Integration Without Erasure:

Preventing the Disintegration of Community-Led Responses in Global Fund Grant Cycle 8

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> *"Community-led services are not a temporary solution, to be absorbed and phased out. They are a permanent, essential part of effective and rights-based health systems. Integration that weakens peer leadership, cuts harm reduction, or sidelines drug user-led organisations is not progress, it is regression. We must ensure that integration happens with us, not to us."*
>
> — *Anton Basenko, Executive Director, INPUD*

Background

The Global Fund to fight AIDS, Tuberculosis and Malaria has declared that in the impending Grant Cycle 8 (GC8) it will accelerate the ***integration*** of HIV, TB and malaria (HTM) efforts into primary health care (PHC) and broader health systems, the stated goals being to sustain HTM services, increase efficiencies, and build resilient health systems.[1]

This emphasis by the Global Fund reflects a broader push at the global, and often national, levels toward such integration. This is informed in part by the laudable goal of Universal Health Coverage (UHC). But more recently, the emphasis on accelerating integration is driven heavily by dramatic, damaging reductions in international funding for global health and other notable political shifts within the global health architecture.

The new *Global AIDS Strategy 2026-2031* identifies "integrated services," and the "integration of HIV interventions and HIV-related health and community systems with primary health care, broader health systems and key, non-health sectors," as top priorities in the next phase of the HIV response.[2] Equally importantly, however, the new Global AIDS Strategy also identifies ensuring "community-led responses, rights-based and gender-responsive approaches and community-led governance" as another priority.[3]

For its part, the Global Fund acknowledges that integration carries risks and costs, and that strategies must be adopted to mitigate those risks.[4] Communities recognise that integration is necessary and, in some instances, beneficial. Under the right circumstances, and when done thoughtfully and carefully, integration holds the promise of improved access to care,

better health outcomes, cost-efficiencies and cost savings, and longer-term sustainability of services. However, integration that is rushed and careless is a recipe for less—and less equitable—access to care, and hence poorer health outcomes, wasted resources, and ultimately a response to HIV, TB and malaria that is less person-centred, less effective, and less sustainable.

The Global Fund declares that it "puts people and communities at the centre of all our work."[5] That commitment must govern how it approaches its stated objective of accelerating integration of HTM into broader health systems and service delivery. **A sensible approach is to advance integration *where it is necessary and reasonable*, with careful attention to the details, which matter for the health, lives and dignity of those whose access to services is at stake. But it is equally important to clearly recognise that integration is sometimes neither necessary nor reasonable—and indeed, in circumstances where it poses risks of significant harm, it should be rejected.**

This document sets out recommendations to the Global Fund Board and Secretariat that are aimed at minimising the risks of integration being done badly and maximising the potential for benefit. The focus is on integration at the level of services. While the recommendations are directed to protecting and promoting the health, well-being and dignity of people who use drugs, the substance of many of the recommendations is broadly applicable to the benefit of all key populations across the three diseases.

Concerns for people who use drugs

> *"Integrated care can be great. It can also be real persecution, where you don't get proper health care. Integration in a well thought-through policy system, with the right practitioners, who are trained and supported, is very different from integration in a hostile policy environment and dealing with inexperienced, unthoughtful practitioners. This underscores the huge benefit of community-led organisations being mediators for people with such systems. Integration can be great, but it's often not about being great, it's often about doing things more cheaply and pushing people back into lower-quality care where stigma and discrimination are maximised."*
> *— Participant, INPUD community consultation, 19 January 2026*

People who use drugs have particular reason to be concerned about an ill-conceived and hastily executed rush to integration. Within the already-inadequately funded global HIV response, the lack of funding has been particularly pronounced when it comes to addressing HIV among people who use drugs. For example, the most recent analysis reports that, in 2022, funding for harm reduction programs accounted for less than 1% of total HIV funding, and harm reduction funding in low- and middle-income countries (LMICs), from both domestic and international sources, was only 6% of what is needed.[6]

The inadequacy of services for people who use drugs worsened significantly in 2025. As INPUD has documented, the impact of drastic cuts to US foreign aid on the health and well-being of people who use drugs "has been massive and monumental," including "significant disruption to core harm reduction services, HIV/Hepatitis C (HCV) programming, and commodity supplies for people who use drugs globally."[7] Other wealthy countries have also significantly cut funds committed to global health. **In the absence of alternative measures to ensure the continuity of, and equitable access to, such services, as people who use drugs, "we are being erased from the HIV and HCV response."**[8]

The push for "integration" risks furthering this erasure, and it risks a ***disintegration*** of effective services and systems that have taken decades to build, including with Global Fund investments:

