GC7 Programmatic Reprioritization Approach

Date updated: 12 June 2025

The information contained in this document is not meant to be prescriptive and any decisions made on changes to current grant activities require tailoring to country context.

Source: GF website

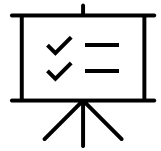
GC7 reprioritization and revisions build a solid foundation for GC8

In preparation for Grant Cycle 8 (GC8)

Reprioritization decisions and grant revisions for GC7 are an opportunity to build momentum on integration, cost effectiveness and sustainability of HIV, TB, malaria programs, in support of countries' primary health care services and health and community systems. This effort will be accelerated under GC8.

The programmatic reprioritization approach document can be used to support countries' dialogue and inclusive decision-making both on reprioritization across interventions and optimizing within interventions.

Detailed Document
English | Español | Français | Português

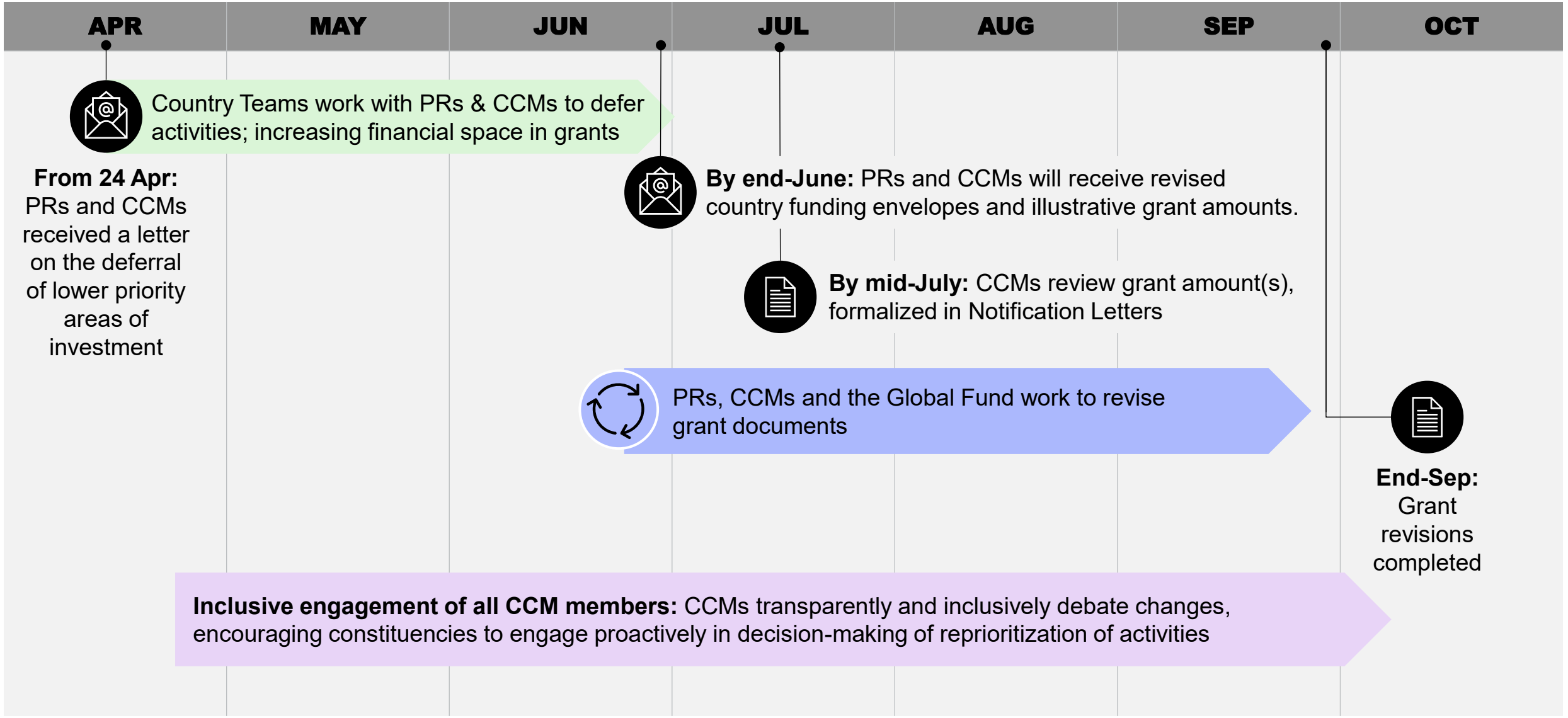


Summary presentation
English | Español | Français | Português

This approach **is not** meant to be prescriptive, and decisions on reprioritization will need to be adapted to country context and follow WHO normative guidance.

Source: GF website

Illustrative timeline for GC7 mid-cycle grant revisions



Source: GF website

Quick Tips for Community Engagement

- **Know your grant and funding landscape:** Carefully review grant documents (e.g., detailed budget, performance framework) and implementation progress (e.g., PU/DR, intervention-specific evaluations, community data on access barriers or service disruptions). Reach out to PRs, SRs, SSRs to inquire about the implementation status.

- **Understand the process guidance:** Carefully read Global Fund guidance to CCMs (e.g., letters, programmatic reprioritization, templates), share and discuss it among community and civil society to ensure a common understanding. Proactively clarify questions with your CCM representative, the CCM Secretariat, Global Fund implementers, Learning Hubs, or Global Fund staff.

- **Ensure rapid two-way feedback from CCM community representatives**: Agree on modalities for communication between CCM community representatives and their constituency to ensure timely sharing of information and two-way feedback.

- **Keep track of engagement opportunities:** Proactively reach out to the CCM Secretariat and the existing community and civil society representatives on the CCM for information on forthcoming opportunities to engage with the reprioritization and revision process (e.g., CCM meetings). Use existing touchpoints with PRs, SRs.

- **Coordinate community and civil society input**: Reach out to community and civil society CCM representatives and other community organizations to prepare for CCM discussions and ensure early alignment on priority issues. This could include conducting a community-oriented review of the grants to identify essential priorities and opportunities to optimize and rescope, look for more integrated approaches and cost efficiency and effectiveness as well as opportunities to advocate for intervention areas to be absorbed though domestic or other sources of funding

