THE GLOBAL FUND

Community Systems and Financing

54th Board Meeting

GF/B54/07

12-13 February 2026, Geneva, Switzerland

For Board Input

As fiscal pressures continue to grow, reaching those most at risk remains critical to ending the epidemics

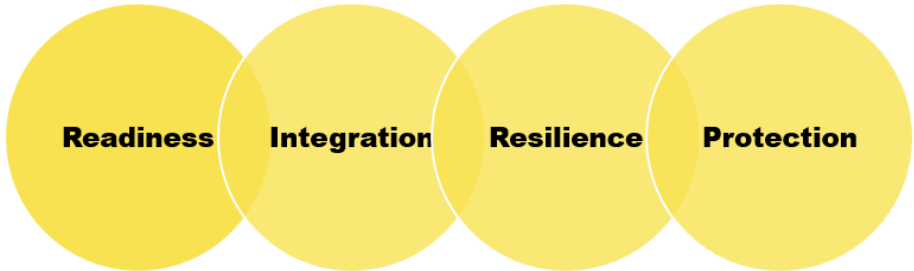
Where new infections are growing

- Over 50% of **new HIV acquisitions** are in key populations and their partners
- People in prisons, migrants and urban poor face 2-10x **higher TB risk**
- For **malaria**, 58% of pregnant women do not receive IPTp

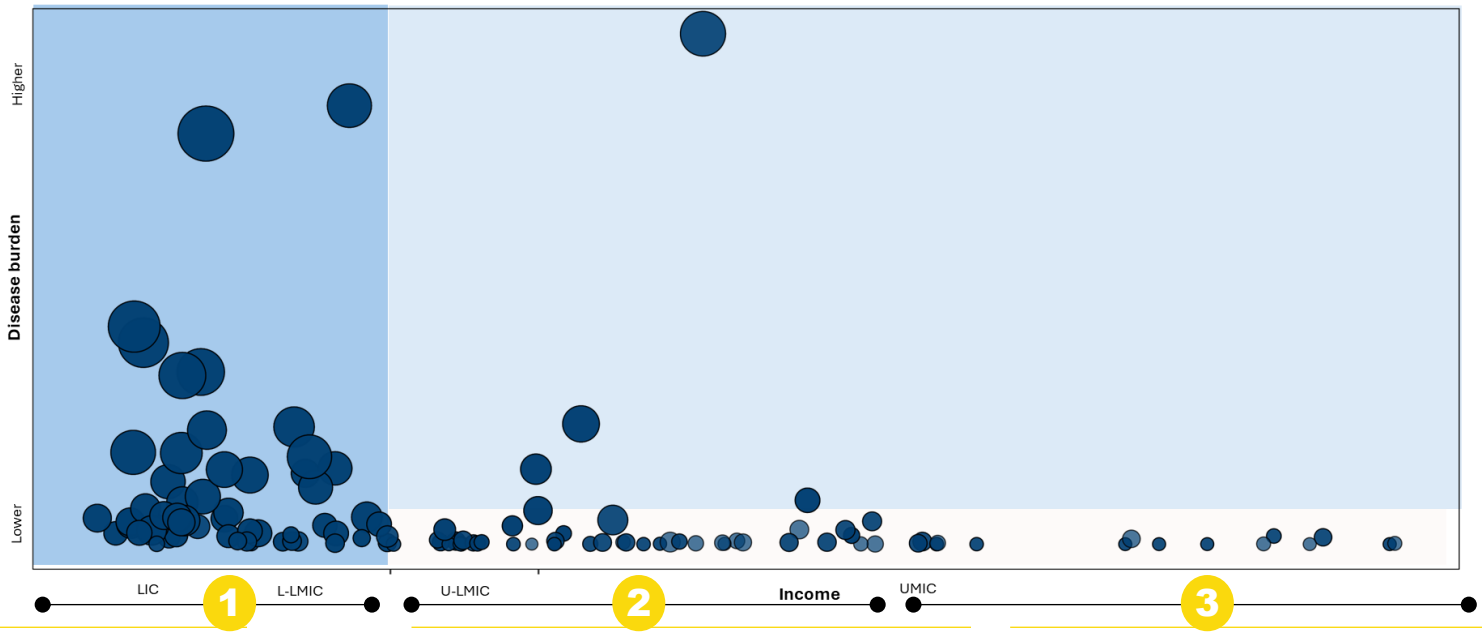
How people are effectively reached ***relies*** on contextual know-how

