

## **INTEGRATION THAT WORKS FOR COMMUNITIES:**

### **Summary**

This position paper was developed in response to the Global Fund's Grant Cycle 8 strategic requirement to 'Drive focused, integrated HIV, TB and malaria and systems investments positioned on a path towards domestic sustainability.' It reflects extensive engagement with community networks, programmatic documentation, and global health evidence. It is submitted as a community advocacy contribution to the GC8 funding request development process.

The Global Fund's Eighth Replenishment strategic objective to 'drive focused, integrated HIV, TB, and malaria and systems investments positioned on the path towards domestic sustainability' represents a critical inflexion point. As the global health community responds to an underfunded replenishment, raising \$12.64 billion against an \$18 billion target, the imperative for integration is both a programmatic necessity and a political reality.

This paper argues that integration, to be effective and equitable, must be designed with and for communities. Integration without community leadership risks consolidating services in ways that erase the specificity of lived experience; Dismantling progress made by community-led platforms in integrating services that improve treatment outcomes and promote overall well-being for communities disrupts the pathway through which discriminated and criminalised populations with higher burdens access services and undermines the very trust that makes health systems function. At the same time, genuine integration, anchored in strong community systems, co-located services, and domestically owned financing architectures, holds transformative potential.

We advance four core propositions:

- Integration must be community-centred to be effective: People living with and affected by HIV, TB, and malaria possess the relational trust, contextual knowledge, and navigational expertise that health systems require. Their organizations must be co-designers and co-implementers, not recipients.
- Community Systems Strengthening (CSS) is the connective tissue of integration: Without investing in the platforms, capacities, and financing of community-led organizations, disease-specific integration will remain superficial, a convergence of programs without mechanisms to ensure access to services and care .
- Domestic sustainability requires a domestic accountability infrastructure: Sustainability is not simply the transfer of donor costs to government budgets. It requires enabling environments (legal, fiscal, and political) that allow communities to hold their own governments accountable for health commitments. This requires country-level institutionalization of community-led monitoring, feedback and response mechanisms.
- Key and criminalized populations require targeted integration strategies: Integration must not erase specificity. For populations facing legal barriers, stigma, and systemic exclusion, integrated services must preserve the safety, confidentiality, and trust that dedicated community-led services provide.

### **1. Introduction: Why Integration, and Integration for Whom?**

Integration has become a central organizing principle of global health strategy. Driven by efficiency imperatives, system-strengthening logic, and the recognition that disease-specific siloes produce

fragmented, costly, and often ineffective care, the Global Fund's GC8 strategy signals a firm commitment to convergence across its three disease portfolios.

But integration is not inherently beneficial. Its value depends entirely on how it is designed, who drives it, and what it preserves or displaces. Historical evidence demonstrates that poorly designed integration can:

- Consolidate services in ways that reduce access for marginalized populations whose health-seeking is shaped by stigma, discrimination, distance, and/or criminalization;
- Merge programs that require distinct competencies and trust relationships, reducing the quality of care for each;
- Defund or absorb community-led organizations into government structures without protecting their independence, identity, or accountability to affected communities;
- Accelerate transitions to domestic funding systems that are underprepared, under-resourced, or structurally hostile to certain populations.

The communities most affected by HIV, TB, and malaria, people living with HIV, those affected by TB, women and children in high-malaria settings, sex workers, people who use drugs, men who have sex with men, trans and gender diverse persons, migrants, Internally displaced persons and prisoners have developed their own platforms for care, peer support, advocacy, and accountability. These platforms are not redundant to health systems. In many contexts, they are the reason health systems reach these populations at all.

*"Integration that does not begin with community is not integration; it is absorption. And absorption, without protection, is loss."*

**Community  
Representative, Africa  
Regional Consultation**

This paper proceeds from a conviction born of lived experience and programmatic evidence: that the most effective path to integrated, sustainable health systems runs through communities. We offer a framework for what community-centred integration looks like in practice, what it requires from the Global Fund and from domestic governments, and how GC8 investments can be structured to advance it.

