, and community advocacy to promote equitable, rights-based healthcare.
- Health System Strengthening: investments may target improvements in supply chains, surveillance and laboratory systems, health workforce training, data systems, community health worker support, essential medicines listing, and integration of HIV content into medical and university curricula.

These activities will be delivered through three primary modalities:

1. Health commodity procurement: this investment may support the procurement of essential HIV-related health commodities to ensure timely access to critical tools for diagnosis, prevention, and treatment.
2. Technical assistance will provide expert support to help countries design, implement, and strengthen their HIV responses.
3. Human resource and administrative support, including funding for critical HR roles within national HIV programs and community programs as well as support for the actual delivery of programs (i.e. per diems, transport costs, rental of venues etc.)

A note on health commodity procurement: ASPHA will fund the procurement of commodities that are immediately required and have a high impact on service delivery, such as pre-exposure prophylaxis (PrEP), needles and syringes for harm reduction, male and female condoms, HIV test kits, and laboratory consumables.

Importantly, the initiative will generally avoid procuring life-long commodities with ongoing demand—such as ART and associated viral load supplies—which will only be sustainable if financed through national budgets.

ASPHA will require an adaptive delivery approach — one capable of rapidly shifting resources, tailoring interventions, and recalibrating priorities as the epidemic progresses, new data and evidence emerge and with changes in national government approaches — to ensure relevance, effectiveness, and impact.

PROPOSED OUTCOMES

GHD has developed a preliminary program logic to help frame the ASPHA investment. Final decisions on which components will be financed — and to what extent — will be made following the evaluation of proposals from implementing partners. A comprehensive and refined program logic will be developed and included in the Investment Design Summary (IDS). The IDS will include an intermediate outcome on gender equality (see GEDSI section).

The goal of the program, shared with the Partnerships for a Healthy Region initiative, is *Australian assistance contributes to improved ability of partner countries to anticipate, prevent, detect and control communicable disease threats and to address equity in the delivery of these functions.*

The strategic objective is *Australia reinforces its role as a trusted development partner in the Pacific and supports effective HIV responses that safeguard public health and mitigate socio-economic risks to the broader region.* This objective reflects broader Australian national interests in investing in public health and the HIV response in the Pacific.

The development objectives for this investment are that i) *Fiji's HIV epidemic is stabilised, with sustained reductions in incidence and HIV related mortality with measurable progress towards the 95-95-95 targets,*

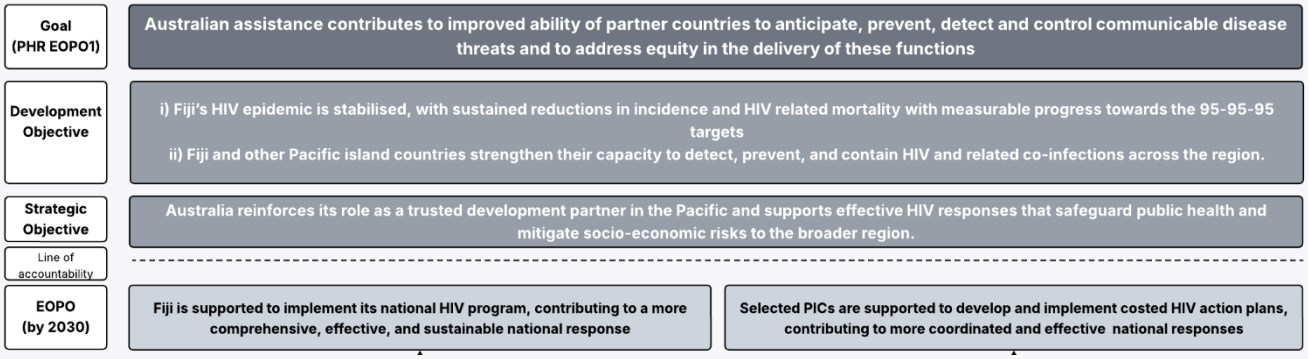
and ii) Fiji and other Pacific island countries strengthen their capacity to detect, prevent, and contain HIV and related co-infections across the region. The 95-95-95 targets refer to global targets that at least 95% of people living with HIV know their HIV status, at least 95% of people who know their HIV status are on treatment, and at least 95% of people on treatment have a supressed viral load.

While these objectives sit above DFAT's direct line of accountability, ASPHA has been structured to deliver two clear End of Program Outcomes (EOPOs):

- EOPO 1: Fiji is supported to implement its national HIV program, contributing to a more comprehensive, effective, and sustainable national response.
- EOPO 2: Selected PICs are supported to develop and implement costed HIV action plans, contributing to more coordinated and effective national responses.

These EOPOs are deliberately framed at the country level, rather than being limited to government-led action, to recognise that a comprehensive HIV response will necessarily involve both government and non-governmental led interventions.

A simplified program logic diagram is included below, with a more detailed version in Annex 5 including indicative intermediate and short term outcomes.



Intermediate outcomes will be defined in the IDS. A detailed ASPHA MEL framework will be developed as part of the IDS and finalised in the inception period.

GUIDING PRINCIPLES

National ownership and leadership are essential elements to enable sustainable progress and impact. ASPHA will work in partnership with governments to strengthen their leadership of their HIV responses, including through negotiated increases in domestic co-financing, as investments are most effective when aligned with a country's own health priorities and spending. Through ASPHA, DFAT will also advocate for policy reforms that enable more effective and inclusive service delivery such as integration of HIV and TB programs into the broader health system and enabling governments to contract civil society organisations to deliver HIV services. DFAT will prioritise funding for activities within existing national strategic plans where they exist. This approach ensures that the investment reinforces country priorities, builds institutional capacity and supports long term sustainability of national HIV responses. Sustainability will also inform funding decisions: DFAT may choose not to fund recurring costs unless a clearly negotiated transition or 'off-ramp' is identified upfront.

Stigma, discrimination and punitive legal environments undermine effective HIV responses, introducing barriers to access to services and uptake of testing and treatment. ASPHA will adopt a rights-based approach that aims to support the ability for all individuals, regardless of HIV status, gender, sexual orientation, disability or other identity markers, to access services safely and equitably. This may include working with partners to identify and address structural barriers, including promoting legal literacy, and supporting advocacy for enabling legal and policy environments. Community and peer-led organisations are uniquely

positioned to build trust with communities and key populations for effective service delivery, and to advocate for those most affected.

