TRP Observations and Lessons Learned Report

54th Board Meeting

GF/B54/16
12 – 13 February 2026, Geneva, Switzerland

Board Information

Purpose of the paper: This report fulfills the TRP's advisory mandate by sharing observations and lessons learned from review of Funding Requests in GC7.

Introduction

During the 2023-2025 allocation period (Grant Cycle 7, or GC7), the Technical Review Panel (TRP) reviewed 188 funding requests totaling US$13.07 billion. These requests covered programs addressing HIV, tuberculosis (TB), malaria, and resilient and sustainable systems for health (RSSH) across seven TRP Windows.[1] The TRP also took part in the GAC/CTAG reviews of the C19RM portfolio optimization, which strategically refocused investments on strengthening health systems priorities and pandemic preparedness.[2] In addition, the TRP contributed to the development of GC7 programmatic reprioritization guidance by the Secretariat, aimed at helping applicants make informed investment decisions in light of revised country allocations.

This report fulfills the TRP's advisory mandate by sharing lessons learned, particularly those with significant strategic, policy, or financial implications, and those that can assist preparation for Grant Cycle 8 (GC8). The TRP's insights are drawn from technical observations and lessons learned during the review of GC7 funding requests, emphasizing findings that will guide the Secretariat and Strategy Committee as they consider GC8's strategic priorities, changes in the global health funding landscape and operational context.

The TRP recognizes that GC8 presents new challenges requiring strategic shifts and a greater ambition for change. These challenges include a significant reduction in global health funding, the closure of the COVID-19 Response Mechanism (C19RM), changes among partners, evolving implementation methods, and increased country-led efforts toward sustainability and self-sufficiency. Therefore, applying the lessons learned from TRP reviews should account for each country's context, portfolio differences, shifting epidemics, and the need for bold, strategic prioritization to maximize the impact of available funds. Applicants must adapt their approaches and focus on what can be achieved with existing resources to maximize impact of investments, keeping in mind where countries are in the sustainability and transition journey.

This report also builds on the Global Fund Secretariat's GC7 reprioritization guidance provided to applicants, ensuring consistent messaging about priority activities and focus areas for GC8.[3]

Summary of TRP Observations and Lessons Learned

The TRP highlights significant concerns about the risk of reversing hard-won gains in HIV, TB, malaria, and RSSH due to increased financial constraints, reduced partner support, and emerging challenges such as serving displaced populations and responding to climate-related events. As applicants prepare for GC8, they will need to navigate unpredictable funding, make difficult trade-offs, and address persistent issues in programming for key and vulnerable populations. To overcome these complexities, the TRP urges applicants to accelerate program optimization by leveraging technology and innovations. Enhanced integration of disease programs within primary health care (PHC), robust human resource planning, and a commitment to maintaining services and impact for vulnerable groups will be vital for continued progress and system resilience.

TRP Observations and Strategic Insights from GC7 Funding Requests

[1] GF/SC29B/11: Update on GC7 Country Funding and Catalytic Investment Operationalization and SI Performance (2025).
[2] GF/SC27/04: C19RM Update (2025).
[3] Alongside Global Fund technical and operational guidance, reviewers of this document should consider the (i) *TRP Observations Report: Grant Cycle 7 Windows 1 & 2*, and (ii) *TRP Observations Report: C19RM Portfolio Optimization Wave 2*.

- **Adopt bold, strategic prioritization to maximize impact and ensure Value for Money (VfM):** In the context of GC8's reduced funding and evolving challenges, applicants should direct limited resources toward interventions with the highest proven impact, ensuring that every investment delivers measurable results and supports long-term health system resilience. This requires making tough, evidence-based decisions to focus on the most effective, efficient, equitable, economical and sustainable activities. To optimize programming, it remains important to embrace innovative approaches and align with national priorities. Applicants are encouraged to employ transparent, data-driven, and inclusive processes that strengthen equity and accountability throughout planning and implementation.
- **Advance sustainability, increase preparations for transition from external financing to self-sufficiency.** To ensure long-term program sustainability amid financial constraints in GC8, applicants must intensify and accelerate preparation for transitioning from external to domestic financing. Progress in institutionalizing sustainability and transition plans, including scaling up domestic funding and meeting co-financing commitments remains inconsistent. Proactive, early planning, reliable domestic resource mobilization, and robust frameworks for social contracting are essential to maintain progress. Prioritizing early transition and sustainability planning will strengthen Global Fund funding requests and grants, helping to address challenges and reinforce the effectiveness of grant design and implementation.
- **Strengthen data systems and health information systems for decision-making:** Investments in digital and interoperable platforms are expanding, yet data fragmentation persists. Applicants need to build interoperable, high-quality data platforms that integrate programmatic, financial, and community data to guide adaptive management and optimize resource allocation at all levels – especially in contexts with limited access to quality data and reduction in partner support.
- **Accelerate integration of disease programs within national systems for health:** To drive greater efficiency, sustainability, and equity in service delivery, applicants should accelerate the integration of disease programs for HIV, TB, malaria, and RSSH within PHC and community systems. Funding requests showed a various degree of integration maturity, reflecting that effective integration depends on the readiness of each system and is therefore highly context specific. While notable progress has been made in joint planning and supervision, persistent fragmentation remains a barrier. Strategic investments in human resources for health (HRH) and community health workers (CHWs), closely aligned with national health / PHC strategies, are essential to strengthen these integration efforts. However, full harmonization and institutionalization of community systems are still incomplete. To fully realize the benefits, applicants must institutionalize community systems strengthening (CSS) and ensure that frontline health workers are embedded within formal health governance structures. This approach will reinforce health system resilience and promote continuous, equitable access to essential services, even in the face of limited resources and shifting health challenges.

