Webinar Report: The Nuts and Bolts of GC7 Reprioritisation

WHAT, WHEN AND HOW COMMUNITIES CAN ESTABLISH RED LINES ON NON-NEGOTIABLE INTERVENTIONS FOR KEY POPULATIONS

Robin Montgomery

JUNE 22, 2025

I. Introduction

On Friday May 30, 2025, INPUD, GATE, NSWP, MPact, in partnership with GBGMC hosted a global webinar to share the latest information on the Global Fund's reprioritisation and revision process. This process is urgently underway at country-level to reprogramme and scale-back Grant Cycle 6 and 7 grants. According to the Global Fund Guidance released on June 6, Principal Recipients (PRs) and Country Coordinating Mechanisms (CCMs) will receive, at the end of June, the revised country funding envelope indicating their reduced country funding amount. This is another grave and devastating consequence of the global financial crisis hitting the health and international development sector. Looking ahead to the first 2 weeks of July, PRs, CCMs and in-country partners (including key population organisations and networks) are meant to convene and consult on how best to optimize the use of remaining GC7 grant investments. The reprioritisation and revision process aims to allow countries to identify and agree on vital programs that preserve and enable access to lifesaving HIV, TB and malaria services.

Close to 200 community and civil society allies participated in the webinar consultation. Participants identified critical interventions for and by key populations (people who use drugs, sex workers, trans and gender diverse communities, and gay, bisexual and other men who have sex with men) to ensure continued access to lifesaving services within this fast-moving re-budgeting process (Appendix A). An online survey accompanied the webinar registration. Sixty (60) online survey responses were received from community members from across 31 countries and were integrated into the outcome document: ***We Insist****: Non-Negotiables for and by Key Populations in the Reprioritisation and Revision of Global Fund Programmes in Grant Cycle 7* (Appendix B).[1]

II. Webinar Objectives

The reprioritisation and revision of mid-cycle grants is unprecedented in the history of the Global Fund and is just one of the many ramifications in the dismantling of the current global financial and multilateral ecosystem. Reduced country funding envelopes, the reprioritisation of programme interventions, and the 'pausing' of certain types of activities place hard won progress against HIV, TB and malaria in jeopardy and community-led responses, their organisations and networks in peril.

The **aim of this global webinar** was to provide community members with up to date information about the monumental changes, decision-making processes, their timelines, and how to engage in the negotiations for in-country planning and reprioritisation. As such the objectives of the session were to:

[1] The online survey received 60 responses during a 10-day period (May 29-June 8, 2025).

Clarify	Clarify the process and demystify the Global Fund's reprioritisation and revision steps, deadlines, and decision-making processes.
Enable	Enable community leaders to equip their communities with actionable steps to initiate and steer national reprioritisation discussions that can influence the decision-making processes at the country level.
Equip	Equip participants to establish critical "red lines" then define and advocate for non-negotiable lifesaving interventions that directly reflect key populations' priorities.
Drive	Drive strategic advocacy by presenting a concrete roadmap for immediate engagement with CCMs and Principal Recipients.

As noted above, an online survey was implemented alongside the webinar consultation. The purpose of the survey was to provide community members with multiple platforms to contribute in shaping the core priorities identified by key population communities. The survey also asked participants to define: (1) what "lifesaving services" mean for them; (2) what value and impact have community-led responses had in ensuring that clinical services and commodities reach those who need them; and (3) who is most at-risk should funding shift heavily toward clinical services to the detriment of community-led programming.

The remainder of this report focuses on sharing the results and key themes drawn from the survey findings. Quotes have been pulled from the findings and categorised according to the subheadings. Responses collected are articulate, knowledgeable and seeped in lived/-ing experience and expertise. They are powerful statements for advocacy, education and awareness raising during, and beyond, the current mid-cycle Global Fund grant reprioritisation. Two questions have not been included as the responses have been integrated into the webinar outcome document (Appendix B).