DFAT recognises that issues related to HIV are sensitive in nature in some Pacific societies. Engagement will be handled carefully to avoid unintended consequences or undermining of local efforts.

Locally led development is a central to ASPHA's approach. ASPHA partners will work directly with local civil society organisations and key population groups to design interventions and activities that reflect local needs and priorities. Over time, partnerships with local organisations will likely grow as organisations build their experience and capability. Empowering locally led organisations will help support inclusive, equitable and sustainable approaches.

WHO WILL BENEFIT

The primary beneficiaries of the program will be those populations most affected by HIV and related co-infections, as identified through epidemiological evidence. While surveillance systems are expected to strengthen over time—providing more precise data on who is most at risk—the program will initially focus on key populations such as men who have sex with men, sex workers, transgender persons and people who inject drugs. Other priority groups include people in prisons or other closed settings, migrant populations, young people (who account for a significant proportion of new infections), pregnant women and infants, and individuals at heightened risk of HIV and co-infections. The scale and reach of the program will ultimately depend on the level of Australian funding available and on national government priorities.

GENDER, DISABILITY, SOCIAL INCLUSION (GEDSI) AND OTHER CROSS CUTTING ISSUES

ASPHA will have at least one GEDSI-specific intermediate outcome as part of its design. This will be articulated in the IDS. The MEL framework will report results disaggregated by sex, gender, age and disability, where the data is available.

Gender norms, unequal power dynamics and entrenched social inequalities are fundamental drivers of health disparities and can shape who is most at risk, who can access services, and who is left behind. Key populations within the context of HIV (men who have sex with men, transgender people, sex workers, people who use drugs and people in closed settings) are disproportionately affected by these dynamics. They often face intersecting forms of stigma, discrimination, and criminalisation, which are underpinned by gender norms and power imbalances. These experiences not only marginalise individuals but also undermine their access to essential health services, including mental health services, and ability to exercise agency over their health and wellbeing. ASPHA will prioritise engagement with key populations in the design and implementation of interventions to help address known barriers and enhance access to health services.

Gender norms and entrenched patriarchal power structures reinforce gender inequality, limiting access to essential health services for **women and girls**. High rates of gender-based violence (GBV), compounded by social and economic disparities, geographic isolation and inadequate sexuality education create significant barriers to sexual and reproductive health care. These factors increase HIV risk and hinder access to timely testing, treatment and care for women and girls. Pregnant women in particular are a priority group for ASPHA, noting vertical transmission of HIV remains a critical concern. Existing HIV programs often lack gender responsive strategies failing to adequately address the specific vulnerabilities of women and girls, contributing to HIV risk **(see Annex 4).**

Whilst data regarding the risk to HIV for **people living with a disability** is limited across Pacific Island nations, people living with a disability have a higher risk of exposure to HIV, whilst also facing a higher likelihood of

being left out of HIV programming. DFAT will consult with organisations of persons with disabilities (OPDs), key population organisations (KPOs) and other relevant civil society organisations to help ensure that perspectives and considerations from this group are captured and factored into programming.

GBV is a cross-cutting issue that significantly impacts key populations, women and girls, and people living with disabilities. GBV increases vulnerability to HIV by limiting access to testing, treatment and care due to fear, stigma and discrimination. Survivors often face barriers such as a lack of confidentiality, lack of or inaccessible services and judgemental attitudes from healthcare workers.

Numerous GEDSI analyses have already been conducted across the Partnerships for a Healthy Region (PHR) program, focusing on HIV, TB and SRH investments. These assessments (see Annex 4) have identified barriers to access that are faced by all populations such as GBV and stigma and discrimination. Insights and learnings from these assessments will inform the integration of considerations of inclusivity, equity, and diversity in the design phase.

Implementing partners will be encouraged to draw upon materials including regional and national commitments related to GEDSI, findings from rapid assessments, Australia's International Gender Equality Strategy and International Disability Equity and Rights Strategy and their own program implementation experience to develop an initial high level GEDSI action plan. The action plan will relate to their proposed program of activities demonstrating their understanding and mainstreaming of GEDSI elements. Partners will also be expected to consider GEDSI as part of their resource and budget allocation, ensuring that any identified needs and gaps are adequately resourced. Within six months of grant signing, partners will be required to refine and finalise their GEDSI action plans. DFAT will develop a whole-of-program GEDSI action plan during the early stages of the implementation phase to support a joined-up approach.

The whole-of-program GEDSI action plan will be integrated into the ASPHA MEL framework. Management meetings will be held to monitor progress of ASPHA implementation and will include progress on GEDSI action plans. Additionally, the mid-term review will include an assessment of GEDSI elements and progress of the GEDSI action plan of partners, with necessary programming adjustments to be made based on findings and recommendations that may identify any gaps or areas requiring a strengthened focus.

Safeguarding

Implementing partners will be required to demonstrate appropriate organisational policies and practices to prioritise the prevention of sexual exploitation, abuse and harassment (PSEAH) and child safeguarding. Additionally, they will need to identify and respond to safeguarding concerns in their risk management strategies and monitoring and evaluation requirements. Key populations are often already marginalised within societies and may face heightened safeguarding risks. Tailored strategies that ensure their rights and wellbeing are protected will be essential, in line with 'do no harm' approaches. In Fiji, data shows a significant proportion of new HIV incidence is among young key populations, meaning that proposed activities are highly likely to involve the engagement of young people under the age of 18. Further detail on risk considerations is outlined in Section E.

CLIMATE CHANGE

This investment will not have a climate change objective but the investment design summary will outline an approach to climate change mainstreaming.

Climate change can worsen many of the social and health conditions that contribute to HIV epidemics. Extreme weather events, food insecurity, migration, and health system strain all disrupt access to HIV testing and treatment, can increase risk behaviours, and weaken immune systems. For example, storms and floods can damage clinics and supply chains, forcing treatment interruptions, while economic hardship from lost livelihoods or food shortages can push vulnerable people toward transactional sex or drug use.

This investment will include activities that contribute to climate resilient health and community systems. For example, this investment may support countries to digitise their health system and records which would make critical patient information (such as HIV case histories and treatment plans) less vulnerable to natural disasters.

