

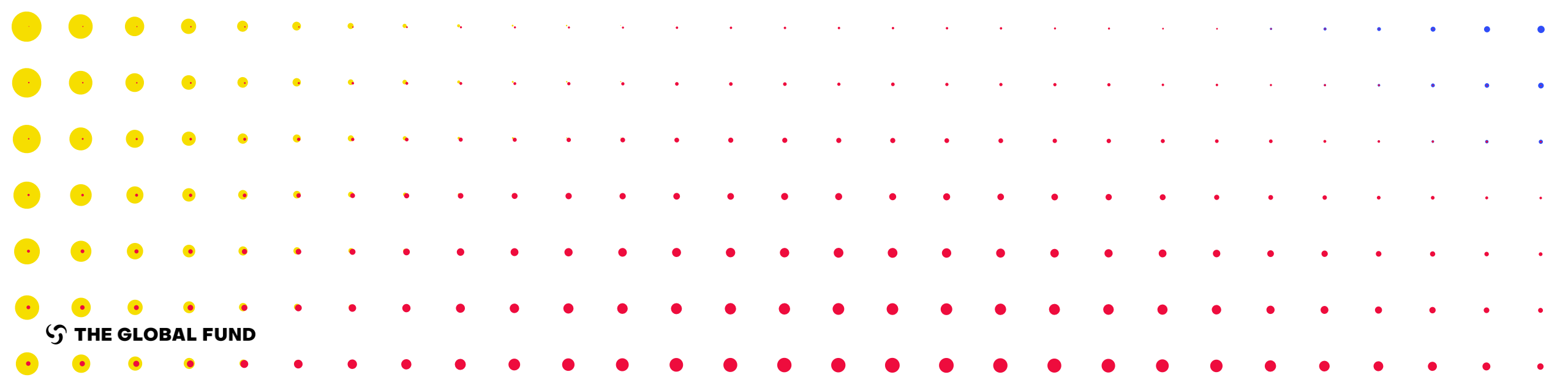
TRP Lessons Learned

GC8 TRP Review Window 2

15 September 2026



1 Window 2 overview



Window 2 outcomes

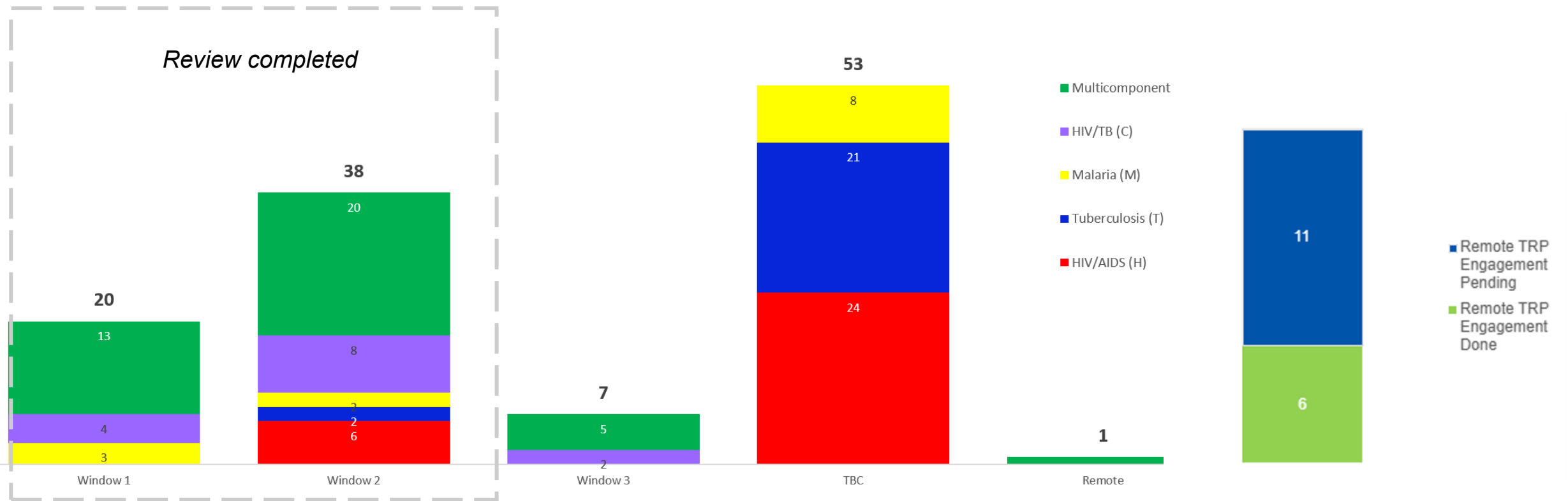
TRP has recommended **37 of the 38 funding requests for grant-making**.
The reviewed funding requests represent **\$4.58B in allocation funding** for grant-making. This accounts for 43% of the allocation amounts communicated for GC8.

	W2 Recommended Amount (US\$)	% GC8 total communicated
Allocation	4,579,321,368	42.5%
Matching Funds	132,893,382	52.2%
Multicountry		
Total	4,712,214,750	

Matching funds recommended for grant-making

	W2 Recommended Amount (US\$)	% GC8 total communicated
Equitable, Resilient Integrated Community & Health Services for Women & Children	56,000,000	57%
Expanding Social Contracting to Enable Access to Services	4,393,379	44%
Integrated HIV Prevention	29,750,000	57%
Digital Solutions Supporting Integration	8,500,000	41%
Public Financial Management	15,900,002	55%
Address Human Rights & Gender Barriers to Services	18,350,001	55%
Total	132,893,382	

Overview of 2026 TRP review windows



*1 TRP Remote Review in Q2 2026 outside review window following the World Bank process for a blended financing arrangement

TRP review criteria and agility

The **GC8 TRP Review Criteria** adapted to the **Strategic Shifts**

- *Shift 3*: Programmatic prioritization
- *Shift 4*: Integrated program delivery within PHC and integrated health systems
- *Shift 5*: Community systems integration and financing
- *Shift 6*: Optimize domestic resources and co-financing

Greater differentiation and agility in GC8:

- Four modalities of reviews and engagements
- Criteria and process differentiated for Tailored for Focused and Transition portfolios
- Early TRP review window to give more time to applicants for grant-making



2

GC8 Strategic Shifts observations and recommendations

Overall Quality and Alignment with National Plans

Alignment of request to national disease and health sector plans

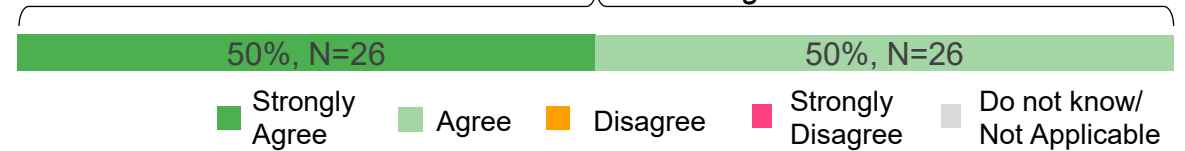
98% of Portfolios *-2pp from W1*



The applicant's funding request(s), demonstrates alignment with national priorities as expressed in the national health sector plan or other national documents.

Use of Evidence in national disease and health sector plans

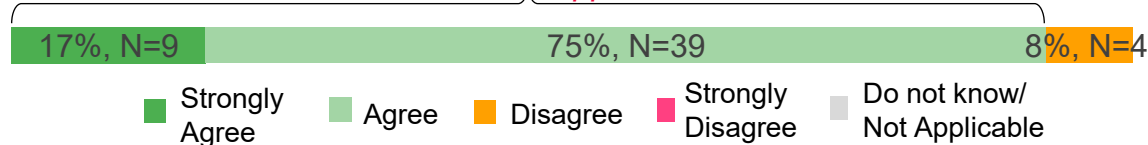
100% of Portfolios *No Change from W1*



The applicant's funding request(s), uses available evidence in the national disease and health sector plans, such as epidemiological and programmatic data, modelling, national reviews, etc.

