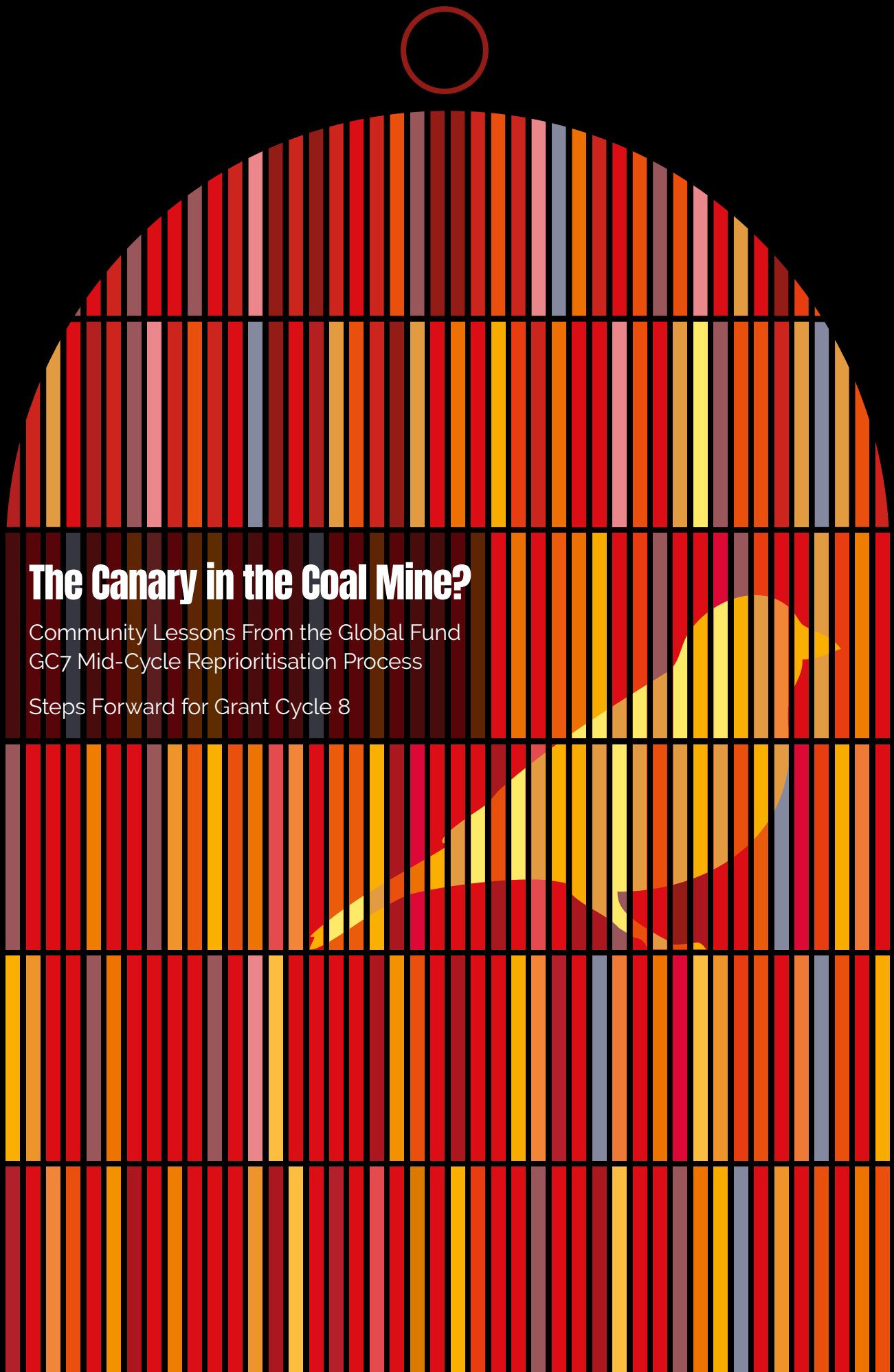
INPUD
International Network *of* People *who* Use Drugs



The Canary in the Coal Mine?

Community Lessons From the Global Fund GC7 Mid-Cycle Reprioritisation Process

Steps Forward for Grant Cycle 8

Contents

Abbreviations

AIDS	Acquired immunodeficiency syndrome
CCM	Country Coordinating Mechanism
CE-SI	Community Engagement Strategic Initiative
CLO	Community-led organisations
CLR	Community-led responses
CSS	Community systems strengthening
GATE	Global Action for Trans Equality
GC7	Global Fund Grant Cycle 7
GC8	Global Fund Grant Cycle 8
HIV	Human immunodeficiency virus
INPUD	International Network of People who Use Drugs
KP	Key populations
LFA	Local Fund Agent
MPact	Global Action for Gay Men's Health and Rights
NSWP	Global Network of Sex Work Projects
TRP	Technical Review Panel
PR	Principal Recipient
SR	Sub-recipient
SSR	Sub-sub-recipient

Foreword

The Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund) is a large organisation that supports programming in over 100 low- and middle-income countries (LMICs). As a global health leader, the Global Fund's pivotal investments in evidence-based interventions to fight HIV, tuberculosis (TB), and malaria secure greater access to lifesaving services for all, which means improved health outcomes, crucial gains for gender equality and human rights protections for at-risk and criminalised groups, and strengthened, more resilient health and community systems. Together, these efforts contribute to a stronger, healthier, and more secure world.

The Global Fund Partnership has made incredible headway in putting an end to HIV, tuberculosis (TB), and malaria as public health threats by 2030.[1] The Global Fund's programming has saved a cumulative total of over 70 million lives since its inception in 2002. It has increased the number of people on HIV antiretroviral therapy to 25.6 million; it has been able to treat a record number of people with tuberculosis (TB) and scale-up malaria prevention efforts, while protecting civic space and the human rights of affected communities in the countries where it invests. The leadership of affected communities, their meaningful engagement, and investments in strengthening community-led responses and systems anchor The Global Fund's 2023–2028 Strategy, which is geared towards building a healthier and more equitable world.

However, as a large organisation, the Global Fund does not always get everything right all the time—then again, no one does. The Global Fund model has been created and continually refined with this knowledge in mind.[2] Its strong oversight structures have demonstrated, on numerous occasions since its creation, that the Global Fund Partnership, comprising governments (donor and implementing), technical partners, the private sector, civil society, and affected communities, is able to listen, learn, and adapt.

The Global Fund's governance structure, at the global and country level, is meant to ensure that power and decision-making are shared equally across all stakeholders, including key populations such as people who use drugs, sex workers, trans and gender diverse people, and gay, bisexual, and other men who have sex with men. It is because of this model that challenges can be more easily identified and discussed, and solutions can be co-created as a Partnership.

It is in this spirit and understanding that we share this report.

Tectonic shifts continue to rock the health and development sector, impacting global health governance and the financial architecture that underpins the 2030 Sustainable

1. Sustainable Development Goal 3: Ensure healthy lives and promote well-being for all at all ages.
2. The Global Fund Advocates Network (GFAN. Reframing Solidarity & Tackling Anti-ODA Narratives. Accessed at: https://hereiam.my.canva.site/reframing-solidarity/

Development Agenda. The mid-cycle reprioritisation of Global Fund GC7 investments has shown that, despite the Global Fund's undeniable results and impact, it is not immune to these external forces. As the reprioritisation process wraps up across Global Fund-funded countries, this report presents the perspectives and experiences of key population communities and their engagement in this significant endeavour.