## **2. The Case for Community-Centred Integration**

### **2.1 Communities as Health System Infrastructure**

Community-led organisations and networks are not peripheral actors in health systems; they are infrastructure. Across sub-Saharan Africa, South and Southeast Asia, Latin America, and Eastern Europe, community organizations provide:

- First-point-of-contact testing, counselling, and linkage to care for HIV, TB, and malaria;
- Adherence support, treatment literacy, and peer navigation that reduce loss to follow-up;
- Stigma reduction and rights protection that enable service uptake in contexts of discrimination;
- Community-based monitoring and accountability that improve service quality and responsiveness;
- Demand generation that drives health-seeking behaviour, especially for vulnerable populations;
- Data collection and reporting on community-level outcomes that are often more efficient and responsive than facility-based surveillance.

Analysis of Global Fund-supported programs found that grants with strong community systems components consistently outperformed those without on key coverage and retention indicators. The relationship is not incidental; it reflects the foundational role that trust, social capital, and community mobilization play in improving health outcomes and sustaining health responses.

## **2.2 The Epidemiological Logic of Integration**

HIV, TB, and malaria share overlapping determinants: poverty, inadequate housing, malnutrition, limited access to water and sanitation, gender inequality, and social marginalization. They also share overlapping populations. HIV significantly increases the risk of TB disease progression; malaria increases maternal and infant vulnerability to HIV transmission; TB-HIV co-infection remains a leading cause of AIDS-related mortality globally.

The epidemiological logic, however, must be tempered by the realities of service delivery. Integration works when it simplifies access and improves continuity. It can fail when it merges services that require distinct competencies (e.g., TB infection control and HIV counselling), different provider-patient relationships, or different community trust dynamics.

## **2.3 What Community-Led Integration Looks Like in Practice**

Community-led integration is not a single model; it adapts to epidemiological context, community geography, health system structure, and the specific populations being served. Common evidence-based modalities include:

### **One-Stop Community Health Hubs**

Community-run facilities or fixed points offering HIV testing, TB symptom screening, malaria rapid diagnostic testing, SRHR services, and primary care navigation in a single location. These hubs are most effective when led by community organisations that are trusted by local populations.

### **Integrated Peer Navigation**

Trained community health workers and peers who accompany individuals across the health system, connecting HIV diagnosis to TB screening, TB treatment to adherence support for ART, and malaria in pregnancy to PMTCT services. Peer navigators are particularly effective for vulnerable populations who face multiple service barriers.

### **Community-Based Monitoring Platforms**

Community organisations are collecting, synthesising, and reporting data on integrated service quality, coverage gaps, and equity outcomes. These platforms serve both accountability and learning functions, providing real-time feedback loops that formal health information systems often cannot capture.

### **Linkage and Retention Networks**

Networks of community organisations that create warm referral pathways across programs, ensuring that a person who tests positive for HIV is connected to TB preventive therapy, that a TB patient is offered HIV testing, and that a pregnant woman receiving malaria prophylaxis is enrolled in PMTCT.

### 3. Community Systems Strengthening as Integration Architecture

#### 3.1 CSS: The Underinvested Foundation

Community Systems Strengthening, as defined by the Global Fund, is support for community-led organisations, networks, and platforms that deliver health and social services alongside advocacy and accountability functions, and is the foundational architecture through which integration becomes possible at the community level.

Yet CSS has been chronically underinvested relative to its demonstrated returns. In GC7, CSS investments averaged approximately 5-7% of grant budgets across most high-burden countries, a fraction of what is needed to build the organisational capacities, digital infrastructure, and financing systems that sustainable integration requires.

The consequences of underinvestment are visible: community organisations with insufficient core funding peer navigators working on short-term contracts without benefits or career pathways; community health workers whose stipends fall below living wages; and advocacy platforms that collapse when external funding cycles end.

#### 3.2 What CSS Investment for Integration Requires

Core CSS Investment Requirements for Integrated Programs
Organisational core funding: Multi-year, flexible funding for community organizations that covers salaries, operations, systems development, and organisational learning, not just program delivery costs.
Digital and data infrastructure: Investment in community-owned data systems, community health information platforms, and digital literacy that enable community organisations to generate, own, and use data effectively.
Capacity building with a sustainability lens: Training and mentoring that builds organisational management, financial governance, program quality, and advocacy competencies, enabling community organisations to access domestic funding.
Legal and enabling environment: Support for policy reform that creates legal space for community organisations to operate, register, access government contracts, and hold their governments accountable.
Peer-to-peer learning networks: Investment in south-south learning, regional networks, and community of practice platforms that accelerate the adoption of integrated models.
Community-led monitoring systems: Resources for community organisations to monitor service quality, equity, and rights, including mechanisms for communities to report violations and drive systemic accountability.