HIV

- **Maturing prevention with targeted innovation but uneven prioritization:** GC7 funding requests reflected progress in pre-exposure prophylaxis (PrEP) scale-up, community-led delivery, and integration within PHC and sexual reproductive health (SRH) systems. Stakeholders broadly acknowledge that prevention targets and investments remain insufficient; however, it is important to note the substantial increase

in both investments and targets from GC6 to GC7. Yet prevention targets and investments often remained modest and misaligned with local incidence, underscoring the need for sharper epidemiological targeting for vulnerable groups and cost-effective prioritization under reduced budgetary space.

- **Sustaining progress along the care cascade but persistent linkage and retention gaps:** Applicants expanded HIV self-testing, transitioned to dolutegravir-based regimens, and included advanced HIV disease (AHD) packages. However, weak linkage to treatment, low paediatric coverage, and uneven long-term retention highlight the need for coherent cascade management and stronger integration across HIV, TB, and non-communicable diseases (NCD) services.
- **Sustainability through integration, digitalization, and system efficiency:** As external funding declines, sustaining gains will require embedding HIV prevention and treatment within PHC and community systems, leveraging digital and private-sector partnerships, and ensuring maximum value-for-money through integrated, evidence-based service delivery.

TB

- **Continued innovation but uneven system readiness:** GC7 funding requests reflected strong alignment with global guidance and adoption of new tools (such as molecular diagnostics, artificial intelligence (AI)-enabled digital X-rays, and shorter regimens), but system readiness, maintenance planning, and financial sustainability of innovations often lagged behind.
- **Need for integration and efficiency under fiscal constraints**: Programs showed progress in community-based case finding and digital data use, yet limited facility-based detection, weak engagement of the private sector, and poor integration with PHC and NCD services constrained impact. Greater efficiency through integrated, evidence-based service delivery will be essential in GC8.
- **Slow uptake of child- and adolescent-focused innovations:** While applicants increasingly prioritized these populations, delayed adoption of non-sputum-based diagnostics and weak decentralization to PHC and maternal, newborn and child health (MNCH) platforms continue to limit case detection and continuity of care. Accelerated implementation and integration into routine systems are critical for sustainability.

Malaria

- **Sharper prioritization and efficiency under constrained resources:** GC7 funding requests demonstrated stronger data-driven planning and sub-national tailoring; however, high-burden settings faced stagnation due to funding gaps, uneven resource allocation, and weak operationalization of stratification. GC8 will require enhanced prioritization and value-for-money in core interventions, particularly vector control.
- **Integrated service delivery and innovation for equitable access:** Applicants expanded community- and facility-based diagnosis and treatment, but preventive chemotherapies and private-sector engagement remained limited. Systematic, cross-programmatic approaches, including the use of multiple first-line treatments (MFT) and introduction of malaria vaccines guided by the Gavi–Global Fund collaborative reviews, will be critical to strengthen access, innovation, and sustainability.
- **Building climate-resilient and adaptive malaria programs:** Malaria is the most climate-sensitive of the three diseases, yet few applicants incorporated climate-informed planning. Translating risk stratification into operational, climate-resilient action

through integrated surveillance, PHC linkages, and regional coordination will be central to accelerating progress and protecting gains in GC8.

These observations collectively emphasize the importance of strategic focus, sustainability, urgent and proactive transitions from external financing, equity, and integration as guiding principles for the next grant cycle where available funding will be significantly reduced. Subsequently, the report addresses the extent to which funding requests contributed to the Global Fund's primary goal of ending AIDS, TB, and malaria and equally providing strategic insights and recommendations for GC8.

Cross-cutting TRP Observations and Strategic Insights from GC7 Funding Requests

This section focuses on topics that represent the principal structural factors influencing Global Fund Funding Requests during GC7.

Strategic Prioritization and Value for Money

The principle of VfM has long been embedded in Global Fund strategies and guidance, however, in the context of reduced funding and growing risks of stagnating or even reversing programmatic gains there is opportunity to streamline program management costs and free up resources that could be reinvested to cover critical gaps in strategic priority areas. Applicants will need to not only streamline operations but also actively prioritize HIV, TB, malaria and RSSH programmatic efforts in GC8 based on country context and strategic goals.

To ensure effective prioritization in GC8, applicants must evaluate each funding request through a lens that maximizes VfM of Global Fund investments, align strategic prioritization decisions with measurable impact indicators, and ensure that resource allocations contribute directly to epidemic control and health outcomes.

GC7 represented **a modest but meaningful shift from rhetorical emphasis toward more explicit, data-informed efficiency measures** although such examples were still not the norm across all submissions.

- Some **applicants proposed targeted sub-national approaches to concentrate limited funds in high-burden areas and most at-risk populations**.
- **GC7 also showed increased use of Wambo.org** (the Global Fund's pooled procurement mechanism (PPM) platform) to **procure quality health commodities at an affordable price.**
- However, **efficiency and other dimensions of VfM were among the most frequently raised themes in TRP reviews (14% of all TRP clarification issues)**, reflecting the need for applicants to demonstrate how each dollar delivers measurable, equitable impact under fiscal constraints.
- TRP observed that **HIV prevention budgets were sometimes directed toward populations with lower incidence and sufficient service reach**, while higher-burden groups with significant coverage gaps received less funding.
- TRP also noted **fragmented implementation arrangements**, multiple sub-recipients, and **overlapping management units**, often special units in Ministries of Health instead of its relevant functional departments, that increased operational costs.
- TRP noted **opportunities for better laboratory network optimization and streamlining of health system delivery channels**. Some applicants still have parallel supply chains systems, and existing laboratory assets that are underutilized (e.g., GeneXpert machines operating at <30% capacity) while requesting funds for additional equipment.

Strengthening VfM will depend on better use of quality, granular and timely data to inform resource allocation and investment decision-making, track efficiency, and guide adaptive course corrections.

VfM principles should be consistently applied across all portfolios, irrespective of where they fall on the sustainability-transition pathway.