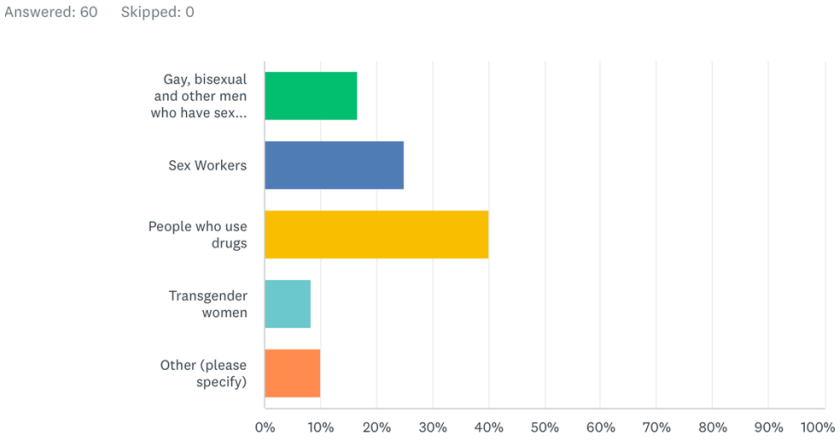
III. High-Level Findings: Survey Responses

Of the sixty responses, the largest respondent group was people who use drugs (41%; n=31), sex workers (21%; n=16), gay, bisexual and men who have sex with men (16%; n=12), and transgender women (16%; n=5). Respondents who indicated "Other" (16%; n=12) included:

- All populations in addition to migrants from sub-Saharan Africa
- All key population groups
- The community of LGBTQI++
- People living with HIV
- Indigenous Peoples
- Transgender men

- TB Champions

Figure 1: Profile of Respondents



Survey Question: ***How do you define "lifesaving" in the context of your community's health and well-being, beyond clinical services and medical commodities?***

The definition of what is 'essential' for the health and well-being of our community may vary depending on specific needs and cultural and social contexts. Key themes drawn from respondents focus on social, structural and systemic interventions that promote healthy living and mitigate the risks to life threatening infections. Key themes include:

Psychosocial Support and Safe Spaces:

- For people facing GBV, stigma, or trauma, a safe space or a trusted peer to talk to can prevent suicide, relapse, or unsafe coping mechanisms.
- In the LGBTI health context, "lifesaving" cannot be limited to clinical services and the medical context but extends to psychosocial support, safe spaces, community connections, self-awareness and socioeconomic empowerment.
- In the context of our community, I see 'lifesaving' as going beyond medical services and medications to include psychological and social support, providing a safe and non-discriminatory environment, and health education that empowers individuals to make informed decisions about their health. It also encompasses providing opportunities for education, employment, and social care that enhance quality of life and reduce the risks threatening individuals' lives.
- Safe spaces to escape violence and persecution
- Mental health support to prevent isolation, trauma, and suicide

- Both prevention and treatment are life savings, including mental health as failure to do so risk the treatment continuum of care and stops saving people at risk.
- In the context of my community, "lifesaving" goes far beyond clinical services and medical commodities. It means creating the conditions where people feel safe enough to seek care in the first place. It's the act of listening without judgment, walking with someone through stigma, and helping them rebuild a sense of worth when the world has told them they don't matter.
- As someone living with HIV and a survivor of tuberculosis-related blindness, I've learned that survival isn't just about having access to ARVs or TB treatment—it's about having the emotional strength, social support, and trust to use those services consistently. That strength often comes from community-led efforts: peer counselling, rights education, safe spaces, and advocacy that challenges the barriers we face daily.

Legal Aid and Rights Awareness:

- Helping someone escape wrongful detention, discrimination, or abuse their survival and dignity in the justice system.
- Repeal punitive laws and integrate legal protections into national HIV, TB and malaria responses.

Food, Shelter and Hygiene Support:

- Malnutrition, unsafe housing, or lack of hygiene can lead to preventable illness or death, especially for those living with HIV or chronic conditions.
- Emergency aid like shelter, transport, and food during crises.

