SCOPE REPORT

Support for Community Organizations & Priorities for Empowerment and Impact

Community-led implementation of Global Fund programs: evidence from the SCOPE study

Abbreviations

AGYW	Adolescent girls and young women
CCM	Country Coordinating Mechanism
CHW	Community health workers
CLM	Community-led monitoring
CLO	Community-led organization
CLR	Community-led responses
CS&R	Community systems and response
CSS	Community systems strengthening
GC8	Grant Cycle 8
KVP	Key and vulnerable population
MSM	Men who have sex with men
PR	Principal Recipient
SR	Sub-recipient
SSR	Sub-sub-recipient

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Executive summary

At a time of high political uncertainty and shrinking international health budgets, the future of lifesaving, community-led HIV, TB, and malaria programming is at risk. The **Support for Community Organizations & Priorities for Empowerment and Impact (SCOPE)** study was launched in response to an urgent question: **how can we protect and strengthen the role of community-led organizations (CLOs) within the Global Fund architecture,** especially in the face of reduced funding and political pressures?

Community-led organizations are not just important partners in health service delivery, they are essential. CLOs are uniquely positioned to reach the populations most affected by HIV, TB, and malaria and research has consistently shown that when communities lead, health outcomes improve. Despite this, CLOs remain underfunded and underrepresented in Global Fund implementation structures—comprising just 5–7% of all Principal Recipients across recent grant cycles—and receiving an even smaller share of the total funding envelope.

The SCOPE study involved global community consultations, a multi-language survey of civil society stakeholders, and in-depth country case studies to define what constitutes a community-led organization, identify which interventions must be implemented by CLOs to be effective, quantify current funding flows to CLOs PRs, and pinpoint the structural barriers that prevent CLOs from serving as Global Fund implementers.

Findings confirm that **many interventions—particularly for key and vulnerable populations (KVPs)—cannot be meaningfully implemented without community leadership**. Yet CLOs continue to face systemic hurdles, including legal and registration barriers, lack of direct funding pathways, delayed payments, and exclusion from decision-making spaces like Country Coordinating Mechanisms (CCMs). These challenges are compounded by a dangerous new reality: recent budget freezes, funding reallocations, and the risk of an underfunded 8th Replenishment threaten to deprioritize community programming.

Against this backdrop, the SCOPE report calls for urgent action. As the Global Fund navigates difficult fiscal trade-offs, it must not revert to a model that favors only commodity delivery or facility-based services. Instead, it must double down on its commitment to equity and rights by **ensuring community-led programming is not sidelined, but rather is safeguarded and expanded**.

This report provides concrete recommendations to the Global Fund Secretariat, CCMs, and community advocates—including the need to track CLO implementation more accurately, ensure that community-prioritized activities are protected in funding requests and reprogramming, and create new pathways for direct investment in CLOs.

Community-led programs are critical to the effectiveness and sustainability of the entire Global Fund model. In a constrained funding environment, sidelining CLOs would be not only a setback for human rights—it would be a missed opportunity to make every dollar work harder. If we are serious about ending the three epidemics, we must fund what works—and what works is community-led programming.

About the SCOPE Study

The SCOPE study was designed to respond to five questions:

1. What is a community-led organization (CLO)?
2. Which Global Fund programs must be implemented by CLOs?
3. What is the current landscape of CLOs, at the Principal Recipient (PR) level?
4. What are the facilitators and barriers of community-led implementation?
5. What are the opportunities to strengthen community-led implementation for GC8 and beyond?

First, **five community consultations were held** in October and November 2024, focused on anglophone Africa, francophone Africa, eastern Europe and central Asia, southern and south-east Asia, and Latin America and the Caribbean. Participants were members of communities most affected by the three diseases, who were recruited by the study leads, members of the Advisory Group, and the Global Fund's Learning Hubs. During the consultations, participants were asked to reflect on two questions: (1) which Global Fund programs should be implemented by CLOs and (2) how to define a CLO. A total of 113 individuals participated in the consultations, which were conducted in English, French, Spanish, Portuguese, Russian, Thai, and Ukrainian. After the consultations, participants and their colleagues were invited to share additional feedback by electronic form or email.

Secondly, based on the findings from the consultations, a **web-based survey** was conducted in the 33 countries with at least one PR categorized as a local, civil society organization in either Grant Cycle 5, 6, or 7[1]. This survey was open to civil society and/or community respondents not currently employed at a Global Fund PR and received a total of 371 eligible responses from November 2024 to July 2025. The survey was available in Bahasa Indonesia, English, French, Portuguese, Russian, Sinhala, Spanish, Thai, Ukrainian, and Vietnamese. Survey respondents were asked to review the definition of a CLO that was defined during the community consultations, and to categorize whether their local civil society PR(s) fit the criteria for being a CLO.

Finally, three countries were selected for an **in-depth qualitative assessment** of the landscape of community-led implementation below the PR level. During this phase, community partners analyzed the list of Global Fund interventions that must be implemented by CLOs, which was defined during the community consultations, and analyzed which activities were implemented by CLOs, non-CLO civil society, or government. In addition, individual interviews were conducted with Global Fund PR, SR, and SSRs, as well as CLOs not currently receiving Global Fund funding. These semi-structured interviews were designed to gather information about the successes of CLO-led implementation and the barriers to serving as an SR or SSR.

The analyses and recommendations described in this report were guided by an Advisory Committee consisting of global and national civil society organizations engaged in Global Fund advocacy. This group

[1] PR data were extracted from the Global Fund's data service.

provided feedback on the overall objectives of the SCOPE study, the methodological approach, and guided the interpretation of findings and recommendations.

What works: Implementation by and for the community

The SCOPE study builds off of previous research demonstrating the benefits of community-led service delivery. We know that infectious diseases know no boundaries, and a Global Fund that reaches only certain populations can never achieve its objectives. Marginalized populations are definitionally those who are not served by traditional health system infrastructure, whether because the services offered are unfriendly, hard to reach, unaffordable, or due to mistrust or fear of governments and nongovernmental organizations. This means that reaching these populations requires **innovative approaches led by trusted partners**.

Implemented in partnership with Africa Frontline First, Project BIRCH supports 22 African countries to increase community health funding and strengthen health systems. Photo credit: Integrate Health/Global Fund

Indeed, **there is no greater expert on the needs of communities than the community itself**, and the evidence is clear: programs designed and delivered by communities work. One academic review, focused on HIV programs, found that community-led implementation was associated with more than 40 beneficial outcomes including for prevention, linkage, retention, service quality, and viral suppression[2]. Multiple studies have highlighted the need for community engagement and peer-led service delivery to support behavior change[3] achieve the best prevention and treatment outcomes.[4] Community involvement at all

[2] Ayala G, Sprague L, van der Merwe LL, Thomas RM, Chang J, et al. Peer- and community-led responses to HIV: A scoping review. PLoS One. 2021 Dec 1;16(12):e0260555.
[3] Indravudh PP, McGee K, Sibanda EL, Corbett EL, Fielding K, et al. Community-led strategies for communicable disease prevention and management in low- and middle- income countries: A mixed-methods systematic review of health, social, and economic impact. PLOS Glob Public Health. 2025 Apr 2;5(4): e0004304.
[4] Ayala G, Sprague L, van der Merwe LL, Thomas RM, Chang J, et al. Peer- and community-led responses to HIV: A scoping review. PLoS One. 2021 Dec 1;16(12):e0260555.

levels including in service design, delivery, and evaluation is associated with better health outcomes, greater community empowerment, and strengthened community systems.[5]

Recognizing the urgency of community leadership in health programming, UN member states committed in 2016 that by 2030, 30% of all HIV service delivery would be implemented by CLOs[6]. In 2021, the global community further agreed that CLOs would deliver 30% of HIV testing and treatment and 80% of HIV prevention for KVPs by 2025[7].