As countries move towards increased self-reliance, investing in **sustainable approaches *now* while protecting life saving services in transitioning contexts** is essential in GC8.

Building from **SC Steer** in July and December, while there is no one size fits all approach, four (4) pillars with ***additive* catalytic funding**, will provide reinforcing investment that put communities at the center.



Against this backdrop of sustainability & transition, the challenges facing contexts are diverse, requiring different approaches



Long-term transition (3+ GCs) where formal systems have limited reach to most-at-risk populations and minimal advancement on how to address through national systems. *Proposed approach on service delivery* ***Readiness***

Medium-term transition (2 GCs) with weak coordination and limited inclusion of community led service delivery in policy, financing and transition plans. *Proposed focus on service delivery* ***Integration***

Short-term transitions (1 GC) with sensitivity of delivering services to most-at-risk populations, creating integration challenges. *Proposed focus on creating and incentivizing financial pathways (context specific) for community-led organizations service delivery to build* ***Resilience*** *in health systems*

4 **Acute crisis *across* contexts.** Countries facing rapid, and/or unanticipated acute shocks that pose risks to operational safety, access to life saving HTM services for the most vulnerable populations, necessitating rapid measures to protect life saving services and legal support. Ensures ***Protection*** *through grant funding or a rapid mechanism*

1 Readiness: Responding to Challenges in LICs, L-LMICs and CoEs

Aim: To accelerate integration of community services into formal health systems and ensure CSOs remain central to delivery, demand, and accountability

What Needs to Change

- Protect service **reach and equitable access** during integration
- Institutionalize community services and systems into **Health Sector Planning and Financing**
- Develop government and CSO capacities to create the **enabling environment and fiscal space** needed for sustainable community integration
- **Use existing flexibilities** *within* GF grants and policies to drive integration and CSO service delivery.

Proposed Approach in subset LICs and L-LMICs in integration cohort

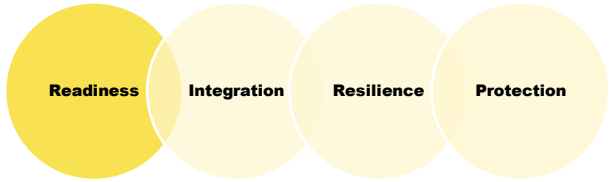
Through Allocations
(non-exhaustive, depending on context)

- Use Allocation Letters, Funding Requests, Country Dialogue, Grant-Making, GAC pre-shaping, TRP processes.
- Use community-led monitoring (CLM) to identify real-time gaps emerging from integration efforts.
- Support communities to maintain service continuity where systems are under strain.
- Leverage community platforms to drive program results, demand generation, advocacy for legal & policy change and service quality.
- Promote results-based contracting (RBC) for service delivery through CSOs and community networks.

Through CIs: Building Community Networks & Engagement

- Catalyze structural and PFM reforms to set up results based-type mechanisms that enable CSO contracting for service delivery.
- Accelerate policy and operational readiness, including accreditation pathways and contracting mechanisms for community providers.
- Unlock and expand fiscal space to finance sustainable integration of community services within national systems and contracting frameworks, through CSO budget advocacy, PFM support, DRM engagement and TA.