D. IMPLEMENTATION ARRANGEMENTS AND DELIVERY APPROACH (HOW WILL DFAT DELIVER IT AND ENGAGE?)

INVESTMENT OPTIONS

DFAT has considered several options for delivering ASPHA. A summary of these options is in the table below. These options draw on the experience GHD has in managing Partnerships for a Healthy Region and other complex regional investments.

No	Option	Advantages	Disadvantages
1	DFAT GHD manages an investment that is managed by three separate delivery partners or consortia, each implementing a separate but interlinked stream of work, sourced through a call for proposals process.	DFAT retains significant control over implementation of activities touching on sensitive topics DFAT can align policy dialogue with program implementation. Risk of poor implementer capacity is diversified. Stronger Australian branding Shared learning across partners working together in multiple countries	Complexity of coordinating multiple partners/consortia across many countries Increased human resourcing demand for GHD and DFAT posts Siloed approach to implementation may cause duplication or reduce impact due to lack of coordination across partners Potential in some countries to increase burden on small group of national stakeholders where they are required to deal with multiple delivery partners
2	Investment is managed by one organisation that has expertise, organisational capacity and country presence to manage something of this size	DFAT would only have to engage with one entity Reduced management load for DFAT If a strong organisation is chosen, arguably higher potential for impact through lower risk of lack of coherence	Lengthy design, procurement and inception process may delay the start of urgent activities Concentrates risk in one entity which may be better suited to certain countries and/or intervention types than others
3	Amend existing PHR and bilateral contracts with existing delivery partners	Partners already have pre-existing relationships and footprints in many of the relevant countries May be administratively easier to amend existing programs	Splitting out activities into other pre-existing investments will make it difficult to demonstrate impact of this investment Multiple program managers required, with risk of losing strategic focus Restricts potential pool of delivery partners

On the basis of consultation and a review of delivery options for comparable investments (see Annex 3), we recommend option 1. While there is considerable complexity and administrative burden that comes with a DFAT-managed portfolio, this option is the most suitable to respond quickly and flexibly. Working directly with a limited number of partners enables DFAT to engage partners best suited to different aspects of HIV programming (e.g. commodity procurement, community engagement, HR surge support) and to varying country contexts. On balance, GHD proposes to retain the portfolio management role (and associated management burden) for ASPHA rather than delegating it to a single partner. This is because of the sensitivities of working in HIV and sexual health, the flexibility needed to manage an evolving program, the imperative to commence activities quickly.

ASPHA will be delivered through three primary work streams, each led by a designated implementing organisation or consortium:

- the National Systems stream will support the government-led response to HIV inclusive of activities done through the national health system (hospitals, health facilities etc)
- the Community stream will focus on working with, strengthening and supporting the community-led and non-governmental response to HIV
- the Commodity stream will focus on the procurement of health commodities and strengthening pharmaceutical and supply chain management systems.

Following approval of this ICN, DFAT will release a call for proposals for the National Systems and Community streams.

Partners will be encouraged to form consortia that bring together organisations with demonstrated technical expertise across the intervention areas.

GHD will establish an evaluation committee to assess the proposals and provide recommendations to the delegate (FAS GHD).

Selected applicants will be required to engage in initial planning meetings to co-develop an overarching program logic and shared monitoring and evaluation framework. They will be contracted to provide a core package of regional and multi-country activities, using flexible arrangements that allow for additional funds and activities to be added at a later point. Partners will be required to submit workplans that are updated periodically to reflect the changing context and activities.

Some interventions will be tailored to individual country contexts, while others will be implemented at a regional level where this will reduce costs, promote standardisation and/or support peer learning and collaboration. Examples of regional activities could include clinical guideline development, study tours, fellowship programs, regional trainings, short-term exchanges and placements.

Ongoing coordination between implementing partners will be critical for coherence, to avoid duplication and maximise the effectiveness of the response. This will be supported by a unified MEL framework and a shared program logic that guides the investment as a whole.

GHD will also seek to work with and through other DFAT Pacific regional investments to achieve the investment goals. This could include:

- working with regional **policing and law enforcement partners** to build awareness among Pacific police on HIV transmission and the value of harm reduction approaches in working with people who inject and use drugs
- working with Pacific **church leaders and networks** to build awareness of HIV in communities in a culturally appropriate manner
- engaging with **local civil society partners**, including women's organisations, organisations of people with disabilities (OPDs) and partners that work with LGBTQIA+ communities

- identifying opportunities to build HIV awareness into training and education modules linked to the PALM scheme and migration pathways.

LEVERAGING OTHER PARTNERS

ASPHA will seek to engage and coordinate with other partners, including:

- other Commonwealth agencies with relevant expertise and interests, especially Department of Health, Disability and Ageing; the Australian Federal Police; Department of Home Affairs; the Australian Border Force; and the Department of Employment and Workplace Relations
- New Zealand as a close partner in the Pacific and especially drawing on its expertise and networks in Realm states
- other bilateral development partners
- other global development partners working in HIV and AIDS
- bilateral development programs including Fiji, PNG and Solomon Islands bilateral health partnerships
- civil society organisations, private sector or philanthropic partners where appropriate.

GOVERNANCE

ASPHA will be overseen within DFAT by a Steering Committee chaired by Assistant Secretary, Centre for Health Security Branch and including

- senior representatives from Pacific posts, bilateral desks and thematic leads
- DFAT's Principal Sector Specialist Health
- members of the ASPHA team (as secretariat).

The Steering Committee will meet semi-annually to discuss portfolio strategy, major funding allocation decisions and high-level risk management.

Informal working level groups including representatives of GHD, posts and desks will oversee country level and day to day implementation of ASPHA, escalating key issues to the Steering Committee as needed. The Steering Committee and working groups will draw upon external technical expertise as needed.

DFAT will seek to utilise engagement in existing Pacific regional mechanisms related to health to inform strategic direction setting and oversight of ASPHA. These include the Pacific Health Ministers' Meeting, Pacific Heads of Health Meeting and other groupings associated with the Pacific Islands Forum and Secretariat of the Pacific Community.

BUDGET

ASPHA will have a core budget of AUD 48 million over six years from 2026-27.

A mid-term review will inform program adjustments and decisions on potential further support.

