NAVIGATING CONSTRAINING ENVIRONMENTS IN GLOBAL FUND'S GRANT CYCLE 8 (GC8)

FROM A GENDER-TRANSFORMATIVE PERSPECTIVE
A W4GF GUIDE FOR WOMEN AND GIRLS

Global Fund's Grant Cycle 8 (GC8) represents an important shift in how the GF approaches funding, partnerships, and implementation across HIV, tuberculosis, and malaria responses. It maintains the foundational structure of a three-year funding period with two main phases: application and implementation, while introducing significant innovations in how investments are prioritized, integrated, and deployed. [1]

Graphic 1.- Grant Life Cycle

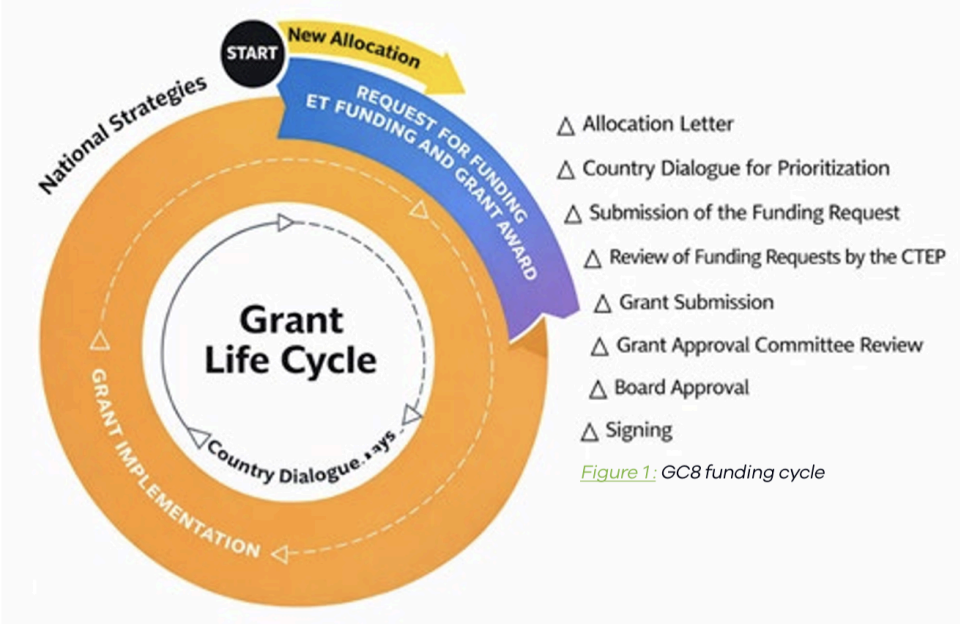

Figure 1: GC8 funding cycle

GC8 promotes more integrated health systems: This means consolidated data systems (DHIS2) for tracking all disease indicators together, shared laboratory networks across

[1] This W4GF guide is designed to help you navigate GC8 with a gender-transformative and human rights lens, ensuring that women, girls, and gender-diverse communities are not left behind in this new funding cycle.

programs, cross-disease approaches to prevention, treatment, and care, among others. The shift toward integration and sustainability can strengthen health systems, but only if women's and girls' voices are centered and community, human rights, and gender priorities are protected, included, and funded.

Integration can strengthen efficiency when addressing the specific needs and contexts of women and girls in all of their diversity. If gender and human rights components are lost at integration, women's programs can be absorbed into generic health systems, losing their gender-transformative focus on gender barriers, sexual and reproductive health rights (SRHR), and gender-based violence response.

Unlike GC7, where dialogues were conducted separately by disease, GC8 requires multi-disease consultations bringing together all health programs, community organizations, sectoral ministries, and technical partners.

The early dialogue aims to:
1) Identify national health priorities and epidemiological needs
2)Analyze opportunities for integrating services into primary healthcare
3)Strengthen coordination among all stakeholders
4)Co-define priorities and integrated approaches

IMPORTANT: To protect women's health priorities demand that integration is evidence-based and informed by community consultation, not driven by cost-cutting. Ensure that health systems integration is adequately resourced; integration cannot work without investment. Protect specialized services: gender-based violence response, SRHR counseling, and menstrual health support require dedicated, skilled personnel.