Global Fund investments in community-focused activities

In its 2023-2028 Strategy, the **Global Fund places communities at the center**, emphasizing serving the needs of people and communities by building people-centered health systems; strengthening the engagement and leadership of communities; and maximizing health equity, gender equality, and human rights. The Global Fund funds two pillars of activities focused on **community systems and responses** (CS&R)[8]:

- **Community systems strengthening (CSS)**: Global Fund grants may include activities focused on CSS, including community-led monitoring (CLM), advocacy, and research, as well as capacity building, leadership development, and community engagement and coordination.
- **Community-led responses (CLR)**: Grant budgets may be used to fund community responses delivered by community-led or community-based organizations.

[5] Haldane V, Chuah FLH, Srivastava A, Singh SR, Koh GCH, et al. Community participation in health services development, implementation, and evaluation: A systematic review of empowerment, health, community, and process outcomes. PLoS One. 2019 May 10;14(5):e0216112.
[6] United Nations. Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030. New York, New York: United Nations. June 2016.
[7] United Nations. Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030. New York: United Nations. 2021. Contract No.: Agenda Item 10.
[8] The Global Fund. Community Systems and Responses (CS&R) in Global Fund GC7 Grants: Update for the 2023-2025 Allocation Period (GC7). 20 February 2023.

I-BreakFree youth ambassador Paulina (middle) provides HIV prevention education sessions to her peers at schools, health facilities and community centres in Ohangwena Region, Namibia. The i-BreakFree program is run by One Economy with support from the Global Fund.. Photo credit: Karin Schermbrucker / Global Fund.

According to one analysis, the **Global Fund provided at least US$ 700 million** in funding for these types of community-focused programs in 2024[9], which included addressing human rights- and gender-related barriers to care, services for key and vulnerable populations (KVP), and community system strengthening. Community-focused programs comprise a larger portion of Global Fund grants in upper-middle income countries, where the three epidemics are more likely to be concentrated among KVP.

In addition to funding community-focused programs, the Global Fund has multiple **pathways for community-led organizations to be funded** to deliver services. A CLO may serve as a Principal Recipient (PR), which is one of the organizations that receive funds directly from the Global Fund Secretariat in Geneva. Since most countries also have a government PR, this form of funding is called "dual-track financing," meaning that the country has both a government PR and a non-governmental PR. However, since there are only a small number of PRs in each country, most CLOs are instead funded as sub-recipients (SR) or sub-sub-recipients (SSR). As a sub-recipient, a CLO can receive funding from one or more PR to perform activities in the Global Fund grant.

[9] amfAR, Data Et cetera. Supporting Community-Focused Programming: New Data Highlight the Global Fund's Key Role. December 2024.

Increasing threats to community-focused programs

Despite the known benefits of community-led HIV service delivery, community-led programs have been historically underfunded and face new and increasing threats due to funding constraints. These threats come in multiple forms, both from the significant disruption to U.S. government-supported bilateral health programs, including PEPFAR and the President's Malaria Initiative (PMI) and decreased funding to the Global Fund from the U.S and other major donors. Indeed the U.S. contribution to the Global Fund from the Seventh Replenishment is at risk of not being converted which is creating **extraordinary risks for the Global Fund portfolio.**

In April, the Global Fund advised countries to immediately pause implementation of non-critical activities, and in May the Secretariat announced additional measures to deallocate unabsorbed funding from grants and conduct a holistic reprogramming exercise in countries, in order to ensure that the highest priority activities remain funded[10]. Looking ahead, the Eight Replenishment (R8) will take place in 2025 during an extraordinarily **challenging resource mobilization landscape**, with early signals from donors suggesting a high risk of a weak replenishment.

Against this funding landscape, difficult decisions will need to be taken about what activities remain funded by Global Fund grants, which activities are integrated into domestic healthcare systems, and which activities are defunded. There is a high risk that community-focused programs become **vulnerable to being deprioritized** in favor of medical commodities and clinical services. Without community input, governments may also seek to find "efficiencies" by prioritizing government-led services in public health clinics over community-led delivery systems. If community programs, such as KVP-focused drop-in centers (DICs), are integrated into public hospitals and clinics, there is a **risk that these community-led partners lose funding and KVPs lose services**. This is a particular risk in contexts where KVP are criminalized or highly stigmatized, and KVP drop-in centers are the primary or sole source of care for these life-saving services.

In this context it is vital that **evidence on the multiple benefits of community-led programming be brought to the country reprioritization discussions**. Since grant activities and implementation arrangements are decided by the Country Coordinating Mechanisms (CCMs), this will require significant advocacy from community leaders on and off the Country Coordinating Mechanisms (CCMs) to protect community programs. The below results and insights from the SCOPE study can be a key source of information to support CCM members and advocates during upcoming grant reprioritization discussions and overall engagement with Funding Request development and grantmaking.

[10] The Global Fund. Grant Adaptation Measures for Grant Cycle 7. 16 May 2025.

In Belarus, CCM representatives, including those from government, NGOs, UN agencies, and academia, participated in an orientation on the principles and goals of the Global Fund, its new strategy for 2023–2028, and the CCM's role in its implementation. Photo credit: UNDP.

Defining Community-led Organizations

Promoting community-led implementation of Global Fund grants first **requires a shared definition of a CLO**. The Global Fund tracks four categories of PR organizations: government, multilateral organizations, private sector, and civil society organizations. However, the Global Fund does not categorize or track implementers by whether or not they are community-led.

As a first step, the SCOPE study established a **community-developed definition of a CLO** through a series of community consultations with participants from countries with at least one civil society PR in GC5, 6, and/or 7. The resulting definition defines the minimum criteria that CLOs must meet, relating to organizational mission and strategy; registration and legal criteria; leadership, management, and staffing; and board oversight (Annex 1).

A community-developed definition of a Community-Led Organization (CLO)

According to SCOPE participants, CLOs must be an organization **rooted in the lived experiences of the community** they serve and must deeply understand people living with and affected by the three diseases, in all their diversity. This must involve building a mission, vision, and organizational strategy in partnership with the community. CLOs bring communities together to understand and advocate for their needs, with the objective of helping people live full and healthy lives. When delivering services, CLOs must be responsive to, and informed by, the unique needs of the community, which typically includes addressing these needs, advocating for rights to decision-makers, and creating lasting social change. Additionally, CLOs must have a **local physical presence** that is felt within the community they serve.