Acceleration of Integration Readiness: Country examples



Ghana –Community NGOs Driving TB Case Finding Under the NTP / Global Fund

Context/ Bottleneck: Ghana still has a sizeable gap in "missing" TB cases, especially in informal settlements and hard-to-reach areas
Breakthrough: Community Delivery & Incentives – networks of TB Champions and community volunteers, working through NGOs under **Stop TB Partnership Ghana** and the **TB Voice Network.** Networks of TB champions and volunteers in member NGOs conduct outreach, symptom screening, referrals and treatment support. NGOs receive Global Fund–financed sub-grants channeled via Stop TB Partnership and TB Voice Network, with financing for TB champions and volunteers tied to agreed outputs (community case finding, referrals, adherence support).

Results: In one recent period, TB champions and volunteers notified **over 1,264 TB cases in a single year**, showing that community-based platforms can significantly contribute to national TB notifications and reach people who would otherwise be missed.

Why It Matters: Ghana shows how a Global Fund-supported NTP can integrate **community NGOs into the core TB response**, using sub-recipient financing and output-linked funding to expand case-finding beyond facilities and move towards a more people-centred TB program.

Nigeria – Advancing HTM Integration in a Complex, Fragmented System

Context: Nigeria is shifting toward government-led HTM sustainability through SWAp reforms, a major domestic commodity allocation, and early HIV/TB inclusion in state health insurance schemes.

Bottleneck: Integration is slowed by **fragmented governance**, multiple unaligned sustainability frameworks, and **parallel data, planning, and supply chain systems**, limiting coherence and state ownership.

Response: The Federal Ministry of Health created an **HTM Working Group** to harmonize planning, initiated work on a single integrated framework, aligned Annual Operational Plans across HTM & RMNCAH programs, and leveraged insurance pilots and integrated CLM to strengthen joint delivery and accountability.

Why it matters: These steps offer a **realistic pathway to government-led integration**—protecting continuity as donor financing declines, reducing inefficiencies, and anchoring HIV, TB, malaria & RMNCAH within broader health system reforms.

2 Integration: Responding to Challenges in U-LMICs and UMICs with higher disease burden

Aim: Strengthen **integrated community systems and fast-track social contracting** in transition-timeline U-LMICs and UMICs through targeted MF and SI support.

What Needs to Change

*"The TRP is concerned that **social contracting models remain predominantly disease-specific and project-based, rather than system-wide,** representing a missed opportunity for integrated, sustainable community engagement.....To be sustainable, **community-led services must be embedded within national service delivery and financing frameworks, supported by legal recognition and predictable funding streams**."*

2023-2025 TRP Observations Report

Proposed Approach in a subset of LMICs and UMICs with high burden

Through Allocations & Domestic Co-financing *(non-exhaustive, context dependent)*

- More targeted investments to finance community service delivery through co-financing programmatic commitments.
- Maintain HTM service continuity throughout integration
- Promote engagement with CSOs through results-based contracting (RBC) for service delivery.

Through CIs: Building Community Networks & Engagement CI

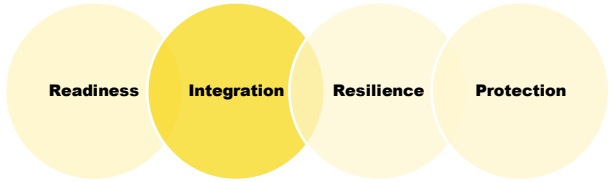
- Establish the policy, PFM, capacity, and financing systems needed for governments to sustainably contract community services at scale through CSO budget advocacy, PFM support, DRM engagement and TA.

Through CIs: Optimizing RSSH CI

- Incentivize contracting of community services for expansion, linkage, retention outcomes and quality.
- Cover short-term operational costs for contract management systems.
- Expansion from pilots to nationwide CSO contracting platforms.

Potentially mobilize **additional private-sector resources**.

Acceleration of integration and social contracting: Country examples



Thailand – Integrating Community-Led Services into UHC in a UMIC, Higher Absolute HIV Burden Setting

Context: Thailand is a **UMIC with a concentrated HIV epidemic** among key populations.

Bottleneck: Facility-centered HIV prevention and testing models were not reaching key populations consistently; community providers were not formally recognized or reimbursed.