> *If drug user-led organisations, networks, and service delivery are permitted to be the first to close because of lack of funding and political will, the entire harm reduction model and its systemic infrastructure is placed in significant jeopardy. The harm reduction model works only because of community-led responses. Peer educators and outreach is how we are able to reach our community. They are the bridge between the community and formal health services. Peer workers build the trust and relationships that allow us to change drug use practices, help get people into care and treatment, and build community strength, leadership, and resilience.*[9]

Despite the demonstrated value and importance of community-led responses, one widely shared view at INPUD's recent community consultation on integration was that absent of significant changes by and to national health systems, integration of services for people who use drugs into those systems was virtually certain to sever the involvement of peers in important ways.[10]

This disintegration of vital community systems and community-led responses need not be the case. It is particularly incumbent upon the Global Fund to take proactive steps to avert this outcome. The Global Fund plays an especially important role in the HIV response among people who use drugs. As of 2022, many countries had no identifiable *domestic* funding for harm reduction programmes, and the Global Fund accounted for 73% of all *donor* funding for harm reduction.[11] The Global Fund is also a major funder, especially in middle-income countries, of "community-focussed programmes," meaning programmes focussed on preventing and treating HIV among "key and vulnerable populations," on reducing human rights- and gender-related barriers to services, and in strengthening community-led organisations and responses.[12] Funding civil society organisations directly (e.g., as Principal Recipients of a grant) is a good investment, with a high absorption rate.[13]

However, the recent, rapid "reprioritisation" exercise in the middle of Grant Cycle 7 (GC7) highlighted the vulnerability of community systems, and of the health and rights of key populations, to rushed and ill-considered decisions in the face of reduced funding.[14] As documented by the Global Key Populations Networks, "in many ways, key populations have been the 'canary in the coal mine' of this most recent Global Fund process, raising early warning alarms as global pressures for 'integration' play out in the lives and realities of our communities."[15] As stated bluntly in the results of a study of integration readiness across nine sub-Saharan African countries:

> *Without guardrails, integrations risks transferring clients from safe, community-led spaces into hostile PHC settings that can expose them to discrimination, embarrassment, violence, or even arrest… Communities articulate a nuanced perspective: they want integration to succeed, but not at the cost of safety, confidentiality, or dignity. Integration must not collapse community-led infrastructures that have taken decades to build, nor should it force [key populations] into PHC facilities that lack readiness.*[16]

Recommendations

Unless undertaken carefully, and with a conscious commitment to our inclusion and welfare, the integration of HIV, TB and malaria services into broader primary health care and health systems will very likely result in the further ***disintegration*** of the already-inadequate response to the three pandemics among people who use drugs.

> *Successful integration hinges on communities having authority to shape service packages, define readiness criteria, evaluate [primary health care] facilities, and hold implementers accountable for safety and quality.*[17]

The *Global Fund* should take steps, through Board policy and/or Secretariat action, to ensure the following:

1) **Dedicated funding supporting communities:**

   a) Create a **direct funding stream** in GC8 to build, protect and expand services and responses that are *led* by key populations, including people who use drugs, so as to ensure equitable access to services for communities most affected by HIV, TB and malaria.

b) In addition, **country allocations should earmark some specified amount of funding** that is dedicated to community-led organisations and responses. Many such organisations already play key roles in providing or connecting key populations to services; their meaningful engagement will be critical to *successful* integration of HTM efforts into broader health systems. This will necessarily include building or sustaining the capacity of such organisations to understand and engage with Global Fund processes and mechanisms, from the process of developing a funding request to grant-making to monitoring and evaluating the implementation of grant-supported activities and of the steps taken toward integration. Supporting such capacity is a necessary aspect of the Global Fund's stated commitment to both advancing integration and putting people and communities at the centre of its work.

2) **Co-financing requirement:** A percentage of a country's grant allocation should be conditional upon the country also making a *realistic* commitment to co-finance evidence-based services necessary for the health of people who use drugs, which should include the full basket of interventions recommended by the WHO.[18]

3) **Essential services packages:**

a) Whatever the sites and modes of service delivery, the integration of HTM services into primary health care must ensure the provision of **essential services packages defined and delivered in collaboration with community-led organisations,** including harm reduction services and treatment for drug dependence (including essential medicines, e.g., methadone, buprenorphine, and naloxone). These services must be available free of charge, without user fees.

b) In some jurisdictions, particularly when it comes to some of the services needed by people who use drugs, the legal environment can include barriers, in addition to societal prejudices and stigma. These can include: criminalisation not only of drugs and people who use them, but also certain health services; unwarranted restrictions limiting who can deliver certain services, and where, how and to whom; and inadequate protection of service users' confidentiality, heightening the risk of harms such as criminal prosecution or other punitive consequences. where and how certain Therefore, ensuring the provision of essential services will, in some instances, require **legislative or policy changes to permit or direct a service or services to be provided** (and to set standards of care that should be met).