- **Strategic prioritization and optimization of programs using** disaggregated data and measurable impact indicators. This will ensure alignment of budget allocations with epidemic dynamics, most critical gaps and most effective and efficient delivery mechanisms.
- **Optimize administrative and operational efficiency, leaning to integration in national structures, long-term sustainability, reducing dependency on external financing and improved self-sufficiency:** Review budgets to minimize high program management costs e.g., training and travel-related costs, as well as dependency for HRH costs.
- **Streamline administrative and program management costs:** establish and restate guidance to maximize allocation of resources towards strategic investment priorities that reflect the GC8 funding realities, noting portfolio differentiation and / or clear, context specific benchmarks, e.g. Challenging Operating Environment (COEs), to inform program design along sustainability and transition pathways.
- Consider **consolidating separate disease-specific program management units**, shifting to virtual training or integrated formats, and using joint oversight, management, and supervision approaches to reduce recurrent expenditures.
- **Rationalize vehicle and equipment purchases** through stringent needs-based assessments, improving asset utilization and program optimization.

Advancing Transition, Financial and Programmatic Sustainability

The TRP observed that while sustainability planning in GC7 was technically sound, applicants could have gone further to promote long-term financial and programmatic sustainability and boost domestic funding. The TRP was pleased to see GC7 funding requests increasingly position HIV, TB and malaria within broader PHC and universal health coverage reforms, signaling an intent to strengthened alignment with national systems.

The TRP also observed some Tailored for Transition funding requests with more robust transition road maps compared to the previous cycle (albeit weaker regarding their human resources and supply chain components), offering clearer road maps than in the previous cycle.

- However, overall progress on sustainability and transition planning has stalled in several countries. In many contexts, **sustainability efforts remained limited to the programmatic level rather than being integrated within national policies or financing frameworks**. This created a gap between Global Fund-supported programs and government systems, particularly in areas such as procurement, human resources, and monitoring.
- With declining external financing, sustaining national HIV, TB and malaria **responses depends increasingly on early, well-planned transitions that are embedded within national systems, financing mechanisms, and governance structures**. However, while many Tailored for Transition funding requests included transition plans, overall, they lacked corresponding reforms in governance, budgeting, or policy.
- Furthermore, the TRP observed **uneven progress in systematic approaches encompassing institutional, financial, and community dimensions**, particularly in institutionalizing social contracting and in increasing co-financing.[4]

[4] Sustainability, transition, health financing and PFM, represented nearly 40 % of all RSSH issues raised by the TRP in GC7, by far the most salient category among all RSSH issues.

Sustainable Domestic Financing:

- The TRP saw an **increase in the number of proposals for blended finance deals**, recognizing the opportunity for improving coordination in multilateral investments at country level, laying initial foundations for more diversified, resilient funding streams. Blended financing showed a promise of optimized program management and potential for integration of disease programming with PHC, however, at least in one instance the TRP observed limited focus on disease outcomes and programming.
- However, several countries showed **weak domestic resource mobilization** (including in some cases of strong economic growth). There was slow progress in expanding mechanisms for financial risk protection, continued high out-of-pocket spending, uneven compliance progress to fully implement co-financing commitments, and a general lack of reliable data on domestic health expenditures in some instances.
- In several high-burden / lower-middle-income countries, fiscal reforms have yet to translate into predictable domestic allocations for health.
- **Weak public financial management (PFM) and limited budgetary space often prevented governments from absorbing essential recurrent costs,** such as community health worker salaries and laboratory maintenance, amid declining external support.

Sustainable Community Systems:

The TRP was encouraged by **early examples of governments directly contracting CSOs**, which shows that channels for social contracting can work in practice. There is a significant improvement in civil society organization (CSO) engagement and mitigation of barriers that existed before such as legal impediments and willingness of government to invest in CSO. From GC5/GC6 to today many countries have made steady (albeit slow) progress towards creating more enabling legal and political environments for social contracting. The multi-country initiatives for HIV supporting social contracting, along with greater attention to key populations and human rights programming demonstrate a strong complimentary value to the national programs, especially in the regions transitioning out from the Global Fund, and facing significant human rights and gender-related challenges.

- However, **the TRP remains concerned about the sustainability of community-led programming that reaches key populations,** even in countries fast approaching transition.
- Few applicants (including Transition Portfolios) demonstrated **meaningful progress in institutionalizing or creating enabling legal and policy environments for social contracting to finance CSO- and community-led services** through domestic public funding or alternative sources such as donors, private sector contributions, or social enterprise models. Where transition timelines outpace progress in social contracting, the applicants and the Global Fund partnership might need to explore alternatives to sustaining community-led services.
- The TRP is concerned that **social contracting models remain predominantly disease-specific and project-based, rather than system-wide,** representing a missed opportunity for integrated, sustainable community engagement. To be sustainable, community-led services must be embedded within national service delivery and financing frameworks, supported by legal recognition and predictable funding streams.

Sustainability should be reframed not as an end-phase activity but as a continuous process that is anchored in national strategies, legal frameworks, and fiscal planning. This will ensure that Global Fund investments progressively strengthen country ownership and resilience over time.

Opportunities for Strengthening Sustainability and Transition in Funding Requests

- **Early integration of transition and sustainability priorities in country dialogue and program design** to address governance, legal and policy reforms, and human rights and gender considerations before applicants transition from Global Fund funding.
- **Mobilize more domestic resources and progressively absorb recurrent costs:** Establish phased schedules and measurable transition milestones for governments to take over salaries of health workers (including CHWs), procurement of commodities, and equipment maintenance. Develop a health-financing strategy that sets incremental budget targets and leverages additional revenues (such as taxes, social health insurance, debt swaps and blended finance deals).
- **Institutionalize social contracting and private-sector engagement.** Conduct legal and policy reviews, pilot contracting of civil-society and private sector providers, create dedicated budget lines, build capacity of both government and CSOs, and generate evidence to inform scale-up. Establish enabling legal and policy environments that accelerate capacity development of community partners for social contracting and service delivery through multiple finance streams (donor, domestic, private and social income generation approaches), moving beyond disease-specific to systemic solutions.
- **Strengthen PFM and expenditure tracking systems to monitor co-financing and domestic spending:** Embed expenditure-tracking indicators in grant performance frameworks, in line with Secretariat reporting timelines on domestic spending, resource gaps and progress toward transition targets. This data is increasingly important to understand gaps in financing of specific categories of spend and should increasingly inform the setting of co-financing commitments and investments through Global Fund grants.
- **Protect community members' privacy, safety, and participation during transition to national ownership,** ensuring community-led services remain represented and financed.