Within this report, we raise critical issues that have intensified as a result of the high political and financial uncertainty facing global health, the fate of lifesaving efforts for HIV, TB, and malaria, and the future of community-led programming and services for and by key populations, more specifically. The issues raised here underscore both what is working well and not well enough, and which, if left unattended or ill-addressed, will place the sustainability of community systems, key population-led responses, and the health, rights, and dignity of key populations in grave jeopardy. **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.**

We remain confident that, as a Global Fund Partnership, and by ensuring that "communities are at the centre", our co-created solutions will further strengthen and reinforce the Global Fund model and its impact on the three diseases, as we move into Grant Cycle 8.

1.0 Executive Summary

The mid-cycle grant adaptation and reprioritisation process under the Global Fund's Grant Cycle 7 (GC7) was an ill-fated yet necessary response to the system shocks, free-falling levels of foreign assistance, and faltering political commitment that have characterised much of this past year. Since January 2025, the international community has borne witness to colossal shifts in the financial, policy, and global governance landscape with nothing less than a profound impact on the global health and international development ecosystem, and the domestic budgets and debt load of low- and middle-income countries.

Within this new reality, and as the largest global financer for HIV, tuberculosis (TB), and malaria, human rights, gender equality, and health and community systems strengthening, the Global Fund's reprioritisation process magnified clear power-imbalances and long-standing systemic weaknesses within its country funding model. These imbalances and systemic weaknesses further disadvantage key population communities, their meaningful engagement, and their community-led systems and responses. The following report offers a community-led report back on the Global Fund's reprioritisation process, with findings that expose the imminent threat to the health, lives, and well-being of marginalised, criminalised communities most at-risk of the three diseases losing equitable access to lifesaving services. Without decisive action, the **same patterns of exclusion, confusion, and de-prioritisation, as witnessed under the G7 reprioritisation process, will repeat under Grant Cycle 8 (GC8)** amidst the unfolding global environment of reduced funding, intensified integration pressures, and increasing political hostility toward criminalised populations. We are the **"canary in the coal mine"**.

Sections I and II of this report set the stage providing an introduction and overview of the methodology, while elevating key findings aggregated from key population communities across many of the geographies where the Global Fund invests.

Section III delves into our findings and addresses key issues and risks regarding: (i) the Global Fund's accelerated integration process; (ii) barriers, bottlenecks, and limited community engagement; (iii) access barriers for key populations that were compounded by language barriers, confusing guidance from the Global Fund Secretariat, last-minute notifications of critical meetings, consultations, and complex budget submissions, and missed opportunities for communities to contribute their expertise, insights, and priorities to planning discussions and decision-making; and (iv) flawed implementation arrangements, including the quality and quantity of funding, which further disadvantages key population-led services and programming. This section also discusses concerns regarding the potential for social contracting for key population-led organisations and networks within criminalised and politically hostile environments and calls for a direct funding mechanism (The Unity Fund) led for and by key populations.

Section IV speaks to the importance of, at a minimum, maintaining levels of investment

for interventions that remove the social and structural barriers to health equity for key population communities. As budgets get tighter and tighter, preserving our focus on eradicating structural barriers to lifesaving services cannot take a backseat. Addressing the social and structural factors that prevent or enable HIV and TB care requires long-term investments. They are as fundamental to ending the three diseases as access to scientific breakthroughs. This is not an either/or dilemma—it is a matter of ensuring continued and holistic investments in both.

Section V outlines key recommendations for Grant Cycle 8 and beyond. Our recommendations are directed at the Global Fund Secretariat, as well as to members of country-level governance structures and implementing agencies of Global Fund programming.

Recommendations

To the Global Fund Secretariat:

1. **The Global Fund, in partnership with the Global Key Population Networks, must create a direct funding stream under GC8 to build, protect, and expand key population-led responses** to ensure equitable access to lifesaving services for communities most affected by HIV, TB, and malaria.

2. **The Global Fund must develop detailed guidance in advance of GC8 to articulate its approach to "integration" in dialogue with the Global Key Population Networks.** Measures to protect key population-led programming, service delivery, organisations, and networks must be firmly embedded in GC8 to ensure equity, science, and rights-based access to lifesaving services for communities most affected by the three diseases and delivered when and where they are needed most.

3. **The Global Fund and Technical Partners must prioritise the scale-up and expansion of ongoing peer-to-peer TA provision** and peer-to-peer capacity building so that key population communities in all Global Fund-funded countries benefit and are able to meaningfully convene, engage, and contribute to fundamental decision-making processes that ultimately affect their lives. Ensure that technical assistance providers recruited by the Global Fund are selected in close partnership with the Global Key Population Networks.

4. **The Global Fund should preserve and enhance the role of the Community Annexe** to support the balance of power dynamics at the country level. The Community Annexe must be included as a core component of the GC8 proposal development process and reviewed by the Technical Review Panel alongside country grant submissions.

5. **The Global Fund (and CCMs and PRs) must increase the transparency of and equitable and timely access to critical grant information for all stakeholders** to ensure meaningful contributions and the engagement of key population communities in all grant-related processes.

6. **The Global Fund must extend community engagement beyond the proposal development** phase to ensure meaningful community engagement and oversight across the full grant lifecycle.
7. **The Global Fund (and LFAs) should conduct a review of in-country implementation arrangements** to ensure that tender requirements do not exclude key population-led organisations and networks from granting opportunities.
8. **The Global Fund must increase the transparency of decisions taken regarding all activities, including any deprioritisation, deferments, and/or cuts from grants throughout the grant lifecycle.** Access to this information is critical to all partners and will support the monitoring of gaps to track the impact of these funding decisions on civic space and equitable access to lifesaving services.

To Country Coordinating Mechanisms, Principal and Sub-Recipients:

1. **CCMs and PRs must increase the transparency of and equitable and timely access to critical grant information for all stakeholders** to ensure meaningful contributions and the engagement of key population communities in grant-related processes.
2. **PRs and CCMs must increase the transparency of decisions taken regarding all activities, including any deprioritisation, deferments, and/or cuts from grants throughout the grant lifecycle.** Access to this information is critical to all partners and will support the monitoring of gaps to track the impact of these funding decisions on civic space and equitable access to lifesaving services.
3. **PRs (LFAs and the Global Fund) should conduct a review of in-country implementation arrangements** to ensure that tender requirements do not exclude key population-led organisations and networks from granting opportunities.
4. **Civil society implementing organisations of key population programming** must do more to lift up and protect key population leadership. For instance, raise questions about voices missing from the table, provide support, and make travel funds available to ensure the participation of key populations in all key grant-related meetings and processes at the country level.