Community Watchdog Mechanisms/Reporting Systems:

- Reporting corruption, abuse by law enforcement, or health worker misconduct can save lives by ensuring services reach those who need them.

Economic Empowerment or Livelihood Support:

- Without income, people may turn to unsafe sex, drop out of care, or go without medication. Supporting livelihoods prevents that spiral.

Flexible, core, long-term funding:

- Funding for feminist and women-led groups, especially those led by sex workers, trans women, adolescent girls, LGBTQI+ people, migrants, women with disabilities, and women affected by HIV, TB, or malaria.
- We clearly understand that without people, there will be no one to carry out activities! In other words, if there is not a minimum number of leaders, interests will not be

represented, and people will be left alone with their problems! We are convinced that every region should have at least one representative, one paralegal, and community organisations should have a financial officer, an office consultant, a development officer, a lawyer, and an accountant! Funding taken away from the community will never be replaced by other donors, and programmes will lose their actual expertise and point of access to target groups.

Gender-transformative systems:

- Education, bodily autonomy, and end all forms of gender-based violence, stigma and discrimination. This includes more education and literacy on sexual and reproductive health for transgender people, as well as the normalization of the fact that we can be pregnant bodies.

Empowerment, self-determination, access to decision making:

- What is vital is everything that enables individuals to be seen, heard and respected. This includes peer support, recognition of their identity, safety, autonomy, active participation in decision-making, and supportive community spaces. Without these things, medical services are not enough.
- Guarantee women's and girls' leadership, with decision-making power in CCMs and strong feminist accountability mechanisms.
- In this light, I define "lifesaving" as anything that restores dignity, protects human rights, and empowers people to stay engaged in their own care. The Global Fund's support for community systems and key population leadership makes this possible—and when these efforts are sustained, lives aren't just saved; they're transformed.

Comprehensive harm reduction services:

- Maintaining existing harm reduction treatment methods such as OST/OAT, Naloxone, sterile injection tools and drug therapy for HIV/AIDS, TB and Hep-C and still getting the right to work
- In the absence of commodities for harm reduction programs, new infections occur. Therefore, ensuring a regular supply of commodities is a lifesaving intervention, essential for providing health and well-being services
- "Lifesaving" can mean an intervention applied at the point of near-death (such as Narcan during an overdose). "Life saving" can also mean preventative interventions that help individuals avoid deadly risks (such as info and access to PrEP).

Survey Question: *Whose lives are at greatest risk if funding shifts heavily toward clinical services and away from community-based programmes?*

Responses have been grouped below in no specific order. Respondents often offered additional explanation, which has been included below:

LGBTQ+ Individuals:

- Often excluded or discriminated against in clinical settings. Community-led interventions are often the only safe, affirming spaces for health access and mental well-being.
- The LGBTQ community members most at risk if funding focuses heavily on clinical services at the expense of community programmes are:
    - LGBTQ youth
    - Transgender and non-binary people
    - LGBTQ people from marginalised communities
    - LGBTQ people living with HIV/AIDS
    - Older LGBTQ people
    - LGBTQ people with mental health issues.
- LGBTI persons in peripheral areas may struggle to access care outside the support that come with community programmes setting, younger LGBTI with limited funding may also struggle with issues like transportation
- Trans and gender-diverse people who fear or face discrimination in health facilities

People who use drugs:

- Without harm reduction outreach, needle exchange, or peer education, they face higher risks of HIV, hepatitis, overdose, and death.
- They often avoid formal clinics due to stigma, fear of arrest, or discrimination.
- Homeless or street-based PWUD who cannot afford services

Female Sex Workers:

- Community-led programs provide safety nets, rights education, and access to prevention tools.
- Without these, they risk increased violence, HIV/STI exposure, and mental health breakdowns.

Adolescents and Young People:

- Many do not seek formal clinical services due to judgment, age restrictions, or lack of youth-friendly care. Community programs offer relatable peer support and critical life skills.
- Young queer people

People Living in Informal Settlements or Remote Areas:

- Rural and remote communities may lack transportation, documentation, or awareness of how to reach health facilities.
- Rural and low-income individuals without access to formal healthcare.

