Operationalizing HIV integration

A framework for sustainable, rights-based and multisectoral responses

UNAIDS

Contents

Executive summary

This technical note on multisectoral integration provides a practical framework for operationalizing HIV integration as a pathway toward sustainable, nationally led and rights-based HIV responses. Grounded in the priorities of the *Global AIDS Strategy 2026–2031* (GAS) and Grant Cycle 8 (GC8) of the Global Fund to Fight AIDS, Tuberculosis and Malaria, the note argues that integration should not be viewed as an end in itself or as the automatic absorption of HIV programmes into broader systems. Rather, integration should be a deliberate, phased and context-specific process that strengthens sustainability, improves efficiency and promotes equitable, people-centred care while safeguarding community leadership, confidentiality, service quality and access for key and vulnerable populations.

The note acknowledges that many countries are dealing with a new model for their HIV responses, with more integrated approaches connected to primary health care (PHC), universal health coverage (UHC), community systems and broader multisectoral platforms. While evidence suggests that integration can improve HIV outcomes, service continuity and overall system performance, the benefits are not automatic. Integration is complex and requires careful planning, adequate investment, strong governance, continuous learning and protection of essential HIV functions, where broader systems remain weak or unable to meet the needs of key and vulnerable populations.

Recognizing that countries begin integration from different starting points, the note proposes a diagnostic approach that identifies distinct integration profiles, ranging from highly system-embedded integration to contexts where 'protective verticality' remains necessary. It emphasizes that integration should proceed according to country readiness, epidemiological patterns, financing realities, health system capacity and community priorities rather than according to a uniform model.

To translate integration ambitions into practical action, the note outlines five interconnected integration pathways: service integration; system integration; financing integration; community systems integration; and multisectoral integration. Together, these pathways move beyond service co-location and focus on aligning governance, workforce, data systems, supply chains, financing arrangements, community platforms and broader social systems to create coherent, sustainable and accountable responses.

Integration succeeds through phased, rights-based transformation guided by readiness, accountability and community leadership.

The note further proposes an integration implementation cycle based on implementation science principles. The cycle guides countries through identifying integration priorities, assessing readiness, strengthening enabling systems, implementing phased reforms and continuously monitoring, learning and adapting. This phased approach is particularly important in fragile settings and challenging operating environments, where protecting continuity of care and maintaining critical HIV functions may take precedence over deeper forms of integration until minimum readiness conditions are met.

A central contribution of the note is its synthesis of lessons emerging from a review of 12 draft GC8 funding requests. The review found that countries increasingly recognize integration as a strategic pathway towards sustainability, resilience and domestic ownership. However, many proposals

frame integration largely as a service delivery issue and do not adequately define patient pathways, system readiness requirements, governance arrangements, financing mechanisms or implementation strategies needed to achieve sustainable system transformation.

To address these weaknesses, the note identifies eight recurring priorities for stronger GC8 proposals:

1. Integration of HIV services into PHC should be designed around clearly defined patient pathways rather than simple service co-location.
2. System integration should be readiness-based across the workforce, supply chains, laboratories and data systems.
3. Community-led systems should be formally recognized, sustainably financed and connected to broader systems while preserving their independence and accountability.
4. Governance integration requires clear mandates, decision authority and accountability mechanisms rather than coordination structures alone.
5. Financing integration should demonstrate credible pathways to sustainability, with clear costing, transition planning and evidence of expected efficiencies.
6. Multisectoral integration should operationalize collaboration across sectors through defined mandates, financing and accountability arrangements.
7. Integration must strengthen equity and rights protections through explicit safeguards for key and vulnerable populations.
8. Integration should be implemented through phased transformation processes supported by 'readiness gates', monitoring and accountability mechanisms.

The Global AIDS Strategy and integration

The *Global AIDS Strategy 2026–2031* (GAS) calls for sustainable, nationally led and rights-based HIV responses that are connected to resilient health, community and social systems. In this note, integration refers to the deliberate coordination, linkage or, where appropriate, merger of selected HIV services and system functions with broader health, community and multisectoral platforms to improve outcomes, equity, user experience, efficiency and sustainability. The appropriate form and degree of integration should be nationally led and shaped by epidemiology, patient pathways, system capacity, financing arrangements, the legal and policy environment and community priorities.

Vertical HIV programmes have enabled major gains in treatment scale-up, but stand-alone models may no longer be sufficient to sustain epidemic control where they miss opportunities to address broader health needs, continuity of care and system efficiency. Integration can help countries move from fragmented and parallel systems towards people-centred, PHC and

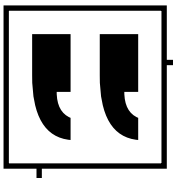
UHC oriented approaches, supported by community systems, multisectoral linkages and aligned governance, financing, supply chain and data systems. However, integration is a means rather than an end and dedicated HIV functions should be retained where necessary to protect technical quality, confidentiality, reach, innovation, community leadership and accountability.

At this pivotal moment for global health and development, the HIV response is transitioning from fragmented, vertical systems toward integrated, sustainable and people-centred approaches. Evidence suggests that integrating HIV and other health services can improve several HIV cascade outcomes, including testing uptake, initiation of antiretroviral therapy (ART), retention in care and viral suppression, while also improving the uptake of some non-HIV services. This shift entails moving beyond parallel programmes to coordinated systems embedded within national health and social frameworks, anchored in PHC and UHC. It reflects a transition from donor dependent models to domestically driven and sustainably financed models, and from fragmentation to aligned health, community and multisectoral systems that deliver comprehensive, integrated care.

However, the effects are not uniform across all outcomes, and evidence remains more limited on costs, cost-effectiveness, mortality and outcomes for key and vulnerable populations. Integration should therefore be deliberately designed, adequately resourced, phased, equity-focused and continuously measured, rather than pursued as a blanket merger, simple co-location, or restructuring exercise.

Integration often progresses at different speeds across system components. Many countries have advanced service integration through PHC platforms, multidisease service delivery and strengthened referral pathways, while governance, financing, workforce, supply chain and data systems remain partially integrated or continue to operate through parallel arrangements. This is a common feature of health system transition and should not necessarily be viewed as a failure of integration. Rather, it highlights the need for deliberate, phased, sustained investment and readiness-based implementation. Countries should therefore focus on progressively aligning system functions while protecting service continuity, quality, confidentiality, community leadership and access for key and vulnerable populations.