The experiences of key population communities during this GC7 reprioritisation process pinpoint key structural hurdles within the Global Fund model that have been magnified by the financial uncertainty for global health and development, as well as the resultant pressures on country-level responses to HIV, TB, and malaria, and the extremely compressed timeframe within which these processes occurred. The findings presented in this report punctuate the need for urgent attention and co-created solutions with and for communities of people who use drugs, gender diverse and gender non-conforming individuals, gay, bisexual, and other men who have sex with men, and sex workers.

2.0 Introduction

Momentous policy shifts, high political uncertainty, and global economic disarray continue to characterise 2025, beginning in January with the sudden withdrawal of U.S. foreign assistance worldwide, the effects of which have been nothing less than harrowing, chaotic, and confounding for the state of global health, its tightly woven architecture, national health systems, already highly constrained domestic budgets of low- and middle-income countries (LMICs) governments, and for those most affected by HIV, TB, and malaria who rely on key population[3] -led programming and service delivery in particular.

United Nations outcome documents, research studies, policy briefs, technical and programmatic guidance, and a plethora of reports consistently show that community-led networks and organisations are the bedrock of effective emergency and long-term public health responses. Evidence-based community-led public health models that reach marginalised, stigmatised, and criminalised populations most affected by HIV and TB are founded on strong peer-led front-line service delivery approaches, such as outreach, peer education, psycho-social support, gender-based violence services, community leadership development, advocacy, and engagement. **Community-led responses are more than disease prevention strategies; they are critical lifelines for people left behind by traditional healthcare systems and serve as vehicles for sustainably tackling long-pervasive systemic health inequities.**

In 2021, United Nations Member States endorsed the U.N. Political Declaration on HIV, committing to ensure that **30 percent of HIV testing and treatment services and 80% of HIV prevention programming for key and vulnerable populations would be delivered by community-led organisations by 2025.** We are still miles away from achieving these targets.

Today's global financial and political crisis has exposed the fragility of the HIV, TB, and malaria response and the even greater vulnerability of key population-led organisations, networks, and communities. **When peer-led organisations and services are among the first to be closed during times of far-reaching financial crisis and system shock, the holistic people-centred model of care that has long been exemplified in the global HIV, TB, and malaria response is placed at significant threat of crumbling from its foundation.**

In April 2025, while the global health and international development sector at global, regional, national, and sub-national-level was still whirling from sudden U.S. funding

3. Key populations are groups considered at heightened risk of acquiring HIV due to a combination of factors including high-risk behaviours and experiences of stigma, discrimination, violence, and social, legal, and structural barriers that frequently barre equitable access to health and social services. Key populations include people who use drugs, sex workers, trans and gender-diverse communities, gay, bisexual, and men who have sex with men, and people in prisons. According to UNAIDS and the Global HIV Prevention Coalition, key populations account for two-thirds of all new HIV infections. Key populations are the best experts on the needs of their community; peer workers are the most adept at reaching those who are the hardest to reach in their community with trusted sources of information and rights-based services. Sources: https://hivpreventioncoalition.unaids.org/en/populations-programmes/key-populations and https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2024/july/20240722_global-aids-update

cuts and mounting uncertainties in international health funding more broadly, the Global Fund issued a communication to its Principal Recipients (PRs) and Country Coordinating Mechanisms (CCMs) with instruction to pause or defer certain grant activities deemed non-critical to the delivery of life-saving services. This decision was taken unilaterally with the aim to support countries in efforts to "optimise the use of Grant Cycle 7 (GC7) investments to protect and preserve progress against the three diseases and enable uninterrupted access to life-saving services". **However, many of the activities that were deemed "non-vital" are in fact fundamentally vital to the protection of strong community-led programming and service delivery** (e.g., trainings, print materials, harm-reduction programmes, advocacy activities, community-led monitoring and data collection, and operational costs).[4 5 6]

In short, April's communication by the Global Fund and the follow-on communications led by in-country PRs occurred in the absence of prior community consultation and resulted in the immediate freezing of critical resources for key population-led community programming and service delivery. This was on top of the already severe funding shortfalls, mass lay-offs, and service disruptions experienced by key population-led organisations and networks resulting from U.S. policy shifts. April's communication became the precursor to what was to become known as the Global Fund's "Grant Cycle 7 (GC7) reprioritisation process"—a country-led process to rapidly reprioritise and revise Global Fund-funded HIV, TB, and malaria programming in accordance with reduced Global Fund country funding envelopes and domestic financing considerations. Formally launched at the end of July with Notification Letters to countries communicating reduced Global Fund funding allocations, the process is due to wrap up by early November with more than 200 revised GC7 grant agreements.

The reprioritisation process was an intensive, time-pressured, high-stakes environment that accentuated and exacerbated key structural challenges and power imbalances within the Global Fund's country funding model. While successes for key population-led community responses were achieved in some country contexts, the results of the decisions taken in terms of impact on programmatic gaps, equitable access to and quality of life-saving services will not become clear without further research and analysis. **It is quite evident, however, that key population-led community interventions and human rights programming remain in grave danger of being deprioritised and subject to receiving even fewer resources moving forward.** Ongoing financial uncertainties and volatile political and policy environments will inevitably result in difficult decisions about which interventions will be sustained by Global Fund investments under Grant Cycle 8, which will

4. The Global Fund to Fight AIDS, TB and Malaria. (8-9 May 2025) Approach to mid-cycle grant adaptations, GF/BR2025/02_Rev1. Accessed at: https://archive.theglobalfund.org/media/vvabjnij/archive_bm53-approach-mid-cycle-grant-adaptations-gc7_presentation_en.pdf
5. The Global Fund to Fight AIDS, TB and Malaria. (16 May 2025) Operational Update. Accessed at: https://archive.theglobalfund.org/media/ohtjuebb/archive_operational-2025-05-16_update_en.pdf
6. The Global Fund to Fight AIDS, TB and Malaria. (16 May 2025) GC7 Programmatic Reprioritization Approach. Updated: 12 June 2025. Accessed at: https://www.theglobalfund.org/media/iacjn0sn/cr_2025-05-gc7-mid-cycle-grant-adaptations_presentation_en.pdf

be subsumed under domestic health budgets, and which will be defunded completely. **Key population communities must be armed to advocate with the evidence base that clearly demonstrates why science and rights-based community-led interventions work, and this must continue even before Global Fund Grant Cycle 8 preparations begin in 2026.**

The following report offers insight into the experiences of key population-led organisations and networks during the GC7 reprioritisation process. In the pages that follow, we provide concrete recommendations for the Global Fund Secretariat, Country Coordinating Mechanisms, Principal Recipients, and civil society implementing partners that are intended to foster co-created solutions to challenges that are intrinsic to sustaining key population-led community systems and responses within a rapidly changing world.

3.0 About This Report

This report has been prepared by the Global Key Population Networks (INPUD, GATE, MPact, and NSWP[7]) on the heels of the recent and unprecedented reprioritisation and revision process undertaken in the midst of the Global Fund's seventh grant cycle, commonly known as GC7 (the 2023–2025 allocation period). The purpose of this report is threefold:

1. Document the engagement of key populations in Global Fund processes, such as the GC7 reprioritisation and revision process.
2. Document key challenges and proposed solutions that have been identified during this pivotal Global Fund process in order to strengthen the efficiency and effectiveness of Global Fund programming and ensure that community leadership, meaningful engagement, and rights-based community-led responses remain at the centre of its investments.
3. Provide a series of recommendations to the Global Fund Secretariat, Country Coordinating Mechanisms, Principal and Sub-Recipients to guide and support preparations for and the implementation of the next funding cycle Grant Cycle 8 (2026–2028 allocation period).