Survivors of Gender-Based Violence:

- Clinics treat wounds, but community programs offer shelter, legal aid, psychosocial support, and long-term safety planning.

People Living with HIV (PLHIV) Facing Adherence Barriers:

- Peer support groups, stigma reduction efforts, and CHV follow-ups are vital for adherence and retention in care.

General responses:

- Those who are most invisible, most stigmatised and have the least knowledge and access to social and health care resources: trans women, people who have experienced violence, migrants or undocumented migrants, chemsex users, sex workers, etc.
- I would say the general population
- Those most at risk of stigma, violence and exclusion include trans women, young people living with HIV, sex workers in precarious situations, people who use criminalised drugs, and isolated gay and bisexual men. Without community mediation, these people remain excluded from the health system.
- Transgender women, women who use drugs, LGBTQI+ individuals, migrant women, Indigenous and racialised women
- The people most at risk are marginalized and excluded groups who rely heavily on community-based programs for support and protection, such as people who use drugs, sex workers, and communities affected by HIV. These groups often face difficulties accessing traditional clinical services due to social stigma or legal barriers, so reducing support for community programs can significantly endanger their health and lives.
- The lives most at risk are those already pushed to the margins—people living with HIV, key populations, those with disabilities, and anyone facing stigma or poverty. Without community-based programs, many will fall through the cracks, not because services don't exist, but because they'll be too afraid, ashamed, or unsupported to reach then.
- The lives of ordinary people, not the rich, not the government, but ordinary people, especially those who are dependent, sex workers, homeless people, those with HIV/AIDS, tuberculosis, hepatitis, and their partners.
- Prisoners, trans people, MSM, sex workers and PWUD… more Indigenous Nations will go extinct without concerted action.

Survey Question: ***How have community systems and rights-based programmes helped ensure that medical treatments and supplies actually reach the people who need them?***

It's a matter of trust:

- They help build trust between service providers and communities, facilitating fair and effective distribution of resources.
- Peer led initiatives have allowed for trust within communities and have facilitated access to medical treatment.
- Community systems and rights-based programs help ensure treatments and supplies reach those in need by:
    - Building trust between communities and healthcare providers
    - Identifying and reaching marginalized groups often excluded from formal systems
    - Providing referrals and follow-up through peer educators and outreach teams
    - Advocating for access and accountability when services are denied
    - Breaking stigma so people feel safe seeking care

Reaching people where they are at:

- Outreach services and mobile clinics to meet people who use drugs where they are at.
- Community outreach such as moonlight testing have increased uptake of services and have also increased awareness about available medication.
- Peer led model has worked for the past 20 years reaching out to their peers with services and linking them to health care services.

Community participation and accountability

- They empower individuals to claim their health rights, monitor the quality of medical services, and identify any barriers or discrimination that hinder access to treatment.
- They engage local populations in decision-making and management of health services, ensuring treatments address specific needs and that resources are used effectively.
- By involving community in planning and decision-making, programs can tailor services to meet specific local needs, improving distribution and uptake.
- Community systems help monitor the distribution of medical resources, holding providers accountable and ensuring that supplies reach underserved populations.
- Establishing channels for community feedback allows for continuous improvement in service delivery, adapting to changing needs and ensuring resources are effectively utilized.

- Having Community Advisory Boards with representatives mirrors the gap from different stakeholders with KP representatives on same table with community leadership, this ensure KP plight are addressed at first hand as well their feedback on service delivery noted by different stakeholders.

Safety and security

- Rights-based programs reduce fear of stigma, discrimination, and arrest, making it safer for key populations to access services.