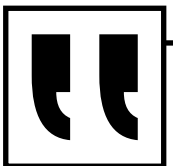
This note supports country teams to translate the *Global AIDS Strategy 2026–2031* and the priorities of GC8 into context-specific, fundable and implementable integration choices that reflect epidemiology, patient pathways, PHC readiness, workforce capacity, financing arrangements and community priorities. It helps countries move from high-level commitments to practical implementation choices, including the services and system functions that need to be integrated, how to sequence integration, what capacities and safeguards are required, and how progress will be financed and measured. It does not prescribe a single model or assume that all HIV functions should be merged into broader systems. Rather, it emphasizes integration approaches that protect quality, confidentiality, differentiated service delivery and community leadership.



Integration advances through nationally led, people-centred transformation strengthening sustainability, equity and resilient systems.

Key messages

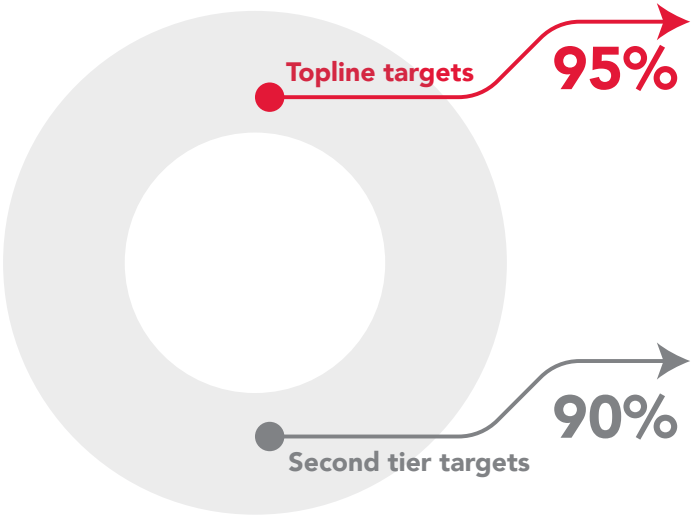
- **Integration can support self-reliance and multisectoral efficiency.** Country ownership and fiscal transition require phased implementation and integration with legal services, social protection and education to maximize HIV outcomes, equity, efficiency and community leadership.
- **Integration is complex and should be phased and well managed.** Gains should be protected while aligning incentives, capacities and funding; equity, rights and confidentiality—especially for key and vulnerable populations—must be safeguarded; and political economy and stakeholder dynamics should be addressed.
- **No single model fits all.** Integration should be designed to reflect the local context—epidemiology, system capacity, financing constraints, legal/policy environment and community priorities.
- **Protective verticality may be appropriate where needed.** Integration should not be interpreted as the automatic absorption of all HIV services or systems into broader platforms. In some contexts, dedicated HIV arrangements may need to be maintained—temporarily or longer term—to preserve continuity of care, technical quality, confidentiality, community leadership and access for key and vulnerable populations, while broader system readiness and integration capacities are strengthened.
- **Strategic system transformation is needed, not simple restructuring.** Countries should move beyond surface-level changes to reimagine HIV service delivery, governance, financing and community engagement as one people-centred, resilient system connected to broader health and social services.
- **Stand-alone reforms or pilots are insufficient.** Integration requires coordinated action across system components and embedding innovation into routine service delivery, not isolated improvements or short-term projects.
- **Integration should be a pathway to equity.** Integration advances equity by reducing disparities driven by fragmented, vertical systems and enabling people and communities furthest behind to access timely, high-quality HIV prevention, testing, diagnostics, treatment and essential non-HIV services where they are needed most.



Integration is strategic system transformation, not programme absorption, requiring phased implementation that strengthens equity, protects community leadership, safeguards essential HIV functions and builds sustainable, people-centred, nationally owned responses.

The 2030 targets for HIV and integration

The 2030 targets introduce a specific set of HIV integration targets as a translation of the *Global AIDS Strategy 2026–2031* into measurable outcomes, an accountability framework for country ownership, domestic financing and transition preparedness, and a tool for moving from broad integration commitments to measurable implementation. Countries can use the 2030 HIV integration targets to shape sustainability roadmaps, integration strategies, GC8 funding requests and government-to-government agreements with development partners. The targets provide a common outcome framework for moving beyond disease-specific programming towards a more sustainable, nationally owned and people-centred response. They can guide transition milestones for domestic financing, HIV inclusion in UHC packages, reduced out-of-pocket expenditure and institutionalized community-led responses, while helping prioritize investments in service integration, interoperable data systems, integrated financing and community systems. In government-to-government and other partner agreements, the targets can align technical assistance, financing, policy reforms and transition commitments around shared sustainability outcomes. The two topline 2030 integration targets focus most directly on integration, PHC alignment and sustainability. The second tier 2030 integration targets and actions are more directly linked to tracking the implementation of integration actions (Figure 1).



- of people who are receiving HIV prevention or treatment services also receive sexual and reproductive health services they need (including for STIs).
- of pregnant women living with HIV and their newborns receive maternal and newborn care that integrates or links to comprehensive HIV services, including for prevention of the triple vertical transmission of HIV and hepatitis B virus and treatment of syphilis.
- of women living with HIV screened for cervical cancer at least once in the last five years.
- of women living with HIV identified with cervical disease are treated and 90% of women with precancer are treated.
- of people living with HIV in HIV care receive screening for depression.
- of gay men and other men who have sex with men and sex workers are screened for syphilis.
- of people living with HIV tested for hepatitis C.
- of people living with hepatitis B diagnosed.
- of people living with HIV in need receive screening for hypertension and diabetes.

Figure 1. Selected 2030 Integration topline and second tier targets

The *Global AIDS Strategy 2026–2031* outlines concrete actions across its eight results areas, supported by measurable targets and an integrated approach to delivering services within national health and social systems (Figure 2).

