Programmatic reprioritization & revisions to Global Fund grants (GC7)

Discussion with Asia Pacific Regional Learning Hub

05 June 2025

INTERIM VERSION

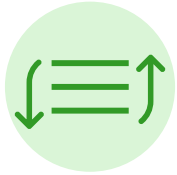
Principles of Global Fund mid-cycle grant adaptations

In the context of reduced international funding for health programs, the Global Fund aims to support Principal Recipients, Country Coordinating Mechanisms and other in-country partners and particularly WHO, to optimize the use of Global Fund grant investments in Grant Cycle 7 (GC7).

The key objective is to support countries to protect and enable access to lifesaving services.

Approach to mid-cycle grant adaptations include:

Defer or pause agreed activities NOW!
to reduce the pace of spending and maximize available funding.



Reprioritize Global Fund investments June-Sept
to preserve access to lifesaving services, considering all sources of funding and holistic support across disease programs and health and community systems.

Revise grants by end Sept
to preserve and enable access to services. If allocated funds for GC7 are reduced, the grant revisions process will be required to amend grant agreements.

If reductions to GC7 allocations occur, reduced country envelopes, with indicative grant amounts, will be communicated to countries through CCMs and PRs, who will inclusively decide how to adjust grants within this envelope.

Illustrative timeline for GC7 mid-cycle grant revisions

APR | MAY | JUN | JUL | AUG | SEP | OCT

Country Teams work with PRs & CCMs to defer activities; increasing financial space in grants

From 24 Apr: PRs and CCMs received a letter on the deferral of lower priority areas of investment

By end-June: PRs and CCMs may receive revised country funding envelopes and illustrative grant amounts.

By mid-July: CCMs review grant amount(s), formalized in Notification Letters

PRs, CCMs and the Global Fund work to revise grant documents

End-Sep: Grant revisions completed

Inclusive engagement of all CCM members: CCMs transparently and inclusively debate changes, encouraging constituencies to engage proactively in decision-making of reprioritization of activities

Lifesaving services in the context of programmatic reprioritization

To preserve and enable access to lifesaving services, HIV, TB and malaria programs need to cover core priorities, considering all sources of funds.

Priority services will differ by disease program, though in many cases the most essential element is treatment:

- Treatment continuity and care for HIV.
- Diagnosis and treatment for TB.
- Case management for malaria.

Countries should continue to follow WHO disease specific normative guidance.

Access to lifesaving services by the populations and communities most impacted by the three diseases is a key principle that underpins the approach to reprioritization. We must consider:

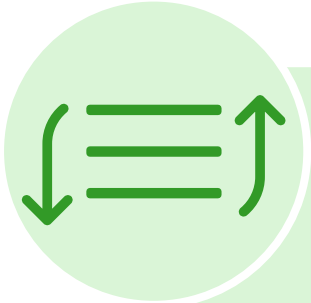
Interventions that remove barriers to accessing services

Essential health and community systems

Service delivery platforms & integration

All these elements (commodities, service delivery, health system functions and access) are context specific.

Preparing for reprioritization



Principal Recipients, CCMs and partners should use this time to consider the right program choices to revise Global Fund grants at lower financial ceilings by:

- Identifying essential priorities and opportunities to optimize and rescope and looking for more integrated approaches, cost efficiency and effectiveness.
- Considering access and equity across populations and services delivery models.
- Analyzing GC7 interventions to reprioritize for grant revisions, tailoring to country context; decision-making should be done with governments, communities, civil society and partners, looking across all sources of funds (domestic and international).

Programmatic Reprioritization is a country level exercise considering context, including *all* sources of funding

- Epidemiological context
- Populations and geographic areas/settings most impacted by HIV, TB and malaria
- Partnership landscape and engagement of community and technical partners.
- Value for money and sustainability of supply
- Service delivery factors

Examples, non-exhaustive

*What is the **minimal package of services** needed to deliver a quality service in this setting?*

*Are there opportunities for efficiency gains and **appropriate/feasible integration** across diseases as well as primary care more generally?*

*What is the **minimum monitoring** needed to inform program decision-making?*

Specific domestic financing considerations, including *what* may transition to domestic financing, *how*, and *when*

- Pre-existing transition commitments
- Cost efficiency and effectiveness
- Domestic financing readiness
- Domestic implementation capacity
- Alignment with government priorities and pathways for transitioning specific interventions in the short or medium term

(*Considered holistically)*

Reprioritization is not technical guidance

These priorities…

- ✓ Provide insights on how to order the prioritization of lifesaving health products and services while increasing cost effectiveness.
- ✓ Incorporate considerations on enabling access and improving sustainability.
- ✓ Align with (*not* create) normative guidance from technical partners.
- ✓ Consider the Global Fund's additive role with domestic financing and how we can deliberately invest to save lives.
- ✓ Encourage health service and system integration, sustainability action, re-thinking how results are delivered, and rapid transition to better or more cost-effective health products.
- ✓ Consider health product market access/sustainability impact.
- ✓ **Are foundational for Grant Cycle 8 planning**.