Gender Diversity, Cultural Appropriateness, Sensitivity:

- Far too often, programmes and funding remain gender-blind, which is to say - failing to acknowledge the distinct needs, realities and rights of women and girls in all their diversity. Gender-blind approaches overlook how power, privilege and patriarchy shape access to care, rights and resources, thus 'invisibilising' the lived experiences of women and girls in all their diversity and leads to policies that are not only ineffective and counterproductive, but harmful, for example, by just counting pills we are not able to understand issue of access.
- Gender-transformative approaches go further than simply including women. They confront the root causes of inequality by shifting harmful norms, redistributing power, and placing the leadership of the most marginalized, which in most cases are women and girls, at the centre. This is why gender-transformative and gender-integrated health responses are the only path to reach global health equity.
- In our case, we are the organizations that knock on the door of health centres to ensure that they treat trans people in a dignified manner and in turn sensitise the staff.
- Community systems and rights-based programmes often provide essential support, which has been very crucial for access to treatment and commodities.
- Community systems have also provided cultural sensitivity that makes LGBTI likely to seek treatment.
- By providing an opportunity to address intersectional areas of health not specifically supported under the Global Fund for trans people such as services for social transitioning, trans-competent mental health services including, psychiatric care treatments, hormone treatments not funded under the Global Fund or other partners and legal and gender recognition.

General comments from respondents:

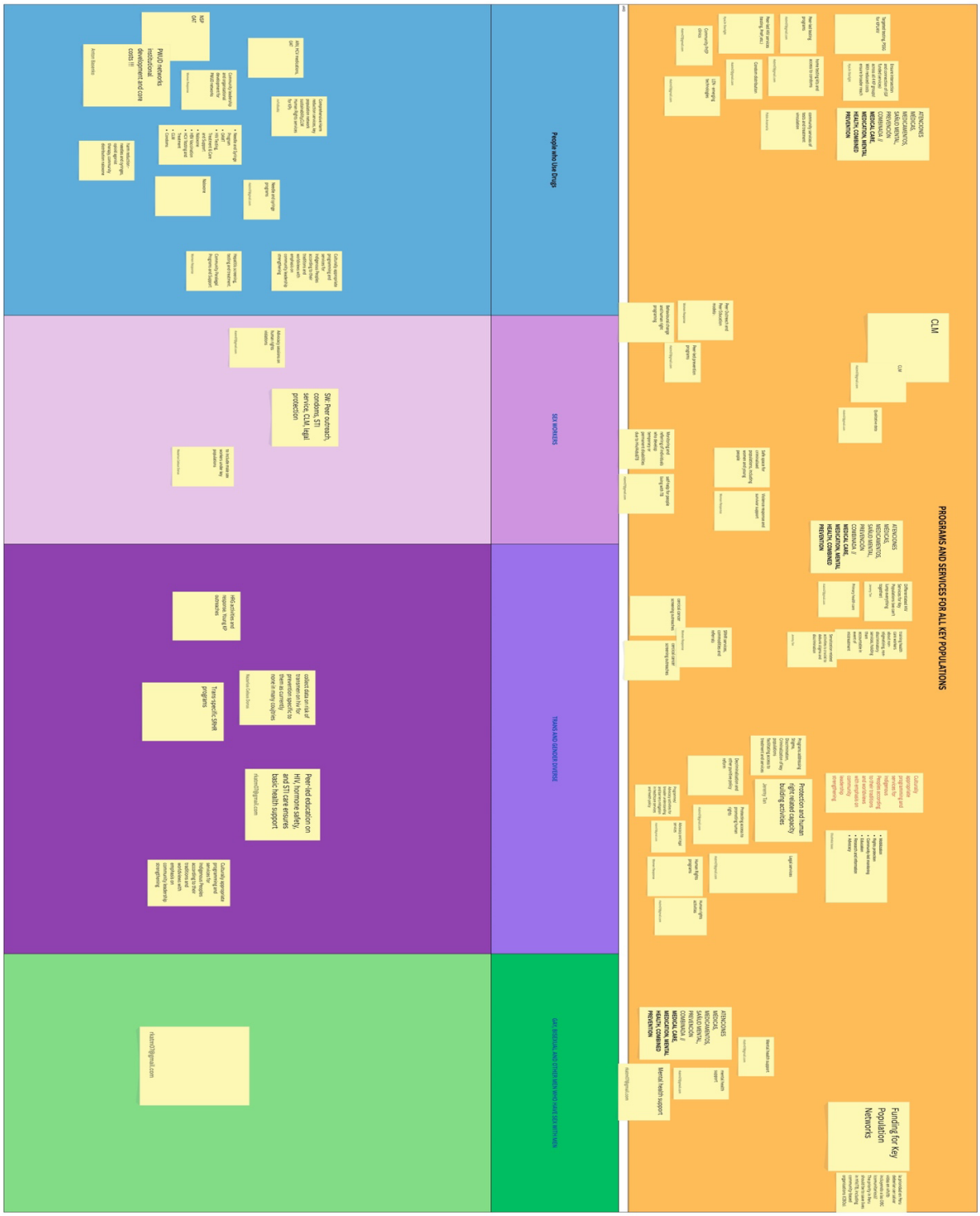
- Community based prevention and testing programs are very effective and reach to groups that are hidden