Data Systems for Evidence-based Decision-Making

Timely, disaggregated and high-quality data are the backbone of effective programming. The TRP noted some encouraging progress in GC7 with several countries beginning to invest in digital transformation, introducing electronic medical records, geo-tagged dashboards, or integrating community-led monitoring (CLM) data with national health information systems.

Such innovations enabled a more granular understanding of service coverage and outcomes across populations, particularly for key and vulnerable groups, and opportunities for more dynamic responses.

- However, **major gaps persist**. While most applicants acknowledged the importance of data systems, the use of data (beyond reporting for real-time decision-making, adaptive management, and resource reprioritization remained limited in GC7. The TRP observed that in GC7 applications, **disaggregated data** encompassing gender, age, sub-populations, geography, and key populations were **frequently absent or underutilized in prioritization and budget allocation.**
- While most applicants acknowledged the importance of data systems, the **use of data for real-time decision-making, adaptive management, and resource**

reprioritization remained limited in GC7. Data was often collected primarily for reporting purposes rather than informing strategic decisions or program adjustments.

- **Only a few applicants linked financial tracking with programmatic outcomes**, limiting their ability to assess efficiency and value for money. Weak data analytical capacity and **insufficient institutional mechanisms for data use** further hindered adaptive management.
- **Many countries still rely on fragmented and parallel systems that are not interoperable**, resulting in duplication, inconsistencies, and underutilization of existing data assets. Weak feedback loops and limited interoperability between programmatic, financial, and community data systems further constrained evidence-based planning and efficiency gains.
- Moreover, several **digital systems supported under GC7 were donor-dependent fragmented systems without interoperability**, and lacked long-term maintenance or integration into national digital-health strategies, raising concerns about sustainability.
- However, **in contexts where access to available data is significantly reduced in-country due to declining partner support, countries must prioritize strategic investments in data and information systems**, identify critical data gaps early, and ensure collection of essential data to inform decision-making despite resource constraints.

Timely, disaggregated and high-quality data are the backbone of effective programming.

- **Strengthen data quality, harmonizing national Monitoring & Evaluation (M&E) indicators across all modules** (HIV, TB, malaria, RSSH), ensuring data is disaggregated by gender, age, location, and key population status to allow equity-focused analysis and planning.
- **Investing in sustainable essential data system operation and maintenance, developing national capacity for data analysis and use, and in real-time dashboards as appropriate,** expanding geospatial analysis, integration of key population and CLM data, and institutionalizing feedback mechanisms that support adaptive program management.
- **Ensure interoperability of all existing national digital platforms and integrate programmatic, financial and community data** to reduce parallel reporting, improve efficiency, and support evidence-based budgeting.
- **Provide targeted technical support to strengthen interoperability across national digital systems** such as health management information systems (incl. District Health Information Software 2 (DHIS2)), Logistics Management Information Systems, Human Resources Information Systems, Integrated Financial Management Information Systems, and CLM, and to build sustainable in-country capacity for data governance and analytics.

System Integration and Optimization for Sustainable Service Delivery

Human Resources for Health and Community Health Workers Investments

Overall, the TRP observed that most HRH investments in GC7 applications were implemented in vertical, disease-specific silos, producing duplication, inequities in remuneration, and weak accountability.

- Across both HRH and community systems, **fragmentation remained a persistent barrier to program efficiency and sustainability**. Strengthening the interface between health

workers and community actors will be essential to deliver integrated, people-centered services.[5]

- **Parallel outreach structures** (government CHWs and non-governmental organization peer educators operating under different incentives and reporting lines) further fragmented coordination and oversight.
- Root cause analysis showed that these challenges stem from, among others, **weak HRH governance frameworks, limited workforce planning linked to budgetary space, and insufficient alignment** between Global Fund–supported HRH interventions and domestic payroll systems.
- The TRP observed that several applicants initiated steps to **integrate CHW remuneration into national budgets** - a positive signal toward sustainability. However, these efforts were largely ad-hoc, disconnected from broader, costed national HRH strategies, and without transition plans to future domestic financing.
- Few applicants demonstrated systematic workforce planning **that linked HRH investments to PHC and RSSH frameworks**, service delivery needs, epidemiological priorities, and fiscal capacity, limiting efficiency and equity. Consequently, frontline cadres were often among the first areas where resources adjustments occurred, potentially affecting service continuity and equity.
- The TRP also noted **overlapping mandates and weak coordination** between the Ministries of Health, Ministries of Finance, and civil service, resulting in fragmented HRH management and accountability. Strengthening inter-ministerial governance and financing mechanisms will be essential to align workforce planning, payroll, and supervision within sustainable national systems.

Applicants need to shift HRH investments from disease-specific to system-based approaches, and ensure they are anchored in national HRH strategies, PHC platforms and fiscal sustainability plans to ensure equity, efficiency, and continuity of essential services.

Integration of Disease Programs into Primary Health Care

The TRP observed **positive trends in funding requests increasingly positioning HIV, TB and malaria within broader PHC platforms** and universal health coverage reforms, signaling an intent to strengthened alignment with national systems, aligning interventions with national service-delivery frameworks and emphasizing people-centered models.

The TRP observed more countries with integrated service delivery. This was demonstrated through joint planning across disease programs, shared supervisory structures, logistics, and use of unified health information systems. However, funding requests showed a various degree of maturity of integration and confirmed that integration is often context specific. Integration allows countries to be generally better positioned to adapt funding through reprioritization and maintain service continuity.