They do *not*…

- X Develop a minimum package of services that can be applied in all contexts.
- X Analyze the shifting partnership landscape or domestic funding opportunities within each country – both are critical and specific to each country and demand tailoring the guidance to context.
- X Cover Global Fund Catalytic Investments (Strategic Initiatives, Matching Funds, multi-country approaches), the COVID-19 Response Mechanism (C19RM) or country-level and/or centralized donor opportunities.

Portfolio level core priorities for HIV

Save Lives

- ✓ Ensure treatment continuity for all people living with HIV.
- ✓ Expand cohort for people newly diagnosed or re-engaging with care.
- ✓ Ensure services to diagnose and manage TB and advanced HIV disease (CD4 testing, diagnosis and treatment of opportunistic infections).

Identify People with HIV

- ✓ Ensure HIV testing for people with higher HIV risk – provider-initiated testing and counselling, testing in TB services and focused testing for priority groups/settings (key populations, STI clinics) and linkage to services.
- ✓ Identify pregnant women living with HIV and prevent vertical transmission to babies – ANC testing in high burden settings and treatment, infant prophylaxis and testing.

Ensure Primary Prevention

- ✓ Ensure primary HIV prevention services – condoms, PEP for all potential HIV exposures, PrEP for current users and new users in high incidence locations and/or people at increased risk.
- ✓ Maintain harm reduction services – opioid agonist management treatment (OAMT) and management, especially methadone, naloxone, safe injecting commodities.

Critical across all priorities *– all necessary support functions (e.g. data, supply), explore integration into primary health care and country health systems where possible, sustain human rights programs/advocacy that most impact service access, maintain peer outreach especially for integrated PHC services including HIV prevention/testing and RMNCAH (aligned to national package) and eval optimal deployment, and safety and security; market shaping and new product introductions*

Portfolio level core priorities for TB

Diagnosis & Treatment

- ✓ Protect diagnosis and treatment—key cost drivers but critical for TB programming—while addressing stigma, discrimination, human rights, and gender-related barriers to timely, effective TB care.
- ✓ Maintain HIV testing for people with TB and initiating ART for those co-infected.
- ✓ Continue TB screening for people living with HIV, diabetes and people who are undernourished.
- ✓ Continue using new screening/diagnosis tools and short treatment regimens.

*On the "how" - Engaging with the **private sector** remains a cost-effective approach*

Targeted, Active Case Finding

- ✓ Focus on key and vulnerable populations and high incidence geographic areas.
- ✓ Continue contact investigation (prioritizing children) and linkage to treatment and prevention.
- ✓ Integrate active case finding for TB with other diseases and conditions.

Engage communities along cascade of care

TB Prevention

- ✓ Maintain TB preventive treatment (TPT) for people living with HIV and children under 5 years old in contact with patients with bacteriologically confirmed pulmonary TB.
- ✓ Use symptom-based screening for TPT initiation and/or antigen-based skin test for household contacts.

Critical across all priorities – *Maintain HRH/CHW for integrated PHC services including HTM and RMNCAH (aligned to national package) and evaluate optimal deployment, surveillance system strengthening, laboratory systems strengthening and market shaping for innovative TB diagnosis and treatment tools.*

Countries are rapidly moving towards optimization, integrated service delivery and enhancing efficiencies

Enhancing Efficiency *within* TB Programs

Integrating & decentralizing.

- Contact screening, ACF, TB treatment and TPT;
- Integrate DR-TB and DS-TB activities;
- Combining screening using digital X-rays with AI and WRDs

Reducing costs.