This report has been compiled from the direct experiences of in-country key population communities and the Global Key Population Networks that support them. It builds on previous key population publications and has been cross-referenced with civil society reports that similarly document the reprioritisation process, as well as communications released by the Global Fund. Our findings have been validated by key population community members from across many Global Fund countries and regions during an online consultation and report-back, hosted by GATE, INPUD, NSWP, and MPact on October 1, 2025.

Limitations to this report include gaps in country-level representation from across all geographies where the Global Fund invests. Similarly, the exclusive focus on HIV grants limits the generalisability of these findings with the Global Fund's TB and malaria portfolios. Despite these limitations, the report provides important observations and lessons learned during what continues to be an intense period of shifting global politics, profound financial upheaval resulting from the withdrawal of U.S. foreign assistance, withering official development assistance (ODA), and significant funding shortages at the largest multilateral financing institution for HIV, TB, and malaria.

7. International Network of People who Use Drugs (INPUD), Global Action for Trans Equality (GATE), MPact Global Action for Gay Men's Health and Rights (MPact), and the Network of Sex Work Projects (NSWP).

4.0 Truth Telling: The Experiences and Observations of Key Populations

> *" The Global Fund remains the core donor supporting human rights programming and community-led responses. As more and more HIV, TB and malaria programming costs are shifted to domestic health budgets, it's more important than ever that we get this right."*
>
> Technical assistance provider

This section provides an overview of general findings, accounts of success, as well as specific challenges encountered during the reprioritisation process, including persisting issues related to key population access to information, meetings, and consultations, meaningful community engagement, and in-country Global Fund grant implementation arrangements.

General Findings

Amidst the political and financial headwinds facing countries and communities, the reprioritisation process saw a number of notable successes for key population-led programming and service delivery. These triumphs, although not uniformly experienced across all country contexts, are the result of the fierce advocacy, courage and peer leadership, collaboration, information sharing, and strategic engagement of key population-led organisations and networks at the global and country level. In this high-stakes environment, community and civil society mobilisation was stronger than ever before.

Technical assistance provided by INPUD, GATE, NSWP, and MPact strongly contributed to securing these successes through ongoing support with document analysis and preparation, strategic advocacy, webinar consultations, local travel support, and tight communications with country partners. For instance, shortly following the release of Global Fund guidance on the reprioritisation process, INPUD, GATE, NSWP, and MPact, in partnership with GBGMC, hosted a global webinar to wade through the guidance, highlight key resources quickly developed by civil society and community partners, exchange in-country updates, and help understand timelines, processes, and next steps. During this webinar consultation, close to 200 community and civil society allies were in attendance and identified non-negotiable interventions for and by key populations to ensure continued access to lifesaving services for our communities. These inputs were further informed by 60 community survey responses from 31 countries. In the end, these resources helped to shape the priorities and costed interventions put forward by in-country organisations and networks of sex workers, people who use drugs, trans and gender-diverse, gay, bisexual and men who have sex with men during in-country consultations, technical working group meetings, CCM meetings and in bilateral communications with Principal Recipients, technical, and other implementing partners.

The inspiring level of community leadership, mobilisation, and advocacy has resulted in the scale-up of harm reduction programming and services for people who use drugs in some countries. It has also led to the modest expansion of key population-led services, including community-led drop-in centres and safe spaces in a small number of country contexts. Moreover, many of the activities that had been paused or deferred as "non-essential" were reincorporated into revised budgets and workplans.

Despite these successes, several challenges were prominent and **common across all implementing countries**, including:

1. Human rights programming, investments in gender equality and key population-led responses were often the first to be deprioritised and to experience significant funding cuts during the in-country reprioritisation dialogues. Key populations were asked to submit budgets and project proposals at the last minute for consideration prior to the country's deadline to submit working documents for the Secretariat's review process. **We are still yet to learn whether budgets submitted by key population-led organisations were incorporated into the final versions approved by the Global Fund Secretariat.**

2. Activities that were paused, deferred, or cut completely were those that are the backbone of community-led responses (e.g., training & capacity building, community engagement, outreach and peer education, advocacy, and community-led data). Reports from community members and civil society partners saw cuts to trainings, such as HIV paediatric trainings; quality assurance and monitoring of supply chains; and substantial cuts to human rights and gender equality programming, such as referrals to legal services and gender-based violence (GBV) peer navigator programmes and trainings. While it was often the case that many of the activities were reintegrated into reprioritised budgets, **the unilateral decision to pause and/or defer these activities jeopardised the continuity of core programmes and services for key populations in the immediate, not to mention the financial viability of community-led organisations and their staff.**

3. The GC7 reprioritisation process was extremely rushed and time-intensive for everyone—particularly for key population-led organisations/networks that tend to be small in size with limited staff and bandwidth. **Leaders needed to dedicate the necessary time "off the sides of their desks" as the hours and days that they invested were often unbudgeted and on top of already very heavy workloads.** Additional resourcing to compensate community-led organisations and enable their valuable contributions is a budgetary "bottom-line" for meaningful community engagement.

4. While the grant review and revision process is a core element of the Global Fund's operational procedures, key population-led organisations are rarely at those decision-making tables. Reprioritisation was incredibly time-intensive and involved communities receiving very detailed requests at the very last minute, but **it also clearly demonstrated the value of making regular grant review and revision processes more inclusive and more transparent for all partners across the grant cycle** to ensure that any

adjustment optimises access to lifesaving services for the communities most affected by the three diseases.

Issues with 'Integration'

> *"Integration is often sold as the ultimate efficiency win, but efficient for whom? Efficiency could mean streamlined budgets for ministries, reduced administrative burden for hospitals, or a one-stop shop for patients. Yet the communities we serve—MSM, trans [and gender diverse] people, sex workers, people who use drugs—often have specific needs requiring trust, confidentiality, and specialised expertise. Integration without a deliberate equity lens can leave those needs unmet."*
>
> APCOM, 13th International AIDS Society Conference on HIV Science (IAS 2025)[8]

The operational guidance provided by the Global Fund was long and detailed and emphasised that changes to the current grant activities be tailored to country contexts with priority for key interventions that reduce equity, human rights, and gender-related barriers. It also introduced "integration" as a means to optimise "cost effectiveness and long-term sustainability of HIV, TB and malaria activities within countries' primary health care services and health and community services." It noted that efforts to integrate services and systems would be accelerated under Grant Cycle 8 (GC8). But as articulately noted by APCOM in the quote above, **efficient [and effective] for whom?**

Importantly, the guidance failed to provide a clear definition for how the Global Fund intended integration to roll out. This caused significant confusion at the country level and panic within communities, particularly in geographies where key populations are highly criminalised. On one hand, the guidance underlined the importance of maintaining and strengthening community systems as essential to reaching the most affected populations. On the other hand, there was a clear push for services to be integrated into primary health care systems (see Fig. 1 and 2). For instance, under the section on HIV prevention, the first sentence of the guidance note begins *"Integrate HIV prevention programmes for KP and AGYW into mainstream services where competency exists and where protections against stigma and discrimination are in place."* (Fig. 2) **Who and how it was to be decided whether these competencies existed was unclear, but the undertone read that it would not be sex workers, people who use drugs, trans or gender-diverse people, gay, bisexual, or men who have sex with men.**

The lack of clarity and the emphasis on integration opened the door for governmental PRs and CCMs to cut, or significantly reduce, the budgets of key population-led services and programmes in place for governmental health systems reeling from the recent withdrawal of U.S. funding support. Canary in the coalmine for accelerated integration under GC8?