The Global AIDS Strategy 2026–2031 results areas framework and integration

1 Sustainable financing and country ownership

- Champion political leadership and multisectoral governance.
- Ensure inclusive participation (communities, civil society organizations (CSOs), private sector).
- Institutionalize HIV services within primary health care.
- Embed community-led delivery, monitoring and accountability.
- Deliver stigma-free, gender-responsive, youth-friendly services.
- Integrate HIV with sexual and reproductive health (SRH), gender-based violence (GBV) and crisis preparedness systems.
- Coordinate policies and co-financing across sectors.
- Establish metrics and accountability systems.

2 Integrated health systems

- Integrate HIV into national health strategies, UHC packages, and budgets.
- Ensure full costing across facility and community services.
- Increase investment from domestic sources.
- Mobilize complementary financing instruments where appropriate, without substituting for predictable public and grant financing.
- Establish pooled HIV financing mechanisms.
- Eliminate user fees and out-of-pocket payments.
- Develop country-led, rights-based sustainability roadmaps beyond 2030.
- Align with health, social protection and legal reforms.
- Strengthen public financial management and expenditure tracking.

3 Data and digital systems

- Align all digital health investments with national systems.
- Build capacity to govern and protect health and HIV data.
- Scale integrated and interoperable digital systems and shared records.
- Link clinical, logistics, HR, financing and community data.

4 HIV prevention

- Deliver comprehensive prevention packages (biomedical, behavioural, structural).
- Integrate prevention into SRH and education platforms.
- Focus on high-incidence settings.
- Mobilize multisector and private sector engagement.

5 Treatment, care and support

- Integrate HIV across PHC and community platforms.
- Link to maternal and child health (MCH), sexual and reproductive health and rights (SRHR), TB, noncommunicable diseases (NCDs), mental health and GBV.
- Engage people living with HIV and key and vulnerable populations as equal partners.
- Ensure involvement of communities in design, delivery and monitoring.

6 Human rights and gender equality

- Ensure safe, inclusive, confidential and accessible care, especially for women, girls and key and vulnerable populations.
- Institutionalize anti-stigma and gender-transformative approaches.
- Expand legal literacy, support and redress mechanisms.

7 Health products and supply systems

- Improve forecasting, planning, and political commitment.
- Ensure reliable access to essential HIV-related health technologies.
- Institutionalize health technology assessment, market intelligence and coordinated procurement.
- Expand access to long-acting and self-administered technologies.

8 Community systems

- Establish social contracting and public financing mechanisms.
- Ensure predictable and flexible funding.
- Fund and embed community roles in service delivery, monitoring, research, advocacy and innovation.

Figure 2. The *Global AIDS Strategy 2026–2031* integration priorities across the eight results areas

Identifying an integration starting point

Countries are pursuing integration from different starting points and under different conditions. As a result, integration does not follow a single pathway or progress uniformly across all system components. Before selecting integration pathways, investment priorities or implementation approaches, countries may find it useful to identify their current integration profile. The profiles below are illustrative, not prescriptive or mutually exclusive, and are intended to help countries apply the principles of the Global AIDS Strategy and GC8 in a context-specific way by identifying priorities, sequencing needs, readiness considerations and appropriate safeguards across different diseases, services and system functions (Box 1).

Box 1. Diagnostic tool to help countries identifying its integration profile

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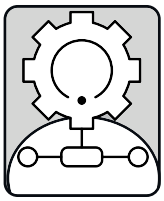
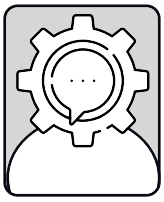
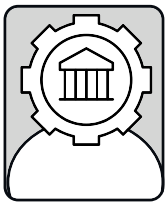
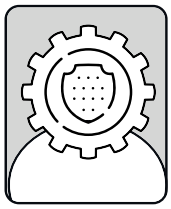
PROFILE	TYPICAL CHARACTERISTICS	PRIORITY FOCUS
 **System-embedded integration**	• HIV services and system functions are largely aligned within PHC, governance, financing and information systems.	• Institutionalization, sustainability, quality improvement and domestic financing.
 **Service-forward integration**	• Service delivery is integrated through PHC or multidisease platforms, but financing, workforce, data or governance systems remain fragmented.	• Functional integration of financing, workforce, supply chains, laboratories and data systems.

PROFILE	TYPICAL CHARACTERISTICS	PRIORITY FOCUS
 **Policy-led, practice-lagging integration**	• Policies and strategies support integration, but implementation remains limited and fragmented.	• Operational pathways, implementation capacity, accountability and subnational execution.

PROFILE	TYPICAL CHARACTERISTICS	PRIORITY FOCUS
 **Protective verticality**	• Dedicated HIV structures remain important to protect continuity, quality, confidentiality, community leadership or access in fragile, concentrated or transition settings.	• Gradual integration, system strengthening and targeted protection of essential HIV functions.

Integration pathways

Integration is complex, multidimensional and extends beyond service delivery. It involves transforming how systems, financing, communities and sectors work together to deliver a sustainable, rights-based HIV response. To move from broad ambition to implementation, countries should define each integration action across three dimensions:

1. **Function:** the service or system area to be integrated, such as service delivery, governance, workforce, supply chains, laboratories, data, financing or community systems.
2. **Level:** where integration will take place, whether at national, subnational, facility or community level.
3. **Intensity:** the degree of integration required, ranging from coordination and referral linkage to co-location, shared platforms, or organizational merger. Countries should select the minimum degree of integration needed to improve outcomes, equity, efficiency and sustainability while protecting quality, rights, confidentiality and community leadership.

These choices should be made with relevant actors and stakeholders at all levels and supported by costed investment actions across domestic and external financing sources. Integration should be progressive and phased, preserving technical quality and continuity of care rather than abruptly dismantling disease programmes. Phased plans should define the practical mechanisms for moving towards more coordinated, connected or unified services, systems and functions, as well as criteria for adaptation, scale-up, pause, or cessation of separate disease programmes.

The pathways below translate this planning lens into practical routes for operational change across services, systems, financing, community platforms and multisectoral action. They are not mutually exclusive or linear; countries may combine and adapt them according to epidemiology, system readiness, financing arrangements and community priorities and context (Figure 3).