The core program budget will provide:

- base funding for multi-year arrangements with delivery partners
- a contribution to national/single-country activities (generally in a co-funding arrangement with bilateral programs)
- funding for regional activities
- support for program personnel (insourced advisers and contractors)
- MEL, GEDSI and other program enabling costs.

Where a significant scale up in funding is required in any country, we anticipate that the relevant post will contribute additional budget to ASPHA. GHD would manage contracting and implementation.

STAFFING

GHD will manage ASPHA under a section within the Centre Health for Security branch.

DFAT Pacific posts will be primarily responsible for engaging with partner governments. Posts will also play a key role in engaging with in-country implementing partners especially where they are primarily funded under bilateral budgets.

The section will also draw on technical expertise in management of ASPHA including:

- GHD's Health Technical Hub
- Specialist Health Service, which provides short- and long-term health expertise and personnel
- GEDSI expertise through existing DFAT platforms
- Other independent international experts in HIV, TB, STI and BBV programming

E. RISKS

The investment has been assessed (in the AidWorks risk tool) as **medium risk.** Prominent risks that will need to be managed include the following:

Fraud and corruption: There is a risk that program funds may be misappropriated, poorly managed, or lost to fraud or corruption due to weak financial management and oversight mechanisms in some implementing entities. Without strong fiduciary controls, program effectiveness could be compromised, resulting in reduced delivery of critical HIV services. Mismanagement would also risk damaging Australia's reputation and reducing political and community support for future health investments.

Safeguarding: There is a risk that safeguarding standards may not be consistently upheld across program partners or their subcontractors which may expose individuals who face increased vulnerability to potential harm. The HIV epidemic in Fiji is affecting many young people (including children under 18 years) increasing the likelihood of their interactions with delivery partners. Any incidents would undermine trust in the response and cause harm.

Gender equality, disability, and social inclusion (GEDSI): There is a risk that despite the inclusion of GEDSI as part of program design, the program may not adequately address GEDSI elements or could reinforce existing inequalities especially for people living with a disability and matters related to gender-based violence.

Political support: There is a risk that national governments fail to implement effective HIV responses due to stigma, competing fiscal or political priorities. This would undermine efforts to scale up best practice, community-based, gender-responsive solutions and slow progress towards stabilising the epidemic.

Community and/or political backlash: There is a risk that community and political backlash could undermine outreach to at-risk populations, including men who have sex with men and people who inject drugs and harm reduction strategies. Contributing factors include legal and cultural barriers and inadequate communication of the public health rationale for targeted programs.

Loss of key personnel in health ministries or HIV taskforces: Significant responsibility in some national HIV responses, especially Fiji, is concentrated in a small number of key individuals. If these individuals step away from their roles, there would be a significant loss of technical leadership, institutional knowledge, and momentum at a critical stage of the outbreak response. This would likely delay or disrupt the implementation of HIV outbreak response planning and weaken overall leadership and coordination among stakeholders.

Health workforce limitations: Human resource constraints in the health sector present a key risk, with finite health workforce capacity to respond to HIV. Reallocating staff from other health programs to support HIV initiatives may also create gaps elsewhere and weaken the overall health system.

Cost of essential health commodities and human resources cannot be progressively absorbed by partner countries. There is a risk that the cost of essential health commodities and critical human resources cannot be progressively absorbed by partner countries. Over time, these costs will need to transition to national governments, but limited fiscal space and competing budget priorities may constrain sustainable funding for these inputs.

F. WHAT ARE THE NEXT STEPS?

The design will follow an approved Adaptive Design and Procurement (ADAPT) design-implement pathway, which will allow rapid response activities to be delivered in 2025-26 without immediate design requirements while the longer-term program and IDS are being developed. A proposed timeframe is outlined below.

Main program (2026-27 to 2029-30)	Date
Approval of Investment Concept Note	November 2025
Consultations on scope of longer-term support with Fiji. Initial rapid assessments.	September-December 2025
Launch call for proposals GHD will host virtual sessions with potential implementation partners to brief them on the proposed program and proposal process and seek feedback.	December 2025 closing February 2026
GHD evaluates proposals, drafts an overarching Investment Design Summary, and negotiates funding arrangements with partners	February-June 2026
Commence long term implementation; transition from inception period to implementation	July 2026 onwards