Source: CE SI / CRG

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

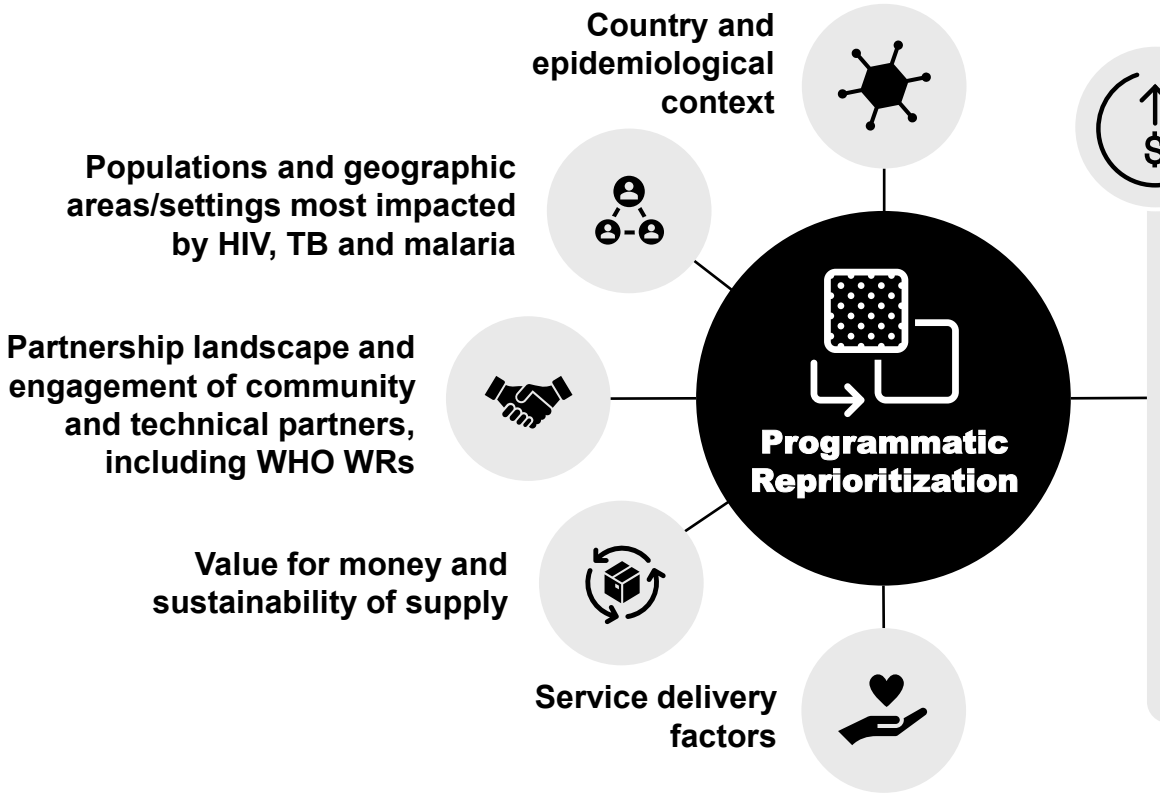
Essential health and community systems

Service delivery platforms

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

Source: GF website

Programmatic reprioritization decisions should consider context and all sources of funding



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

Reprioritization is intended to impact GC7 grants only. Currently approved C19RM-related activities are expected to continue given the need to maintain the pace of execution within the C19RM implementation period. **In cases where reprioritization discussions impact private sector contributions, catalytic investments such as matching funds or blended finance transactions, please consult with the Global Fund directly.**

Source: GF website

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 (PHC) and country health and community systems where possible, sustain human rights and gender 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 evaluate optimal deployment, and safety and security; market shaping and new product introductions.*

Source: GF website

Portfolio level core priorities for tuberculosis

Diagnosis & Treatment

- ✓ Protect diagnosis and treatment—key cost drivers but critical for TB programming
- ✓ 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.

Critical across all priorities – *Maintain HRH/CHW for integrated primary health care services including HIV, TB, malaria and RMNCAH (aligned to national package and evaluate optimal deployment), addressing stigma, discrimination, human rights, and gender-related barriers to timely, effective TB care. Surveillance system strengthening, laboratory systems strengthening and market shaping for innovative TB diagnosis and treatment tools.*

Source: GF website

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, especially. 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 primary health care services including HIV, TB, malaria and RMNCAH (aligned to national package) and evaluate optimal deployment, supply chain, HMIS, and appropriate product selection to combat biological threats.*

Source: GF website

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

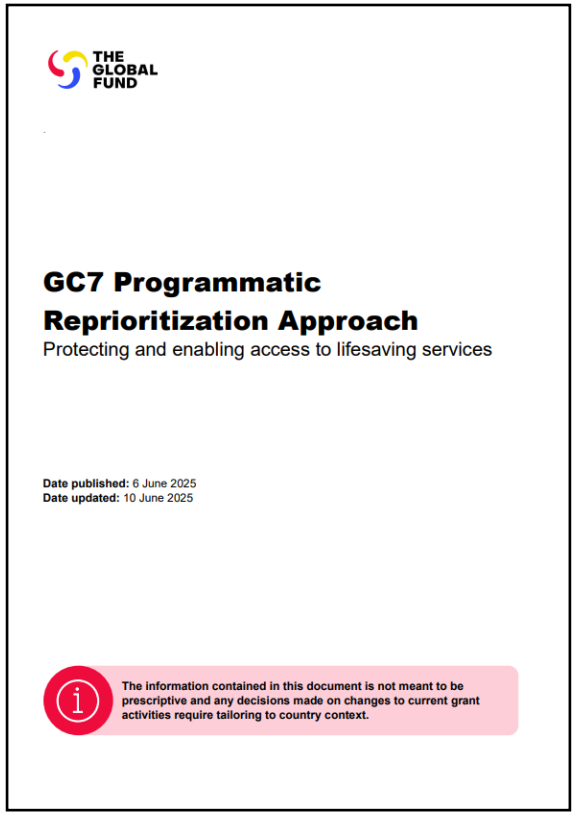
Consider how we achieve lifesaving impact through our investments in RSSH, human rights and community systems