- There needs to be supervision carried out by civil society outside of program managers, and the government in each country should finance rights-based programs so that there is sustainability and becomes a national program. and most importantly, do not worry if a situation like this occurs.
- Community outreach teams identify and reach people who are excluded or hidden from formal health systems and provide follow-up, and support to ensure individuals complete treatment and stay in access to services.

IV. Conclusion

The webinar consultation involved a rich conversation, the sharing of information, in-country experiences, and an opportunity to strategically brainstorm non-negotiable priority interventions led by and for key population communities. The accompanying survey has provided an anonymous platform for even deeper community feedback and input into the final document (Appendix B). The responses gathered are vital in shaping and sharing core advocacy messages throughout this process as well as providing early preparation for the next Global Fund grant cycle.

Appendix A: Webinar Canva Whiteboard



Appendix B:

WE INSIST!

Non-Negotiables for and by Key Populations in the Reprioritisation and Revision of Global Fund Programmes in Grant Cycle 7

June 2025

On Friday May 30, 2025, INPUD, GATE, NSWP, MPact, in partnership with GBGMC hosted a global webinar to share the latest information on the Global Fund's reprioritisation and revision process. This process is urgently underway at country-level to reprogramme and scale-back Grant Cycle 6 and 7 grants. According to the Global Fund Guidance released on June 6, Principal Recipients (PRs) and Country Coordinating Mechanisms (CCMs) will receive, at the end of June, the revised country funding envelope indicating their reduced country funding amount. This is another grave and devastating consequence of the global financial crisis hitting the health and international development sector. Looking ahead to the first 2 weeks of July, PRs, CCMs and in-country partners (including key population organisations and networks) are meant to convene and consult on how best to optimize the use of remaining GC7 grant investments. The reprioritisation and revision process aims to allow countries to identify and agree on vital programs that preserve and enable access to lifesaving HIV, TB and malaria services. This is not a process where new ideas and interventions can be added to the country grant; **this is a crucial moment when we must protect current services and programmes for and led by key populations funded by the Global Fund.**

During this global webinar, close to 200 community and civil society allies **identified critical interventions for and by key populations** (people who use drugs, sex workers, trans and gender diverse communities, and gay, bisexual and other men who have sex with men) to ensure ***continued access to lifesaving services*** within this fast-moving re-budgeting process. Sixty (60) online survey responses from community members from across 31 countries have also contributed critical input into defining these core priorities.[2] While these Global Fund-funded interventions may vary depending on country context, **it is clear that we have a set of overarching non-negotiables**. **These are our red lines, and they can be used and/or adapted to your country's context**.

This is a crucial moment in time when we need to protect key population programming and services under Global Fund grants.

[2] The online survey received 60 responses during a 10-day period (May 29-June 8, 2025).

The following non-negotiables are grounded in community priorities identified for HIV and have been categorised according to the Global Fund grant modules for easy reference. These non-negotiables are overarching in nature and should be adapted/modified to fit your country's context. For instance, while some Global Fund funded services listed below may be available in some countries, they may not be available in others.