8. Magak, Edith. (23 July 2025). Is HIV integration a response or a death sentence? Communities demand answers. Aidsmap. Accessed at: https://www.aidsmap.com/news/jul-2025/hiv-integration-response-or-death-sentence-communities-demand-answers

Fig. 1

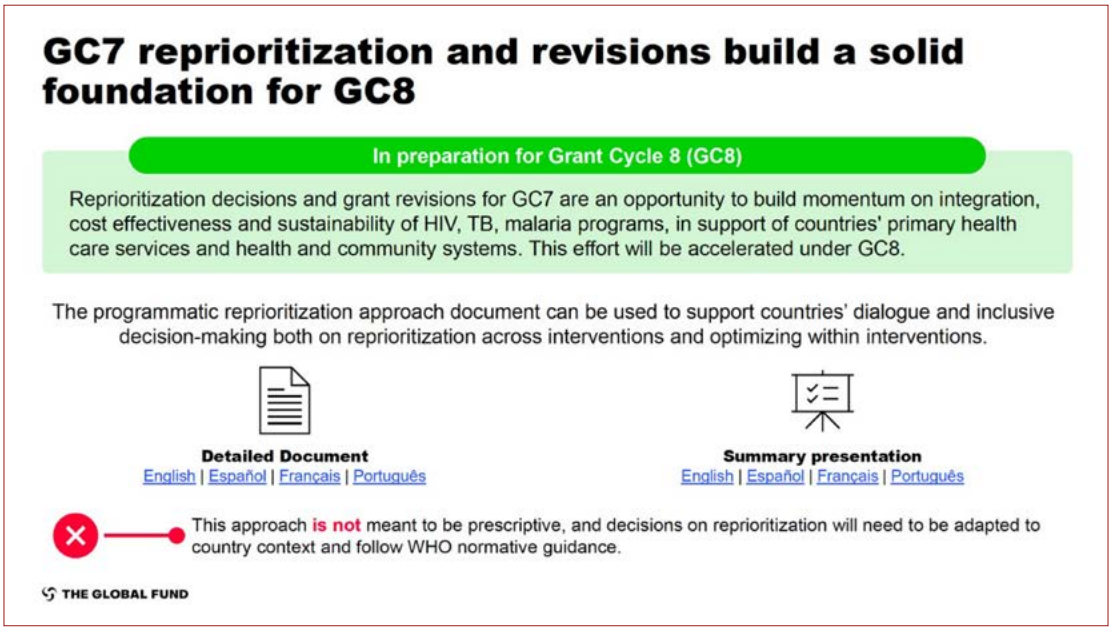
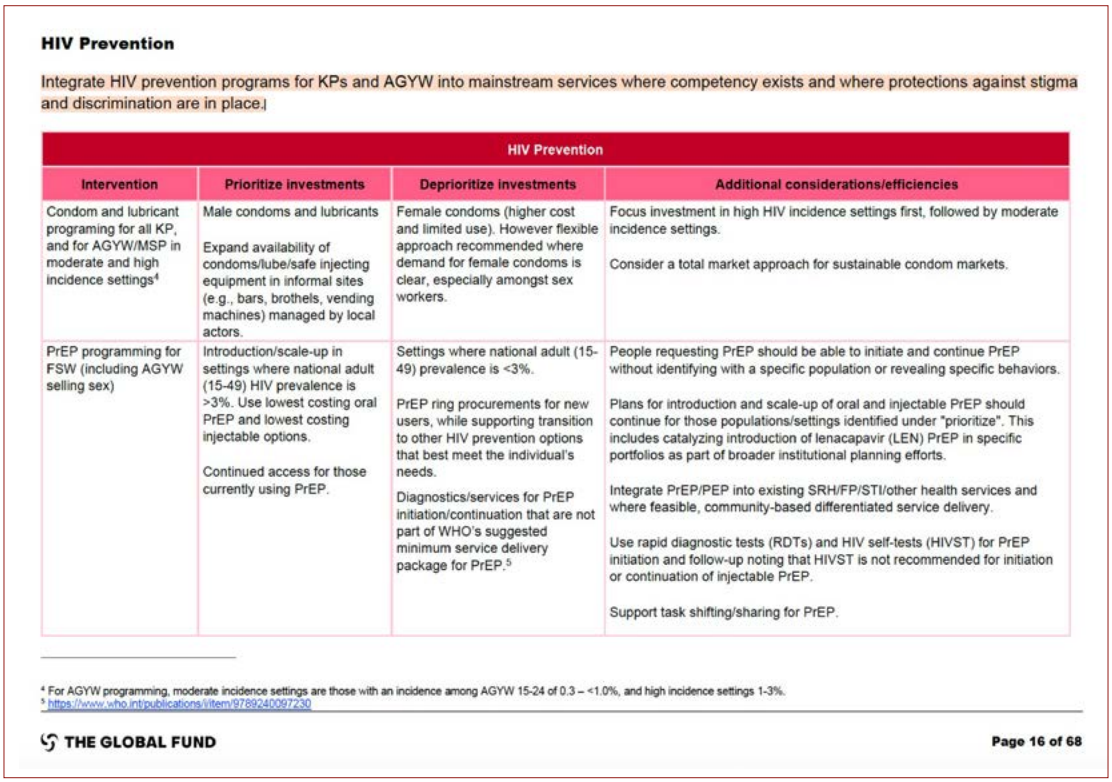


Fig. 2



HIV Prevention

Integrate HIV prevention programs for KPs and AGYW into mainstream services where competency exists and where protections against stigma and discrimination are in place.]