In order to be considered a CLO, an organization does not necessarily require formal legal registration, and indeed in some contexts there are significant barriers to registration. However, for those that are legally registered, CLOs **must be registered as non-profit organizations** and must be registered in the countries where they are delivering services. Regardless of legal status, all CLOs must be **physically based within the community** and wherever possible should explicitly state in their name, charter, or legal documents that they serve the community.

In general, CLOs must be staffed such that **community members hold 80% of leadership roles**, and otherwise hold significant, primary decision-making power across the organization. This should include having community members in the roles of Executive Director and senior leadership, and for the organization to be governed by a board where 75% of the members are from the community. At least 50% of staff must come directly from the communities the organization serves, and it is essential that **the roles held by communities are staff positions**, rather than temporary, consultant, or volunteer appointments. In the case of membership organizations, typically at least 70-75% of members must be from the community.

Specific to malaria and tuberculosis, participants in consultations noted the **broader susceptibility of the entire population** to both infections and described the communities representing the two diseases as being less established and formalized. Where community leadership is less feasible, community-focused programs may be implemented by nongovernmental organizations that represent people affected by TB and malaria, with shared values and goals, and who have deep experience working in the community delivering services.

In contexts with weak or informal community systems, participants highlighted the need to actively take steps to transition implementation to community-led organizations. This must involve both support for community systems strengthening as well as capacity building to **prepare organizations to serve as SRs** and SSRs. This support must be targeted and time-bound, rather than long-term general support. For sustainability, support must be focused on strengthening community organizations and institutions, not only individuals, with the ultimate goal of fully transitioning programs to CLOs in the short to medium term.

A mother and baby visit the Sitio Pinagar, Barangay Ransang halfway house in Rizal, Palawan, Philippines to receive routine health services. The halfway house is a rural outpost that is named because it is located halfway between mountainous regions inhabited by Indigenous tribes and the closest medical clinic. Members of surrounding Indigenous communities travel for hours on foot through dense, mountainous jungle to receive healthcare – including malaria tests, vaccinations, nutritional support, pre- and postnatal care.. Photo credit: Vincent Becker / Global Fund.

Considerations for Key and Vulnerable Population-Led Organizations

Several additional considerations for key and vulnerable population (KVP)-led organizations were flagged during the SCOPE consultations. In addition to general criteria for community leadership, KVP organizations must serve the specific interests and needs of populations disproportionately affected by the three diseases. Defining KVP-led organizations is additionally important in the context of the CCMs, which are required under Global Fund policies to engage with and include representation of KVPs.

In every Global Fund-supported country, at least one KVP is criminalized. In situations of legal repression, the leadership of KPs in community-led organizations may **jeopardize the right to privacy and non-disclosure of diagnosis**, especially for people living with HIV or people from the LGBTIQ+ community. In such cases, implementation of KVP-focused programs by KVP-led organizations may need additional precautions and considerations. In criminalized contexts, organizations are at times not able to obtain legal registration documents from the government, challenging the ability for community organizations and associations to receive funding for their work.

Which programs must be implemented by CLOs?

Through a series of SCOPE study consultations, community partners in five Global Fund regions were asked to define **which Global Fund activities must be implemented by CLOs**. This list is meant to serve as a roadmap during Funding Request development, grant-making, and grant reprioritization exercises to define which activities in the Modular Framework should not be implemented by government, private sector, or other civil society organizations that are not led by communities (Annex 2).

HIV programs that must be implemented by CLOs

Consultations found that in general, all services that are community-based, community-integrated and/or peer-led must be implemented by community-led organizations. Differentiated, community-based HIV **testing, counseling, and awareness** campaigns must be led by CLOs; similarly, key populations-led organizations must lead all KVP-focused HIV testing. All community-based differentiated service delivery must be led by community-led organizations, including **last mile programs**, community-based early screening for opportunistic infections, and community-based case management and treatment.

Differentiated **adherence and treatment support**, including community support groups, peer-support, psychosocial and mental health counseling, and treatment literacy, must be led by community-led organizations. All community-based TB and HIV care, including contact tracing and referrals, must be implemented by community-led organizations.

As a community health worker and an HIV peer educator in Dodoma, Tanzania, Neema Waziri (left) knows how early pregnancies and HIV infections have derailed the dreams of many girls and young women in her community. To support her peers overcome this challenge, Neema leads a community initiative to empower girls. She has lit a fuse in her community, galvanizing young women to gain the knowledge, the passion and the agency they need to shape their destiny.. Photo credit: Global Fund.

Prevention and harm reductions activities focused on communities and key populations were highlighted as high priority for community implementation. Community-led organizations must lead the delivery of peer-to-peer and social enabler services, including peer navigation and peer support with treatment adherence. Adolescent and youth-focused activities must similarly be implemented by community organizations.

Community-led advocacy work around reducing stigma and discrimination, decriminalization, human rights, and policy change must be led by community-led organizations. This is due to community-led organizations' lived experiences, trust within communities, and sensitivity to and understanding of community needs. Community-led organizations must implement rights education programs and the development of redress mechanisms focused on rights violations, as well as programming for **rights-based policing, access to justice**, changing legal frameworks, and legal support.

The funding of community-led organizations for community empowerment activities was also described as a strategy for ensuring the engagement and participation of civil society and KPs in **technical working groups and other decision-making bodies**. Some participants suggested that CLOs should be part of providing public sector health services that cover not only their communities but also include the general population and vulnerable groups. Demand creation and social protection interventions should be co-led by community-led organizations.

Tuberculosis programs that must be implemented by CLOs

All **community-based TB and DR-TB care** must be implemented by community-led organizations. This includes community-led monitoring of services, community-led screening and active case-finding, peer counseling, training and capacity building of community care providers and advocates, directly-observed therapy (DOT), specimen transport, and implementation of community-led interventions.

Additionally, all TB programs focused on people in prisons, jails, and detention centers, mobile populations, migrants, refugees, and other key and vulnerable populations must be implemented by organizations led by these same key and vulnerable populations.

Yulia Malik, 29, an advocate with 100% Life for HIV and TB awareness, walks through destroyed downtown buildings between assignments canvassing for high risk TB cases in Kharkiv, Ukraine, on August 18, 2022. The organization works with over 170,000 people that are HIV-positive or suffering from tuberculosis. According to government sources, 1.4% of Ukrainian citizens have tuberculosis. The number is expected to rise since the the full scale war broke out in February. Major concerns in Ukraine include widespread multi-drug resistant (MDR) tuberculosis (TB), relatively high mortality from untreated or inappropriately treated TB, and increasing TB/HIV co-infection rates.. Photo credit: Ashley Gilbertson / Global Fund.

As with HIV programming, all community-led advocacy work around reducing stigma and discrimination, decriminalization, human rights, and policy change must be led by community-led organizations. Similarly, community-led organizations must also implement **rights education and redress programs**, rights-based policing, access to justice, and legal support.