- Despite this progress, **most funding requests remained structurally vertical**, with no tangible steps towards integrated service packages co-managed by disease and PHC teams.
- Few countries integrated RSSH modules across the three diseases. While narrative sections of funding requests referenced “integration,” often operational planning remained

[5] See also Section 2.4 on Community Systems Strengthening for complementary observations on CHW governance and financing.

siloed treating HIV, TB, malaria, and RSSH modules as separate programs. Budgets, supervision, and M&E structures were seldom unified. Coordination between multiple Principal Recipients was often weak, and digital platforms for integrated monitoring were rare.

Integration at the service-delivery level is not only a matter of co-location but also of coordination, ensuring that front-line workers, community providers, and facility staff operate under coherent supervision, aligned reporting lines, and harmonized training and incentive systems.

Applicants should pursue stepwise integration aligned with national PHC and UHC reforms, focusing on service quality, referral linkages, and people-centered models of care.

There is an opportunity to consolidate the disease-specific programs within a unified PHC delivery framework that ensures continuity, equity, and efficiency.

- **Prioritize inclusion of HIV, TB, and malaria services into PHC through targeted policy reforms** and integration into essential PHC packages, stronger health financing systems (e.g., health financing schemes including service delivery by CSOs / community-led organizations (CLOs) / community-based organization (CBOs) via social contracting).
- **Invest in operationalization of integration in PHC:** Actively ensure cost integration e.g. in terms of HRH costs, joint training, supervision, logistics, and M&E, prioritizing the measures for system strengthening and sustainability, as opposed to system support.
- Incorporate **interoperable data systems** connecting facility, community, supply-chain, and finance data for real-time decision-making data for continuous PHC quality improvement.

Strengthening Community Systems for Service Delivery and Integration

The TRP observed some encouraging investments in CLM predominantly in HIV programs; these investments should be extended to TB and malaria programs to benefit systems for health more comprehensively.

The TRP noted the positive effect of including CSS interventions in the RSSH module, acknowledging the role of communities in ensuring community linkages to care, service delivery and monitoring quality, equity and accessibility of lifesaving services, and representation in decision-making processes that determine health priorities, resource allocation, and service design.

- However, **the TRP is concerned by suboptimal overall prioritization of CSS**, which has been noted in prior grant cycles. CSS investments remain project-based rather than system-wide and disconnected from HRH and PHC strategies. Governance frameworks for civil-society engagement are weak, and social-contracting mechanisms that allow public financing of CSOs are rare.
- These challenges reflect **limited institutional recognition of community organizations within PHC governance, weak social contracting mechanisms for sustainable CSO financing, and insufficient integration of community-generated data** into planning and decision-making. Without addressing these gaps, CSS will remain fragmented and unable to contribute effectively to resilient, people-centred PHC.

- Furthermore, the funding requests **lacked systemic efforts to address capacity and structural issues** to enable a greater role of CLOs and CBOs in improving program outcomes. Applicants should view CSS as an essential component of integrated, sustainable health systems, bridging community evidence, financing, and service delivery under unified governance and accountability frameworks.

Opportunities for Strengthening Community Systems in Funding Requests

- **Embed CSS within national and subnational health strategies:** Institutionalize community actors within health system and HRH frameworks, including defined roles, supervision, and remuneration. Define governance mechanisms for CSO participation in planning and oversight. Explore certification of CSO/CBOs as a tool for quality management of CSS. Support the institutionalization of CLM platforms into national quality assurance and accountability mechanisms to ensure that community feedback is acted upon to improve quality and access to services.
- **Extend CLM investments from HIV to TB and malaria programs** to benefit systems for health more comprehensively and address missed opportunities for systemic efforts to strengthen CLOs and CBOs' capacity.

Investing to Remove Structural Barriers for Equitable Access to Health

Overall, the **TRP observed encouraging progress in recognizing and addressing structural barriers to equitable access to HIV, TB and malaria services**. Countries participating in the *Breaking Down Barriers* initiative[6] as well as those supported through Human Rights Matching Funds demonstrated measurable improvements in quality and comprehensiveness of rights-based programming including planning for safety and security measures.

These countries also allocated more funding to removing inequities, human rights- and gender-related barriers, and to strengthening accountability for rights-based and gender-responsive service delivery. These initiatives supported integration of access to justice activities within broader national human rights mechanisms and institutions, including accountability mechanisms for rights-based services and reporting mechanisms for patients.

Matching Funds were instrumental in expediting comprehensive efforts to remove equity, human rights, and gender-related barriers to accessing services, including reforming the legal environment and punitive laws against key and vulnerable populations, and addressing stigma and discrimination.

- However, the TRP noted **several missed opportunities to invest in addressing punitive laws, policies, and law enforcement practices,** particularly in countries where civic space is shrinking and key population organizations face growing restrictions. These include new or more strictly enforced laws criminalizing same-sex relationships, tighter controls on civil society such as barriers to organizational registration, and legislation that limits or prohibits access to international funding.
- There is need **to shift from short-term mitigation measures to addressing root causes of human rights barriers** through sustained legal, policy and institutional reforms. Where measures to remove human rights barriers were included, often the primary focus was on mitigating their harmful impact on access to lifesaving services by investing in legal literacy,

[6] The Global Fund's Breaking Down Barriers initiative has provided financial and technical support to countries to tackle human rights-related and gender-related barriers to HIV, TB and malaria services.

paralegal support, and reduction of stigma and discrimination among health providers and law enforcement.

- The TRP appreciates that more applicants have conducted **gender assessments**, especially in HIV, increasingly in TB and malaria, following the TRP's consistent requests for such assessments during GC6. However, the use of recommendations from these assessments has been uneven in GC7.
- While progress is evident in some portfolios, the TRP is concerned that **human rights, gender equality, and gender-based violence (GBV) interventions** continue to receive **marginal allocations** within GC7 funding requests, despite their critical role in sustaining impact. In several cases, equity- and rights-related interventions were placed in the PAAR, suggesting that they are still perceived as optional or secondary rather than integral to program success. This pattern risks reinforcing the very inequities these investments aim to address.