Use of Costing in national disease and health sector plans

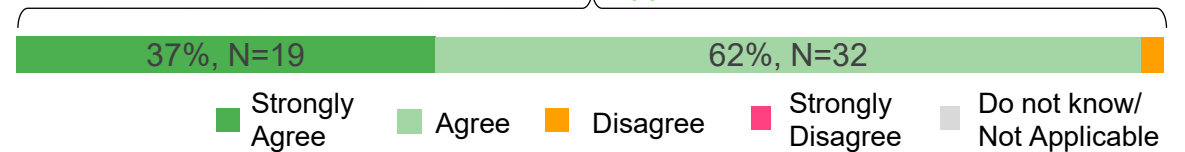
92% of Portfolios *-3pp from W1*



The applicant's funding request(s), uses costing in the national disease and health sector plans, for financial gap analysis and budgeting.

Use of Targets in national disease and health sector plans

98% of Portfolios *+3pp from W1*



The applicant's funding request(s), uses the national disease and health sector plans targets and monitoring plan to guide its measurement approaches and maximize impact.

Strategic Shift 3: Programmatic Prioritization

Observations

- **Prioritization is stronger, but the basis for major choices is not always clear.** Stratification helped focus investments within limited fiscal space, while modelling informed key trade-offs and investment decisions.
- **Essential treatment, diagnostics and health commodities should remain protected in the main allocation.** The TRP saw essential needs being placed in the Prioritized Above Allocation Request (PAAR).
- **Reduced Global Fund allocations should not automatically result in program cuts.** Applicants should show the overall funding envelope, what domestic financing can absorb, and any remaining material trade-offs. In some cases, ITN replacement was prioritized while severe-malaria commodity needs remained exposed.
- **Case-finding approaches are often presented without comparing expected yield and cost.** For example, TB case-finding gaps among women required clearer targeting and use of more sensitive triage and testing.
- Clearer prioritization is needed to ensure investment choices aligned with epidemiological needs and available resources.

Recommendations

Applicants

- State the rationale for major prioritization choices and material trade-offs, including what was reduced, deferred or stopped.
- Show the total funding envelope and how domestic financing changes the remaining gap.
- Protect essential treatment, diagnostics and commodities in the main allocation.
- For case finding, show expected yield and cost per case and link allocation and PAAR choices to budget lines.

Technical Partners

- Assist Applicants to use epidemiological evidence to guide where limited resources will have the greatest impact
- Assist Applicants to develop clear criteria for what is included in or removed from the funded application.

Secretariat

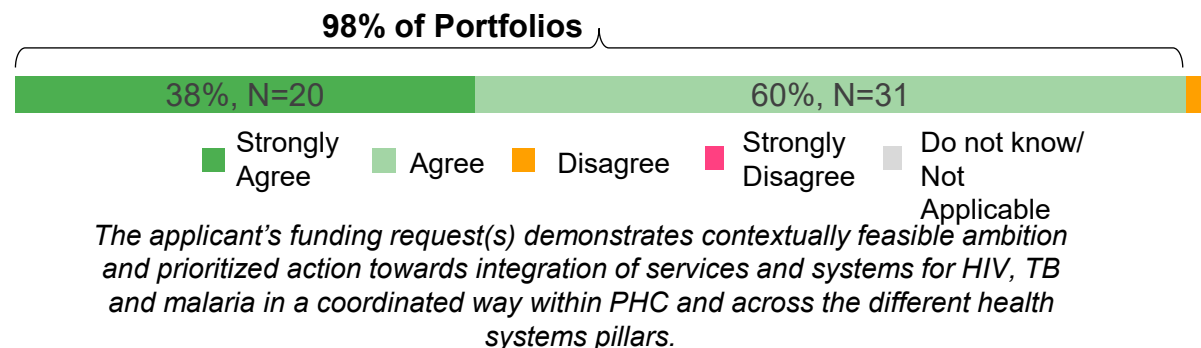
- Provide clearer guidance to Applicants on deprioritization.
- Require one cross-component PAAR ranking, with essential continuity items clearly identified.

■ Strategic Shift 4: Integrated program delivery within PHC and integrated health systems

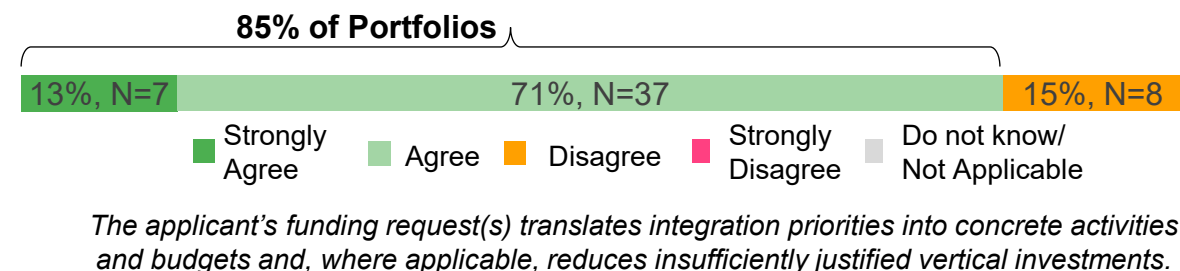
Observations

- While funding requests demonstrated strong integration, **implementation plans often exceed available capacity and budgets**. Funding requests should clearly define community and primary care delivery models and demonstrate how integration can be achieved within operational and budget constraints.
- Integration models should specify what is being integrated, why, how, by whom and with what accountability.** For example, which HIV services would move to primary care, which remain community-led and how key-population services would be protected.
- Integration should follow a coherent pathway **linking service priorities, financing, ownership and sequencing**.
- Major reforms are sometimes launched together without clear sequencing**, where shared diagnostic platforms delivered efficiency, but maintenance, consumables, calibration and staffing were not fully costed.
- In some cases, **integration is measured more by activities than results** where maturity monitoring offered a stronger way to track progress.
- Specialist capacity may still be needed for initial diagnosis, periodic review and laboratory support** where maintenance care is integrated.

Integration Priorities



Operationalization of Integration Priorities



■ ■ ■ Strategic Shift 4: Integrated program delivery within PHC and integrated health systems

Recommendations

Applicants

- Define what will be integrated, what stays separate, why, how and who is accountable.
- Sequence major reforms and match them to delivery capacity, financing and system readiness.
- Maintain differentiated and specialist services where clinically or programmatically needed.
- Name accountability for referral, patient tracking, data, workforce and financing.

Technical Partners

- Work with Applicants to assess the readiness of receiving services before recommending integration.
- Support Applicants to use routine program indicators to track integration.

Secretariat

- Develop a common approach to assess integration readiness and progress, where applicable.
- Support practical learning across countries on what integration models work.

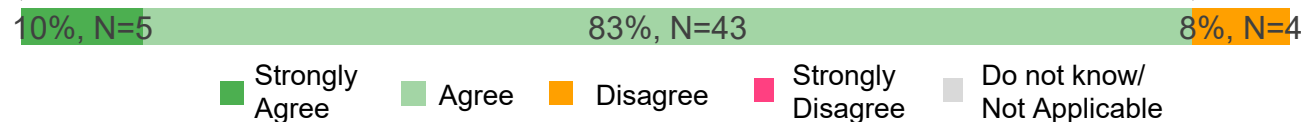
Strategic Shift 5: Community systems integration and financing

Observations

- **Social contracting depends on government systems that can legally contract, accredit and pay community providers.** In some contexts, Roadmaps needed a clearer financing, milestones and contracting arrangements while in others the importance of certification/licensing arrangements was clearly illustrated.
- **CSO transition and CHW transition are related but distinct.** CHWs may need integration into PHC and public payroll systems, while CSOs require sustainable contracting or other financing mechanisms.
- **Not all settings can establish social contracting quickly, and it is not the only sustainability pathway.** Alternative arrangements, including social enterprise models where appropriate, may be needed.
- **Community and key-population services, including community-based HIV and EHRG services, may face increased risks as financing shifts to domestic sources and may require protected funding and service delivery arrangements.**
- Community-led monitoring should **show whether barriers are resolved**, not only whether a mechanism exists.