Malaria programs that must be implemented by CLOs

All **community-based case management**, mobilization, and messaging must be implemented by community-led organizations. This includes community-based integrated community case management (iCCM) and social and behavior change (SBC). Additionally, all community-based **distribution of insecticide-treated nets** (ITNs) must be implemented by CLOs.

RSSH programs that must be implemented by CLOs

All **community systems strengthening** (CSS) activities must be implemented by community-led organizations. Community-led organizations must implement programs focused on community-based referral, health promotion and campaigns, linkage to treatment for care and treatment, and post-diagnostic follow-up. Organizational capacity building and social contracting are vital for community-led organizations.

Community-led monitoring, including the monitoring of domestic resource mobilization, must always be led by community-led organizations. Community-led organizations must lead or co-lead participatory **implementation science research**, including on drug resistance, treatment literacy, and advanced HIV disease. In parallel, respondents highlighted a need to strengthen the leadership of communities in this area. Key populations-focused research, such as the Stigma Index, must be led or co-led by KVP-led and PLHIV-led organizations. Program oversight, review, and other quality improvement activities outside of CLM must be co-led by community-led organizations.

Community health worker Marc Ilboudo uses a mobile application during a consultation with a child in Pousghin, Burkina Faso. Photo credit: Olympia de Maismont / Global Fund.

The training of **community health workers** (CHWs) must be implemented by community-led organizations. Respondents described a key role for community-led organizations in the community health workforce, given that CHWs increase community capacity for self-protection and self-care, and given their knowledge of the community needs, barriers, and priorities. Community-led organizations should lead **sensitization activities and trainings** for professionals and officials engaged with key and marginalized populations.

Prevention program stewardship programs must be co-implemented by community-led organizations. These activities were described as a key strategy for ensuring the leadership of key populations and communities in technical working groups and prevention program oversight. This should include engagement in capacity development, last mile systems for prevention, and national and subnational coordination and review mechanisms. Similarly, community organizations must be part of the

implementation of **health sector planning** and governance activities, including the integration/coordination across disease programs and at the service delivery level.

How to use this list of activities

The Global Fund is implemented as a partnership of governments, bilateral funders, technical agencies, academic partners, community-led organizations, and other sectors. Ensuring that services are tailored to the needs of communities does not require that CLOs implement every activity in the grants. Instead, Global Fund stakeholders must develop a nuanced understanding of which partners are best positioned to implement each component of the care continuum. Given the important role of the public healthcare system and the need for governments to coordinate national efforts, some activities are best led by government partners. For example, in many contexts governments are best suited to implement aspects of human resources for health, supply chain, and laboratory infrastructure. Others, by contrast, must be implemented by communities themselves to be effective.

This list is therefore a tool for mapping Global Fund implementers to grant activities. Particularly during the Funding Request and grant planning phases, this list may help to clearly articulate which activities in the Modular Framework must, wherever possible, be led by communities.

What proportion of Global Fund programs are community-led?

Community-led organizations as Principal Recipients

In Grant Cycles 5, 6, and 7 (2017-2025), the Global Fund reported supporting 271 unique PRs, according to its Data Service[11]. The majority (46%) of PRs were classified as government entities, including Ministries of Health and Ministries of Finance, and another **38% were classified as civil society organizations** (Fig. 1). Among civil society PRs, **45 (44%) were categorized as locally-based**, which were further disaggregated into 40 non-governmental organizations, four local faith-based organizations, and one community-based organization. However, the Global Fund's categorization system does not categorize whether organizations are community-led - an important distinction for the community and a key question of the SCOPE study.

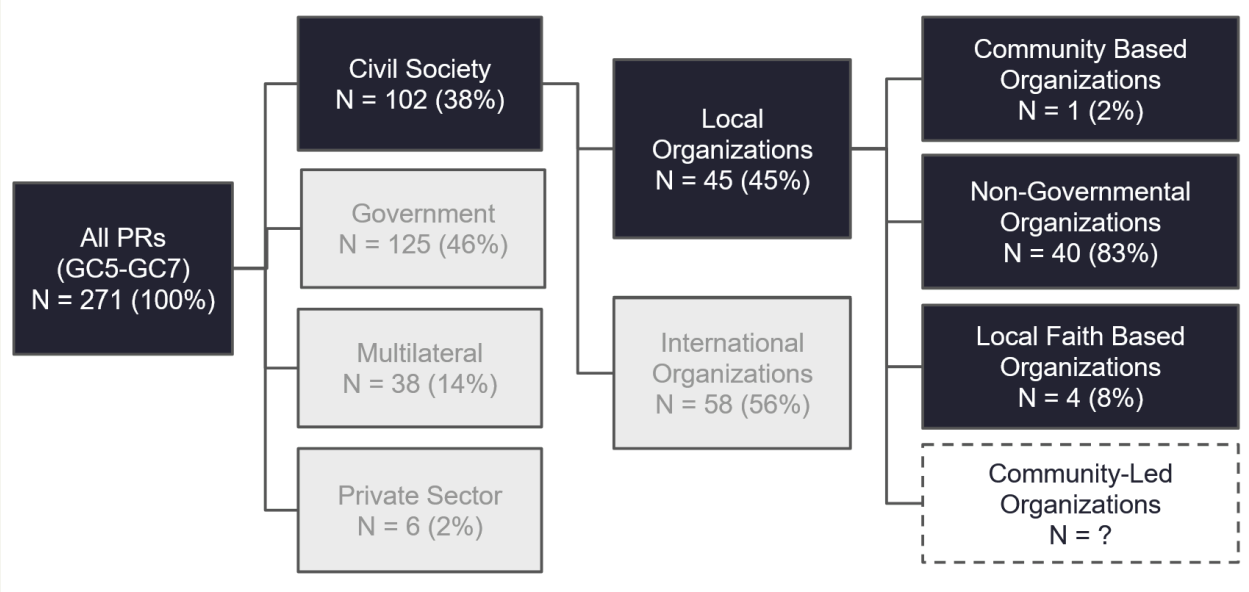
[11] Data extracted from the Global Fund's Data Service on 13 June 2025.

Resty Nakate, a Warehouse Officer at the National Medical Stores (NMS), scans medical kits at the warehouse in Entebbe, Uganda. Photo credit: Brian Otieno / Global Fund.

Over time, the number of Global Fund PRs has decreased, from 231 in GC5 to 185 in GC7. However, according to this classification, the proportion of all PRs classified as civil society organizations was stable, fluctuating between 36% and 38%[12]. While more than one-third of PRs were categorized as civil society organizations, the proportion of Global Fund budgets allocated to civil society PRs ranged from 27-29%.