- **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.

Source: GF website

What does the document say about equity, human rights, gender and community systems – General considerations (p. 4-6)

- Key interventions to reduce **equity, human rights and gender-related barriers** should be prioritized to ensure that the most affected populations can effectively access HIV, TB and malaria services (page 4).
- Maintaining and strengthening **community systems** is essential to reaching the most affected populations. This includes preserving **community peer cadres** and ensuring that **community led-service delivery** mechanisms are optimized, remain functional and well-supported (page 5).
- **Integration into primary care services** should be accompanied by efforts to make services equitably accessible and acceptable to the most affected populations, including activities to strengthen competencies in delivering inclusive, respectful, stigma-free, gender-responsive and age-appropriate care. (page 5)
- **CLM and accountability mechanisms** are critical to identifying and addressing rights violations and ensuring that health systems remain responsive to the needs of those most at risk (page 5). However, standalone or pilot CLM programs should be avoided. At minimum ensure there is a feedback mechanism in place to monitor AAAQ of lifesaving services.
- EHRGE and CSS areas of investment should **not be disproportionately reduced**, given the immediate long-term benefits in overcoming service access barriers (p. 5).


THE GLOBAL FUND

GC7 Programmatic Reprioritization Approach

Protecting and enabling access to lifesaving services

Date published: 6 June 2025
Date updated: 10 June 2025

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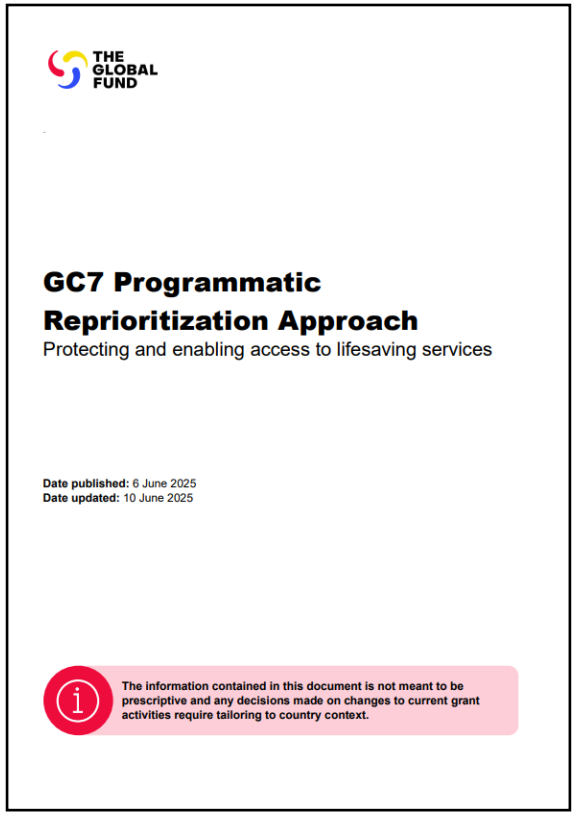
Source: CE SI / CRG

What does the document say about equity, human rights, gender and community systems? Considersations per Module (p. 8-68)

- The document provides detailed **considerations per module**, using the structure of the GC7 modular framework. Considerations on equity, human rights, gender and community systems are integrated in disease specific and RSSH modules.

