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A COMMUNITY GUIDE TO INTEGRATION IN THE GLOBAL FUND GRANT CYCLE 8 (GC8)

What to protect, push for, and how to engage?

By Asia-Pacific Regional Learning Hub (APRLH) hosted by Seven Alliance.

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WHY THIS MATTERS TO COMMUNITIES?

Integration is a strategic process that supports sustainability, efficiency, and responsiveness to people's needs. It replaces fragmented approaches with a unified model that maximizes impact and promotes equity and accountability.

Across many countries, funding for HIV, TB, and Malaria (HTM) is shrinking, while needs are growing. Integration is a major focus of Global Fund Grant Cycle 8 (GC8) to protect hard-won gains, build resilient health systems, and discontinue siloed, vertical programs that are no longer sustainable. **For communities, integration can be a powerful opportunity—but also a risk if it is done without safeguards.**

This guide was developed based on the Global Fund GC8 guidance on **'Enabling Impact: Advancing Integration'**, and two consultations with the global networks of key populations, TB and Malaria networks, regional learning hubs, and civil society organizations working across the three diseases. This guide helps community-led organizations, key and vulnerable population networks, civil society groups/organizations, and Country Coordinating Mechanisms (CCMs) understand what integration means in GC8 and how to engage, influence, and protect community priorities.

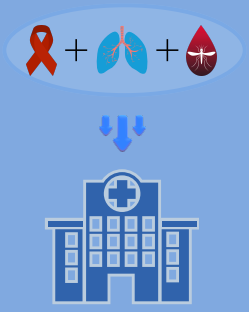
This guide is for you if you want to:

- Make sure integration improves services for communities;
- Ensure sustained funding for community-led responses and systems, particularly for key populations;
- Advocate effectively with CCMs, principal recipients (PRs), and governments.

WHAT DOES "INTEGRATION" MEAN IN GC8?

Integration is not just putting services in the same building. It is about changing how the health system works so it serves people better.

There are two main parts: "Part 1: Integration of service delivery" and "Part 2: Integration of health systems", which are explained in the table below:

	PART 1: INTEGRATION OF SERVICE DELIVERY	PART 2: INTEGRATION OF HEALTH SYSTEMS
GLOBAL FUND DEFINITION	Converging HIV, TB, and Malaria interventions into primary health care (PHC) and other health services for people-centered care.	Aligning and strengthening building blocks such as workforce, data, surveillance, supply chain, laboratories, community engagement, and financing – so they function cohesively across programs.
GOAL	People receive a continuum of healthcare services, coordinated across the different levels and sites of care within (*vertical integration*) and beyond the health sector (*horizontal integration*) - according to their need.	Build strong foundation for financing and sustainability of these services.
WHAT IS BEING INTEGRATED?	HIV, TB, and Malaria services into Primary Health Care (PHC) and other public health facilities.  (i.e., prevention, demand-creation, testing/diagnosis, treatment, follow-up, referrals)	Health system building blocks across diseases: Human resources for health (including community health workers such as, outreach workers, peer educators, peer paralegals, etc.) Laboratory Systems National health information and strategic data system (including surveillance, M&E, digital health)

		Procurement and supply chain systems Community systems Health financing systems
WHAT DOES IT MEAN ON THE GROUND?	• HIV, TB and malaria services are provided through existing PHCs and community platforms. • Community health workers (i.e., outreach/peer educators) delivering integrated (HTM) outreach, screening/testing, referrals, and follow-up. • Services work across the life-course (children, adolescents, adults, older people) • Care is linked with sexual and reproductive health, mental health, non-communicable diseases (NCDs), legal support, and social services when needed. • Integrated HTM recording and reporting tools for CHWs - linked to the national health information system. • Joint HTM planning, budgeting, supervision, M&E, and reporting. • Embedding human rights, gender, and community-led monitoring across programs • Community-led monitoring (CLM) covering HIV, TB, malaria and broader health system issues	• Common program management unit for all three diseases. • Trained clinical and other health workers on multiple disease prevention and treatment placed within PHCs. • Community health workers (i.e., outreach/peer educators) accredited and deployed through PHCs and other health facilities. • Unified laboratories for multi-disease testing and diagnosis. • Consolidation of all disease-specific health information system, ensuring interoperability of data. • Community systems integrated into national health system (rather than operating parallelly) through social contracting or performance-based financing to integrate community providers and peer-led services into PHC systems. This also means maintaining some specialized services to ensure quality and access, e.g., harm reduction services. • Multiple ministries working together to integrate HTM into domestic financing and universal health coverage (UHC).