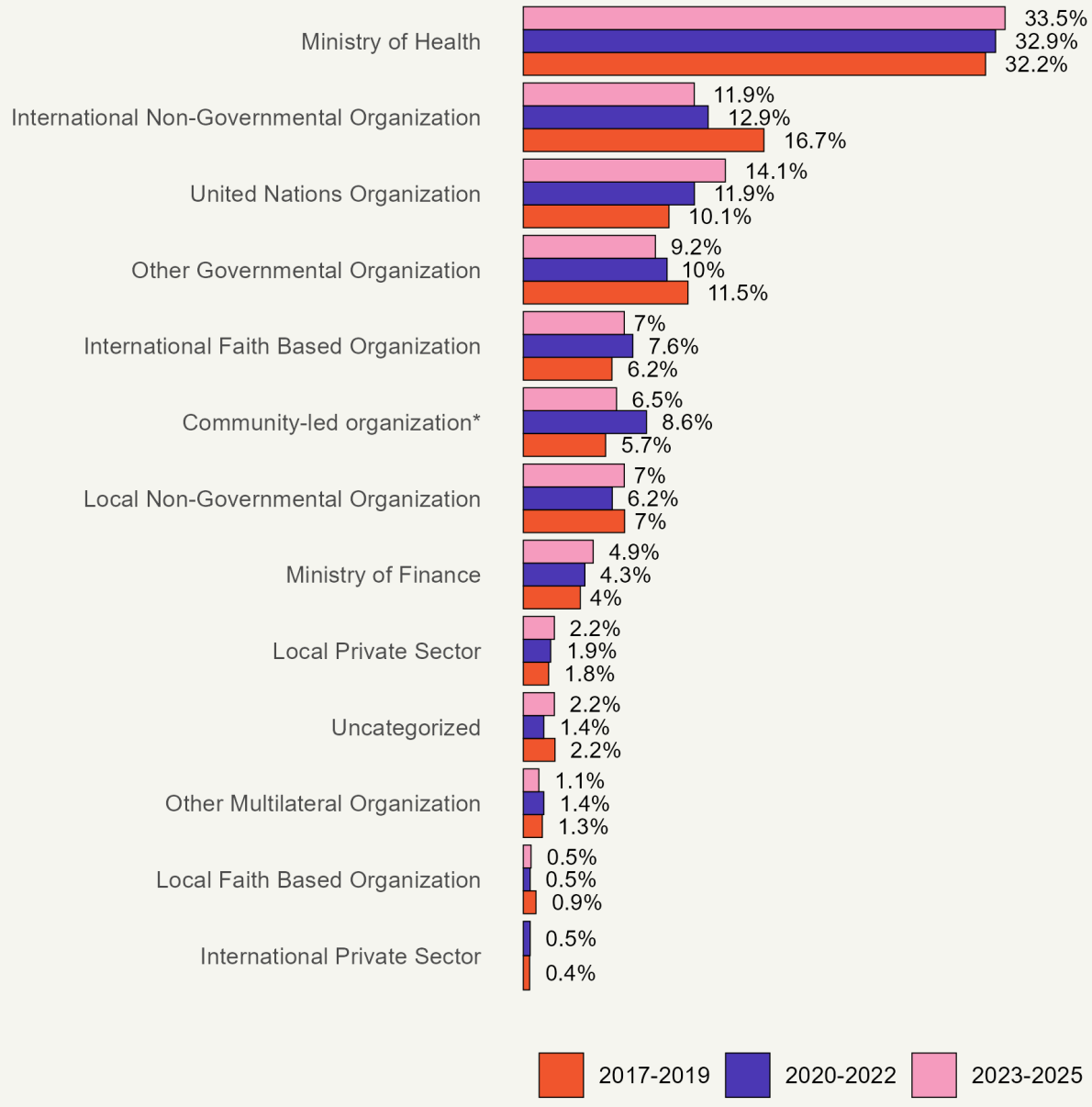
Figure 1. Global Fund categorization of Principal Recipient types, GC5-GC7.

[12] The Global Fund. The Global Fund's Funding for Community and Civil Society Organizations. 19 Jul 2024.



Using the SCOPE definition of a community-led organization and survey data of community partners, civil society PRs were further disaggregated into community-led organizations and non-community-led organizations. These data find that **community-led organizations made up 6% to 9% of all PRs** from GC5 to GC7 (Fig. 2A). These **CLO PRs received 6-8% of all Global Fund grant budgets** across this period, excluding multi-country grants (Fig. 2B).

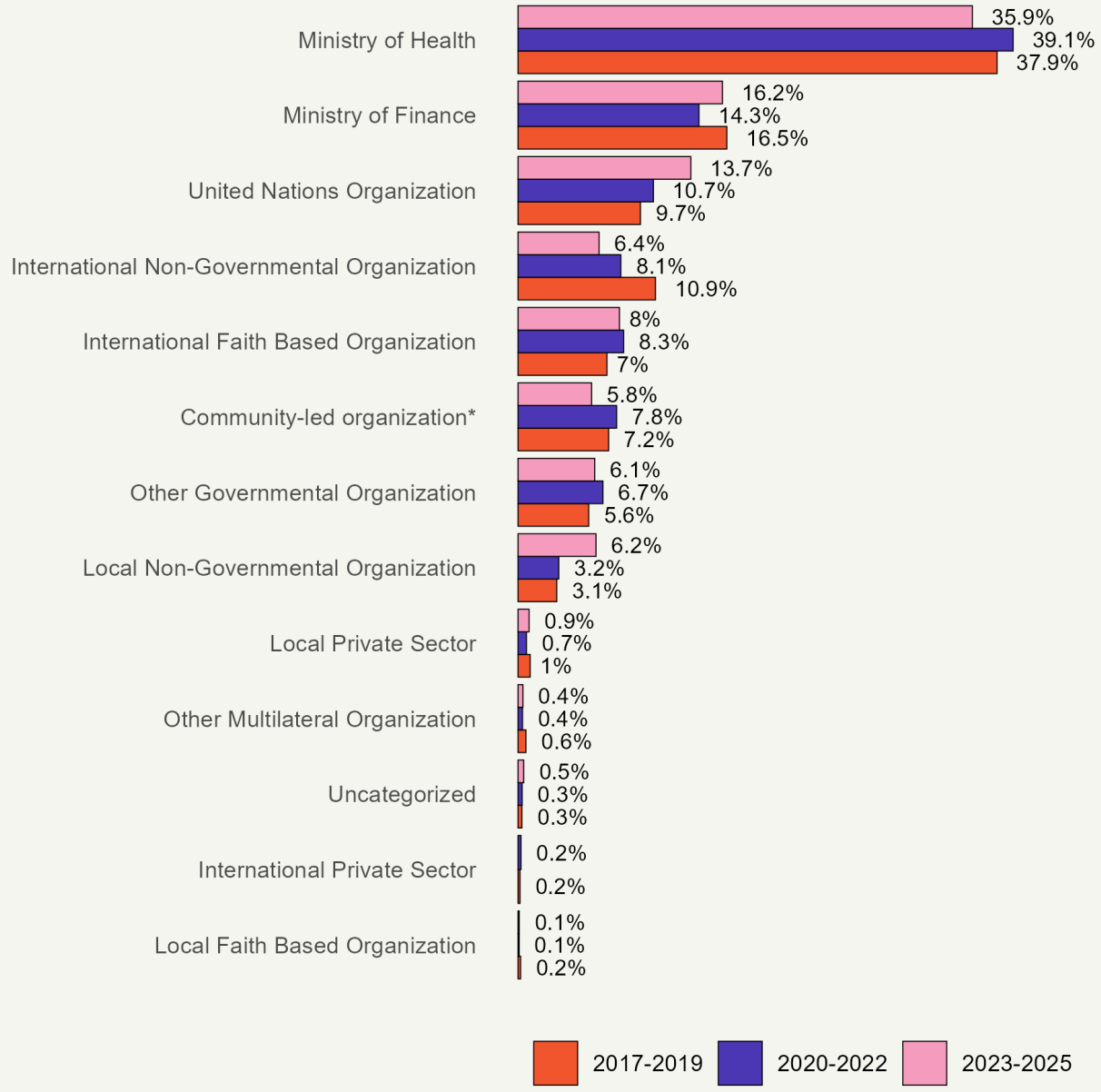
Figure 2A. Number of unique PRs in each Global Fund category, as percent of all PRs, GC5 - GC7[13]. The community-led organization category is from SCOPE data, while all others are based on Global Fund's own classification.