Community Systems Integration

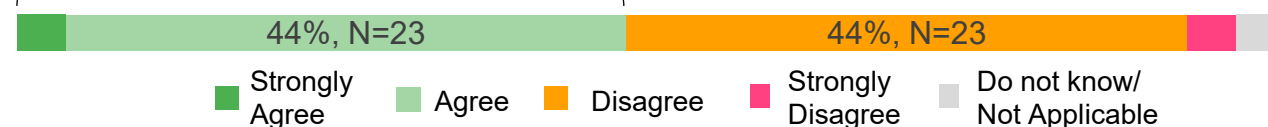
92% of Portfolios



The applicant's funding request(s) demonstrates feasible and appropriate integration of community-led and community-based services into national health systems, national strategies, policies, and financing frameworks, including through social contracting, policy reforms and safeguards where integration is not appropriate or feasible.

Community Systems Financing

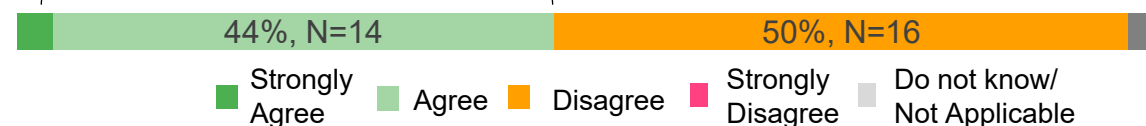
48% of Portfolios



The applicant's funding request(s) and co-financing commitments demonstrate credible pathways for progressive government uptake of prioritized community interventions, identified community systems and community-led service delivery costs through domestic financing, with a focus on key and vulnerable populations.

Community Systems Sustainability*

47% of Portfolios



In contexts where government integration is not feasible/appropriate, the applicant's funding request(s) identifies credible, costed alternative sustainability pathways that protect community systems continuity and key population access.

*Omits portfolios for which government integration is feasible/appropriate

Strategic Shift 5: Community systems integration and financing

Recommendations

Applicants

- Provide a costed, time-bound pathway for community health worker financing.
- Include planned domestic financing in co-financing commitments.
- State which services must remain community-led and why.

Technical Partners

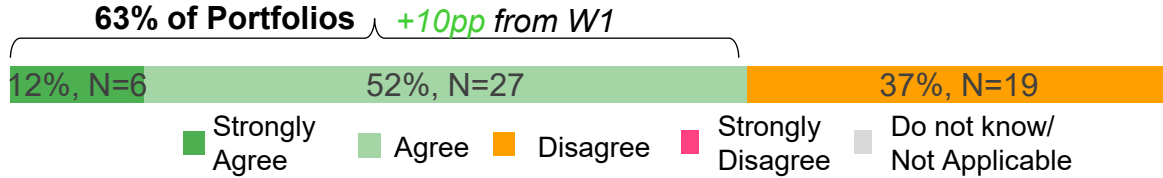
- Assist applicants to build CSO institutional capacity as well as delivery capacity.
- Assist applicants to put in place the legal authority, accreditation/certification, licensing and payment systems needed for social contracting.
- Assist applicants to design distinct transition pathways for CHWs and CSOs, including alternative sustainability models where social contracting is not feasible.

Secretariat

- Assess government readiness to purchase and finance community services.
- Clarify expectations for community health worker financing.
- Protect financing and autonomy for key-population-led services where needed.

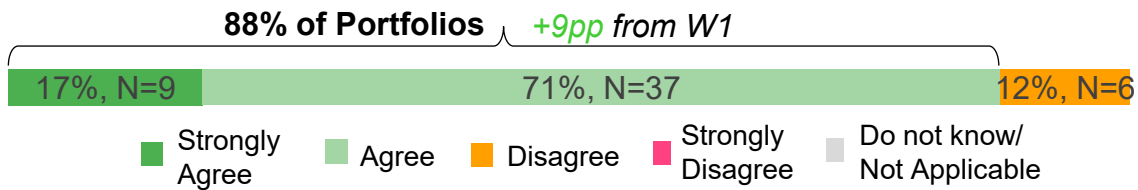
Optimize Domestic Resources and Co-financing

Domestic Financing Trajectory, Needs and Gaps



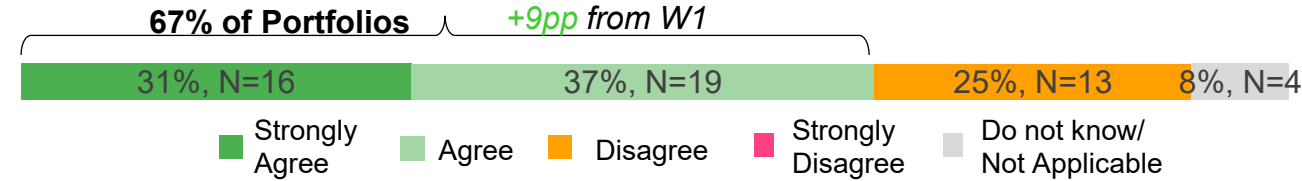
The applicant's funding request(s) demonstrates a robust plan to increase and/or improve domestic financing for health and progressively assumes greater responsibility for HIV, TB and malaria responses, critical RSSH costs and specific programmatic interventions, with clear articulation of financing needs, available resources, projected government spending, remaining gaps and efforts to address those gaps.

Alignment with National Systems and PFM



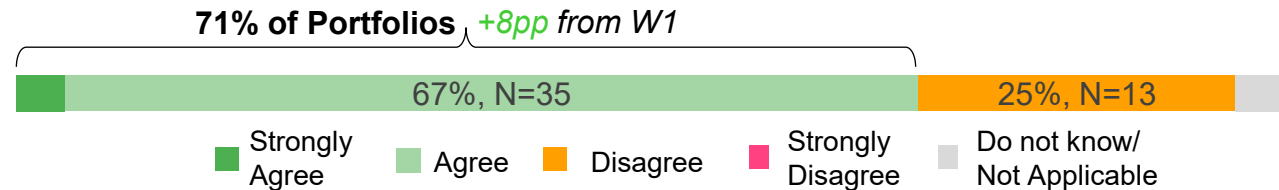
The applicant's funding request(s) is planned within wider national strategies and budgetary processes, progressively aligns with national public financial management, health financing and planning systems, and strengthens the country's ability to plan, budget and execute health funding effectively, where applicable.

Co-financing Commitments



The initial co-financing commitments included in the funding request are clear, strategically focused, improve health system financing, reduce reliance on the Global Fund for specific programmatic interventions, and are directed toward critical programmatic gaps.

Sustainability and Transition Readiness



The applicant's funding request(s) identifies key sustainability and transition challenges and includes clear national plans, actions and investments to address them.



Strategic Shift 6: Optimize domestic resources & co-financing

Observations

- **Co-financing commitments should demonstrate absorption of Global Fund-financed interventions and priority gaps**, rather than simply increasing spending in areas already financed through domestic resources.
- **The composition of co-financing matters** when Global Fund-supported functions move to domestic financing. As Global Fund support for HIV and TB commodities declines, requests should include a clear annual absorption schedule to ensure continuity of service delivery.
- **Past commitments should be assessed across the full execution chain** from appropriation and release to procurement and expenditure,
- **In defining GC8 commitments, particular attention should be paid to implementation factors that led to under-realization of GC7 commitments** to ensure credibility of new commitments.
- **Low execution requires case-by-case analysis.** Bottlenecks may arise in planning, appropriation, release, procurement or expenditure.
- **Large recurrent costs funded from the Global Fund allocation should be tested** for value and additionality.

Recommendations

Applicants

- Present **realistic, context-specific financing and transition plans**, including clear financing pathways and sustainability risks, including continuity arrangements for critical commodities and diagnostic services during transition.
- Justify **operational costs using government salary scales and national cost norms where available**, while ensuring budgets reflect prioritization and value for money.