4) **Co-governance**: It must be a condition of all grants that communities, including representatives of key populations, are equal partners in all bodies and processes responsible for making decisions regarding the integration of services. Adequate funding must be allocated to ensure meaningful community engagement, including in the

development of integration readiness standards and plans, which must be co-created with communities (including community organisations led by people who use drugs), and in the assessment of integration readiness.

5) **Standards for "integration readiness" of PHCs:** Integration must be tailored to the local contexts and not forced prematurely, considering the readiness of providers and legal/policy frameworks. Integration of services currently provided by community-led organisations into PHC settings will cause harm if those settings do not provide care that respects and protects the human rights of key populations, including people who use drugs. The quality and competence of those working in health services, including whether and how they respect and protect the human rights of key populations, are key to determining whether integration is successful or leads to resources wasted because services are not accessible to those who need them.

    a) As one way of accelerating integration responsibly and ethically, Global Fund grants should require that countries develop a **mechanism whereby PHC facilities and staff are certified as competent** to provide care to key populations *before* any services are transferred. At a minimum, this must include: demonstrating the ability to provide services free of stigma and discrimination, and otherwise meeting quality guidelines such as those from the WHO;[19] having mechanisms and policies in place to protect informed consent and patient privacy (including in their physical set-up, handling of personal information, and safeguards against facility collaboration with law enforcement); and clear safeguarding and reporting mechanisms to protect against abuse and stigma (including gender-based abuses).[20]

    b) **Community-led organisations must be involved** in designing, monitoring and validating these standards. Minimum standards of "integration readiness" must include evidence of effective partnerships with key population-led organisations and networks, and details as to how PHC facilities will continue, under integrated service delivery, to support the vital work of key population-led community partner organisations.

6) **Community-led data collection, including community-led monitoring:** Community-led monitoring (CLM) must be a mandatory, and adequately funded, component of GC8 funding requests and grants, including monitoring of integration of services, as a vital accountability mechanism and as a tool for supporting successful integration. All health facilities serving key populations must be required to have a plan for participating in CLM and implementing documented improvements in line with the results of CLM within clear and enforceable timelines. For example, the Global Fund must require Country Coordinating Mechanisms (CCMs) to include community presentations of CLM findings as standing agenda items in order to support transparent monitoring, shared learning, accountability and timely corrective action.

7) **Community systems strengthening (CSS)**: Integration must not be defined, or simply assumed, to mean the absorption of community-led services by or into PHC services. **The best model of integration is one in which community-led services create the 'low-threshold' sites of engagement** with people who use drugs, and HTM and other health and social services can be brought to bear around or through that point of engagement. Global Fund guidance and practice in grant-making should reflect the following:

    a) Integration must not come at the expense of weakening the community-led systems that are essential to creating safety and trust and thereby enabling access to health and other services. Global Fund technical guidance expressly recognises that: "In some settings, some HIV or TB specialized services will need to be maintained in order to ensure quality and access, e.g., in harm reduction services."[21] In some instances, **the sensible approach to integration is to further strengthen the capacity of community-led systems to deliver enhanced services**. Particularly in criminalising or otherwise hostile environments, preserving and strengthening community-led services is essential to rights-based and sustainable responses.

    b) In addition, where feasible, given the nature of the service, Global Fund guidance should **prioritise an approach to co-location of services that brings PHC services directly into community settings**. This preserves the safety of trusted spaces while expanding availability of services.

    c) Countries should harmonise national health human resource strategies, including equitable wage scales/compensation, so as to **fairly incorporate peer workers and staff of peer-led health and social services** into the response.

    d) Beyond providing or connecting people to health services, community-led organisations undertake **other activities essential to reducing barriers to HTM and other health services**, such as: eliminating stigma and discrimination in all settings (including health care); improving the legal and policy environment to enable a more effective response; improving legal empowerment and access to justice; transforming harmful gender norms; and addressing gender-based violence—interventions which the Global Funds recommends be included in every funding request.[22] Even in a context of 'integration,' the essential role of communities in these aspects of the response to HIV, TB and malaria must be preserved.