* Per SCOPE data.

[13] Note: multi-country grants are excluded.

Figure 2B. Proportion of Global Fund budget implemented by Global Fund PR category, GC5 - GC7[14]. Community-led organization category is from SCOPE data, while all others are from Global Fund.



* Per SCOPE data.

These findings suggest that civil society organizations are a core part of the Global Fund's service delivery model, responsible for implementing more than one-quarter of all grants. This analysis finds that at the PR level the proportion of funding held by community-led organizations is **below the global target** for at least 30% of all service delivery being led by communities by 2030[15]. However, this analysis does not

[14] Note: multi-country grants are excluded.
[15] United Nations. Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030. New York, New York: United Nations. June 2016.

quantitatively assess the proportion of funding held by SR and SSR community-led organizations, which may be significantly higher. The SCOPE study does provide some qualitative insights into CLO service delivery in three countries in the next section.

Community-led organizations as Sub-Recipients

Global Fund PRs implement their programs by subcontracting to SRs, who may then in turn sub-contract to SSRs. The Global Fund does not publicly release data on SRs and SSRs. However, these organizations play an essential role for the Global Fund, since they are generally the organizations that implement HIV, tuberculosis, and malaria programs at the facility and community level.

The SCOPE study collected data from three countries to examine the proportion, types, and benefits of community-led programming by Global Fund SRs. While the findings from these case studies may not be representative of the full Global fund profile, they provide valuable insights into community programming below the PR level.

Case study 1

In this country, there are **two PRs** implementing Global Fund's HIV grants: the first Principal Recipient (PR1) is the government implementer and the second (PR2) is a community-led organization, as defined by the SCOPE methodology.

In Grant Cycle 7, the two HIV PRs delivered several categories of community-focused activities. At the PR level, the **community-led PR (PR2) was the lead implementer** on prevention communication and demand creation for KPs, removing human rights barriers, social protection, community empowerment, legal support, and community systems strengthening including capacity building, community-led monitoring, and community-led research. By contrast, the **government PR (PR1) was the lead implementer** on all testing programs, prevention programs for adolescent girls and young women (AGYW), eliminating stigma and discrimination, improving the legal environment, and PrEP for all populations.

Both PRs reported sub-contracting to sub-recipient organizations. The government PR1 reported that all of its community-focused programs were **sub-contracted to government agencies** and departments. While PR1 did not sub-contract to any nongovernmental organizations, including community-led organizations, it reported consulting them in program planning. As such, 100% of community-focused programs implemented under the government grant were implemented by government agencies.

The community-led PR2 subcontracted to several sub-recipient organizations. All of its SRs were described as being civil society organizations with deep roots in the communities they serve. Nearly **20% of the SRs were CLOs**, according to the SCOPE criteria for community ownership, leadership, staffing, and governance.

An analysis of budgeted activities finds that **CLOs were responsible for implementing 60%** of all community-focused activities budgeted in the PR2 grant. Specifically:

- All community-focused activities for men who have sex with men, people who use drugs, sex workers, and transgender people were implemented by CLO SRs. By contrast, no community-focused activities for prisoners were implemented by CLOs
- CLOs were less likely to be engaged in AGYW-focused programming
- Nearly one-fifth of community systems strengthening activities were implemented by CLOs, with CLOs less involved in improving laws, regulations and policies relating to HIV and HIV/TB, community-led monitoring, community-led research and advocacy, prevention program stewardship, and social and behavior change (SBC).
- Community-focused TB/HIV activities were not implemented by CLOs, with the exception of TB/HIV services for key populations.

Respondents described several challenges with community-led implementation of Global Fund activities. Community-led organizations highlighted the **very bureaucratic process** of becoming a Global Fund SR or SSR, which was described as burdensome for small organizations. Some noted a tendency for organizations to **claim to be community-led** as a strategy for fundraising, without genuinely representing community interests. Others noted a **lack of clear selection criteria** for selecting organizations as SRs, leading to the perception that only well-established CLOs with a long track record as an implementer were selected. Respondents recommended clear and transparent selection criteria, with open calls for SRs. Others noted the need for **capacity building** to strengthen organizations and prepare them to become SRs.

For community members not engaged as sub-recipients, the community-led SRs were described in positive terms; however, the implementation of community-focused activities was described as uncoordinated. Others noted a **lack of transparency** into Global Fund activities and the role of CLO implementers, highlighting insufficient community involvement in funding decisions. Respondents identified the need for dedicated web platforms to inform the public about Global Fund activities and partners.

Organizations currently acting as SRs described the importance of their work, including their ability as a CLO to foster local ownership, achieve performance targets, build on their strong partnerships with community leaders, strengthen community engagement and collaboration with government, and deliver impactful peer-led service delivery approaches. However, SRs described small budgets and a **lack of funding for overhead** costs and human resources in Global Fund grants, which has restricted organizational growth and forced organizations to seek external funding, a process that has become increasingly difficult over time.

Case study 2

In this country, there is one government Principal Recipient (PR1) and **one non-community-led, civil society Principal Recipient** (PR2) implementing Global Fund's HIV and TB programs, as defined by SCOPE.

In Grant Cycle 7, the government PR1 was primarily responsible for human resources for health and laboratory systems. By contrast, PR2 was responsible for **all client-facing service delivery** for both HIV and TB, including diagnostics, prevention, human rights programs, treatment, and integrated TB/HIV programs. This included **all of the community-focused activities**, including key population prevention programs, community-based service delivery, and reducing human rights barriers to care. While PR1 was not directly involved in implementing these programs, it maintained a **coordinating role** in Global Fund programs and was responsible for maintaining the clinic infrastructure in public health facilities.