HIV Prevention			
Intervention	**Prioritize investments**	**Deprioritize investments**	**Additional considerations/efficiencies**
Condom and lubricant programing for all KP, and for AGYW/MSP in moderate and high incidence settings[4]	Male condoms and lubricants Expand availability of condoms/lube/safe injecting equipment in informal sites (e.g., bars, brothels, vending machines) managed by local actors.	Female condoms (higher cost and limited use). However flexible approach recommended where demand for female condoms is clear, especially amongst sex workers.	Focus investment in high HIV incidence settings first, followed by moderate incidence settings. Consider a total market approach for sustainable condom markets.
PrEP programming for FSW (including AGYW selling sex)	Introduction/scale-up in settings where national adult (15-49) HIV prevalence is >3%. Use lowest costing oral PrEP and lowest costing injectable options. Continued access for those currently using PrEP.	Settings where national adult (15-49) prevalence is <3%. PrEP ring procurements for new users, while supporting transition to other HIV prevention options that best meet the individual's needs. Diagnostics/services for PrEP initiation/continuation that are not part of WHO's suggested minimum service delivery package for PrEP.[5]	People requesting PrEP should be able to initiate and continue PrEP without identifying with a specific population or revealing specific behaviors. Plans for introduction and scale-up of oral and injectable PrEP should continue for those populations/settings identified under "prioritize". This includes catalyzing introduction of lenacapavir (LEN) PrEP in specific portfolios as part of broader institutional planning efforts. Integrate PrEP/PEP into existing SRH/FP/STI/other health services and where feasible, community-based differentiated service delivery. Use rapid diagnostic tests (RDTs) and HIV self-tests (HIVST) for PrEP initiation and follow-up noting that HIVST is not recommended for initiation or continuation of injectable PrEP. Support task shifting/sharing for PrEP.

[4] For AGYW programming, moderate incidence settings are those with an incidence among AGYW 15-24 of 0.3 – <1.0%, and high incidence settings 1-3%.
[5] https://www.who.int/publications/i/item/9789240097230

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To be clear, integrating services into government-run primary health care facilities risks the health and the lives of key populations, their loved ones, and the community-led organisations that serve them. Integration can occur at a policy level, at a functional level (e.g., health human resources), and at a service level, including across diseases.[9] Without clear protections (funding included) for key population-led services, programming,

9. Magak, Edith. (31 July 2025). Integration of services – what does that really mean? Aidsmap. Accessed at: https://www.aidsmap.com/news/jul-2025/integration-hiv-services-what-does-really-mean

organisations, and networks, integrated service delivery through primary health care will continue to fail our communities who are stigmatised, marginalised, criminalised, and most affected by the three diseases. Key populations mistrust government-run clinics due to the continued history of pervasive stigma, discrimination, surveillance, threats to personal privacy and security, breached confidentiality, and experiences of increased policing and persecution, especially in settings where the criminalisation of HIV status and key populations are a daily reality.

Mixed messaging from the Secretariat's guidance also raised confusion about the prioritisation of community-led monitoring and whether the reprioritisation process should also identify efficiencies by bridging the gaping holes in HIV, TB, and malaria programming left by the retraction of U.S. foreign assistance.

Recommendations:

The Global Fund must develop detailed guidance in advance of GC8 to articulate its approach to "integration" in dialogue with the Global Key Population Networks. Measures to protect key population-led programming, service delivery, organisations, and networks must be firmly embedded in GC8 to ensure equity, science and rights-based access to lifesaving services for communities most affected by the three diseases and delivered when and where they are needed most.

Community Engagement

> *"As representatives of key populations, we saw that we had to fight harder than we ever have had to get into the decision-making rooms and have our voices heard. We have made progress in some areas, but we won't know the outcome until we see the final budgets and the revised grant agreements."*
>
> Representative of an in-country key population

One of the building blocks of strong, meaningful community engagement is **being able to access the right information at the right time to be able to influence the right discussions and participate in the right spaces**. Equal access to information addresses power dynamics from the onset by ensuring that the community is well prepared with all necessary information in order to make well-informed strategic decisions and recommendations. **Equal and timely access to grant information was not the case for all key population communities during the reprioritisation process**. Many key populations were left out completely from this critical planning and decision-making process (e.g., young key populations and key population migrants and refugees). As financial pressures and uncertainties continue to mount at the country and global levels, meaningful community engagement must not be caught in the mix of trade-offs. **Fairer processes for key population communities must be embedded as priority guardrails for Grant Cycle 8.**

Additional observations include:

1. **Community Annex:**
   The Community Annex was not used in this critical revision process, but should have been as an essential tool to collect, document, and transparently synthesise community priorities. Without it, there is no mechanism to collectively document, give visibility to, or track community input into Global Fund grant processes.

2. **Technical Assistance (TA):**
   In some cases, TA providers hired by the Global Fund were ill-suited to meaningfully support in-country key population organisations and impacted their ability to engage meaningfully. Technical assistance providers for key population communities must be recruited and selected in consultation with Global Key Population Networks to ensure coherence, collaboration, and acceptability. Community trust and experience working alongside key population communities must be a central criterion.

3. **Burnout:**
   The intensity, pace, and time-sensitive demands of the reprioritisation process exacerbated levels of burnout in the community already burdened with extensive staffing shortages and service disruptions. Burnout has been intensified because of being denied line of sight on the final grant decisions, which ultimately determine the future of their lifesaving programming, which their community relies upon. Community engagement must mean full and meaningful participation across the entire grant cycle. Central to this is transparency and accountability of final grant agreements, including budgets.

Recommendations:

- **The Global Fund and Technical Partners must prioritise the scale-up and expansion of ongoing peer-to-peer TA provision** and peer-to-peer capacity building so that key population communities in all Global Fund-funded countries benefit and are able to meaningfully convene, engage, and contribute to fundamental decision-making processes that ultimately affect their lives. **Ensure that technical assistance providers recruited by the Global Fund are selected in partnership with the Global Key Population Networks.**

- **The Global Fund should preserve and enhance the role of the Community Annex** to support the balance of power dynamics at the country level. The Community Annex must be included as a core component of the GC8 proposal development process and reviewed by the Technical Review Panel alongside country grant submissions.

The Issue of Access

> *" The technical assistance from the Global Key Population Networks was intensive. And it was absolutely critical for us… critical for us to be able to access information, know about meetings and consultations, advocate our priorities, and contribute to grant revision documents and budgets—even at the last minute."*
>
> Representative of an in-country key population

Access to timely and accurate information, invitations to consultations, meetings, and decision-making tables varied significantly across country contexts. However, key population groups and, in particular, young key population representatives were notably excluded, or had to fight to get into the room, and stakeholder participation was largely concentrated to those in capital cities. Key populations within migrant and refugee settings were also visibly absent from these proceedings.

The fact is, the challenges encountered are not unfamiliar to those that have been already well-documented by key population communities during previous country funding request development processes. Yet, it was the presence of the many new and evolving pressures that exacerbated these hurdles to an almost insurmountable level.

> *"I agree [there was] lack of transparency and inclusiveness. Also, criminalised key populations have limited space and opportunities."*
>
> Representative of an in-country key population

Rapidly evolving financial pressures were experienced by all partners and rendered the discussions and decision-making highly charged, lacking in transparency (more often than not), and in great need of a healthy infusion of "inclusivity".

The urgency with which the process was launched and the extremely tight time constraints significantly restricted consultation and planning, particularly since many of those budget line items were no longer available, since they had been paused/deferred in April. Long guidance notes (69 pages with accompanying slide decks) were often updated by the Global Fund Secretariat throughout the process and released in English with translations into other working languages posted weeks later. Access to up-to-date financial information and performance data from the PRs and implementing partners was often unattainable for communities. Financial documents that were provided were complex, lengthy, and difficult to track how certain cuts to one budget line would impact the ability to deliver results tagged under another activity within a separate budget module.