Breakthrough: Adoption of **Key Population-Led Health Services (KPLHS)**: certified lay providers deliver HIV testing, PrEP, PEP and STI services in community settings. **2019–2021 reforms** allowed task-sharing, recognition of lay providers, and **inclusion of community-led PrEP into the national Universal Coverage Scheme** with reimbursement.

Why It Matters: A UMIC example where **community-led organizations are contracted, regulated, and paid** within the national health system – shifting key HIV services out of hospitals and into trusted community platforms.

Philippines – Localized, People-Centred Integration Linked to PFM & National Insurance

Context: L-UMIC with a mixed HIV/TB burden and rapidly evolving UHC reforms. Services are devolved to local government units (LGU), with strong CSO engagement in HIV prevention, TB support.

Bottleneck: Community responses are largely funded off-budget through Global Fund; CSOs are not systematically accredited or contracted by PhilHealth/LGUs, and PFM rules and procurement processes remain complex. This leaves KP and community services vulnerable as external funding declines and UHC rolls out.

Breakthrough: Dual approach to social contracting (1) CSO readiness to meet contracting requirements; (2) Government accreditation of provider networks that leverage communities for prevention, treatment support, and social services. Technical discussions with DoH and partners have set an ambition to institutionalize social contracting for CSO outreach across the majority of high-burden LGUs by 2030. Subnational financing and insurance are increasingly used to fund CSO-led interventions.

Why It Matters: In GC7, the foundations were laid **-** CSO readiness, advancing PFM reforms, and through **PhilHealth** build community eligibility for social contracting under the UHC Law. GC8 is for implementation.

3 Resilience: Accelerating financing mechanisms in U-LMICs and UMICs with low disease burden

Aim: Fast-track social contracting in transition-timeline U-LMICs and UMICs through targeted support

What Needs to Change

*"The TRP remains concerned about **the sustainability of community-led programming that reaches key populations,** even in countries fast approaching transition."*

*"Where transition timelines outpace progress in social contracting, the applicants and the Global Fund partnership **might need to explore alternatives to sustaining community-led services**."*

2023-2025 TRP Observations Report

Proposed Approach in a subset of UMICs Low Burden

Through Allocations *(non-exhaustive, depending on context)*

- Deploy allocations against a limited set of catalytic priorities to **fast-track transition of community service delivery into national systems**

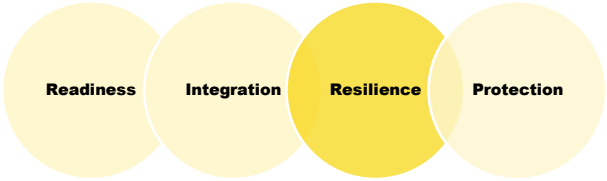
Through CIs: Optimizing RSSH CI

- **Accelerate domestic co-financing** by incentivizing governments, insurers, to allocate budget lines for community services early in the transition timeline.
- **Enable scale**, converting proof-of-concept contracting into multi-district or national purchasing platforms.
- **Invest in start-up and early-scale costs** of payments, verification, and contract management during the transition phase.

Through CIs: Building Community Networks & Engagement CI*

- **Fast-tracks policy, legal, and PFM** reforms so CSOs become eligible for social contracting within a single grant cycle rather than multi-year reform processes.
- **Rapidly build operational readiness —** establishing accreditation systems, standardized contracts, verification mechanisms, and results-based payment models.

Acceleration of Social Contracting: Country examples



Honduras: Results-Based Contracting (RbC) Model in an Upper-LMICs with Lower Absolute Burden

Context: Outreach prevention and diagnosis services for key populations provided by local NGOs funded by external donors.

Bottleneck: The prospect of a reduction in donor support to these activities creates the need for greater efficiency and a clear path towards transition.

Breakthrough: Results-based approach (RBC) permitted to favor the contracting of community-led organizations, leverage their knowledge of their constituencies, reward adaptation, efficacy, and innovation, while modeling the approach in sight of potential social contracting arrangements with the Ministry of Health.