At the sub-recipient level, the government PR did not sub-contract any activities to non-governmental partners. The civil society PR2 sub-contracted to more than one dozen sub-recipient organizations, including international nongovernmental organizations (NGOs) and faith-based organizations (FBOs), local NGOs, and one CLO. This one CLO sub-recipient in turn sub-contracted to more than two dozen other CLO SSRs, serving as the **single pathway for CLOs to be contracted** as program implementers. These SSRs were all described as being locally-based, community-led, and with organizational missions focused on human rights, LGBTQI+ rights, discrimination and stigmatization, people living with HIV, youth, women and girls, and key populations.

With the exception of services for people in prisons, every community-focused activity in this country's HIV and TB grant was at least partially implemented by one or more CLO SSRs. According to SCOPE data, programs focused on AGYW, PrEP, transgender people, condoms and lubricants, and other vulnerable populations had **fewer sub-recipient CLOs engaged** in implementation, while larger numbers of CLOs were sub-contracted to deliver programs serving men who have sex with men (MSM), sex workers, and focused on prevention communication, sexual and reproductive health, and reducing stigma and discrimination. Nearly three dozen CLOs were sub-contracted to deliver programs funded by the **COVID-19 Response Mechanism** (C19RM).

The Global Fund SSRs described their role primarily as being a **resource for people not served by the public healthcare system**. By delivering community-based and community-focused services, these organizations described being able to reach people who are in geographically remote areas, increasing uptake of life-saving medicines and services by distributing them in accessible and convenient locations. These organizations reported acting as a trusted resource within the community, using this close relationship to effectively deliver prevention and psychosocial support services. The participatory approach used by CLOs to design and deliver services was described as a strategy for building trust, reducing stigma, and increasing uptake of care.

However, serving as a Global Fund SSR was described as a challenge for CLOs. One major difficulty was a **lack of consistent organizational funding**, either due to the lack of a regular, annual budget, or due to long delays in the disbursement of funds and reimbursement for work. Organizations often faced difficulties paying peer educators for their work, either due to funding delays or because Global Fund budgets were too small to cover costs. In some cases, the SSR's rights, expectations, and duties were not clearly defined or well-understood. For organizations delivering services outside of urban centers, an additional challenge was stock-outs or shortages of products and materials, as well as difficulties safely accessing remote areas.

Case study 3

This country has four PRs: **one government PR and three civil society PRs**. In Grant Cycle 7, the civil society PRs led the implementation of prevention programming focused on communication and PrEP (for MSM, sex workers, and transgender people) and removing social barriers; social protection and community empowerment; community-led research and advocacy; and mass drug administration. The **government PR led facility-based** HIV and tuberculosis testing and treatment; prevention programming focused on condoms, lubricants, PrEP (for AGYW and their partners), and harm reduction programs; all human resources for health; all laboratory systems and health products; monitoring and evaluation; and indoor residual spraying.

The **government does not sub-contract** to any community-led organizations. At the sub-recipient level, CLOs are responsible for the implementation of all HIV and tuberculosis programs under the civil society PRs. **No malaria activities were implemented by CLO** SRs or SSRs.

When describing their roles as SRs and SSRs, CLOs described the strengths of their positioning, including their **deep connection to the community** and its needs. This connection and trust is achieved by hiring community members as volunteers and conducting regular community dialogues, which allows them to facilitate **stronger referrals and linkages** between key and vulnerable populations and health services. These close relationships have allowed the CLO implementers to **elevate community concerns** and needs, making them more visible to the health system and stakeholders.

Other, non-CLO Global Fund implementers described the **value of partnering with CLO** implementers, describing them as playing a crucial role in improving service quality, particularly in enhancing access to services for people living with HIV and key populations. CLOs are described as providing insights into how to improve service delivery, **advocating for people's rights**, and being well-positioned to address local needs.

Several challenges with community-led implementation were described. Financial constraints were a significant obstacle, with Global Fund budgets primarily allocated for salaries, **leaving little for**

administrative costs and organizational capacity building. CLO implementers expressed difficulty in reaching more people with services due to these limitations.

Respondents noted the stringent conditions imposed by Global Fund on potential implementers, which act as significant barriers. Specifically, organizations described Global Fund as imposing a prerequisite requirement that all potential SRs and SSRs have **experience managing large sums of money**, acting as an impossible barrier for small organizations. Another barrier for community organizations is the **requirement to be legally registered** and to submit documentation they do not have. In order to be funded for their work, many **CLOs join coalitions that do not benefit them**, where funding amounts are very small. Others noted a lack of capacity and mature governance among some small CLOs.

Respondents noted that the challenges to being eligible for funding means that **international nongovernmental organizations are often funded** for community-focused projects, sidelining experienced CLOs that are considered better positioned to implement these programs. With most funding going to international organizations, the competition to become an SR or SSR becomes very difficult for local organizations. Some noted the need for stronger advocacy at the CCM for local community organizations to receive Global Fund support and called for **greater transparency around the selection process**. They noted that the same organizations receive funding year after year, calling for a change in this practice.

These case studies reveal several characteristics of SR- and SSR-level contracting to CLOs. First, the case studies revealed a perception of CLOs as **trusted implementers**, who are able to leverage their strong connection to communities in order to deliver services for people that are not well-served by public facilities. CLOs were described as being more responsive to the needs of key and vulnerable populations, by virtue of their regular engagement and consultations with communities.

Secondly, the only time that CLOs were contracted to implement programs is **under a civil society PR** or SR. In these three case studies, all funding to government PRs remained within government agencies and implementers and was never sub-contracted to civil society. Within community-focused programs, government implementers were more likely to implement PrEP programs, AGYW-focused activities, and activities for people in prisons, whereas CLOs were more likely to be responsible for other prevention activities and KP-focused programs. In this set of case studies, implementation of TB and malaria programs tended to be implemented by international NGOs and government implementers, with more CLOs responsible for HIV. Notably, **C19RM** emerged as a key source of funding for CLO implementers.

The process of becoming an SR or SSR was described as challenging, with **difficult eligibility criteria** that tended to displace CLOs in favor of larger NGOs. CLOs faced significant bureaucracy and described requirements to become legally registered and demonstrate proof of experience receiving large grants. Community respondents described a need for **greater transparency** in the SR and SSR selection process. Once selected, CLOs described receiving small budgets, with insufficient funding for overhead costs or salaries for community staff.

Recommendations

In this challenging environment, the role of the Global Fund in safeguarding community programs is urgent and critical. According to data from Aidsfonds, from 2019-2023 the Global Fund contributed 40.1% of funding for HIV programs for KVP in low and middle income countries[16]. With KVP-focused programs supported by PEPFAR now under threat, which previously contributed 40.5%, Global Fund may prove the **last standing major funder of community programs**.

Domestic resources have the potential to continue supporting community programs, and from 2019-2023 public sources were responsible for 14.2% of KVP programs for HIV. However, in many countries there are political barriers to funding community programs, a lack of an enabling environment for civil society, as well as **legal barriers to social contracting**. The Global Fund has a duty to proactively ensure that the progress it has made is not lost to competing donor priorities and rapid transitions of programming to government implementation.