Applicants should account for human rights, gender, and community engagement interventions across all program modules and financing frameworks, ensuring that equity-focused interventions are systematically budgeted for, tracked, and monitored. Investments should also address the enabling legal and policy environment required to sustain inclusive and rights-based service delivery.

The TRP further notes that COEs represent contexts requiring tailored approaches due to widely spread and systematic human rights violations and unique barriers to implementation and access.

Opportunities for addressing structural barriers in Funding Requests

- **Prioritize comprehensive legal and policy reform** through longer-term effort to remove punitive laws, policies and law enforcement practices that create barriers to prevention and access to services.
- **Systematically use findings from gender, legal environment, and malaria Matchbox assessments and existing sources of credible data** by local organizations or development partners to define interventions, set priorities, and allocate budgets for programs that remove structural, human rights and gender-related barriers.
- **Ensure long term sustainability of interventions through more integration of access-to-justice and legal literacy activities with broader national human rights and accountability mechanisms,** including those overseeing rights-based health services.
- **When prioritizing populations or geographic areas**, especially in COEs, ensure equitable access and coverage of populations which have particularly limited access to lifesaving services due to structural barriers.

TRP Observations and Strategic Insights on HIV, TB and Malaria from GC7 Funding Requests

TRP Observations on HIV Funding Requests

HIV Prevention

The TRP observed continued progress and maturity in HIV prevention in GC7, with more data-driven, differentiated approaches and expanded investments in PrEP, programs for key populations and adolescent girls and young women (AGYW) at highest risk for HIV acquisition, and integration within health and community systems. Despite constrained resources, most funding requests introduced innovations such as HIV self-testing and virtual consultations, and community-led service delivery, aligned well with the UNAIDS 95-95-95 targets and normative guidance.

- Applicants also demonstrated broader inclusion of people who use drugs, incarcerated populations, and gender-diverse communities, reflecting a more rights-based and inclusive approaches.
- Digital adherence tools and virtual support models indicated learning from GC6 and increased programmatic maturity.
- However, the TRP noted that investment levels remained misaligned, leaving some key population groups at epidemiological risk.
- Programming for key and vulnerable populations remained uneven and often underfunded, particularly in high-burden or shrinking fiscal and legal restrictive environments.

Pre-Exposure Prophylaxis: The TRP welcomes the expansion of Pre-Exposure Prophylaxis (PrEP): delivery and introduction of newer biomedical options such as long-acting Cabotegravir and the Dapivirine vaginal ring.

- However, coverage targets were often conservative and not grounded in local transmission data.
- Some applicants did not base PrEP programming on local transmission dynamics, incidence trends, prioritize equitable inclusion of adolescents, pregnant and breastfeeding women among those with the highest incidence, and key populations, and integrate service delivery within PHC and SRH platforms.

Key Populations and Adolescent Girls and Young Women: The TRP observed clear progress in the use of data and normative guidance to identify priority groups and tailor responses. For AGYW, big steps were made in GC7 by using the UNAIDS SHIPP tool and the UNAIDS/GPC Decision making aide for AGYW programming, which supported a substantial change to more impactful investments from GC6 to GC7. Encouragingly, several funding requests designed layered, community-based interventions combining PrEP, GBV prevention, and adolescent-friendly services.

Prevention of Vertical Transmission: Most funding requests coming from high-impact and core countries in GC7 continued to prioritize elimination of vertical transmission, primarily through integration of HIV testing and treatment within antenatal care and maternal health services, aligned with the triple elimination strategy for HIV, syphilis, and hepatitis B.

- Universal testing and treatment of pregnant women and HIV-exposed infants remains widely implemented, ensuring early diagnosis and treatment initiation for HIV-positive pregnant women and their infants.
- Several applicants also proposed improvements in early infant diagnosis and inclusion of PrEP in maternal health packages.
- However, the TRP remained concerned about service continuity, particularly during the postnatal period and among adolescent mothers and rural populations and pregnant women from key populations.

Applicants should reinforce the full maternal-infant cascade, linking prevention of vertical transmission, with postnatal and paediatric care, and ensure sustained integration within MNCH and PHC platforms to sustain coverage and maintain continuity of care.

Continuum of Care for HIV Diagnosis, Treatment & Care

GC7 funding requests reflected steady progress across the HIV care cascade, notably through expanded HIV self-testing and index-partner testing, introduced rapid diagnostics in community and prison settings, and increased ART coverage through wider use of dolutegravir-based regimens and differentiated service delivery. Inclusion of budgets for AHD packages demonstrated increasing recognition of key mortality drivers.

- However, many programs still lacked coherent cascade management. Linkage to treatment after testing was often fragile, paediatric and adolescent ART coverage lagged, and long-term retention remained inconsistent.
- Integration of TB, viral hepatitis, and NCD management remains limited, as does the use of digital or community-based adherence and patient tracking systems.

Applicants should present evidence-driven cascade strategies; integrating HIV care within PHC and community systems, emphasizing cost-effectiveness, and prioritizing groups, modalities and settings that maximize impact and sustainability.

TRP Observations on TB Funding Requests

During GC7, the TRP observed significant progress, with applicants increasingly aligning with normative guidance and adopting innovative approaches such as, WHO-recommended molecular diagnostics and AI-enabled digital X-rays, shorter regimens for both drug-resistant TB and preventive therapy. Applicants also demonstrated stronger commitments to reaching key and vulnerable populations, and regional initiatives toward TB elimination. However, despite these gains, interventions were not always supported by health systems infrastructure or financial resources needed for sustainability.