- Each module includes the following information:
  1. Investments to **prioritize**
  2. Investments to **deprioritize**
  3. Considerations for **making efficiencies**

- Instead of reading the full document in detail, you can do a **quick search** for the modules and interventions that matter most to communities.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RSSH thematic areas, reprioritization considerations (1/2)

Human Resources for Health

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

What to consider prioritizing

- **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.**
- **Pre-service training of new polyvalent CHWs,** in line with national community health strategies.
- **Pre-service education HRH (non-CHW) can be considered in certain circumstancies,** 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 and pre-service training for **new HRH/CHWs for single-disease/vertical functions.**
- **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

- Develop / update **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, and 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.

Source: GF website

RSSH thematic areas, reprioritization considerations (2/2)

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.
  - Ensure CLM programs have approved access to facilities and service delivery sites with 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 and 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. At minimum, it is important to ensure there is a feedback mechanism between service providers and clients on quality and equity in every country.**
- **CLM-focused research** especially in countries where the CLM program is new or has not yet completed more than two data cycles.
- **Research activities** led or implemented by community partners if not directly linked to supporting quality service delivery.

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).**

Source: GF website

TB: Reprioritization by intervention

Prioritization of interventions and considerations

Interventions	Priority investments	Considerations
Screening and Diagnosis (DS-TB, DR-TB, TB/HIV, TBI)	• Case finding activities in health facilities including intensified case finding mainly in high-volume facilities. • Maintain essential diagnostic services and optimize the use of WRDs. • Sample transportation to increase access to existing WRDs and DST. • TB/HIV collaborative activities • Integrated service delivery for those with other diseases such as diabetes, undernutrition and other co-morbidities. • Private sector engagement in TB, especially in countries where most people with TB symptoms access services in the private sector. • Maintain community engagement to reduce stigma, building trust and improving service uptake, and sustained access to TB care for KVPs.	• Review community-based ACF and map/prioritize high risk groups and areas using available data, simple approaches/tools. • Wherever applicable, consider pooling sputum samples to optimize cartridge costs (*limited evidence available, requires WHO review/approval*) and using digital X-rays for triaging to reduce cartridges/chips needed. • Use alternative sample testing for specific groups, e.g., stool samples for children.

Source: GF website

Prioritization of interventions and considerations

Interventions	Priority investments	Considerations
Treatment of DS-TB/DR-TB, TB/HIV and TBI	• Ensure patients with all forms of TB receive appropriate treatment and support with first-line medicines procured through domestic financing and increasingly taking over procurement of second-line medicines as much as possible. • Use the newer, shorter, more effective regimens like 6-month BPaL/M (BDLLfx/C for children and pregnant women) for DR-TB, 3HP for TPT and 4-month regimen for children with non-severe form of DS-TB. • For TPT, prioritize PLHIV and household contacts of patients with bacteriologically confirmed PTB. • IPC, especially PPE: mask for patients with DR-TB and respirators for staff including CHWs.	• Accelerate transitioning to shorter DR-TB and TPT regimens. • Integrate DR-TB and DS-TB services and transition to people-centered treatment models supported through DTA, family members and/or communities. • Consider using symptom-based screening than IGRA/TST testing to provide TPT as per WHO recommendation.