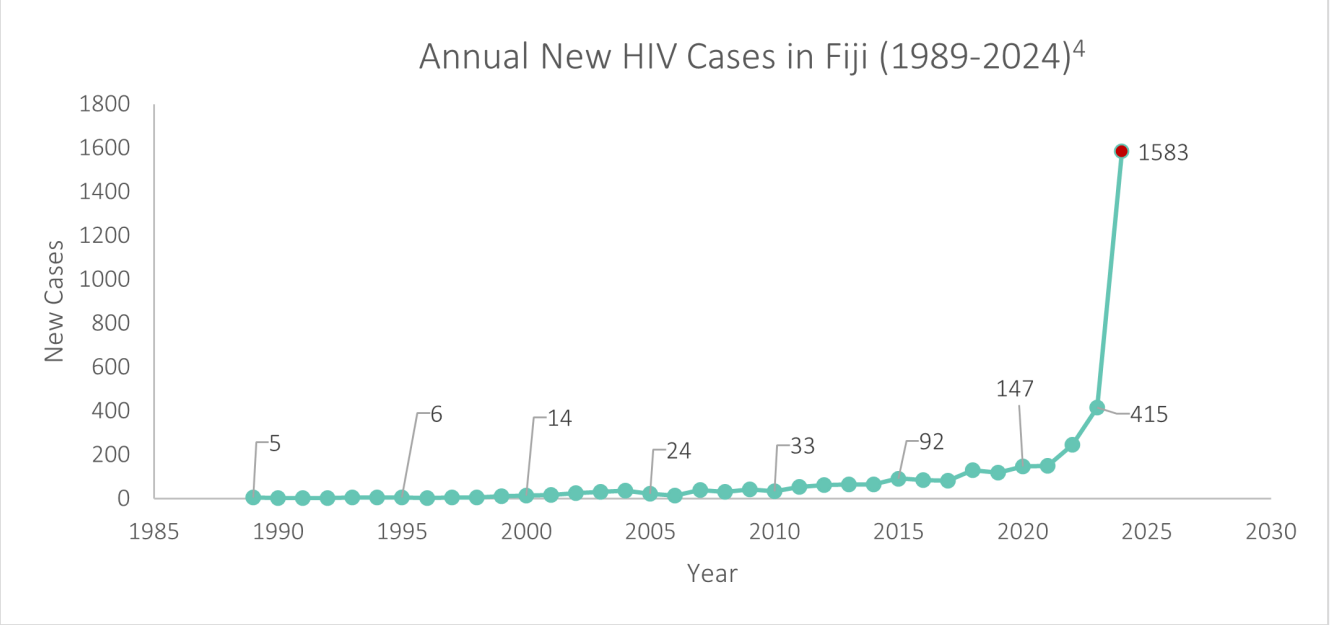
ANNEX 1: SITUATIONAL UPDATE

HIV IN FIJI

According to UNAIDS, Fiji now has the world's fastest growing HIV epidemic. Since 2018, the number of new HIV infections in Fiji has risen nine-fold. UNAIDS estimates that in 2014, there were fewer than 500 people living with HIV in Fiji. Ten years later, that number was estimated at 5,900 (range: 4,500 – 8,900)[5]. In 2024, 36% of the estimated people living with HIV in Fiji were aware of their HIV status, and 24% were receiving treatment.[1]

In 2024, the number of people newly diagnosed with HIV in Fiji (1,583) tripled from 2023 levels. In response, Fiji's Ministry of Health and Medical Services (MHMS) formally declared a national HIV outbreak in January 2025.

Available 2024 Government of Fiji data demonstrate that the majority of diagnosed HIV cases are male (70%) with the most affected age group 15-34 years (76% of cases). Preliminary data indicate that half of people likely contracted HIV through injecting drug use.[1]



The Minister for Foreign Affairs announced an initial AUD 3.9m package of assistance for Fiji on 20 May 2025. The contents of the package and other existing HIV support is summarised in Annex 3. New Zealand has also provided support to the outbreak response.

Current prevention efforts remain inadequate and under-resourced. Simultaneously, rising TB rates and increasing HIV/TB co-infections compound the crisis.

Estimates of the cost of comprehensively responding to Fiji's rapidly growing HIV epidemic evolve as new data becomes available. The estimated cost of a comprehensive response is significantly higher than available funding. Epidemic response costs are expected to increase in the near term before stabilising and eventually declining.

Fiji's capacity to meet urgent treatment, testing, and prevention needs will remain constrained without significant extra support. Bridging this gap will require not only DFAT's direct investments but also ongoing advocacy with multilateral institutions and other bilateral donors to mobilise increased funding and ensure coordinated support for a sustainable response.

In June 2025, the Minister for Health announced the establishment of a dedicated HIV and SRH Unit to lead a coordinated, whole-of-system response. The government has also significantly increased funding to the HIV response for the 2025-26 financial year.

HIV IN THE BROADER PACIFIC

Until recently, HIV prevalence across other PICs has been extremely low or near non-existent. But rising case numbers in the Pacific and gaps in national HIV programs have significantly increased the risk of new outbreaks.

Most PIC health systems are unprepared to prevent, detect, or treat HIV at scale. Key contributing risk factors include limited HIV awareness, persistently high rates of STIs, increasing injecting drug use, limited or non-existent access to pre-exposure prophylaxis (PrEP) and needle and syringe programs, ongoing stigma and discrimination, underdeveloped healthcare systems, significant regional labour mobility, and inadequate surveillance and data systems.

Targeted early intervention is critical to avoid broader generalised outbreaks across the Pacific. Strengthening regional HIV surveillance, prevention programs, testing capacity, and treatment readiness will be central to containing HIV within manageable levels and avoiding downstream health, economic and social impacts across the region.

HIV IN PNG

New infections in PNG have been rising sharply in recent years. In 2024, there were an estimated 11,000 new infections, a rate of 110 infections per 100,000 population. The total number of people living with HIV in 2024 was approximately 120,000, prompting the Minister of Health to declare a 'National HIV Crisis' in June 2025. National adult HIV prevalence is estimated at 1.5%, but provincial and key population prevalence rates are significantly higher.

Treatment coverage remains insufficient to suppress transmission. Of the estimated 120,000 people living with HIV in 2024, fewer than 60% were aware of their status and less than 50% were receiving antiretroviral therapy (ART). Viral load testing is limited, with only 10,258 people confirmed to have achieved viral suppression. New paediatric infections remain high, with an estimated seven babies born with HIV each day in 2024, reflecting gaps in prevention of vertical transmission.

TB further compounds the crisis. PNG faces a dual HIV-TB epidemic, with high co-infection rates placing additional strain on already fragile health services. Other factors such as PNG's dispersed population, geographical barriers, and systemic workforce shortages constrain both prevention and treatment efforts.

Australia currently provides bilateral and regional funding (through the Partnerships for a Healthy Region initiative) including to support efforts to reduce vertical transmission of HIV, syphilis and Hepatitis B.

PNG's needs (articulated in its National STI and HIV Strategy) outstrip current national and donor support.

TB IN THE PACIFIC

In the last two decades PICs have seen an increasing trend in TB cases, estimated incidence and deaths with Kiribati, the Marshall Islands and the Federated States of Micronesia having the highest estimated incidence per capita in 2020. HIV status among people diagnosed with TB is poorly reported in many countries, and reported co-infection with HIV among people with notified TB is overall low. A key exception is Fiji, with HIV status recorded in 79% of people diagnosed with TB, of which 14% were living with HIV.

Several Pacific Island countries have treatment success rates well below the WHO target of 90%. Despite the availability of shorter duration regimens, overall treatment success rates have decreased in Fiji, from 86% in 2015 to 59% in 2022 for all new and relapse cases. While reported cases of drug-resistant TB are low in the region, bacteriological confirmation, which is necessary to test for resistance to TB drugs, is relatively low in many countries, thus the available data are likely an underestimate. For instance, in Fiji only 49% of pulmonary TB cases were bacteriologically confirmed in 2023.