TIP: Take a look at the results from our Global Consultation to women and girls in their diversity: "what we cannot live without" and find out the top priorities to protect[2]

[2] The Top Five Priorities Globally was the result of a global consultation made by W4GF & ICW during Grant Cycle 7th reprioritisation process. You can find more here: https://women4gf.org/2025/06/30/a-feminist-manifesto-for-the-global-funds-reprogramming/

HIV

1.	Ensure uninterrupted access to PrEP, ART including essential diagnostics(viral load & CD4) and related support including nutrition supports for women, with gender-transformative adherence support (childcare during clinic/service visits, flexible hours).
2.	Respectful, rights-based maternal and infant care, including but not only prevention of vertical transmission of HIV, hepatitis B and syphilis free from coercion, stigma and discrimination.
3.	Sustain planning and preparation to ensure essential HIV, SRHR and maternal care and humanitarian services for women living with HIV in conflict, emergency and disaster settings
4.	Fund women-led responses including, peer support groups, peer-led treatment literacy programs, peer navigators and community health workers to improve testing, counseling, retention in care and viral suppression.
5.	Harm reduction services must be gender-responsive, community-led, and rooted in human rights and respond to the intersectional experiences of women living with HIV, transwomen, women who use drugs, and/ or who are sex workers.

TUBERCULOSIS

6.	Maintain and expand active case finding focused on women - including clinically diagnosed pulmonary TB and extra-pulmonary forms of TB, including maternal TB screening during antenatal care and postpartum.
7.	Ensure TB diagnostic and treatment services are accessible to women who face mobility restrictions, with options for community combination screening services and home-based care. Ensure people-centred and gender-transformative TB comprehensive responses to treat drug-resistant TB, multidrug-resistant [MDR] and extensively drug-resistant [XDR] TB.
8.	Address gendered barriers to TB diagnosis, treatment adherence and comprehensive healthcare, such as biological barriers, finances and economic status, caregiving responsibilities, and stigma
9.	Maintain and expand routine TB screening for women living with HIV, including pregnant and lactating women.
10.	Continued support for tools like CLM, TB OneImpact, human rights documentation, gender assessments, and the Stigma Index efforts that allow communities to monitor rights violations and demand accountability.

MALARIA

11. Support gender-transformative community-led malaria education programmes, including messaging addressing women's decision-making power in households, educational programs at schools and antenatal and postpartum care at healthcare facilities and community services.
12. Ensure access to malaria treatment and prevention in reproductive health settings, IPTp (Intermittent Preventive Treatment in pregnancy) included at the antenatal care.
13. Fund women-community health workers for malaria surveillance, prevention, and case management.
14. Enhance and optimize vector control and case management, strengthen the implementation and integration of the malaria matchbox assessment actions plans , prioritising gender-transformative and evidence-based tailored malaria interventions; including addressing the behavioural barriers and an effective distribution and monitoring of use of insecticide-treated nets to pregnant women and adolescent girls, acknowledging and addressing the increasing risk of (ACT) resistance.
15. Continued support for tools like CLM , human rights documentation, gender assessments, and the Stigma Index efforts that allow communities to monitor rights violations and demand accountability

Transition Pathways and Sustainability:

GC8 emphasizes 'sustainability'gradually shifting responsibility for HIV, TB, and malaria programs to countries' own budgets. At least 15% of funding is contingent on increased domestic co-financing. While this can strengthen long-term commitment, it poses a significant risk: Women-led organizations, peer-led services, and community health workers often face underfunding in transition plans.

You can find here the list of Global Fund transitioning countries in Grant Cycle 8th and 9th.

Governments and other stakeholders may prioritize commodities and clinical services while cutting community, gender, and human rights programs and approaches; which are core to the Global Fund's Strategy. Without clear safeguards, transition can mean withdrawal of support for women-centered responses.

What "Lifesaving" Means to Us: A Feminist Perspective

For Women4GlobalFund, lifesaving transcends pills, diagnostics, and clinical indicators: it is a political commitment to gender justice. Lifesaving means ensuring women and girls in all their diversity have the power to live with dignity, rights, choice, and bodily autonomy; it demands gender-transformative approaches that confront root causes of inequality rather than treating symptoms of patriarchy, criminalization, and structural violence. In a context where funding for gender-justice and women-led responses is being cut, where bodily autonomy is criminalized, and where women's unpaid labor subsidizes global health systems, lifesaving requires us to redistribute power, decriminalize diverse identities and survival strategies, fund women-led accountability and care, and ensure that gender-transformative health systems, not biomedical shortcuts, center the leadership of those most marginalized. This is not neutral: it is a radical, lifesaving choice to invest in feminist movements, women-led organizations, and comprehensive gender-integrated care as the most effective pathway to ending AIDS, TB, and malaria while advancing health equity for all.