Impact in the first year:

- ✓ **66% increase** in HIV testing
- ✓ **98% linkage to care** (from 89%)

Why It Matters: Shows how harnessing the specific capacities of CLOs can lead to improved results and efficiency, making the case for social contracting.

Kazakhstan – Institutionalizing Community Outreach Through Social Contracting in a UMIC, Lower Absolute HIV Burden Setting

Context: Kazakhstan, a UMIC with a concentrated HIV epidemic, has growing incidence among key populations.

Bottleneck: Community NGOs delivering outreach, harm reduction and HIV testing were dependent on donor grants and not integrated into national service delivery or budgets.

Breakthrough: Scale-up of **HIV social contracting**: NGOs contract with local governments to deliver HIV prevention and treatment services to KPs. By 2024, social contracting was active in **11 regions**; in 2025 in 17 regions, and it is expected to expand to **all 20 regions** in 2026. Currently, Government AIDS Centres also fund community outreach workers, commodities and case management.

Why It Matters: Demonstrates a UMIC successfully **transitioning NGO-led services into state-financed, contracted service delivery** — institutionalizing community roles within the national HIV programme.

4 Protection: Responding to Acute Crisis for Key Populations across All Contexts

Readiness | Integration | Resilience | **Protection**

Aim: Rapid Community Protection Fund, criteria-based small-grant mechanism, that can disburse urgently in moments of unanticipated acute risk, supporting the physical, legal, and operational safety of community organizations to allow life-saving HTM services to continue.

via Building Community Networks & Engagement CI

TRIGGER !

Unanticipated, acute crisis and access to HTM services shock: A documented event within the past 30 days that materially increases risk or blocks access to HTM services for KP groups.

Imminent Harm / Service Disruption: Without action within ≤ 7 days, there will be treatment interruption, lost contact with clients, loss of safe premises, or credible threat to staff/volunteers/clients.

PARAMETERS

- **Minimal, Targeted, Time-Bound & Protective, and continuity-focused**
- **Within Global Fund Footprint & Mandate**
- **Community Protection Fund activates only** where other mechanisms fail
- **Sunset: 3 months**

WHAT FOR

- **Organizational Continuity:** critical safety, preservation, and response measures to protect staff, community members, and essential infrastructure
- **Protection & Legal:** emergency infrastructure; legal support; digital security
- **Safety & security TA** to strengthen security and respond to immediate safety needs

ELIGIBILITY

KP-led CLOs/CBOs/NGOs & networks serving criminalized and marginalized populations most-at-risk of HIV infection and mortality.

(Based on UNAIDS definition of community-led)

Not included: *service delivery covered within allocation; routine programmatic costs; advocacy to change legislation; major capital assets; salary commitments above 3 months. Noting also the HRGE CI provides complementary support longer-term TA, S&S, legal support etc.*

As discussed with the SC, other approaches were considered, but ruled out due to trade-offs

Approach considered	Trade-offs, leading approach to be ruled out
Direct funding to community-led organisations	Undermines CCM incentives to program allocations through communities; side steps efforts to encourage governments to integrate community systems and financing through national systems which is critical for sustainability and ongoing service provision post-transition.
Earmarking or ringfencing financing for communities within allocations for specific purposes (e.g., community outreach, service integration)	Likely to disincentivize larger community investments; contrary to country ownership; undermines CCM role in considering how to best prioritize overall resources for maximum impact.
In closed civic settings, funding communities to urgently adapt through the Emergency Fund	Emergency Fund typically used for emergencies graded by the IASC or WHO to cover service delivery and commodity gaps rather than to support safety and security adaptations; not always an appropriate mechanism to provide resources directly to community organizations (Emergency Fund typically programmed through country grants)

In dialogue with SC, members highlighted that community systems vary across contexts and are often underfunded, requiring a longer-term approach – hence the 4 pillars are reinforcing with allocation/grant resourcing and domestic, tailored to the realities of diverse context.