Module: Priority HIV interventions

We insist that the reprioritisation and revision process:

- **Maintains equitable access to lifesaving services using evidence-based low-threshold, community-led service delivery approaches for prevention, treatment and care,** including but not limited to: peer-led outreach and education models; condom and lubricant distribution, peer-led HIV/TB testing programmes; drop-in centres for/led by Key Populations; community-led harm reduction service delivery; community paralegal programmes, psycho-social and mental health support.

- **Maintains investments in evidence-based community-led innovations for effective and resource-efficient ART programmes and service delivery** including, mobile and community treatment and PrEP clinics, multi-month dispensing and peer-based adherence support models, etc. These models must ensure particular attention to the needs and preferences of each key population community, including people living with HIV.

- **Protects investments for comprehensive, low-threshold, peer-led harm reduction service delivery**, including outreach and peer education, procuring safe injection and smoking equipment that reflects the values and preferences of people who use drugs, community-led naloxone distribution, wound care, hepatitis testing and treatment, and opiate substitution treatment (methadone and buprenorphine).

- **Secures gender-transformative and evidence-based low-threshold sexual reproductive health and rights services**, including but not limited to access to PrEP/PEP (including Lenacapavir (LEN)), gender affirming care, hormone replacement therapies, tailored sexual health services to ensure anal health, differentiated STI screening and treatment services, cervical cancer screening and treatment, and violence response services.

- **Integrates comprehensive and culturally appropriate programming for Indigenous Peoples** according to their traditions and worldviews with an emphasis on ancestral science and community leadership.

- **Protects advocacy initiatives that support rights-based policy reform, access to justice, and anti-stigma and discrimination efforts for and by key populations** (e.g., in healthcare, police/legal and community settings). Stigma and discrimination affect access to care for all

key populations and therefore, ongoing investment to fight against stigma and discrimination are lifesaving endeavours for all key populations. Advocacy initiatives are essential for

improving sustainable access to prevention, treatment and care services, including through decriminalisation efforts.

RSSH Modules: Health Financing, Human Resources for Health

We insist that the process:

- **Safeguards community-led service delivery** by accelerating social contracting arrangements and other direct financing mechanisms to community-led services, organisations and networks.
- **Formalises and integrates peer health workers (e.g., peer outreach workers, peer educators, mentor mothers) as essential components of the community health workforce** into health human resource strategies and costing to equalise pay scales and job protections that ensure resilient and sustainable community systems.

RSSH Modules: Community System Strengthening

We insist that there is:

- **Maintained levels of investment in the capacity development of community-led organisations** to support the delivery of lifesaving services and to accelerate country-led sustainability plans.
- **Unwavering investment in new and mature Community-Led Monitoring (CLM) initiatives** to improve health service delivery, identify new and emerging gaps and trends, and to pinpoint quality improvement areas to maximize efficiency gains and sustainability.

Module: Health Products and Procurement Systems

We insist that reprioritisation and Global Fund country budget revisions:

- **Secure equitable access to scientific progress prioritising innovations that specifically respond to HIV prevention and care gaps,** including, Lenacapavir, digital health innovations, and AI infrastructure, capacity, technology and tools for key populations and community-led organisations and networks.

Advocating Our Non-Negotiables

On June 6, the Global Fund released updated guidance outlining high-level considerations for countries during the reprioritisation process, including key interventions. **The full document can be found HERE**. The Global Fund will share translations in mid-June. In the meantime, **AI-generated translations of the document can be found HERE** in French, Spanish, Portuguese and Russian.

It is vital to get informed and avoid going into meetings under-prepared!

Below are six essential advocacy strategies to support community engagement in this priority and re-budgeting process.

1. **START NOW!!** There is no time to wait to be invited to participate. This is an extremely fast-paced process with much of the negotiation happening between the PR(s), the Global Fund Country Team and the CCM in your country.

2. **Follow the Money!** Try to get access to the Global Fund-approved country budget and the most recent budget report to review and understand what activities are in your country grant, how much has been spent, and how much money remains available for each intervention. You can find a lot of this information on the Global Fund Data Explorer. Financial overviews that are broken down by country, component, and programme module are available here: CCM Dashboard. These are excellent resources to better understand what money is currently being considered for reprioritisation, revision (pausing), or cutting.