FOCUSES ON	How and where services are delivered to people."Better experience for people"	How the health system is organized and financed."Strong foundation for services"
CORE QUESTION	Can a person get the care they need easily, and in one place without fearing stigma, arrest, or breach of confidentiality (disclosure)?	Do the systems behind services work together sustainably?

SIX CORE PRINCIPLES GUIDING INTEGRATION IN GC8

Financing for impact
Financing should support quality, efficient, and sustainable integration, guided by measurable outcomes.

Differentiated approaches
Approaches must be based on the local contexts, diseases burden, available resources and ensuring inclusive and people-centered care.

County Ownership
Integration should be country -led and alinged with national priorities.

Working in partnership
Strong partnership across sectors are essential to harmonize efforts beyond the Global Fund's scope.

Community engagement
Integration should be co-led with community and key population representatives at national and sub-national level as an iterative process.

Rights-based approach
A rights based approach must be underpin integration, promoting equity and accountability, appropriately scaled to balance short-term grant goals with long term systematic reforms.

HOW THE GLOBAL FUND GC8 GRANTS SUPPORT INTEGRATION EFFORTS?

In GC8, countries are encouraged to use Global Fund grants to accelerate integration, even with reduced funding.

Countries eligible for the Global Fund grants in GC8 have the opportunity to:

- Assess existing country efforts that enable integration and identify integration progress and gaps (i.e., "Integration Readiness") to inform the country dialogue and funding request. Countries can reach out to technical assistance providers, as well as regional learning hubs, to consider applying for technical assistance to conduct 'integration readiness assessment'.
- Consider the selection of principal recipient/s that advance integration priorities.
- Submit funding requests at the same time to support integrated planning. The GC8 could be an appropriate time to consider whether a single funding request for all eligible components will allow greater visibility on how RSSH investments meet country priorities.
- Use RSSH investments to strengthen PHC and community systems for **the gradual integration of services that offer grounds for learning and adapting.**
- Form a **national integration task force**, which includes government, partners, community and civil society, and private sector stakeholders, to oversee and guide the integration process. This can also have a subnational equivalent.
- Fund shared training, supervision, labs, supply chains, and data systems
- Use financing tools (like social contracting) to support community-led integrated services
- Adapt services for key and vulnerable populations to avoid the risk of reduced coverage or continuation of care. In some settings,some HIV or TB specialized services need to be maintained to ensure quality and access. e.g., harm reduction services.
- Align Global Fund investments with domestic financing and other donors investing in HTM in the country.

Importantly, in GC8, integration should be visible in grant design, budgets, and indicators, not just mentioned in the funding request narrative.

WHAT INTEGRATION SHOULD MEAN FOR COMMUNITIES?

Health service integration is increasingly promoted as a strategy to strengthen health systems and improve efficiency in delivering services for HIV, TB, malaria, and other health conditions. However, integration isn't about simply combining the three diseases' programs, but should represent a comprehensive, people-centered primary healthcare approach that includes:

- *Prevention, diagnosis, and treatment services for HIV, TB, and Malaria are available through primary health care and community-led platforms.*
- *One-stop services with fewer referrals, fewer visits, and lower out-of-pocket expenses to access health services.*
- *Better care for people with multiple health needs in a single visit (i.e., mental health, sexual and reproductive health, nutrition support, among others).*
- *Social protection services.*
- *Co-infections and non-communicable diseases.*
- *Pandemic preparedness and emergency response.*
- *Functional referral and counter-referral mechanisms for broader health, social, and other needs.*