- Use more sensitive/specific tools and algorithms for screening/diagnosis when available and recommended
- Cost-effective, short treatment regimens;
- Digitalizing TB recording & reporting, ensuring systems interoperability and strengthening surveillance & data use

Scale up innovative and most efficient **private sector engagement** models in TB

Improve **domestic financing** and explore innovative and blended financing

Integrating TB services *with other* programs

- ✓Integrate disease screening (such as TB, HIV, diabetes, maternal health and nutrition)
- ✓Promote multi-disease screening/testing platforms across health programs for comprehensive care
- ✓Strengthen and empower community health workers for disease detection, treatment adherence, and delivery of integrated health services across multiple conditions
- ✓Expand integrated sample transport networks constructed on national/local platforms and systems for TB and other diseases
- ✓Utilize digital and online platforms for training, community engagement, digital solutions for integrated health surveillance and reporting

Examples only, Non-exhaustive

Portfolio level core priorities for malaria

Deploy a sub-nationally tailored approach prioritizing most impactful activities to minimize malaria related mortality.

Case Management

- ✓ Ensure effective diagnosis and treatment at public facility and community level with continued attention to drug resistance mitigation strategies (multiple first-line therapies).
- ✓ Ensure sufficient support to provide access to quality services with a focus on leaving no one behind.

Disease Prevention

- ✓ Target prevention services first to the most vulnerable and highest burden.
- ✓ Aim for universal vector control coverage. Where not feasible use the most effective and efficient distribution channels to achieve as high coverage as possible, esp. in vulnerable groups.
- ✓ Seasonal malaria chemoprevention should first focus on highest burden areas and children under 5
- ✓ Intermittent preventive treatment of malaria in pregnancy (IPTp) and other chemoprevention deployed through routine services should be fully integrated and covered by national funding, where possible.

Surveillance

- ✓ Continue to support efforts to improve the subnational tailoring approach.
- ✓ Transition from large scale surveys to more efficient monitoring approaches (e.g., ANC1 surveillance, targeted LQAS).
- ✓ Maintain monitoring of biologic threats (TES, hrp2/3 deletion surveys, insecticide resistance monitoring)
- ✓ Integrate and decentralize epidemic preparedness efforts.

Critical across all priorities – *Maintain HRH/CHW for integrated PHC services including HTM and RMNCAH (aligned to national package) and evaluate optimal deployment, supply chain, HMIS, and appropriate product selection to combat biological threats.*

Deliberate integration of RSSH, human rights, gender and community systems is essential across disease priorities

Consider how we achieve lifesaving impact through our investments in RSSH, human rights and community systems

- **Quality service delivery and access to care.** Human resources for health including community health workers, product innovations and delivery, and diagnostic services are the backbone of providing lifesaving HIV, TB and malaria services with relevant capacity and capabilities, including gender responsiveness.
- **Robust foundations of inclusive health systems that will sustain gains.** Laboratory systems, health information & surveillance systems and supply chains are fundamental to effective health responses for HIV, TB and malaria and ensure self-reliance for countries facing future pandemics.
- **Effective integration.** Integration of HIV, TB and malaria services at primary health care level and within existing health systems is essential for efficiency and self-reliance. In doing so, purposeful investment that removes human rights and gender related barriers to access for key, vulnerable and underserved populations is critical for effective response.
- **Improved health delivery.** Monitoring and feedback loops for quality improvement through community-led monitoring; including identifying human rights and gender-related barriers to health progress.

Non-exhaustive

Example: RSSH thematic areas, prioritization considerations (1/5)

Human Resources for Health

Optimizing the performance of existing HRH/CHW for service delivery while **advancing on integration and sustainability of HRH/CHW programming**:

What to consider prioritizing

- HRH-CHW and other integrated investments for women and girls **that received private donors** / match funding
- **Maintain remuneration and equipment (inc. digital tools) for HRH/CHW,** prioritizing functions that provide integrated **services at primary health care level** and high-volume facilities. Consider **efficiency** of deployment, **integration** opportunities and **co-financing as feasible.**
- Support to **pre-service training of polyvalent CHWs,** in line with national community health strategies
- **Pre-service training programs for PHC workforce,** if aligned with HRH strategies, or fast-tracking innovation e.g., blended learning
- **HRH analytics, policy & planning activities, if they have a focus on integration, sustainability and transition**, or they can be catalytic of such processes
- **Continuous quality improvement for integrated services** at PHC or high-volume facilities

What to consider deprioritizing

- Recruitment, remuneration and deployment of **new HRH/CHWs for single-disease/vertical functions**
- **Pre-service training for new CHW** for single disease/vertical CHWs (e.g., peers).
- **Off-site refresher/standalone in-service training**
- Single topic **CHW training** for elements not included in pre-service education packages
- **Hotel-based workshops/meetings for any policy and strategic planning, dissemination, validation purpose**
- **Single disease/service supervision for HRH/CHW**
- **HRH information systems maintenance**
- **Other quality of care activities**, unless directly benefitting the service delivery level