Needless to say, access to information was compounded by language barriers, excessive and confusing documentation, conflicting messages from the Secretariat, frequent misinterpretation of the guidance at the country-level, and missed opportunities for communities to contribute their expertise, insights, and input to planning discussions and decision-making.

Additional access barriers included:

- **CCM meeting schedules were often difficult to obtain and were constantly changing without advance notification.** Key population leaders were sent meeting invitations at the last minute, with Zoom links often just as meetings were about to begin. This meant that they either dropped everything to attend or risked being left out of the conversation. In a similar instance, one community leader had to drop everything and jump at the last minute onto an evening bus to be able to arrive in time for the national consultation, which was set to begin the next morning and where they were informed they were to present their communities' priorities and rationale.
- **Key population-led organisations also received last-minute notice to complete proposal templates, work plans, and detailed project budgets,** with submission deadlines often early the next day.
- **Across a number of countries, key populations raised concerns about the lack of transparency** in how members of Technical Working Groups (TWGs) were selected and how meeting participants were chosen. Key population voices were often missing and excluded. Those who were the most vocal had to fight even harder to get in the room.
- **Communities were often working within an information vacuum** and expected to contribute to planning processes (e.g., TWGs) and provide their costed priority interventions. In many cases, it was difficult to get the right grant documents at the right time—especially detailed grant budgets with up-to-date absorption data and work plans to help inform and guide their inputs. Efforts to obtain these critical documents were often unsuccessful.
- **Key population representatives had to pay their own travel expenses to attend national meetings/consultations, as well as for internet data plans to join online.** Those organisations that are part of the Global Fund Community Engagement Strategic Initiative (CE-SI) were able to draw on small grants from Global Key Population Networks and Learning Hubs; however, these resources were available for only a small cohort of countries and communities.
- **Engagement with the Global Fund Secretariat was extremely helpful throughout the reprioritisation process.** However, additional protections must be put in place for key population leaders. In some instances, community leaders experienced repercussions in-country if it was learned that they had spoken to or had raised questions about the process directly with the Secretariat teams in Geneva.

On the positive side, the community noted greater accessibility to the revised allocation letters with the proposed funding cuts across the country programme portfolios. Technical assistance providers contracted by the Global Key Population Networks helped to push for community access to critical meetings and documents from PRs and CCMs. Communities

that received technical assistance from the Global Key Population Networks helped to ensure that PRs worked closely with communities to include their priorities in the revised budgets. Similarly, civil society partners rapidly developed extremely valuable resources that helped distil key information and high-level data to support the preparation and monitoring of in-country community and civil society participation.

Recommendations:

- **The Global Fund, CCMs, and PRs must increase the transparency of and equitable and timely access to critical grant information for all stakeholders** to ensure meaningful contributions and the engagement of key population communities.
- **The Global Fund must extend community engagement beyond the proposal development phase** to ensure meaningful community engagement and oversight across the full grant lifecycle.
- **The Global Fund, CCMs, and PRs must provide timely and clear reporting on what activities have been deprioritised, deferred, and cut from grants** to monitor gaps and track the impact of these funding decisions on civic space and access to lifesaving services for key populations and community-led programming.
- **Civil society implementing organisations of key population programming must do more to lift up and protect key population leadership.** For instance, raise questions about voices missing from the table, provide support and make travel funds available to ensure the participation of key populations in all key grant-related meetings and processes at the country level.

Implementation Arrangements

Validated by the recent experiences of COVID-19, it is clear that pandemics begin and end in communities.[10] Communities are where early detection occurs and where evolving trends can be first witnessed, documented, and tracked. Key population-led organisations, networks, and programmes are resilient, innovative, and know how to best reach those who are the most affected with the services they need. When communities lead, enabling environments and human dignity thrive, HIV-related stigma plummets, and health outcomes and quality of life improve for communities most affected by HIV.[11] **Yet, key population-led organisations and networks continue to confront substantial obstacles within the Global Fund's country-led model, including legal and registration barriers, under-resourcing and lack of direct funding, delayed payments, and exclusion from in-country decision-making tables**.[12]

10. Zero Draft of the WHO CA+ for the consideration of the Intergovernmental Negotiating Body at its fourth meeting: WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response. A/INB/4/3. 1 February 2023. Accessed at: https://apps.who.int/gb/inb/pdf_files/inb4/A_INB4_3-en.pdf Article 16.1.
11. Let Communities Lead: World AIDS Day report, 2023. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS); 2023. Accessed at: https://www.unaids.org/sites/default/files/media_asset/2023WADreport_en.pdf
12. AmfAR. Scope Report: Support for Community Organisations & Priorities for Empowerment and Impact. (August 2025). Accessed at: https://www.amfar.org/news/community-led-health-programs-benefit-people-impacted-by-hiv/

While key population-led organisations and networks have yet to be notified of the final revised grant agreements and revamped project budgets, the reprioritisation process shone light on important implementation barriers.

> *"Principal Recipients and sub-recipients often engage with their 'friends' and exclude those who ask too many questions."*
>
> Representative of an in-country key population

i. Quality and Quantity of Funding for Key Population-Led Organisations Under GC7

Through the reprioritisation process, it has become even clearer that funding for in-country key population-led organisations and networks is already extremely limited under GC7 (prior to reprioritised budgets), with very few resources eligible to support core capacity building, organisational growth, or project management costs. For instance, in some countries, trans-led interventions were frequently funded at a level so low that it would be nearly impossible to demonstrate scalable impact. Drug user-led harm reduction programmes were often contracted by non-governmental PRs, SRs and sub-sub recipients (SSRs) through stipends for outreach work, peer education, data collection, and often one-off activities—none of which contribute to ensuring thriving and more sustainable community-led responses.

Lengthy delays with in-country payment processes also often bore witness to critical community-led interventions being put on an indefinite hold for key populations, resulting in inadequately addressed HIV prevention, treatment, and care needs of communities. In many instances, key population-led organisations have sought alternate sources of interim funding or have worked on a volunteer basis to avoid service disruptions for their community members.

ii. In-Country Implementation Arrangements

In-country implementation arrangements were also identified as a substantial barrier to enabling greater resources for community-led responses. Project-based tenders are reported as extremely arduous for small organisations with few staff. They are reportedly overly bureaucratic and require extensive documentation and a funding track record that renders key population-led community organisations at a competitive disadvantage. This is particularly relevant in countries where criminalisation and difficult policy environments present significant hurdles for community-led organisations. At a PR level, the Scope Report identified that community-led organisations made up only 6–9% of all PRs across GC5 to GC7 and received 6–8% of all Global Fund grant budgets across this same period.[13] These findings do not quantitatively assess the proportion of funding for community-led organisations as Sub-Recipients or sub-Sub-Recipients, but **it does raise the question about the quality and quantity of funding for community-led organisations in relation to the global targets set in the 2021 U.N. Political Declaration on HIV.**[14]

13. Ibid.
14. Ibid.

iii. Social Contracting Considerations

Social contracting mechanisms are important developments for the sustainability of civil society and community-based service delivery. However, as noted elsewhere in this report, the proof will be in the pudding. In contexts where non-governmental community and civil society organisations are met with "foreign agent" laws, difficult registration processes, and excessive government auditing requirements, social contracting must be established as a mechanism to carve out an enabling environment for civil society to thrive and not be strangled.