Delivering across multiple CIs will reinforce approaches with *more resources mobilized* through the private sector since December

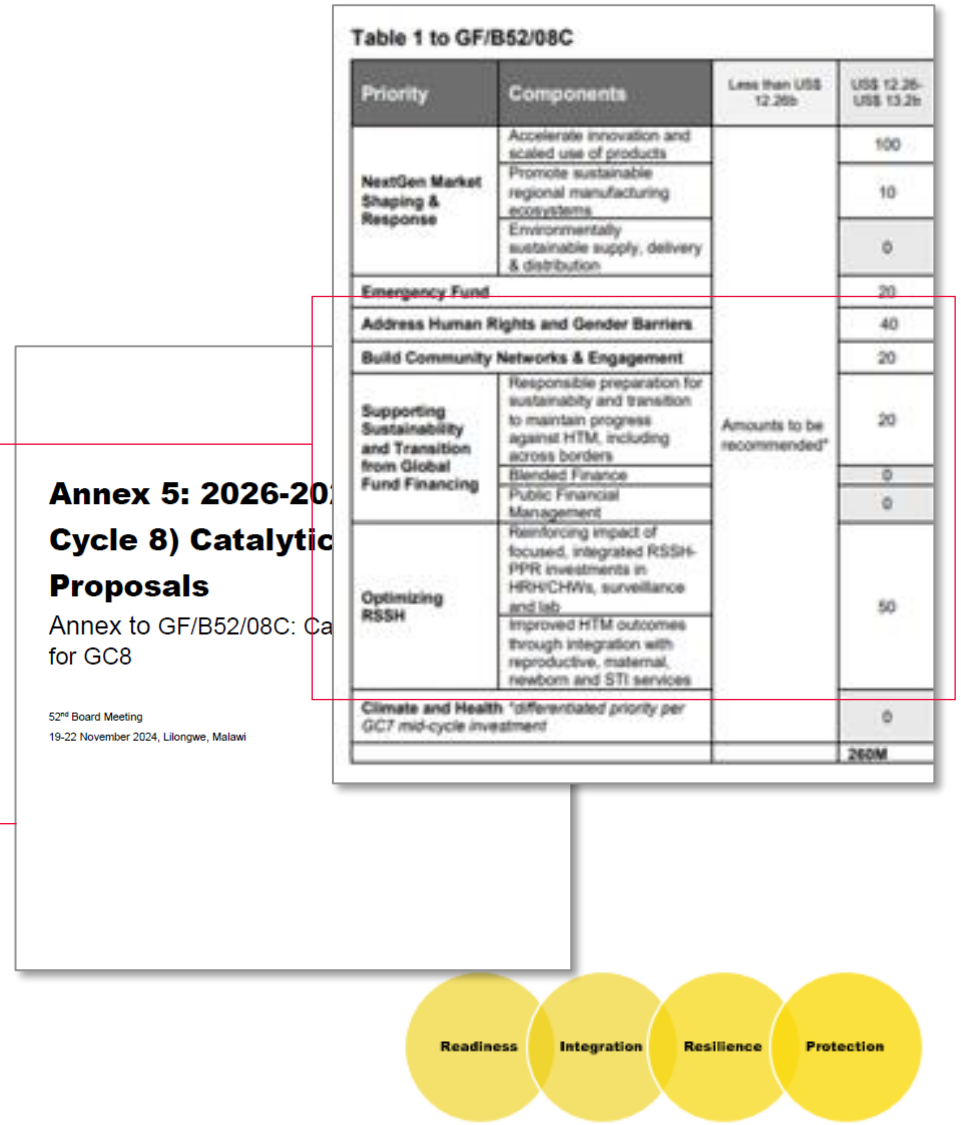
Country allocations present the *greatest opportunity* to end HTM, including reaching those most at risk, by putting communities at the center. Deliberate and transparent investment to operationalize Results Based Contracting and scale social contracting will help the partnership deliver on this.