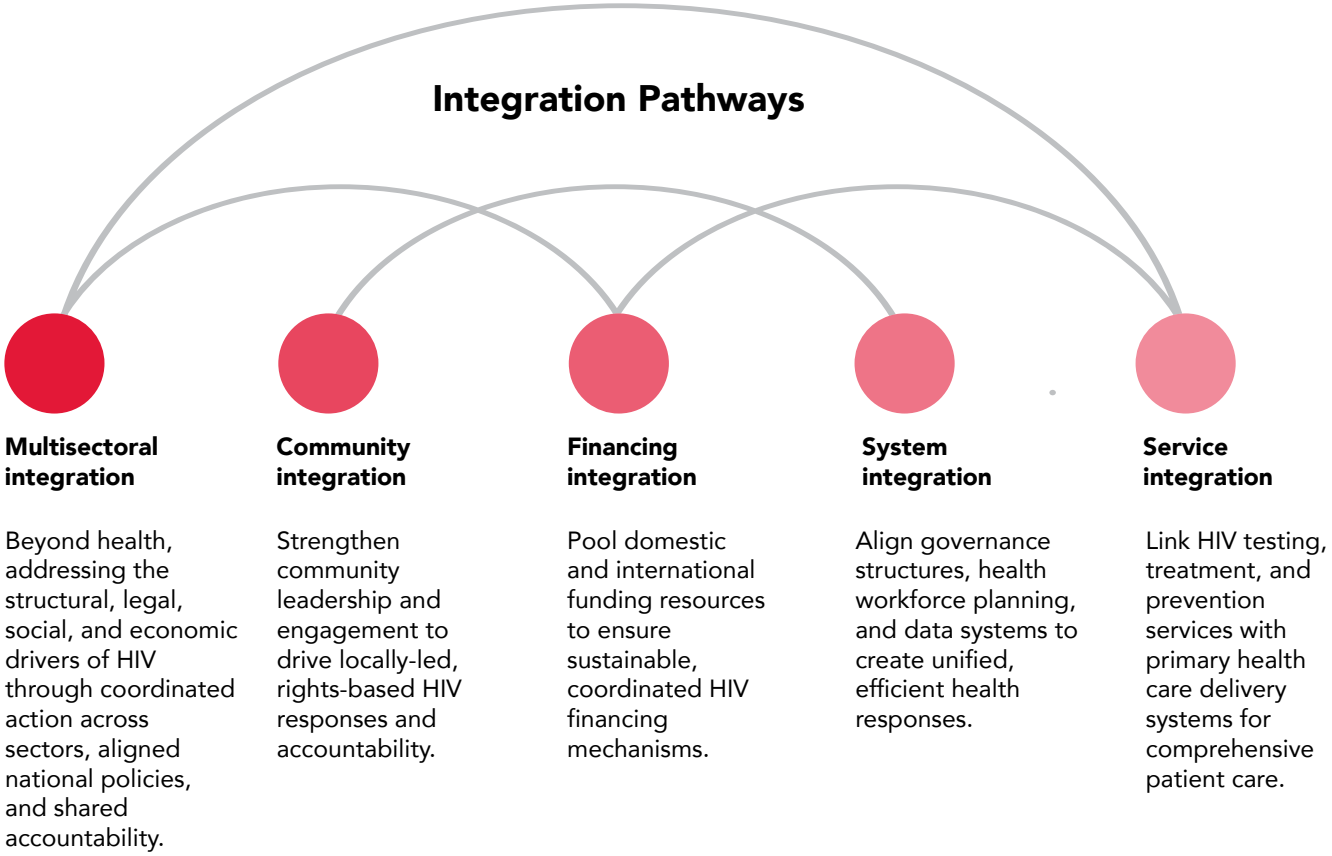


Figure 3. Pathways for driving equity, sustainability, efficiency and people-centred responses

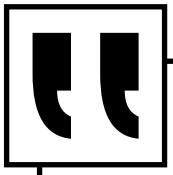
The **service integration pathway** shifts delivery of multiple services through a common care platform, such as PHC. Here HIV prevention, testing, treatment and care are embedded in PHC services for comprehensive, people-centred care to improve continuity of care, convenience of services and efficiency. This pathway also includes the integration of HIV services with services in related health areas, such as TB, antenatal care, sexual and reproductive health and rights services and one-stop services for adolescent and key and vulnerable populations.

System integration includes aligning governance, workforce, supply chains and data systems as core enablers to improve efficiency and coherence. To improve coordination and country ownership, it is important that programmes move progressively from separate management and coordination structures towards unified governance. This pathway also focuses on workforce harmonization to support workforce adaptation for multidisease service delivery. Reducing parallel logistics systems through supply chain integration is another critical system enabler that is foundational to integrated service delivery, directly advancing efficiency, equity, resilience and service continuity. Integrated information systems will be crucial for continuity of care, efficiency and accountability. Many countries are migrating towards integrated health management information systems (HMIS), unified dashboards, electronic medical records (EMRs), integrated surveillance systems and shared monitoring platforms. The key is the reduction and simplification of platforms.

Financing integration is a pathway for coordination and pooling of different funding streams to create sustainable, coordinated funding mechanisms. It provides an opportunity for better understanding and alignment of fragmented financing flows for health and HIV. Many countries are also adapting sector-wide approaches (SWAPs) to reduce duplication, transaction costs and donor fragmentation. Actions under this pathway range from improving visibility of fragmentation, duplication and gaps, to embedding various services into routine health financing mechanisms and health insurance benefit packages, and to expanding pooled funding and reducing out-of-pocket payments.

Community systems integration pathways allow multiple disease programmes to share community structures and platforms. It also provides an opportunity for strengthening community leadership and embedding community roles in delivery and accountability mechanisms. Community-led monitoring has been a critical enabler of effective and equitable HIV responses, driving accountability, providing real-time feedback on service quality and gaps in care, and providing evidence for decision-making. Effective community systems integration also depends on enabling legal, regulatory and financing environments that allow community-led organizations to register, operate safely, access funding and participate in planning, accountability and service delivery functions. Connecting community systems across disease responses can reduce fragmentation while preserving community leadership and accountability.