### 3.3 Direct Funding as an Integration Enabler

The modality through which Global Fund resources reach community organizations is not a technical detail; it is a determinant of integration quality and sustainability. When community organizations receive funding indirectly through government principal recipients or large international NGOs, several integration-specific problems emerge:

- Community organisations lack the negotiating power to influence program design decisions that prioritise government convenience over community needs;
- Subgrant timelines and reporting requirements are often incompatible with the flexible, relationship-based work that integration requires;
- Community organisations are excluded from integrated planning processes that determine the design of services they are expected to deliver;
- Financial accountability flows upward to the PR, not horizontally to communities, reducing accountability for integration quality.

Direct funding mechanisms, in which community organisations receive grants from the Global Fund or through their global and regional networks, address these structural issues. The evidence from existing programs demonstrates improved organisational stability, stronger community accountability, and greater innovation in integrated service delivery models.

GC8 presents a historic opportunity to expand direct funding for community-led integration, with explicit carve-outs for organisations led by key and criminalised populations who are systematically excluded from government-channelled funding streams.

## 4. Domestic Sustainability: Beyond Budget Transfer

### 4.1 The Limits of the Fiscal Transfer Model

The dominant framing of 'domestic sustainability' in global health is fiscal: the progressive transfer of disease program costs from international donors to domestic government budgets. This framing, while important, is insufficient.

Fiscal sustainability without accompanying reforms in health system governance, The commodity value-chain, community engagement, procurement, and equity produce transitions that are regressive for the most marginalised. Countries that have transitioned HIV program financing to domestic budgets without enabling environments for community engagement have frequently seen:

- The defunding of community-led organizations as governments prioritise facility-based, government-delivered services;
- The erosion of services for key populations as political accountability replaced donor accountability;
- The loss of data quality and coverage data as community-based monitoring systems were absorbed into government information systems;
- Reversals in epidemic progress as coverage declines among hard-to-reach populations.

*"Sustainability means communities can still access services, advocate for their rights, and hold governments accountable, not just that governments have taken over the budget line." - TB Women Global Network Consultation, 2024*

## 4.2 A Community-Centred Sustainability Framework

Genuine domestic sustainability for integrated programs requires investment across four dimensions simultaneously:

### **Fiscal Sustainability**

Progressive integration of disease program costs into domestic health budgets, supported by domestic resource mobilisation strategies, health financing reforms, domestic production of health commodities and accountability for the execution of the health budget. This includes advocacy for increased domestic investment in community health workers, community organisations, and CSS.

### **Systems Sustainability**

The strengthening of integrated health information systems, supply chain systems, human resources for health frameworks, and quality assurance mechanisms that can sustain integrated service delivery as external financing declines. Community organisations must be embedded within, not peripheral to, these system architectures.

### **Political and Accountability Sustainability**

The development of domestic accountability infrastructure: civil society capacity to monitor health commitments; community platforms to report on service quality and rights violations; parliamentary oversight mechanisms; and independent national HIV/TB/malaria monitoring bodies that include community representatives.

### **Community Organisational Sustainability**

The organisational and financial sustainability of community-led organisations themselves, their ability to access domestic funding, government contracts, social contracting mechanisms, and philanthropic resources, as international funding declines. This requires investment in organisational development, legal enabling environments, and social contracting frameworks.

## 4.3 Social Contracting as a Bridge Mechanism

Social contracting represents a promising bridge mechanism between Global Fund-supported community programs and domestically financed sustainability efforts. However, it is not a universal solution. Its effectiveness depends heavily on the enabling environment: the strength of government systems, the legal recognition of community organisations, the political will to fund civil society, and the degree to which key populations can operate openly without fear of criminalisation or reprisal. In contexts where these conditions are absent or fragile, social contracting frameworks may be premature or even counterproductive, exposing community organisations to regulatory capture, co-optation, or loss of independence.

Where enabling conditions do exist, early evidence from countries in the Global Fund portfolio suggests that well-designed social contracting can:

- Provide community organisations with predictable, multi-year funding streams that enable organisational planning;
- Establish formal accountability relationships between governments and community organisations, strengthening both parties.

- Create quality standards for community-delivered services that improve program consistency;
- Enable community organisations to scale integrated service models with government backing;
- Preserve community independence while integrating community services within national health architectures.