3. **Remember, there is Strength in Numbers!** Exchange information with your community partners and allies. If possible, meet, plan and strategise together. There is a lot to do – share the roles and responsibilities across your group and make sure that you are clear about who is doing what, and by when.

    - *Contact your Key Population and civil society CCM representatives* to gather information and invite them to your meetings.

    - *Map your key stakeholders and decision-makers in this process* (for example, the Chair and Vice-Chair of your CCM, CCM members, focal points at the Principal Recipient (PRs) and sub-Recipient (SRs) level, Local Fund Agency (LFA), and your Global Fund Fund Portfolio Manager (FPM). Get their names, positions and email addresses.

- *Understand who holds the decision-making power* at the PR-level and at the CCM-level. These are the people you need to prioritise and continue to share your advocacy materials with.

- *Demand your own meeting as a group*. Be sure to follow up by email, documenting everything that was discussed and agreed upon so that you have a paper trail and can hold them accountable for decisions made. For helpful email templates to CCM members, PRs and others, please see the annexes to the Frequently Asked Questions produced by the Global Advocacy Data Hub. **This is a regularly updated website, so be sure to bookmark it!**

- *Demand the schedule of meetings and consultations* for the reprioritisation and revision process so that you can plan accordingly.

- *Demand access to all documentation* being used in the revision & reprioritisation **in advance of each meeting/consultation.** It is very important that you have time to properly review the documents (including previous meeting minutes) beforehand so that you can actively participate in the discussions and defend your red lines.

4. **Write clear statements with your red lines,** including why they are non-negotiable and provide supporting evidence. These will be your key arguments (your key messages) to use in your negotiations.

    - *Hold consultations with your community*, if possible, to develop a shared list of key priorities. These priorities (red lines) may be different or more specific than the ones presented here because of your country's context.

    - *Use data from your CLM activities to back-up your arguments*. You can also use all the important work that you prepared during the country proposal development process at the beginning of GC7. Examples include community data to highlight access gaps, service satisfaction, as well as the impacts of criminalisation.

    - *Use helpful examples* of how to structure your arguments using "Global Fund evidence and language". There are helpful tips in Section 5.3 of the **Frequently Asked Questions** and a template to use (**Template 4**).

    - *Share your written priorities/red lines with all stakeholders in your country*. This should include first and foremost: all members of the CCM and the CCM Secretariat, the PR focal point, the UNAIDS regional or country office, the Country Team and Fund Portfolio Manager (FPM) at the Global Fund Secretariat.

5. **Keep clear and detailed notes of discussions and decisions** that you can refer back to track discussions and hold people accountable for the discussions and agreements made.

6. **Immediately report any concerns or challenges** that you are encountering, including getting timely access to the information that you are requesting. The decision-making timeline is very short, so it is very important that you share your concerns immediately and not wait. There are a couple of things that can help:

    - *Share your concerns in writing with all the relevant decision-makers at once, and not one at a time*. This will help to make sure that everyone is aware of your concern. If you do not hear back from anyone, re-send the email and demand a response. An example email is provided in **Template 5**.

    - Report the issue using different community platforms that have been created for this purpose. For example, the Community Escalation Platform is run by civil society and will help you connect with partners to help contact the right people at the Global Fund, connect you with other people having the same issue, and/or advocate on your behalf. It is also critical that you contact your Global Fund Leads at the Global Key Population Networks who will also be able to provide you with support and help to escalate your issue to the appropriate people at the Global Fund.

      INPUD - Isaac Ogunkola: isaacogunkola@inpud.net

      GATE – Anil Padavatan: padavatan@gate.ngo

      MPACT – Aria Shahbazpour Shahbazi: ashahbazpour@mpactglobal.org

      NSWP – Mick Matthews: mick.matthews@nswp.org

      GBGMC - Kingford Khanyiso: kkhanyiso@gbgmc.org