What to consider promoting for sustainability and integration

Policy and planning, including workforce deployment

- Development / updates of **costed HRH/CHW** strategies
- Develop HRH compacts/sustainability plans for HRH/CHWs
- Formalization of CHW role
- Task sharing reform to enable service integration

Financing and remuneration

- Harmonization of pay scales
- Resource mapping and expenditure tracking for HRH/CHW

Training capacity building and supervision

- Outline and fast track the **inclusion of disease specific functions and competences in pre-service training** programs for relevant PHC cadres including CHWs, supervision & data collection systems, as well as equipment lists
- **Redesign training approaches** to enable shift to quality improvement
- Joint planning for training and supervision across HIV/TB/malaria grants, integrating approaches at different levels of the system
- Integration of HIV/TB/malaria elements into integrated supervision systems at PHC level

Example: RSSH thematic areas, prioritization considerations (2/5)

Community Systems Strengthening

What to consider prioritizing

Protect **investments that contribute to improved linkage, referral and human rights support between formal and community health delivery platforms,** including:

- **Maintain existing OR mature CLM programs** that provide real-time data on accessibility and quality of lifesaving services, including commodities and diagnostics.
  - TA and advice is available in Secretariat to support prioritized site selection (coverage) and duration of implementation (costing).
  - Ensure CLM programs have approved access to facilities and already trained and deployed monitors and data collection and analysis frameworks for quality improvement
- Continue investing in **capacity development of community-led and –based organizations** supporting delivery of lifesaving services. This must be accelerated for sustainability and transition.
- **Maintain peer cadres** (e.g., mentor mothers) with fair remuneration and supervision to ensure quality, lifesaving services.
  - Where feasible, expand peer roles to cover multiple diseases and human rights, supported by in-service training.
  - Paralegals + other legal redress mechanisms are vital, separate, complementary components focused on improving access to justice where human rights barriers affect health access. Where appropriate, explore opportunities for efficiency and integration.

What to consider deprioritizing

- **Community-led research and/or advocacy** – not linked to CLM data use for QI or removal of service barriers.
- **Standalone CLM pilots** not linked to program improvement cycles and/or **parallel structures for monitoring without a clear pathway to change.**
- Redundant feedback mechanisms outside national systems.

What to consider promoting for sustainability and integration

- **Integrated CLM (multiple diseases/PPR)** into routine QA/QI systems and processes at point of care.
- **Use existing data systems** (HMIS, eLMIS) to streamline community feedback, solutions and reporting.
- **Leverage RSSH investments** (e.g., in M&E, HRH, digital tools) **to support CLM activities**
- **Investing in enabling environments to fast-track social contracting or delivery of services through other finance streams (donor, domestic, private, social income generation approaches).**

Example: RSSH thematic areas, prioritization considerations (3/5)

Health Product Management Systems.

The prioritization of supply chain investments should be driven primarily by interventions and costs that are lifesaving in nature and ensure equitable access to health products, while accelerating efficiency, integration and sustainability of health product management systems.

What to consider prioritizing

- **Procurement and Supply Management (PSM) costs** to ensure comprehensive and effective freight, quality assurance, warehousing and storage and in-country distribution services. Identify efficiency opportunities in downstream PSM costs being paid
- **Prioritize operations improvement interventions including integration** across existing facilities, operational approaches and assets
- **Accelerated deployment and support of interoperable, disease agnostic information systems**, such as an electronic logistics management information system (eLMIS), warehouse management systems (WMS), enterprise resource planning (ERP) systems and digital transport management systems (TMS).
- **Development and/or revisions of National Strategic Plans (NSPs),** including digital health strategies (where needed).
- **Coordinated, comprehensive national supply chain governance** including performance management, strategic planning, quantification, and execution of all key policy related activities.

What to consider deprioritizing

Consider deprioritizing siloed/disease specific supply chain investments including in areas such as information systems and infrastructure. Ensure these are integrated. Other considerations and areas include:

- **Infrastructure upgrades** that have not started or at risk of incompletion before the end of GC7
- Review new equipment procurement, including that for waste management, on case-by-case basis and **deprioritize based on lack of site operational readiness**
- **Deprioritize funding residential workshops** for supply chain- related activities
- **Single disease-specific supply chain supervision** for data quality, product availability or other supervision areas that are not integrated

What to consider promoting for sustainability and integration

- **Aligned national supply chain strategies that accelerate and embed supply chain sustainability** across all core areas
- A focus, under the stewardship of countries and in coordination with core partners, on **designing and implementing more integrated supply chains**