Technical Partners

- Assist countries in **benchmarking operational costs against government standards and identifying opportunities for greater programme efficiency.**
- Support coordinated financing approaches and provide technical assistance **tailored to fragile and COE settings.**

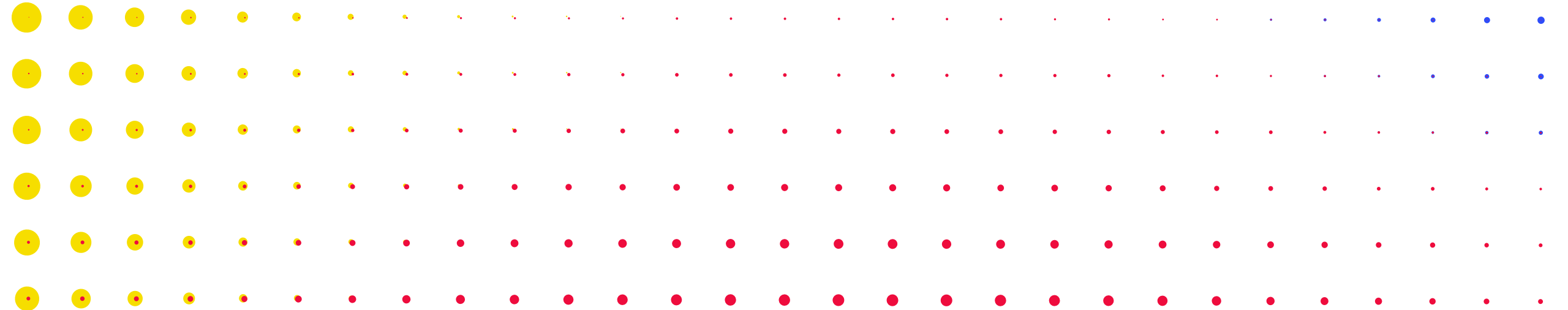
Secretariat

- Continue operationalizing guidance on assessing budget execution, public financial management constraints, and context-specific sustainability planning.
- Strengthen guidance on benchmarking operational costs against government standards and reviewing consistency between budgets, prioritization and value for money.



3

Technical observations and recommendations



HIV Lesson: Prevention innovation and persistent paediatric HIV gaps



Observations

- **Paediatric HIV and PMTCT:** Paediatric HIV cascade gaps persist, with testing and follow-up major bottlenecks. Some Applicants showed persistent gaps in identification and treatment.
- **Prevention and PrEP innovation:** Long-acting prevention adds complexity in transitioning countries. Some transition portfolios plan substantial LEN scale-up while financing and procurement are still being defined. The TRP noted a need for phased introduction alongside oral PrEP and domestic financing.
- **HIV cascade and treatment outcomes:** Many Funding Requests remained testing-focused, with less attention to linkage, retention and viral suppression.
- **Key and vulnerable populations:** KVP prioritization was stronger, but choices were not always clear. Some Applicants showed wide variation in prevention coverage, as well as high HIV prevalence among PWID but very low ART coverage in others.

Recommendations

Applicants

- Develop costed paediatric HIV plans with clear accountability across the cascade.
- Strengthen PMTCT and mother-infant follow-up, including EID and maternal viral suppression.
- Provide a phased PrEP roadmap addressing choice, affordability and delivery readiness. Use a full cascade approach from testing through linkage, retention and viral suppression.
- Strengthen KP prioritization and protect differentiated community delivery where needed.

Technical Partners

- Assist applicants with root-cause analysis where paediatric outcomes remain poor.
- Support evidence-based, phased introduction of new prevention technologies.
- Strengthen viral load, EID and the laboratory, supply-chain and data systems that support them.

Secretariat

- Keep paediatric HIV and cascade performance visible in portfolio monitoring.
- Clarify expectations for long-acting prevention in transitioning countries.
- Protect essential HIV commodities and continuity of key services.
- Track harm-reduction transitions and community-led referral pathways.

TB Lesson : Case finding, diagnostics and DR-TB integration need sharper targeting



Observations

- **Case finding and prioritization:** Screening was not always prioritized by expected yield, risk and cost, and root causes of low detection remain unclear. The TRP saw weak yield-based targeting, as well as persistent gaps among women, children and adolescents.
- **Diagnostic networks and data:** Diagnostic investments were not always matched by network planning and treatment linkage. The TRP observed equipment placement gaps, low GeneXpert utilization and moderate increase in notifications despite increased capacity.
- **New platforms need a sustainability plan before purchase.** The TRP noted the need for a clear HR-TB testing and treatment pathway, and sustainability questions around rapid expansion of AI-enabled chest X-ray.
- **DR-TB, HR-TB and decentralization:** DR-TB integration and decentralization remain uneven. The TRP saw low DR-TB treatment coverage in some cases and limited attention to understand why persistent gaps have not improved despite earlier strategies.

Recommendations

Applicants

- Prioritize screening groups using expected yield, risk and cost.
- Plan diagnostic networks before procurement and link capacity to testing and notification targets.
- Quantify losses from screening through diagnosis and treatment.
- Strengthen decentralization and integration of DR-TB and DS-TB services.

Technical Partners

- Assist applicants with diagnostic network planning and use of local data to define priority groups.
- Support application of normative guidance and generation of current evidence.
- Clarify guidance on DR-TB integration, Hr-TB pathways and paediatric diagnosis.

Secretariat

- Require a clear diagnostic network plan at submission.
- Strengthen guidance on evidence-based prioritization of target populations.
- Clarify expectations for school-based screening.
- Strengthen TB guidance on addressing barriers to TB service delivery, including gender and human rights barriers.



Malaria Lesson : Stratification is improving, while commodity quantification remains uneven

Observations

- **Stratification and prioritization:** Countries are using stratification and most use it to effectively target their intervention package, as well as target vulnerable populations—reflecting TRP recommendation over the last decade. Note, not all countries are budgeting for updated stratification, quality of data can be uneven, and monitoring the effectiveness of stratification is limited.
- **Quantification of critical interventions:** Quantities, buffers and trade-offs of critical interventions (i.e., rapid diagnostic tests, drugs, bednets) need clearer justification. Some Applicants raised questions about ITN replacement while severe-malaria commodities remained exposed; some Applicants budgeted a 20% ITN buffer, while had significant net shortfalls.
- **Elimination and case management:** Elimination ambitions need to match financing, surveillance and commodity capacity. The TRP saw some Applicants with the risk of budgeting severe-malaria medicines without a buffer.
- **Case Management:** Diagnostic choices should match the delivery model. Some Applicants take different approaches to microscopy. Many countries are switching drugs as per MFT guidance; however, cost-benefit is less clear (incl. better quality of case management and possible development of resistance).

Recommendations

Applicants

- Justify intervention choices, quantities and buffers using current guidance.
- Protect appropriate buffers for critical malaria interventions, i.e., rapid diagnostic tests, drugs, ITNs.
- Link elimination targets to epidemiological, operational and financing milestones.

Technical Partners

- Assist applicants to develop quality-assured case management plans that match context-specific delivery models.
- Support large-scale investment in new interventions or operational modalities with data and evidence justifying such investments..

Secretariat

- Clarify expectations for shortfalls and buffer norms for critical malaria interventions.
- Clarify the appropriate mix of diagnostic tests and drugs by delivery setting.
- Apply commodity-quality requirements consistently.

RSSH Lesson : Plan for the full life of systems investments



Observations

- **Systems investments need more than a purchase plan.** The TRP saw some new diagnostic platforms which needed a clear testing and treatment pathway. In some cases, maintenance, consumables, calibration, connectivity and staffing for shared platforms were not fully costed.
- **Health workforce transition plans need to specify which cadres move to domestic financing, through which payroll line, and when.** The TRP saw this among Applicants with vulnerability to fiscal shocks.
- **Commodity transition depends on both financing and the ability to procure on time.** The TRP saw Applicants without a credible domestic financing and procurement pathway, and not protecting commodity security during full domestic absorption.
- **Data investments should be linked to decisions and action.** Some Applicants showed the value of collecting once and using data across programs, while making surveillance choices explicit in low-burden districts.
- **PFM constraints need an implementation route and clear ownership.** The TRP saw the need for stronger institutional responsibility, and some Applicants that identified PFM constraints but had no PFM Matching Funds.