Read more in our “What life-saving means to us manifesto”

Critical Actions:

- Demand that transition plans explicitly map and protect women-led CSOs, community-led, peer-led services, community health workers, peer-educators, navigators, paralegals, etc. Ensuring they are meaningful and engage in social contracting planning.
- Require quantified domestic co-financing commitments (written and explicit budgets) for community systems with human rights and gender focus alongside clinical and biomedical services.
- Ensure that transition pathways explicitly include plans for sustaining women-led and community responses with quantified domestic financing commitments.
- Advocate for transition timelines that allow adequate notice and planning for women-centered organizations (ensure that there are budgets and meaningful participation in processes for consultation, dialogue, and joint transition planning connected to sustainability)
- Protect the CCM structure and ensure meaningful engagement and participation of CSOs and women-led organizations.

Where Gender Interventions Live in GC8

GC8 introduces an important change: gender and human rights interventions are now classified under RSSH (Resilient and Sustainable Systems for Health) modules, rather than in disease-specific buckets.

This means: Gender activities must be explicitly claimed and resourced within RSSH. Every funding request must include clear, dedicated budgets for 'Reducing Gender-related Vulnerabilities and Barriers to HIV, TB and Malaria Services'

NOTE! Gender-transformative interventions and human rights barrier removal must be integrated across HIV, TB, and Malaria disease modules as well as RSSH!

Action: Monitor funding requests to ensure gender modules are adequately resourced, this is where your advocacy power lies.

Key Entry Points to Shape GC8:

- **The Early Country Dialogue:** Before countries even receive their funding allocations, GC8 requires an 'early country dialogue' bringing together government, health programs, CSOs, and communities. This is your earliest and most influential entry point.

  What you must do:

  1. Contact your Country Coordinating Mechanism (CCM) to find out when your country's early dialogue is scheduled.

  Find here W4GF Guide on how to become an effective CCM member

  Find here the Global Advocacy Data Hub CCMs Dashboard to explore data and find contact info and more.

2. Organize pre-dialogue meetings with women's organizations, HIV, TB, and malaria CSOs to identify shared gender priorities.

3. Compile and present evidence on women's health gaps, SRHR barriers, gender-based prevalence, and gender-related barriers to accessing services.

NOTE: You can find all evidence we have produced in our Digital Dossier.

4. Propose 2-3 concrete integrated solutions: e.g., integrating SRHR into TB programs, or embedding gender-based violence response in all three disease components.

- **Community Priorities Annex For 'High Impact' and 'Core' funding portfolios**, countries MUST submit a Community Priorities Annex documenting what civil society and affected communities want. This is a formal, required mechanism for your voice. Treat the Community Priorities Annex as a non-negotiable tool. The TRP evaluates whether priorities listed in this annex are reflected in the main funding request and budget.

What You Must Do:

1. Mobilize women's organizations, girls' groups, and gender-diverse communities to document their priorities through online and in-person gatherings.

2. Ensure the annex includes: SRHR access, gender-assessments, gender-based violence services, menstrual health, access to HIV prevention innovations like lenacapavir[3],near Point-of-Care (nPOC) TB test and removal of gender-related barriers to care.

3. Submit priorities before the Community Annex deadline, once submitted, they become part of the official funding request.

Note: You can use the Community Engagement Toolbox developed by partners from the Global Fund with resources and strategies for engagement.

[3] Even where Lenacapavir and nPoC TB testing have not yet been rolled out or formally incorporated into national guidelines or strategic plans, advocates can still push for the inclusion of targets in the CCM funding requests.

- **GC8 places a stronger emphasis on dedicated financing for Community Systems**, including community-led service delivery, peer support, and community-led

  monitoring[4]. This creates opportunities to secure sustained funding for women-led organizations and community health workers.

  What You Must Do:

  1.- Advocate for explicit, dedicated budgets for women-led community organizations within community systems financing:

  💡Organize a Women-Led CSO convening: Bring together 10-15 women-led organizations in your country to collectively quantify current funding gaps and prepare a joint position paper demanding dedicated budget lines for women-led community systems.
  💡Send a formal letter to the CCM: Signed by coalition of women's organizations, requesting that GC8 funding requests explicitly allocate a minimum 20%[5] of community systems financing to women-led groups
  💡Create a Funding Tracker: Map all current Global Fund-supported women-led activities and their budgets, then present gaps to government health officials and Global Fund representatives during country dialogue
  💡Prepare a Costed Implementation Plan: Submit concrete proposals showing how specific budget allocations to women-led organizations would strengthen service delivery (e.g., "X amount funds 50 peer educators providing treatment adherence support")

IMPORTANT:
Leverage Catalytic Matching Funds**:** Actively advocate for country applications to meet

[4] **Institutionalize Community-Led Monitoring (CLM):** Ensure funding requests explicitly allocate budget lines for women-led CLM to track service access, stockouts, stigma, and gender-based violence in health facilities.
[5]While the Global Fund strongly encourages Community Systems Strengthening (CSS) and community-led service delivery under GC8, the Global Fund Board has not established a legally binding 20% set-aside quota exclusively for women-led groups at the country level. W4GF positions the 20% target as a **strategic country demand** grounded in the *GC8 RSSH Prioritization Guidance*.