Example: RSSH thematic areas, prioritization considerations (4/5)

Laboratory Systems Strengthening

What to consider prioritizing

All integrated laboratory systems (Specimen Referral Systems, laboratory information systems (LIS), laboratory quality management systems (LQMS), etc.) investments, based on country context/need. This may include:

- **Integrated specimen referral systems** and communication of test results
- **Enable participation in integrated proficiency testing schemes** (i.e., HIV/TB/malaria diagnostics), leveraging on ISO 17043 certified regional/national schemes
- **Interoperability of LIS** with other data systems
- Utilization of **existing diagnostic network optimization data** to improve entire laboratory network functions
- **Equipment maintenance contracts and warranties** for existing equipment
- **Replacement of modules for Xperts** instead of procuring new equipment

What to consider deprioritizing

- All previously funded siloed **(disease-specific) SRS or LIS reprogrammed** to prioritize integrated systems
- **Infrastructure upgrades** that have not started or at risk of incompletion before the end of GC7
- **Disease/equipment specific** diagnostic network optimization (DNO)
- Review new equipment procurement on case-by-case basis and **deprioritize based on lack of site operational readiness**
- Disease specific site supervision and mentoring of lower-level laboratories from central level
- **Hotel-based meetings/workshops** for development/validation of lab guidelines/tools/SOPs – these can consider other no cost options e.g., MOH lab /partner boardrooms

What to consider promoting for sustainability and integration

- Promote **regional initiatives** including **peer-to-peer learning** that enhance implementation of integrated laboratory systems
- Leverage **existing country capabilities** e.g., “homegrown “ and /or open-source integrated LIS to expand coverage of LIS for improved patient management
- Support the **roll out of the Lab maturity model (LMM)** in collaboration with regional partners

Example: RSSH thematic areas, prioritization considerations (5/5)

Health Information Systems (HIS) and M&E

What to consider prioritizing

Cross-cutting (in order of indicative priority):

- **Maintain M&E core staff** across HIV/TB/malaria programs and HIS directorate
- Ensure availability of **paper-based data collection and reporting tools** for all sectors
- Ensure the **maintenance of national digital HIS system** and system interoperability/integration based on maturity
- Trainings should be **limited to essential data-related processes**. Where possible, explore virtual training modalities
- Support **configuration of data quality functionalities in** digital **HMIS** software (e.g., the DHIS2 Data Quality Toolkit)
- Implement **integrated eRDQA** (digital data quality supervisions) in high volume sites
- Support routine **data analysis and use monitoring meetings** with a focus **on district and health facility levels**
- Support **case-based /patient level data systems only if already introduced**
- **Maintain existing data repositories** and support those that are in the process of being set up
- Adapt **efficient methodology for program reviews**

HIV: Support system security; patient monitoring; monitoring ARVs dispensing for ART, PrEP and PEP; monitoring of lab tests; patient level and aggregated digital data systems; integration of prevention outcome monitoring (POMT) in routine monitoring of services.

TB: Prioritize TB routine surveillance system strengthening activities; accelerate transitioning to real-time reporting according to country context.

Malaria: Continue support for strengthening routine malaria surveillance; targeted surveillance around biological threats, e.g. entomological assessments; support for surveys that are in the pipeline. Support introduction of ANC1-based surveillance as an alternative to MIS.

What to consider deprioritizing

(1) vertical data processes that can be optimized through integrated ones;
(2) resource-intensive assessments and surveys;
(3) printing strategy documents, guidelines and bulletins; and
(4) costly data-related national workshops.

More specifically, countries should consider:

- Pausing **new digital decentralization in hybrid (paper/digital) systems** (not applicable in near fully digital systems).
- When planning the development of a new **patient-level system** (Tracker or EMR), **avoiding** opting for **disease-specific systems** and aim for integrated systems.
- Discontinuing funding **residential workshops** for data related activities
- **Discontinuing disease specific data audits**, routine data quality assessments (RDQA) **using excel format**. Favor **integrated and digital** approaches.
- Stopping or **reducing printing** of guidelines, reports, bulletins etc.
- Refraining from **new standalone surveillance system assessments**
- Refraining from implementing **new surveys/studies or assessments,** decide on a case-by-case basis.

What to consider promoting for sustainability and integration

To identify medium- to long-term efficiencies, it is necessary to embrace novel approaches that will initially incur a cost but will subsequently generate longer-term savings. These may include:

- **eRDQA** for routine data quality assurance
- Virtual trainings
- **Improved methodology for data monitoring meetings**
- **Continued system digitalization and integration**
- Avoid residential workshops