Equally as important to protecting budgeting for community programs is to ensure that community-led organizations retain and expand their key role in Global Fund program implementation. This must include erecting **protective measures against the deprioritization** of community-led programs.

To this end, the SCOPE study recommends:

For the Global Fund Secretariat and CCMs:

1. **Recommendation 1: Proactively monitor implementation arrangements for community-focused activities.** Ensuring that community-focused activities are implemented by local, trusted partners is key. The Global Fund should incorporate the list of SCOPE-identified activities that must be implemented by CLOs (Annex 2) into the process of Funding Request development and Grant Making. Proposals for government or international organizations to implement these community-focused activities should trigger additional review from the Technical Review Panel, Grant Approvals Committee, and Country Teams.
2. **Recommendation 2: Develop pathways for direct funding to CLOs.** The findings from the SCOPE study highlight the challenges for local, community-led organizations to become eligible to serve as a Global Fund implementer. Additionally, SCOPE case studies suggest that government PRs are considerably less likely to sub-contract to CLOs. While capacity building to prepare organizations to take on this role is key, not all partners can or should need to meet standard administrative and financial criteria to become a PR, SR, or SSR. Creating new pathways to fund CLOs, without requiring formal accreditation and without needing to pass through the standard PR to SR route, will mitigate barriers and strengthen community implementation and leadership.

[16] Aidsfonds. Dangerously Off Track: How Funding for the HIV Response is Leaving Key Populations Behind. 27 Jan 2025.

3. **Recommendation 3: Prioritize the continued funding of community-focused programs.** In an extremely resource constrained environment, critical decisions will need to be taken by the Secretariat and CCMs to ensure the continuity of life-saving services. Ensuring that community-focused and community-led programs are prioritized will require clear and visible guidance highlighting the importance of these programs as a core pillar of life-saving care. Resources must be allocated equitably in order to prioritize treatment continuity, prevention, and access to essential health services for all people.
4. **Recommendation 4: Implement granular tracking of implementing partner categorization.** The categorization of Global Fund PRs is a valuable tool for understanding grant implementation arrangements. However, the 'civil society' category is too broad and encompasses a wide range of organizational types. Additionally, it is not granular enough to measure which partners are community-led. The Global Fund should update its PR categorization schema to include a category for "community-led organization."

Acknowledgements

Thank you to the SCOPE advisory group who donated their time and expertise to define the study's objectives, methodology, analyze the findings, and review the recommendations. Thank you to everyone who completed the survey and participated in the consultations, including the facilitators and translators who contributed to the consultations. Thank you to amfAR The Foundation for AIDS Research for funding this study.

Annex 1: Definition of community-led organizations

Organizational mission and strategy

A community-led organization must:

1. Be rooted in the lived experiences of the community it serves and must deeply understand people living with and affected by the three diseases, in all their diversity,
2. Deliver services that are responsive to, and informed by, the unique needs of the community, and that address their needs, advocate for their rights, and create lasting social change,
3. Have a local presence that is felt in the community,
4. Build its mission, vision, and strategy with the community.

Registration and legal

A community-led organization must:

5. If it is legally registered, it must be registered as a non-profit organization, in the country where it is providing services; however, community-led organizations do not necessarily have formal legal registration,
6. Be physically based within the community,
7. Explicitly state in its name, charter, or operating and legal documents that it serves the community, where possible.

Leadership, management, and staffing

A community-led organization must:

8. Be staffed with community members in typically 80% of leadership roles, with significant, primary decision-making power across the organization,
9. Have community members in the roles of Executive Director and senior leadership,
10. In general, have at least 50% of staff directly from the communities it serves, in staff roles other than consultants,
11. In the case of membership organizations, typically at least 70-75% of members must be from the community.

Board oversight

A community-led organization must:

12. Be governed by a board where 75% of the members are from the community

Annex 2: Activities that must be implemented by community-led organizations

HIV-focused programs

Module	Intervention
Differentiated HIV Testing Services	Key populations-focused HIV testing activities
	Community-based testing
Elimination of vertical transmission of HIV, syphilis and hepatitis B	Retention support for pregnant and breastfeeding women (community-based)
HIV Prevention packages	Community empowerment
	Comprehensive sexuality education
	Condom and lubricant programing
	HIV prevention communication, information and demand creation
	Pre-exposure prophylaxis (PrEP) programing
	Removing human rights-related barriers to prevention
	Sexual and reproductive health services, including STIs, hepatitis, post-violence care
	Social protection interventions
Reducing human rights-related barriers to HIV/TB services	Community mobilization and advocacy for human rights
	Ensuring rights-based law enforcement practices
	Improving laws, regulations and policies relating to HIV and HIV/TB
	Increasing access to justice
	Legal literacy (“Know Your Rights”)

	Reducing HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity
TB/HIV	Community-based TB/DR-TB care
	TB/HIV - Community care delivery
	TB/HIV - Key populations
Treatment, care and support	Differentiated service delivery based in the community

Tuberculosis-focused programs

Module	Intervention
Collaboration with Other Providers and Sectors	Community-based TB/DR TB care
Key and Vulnerable Populations (KVP) – TB/DR-TB	KVP - Children and adolescents
	KVP - People in prisons/jails/detention centers
	KVP - Mobile population (migrants/refugees/IDPs)
	KVP - Miners and mining communities
	KVP - Urban poor/slum dwellers
	KVP - Others
Removing Human Rights and Gender-related Barriers to TB Services	Eliminating TB-related stigma and discrimination
	Ensuring people-centered and rights-based TB services at health facilities
	Ensuring people-centered and rights-based law enforcement practices
	Legal literacy (“Know-Your Rights”)
	Increasing access to justice
	Monitoring and reforming policies, regulations and laws
	Addressing needs of people in prisons and other closed settings

	Reducing TB-related gender discrimination, harmful gender norms and violence
	Community mobilization and advocacy, including support to TB survivor-led groups

Malaria-focused programs

Module	Intervention
Case management	Integrated community case management (iCCM)
	Social and behavior change (SBC)
Vector control	Insecticide treated nets (ITNs) - Continuous distribution: community-based

RSSH-focused programs

Module	Intervention
Community systems strengthening	Capacity building and leadership development
	Community engagement, linkages and coordination
	Community-led monitoring
	Community-led research and advocacy
Human resources for health (HRH) and quality of care	Quality improvement and capacity building for quality of care
	Community health workers: In-service training
Monitoring and evaluation systems	Analyses, evaluations, reviews and data use
	Operational Research
Prevention program stewardship	Capacity development including building individual skills, institutional and systems capacity such as defined functions, quality assured processes and standard operating procedures
	Community-based or community-led prevention models for outreach, social contracting and safety

	of programs with key populations and young women
	Last mile supply and distribution systems for prevention commodities
	Management, coordination and oversight of prevention programs, technical working groups, national and subnational coordination and review mechanism
Health financing systems	Community-led advocacy and monitoring of domestic resource mobilization
Health sector planning and governance for integrated people-centered services	Integration/coordination across disease programs and at the service delivery level