In many countries, community-led/-based organizations deliver essential HIV, TB, and Malaria services such as outreach, screening, active case finding, harm reduction, community home-based care, stigma reduction, and community-led monitoring. These services are often the most trusted and accessible for key populations, including people who use drugs, sex workers, migrant workers, and LGBTQ+ communities. Integration should strengthen existing community systems rather than replace them. For key populations, criminalization and

stigma create significant barriers to access; therefore, integration should be broadly defined to address country-specific context (barriers) and communities' needs, especially by maintaining community-led platforms for specialized services, including harm reduction for people who use drugs and sex workers and DR TB treatment support. Similarly, for TB, these specialized services can be particularly impactful at reaching key and vulnerable or underserved populations. **Integration and specialization are not opposites – both are necessary. They must coexist**.

Integration is a necessary process to ensure the sustainability of HIV, TB, and Malaria responses. However, integration must be planned and done gradually, with sufficient time for learning and adapting. It requires a multi-sectoral approach involving the government, civil society, private sector, and local governments, with community engagement as central throughout the process. Successful integration of services spans horizontally across different services/programs and vertically across different levels of care.

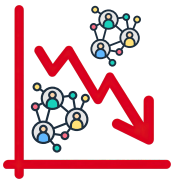
Integration of service delivery is more sustainable, efficient, and resilient only when health systems are integrated. This means establishing policy-level decisions that formally institutionalize integration at national and subnational health policies, financing, and accountability frameworks, and strengthening building blocks, such as workforce, data, surveillance, supply chain, laboratories, community, rights and gender engagement, and financing.

WHAT ARE RED LINES FOR COMMUNITIES?

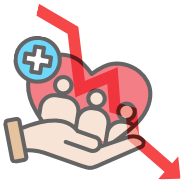
Poorly designed integration could inadvertently weaken community-led systems and responses and access to lifesaving HIV, TB, and Malaria servicesIntegration should maintain or improve existing program strengths, while improving the effectiveness of current interventions, approaches, and initiatives. Integration should be designed around people's lived realities and measured not only by efficiency gains, but by whether people continue to access services safely, equitably, and with dignity.There are clear "red lines" that must not be crossed. These are critical safeguards to ensure that integration does not undermine community-led responses, human rights, or access to services for key populations. Communities must remain vigilant to ensure integration does not lead to:

- **Loss of community-led services and access points**: In the long run, integration of HTM services into PHCs and the broader health system will inevitably result in closure of community-led services and access points. Where such closure is deemed, integration must be carefully and gradually carried out to ensure that integrated service access points are competent, safe and stigma-free for communities. This requires appropriate training, mentoring, and ongoing support for health workers to deliver tailored, high-quality services for KPs. It is important to acknowledge that government systems cannot often effectively deliver outreach, harm reduction, peer support, and stigma reduction services that are currently delivered through community-led service delivery models (i.e., access points such as drop-in-centers). Depending on the country context and communities' needs, communities must be prepared to advocate and preserve specialized services (i.e., community-led access points).

- **Loss of community workforce**: Integration should not lead to dismissal or exclusion of entire community outreach workers and peer educators. Community outreach and peer educators are the heart of HTM response, and retaining them in the integrated services could be an effective strategy to ensure that services reach most hard-to-reach populations and are trusted, safe and stigma-free. Therefore, while integration might result in many communities losing their jobs, advocacy should be done to have the community workforce formally recognized and accredited to play a critical role within integrated health systems and service delivery.



- **Loss of youth- and gender-friendly or specific services:** As integration planning begins amid significantly reduced country allocations, arguments will likely claim that young key populations, women, and gender-diverse people are merely subgroups of the larger key populations and people living with HIV. Integration should not be an excuse to deprioritize andapply a 'one-size-fits-all' approach to the unique and specific needs of young people, women, and gender-diverse people. While investing in a separate service site may not be feasible in many cases due to limited resources, integrated services must retain or ensure clear indicators of youth- and gender-friendliness in health services, including in staffing, opening hours, meaningful engagement in service design, etc.