Multisectoral integration is a strategic pillar for sustaining HIV gains while advancing UHC and broader development goals. Health outcomes are shaped by non-health factors such as poverty, gender inequality, education, housing, nutrition and the environment. Addressing structural, legal, social and economic drivers through coordinated cross-sector action therefore tackles the root causes of vulnerability, not only biomedical outcomes. The goals of reducing inequities and improving access among underserved groups, including key and vulnerable populations and adolescent girls and young women, cannot be achieved without whole-of-government engagement. Embedding HIV strategic priorities into national development plans, social protection and education programmes strengthens domestic ownership and reduces donor dependency over the long term.



Integration transforms fragmented programmes into coordinated, resilient, equitable systems delivering sustainable health outcomes together.

To support this transformation, countries should consider using a structured integration implementation cycle to translate integration ambitions into practical, phased action (Figure 4). The cycle helps define what will be integrated, how implementation will occur, who is responsible, when actions will take place and how progress will be measured, reviewed and adapted over time.

Drawing on implementation science principles, the cycle guides countries through a phased process to:

- Assess integration opportunities and readiness.
- Specify implementation strategies, roles and responsibilities.
- Strengthen enabling systems, including governance, financing, workforce, data and community platforms.
- Implement integration in phases while protecting technical quality and continuity of care.
- Monitor performance, learn from implementation and adapt course over time.

By linking implementation actions to measurable outcomes, the cycle supports countries in embedding HIV responses within PHC, broader health and social systems, and sustainable financing arrangements, while maintaining equity, community leadership and quality of care.

For Stage 3, countries should focus on governance (joint planning, accountability and integrated district reviews), workforce (task sharing, integrated training and joint supervision), data (interoperable systems, shared indicators and community-led monitoring), supply chain (multidisease procurement and integrated logistics), financing (pooled financing, strategic purchasing and domestic transition plans) and community systems (social contracting, community monitoring and peer navigation). The recommended phased approach can include a stabilizing phase, where countries protect HIV outcomes, maintain access and prepare governance, policy and workforce systems. An integration phase, where countries consolidate

Integration implementation cycle

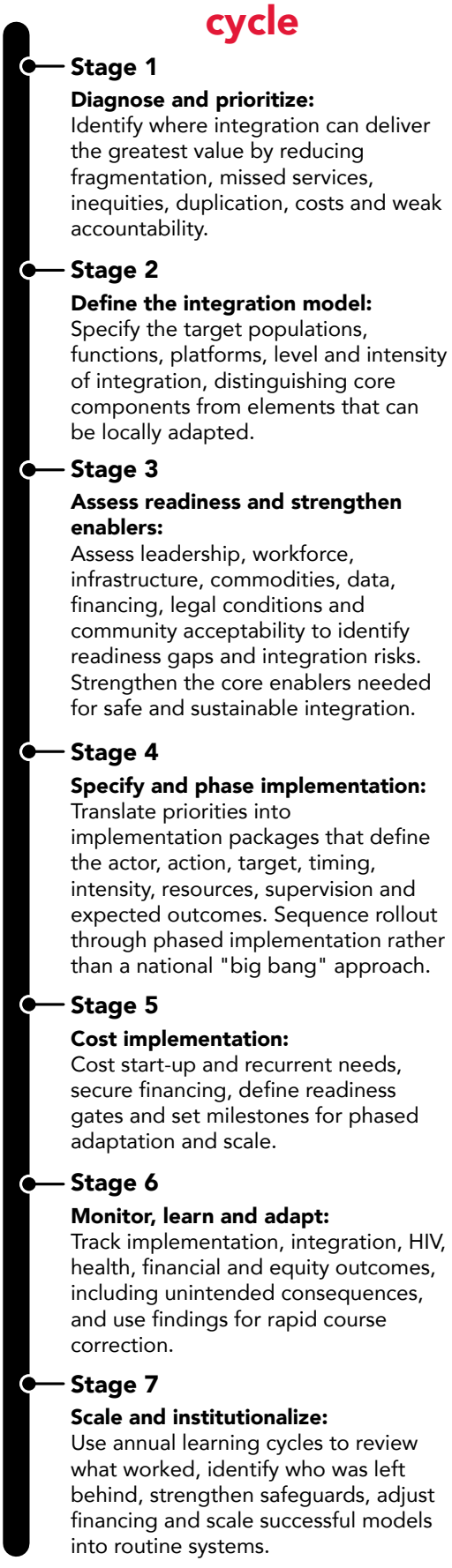


Figure 4. Integration Implementation Cycle

service platforms and harmonize data systems and supply chains and an institutionalization phase where integration is embedded in domestic financing, national budgets and performance management (Box 2).

Box 2. Integration in fragile settings and challenging operating environments

Core principle: protect before integrating

In fragile settings and challenging operating environments, integration should focus continuity of care, flexible implementation arrangements, trusted partnerships, community systems financing and system readiness. The priority is not rapid merger of HIV functions into weak or unstable platforms, but protection of essential services while progressively strengthening the systems, partnerships, financing arrangements and safeguards needed for integration. Countries may need to retain dedicated HIV financing, supply, workforce, data or community arrangements where these are necessary to safeguard treatment continuity, confidentiality, quality, differentiated access and community trust, while coordinating closely with government, community-led, humanitarian, development and other non-traditional partners to sustain last-mile delivery, finance community-led functions and reach crisis affected populations.

Phased pathway

Move to the next phase only when readiness gates are met and risks are controlled.

1 Stabilize: prevent disruption

Protect HIV service continuity through multimonth dispensing, decentralized refills, community delivery, patient tracing, emergency stock arrangements and continuity plans for displaced, mobile, or crisis affected populations.