GC8 resources should therefore support a differentiated approach: funding the development and piloting of social contracting frameworks in high-burden countries where enabling conditions are present, or actively being strengthened, while simultaneously investing in alternative sustainability mechanisms, including direct funding channels and regional civil society pooled funds, for contexts where social contracting is not yet viable. Funding should also be provided to develop and pilot other sustainable community funding models, such as social entrepreneurship. In all settings, community organisations, particularly those led by key and criminalised populations, must be active co-designers of any contracting or sustainability mechanisms that affect them, not passive recipients of government-determined frameworks.

## 5. Key and Criminalised Populations: Integration Without Erasure

### 5.1 The Specific Integration Challenge

For key populations facing criminalization, severe stigma, or systemic exclusion, sex workers, people who use drugs, men who have sex with men, trans and gender diverse persons, and people in prisons, integration presents a specific and underappreciated risk: the risk of erasure.

Programs designed for key populations require specialised competencies: harm reduction approaches, rights-based service delivery, peer-led models, confidentiality protections, and environments where communities set the terms of their own care. When these programs are merged into general health system services, even well-intentioned integrated platforms, the specific trust, safety, and accessibility that key population programs provide are frequently lost.

The consequences are measurable: in countries and settings where key population-specific programs have been merged into general health services without adequate transition planning, uptake has declined, incidents of stigma in clinical settings have increased, and loss to follow-up has risen.

### 5.2 Principles for Integration That Preserves Access

#### Non-Negotiable Principles for Integration Serving Key and Criminalised Populations

**1. Community Control:** Key population-led organisations must retain decision-making authority over how integration affects their programs. They must be co-designers, not recipients of integration designs.

**2. Safety Preservation:** Integration must never compromise the confidentiality, dignity, or physical safety of key population clients. This requires dedicated spaces, trained providers, and community oversight.

<p><b>3. Legal Environment Alignment:</b> In criminalised contexts, integration must not expose key population clients to greater legal risk; integrated data systems, referral pathways, and provider training must account for legal vulnerabilities.</p>
<p><b>4. Specificity Within Integration:</b> Integrated platforms can serve key populations only if they retain the competencies, peer models, and rights-based approaches that key population programs require; 'integration' must not mean 'generalisation.'</p>
<p><b>5. Protected Funding Streams:</b> Direct funding to key population-led organisations must be included in integrated financing frameworks; these organisations must not be required to access integrated funding through channels that exclude them or expose them to potential harm.</p>
<p><b>6. Community Monitoring of Integration Outcomes:</b> Key population communities must have dedicated mechanisms to monitor whether integration improves or harms their access to services, and to trigger corrective action when harm is occurring</p>

### 5.3 Integration as Rights Realization

For key and criminalised populations, the most meaningful form of integration is the integration of health with rights. This means:

- Community-led legal services co-located with health services, providing legal aid for key population clients facing discrimination, arrest, or rights violations;
- Integrated advocacy platforms that connect health outcomes data with rights advocacy, enabling communities to use health data as evidence for law and policy reform;
- Peer-led psychosocial support integrated with clinical care, addressing the mental health impacts of criminalisation and stigma that undermine treatment adherence;
- Integration of SRHR, including contraception, and gender-based violence services, with HIV, TB, and malaria programs, particularly for women and girls living with HIV.

The Global Fund's GC8 strategy should explicitly recognise rights-integrated service delivery as a core component of effective integration for key populations, with dedicated investment in community-led legal empowerment and rights protection platforms.

### 6. GC8 Investment Priorities: What Communities Are Calling For

Based on community consultations across regions, engagement with community networks, and evidence from programmatic experience, we identify the following GC8 investment priorities for community-centred integration:

Priority Area	Specific Investment	Expected Outcome
Direct Funding for Community-led Organizations, particularly in criminalized contexts	Dedicated direct funding mechanisms for community-led organisations to design and deliver integrated HIV/TB/malaria services. This is particularly urgent in criminalized contexts	Stronger community organisations with operational independence and accountability to communities.