Recommendations

Applicants

- Cost the full lifecycle: purchase, installation, maintenance, consumables, connectivity, replacement and staffing.
- For workforce transition, specify the cadre, payroll line and date for domestic financing.
- For data investments, state the decision the data will inform and who will act on it.

Technical Partners

- Assist applicants with diagnostic and laboratory network design before procurement, based on access and expected yield.
- Assist applicants to assess whether procurement and supply systems can use the financing available.
- Assist applicants to assess whether institutions can operate and maintain systems after handover.

Secretariat

- Require lifecycle costing and a maintenance plan for equipment and digital systems at submission.
- Clarify the purpose and eligibility criteria for PFM Matching Funds, including how findings are followed up.
- Apply the same sustainability test to regional platforms as to national systems.

EHRG Lesson : EHRG investments need measurable results and follow-up



Observations

- **Structural barriers require institutional policy responses not training alone.** Legal, cultural, religious and gender-related barriers, including criminalization, stigma and discrimination, require different, context-specific approaches.
- **EHRG investments remain fragmented, underfunded and weakly operationalized,** particularly in gender. Commitments often lack implementation plans and measurable outcomes. In some Funding Requests, the survivor-centered SGBV response needed clearer coverage, referrals and standards.
- **CLM integration is improving, but sustainable financing and use of findings remain unclear.** Barriers and their resolution must remain visible in integrated reporting.
- **Follow-up on recommendations remains inconsistent.** The TRP saw gender-related barrier recommendations being unmonitored.
- **Universal systems and treatment targets do not guarantee equitable access.** Among some Applicants, benefit-package design highlighted the need to identify populations outside mainstream coverage.
- **Confidentiality, safeguarding and data protection require explicit attention for all populations** across service delivery, research and community-led activities.

Recommendations

Applicants

- Develop costed, context-specific packages to remove EHRG-related service delivery barriers with implementation responsibilities and outcome measures for access, denial of care, redress and coverage. Embed these in funded health-system functions, with explicit interventions targeting key and vulnerable populations.
- Specify sustainable CLM financing, including social contracting and links from findings to decisions, preserving community leadership and independence. Include safeguarding, informed consent, confidentiality and secure data management across activities.

Technical Partners

- Provide applicants with practical guidance on legal/policy and social-norm responses related to the provision of health care, particularly for TB, malaria, COEs and criminalizing settings.
- Assist applicants to strengthen gender expertise and outcome measurement, linking training to supervision, performance management and accreditation.

Secretariat

- Keep EHRG outcome indicators visible in performance frameworks and integrated reporting. Specify monitoring actions whether or not country receive dedicated EHRG-related matching funds.
- Track recommendations during grant-making and implementation, not only between review cycles. Assess financing and continuity of programs to address EHRG-related barriers and community functions through transition.

HFS Lesson: Sustainability plans need clear costs, financing and responsibility



Observations

- Sustainability strategies are now common, but many **do not clearly identify funding sources and responsibilities**. The TRP saw volatile Treasury releases and execution gaps among some Applicants.
- **High insurance enrolment does not assure equitable program financing**. One Applicant showed that even 95% enrolment may leave key and vulnerable populations outside effective coverage.
- In devolved systems, **commitments need to be agreed and financed at the level of government** that delivers and executes the budget. In some cases, no absorption pathway was shown for Global Fund-financed positions.
- **PFM constraints are identified but need a systematic response**. In some cases, PFM investments needed clearer institutional ownership and a route to implementation.
- **For innovation, define the domestic purchaser and benefit package before scale-up**. The TRP saw some good examples of external financing supported introduction and demonstration.
- The role of the **Ministry of Finance, including as Principal Recipient where relevant, should be considered in sustainability planning**, with benefits and trade-offs made explicit.

Recommendations

Applicants

- Turn sustainability strategies into plans showing sources of funding, who finances and delivers each function, and by when.
- Link recurrent functions to real budget lines, purchasers or social contracting arrangements.
- Identify who remains outside insurance or benefit-package coverage and cost the steps needed to reach them.

Technical Partners

- Assist applicants to identify why budgets are not executed and absorption commitments are missed.
- Assist applicants to test whether insurance can realistically finance prevention, community and key-population services.
- Assist applicants with benefit-package design, costing and reimbursement that match the delivery model.

Secretariat

- Clarify what meeting a co-financing commitment demonstrates when sustainability concerns remain.
- Bring health and finance ministries together during request development where PFM barriers exist.

5

Detail on Funding Request Quality Windows 1-2

Overall Quality and Alignment

In Windows 1 and 2, the TRP reviewed 58 Funding Requests from 53 Portfolios representing 136 disease components.

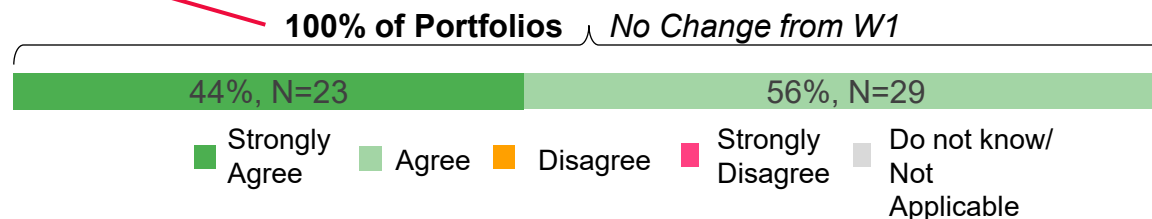
100% of the portfolios submitted quality requests.

The applicant's funding request(s) demonstrates a technically sound and strategically focused approach that is aligned with the epidemiological context and GC8 Strategic Shifts, maximizes impact, and supports sustainable program design.

96% of the Portfolios submitted in W1-W2 demonstrated alignment with the Aims of the Allocation.

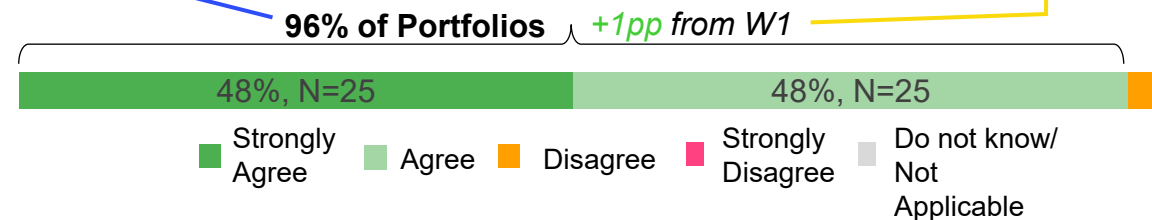
The applicants' funding request(s), demonstrates alignment with the Aims of the Allocation included in the Allocation Letter.

Q1. Overall Quality of the FRs and Alignment with the GC8 Strategic Shifts



96% is a 1 percentage point (pp) increase from W1, when 95% of the Portfolios demonstrated this alignment.

Q2. Aims of the Allocation



Overall Quality and Alignment with National Plans

Q3. Alignment of request to national disease and health sector plans

98% of Portfolios *-2pp from W1*

63%, N=33

35%, N=18

Strongly Agree Agree Disagree Strongly Disagree Do not know/ Not Applicable

The applicant's funding request(s), demonstrates alignment with national priorities as expressed in the national health sector plan or other national documents.

Q4. Use of Evidence in national disease and health sector plans

100% of Portfolios *No Change from W1*

50%, N=26

50%, N=26

Strongly Agree Agree Disagree Strongly Disagree Do not know/ Not Applicable

The applicant's funding request(s), uses available evidence in the national disease and health sector plans, such as epidemiological and programmatic data, modelling, national reviews, etc.

Q5. Use of Costing in national disease and health sector plans

92% of Portfolios *-3pp from W1*

17%, N=9

75%, N=39

8%, N=4

Strongly Agree Agree Disagree Strongly Disagree Do not know/ Not Applicable

The applicant's funding request(s), uses costing in the national disease and health sector plans, for financial gap analysis and budgeting.