2 Connect: build safe linkages

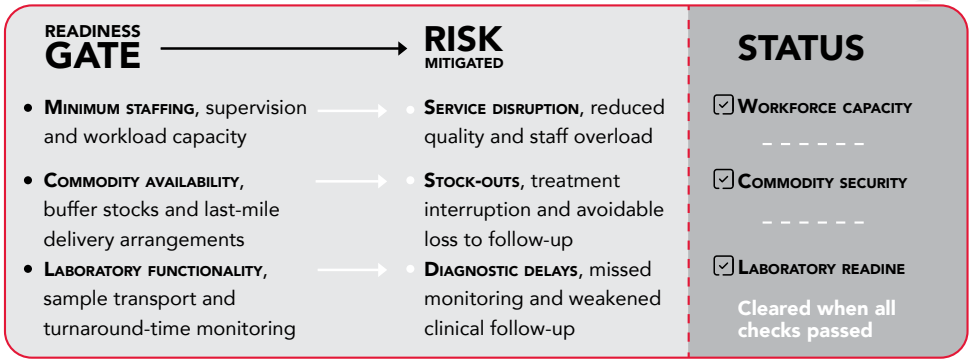
Strengthen facility–community linkages, referral tracking, integrated supervision, sample transport, commodity monitoring and secure data flows without overloading weak systems.

3 Embed: institutionalize when ready

Progressively align HIV functions with national planning, budgeting, workforce, supply chain, laboratory, information and emergency preparedness systems once minimum readiness conditions are met.

Readiness gates and risk controls

Before moving to deeper integration, countries should verify that minimum safeguards are in place and linked to defined risks.

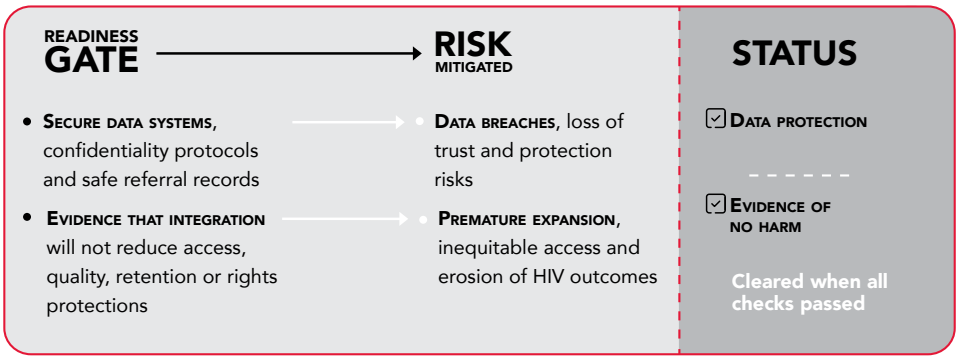


Gate Pass 1
Service Readiness

Destination
Integrated Service Delivery

Gate Pass 2
Community and Rights Readiness

Destination
People-centred Integration



Gate Pass 3
Governance and Assurance

Destination
Sustainable Scale-Up

Adaptive learning and protective verticality

Integration decisions should be reviewed through routine quality, safety and equity checks, with rapid course correction where service disruption, reduced quality, exclusion, or protection risks emerge. Protective verticality may be appropriate where dedicated HIV financing, supply, workforce, data, or community arrangements are needed to preserve continuity, rights, confidentiality, community trust and access while broader systems mature.

Countries should monitor integration at three levels including implementation outcomes (adoption, acceptability, feasibility, fidelity, coverage and sustainability), integration outcomes (integrated services, joint planning, supervision and interoperable reporting systems) and HIV and health outcomes (retention, viral suppression, financial protection, service use and equity).

The Global Fund Grant Cycle 8 (GC8) and integration

GC8 makes integration an important route to sustainability, impact and value for money, but it does not require a blanket merger of all programmes. Current guidance prioritizes integration while maintaining a differentiated approach based on disease burden, economic capacity and country context. To advance integration, countries should identify a small number of prioritized investments and clearly earmark the resilient and sustainable systems for health, disease component and domestic resources required to implement and sustain them.

Eight key insights for strengthening GC8 proposals

As countries articulate their GC8 proposals, integrated, people-centred, PHC-based systems supported by aligned governance, financing, data, and community platforms are emerging as the main model for transformation. The findings below draw on a review of 12 draft funding requests from all UNAIDS regions, undertaken between May and June 2026. Documents were reviewed against five dimensions: service delivery; enabling system functions; governance and financing; community systems, rights and equity; and implementation, measurement and sustainability. The findings identify recurring themes in the reviewed documents and should not be interpreted as representative of all GC8 applications.

Overall, integration is consistently framed as a system-wide agenda that anchors HIV, TB and malaria within PHC systems, expands into broader health system integration across workforce, supply chains, data and financing, and extends further into multisectoral development systems while prioritizing equity, sustainability and domestic ownership. While this ambition is strong and aligned with GAS priorities and GC8 principles, proposals consistently fall short on operationalizing integration as a financed, system-level, scalable and accountable transformation process. Additionally, proposals need strengthening in identifying key risks and proposing mitigation measures. Strong proposals should demonstrate intentional integration, institutionalization and system alignment. Below is a synthesis of the key insights and lessons emerging from the review of the draft funding request.

1 PHC integration is the main convergence point, but it must be designed as a patient pathway—not simply co-location.

In all the proposals reviewed, integration is commonly anchored in PHC as the main delivery platform, with countries prioritizing HIV testing, prevention, treatment and care through routine PHC entry points, community-based models and outreach services. However, PHC integration should not be equated with placing multiple services in the same facility. Stronger proposals describe a defined patient pathway, including entry points, service package, referrals, staffing arrangements, records, commodities and follow-up mechanisms. Services are increasingly being packaged across HIV, TB, malaria, sexual and reproductive health and rights, maternal and child health, noncommunicable diseases, mental health and nutrition, creating opportunities for more person-centred, life-course care, fewer missed opportunities and improved continuity. At the same time, integrated service models should be assessed for acceptability to intended users, since evidence shows that integration can improve outcomes, but may also impact waiting times, be affected by capacity constraints and variations in user preferences.

Key gap

Despite this progress, integration remains concentrated on service delivery and is often under-specified. Many proposals identify PHC entry points but do not define the full patient pathway, operational model or system changes needed to make integrated care work in practice.

Risk

This creates a risk of co-location or 'light integration' rather than the system-level transformation envisaged in the *Global AIDS Strategy 2026–2031*. Poorly specified models may increase waiting times, overburden staff, weaken continuity, or fail to reflect user preferences. In addition, proposals that rely on pilots or demonstration sites without clear pathways to national scale risk keeping integration fragmented and localized rather than institutionalized across the system.