Source: GF website

Prioritization of interventions and considerations

Interventions	Priority investments	Considerations
Data, monitoring, supervision, training, program review	• Maintain routine reporting system and strengthening the surveillance activities. • Routine analysis and use of data to identify gaps and for better targeted interventions. • Support the completion of ongoing surveys and routine analyses. • Review and reprioritize training including ensuring human rights and gender considerations are integrated. • Continue supporting routine program supervision and M&E activities, including integrate with other programs (e.g., HIV) wherever relevant and efficient.	• Tools like hotspot mapping and TB care cascade analyses can guide targeted interventions, populations and areas to optimize resource allocation. • Use surveillance data, epi-review and simple modelling to inform planning and prioritization. • If required, support a streamlined process of epi and program reviews to inform NSP revision/development, with a focus on prioritization based on available data and through remote support in line with the new approach recently announced by WHO. • Leverage e-learning platforms and technologies to provide remote training, establishing mentoring networks and supervision to reduce costs related to transport, *per diems*, and time away from programmatic duties.

Source: GF website

Interventions to consider deprioritizing

Interventions	Deprioritize investments	Considerations
Screening and Diagnosis	• Procurement of new equipment	• Prioritize use of microscopes for treatment follow up than for diagnosis. • Optimize the use of cartridges, e.g., sample pooling, using X-rays with AI for screening and triaging people seeking care, testing stool samples for children. • Replacement of faulty modules than procuring new machines. • Use new affordable near point-of-care tests (when available).
Active Case Finding	• Mass chest camps or campaigns and unprioritized/untargeted active case finding	• Consider mapping and targeting high-risk groups and geographic areas using available data including vulnerability index.
Treatment	• Long and expensive treatment regimens while shorter, more effective and cheaper alternatives are available.	• Accelerate transitioning to new shorter treatment regimens (e.g. 6-month regimens for DR-TB, 3HP/1HP, 3HR for TPT, 4-month DS-TB for children with non-severe form of the disease). • Continue using 6-month regimen for adults with DS-TB as a cost-effective option.
Enablers, nutritional support	• Blanket nutritional support and incentives	• Maintain/prioritize provision of nutritional and transport support to targeted groups such as patients with DR-TB, children with severe undernutrition, homeless people.
Surveys	• New TB surveys including Prevalence Surveys • Non urgent and costly operational research projects	• Use existing data to update TB burden estimation as needed. • Limit operational research to critical ones and use existing data and evidence to improve coverage and quality of TB services.
Program management, HRH/CHWs New Constructions Technical Assistance (TA)	• Scale-up of community workers and paralegals • Infrastructure upgrades that have yet to substantially progress, or yet to convincingly demonstrate likelihood of successful completion before the end of GC7	• Maintain CHWs and TB champions currently engaged. Please refer to the RSSH/HRH section below for more considerations on integration of CHWs. • Critically review program management costs and salaries for all cadres of health care providers including CHWs. • Consider remote participation than travelling for international conferences, meetings and training. • Reduce expenditure on in-country meetings, workshops, and others. • Review and prioritize TA to make this more targeted and efficient including through remote support.
Removing barriers	• New legal and policy frameworks to prevent punitive or coercive measures and improve rights-based TB-services.	• Support integrating efforts on TB-related legal and policy frameworks and access to justice activities within broader national human rights mechanisms and institutions.

Source: GF website

HIV: Reprioritization by intervention

Prioritization of interventions and Considerations

Interventions	Priority investments	Considerations
HIV treatment and care, including DSD, AHD, TB/HIV, management of co-infections and co-morbidities	• Measures to maintain key and/or vulnerable populations (KVPs) on treatment, including maintaining safety and security, peer-based support for treatment continuation. • (…)	
HIV Prevention	• Community empowerment for all KP: targeted outreach-based HIV prevention delivery focused on use of HIV prevention options; safety and security • Harm reduction: safe injecting equipment that reflects user choices; wound care; opiate substitution treatment for PWID; overdose prevention and management • Human rights activities directly linked to improving access to services (including addressing harmful policing practices). • (…)	• Prioritize demand creation/communication activities that address multiple HIV prevention/testing options rather than single option campaigns; combine interpersonal with online and m-health modalities
Reducing human rights related barriers to HIV/TB services	• Activities to reduce stigma & discrimination in (1) healthcare settings and (2) community settings for the purpose of reducing barriers to health services • Maintain existing multistakeholder mechanisms for coordination and oversight of implementation of human rights strategic plans and programming • Maintain existing CLM of human rights violations and redress in health facilities • Maintain community-led interventions (e.g. Community Paralegals) to support access to justice, accountability and redress in context of human rights barriers to health services • Maintain community capacity to deliver stigma and discrimination monitoring and reduction including in health care, community and justice settings.	• Integrate non-discrimination, KP and gender competencies in relevant capacity building activities for healthcare providers • For longer-term sustainability, support integration of HIV access to justice activities within broader national human rights mechanisms and institutions, including accountability mechanisms for rights-based HIV services and reporting mechanisms for patients