Q6. Use of Targets in national disease and health sector plans

98% of Portfolios *+3pp from W1*

37%, N=19

62%, N=32

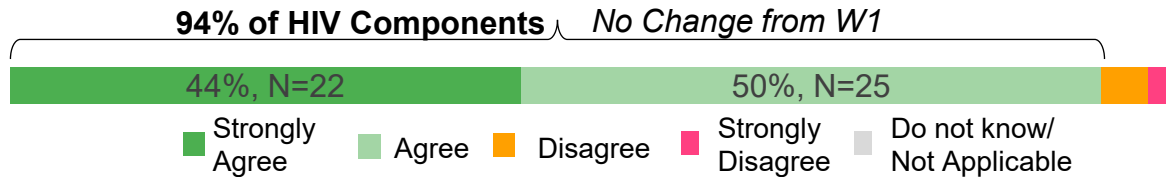
Strongly Agree Agree Disagree Strongly Disagree Do not know/ Not Applicable

The applicant's funding request(s), uses the national disease and health sector plans targets and monitoring plan to guide its measurement approaches and maximize impact.

Programmatic Prioritization

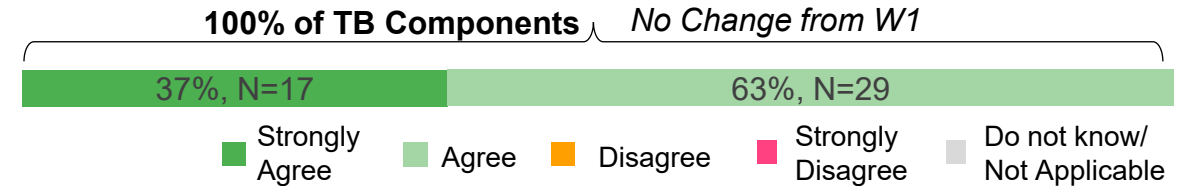
Question 7 looks at % of disease components, rather than % of portfolios

Q7-H. Programmatic prioritization - HIV



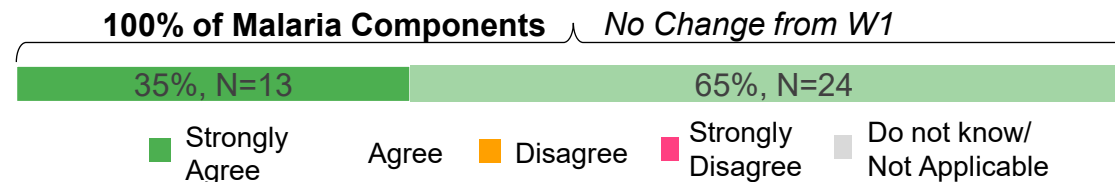
HIV investments included in the applicant's funding request demonstrate evidence-based prioritization of interventions (based on up-to-date country epidemiological data) that maximize impact within available resources, target high-burden populations, geographies and barriers to access, and reduce lower-impact or poorly aligned activities.

Q7-T. Programmatic prioritization - TB



TB investments included in the applicant's funding request demonstrate evidence-based prioritization of interventions (based on up-to-date country epidemiological data) that maximize impact within available resources, target high-burden populations, geographies and barriers to access, and reduce lower-impact or poorly aligned activities.

Q7-M. Programmatic prioritization - Malaria

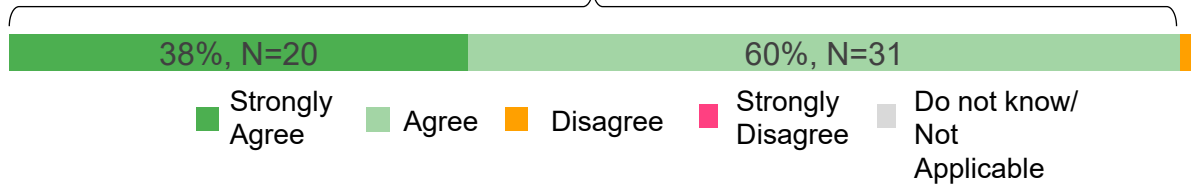


Malaria investments included in the applicant's funding request demonstrate evidence-based prioritization of interventions (based on up-to-date country epidemiological data) that maximize impact within available resources, target high-burden populations, geographies and barriers to access, and reduce lower-impact or poorly aligned activities.

Integrated program delivery within PHC and integrated health systems

Q8. Integration Priorities

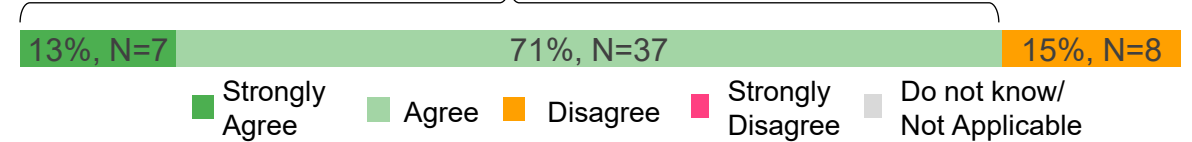
98% of Portfolios *-2pp from W1*



The applicant's funding request(s) demonstrates contextually feasible ambition and prioritized action towards integration of services and systems for HIV, TB and malaria in a coordinated way within PHC and across the different health systems pillars.

Q9. Operationalization of Integration Priorities

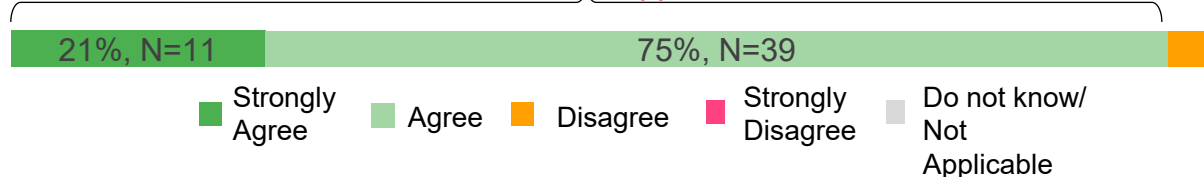
85% of Portfolios *+6pp from W1*



The applicant's funding request(s) translates integration priorities into concrete activities and budgets and, where applicable, reduces insufficiently justified vertical investments.

Q10. Focus on RSSH Prioritization

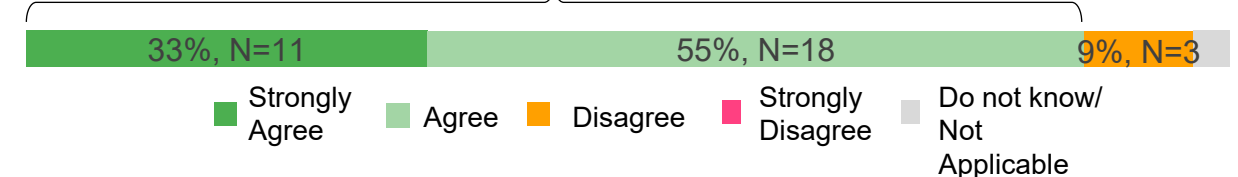
96% of Portfolios *-4pp from W1*



The applicant's funding request(s) demonstrates strategic focus with sufficiently prioritized cost-effective investments in resilient and sustainable systems for health that directly improve the sustainability of HIV, TB, and malaria interventions; accelerates implementation and achievement of the integration priorities; and ultimately improves health outcomes.

Q11. Alignment of Integrated Program Delivery and Transition Plans

88% of Portfolios *New Q for W2*

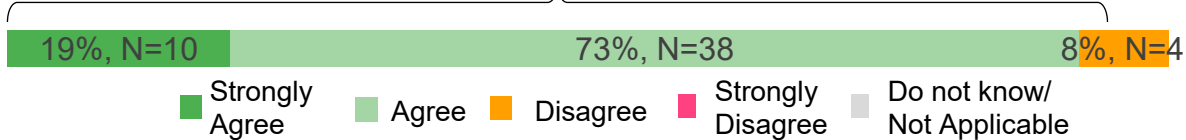


The applicant's funding request(s) reflects the use of integrated activities (and/or investments in integration of services and systems for HIV, TB and malaria within PHC) as part of a strategy to contribute to smoother transition and activities are aligned with transition plans, as applicable.