Catalytic Investments *incentivize new and different* ways of working and mobilize resources from the private sector to crowd in funding (+US $17.9M for CNE in GC8). Combined these can accelerate progress.

Building Community Networks & Engagement (CNE)

Optimizing RSSH

Scopes are most relevant* <u>but</u> require evolutions that consider momentum and successes of GC6, GC7 and what is needed in GC8



Annex 5: 2026-20
Cycle 8) Catalytic
Proposals
Annex to GF/B52/08C: Ca
for GC8

52nd Board Meeting
19-22 November 2024, Lilongwe, Malawi

Table 1 to GF/B52/08C

Priority	Components	Less than US$ 12.26b	US$ 12.26-US$ 13.2b
NextGen Market Shaping & Response	Accelerate innovation and scaled use of products	Amounts to be recommended*	100
	Promote sustainable regional manufacturing ecosystems		10
	Environmentally sustainable supply, delivery & distribution		0
Emergency Fund			20
Address Human Rights and Gender Barriers			40
Build Community Networks & Engagement			20
Supporting Sustainability and Transition from Global Fund Financing	Responsible preparation for sustainability and transition to maintain progress against HTM, including across borders		20
	Blended Finance		0
	Public Financial Management		0
Optimizing RSSH	Reinforcing impact of focused, integrated RSSH-PPR investments in HRH/CHWs, surveillance and lab		50
	Improved HTM outcomes through integration with reproductive, maternal, newborn and STI services		
Climate and Health *differentiated priority per GC7 mid-cycle investment*			0
			260M

*Human Rights and Gender reinforces this work though its scope is fully maintained to address urgent priorities in GC8

The momentum from GC6 & 7 across relevant CIs provides the foundation and evolutions for GC8

GC6 & GC7 Approaches *(non-exhaustive)*

- Provided short-term, peer-to-peer TA and flexible support
- Extended the reach and capacity of Regional Platforms
- Increased & enabled representation of key and vulnerable populations in decision-making spaces (e.g. NSP development)
- Supported Community Led Monitoring including now publicly available resources, guides and learning exchanges
- Provided regionally tailored, multi-country grants for disease and population specific responses

GC8 Objectives *(evolved to the current context)*

- ❑ Identify & resource opportunities to increase and/or accelerate the roles of community-led organizations in service delivery & accountability (readiness)
- ❑ Incentivize integrated service delivery and demand generation through community-led organizations (integration & resiliency)
- ❑ Provide rapid response to safety and security crises impacting KVPs access to HTM services and service continuity (protection)
- ❑ Maintain targeted support for community engagement with smart use of developed platforms and learning hubs to maintain the gains (retaining engagement*)
- ❑ Maintain and align regional investments in innovative HIV prevention & service delivery for KPs in transition contexts, including through CLOs/CBOs. These are operationalized as catalytic multicountry grants (MCs) in GC7**.

Evolving from a model of short-term support & capacity building for CLOs, to enabling CLOs to drive impact - delivering services, generating demand, strengthening accountability & removing barriers through trusted community approaches, with the right capacity, engagement and mechanisms. It may not work everywhere, but starting where it can accelerate reach, equity and HTM outcomes.

*While not a focus of this Board requested response, Engagement remains a critical pillar of the Community Networks and Engagement CI and reinforces the work across the 4 areas. For GC8, this remains essential within the evolving context to maintain the gains. **GC7 MCs mostly ending in 2028, with proposed extensions until 2029 for the Caribbean; Latin America; Middle East and North Africa (MENA); Eastern Europe and Central Asia (EECA)

Preliminary CI application below, to be further adapted based on replenishment and resources mobilized*