CSS as Integration Foundation	CSS allocation in all integrated grants, covering organisational development, digital infrastructure, and advocacy capacity.	Sustainable community platforms that can anchor integrated programs through and beyond the GC8 period.
Social Contracting	Country-level support for developing social contracting frameworks and piloting government-community contracting for integrated services.	Domestically-funded pathways for community organisations as Global Fund resources decline.
Other sustainable community funding models	Investment in other models for sustainable financing of community systems.	Diversified sustainable funding models that protect independence and accountability in contexts with limited civic space.
Key Population Protection	Ring-fenced funding for KP-led organisations within integrated financing frameworks, with community-controlled access.	Preserved access and safety for key and criminalised populations in integrated service environments.
Community Accountability Systems	Investment in community-based monitoring, CLM platforms, and domestic civil society advocacy capacity across all three disease areas.	Independent accountability infrastructure that outlasts external funding cycles.
Legal Enabling Environment	Explicit advocacy and legal reform investment as part of integration strategies in criminalised contexts.	Reduction of legal barriers that prevent key populations from accessing integrated services.
Data for Communities	Community-owned data systems and capacity to generate, interpret, and use integrated data for advocacy and program improvement.	Evidence base for community advocacy on integration quality and equity outcomes.

## 7. Recommendations

We call on the Global Fund Board, Secretariat, Country Coordinating Mechanisms, and national governments to adopt the following recommendations in implementing GC8 integration objectives:

### To Global Fund Secretariat

- Adopt a community-centred integration framework as the operational standard for GC8, explicitly requiring that community organisations are co-designers of integrated grant designs and implementation strategies.
- Establish CSS allocation in all integrated HIV/TB/malaria grants, with accountability mechanisms for grant-level compliance.

- Expand direct funding mechanisms to enable community-led organisations, particularly those led by key populations, to access Global Fund resources without dependence on government principal recipients.

*"We are not asking to be included in integration. We are asking to lead it. The difference matters, because what communities build for ourselves, we sustain."*

**Community Delegation  
Statement, Pre-GC8  
Consultation**

- Develop explicit guidance on integration approaches for key and criminalised populations, including safety standards, data confidentiality requirements, and ring-fenced funding protections.
- Establish a dedicated GC8 community accountability mechanism that enables communities to report integration-related harms and trigger corrective action.
- Invest in social contracting and other sustainable community systems financing frameworks as a core domestic sustainability strategy, where possible, with technical assistance for country-level development and piloting.

### **To Country Coordinating Mechanisms**

- Ensure meaningful community representation, including organisations led by people living with HIV, TB-affected communities, and key populations, in all CCM processes related to integrated grant design.
- Advocate for national enabling environments for community organisations, including legal registration pathways, access to government contracting, and protected civic space for health advocacy.
- Commission community-led monitoring of integration quality and equity, with results feeding into grant performance reviews and grant revision processes.
- Develop national social contracting roadmaps that map community organisations currently delivering integrated services and create pathways for domestic financing.

### **To National Governments**

- Invest in domestic financing for community health systems, including community health worker stipends, organisational core funding, and government contracts for community-delivered integrated services.
- Create or strengthen legal enabling environments for community organisations, removing barriers to registration, operation, and advocacy for organisations serving key populations.
- Integrate community-led monitoring data into national health information systems and use it in national health planning and accountability processes.
- Establish or strengthen health financing equity mechanisms that ensure integrated services reach the most marginalised populations as domestic financing grows.

## **8. Conclusion: Integration as Transformation**

The GC8 mandate to drive integrated investments on the path to domestic sustainability is, at its core, a mandate for transformation not just of programs and financing, but of the relationship between health systems and the communities they serve.

Integration designed by and for communities has the potential to build more effective, equitable, sustainable, and accountable health systems . It can create platforms where a person living with

HIV also receives TB prevention, where a woman with malaria in pregnancy is connected to PMTCT, where a person who uses drugs accesses harm reduction alongside HIV treatment, not because a program requires it, but because the community-led platform through which they access care makes it natural.

But this potential will only be realised if communities are positioned as architects of integration, not its objects. It will only be realised if Community Systems Strengthening is treated as the essential infrastructure it is, not an add-on. It will only be realised if domestic sustainability means the sustainability of community-led accountability, not just the transfer of budget lines.

The communities living with and affected by HIV, TB, and malaria have built systems of care, support, and advocacy that health ministries and global institutions depend upon, often invisibly. GC8 is an opportunity to make that dependence visible, to invest in it deliberately, and to build integration that endures because it belongs to the people it serves.

## References and Evidence Base

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