Community Systems Integration & Financing

Q12. Community Systems-and Barriers to Equitable Access

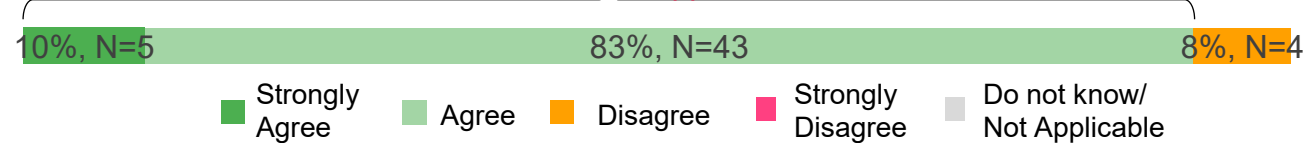
92% of Portfolios *-3pp from W1*



The applicant's funding request(s) demonstrates evidence-informed community systems investments that are linked to epidemiological data, with service delivery models that are sufficiently tailored to address critical programmatic gaps, service continuity, equity outcomes, and barriers to accessing HTM prevention, treatment and care.

Q13. Community Systems Integration

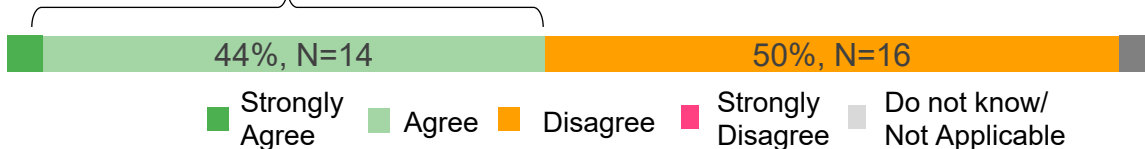
92% of Portfolios *-3pp from W1*



The applicant's funding request(s) demonstrates feasible and appropriate integration of community-led and community-based services into national health systems, national strategies, policies, and financing frameworks, including through social contracting, policy reforms and safeguards where integration is not appropriate or feasible.

Q14. Community Systems Sustainability*

47% of Portfolios *New Q for W2*

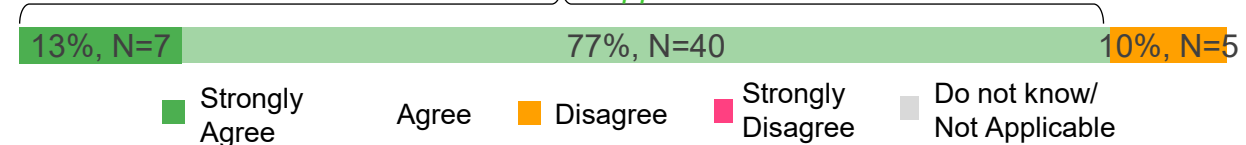


In contexts where government integration is not feasible/appropriate, the applicant's funding request(s) identifies credible, costed alternative sustainability pathways that protect community systems continuity and key population access.

*Omits portfolios for which government integration is feasible/appropriate

Q15. Community-led Monitoring and Accountability

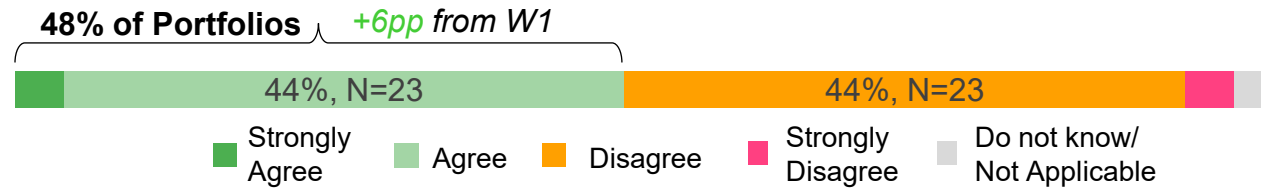
90% of Portfolios *+1pp from W1*



The applicant's funding request(s) includes a robust CSS approach, including integrated community-led monitoring and strengthened community platforms that enable communities to influence policy, funding decisions, planning, oversight and monitoring at national and sub-national levels.

Community Systems Integration & Financing

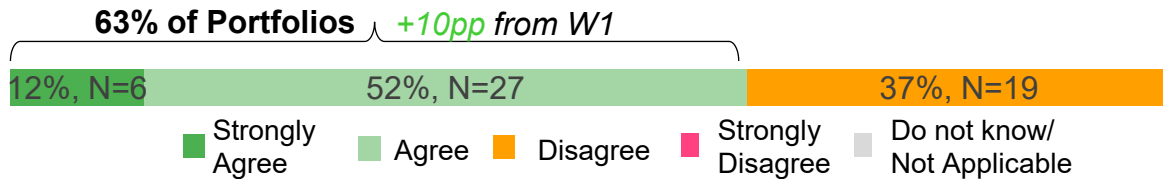
Q16. Community Systems Financing



The applicant's funding request(s) and co-financing commitments demonstrate credible pathways for progressive government uptake of prioritized community interventions, identified community systems and community-led service delivery costs through domestic financing, with a focus on key and vulnerable populations.

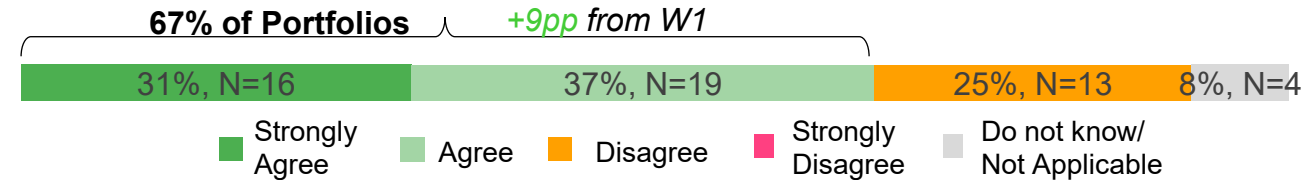
Optimize Domestic Resources and Co-financing

Q17. Domestic Financing Trajectory, Needs and Gaps



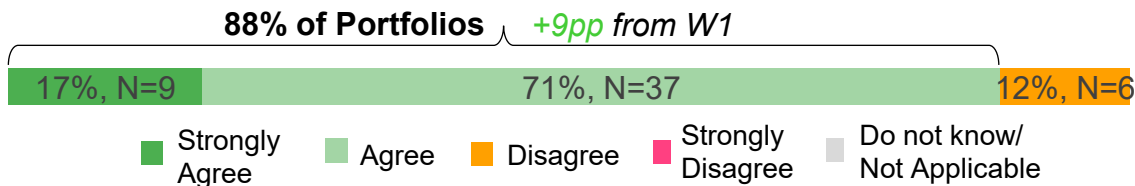
The applicant's funding request(s) demonstrates a robust plan to increase and/or improve domestic financing for health and progressively assumes greater responsibility for HIV, TB and malaria responses, critical RSSH costs and specific programmatic interventions, with clear articulation of financing needs, available resources, projected government spending, remaining gaps and efforts to address those gaps.

Q18. Co-financing Commitments



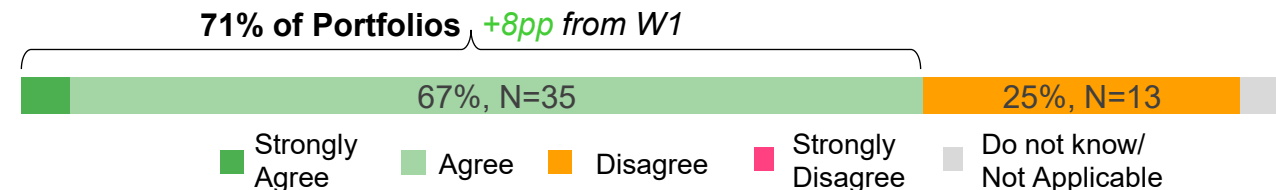
The initial co-financing commitments included in the funding request are clear, strategically focused, improve health system financing, reduce reliance on the Global Fund for specific programmatic interventions, and are directed toward critical programmatic gaps.