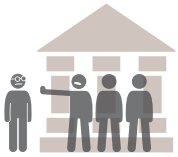


- **Elimination of dedicated funding for communities**: Integration should not be used as a justification to cut funding for or de-prioritize community-led responses, including service delivery and advocacy by national key population networks. More importantly, it must not be used for eliminating specialized services for key populations.

- **Breach of confidentiality and unsafe data sharing:** Integration must not compromise the privacy and confidentiality of key populations. The collection and inclusion of KP personal data in national health data systems must take place in ways that ensure confidentiality and, where needed, the anonymity of KP service users, to avoid the risk of the same data being used for surveillance, arrests, or the outing of individuals.

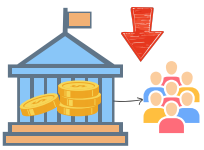
- **Increased stigma and discrimination:** Integrated services must not force people into unsafe or stigmatizing facilities. Often, health workers at PHCs or mainstream health facilities serving the general population are not trained in human rights, stigma reduction, and culturally competent care, which can deter access and retention.

- **Loss of harm reduction and prevention services:** Integration must not weaken access to essential prevention and harm reduction services for key populations. Where necessary, these services must be maintained as specialized services and remain available through low-threshold and community-led platforms.



- **Government takeover without community participation:** Integration must not be defined, or simply assumed, to mean absorption of community-led services by or into the PHC or other public health facilities. It should not result in community leadership being replaced by top-down government control (centralized) without meaningful community participation.

- **"One-size-fits-all" integration models:** Integration should not be implemented through a blanket approach that ignores local context and community realities. It must be adapted to epidemiological, legal, and socio-economic conditions within each country's national and subnational contexts.



- **De-prioritization or elimination of investment in community systems, human rights, and gender programming, and other accountability mechanisms for the government, including community-led monitoring.**

Moreover, reduced allocations in GC8 might force countries, CCMs, and communities to make difficult prioritization decisions or "**hard choices and trade-offs**". Not all interventions in the national strategic plans or community priorities can be funded. These hard choices and trade-offs may manifest in numerous prioritization decisions, which, for example could mean choosing between procurement of lifesaving medicines vs interventions that enable access to them, provision of a full package of services to fewer people vs a limited package to more people, maintaining national coverage vs focusing on high-burden districts, interventions to prevent HTM vs interventions to treat HTM, etc. If hard choices need to be made, they should be made collectively, with meaningful engagement from communities and civil society, and informed by evidence, national and subnational contexts, and grassroots realities

WHAT ARE THE RISKS TO COMMUNITY-LED SYSTEMS AND RESPONSES?

CHALLENGES & RISKS	POTENTIAL IMPACT	MITIGATION STRATEGIES
Integration of service delivery will require added costs of training, supervision, staffing, infrastructure, etc.	Increased initial cost	Ensure appropriate coordination across programs, health systems, and level of care. Integration of service delivery can be implemented gradually and based on the availability of funds for initial investment.
Integration may increase workload for already stretched health facilities and	Reduced service quality, burnout among providers, and longer waiting times.	Invest in workforce capacity, task-sharing reform, digital systems, and supportive

workers, especially our community outreach workers without remuneration that commensurate to the workload.		supervision.
Integrating services into PHCs or mainstream facilities may create barriers due to stigma, discrimination, or criminalization.	Key populations avoid services, leading to lower coverage and worse health outcomes.	Maintain community-led service delivery models, peer outreach, and safe entry points such as drop-in centers for HIV or TB specialized services to ensure quality and access. e.g., harm reduction services.
Integration may lead to government centralization of services, closure of community-led services, and major funding cuts for community-led systems and responses.	Underfunding or elimination of high-impact interventions for key populations.	Protect funding for community-led and KP-focused services within integrated budgets and joint advocacy for dedicated funding and social contracting to community-led organizations.
Exclusion or insufficient community engagement in integration planning and decisions.	Program fail to meet community needs and lose trust.	Ensure meaningful participation of communities and civil societies throughout the entire integration process.
Increased stigma and confidentiality risks for key populations.	Fear of disclosure, reduced service uptake, and increased vulnerability.	Strengthen confidentiality protocols, staff training, and rights-based service standards.