	Objectives	Context/Reach	Funding** (US$12.26-13.2b)
Building Community Networks & Engagement	A. Identify & resource opportunities to increase and/or accelerate the roles of community-led organizations in service delivery & accountability (readiness)	1 *Long Term Transition* Up to 5 countries	US$2M *+ US 4M from private sector*
	B. Incentivize integrated service delivery and demand generation through community-led organizations (integration & resiliency)	2 3 *Medium- & Short- Term Transition* Up to 8 countries	US$ 8M
	C. Provide rapid response to safety and security crises impacting KVPs access to HTM services and service continuity (protection)	4 *Across contexts* Up to 30 countries	US$2M**
	D. Maintain targeted support for community engagement through trusted community partners and learning hubs to build on gains to date (*engagement*)	Retaining global reach	US $8M *+ US 5.4M from private sector*
	E. Regional investments (MCs) focused on innovative HIV prevention and service delivery, including through CLOs/CBOs, for key populations *(integration & resiliency)*	2 3 *Medium- & Short- Term Transition* 4 regions	*US $6M (estimate)****
Optimizing RSSH	Expand social contracting in MICs/UMICs to sustain HTM services	2 3 *Medium- & Short- Term Transition* 5 with opportunities to accelerate progress	US$10M

*To date, Private Sector contribution of US$ 17.9M for Building Community Networks and Engagement and US$ 188.5M for Optimizing RSSH; **Amounts are estimates to be further refined during the CI design process which will include the totality of resourcing including from the Private Sector; split of contributions across CI priorities may evolve. ***Final figure will be based on GC7 financial performance with funding identified from emerging private sector investment optimized across the BCNE CI for GC8 and/or PO or reallocation based on savings.

While need outpaces fiscal capacity, an analysis of diverse country contexts provides foundational insights for GC8 preparation

1. **Sustainability depends on governments.** Long-term impact requires governments to adopt, integrate and finance disease responses through national systems, inclusive of those most at risk and where incidence is growing.
2. **Communities remain essential to reaching those most at risk and sustaining HTM impact** – and the Global Fund's model (CCMs, country dialogue, CLM, integrated planning) is uniquely positioned to reinforce this by bringing government and community systems together.
3. **Maintaining impact requires programmatic *and* financial sustainability.** Ensuring continued reach to those most at risk depends on uninterrupted HTM service delivery across community and facility platforms, supported by allocations (readiness), alongside public financing mechanisms that allow governments to contract community-delivered services, and community engagement that strengthens and influences domestic resource mobilization within national systems.
4. **Where health systems cannot yet reach priority populations, shifts are needed** to accelerate social contracting, enabling public financing to flow to CLOs as part of national systems and to continue reinforcing the advocacy and accountability roles of CLOs in sustaining equitable services.

As reinforced by the SC, the Global Fund has a role to play in GC8 through multiple approaches with course correction and learning *integrated into the interventions themselves*.

These will be measured and reported upon across channels including semi-annually through the SC/Board

In summary, what will be different by the end of GC8?

Integrated community systems. By the end of GC8, the Global Fund will have advanced a more consistent understanding of how community systems deliver HTM services, advocacy, and accountability—shifting from siloed CSS investments toward integrated, system-level approaches, anchored in the CRSS Maturity Model Framework and linked to formal health sector planning and financing.

Catalyzed allocations that deliver the largest near-term impact. In readiness contexts in particular, country allocations will more deliberately protect HTM service continuity and community reach, while strengthening the foundations for integration through clearer signaling and prioritization.

Clarified pathways demonstrating where integration is possible and protection where it is not. GC8 will accelerate social contracting and domestic financing pathways where feasible, while strengthening protection mechanisms and alternative approaches in criminalized and high-risk contexts to avoid loss of impact.

Increased visibility, monitoring and course correction. Performance and risk will be tracked including early signals on service disruption, community financing, and HTM service rights and protections, enabling earlier course correction.

Aggregated learning to inform GC9 and beyond. Targeted use of Matching Funds and Catalytic Investments in GC8 will generate concrete evidence on what works to sustain community systems through transition, shaping more durable approaches in future cycles.

Thank You

The Global Fund to Fight
AIDS, Tuberculosis and Malaria

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