Suggested minimum elements for GC8 proposals

- A defined patient pathway showing entry points, service package, referrals, staffing, records, commodities and follow-up;
- Evidence that the proposed model is acceptable to intended users, including key and vulnerable populations;

- Measures to track waiting time, continuity, quality and retention, alongside HIV and PHC outcomes;
- How PHC-based service integration will be linked to governance, financing, workforce, data and accountability reforms; and
- How pilot or phased approaches will transition to national scale, with clear timelines for institutionalizing integrated models within routine systems and budgets.

2 System integration must be readiness-based across the workforce, commodities, laboratories and data systems.

Across proposals, countries consistently prioritize integration of core health system building blocks, including workforce, commodities and supply chains, laboratories and diagnostics, and digital and data systems. These priorities are essential for integrated, multidisease service delivery, but proposals should demonstrate that these capacities are in place before additional services are assigned or modalities are shifted. For instance, workforce integration requires more than joint training or task sharing. It also requires defined roles, supervision arrangements, workload assessment, decision authority and adequate staffing. Similarly, commodity, laboratory and data integration require reliable supplies, functioning sample transport and diagnostic networks, quality assurance, interoperable records and timely data use for planning, targeting and accountability.

Key gap

Despite this ambition, system integration remains partial and uneven across proposals. Many proposals describe training, interoperability or harmonized procurement, but do not show whether sufficient workforce, commodity, laboratory and data capacity exists to absorb additional services safely and effectively. Supply chains often remain disease-specific, laboratory systems show uneven quality assurance and accreditation, data platforms are not fully unified, or interoperable in practice and workforce integration is not yet supported by multiskilled teams, joint supervision, workload planning or changes in roles and authority.

Risk

Without verified system readiness, integration may overload existing platforms, increase stock-outs, compromise diagnostic quality, weaken data use, increase staff workload and reduce service quality. Training alone is insufficient if it is not accompanied by changes to roles, supervision, workload, supplies and decision authority. In such cases, the expected gains in efficiency, resilience and value for money are unlikely to materialize, and fragmentation across system functions will continue to limit coordination, accountability and sustainability.

Suggested minimum elements for GC8 proposals

- Evidence that workforce, commodity, laboratory and data capacities are ready before additional services are assigned to a platform.
- A workforce plan covering roles, task-sharing, supervision, workload, staffing levels and decision authority—not training alone.
- A commodity and supply chain readiness plan covering quantification, forecasting, procurement, stock management and last-mile delivery.

- A laboratory and diagnostics readiness plan covering sample transport, networked diagnostics, quality assurance, accreditation and turnaround time.
- A data readiness plan showing interoperable records, shared indicators, data quality, data use and links to financing and performance management.
- Measures to track efficiency gains, cost savings, service quality, workload, stock-outs, turnaround time and value for money.

3 Community-led systems should be formally recognized, financed and connected—while preserving independence

Across proposals, countries increasingly position community systems as integral to service delivery, accountability and equity rather than as parallel outreach functions. Priorities commonly include expanding community-led service delivery, strengthening community–facility linkages, institutionalizing community-led monitoring (CLM), and extending services to key and vulnerable populations and rural, remote, displaced and mobile groups. Several proposals also point to the need to connect community platforms with PHC, social protection and broader multisectoral systems. However, this connection should not imply absorption into government or PHC workforce structures. Community functions should be formally recognized, financed and connected to PHC and subnational governance arrangements, while preserving the organizational independence, safety and accountability of community-led organizations to affected communities (Box 3).

Key gap

Despite this strong narrative, proposals often do not clearly explain how community functions will be formally recognized, financed and connected to PHC, subnational planning, quality improvement and governance systems while preserving community independence. There is also limited articulation of how CLM and other community platforms will be institutionalized through sustainable financing, social contracting, or similar mechanisms without weakening their role as independent accountability actors.

Risk

Without clear institutional pathways and sustainable financing, community systems may remain parallel, disease-specific and dependent on external resources. Conversely, if integration is interpreted as absorption into PHC workforce structures, community-led organizations may lose their independence, safety, trust and accountability to affected communities. Either risk would weaken accountability, reduce equity benefits and limit the ability of community-led approaches to reach key and vulnerable populations and other underserved groups.

Suggested minimum elements for GC8 proposals

- How community functions will be formally recognized, financed and connected to PHC and subnational governance arrangements while preserving organizational independence, safety and accountability to affected communities.
- How CLM and other community platforms will be embedded in subnational planning, quality improvement and governance processes without compromising their independent accountability role.

- How community functions will be financed through context-appropriate pathways, including social contracting where enabling conditions exist, direct funding or pooled civil society mechanisms where social contracting is premature or risky, and protected financing arrangements for key population-led organizations where needed to preserve independence, safety, trust and reach;
- How community–facility linkages will support referral, follow-up, peer navigation, differentiated service delivery and rights-based accountability.
- How national scale social contracting or similar mechanisms will support long-term sustainability of community-led responses.

Box 3. Choosing the right community financing pathway

Community systems integration requires predictable financing, but not all contexts are ready for the same financing model. Countries should select a pathway that protects community leadership, independence, safety and accountability while progressively moving towards domestic sustainability.

The goal is not to force all community financing through one mechanism, but to match the financing pathway to the country specific context, including the enabling environment, fiduciary readiness, community safety and sustainability objectives. Social contracting is one important route, but direct, pooled or protected financing may be more appropriate where legal, political or operational conditions are not yet in place.

Social contracting through government systems

- **When it may be appropriate**
  Where civil society organizations can legally register, contract with government, receive public funds and operate safely.
- **What it should protect or enable**
  Domestic institutionalization of community-led service delivery, peer navigation, adherence support, community-led monitoring and rights-based accountability.

Direct funding to community-led organisations

- **When it may be appropriate**
  Where social contracting is not yet feasible, public financial management systems are not ready, or there are risks of delays, exclusion or loss of independence.
- **What it should protect or enable**
  Continuity of trusted community-led functions, especially for key and vulnerable populations, while enabling conditions are strengthened.