Weak coordination between programs with separate systems, budgets, and governance structures.	Fragmented implementation and inefficiencies.	Institutionalize coordination mechanisms, integrated planning, and joint monitoring systems.
Integration of information and strategic data systems can weaken monitoring and usability.	Loss of critical data on key populations and specific diseases.	Develop integrated data systems while preserving KP-disaggregated indicators.
Community-led organizations working across HTM may lack resources to engage and advocate effectively in integrated responses.	Reduced role of communities, resulting in weak community-led systems and responses.	Invest in community system strengthening and community-led monitoring for HTM communities.
Integration amid shrinking funding is likely to prioritize service delivery over human rights and gender programming, and accountability mechanisms, including community-led monitoring.	Increased human rights, gender, and other structural barriers to access available services among key populations.	Improve our vocabulary to sell them in a language that is more receptive and relatable for governments. This might include calling them 'addressing social determinants of health' rather than 'advocacy for human rights', and 'quality assurance of health services' instead of 'community-led monitoring', etc. Remember to always link to health outcomes.

WHAT COMMUNITY AND CIVIL SOCIETY ORGANIZATIONS (CSOS) SHOULD PUSH FOR?

When done right, integration can protect hard-won gains, strengthen communities, and build health systems that are ready for the future. To ensure it, **integration must be built with us, not done to us.** For communities (i.e., key populations), integration can be helpful or harmful. It all depends on how it is done and who is involved. Therefore, community and civil society organizations have a critical role in shaping integration.

To protect community-led systems and responses in the integration process, community and civil society organizations must demand and push for:

- Meaningful participation of communities in integration planning, including a formal representation at the 'National Integration Task Force' (if it exists in the country) and GC8 grant writing team, ensuring participation (with special attention to communities) in all consultations and decision-making.
- Develop new or revise (i.e., update and harmonize) existing national strategic plans, guidelines, and service protocols to embed integration while maintaining clear roles for community systems.
- Social contracting and direct/dedicated financing mechanisms at national and subnational levels that enable the government to partner with community-led organizations for the delivery of essential services.
- Government accreditation system for community-led service centers and community workforce, including outreach workers, peer educators, paralegals, etc., to deliver essential services through PHCs and community platforms.Recognition of community-led monitoring of service access, quality, stockout, stigma, and human rights, so that it is integrated into the national information and strategic data system.

- Integration of HIV, TB, and Malaria prevention and treatment services into the national health insurance or universal health coverage plan, pandemic preparedness, and antimicrobial resistance plans.
- Increased allocation of domestic resources to sustain community-led services, advocacy, and community-led monitoring.
- Protection of rights, confidentiality, and specialized services such as harm reduction for people who use drugs, sex workers, and other communities.
- Transparency in decisions about what services are integrated—or deprioritized

WHAT ARE THE ROLES OF COMMUNITIES, CIVIL SOCIETY, AND COUNTRY COORDINATING MECHANISM (CCM)?

All CCM members, including community and civil society representatives, must advocate their priorities and play a "watchdog" role throughout integration planning and GC8 grant implementation. Where possible, **communities across HIV, TB, and Malaria should collaborate to form unified alliances to avoid conflict, reduce competition for limited funding, and present with a stronger voice.**

The Global Fund GC8 process and documents, such as the modular framework, funding request, detailed budget, and performance framework, are highly technical. Therefore, communities must identify representatives with the capacity to navigate these documents and ensure their CCM representative has the necessary technical guidance and moral support.