SEXUALLY TRANSMITTED INFECTIONS (STIS) IN THE PACIFIC

Sexually transmitted infections are a significant public health concern across PICs. *Chlamydia trachomastis, Neisseria gonorrhoeae* and *trichomoniasis* have the highest reported prevalence. Active syphilis prevalence is high in several countries across the region with particularly concerning rates in pregnant women. The WHO classifies Fiji (3.89%), PNG (4%), and Solomon Islands (13.5%) as having very high rates which significantly increase the risk of infants born with congenital syphilis. The high proportion of asymptomatic cases associated with these STIs, and syndromic management in many PICs, means cases often go undiagnosed. For curable STIs, untreated infections can lead to infertility, pelvic inflammatory disease, chronic pain and cancers and increase the risk of acquiring HIV. Untreated STIs are particularly concerning in pregnant women and can cause pregnancy and birth complication, post-partum infection, low birth weight and maternal and neonatal death.

Risk factors are similar across PICs, including limited knowledge on modes of transmission, large numbers of young people, low condom use, significant movement of people through the region, sex work driven by economic need and high levels of gender-based violence. There are significant barriers for STI control ranging from social, economic, geographic and cultural factors, and policy and legal environments. At a health system level, there is insufficient and inequitable access to prevention and testing, supply chain challenges, limited health sector capacity including laboratory services, poor surveillance, a lack of capacity strengthening opportunities and persistent STI related stigma and discrimination broadly across the region.

OTHER BLOOD BORNE VIRUSES IN THE PACIFIC

Hepatitis B (HBV) is the most common BBV across the region and endemic in many PICs. Transmission is predominantly perinatal or acquired in early childhood. Adult transmission (sexual or blood exposure) occurs but contributes less to overall prevalence. Chronic HBV is a leading cause of liver cirrhosis and hepatocellular carcinoma (liver cancer) in PICs, however since the introduction of infant vaccination in the 1990s across the region the incidence of HBV has significantly reduced in infants and children. While the region has achieved high infant vaccination coverage the testing and treatment cascade remains critically underdeveloped with many adults with chronic HBV undiagnosed and untreated. Significant challenges exist for HBV testing and treatment programs including geography, shortage of trained health workers, inadequate infrastructure for laboratory testing, procurement and supply chain systems, weak surveillance and data collection systems, regular stock outs of essential commodities, limited funding and low public awareness.

Historically, hepatitis C (HCV) has been considered low prevalence across PICs, however, weak surveillance and data systems, and a lack of national screening procedures, mean reliable epidemiological data is not available for many countries. HCV is a growing concern in Fiji and across the region where injecting drug use is increasing and is a shared risk factor for both HIV and HCV due to shared blood-borne transmission routes. HCV programs are often poorly integrated with HIV, SRH or primary health care services which limit opportunities for combined prevention, testing and treatment.

Across the Pacific, prevention and management of HBV and HCV is constrained by weak surveillance, limited access to diagnosis and treatment, health workforce capacity constraints, fragmented programming, low awareness, stigma and limited political commitment. Addressing HBV and HCV requires a tailored approach that includes strengthening prevention, expanding testing and diagnosis, improving access to treatment and care, integrating services and addressing social and structural barriers that includes harm reduction approaches.

ANNEX 2: OVERVIEW OF EXISTING FIJI HIV SUPPORT

Table 1: Summary of existing DFAT-funded HIV support in Fiji via bilateral funding (AUD 3.9m TA support announced in May 2025)

Partner	Description
ASHM	Support Fiji's health workforce development; and the scale-up of decentralised HIV testing, treatment, care and support services.
The Doherty Institute	Expand HIV, STI, and BBV testing; clinical training; and ongoing mentorship in case management.
Health Equity Matters (HEM)	Revitalise and strengthen Fiji's community-led HIV response to deliver prevention, testing, treatment literacy, and peer-led support.
Kirby Institute	Support HIV prevention amongst people who inject drugs; and assess and make recommendations on improvements to the country's HIV surveillance system.
UNDP	Health commodity procurement to support Fiji's prevention and testing scale-up efforts.
Beyond Essential Systems (BES)	Support Fiji to implement a patient information system and digitise case management for HIV patients, from screening, to diagnosis, treatment, and long-term management.
UNDP	Integrated bio-behavioural survey amongst key populations (including men who have sex with men, sex workers and transgender persons)
UNDP	Integrated bio-behavioural survey amongst people who inject drugs
UNAIDS & HEM	Fiji component of Partnerships for a Healthy Region grant, delivering on various aspects of the HIV response.

Table 2: Summary of existing DFAT-funded HIV support in Fiji via Global Fund Set Aside

Partner	Description
UNDP	Integrated bio-behavioural survey amongst key populations (including men who have sex with men, sex workers and transgender persons)
UNDP	Integrated bio-behavioural survey amongst people who inject drugs

Table 3: Summary of existing DFAT-funded HIV support in Fiji via Partnerships for a Healthy Region

Partner	Description
UNAIDS & HEM	Fiji component of Partnerships for a Healthy Region grant, delivering on various aspects of the HIV response.

ANNEX 3: SUMMARY OF PROPOSED RAPID RESPONSE PHASE

A summary of proposed activities under the rapid response phase is as follows:

Fiji

- Procurement of Essential Health Commodities: Fast-tracked procurement of HIV commodities in close coordination with government funding streams. Addressing Fiji's significant commodity needs early is critical given 3–6 month procurement lead times and risks of supply shortages.
- Human Resource Surge Support: Limited funding to secure critical HIV program roles within the Ministry of Health's SRH/HIV Unit, including potential extension of DFAT-funded human resource (HR) positions under the AUD 3.9m TA package. This support would be programmed through mechanisms at the WHO Fiji office and/or existing human resourcing mechanisms under the existing AUD 3.9m TA package.
- Strengthening Law Enforcement Support for Harm Reduction: Targeted activities to support Fiji to implement a needle and syringe program, including training, possible study tours for Fijian police and church leaders to Australia and coordination with Pacific policing programs.

Solomon Islands

The rapid response will focus on implementing critical recommendations from the 2025 Burnet Institute rapid assessment of the HIV and TB response. Additional technical assistance would work with the National HIV program to ensure that HIV prevention, testing, and treatment enrolment occurs earlier, healthcare workers have the skills and confidence to provide care for all clients accessing HIV services, and greater coordination of people, resources, and data lays the foundation for further planning of program activities.