Note: This slide shows a selection of interventions. Full considerations for HIV are available on the Global Fund website

Prioritization of interventions and Considerations

Considerations for prioritizing HIV prevention service delivery:

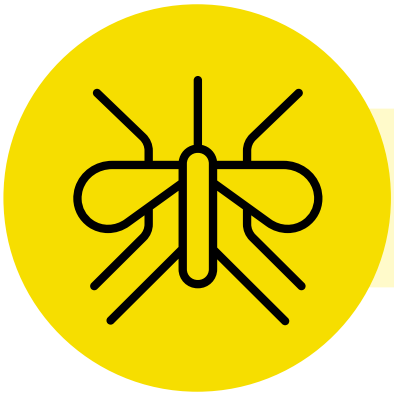
Community outreach:

- Strengthen community outreach system for a continuum of HIV prevention, testing, treatment & support. Avoid single-issue/intervention outreach.
- Prioritize CBOs/CLOs with significant reach.
- Ensure outreach is focused on HIV prevention/testing and linkage to care outcomes.
- Increase online and m-health service delivery.
- Shift CBO/CLO/outreach-related human resource costs to sustainable and standardized national salary scales. Where context does not permit an immediate shift without disruptions to outreach services, initiate planning for a shift to standardized national salary scales to start with GC8 funding cycle (refer to RSSH - HRH/CHW section for more information).

Leverage existing service delivery platforms:

- Sexual and reproductive health, family planning and sexually transmitted infections services (government and CSOs) are under-used as sites for HIV prevention/testing. Consider shift to sexual and reproductive health service platform as key delivery platform for HIV prevention and testing.
- Expand pharmacy-based delivery of HIV prevention commodities.
- Review the costs of mobile services and fixed sites (e.g., KP drop-in centers, KP safe spaces), assessing performance towards HIV targets. Focus investment on locations with high KP concentration.