The key roles that CCM and communities should play during integration planning, country dialogue, funding request development, and submission are presented in the table next page:

STAGES	ROLES OF CCM	ROLES OF COMMUNITIES & CIVIL SOCIETY
INTEGRATION PLANNING	• Under the MOH's leadership, convene all national stakeholders to identify domestic and external resources available for HTM and integration priorities before disease-focused planning.Ensure meaningful participation of communities and civil society in integration planning.	• Hold meetings within/among constituency members to identify integration priorities, red lines, gaps, and structural barriers. • Submit an advocacy brief to the CCM and MOH, outlining integration priorities and the need for specialized services (if any). • Participate in all national meetings and consultations related to integration and ensure representatives are present at all subnational planning processes. • In the countries that form 'national integration task force', communities should advocate and ensure formal representation in the task force.
COUNTRY DIALOGUE	• Develop a clear timeline and roadmap for country dialogue and share it among all CCM members and stakeholders. • Hold orientations on allocation letter and roadmap for CCM members and national stakeholders. • Convene and lead an inclusive country dialogue early, organizing national and subnational consultations • Ensure meaningful participation from diverse stakeholders with special attention given to communities.	• Review the Global Fund GC8 prioritization guidance and modular framework, and help other community members and CCM representatives understand GC8 guidance. • If possible, hold pre-consultations within your community (constituency) before key country dialogue meetings. • Bring community voices and lived experience to all national and subnational consultations and ensure community needs and priorities are captured by grant writers (consultants). • Submit community priorities in the required annex[1], orienting on the modular framework so that the grant writers can easily understand

[1] In GC8, the annex on Funding Priorities of Communities and Civil Society most Affected by HIV, TB and Malaria is mandatory for High Impact and Core portfolios

	• Where necessary, conduct small meetings with communities only to provide them safe and meaningful space. • Where applicable, engage in the national strategic plan development process and ensure integration is a core strategy for a sustainable response to HTM.	and simply copy-paste into the funding request. • For each identified priority, need, or gap, if possible, provide evidence such as epidemiological data, size estimations, CLM and regular program data, and other research publications. • Participate in all national and subnational meetings and consultations.
FUNDING REQUEST DEVELOPMENT AND SUBMISSION	• Ensure the country dialogue consultations inform the funding request. • Ensure that the technical (narrative) proposal aligns with the detailed budget. • Ensure integration priorities and plans are included and earmarked in the detailed budget. • Ensure funding request, detailed budget, and performance framework are drafted in time and shared among CCM members with at least two weeks for review and feedback. • Convene a validation workshop before the finalization of the funding request. • With the endorsement of CCM, submit the funding request to the Global Fund.	• Engage with CCM, particularly the key population and civil society representatives on the CCM, to ensure community priorities are well-reflected in both funding request and detailed budget. • Ensure clear roles of communities in implementation are mentioned in the funding request. • Where a single integrated funding request will be developed, the roles of KPs and community networks become more important. • Participate in the national validation workshop. • In case if any of the community priorities could not be included in the funding request, then advocate/negotiate to include them in the prioritized above allocation request (PAAR).

GRANT-MAKING	• Monitor progress of grant negotiations between principal recipients (PRs) and the Global Fund. • Track and document changes in the funding request, detailed budget, and performance framework throughout the process. • Ensure timelines are respected and bottlenecks are addressed early. • Hold consultations with communities and civil societies on the progress and changes, and ensure country dialogue priorities are retained.	• Actively engage with CCM members, and provide technical support to CCM representatives in tracking and documenting changes in funding request, detailed budget, and performance framework.

REFERENCES TO KEY DOCUMENTS

- Planning and Managing HIV Programmes with Key Populations.
- INPUD (2026) Integration Without Erasure: Preventing the disintegration of community-led responses to HIV, TB, and other health challenges
- GC8 Enabling Impact Guidance on Advancing Integration
- Key harm reduction messages on integration for GC8
- Stop TB Partnership Global Plan to End TB 2023-2030

SEVEN ALLIANCE

ASIA-PACIFIC LEARNING HUB

https://sevenallianceap.com/ https://sevenallianceap.com/learninghub/