W4GF suggest backing this request with costed implementation plans demonstrating how funding women-led CSOs directly improves programmatic outcomes (e.g., PrEP retention, TB screening in maternal health, and GBV response).

the conditions for GC8 Catalytic Investments, specifically the *Addressing Human Rights & Gender Barriers Match Fund* and the *Integrated Community & Health Services for Women & Children Match Fund*. More information here.

Note: You can check KNCV's GC8 Stigma Information Note that provides country teams with an overview of the GC8 modules where stigma reduction activities can be prioritized and financed.

2.- Ensure peer-led services (peer counseling, treatment support, gender-based violence response) are recognized as essential components.

💡Peer-led storytelling: Develop 3-minute videos, infographics, and social media content featuring peer leaders sharing impact stories; distribute via email, WhatsApp, and community networks.

💡Conduct Evidence Documentation: Work with peer-led organizations to document and quantify their impact (e.g., adherence rates, retention in care, gender-based violence survivors reached) and present findings to policymakers

💡Embed Peer Leaders in Funding Request Development: Advocate for CCMs to include peer-led organization representatives on technical working groups writing GC8 funding requests

3.- Push for flexible funding mechanisms that work for grassroots, women-led and community organizations

💡Host a "Funding Mechanisms Dialogue": Bring together 5-6 grassroots women-led organizations with donor representatives and Global Fund staff to discuss barriers (reporting requirements, bank accounts, organizational registration, etc.)

💡Co-develop alternative Funding Models: Work with organizations to design context-related funding pathways: e.g., direct funding or block grants. Advocate for social contracting mechanisms, fiscal host/Intermediaries PR models, and simplified/adapted reporting templates within official LFA guidance. Advocate for RSSH (Resilient and Sustainable Systems for Health)

capacity-strengthening funds specifically allocated to help grassroots women-led groups meet eligibility requirements for SR/SSR status.

💡Send Advocacy letters to Ministry of Health and Global Fund: Signed by grassroots organizations, requesting that GC8 proposals include dedicated funding streams with reduced compliance requirements for community groups

- **Gender-responsive and transformative indicators in the Modular Framework that measure gender outcomes, barriers, and disparities.**

  What you must do:

  1. Organize a Gender Indicators Working Group: Convene women's organizations, researchers, and health data experts to collectively identify which gender-specific indicators are missing from the Modular Framework

  2. Host Indicator Learning Sessions: Run webinars/workshops teaching women CSOs how to read the Modular Framework, identify where gender indicators should appear, and what to propose

  4. Monitor Funded Grants: Once grants are approved, track whether proposed gender indicators actually appear in implementation plans and conduct mid-term advocacy if they disappear

Implementation phase advocacy:

Advocacy does not end when the grant is signed.

The implementation phase (a 3-year cycle) provides crucial opportunities to redirect resources to gender and human rights priorities through mid-term reviews, savings, and reprioritization exercises.

- **Protecting Gender & Human Rights during mid-cycle reprioritization**

During global or national financial adjustments, grants undergo ***Reprioritization and Revisions exercises***. Official Global Fund guidance explicitly mandates that:

- ❖ Interventions reducing gender- and human rights-related barriers to health, addressing stigma, discrimination, and GBV **must be prioritized and protected from budget cuts**.
- ❖ Community systems, peer strategies, and Community-Led Monitoring **must be maintained**.

What you must do:

1.- Women's networks on CCMs must use official Global Fund Reprioritization Guidance to block proposed cuts to gender and human rights programs, pointing out that these are protected interventions under GF Secretariat rules.

- **Tracking unspent budgets & grant savings for reallocation**

Throughout implementation, Principal Recipients (PRs) often accumulate unspent funds due to delayed activities, procurement efficiencies, or favorable foreign exchange fluctuations.

What you must do:

1. Monitor PU/DRs (Progress Update / Disbursement Requests): Require civil society CCM representatives to review quarterly PU/DR variance reports to identify underutilized budget lines.
2. Submit Reallocation Proposals: Formally request that the CCM and PR reallocate saved or unspent funds toward unfunded gender priorities registered in the **Prioritized Above Allocation Request (PAAR)** or Unfunded Quality Demand list.
3. Target Non-Clinical Efficiencies: Push for cost savings from commodity procurements to be reinvested into women-led community outreach, peer support networks, and SRHR/HIV integrated services

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JOIN US
Global Coordinator: Ángela León Cáceres / Email address: angela@women4gf.org
Inquiries: info@women4gf.org / To subscribe to our newsletter and updates: communications@women4gf.org