Source: GF website



Malaria: Reprioritization by intervention

Prioritization of interventions and considerations

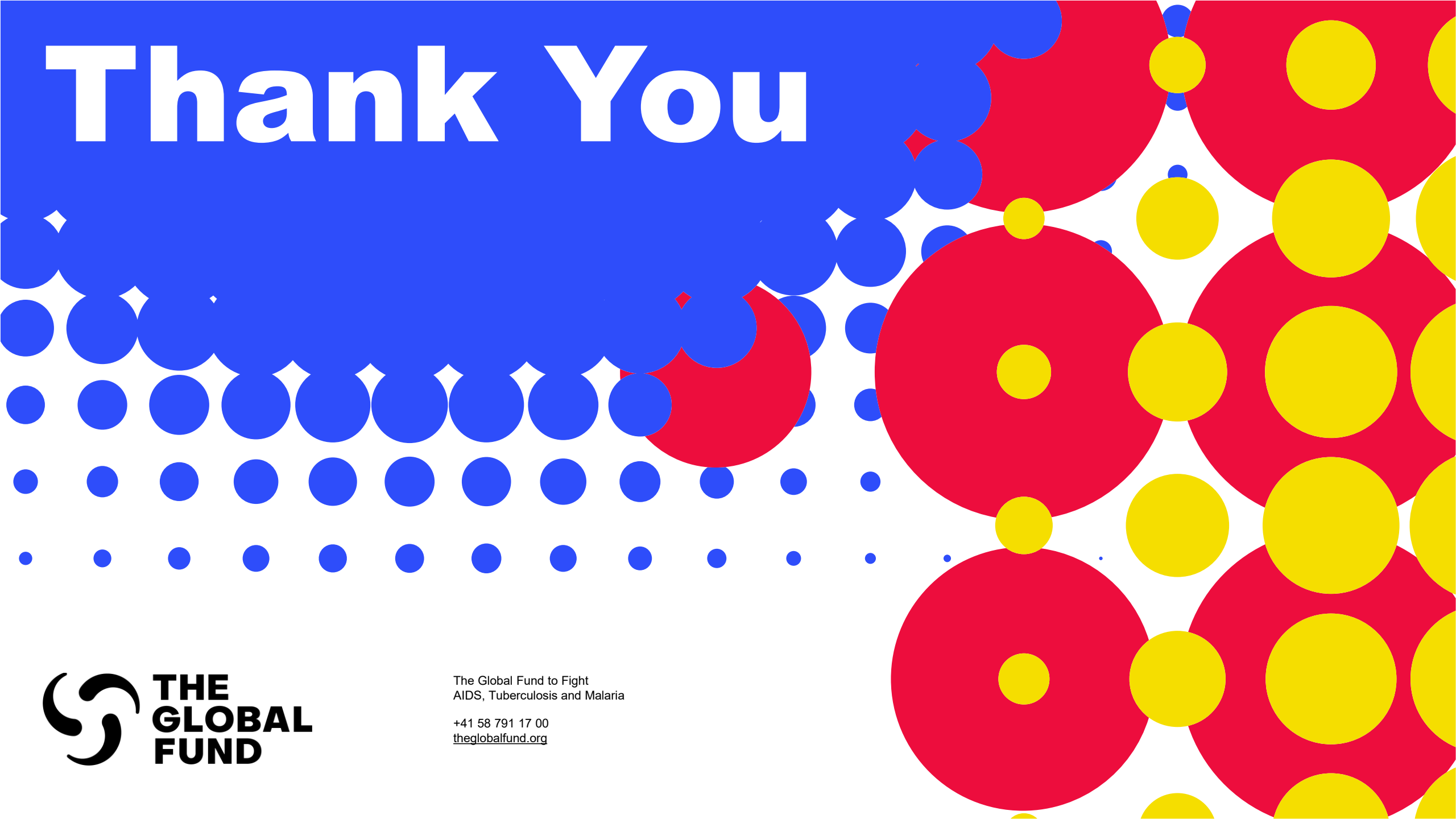
Case management

Public sector case management (facility-based and community):

- **Countries should include at a minimum:** commodities (ACTs, RDTs, IVAS, RAS & CQ, PQ in Pv contexts) and essential supply chain costs for public sector (facility and community level), with preference of using or transferring to national supply chains.
- **Quantification**: recalibrate as preventive interventions change (and changes in epi context. Gaps in cases of other external funding not materializing should be documented.
- Ensure most cost-effective **product selection** for any MFT strategy (e.g. AL&ASAQ) and RDTs (e.g. significant price difference between POCT and boxes of RDTs).
- **Quality of care:** transition malaria training/supervision (T&S) to integrated primary health care T&S; prioritize T&S for lower performing districts/facilities. Embed equity, human rights, gender equality strategies into T&S.
- **Access to care:** Evaluate optimal deployment of CHWs; continue non-malaria iCCM commodities but plan to transfer to domestic funding should be made. Private sector continuation on case-by-case review. Ensure access in COE contexts, as populations may be deprioritized. In hard-to-reach areas/populations without health facilities/CHW, seasonal/mobile approaches should be considered.

Note: This slide shows a selection of interventions. Full considerations for malaria are available on the Global Fund website.

Thank You



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