Furthermore, social contracting can only be successful when community and civil society organisations have the freedom to receive government funding for their community priorities, and not those of the government, should they differ. In many contexts where the Global Fund invests, key populations are not officially recognised and thus remain outside of government health priorities, and in contexts where key populations are criminalised, government funding for organisations led by so-called criminalised groups is a non-starter. **The findings presented here provide further argument and a clarion call for a direct funding stream for key population-led responses as part of the Global Fund's upcoming Grant Cycle 8.**

Recommendations:

- **The Global Fund, in partnership with the Global Key Population Networks, must create a direct funding stream under GC8 to build, protect, and expand key population-led responses that ensure equitable access to lifesaving HIV, TB, and malaria services.**
- **The Global Fund and PRs should conduct a review of in-country implementation arrangements** to ensure that tender requirements do not exclude key population-led organisations and networks from granting opportunities.
- **The Global Fund and PRs must increase the transparency of decisions taken regarding all activities, including any deprioritisation, deferments, and/or cuts from grants throughout the grant lifecycle.** Access to this information is critical to all partners and will support the monitoring of gaps to track the impact of these funding decisions on civic space and equitable access to lifesaving services.

5.0 Conclusion: Prioritising Structural Barriers to Lifesaving Services

The present environment of rapidly shrinking resources, coupled with drastic changes to our global and country-level political landscapes, threatens to undo decades of hard-won progress, evidence, and best practice in the HIV response.

Key population communities and the organisations that they lead are fundamental to ensuring equitable, rights-based, effective public health responses. Yet we are now seeing the biggest gaps in key population-led programming with plummeting levels of ODA, the shuttering of USAID, the stark revisions to PEPFAR priorities, and the impact and implications of U.S. foreign policy more broadly.

As budgets get tighter and tighter, preserving our focus on eradicating structural barriers to lifesaving services cannot take a backseat. Addressing the social and structural factors that prevent or enable HIV care requires long-term investments. They are as fundamental to ending AIDS as a public health threat as access to scientific breakthroughs. This is not an either/or dilemma—it is a matter of ensuring continued and holistic investments in both. **Afterall, as the history of the HIV response has demonstrated, prevention and treatment are only effective so long as those who are most underserved by healthcare systems are able to easily and equitably access it.** This means protecting community-led responses, human rights programming, and culturally competent, gender-transformative, and gender-affirming care.

It also means protecting key population-led responses by moving away from service-based contracts to more holistic approaches to advancing key population-led organisations, networks, capacities, and leadership.

6.0 Recommendations for Grant Cycle 8

The experiences of key population communities during this GC7 reprioritisation process pinpoint key structural hurdles within the Global Fund model that have been magnified by the financial uncertainty for global health and development, as well as the resultant pressures on country-level responses to HIV, TB, and malaria, and the extremely compressed timeframe within which these processes occurred. The findings presented in this report punctuate the need for urgent attention and co-created solutions with and for communities of people who use drugs, gender-diverse and gender non-conforming individuals, gay, bisexual, and other men who have sex with men, and sex workers. The following section offers a series of recommendations for the Global Fund Secretariat, as well as for members of country-level governance structures and implementing agencies of Global Fund programming.

To the Global Fund Secretariat:

1. **The Global Fund, in partnership with the Global Key Population Networks, must create a direct funding stream under GC8 to build, protect, and expand key population-led responses** to ensure equitable access to lifesaving services for communities most affected by HIV, TB, and malaria.

2. **The Global Fund must develop detailed guidance in advance of GC8 to articulate its approach to "integration" in dialogue with the Global Key Population Networks.** Measures to protect key population-led programming, service delivery, organisations, and networks must be firmly embedded in GC8 to ensure equity, science and rights-based access to lifesaving services for communities most affected by the three diseases and delivered when and where they are needed most.

3. **The Global Fund and Technical Partners must prioritise the scale-up and expansion of ongoing peer-to-peer TA provision** and peer-to-peer capacity building so that key population communities in all Global Fund-funded countries benefit and are able to meaningfully convene, engage, and contribute to fundamental decision-making processes that ultimately affect their lives. Ensure that technical assistance providers recruited by the Global Fund are selected in close partnership with the Global Key Population Networks.

4. **The Global Fund should preserve and enhance the role of the Community Annex** to support the balance of power dynamics at the country level. The Community Annex must be included as a core component of the GC8 proposal development process and reviewed by the Technical Review Panel alongside country grant submissions.

5. **The Global Fund (and CCMs and PRs) must increase the transparency of and equitable and timely access to critical grant information for all stakeholders** to ensure meaningful contributions and the engagement of key population communities in all grant-related processes.

6. **The Global Fund must extend community engagement beyond the proposal development phase** to ensure meaningful community engagement and oversight across the full grant lifecycle.

7. **The Global Fund (and LFAs) should conduct a review of in-country implementation arrangements** to ensure that tender requirements do not exclude key population-led organisations and networks from granting opportunities.

8. **The Global Fund must increase the transparency of decisions taken regarding all activities, including any deprioritisation, deferments, and/or cuts from grants throughout the grant lifecycle.** Access to this information is critical to all partners and will support the monitoring of gaps to track the impact of these funding decisions on civic space and equitable access to lifesaving services.

To Country Coordinating Mechanisms, Principal and Sub-Recipients:

1. **CCMs and PRs must increase the transparency of and equitable and timely access to critical grant information for all stakeholders** to ensure meaningful contributions and the engagement of key population communities in grant-related processes.

2. **PRs and CCMs must increase the transparency of decisions taken regarding all activities, including any deprioritisation, deferments, and/or cuts from grants throughout the grant lifecycle.** Access to this information is critical to all partners and will support the monitoring of gaps to track the impact of these funding decisions on civic space and equitable access to lifesaving services.

3. **PRs (LFAs and the Global Fund) should conduct a review of in-country implementation arrangements** to ensure that tender requirements do not exclude key population-led organisations and networks from granting opportunities.

4. **Civil society implementing organisations of key population programming** must do more to lift up and protect key population leadership. For instance, raise questions about voices missing from the table, provide support and make travel funds available to ensure the participation of key populations in all key grant-related meetings and processes at the country level.

The International Network of People who Use Drugs (INPUD) is a global peer-based organisation that seeks to promote the health and defend the rights of people who use drugs.

INPUD will expose and challenge stigma, discrimination, and the criminalisation of people who use drugs and its impact on the drug-using community's health and rights. INPUD will achieve this through processes of empowerment and advocacy at the international level, while supporting empowerment and advocacy at community, national, and regional levels.

ROBERT CARR FUND For civil society networks

This publication was supported through the Robert Carr Fund (2025-2026).

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Designed by: Mike Stonelake

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First published in 2026 by:
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INPUD International Network of People who Use Drugs
M•PACT
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