Diagnostic Capacity and Readiness for Early and Accurate Detection

During GC7, most applicants moved towards earlier and more accurate TB detection through expansion of WHO-recommended rapid diagnostic and AI-enabled digital X-rays. For example, portable diagnostic platforms such as Truenat are particularly suitable for peripheral and hard-to-reach settings due to their low infrastructural requirements (battery-operated, minimal laboratory setup) rather than connectivity advantages. However, progress in deploying new diagnostic tools often outpaced health system readiness.

- Maintenance, interoperability with other national information systems, and workforce capacity were frequently underfunded or absent from proposals, undermining long-term functionality and efficiency.
- In some cases, microscopy remained the primary diagnostic method, reflecting a lag in policy adoption or incomplete transition to up-to-date algorithms.
- In addition, diagnostic algorithms were also often insufficiently differentiated by epidemiological context or target populations, limiting efficiency and cost-effectiveness of diagnostic strategies.

Future applications should move beyond procurement-driven approaches towards end-to-end diagnostic system planning that links investments in equipment with maintenance, data integration, and linkage to treatment workflows. Under constrained funding, such system-level planning (combined with domestic co-financing and integration into national laboratory and digital health platforms) will be critical to sustain TB diagnostic capacity.

Integration and Efficiency in TB Detection, Treatment, and Care

Many applicants clearly proposed innovative, community-led TB case-finding strategies and expanded use of digital data systems such as DHIS2, while integration of TB/HIV services was strongly progressed. These efforts reflected growing recognition of the need for more people-centered and data-informed TB care.

- Nevertheless, limited emphasis on health facility-based TB detection contributed to persistent high rates of pre-treatment loss-to-follow-up and underutilization of available diagnostic and treatment capacity.
- Engagement with the private sector, which is critical for TB prevention, detection and treatment in many contexts, was frequently mentioned, but rarely supported by clear roles, budgets, or accountability frameworks.
- Furthermore, integration of TB and co-morbidities beyond HIV and diabetes remained insufficiently addressed, despite their growing contribution to TB burden.
- Weak integration of TB with broader health programs was further compounded by fragmented data systems and reliance on modelled estimates rather than routine

surveillance-based data, limiting the precision of planning and performance monitoring. Such fragmentation and missed opportunities for integration risk undermining both efficiency and sustainability.

Applicants will need to make more deliberate use of integrated, evidence-based approaches that link TB with PHC, NCDs, and digital health platforms. This will not only improve case detection and continuum of care but also enhance cost-efficiency and resilience under fiscal constraints. Greater impact can be achieved by leveraging shared data systems, aligning incentives across sectors, and fostering structured partnerships with private providers that extend beyond pilot initiatives.

Children and Adolescents TB

The TRP welcomes the progress in addressing TB in children and adolescents, incorporating child- and adolescent-specific targets and introducing, in some cases, non-sputum-based diagnostic tools.

- However, uptakes of newly recommended diagnostic approaches remained slow, limiting progress in case detection, particularly among younger children who cannot produce sputum.
- Moreover, services for children and adolescents were rarely decentralized to PHC or MNCH platforms, where access and continuity of care could be significantly improved.
- These gaps underscore the need for a more systematic approach that ensures rapid adoption of new diagnostic technologies, operational integration of child and adolescent TB services within PHC and MNCH programs, and stronger data systems for age-disaggregated target setting and monitoring. Embedding these services within existing health platforms offers one of the most cost-effective strategies to expand coverage and sustain quality under constrained budgets.

TRP Observations on Malaria Funding Requests

The TRP noted an overall improvement in the quality of malaria funding requests in GC7, with stronger data-driven prioritization, increased stratification, and sub-national tailoring of interventions. Several applicants, particularly those in low transmission settings, demonstrated encouraging progress in reducing malaria burden and advancing toward elimination.

- However, in high burden settings, stagnation or even reversal of hard-won gains remains a concern. Applicants will need to make strategic and evidence-based choices to sustain high-impact core interventions, strengthen system resilience, and accelerate reduction in the highest-burden settings before expanding toward elimination.
- Sustained impact continues to be threatened by persistent funding gaps for core interventions, changing epidemiology patterns (e.g., urban malaria transmission), expanding therapeutic and insecticide resistance, and limited capacity to respond to climate, environmental, and man-made disasters.
- Among the three diseases, malaria remains the most climate-sensitive, with rainfall variability, temperature shifts, and expanding altitude distribution directly influencing transmission dynamics.

As such, malaria programs provide a critical area for operationalizing the Global Fund's broader climate-and health resilience agenda, linking malaria control to adaptive and resilient health systems.

Optimal Vector Control Mix and Coverage for Impact

The TRP observed progress in optimizing the mix of vector control interventions, i.e., balancing between indoor residual spraying (IRS) with insecticide and insecticide-treated nets (ITNs) to improve efficiency and achieve full coverage of at-risk populations.

- In line with previous TRP recommendations, some applicants replaced IRS with next generation ITNs to expand coverage within limited budgets. The TRP also observed improved alignment with WHO guidance, including adoption of dual-active-ingredient ITNs or targeted IRS in areas of insecticide resistance.
- Despite these advances, some applicants continued to propose universal ITN coverage without a clear justification (e.g., based on population at risk, resistance profiles or transmission dynamics), or prioritizing higher-cost IRS over next-generation ITNs, reducing overall coverage and cost-effectiveness.
- In a context of reduced budgetary space, such inefficiencies directly threaten program equity and impact.

Further progress requires evidence-guided optimization of vector control, supported by strong entomological and epidemiological data, efficient procurement and logistics, and community mobilization to ensure sustained ITN use and replacement.

Equitable Access to Case Management and Preventive Chemotherapy

The TRP observed that several applicants expanded access to quality-assured diagnosis and treatment through community- and facility-based service delivery platforms. Several applicants also included targeted interventions for vulnerable populations, such as pre-referral treatment of severe malaria (e.g., rectal artesunate) in line with WHO guidance.