8) **Implementation of grant activities:**

    a) Too often, between initial funding request and final grant-making, revisions to workplans and budgets lead to funds for community systems and community-led responses being substantially reduced or removed. The Global Fund country team has a key role to play in upholding the Fund's commitment to putting

communities at the centre. Rather than prioritising accelerated country dialogue and grant-making processes, the Global Fund should closely **review the grant implementation arrangements** to preserve meaningful support for community systems, leadership and responses, and to ensure that tenders and other requirements do not exclude drug user-led organisations and networks.

b) Where necessary, the Global Fund should require time-bound plans for **enabling 'social contracting'** so that community-based organisations, including community-*led* organisations, can be contracted to provide services, particularly for key populations.'

c) INPUD is concerned that, in the name of advancing integration, the Global Fund appears to be biased in favour of selecting a **single government entity as Principal Recipient**.[23] It does caution that consideration should be given to "how this change may impact populations who may fall outside of the [national] systems' reach."[24] In many instances, governments criminalise and/or vilify people who use drugs and the health services they need; some maintain legal and policy hurdles to the effective operation of drug user-led organisations. In such circumstances, a single government PR is far from the ideal arrangement to ensure funds ultimately flow adequately to such organisations.

9) **Monitoring & Evaluation:** During grant-making, the Global Fund should ensure that grants' Performance Frameworks include monitoring and evaluating the extent to which the implementation of integration is (i) informed by the meaningful involvement of key populations; (ii) affecting the delivery of services by community-led organisations;[25] and (iii) affecting uptake of services, including by key populations.

[1] Global Fund, *Accelerating Integration of HIV, TB and Malaria to Strengthen Health Outcomes: Technical Brief (Grant Cycle 8)*, 15 December 2025 ["Integration Technical Brief"].
[2] UNAIDS, *United Towards Ending AIDS: The Global AIDS Strategy for 2026-2031*, adopted by the UNAIDS Programme Coordinating Board, December 2025, UNAIDS/PCB (57)/25.30.
[3] Ibid.
[4] Global Fund, Integration Technical Brief.
[5] Global Fund, *Fighting Pandemics and Building a Healthier and More Equitable World: Global Fund Strategy (2023-2028)*.
[6] Harm Reduction International, *The Global State of Harm Reduction 2024* (London, 2024).
[7] International Network of People who Use Drugs, *The Human Cost of Policy Shifts: The Fallout of United States' Foreign Aid Cuts on Harm Reduction Programming and People who Use Drugs: Rapid Assessment Findings—April 2025* (INPUD, 2025).
[8] Ibid.
[9] Ibid.
[10] Numerous participants, INPUD community consultation on integration, 19 January 2026.
[11] Harm Reduction International, *supra*.
[12] amfAR, Issue Brief: Supporting Community-Focused Programming: New Data Highlight the Global Fund's Key Role (December 2024).
[13] Ibid.
[14] Developing Country NGO Delegation, *Community Engagement in Global Fund Reprioritization: Findings from a rapid, independent, civil society-led analysis* (September 2025).
[15] Global Key Populations Networks, *The Canary in the Coal Mine?: Community Lessons from the Global Fund GC7 Mid-Cycle Reprioritisation Process – Steps Forward for Grant Cycle 8* (2025).
[16] *Guardrails for Integration: KVP Community Leadership in Shaping HIV-Primary Health Care Integration – Study Conducted Across East, West and Southern Africa 2023-2025* (COMPASS & Key Populations Trans-National Collaboration, 1 December 2025).
[17] *Guardrails for Integration: KVP Community Leadership in Shaping HIV-Primary Health Care Integration – Study Conducted Across East, West and Southern Africa 2023-2025* (COMPASS & Key Populations Trans-National Collaboration, 1 December 2025).
[18] World Health Organisation et al. *Recommended package of interventions for HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for people who inject drugs: Policy brief* (2023).
[19] Ibid.
[20] UNAIDS has provided practical guidance, including checklists, outlining why and how to ground HIV prevention, testing, and treatment services in human rights standards, including ensuring equitable access for key populations such as people who use drugs: *Fast-Track and human rights: Advancing human rights in efforts to accelerate the response to HIV* (2017). Although the guidance is focused on HIV services, the human rights standards outlined are applicable to health services more broadly. This guidance could serve as a resource for defining and assessing "integration readiness" of services. Some approaches to integrating HTM services into broader health systems come at the likely expense of community-organised spaces and services; this leaves key populations such as people who use drugs at heightened risk of harm when accessing generic, mainstream health services that have too often breached their rights. The push for integration heightens the importance of compliance with human rights standards.
[21] Global Fund, "Integration Technical Brief," p. 7.
[22] Global Fund, *Reducing human rights and gender related barriers to HIV, TB and malaria services: Technical brief (Grant Cycle 8)*, 15 December 2025.
[23] Global Fund, Integration Technical Brief, p. 9 ("Implementation Arrangements").
[24] Ibid.
[25] As set out in the *Global AIDS Strategy 2021*-2026, community-led organisations should be delivering 30% of testing and treatment services; 80% of HIV prevention services; and 60% of programmes addressing society enablers. Those targets have been preserved in the new *Global ADS Strategy 2026-2031.*