Broader Pacific Island countries (excluding PNG)

The rapid response phase will include the rollout of Rapid HIV Program Assessments and the provision of short-term technical assistance across up to ten Pacific Island countries. The assessments will be led by the Burnet Institute, building on similar work already completed in the Solomon Islands. A consistent assessment methodology will be applied across all participating countries, enabling a comparative analysis of national HIV programs while identifying strengths, critical gaps, and opportunities for improvement. The findings will provide evidence to inform national and regional planning, identify priority areas for DFAT and other donor support, and guide the development of coordinated strategies to address shared challenges across the region.

Following the completion of assessments, the Burnet Institute will provide targeted short-term technical assistance (TA), subject to consultation with governments, partners, and DFAT approval. This TA will help maintain momentum and translate early findings into action. Delivery will be tailored to country-specific needs and may involve face-to-face training, virtual workshops, and remote advisory support, with each country receiving up to three weeks of combined assistance. Examples of potential TA include improving surveillance and data analysis for decision-making, optimising diagnostic and treatment algorithms, developing standard operating procedures and clinical protocols, training healthcare workers in HIV clinical management, strengthening supply chains for essential commodities, and designing strategies to improve community engagement and demand creation.

ANNEX 4: GENDER EQUALITY, DISABILITY AND SOCIAL INCLUSION

This annex provides a high-level summary of findings from gender equality, disability and social inclusion (GEDSI) assessments within the context of HIV, TB and SRH that were undertaken across PHR investments. The annex synthesises key themes and identifies opportunities to ground ASPHA with a primary understanding of the gender and social inequalities in the local context.

Social norms, power dynamics and social inequalities influence a person's susceptibility to different health outcomes and their opportunity to access and uptake health services. Gender, disability and social disadvantage all intersect with HIV, TB and SRH. Key populations (groups of people who are at increased risk of HIV because of specific behaviours and social factors) often face barriers to accessing services due to stigma, discrimination and criminalisation.

This summary identifies key themes from existing GEDSI assessments. A more detailed version of this document will be a reference for program partners (once selected) to help inform their GEDSI programming, risk management and GEDSI Action Plans. It will capture additional and updated sources partners can draw upon, whilst encouraging them to conduct their own deeper analysis to suit their proposed programming. Furthermore, DFAT will coordinate consultations as early as possible to seek input from relevant OPDs, KPOs and other civil society organisations on considerations for program design and implementation. A GEDSI lens will be embedded throughout the program design, proposal, implementation and monitoring phases.

The design team has reviewed several 2025 GEDSI assessments related to Partnerships for a Healthy Region initiatives in the Pacific including the Indo-Pacific HIV Partnership.

2. SUMMARY OF KEY REGIONAL GEDSI THEMES IDENTIFIED

Supporting equitable access, strengthening inclusion and advancing gender equality requires tailored service delivery models that remove barriers, extend reach to underserved communities and strengthen local ownership, centering lived experience of HIV and social disadvantage.

2.1 Gender Equality

Access & Barriers

- Women and adolescent girls face barriers to HIV services due to unequal power relations, limited financial independence owing to income earning disparities and/or employment opportunities, and exposure to gender-based violence.
- Men, including men who have sex with men, may experience a reluctance to seek testing or treatment due to social norms around masculinity.
- Commonly within the region, men dominate decision-making within families or broader society. Patriarchal structures and customary laws tend to adversely impact the ability and of women and young girls to equitably participate in society.
- Transgender women experience high levels of stigma and criminalisation, creating barriers to prevention and treatment.

Power Dynamics

- The division of power and hierarchies both within broader society and within the household are predictors of health outcomes.

Gender based violence

- Rates of gender-based violence (GBV) in the Pacific are amongst the highest in the world.
- Impacts of GBV include fear of engaging with health services.

2.2 DISABILITY EQUITY

- Limited data exists on the intersection between people living with HIV and disability in the region however this is an identified and known issue. Additionally, women and girls with disability experience higher levels of GBV than those without disability.
- People with disabilities are often excluded or overlooked from HIV and other health services due to physical inaccessibility of facilities and also lack of information, education and communication in accessible formats. This includes the assumption that people with disability are not sexually active or do not engage in behaviours such as drug use, which can result in them being excluded from HIV and SRH services.
- People with disability and their families experience higher levels of poverty due to exclusion from the labour market and lower incomes. They also experience higher costs of living due to disability-related costs. In some countries, lack of labour market inclusion has been linked with risky sexual behaviour such as sexual favours or sex work to gain income.
- Organisations of Persons with Disabilities (OPDs) remain under-represented in health programming.

2.3 SOCIAL INCLUSION

Stigma and discrimination

Stigma and discrimination are experienced differently by different key populations and other groups. However:

- Stigma continues to be widespread across key marginalised populations, reinforced by harmful social norms, restrictive laws, and discriminatory practices in health systems.
- Misconceptions about HIV transmission drive fear and misinformation, leading to reduced family and community support for people living with HIV.
- Breaches of confidentiality and mistreatment in clinical settings deter individuals from seeking timely testing, treatment, and care, contributing to delayed diagnosis and poorer health outcomes.
- Fear of disclosure often results in people travelling outside their communities for services, increasing financial and logistical barriers.
- Experiences of stigma and discrimination are contributing factors towards poor mental health outcomes in people living with HIV.
- Addressing stigma at both community and institutional level is essential for supporting access, building trust and supporting an effective response.

Intersectionality of vulnerabilities

- Many individuals face overlapping disadvantages across gender, disability, age, poverty, ethnic status and geographic isolation. These intersecting barriers amplify vulnerability and reduce access to health and social services especially for women, people with disabilities and young people experience intersecting identifies and disadvantage.
- Socio-economic inequalities including income disparity and limited employment opportunities create structural disadvantages that undermine health equity, which is exacerbated for those groups who experience additional marginalisation on account of gender, disability, age etc.

- Current policy and program responses often fail to adequately recognise or address intersectionality, resulting in gaps in service provision and exclusion of the most marginalised groups.

Equitable access to services

- Access barriers persist, including distance to health facilities, limited transport options, and service hours that do not align with varying community needs (for example, opening hours of clinics to suit the needs of sex workers).
- Key populations face heightened barriers including fear of discrimination, limiting mobility and their ability to engage safely with services.