Q19. Alignment with National Systems and PFM



The applicant's funding request(s) is planned within wider national strategies and budgetary processes, progressively aligns with national public financial management, health financing and planning systems, and strengthens the country's ability to plan, budget and execute health funding effectively, where applicable.

Q20. Sustainability and Transition Readiness

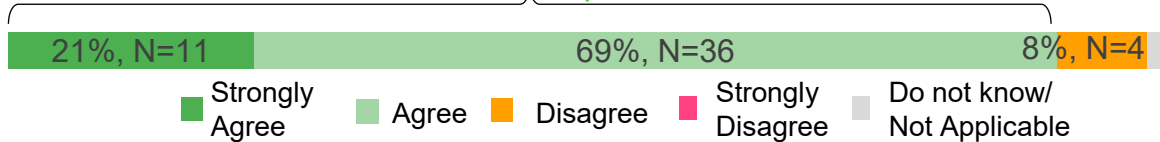


The applicant's funding request(s) identifies key sustainability and transition challenges and includes clear national plans, actions and investments to address them.

Optimize Domestic Resources and Co-financing

Q21. Alignment with country specific health and health financing reforms

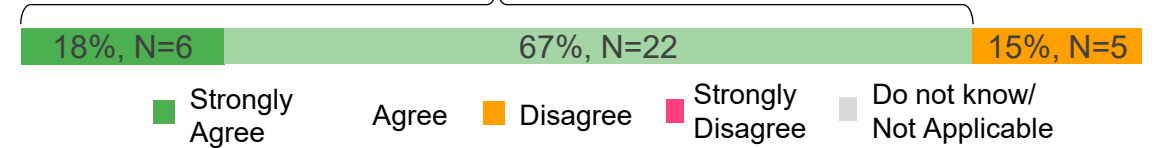
90% of Portfolios +6p from W1



The applicant's funding request(s) is aligned with and/or advances the financing and policy reforms (where application) needed to strengthen long term sustainability of the national response.

Q22. Cost Drivers

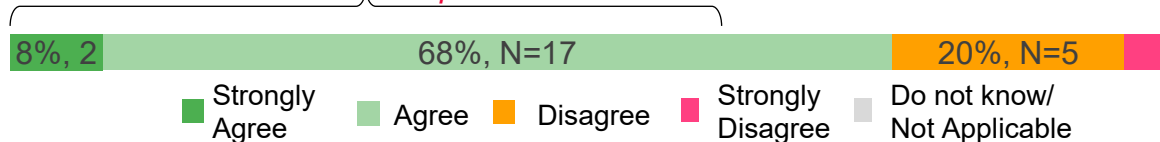
85% of Portfolios New Q for W2



The applicant's funding request(s) demonstrates an understanding of the main cost drivers of the response and includes clear plans and actions to minimize them without compromising quality.

Q23. Alternative & Innovative Financing*

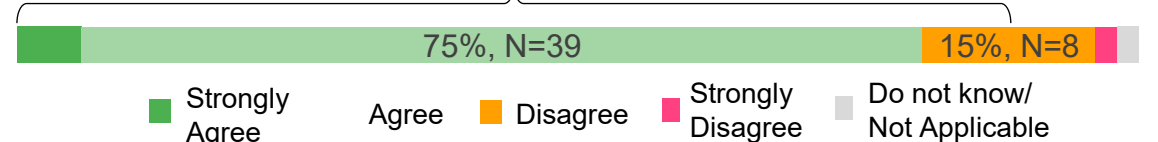
61% of Portfolios -10p from W1



(Where relevant) The applicant's funding request(s) uses innovative or alternative financing modalities, such as blended finance or Debt2Health, in a strategically focused way that complements core investments.

Q24. Value for Money

81% of Portfolios -8pp from W1



The applicant's funding request(s) demonstrates efficient, effective and equitable use of resources aligned with the GC8 Strategic Shifts and Aims of Allocation, including cost-effective procurement, appropriate integration, justified program management and travel-related costs, and evidence-driven trade-offs to maximize health impact of funding request investments including for key and vulnerable populations. 31

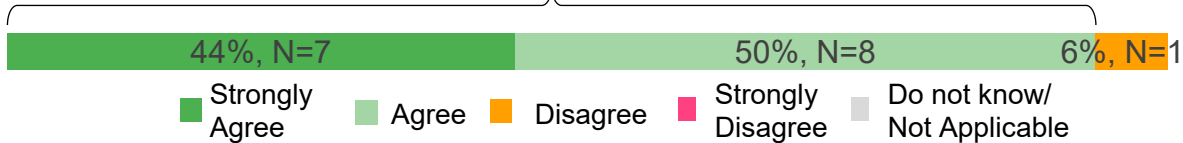
*Omits portfolios that did not use innovative or alternative financing modalities

Effective Transition

Questions 25-28 only for Portfolios with Components Transitioning in GC8/GC9. Questions not reported for Window 1 considering small number of responses.

Q25. Transition Challenges and Pathway

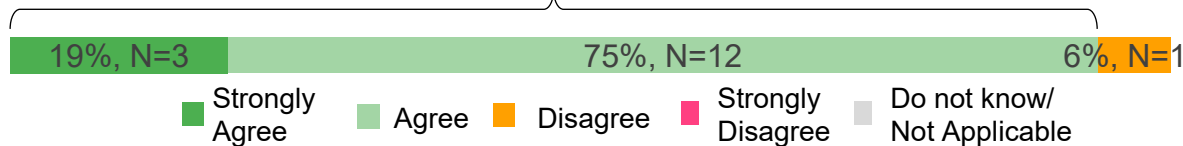
94% of Portfolios



The applicant's funding request(s) identifies the main transition, financing and sustainability challenges and presents a sequenced pathway to address them, including transition prioritized investments, services and costs into domestic financing and management.

Q27. Service Continuity and Access to Quality Health Products

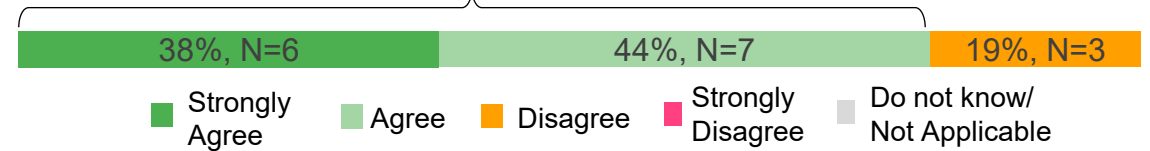
94% of Portfolios



The applicant's funding request(s) identifies essential grant-funded interventions and functions to be sustained, with realistic plans to protect service continuity, including for key and vulnerable populations, addresses risks to continuity of priority programmatic interventions and services, and sustains access to quality health products.

Q26. Co-financing Commitments and Transition of Key Costs

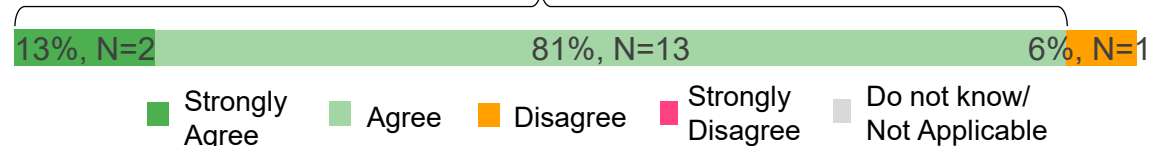
81% of Portfolios



The applicant's funding request(s) demonstrates co-financing commitments and transition arrangements that are specific, strategic and directed toward progressive domestic uptake of key remaining, relevant program costs and functions to domestic budgets, including community and equity-related priorities where relevant.

Q28. Community Systems Financing and Accountability

94% of Portfolios



The applicant's funding request(s) supports sustainable financing of community systems and community-led accountability, including social contracting where relevant, and country-level reforms needed for transition.