- However, coverage of core case management interventions for high-risk groups remains limited due to resource constraints, variable access to and use of public healthcare services, and weak community systems.
- Private sector engagement remains underutilized despite its contribution to malaria diagnosis and treatment in several endemic contexts.
- Implementation of preventive chemotherapies (i.e., Intermittent Preventive Treatment in Pregnancy (IPTp), Seasonal Malaria Chemoprevention (SMC), and Perennial Malaria Chemoprevention (PMC)) also remains inconsistent, with gaps in coverage and adherence.
- A number of applicants proposed mass drug administration (MDA) as a strategy for sub-national elimination; however, MDA is likely to provide only temporary reductions in malaria burden, and its long-term value is limited unless integrated within a comprehensive malaria program package including effective case management, surveillance and vector control.

Malaria Innovations

- ***Multiple First-line Therapy****:* The TRP also reviewed proposals for Multiple First-line Therapy (MFT) within countries. Properly designed MFT strategies can be a proactive tool to delay or mitigate resistance to first-line antimalarials and extend the useful therapeutic life of artemisinin-based combination therapies. MFT can be justified not only in areas with documented resistance, but also preventively provided robust pharmacovigilance, supply chain management, and resistance monitoring systems are in place.

- ***Malaria Vaccines:*** Furthermore, GC7 marked an important milestone with the introduction of malaria vaccines, guided by lessons from the GAVI-Global Fund collaboration in funding request and grant support processes. This experience highlights the need for a national coordination across malaria and immunization programs, on one hand, and, on the other hand, a greater alignment in Global Fund and GAVI funding cycles with a systematic, joint approach to introducing new innovations.

The shift to greater alignment and coordination requires ensuring early policy dialogue, coordinated costing and decisions on the best mix of interventions in a tight fiscal environment, and alignment between malaria and immunization platforms and RSSH and EHRG investments across the national budgets and the two global health institutions to maximize efforts to save lives and value for money.

Accelerating Reduction in Malaria Burden and Elimination: Sub-nationally Tailored, and Climate-resilient Programs

The TRP acknowledges the positive shift toward malaria risk stratification and sub-national tailoring of interventions to address geographic and population-based differences in malaria transmission. Many high burden and High-Impact countries applied risk stratified data to focus resources on the highest-burden areas, while several low-transmission settings advanced toward elimination through targeted outbreak response and focus investigation and response.

- However, in many high-burden settings, stratification remains largely analytical rather than operational. Few applicants conducted root-cause analyses to understand stagnating trends, and costed, actionable plans translating stratified data into intervention packages were often missing.
- Post-elimination settings also lacked comprehensive plans to prevent re-establishment of transmission (e.g., “1-3-7 framework”). Surveillance, as a key intervention for burden reduction and elimination and re-establishment prevention, was not consistently treated as a program priority.
- TRP noted that increasing climate variability (including floods, droughts, and temperature shifts) continues to influence malaria transmission patterns, driving outbreaks in new or previously low-risk areas. Yet, most applicants did not incorporate climate-informed risk analysis or adaptive contingency measures into their planning.

To accelerate progress, countries should institutionalize subnational tailoring (SNT) as a planning and budgeting framework, embed malaria surveillance within PHC and national digital health systems, and link data to real-time decision-making and response.

Integration of climate and environmental data into malaria programs will be essential to strengthen resilience and sustain gains.

Conclusion

Across funding requests reviewed in GC7, the TRP observed clear maturation in the approaches of applicants. Applicants demonstrated stronger alignment with national strategies, greater use of data for prioritization, and more adaptive programming within reduced budgetary space. These developments reflect progress toward strategic focus and efficiency, even as resource limitations, fragmentation, and uneven system readiness persisted.

GC7 reaffirmed the importance of striking a balance between ambition and realism, protecting essential services while advancing integration, preparing for transition, sustainability, equity, and the strategic use of innovation. The TRP noted that applicants increasingly applied data-driven prioritization frameworks, but impact linkages and transparency could be strengthened.

Sustainability and transition efforts advanced in some contexts but remained fragile, highlighting the need for improved and more predictable domestic financing and integration of donor-supported services into national systems. Progress in meeting co-financing commitments also varied significantly, underscoring the need for clearer domestic financing pathways and stronger accountability mechanisms.

Moving into GC8, the TRP emphasizes four critical opportunities:

1. **Bold ambition, pushing harder on strategic prioritization and resource efficiency.** Focus limited resources where they maximize measurable, equitable impact, guided by robust data and epidemiological evidence.
2. **Advance sustainability, prepare for effective transitions, and improve domestic financing**. Institutionalize sustainability and transition planning, strengthen PFM, and embed essential programs within national budgets.
3. **Strengthen data and health information systems for decision making**. Integrating digital tools, surveillance, and regional coordination into program design will be key to improving responsiveness and readiness.
4. **Integrate disease programs within PHC and health systems.** Joint planning, budgeting, and supervision across HIV, TB, malaria, and RSSH will reduce fragmentation and enhance resilience. Strengthening HRH and community systems as integral pillars of service delivery, social accountability, and system continuity.

Looking ahead, GC8 funding requests must anticipate a more complex landscape, marked by multiple strategic priorities and challenges including fiscal constraints, climate impacts and recurring public health emergencies.

At the same time, the Global Fund partnership should take advantage of innovations and health technologies that offer a great value for money, working on several dimensions in parallel: health system readiness across system blocks, readiness for uptake, scale for impact informed by comparative value added to the mix of interventions, institutionalization of and sustaining innovations and alignment across different funding streams and national and global health institution planning cycles.

The TRP emphasizes that GC8 provides a pivotal opportunity to consolidate progress, correct structural inefficiencies, and ensure that every investment delivers maximum, equitable, and sustainable impact. Applicants are encouraged to apply GC7 lessons, tailored to epidemic contexts and country resource constraints, to develop coherent, country-led, and forward-

looking funding requests that protect current gains while building stronger, integrated and sustainable systems for the future.