2.4 CROSS CUTTING THEMES

Legal and policy environments

- Punitive laws against same-sex relationships, sex work and drug use exacerbate discrimination and exclusion

Data gaps

- HIV data commonly lacks disaggregation by sex or disability limiting identification of inequalities, and affecting effective decision-making and healthcare planning that addresses and tracks gender and social inequalities

3. GEDSI CONSIDERATIONS IN PROGRAM DESIGN, DELIVERY AND MONITORING

As outlined in Australia's International Gender Equality Strategy and International Disability Equity and Rights Strategy, DFAT recognises GEDSI as foundational to achieving effective and sustainable development outcomes. This directly informs the ASPHA investment. GEDSI is not considered a 'stand-alone' activity, but rather a critical lens and process through which program design, delivery and monitoring are viewed. This approach aligns with DFAT's International Development Policy and reflects a commitment to inclusive programming that leads to stronger health outcomes, greater community ownership, and reduced inequities over time.

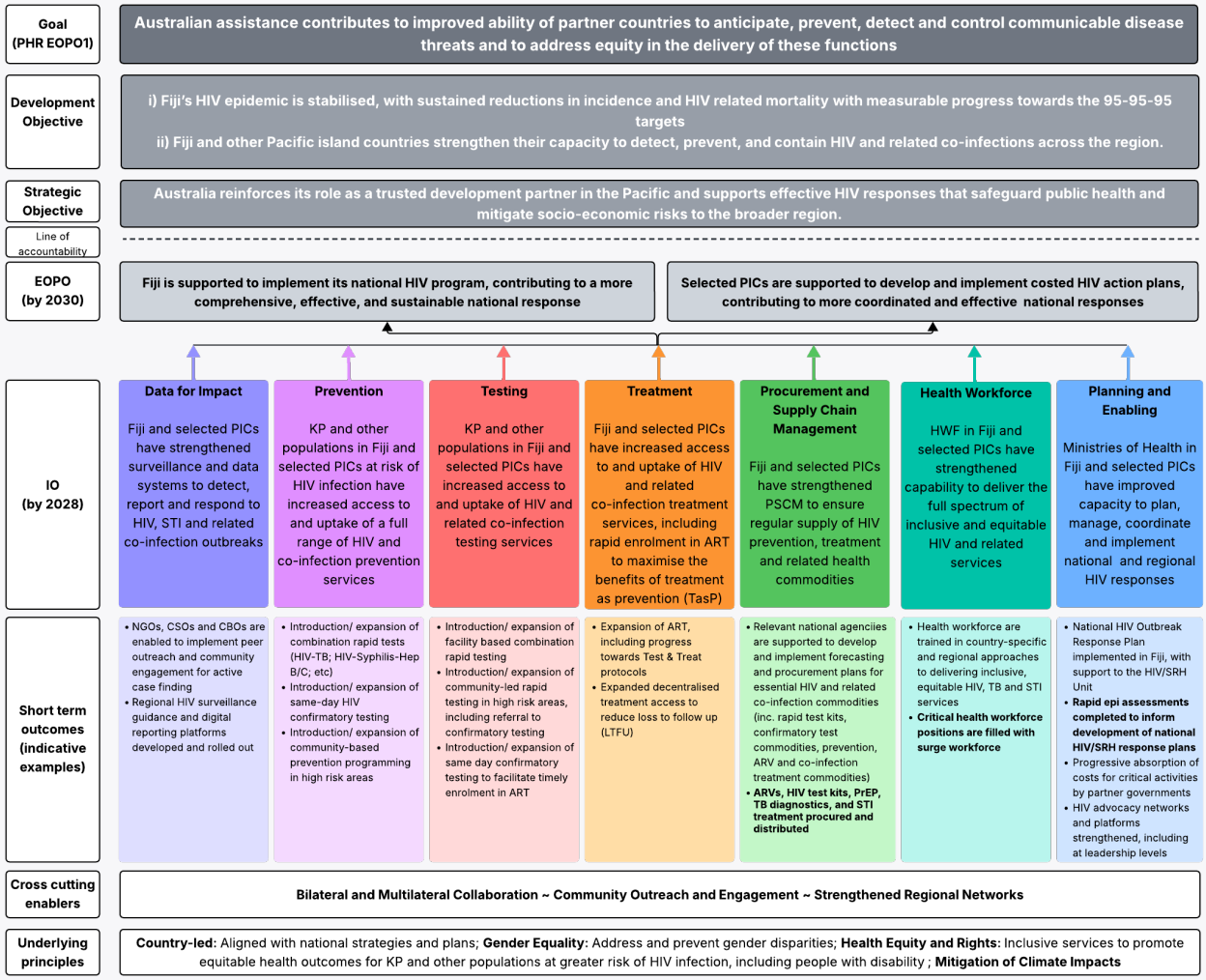
Expectations of partners

Selected partners will be required to embed GEDSI considerations systematically throughout their workplans. Program partners will be required to demonstrate that they have GEDSI, safeguarding and 'do no harm' policies and practices, supported by evidence of their track record integrating GEDSI considerations into their work and the allocation of appropriate human and financial resources to operationalise these commitments. During this phase, partners will be required to develop initial high-level GEDSI action plans relevant to the countries in which they will work. Successful partners will be required to refine these action plans within six months of grant signing. These plans will feed into an overarching whole-of-program GEDSI action plan monitored by DFAT.

Where applicable, partners will be required to collect and report sex-, gender-, age- and disability-disaggregated data to enable tracking of equitable outcomes, and partners should be prepared to adapt their activities based on these findings. They will also be required to develop GEDSI quantitative and qualitative indicators and integrate GEDSI into their individual program logics.

Partners will also be expected to collaborate closely with local community-led and peer-led organisations to co-design and co-deliver activities. This partnership approach strengthens local capacity and ensures that GEDSI integration is not tokenistic but meaningful. DFAT will work with partners in meeting these expectations.

ANNEX 5: DRAFT PROGRAM LOGIC AND MONITORING, EVALUATION AND LEARNING FRAMEWORK



The draft program logic and MELF is also detailed on page 7. The above also includes investment outcomes; data for impact, prevention, testing, treatment, procurement and supply chain management, health workforce and planning and enabling. These preliminary indicators are under development and will be included in the IDS.