Pooled civil society or community funds

- **When it may be appropriate**
  Where multiple donors or domestic actors can coordinate financing but direct government contracting remains premature or fragmented.
- **What it should protect or enable**
  Reduced duplication, more predictable funding, transparent allocation and support for smaller or key population-led organizations.

Protected financing for key population-led organizations

- **When it may be appropriate**
  Where criminalization, stigma, restrictive civic space or security risks make integration into government systems unsafe or inappropriate.
- **What it should protect or enable**
  Organizational independence, confidentiality, trust, safety and continued reach to populations that may not access general PHC platforms.

Transition pathway to domestic financing

- **When it may be appropriate**
  Where external financing still supports core community functions but a phased shift to national budgets, insurance, social protection or pooled funds is planned.
- **What it should protect or enable**
  Clear milestones for domestic uptake, costed functions, safeguards against unfunded transfer of responsibilities and sustained community accountability.

4 Governance integration must define mandates, decision authority and accountability—not only coordination platforms.

Across proposals, integration is increasingly framed as an institutional and governance reform, not only a service delivery transformation. Countries commonly emphasize joint planning and budgeting across programmes, integrated coordination platforms, alignment with national strategies and UHC agendas, and a shift from partner-led coordination towards stronger government stewardship. However, governance integration requires more than creating or naming coordination platforms. Proposals should define the mandates, decision authority, resource allocation mechanisms, accountability arrangements and subnational roles that will enable integrated services and systems to function in practice.

Key gap

Despite this emphasis, governance integration remains underdeveloped in many proposals. In several cases, services are integrated at the front end while planning, budgeting, accountability and coordination arrangements remain siloed across programmes. Proposals often reference integrated governance structures but do not clearly define who has authority to make decisions, allocate resources, resolve bottlenecks or hold actors accountable across diseases, sectors and levels of the system.

Risk

Without clear mandates, decision authority and accountability arrangements, integration may remain 'soft', with services co-located or partially aligned while the underlying governance architecture remains fragmented. This would weaken government ownership, slow implementation, limit course correction and make it harder to sustain integrated approaches at scale.

Suggested minimum elements for GC8 proposals

- Defined mandates, roles and decision authority for integrated governance platforms at national and subnational levels.
- A 'light governance' model linking long-term integration goals with routine decision-making, including who sets priorities, who adapts them subnationally, who monitors performance and community feedback and how unresolved financing, workforce, commodity, data or accountability issues are escalated and acted on (see Box 4).
- How joint planning, budgeting and coordination will operate across diseases and broader health and social sector actors.
- How resource allocation, bottleneck resolution and accountability decisions will be made and documented.
- How government stewardship will be strengthened over time, including transition from partner-led to nationally owned coordination.
- How governance reform will support scale-up, sustainability and system-wide institutionalization of integration.
- How integrated governance will be linked to routine performance review, data use, community feedback and course correction.

Box 4. Light governance model

Countries should define a simple governance chain that links long-term integration goals to routine implementation decisions. At minimum, this should include:

- A national stewardship body with authority to set integration priorities, approve phased transition plans and align financing.
- Subnational coordination platforms responsible for adapting national priorities to local readiness, service pathways and community priorities.
- Facility and community review mechanisms that use routine data, community feedback and quality indicators to identify bottlenecks and adjust implementation.
- Clear escalation pathways so unresolved financing, workforce, commodity, data or accountability issues can be acted on by the appropriate decision-making level.

5 Integration can support sustainability and efficiency, but savings must be costed, evidenced and time-bound.

Across countries, integration is framed as a strategic pathway to sustainability and resilience in the context of declining external financing and growing transition pressures. However, integration does not automatically generate an efficiency dividend. Proposals should clearly present the additional implementation costs, expected recurrent savings or efficiencies, the timeframe over which these may arise and the evidence, costing methods and assumptions used. The goal should be to reduce avoidable fragmentation and duplication while strengthening domestic ownership, equity, continuity and quality of services.

Sustainable financing is a recurring priority across proposals. Countries commonly express plans to: embed HIV within national budgets, insurance schemes and UHC benefit packages; align disease financing with national health financing systems; develop sustainability roadmaps; and strengthen public financial management, resource tracking and co-financing arrangements. Stronger proposals should show how integration will be financed during transition, not only how it may reduce duplication over time.

Key gap

Despite this strong strategic framework, financial integration remains one of the most persistent weaknesses across proposals. Funding streams often remain fragmented across donors, insurance schemes and domestic budgets, with limited clarity on how resources will be pooled, aligned or transitioned over time. Many proposals also claim efficiency gains without costing the additional investments required for integration or specifying when, where and under what assumptions savings may occur. Community systems financing also remains insufficiently institutionalized and highly exposed to declining external financing.

Risk

If efficiency gains are assumed rather than demonstrated, integration may be used to justify budget reductions before systems are ready. This could underfund implementation, weaken service quality, increase pressure on facilities and communities and place HIV gains at risk. Without credible financial integration, the broader integration ambition is unlikely to translate into a sustainable and equitable HIV response.

Suggested minimum elements for GC8 proposals

- Costed integration plans showing both additional implementation costs and expected recurrent savings or efficiencies.
- Transparent evidence, costing methods and assumptions used to estimate savings, efficiencies or value for money gains.
- A realistic timeframe for when efficiencies may arise, recognizing that upfront investment may be required before savings are realized.
- How disease-specific financing will align with national budgets, public financial management systems and UHC financing arrangements.
- Pathways to pool or coordinate donor, domestic and insurance funding streams.
- How community systems financing will be institutionalized and sustained beyond donor support.

6 Multisectoral integration must define practical linkages, mandates, financing and accountability—not only cross-sector ambition.

Across proposals, multisectoral integration is emerging as a strategic layer of the integration agenda, extending beyond health sector alignment to connect HIV and other disease-specific responses with social protection, education, gender and gender-based violence (GBV) programming, labour and justice systems. Countries increasingly recognize that equitable outcomes require not only integrated health services, but also coordinated action on the structural and social determinants that shape vulnerability, access and long-term wellbeing. However, multisectoral integration should move beyond broad references to 'linkages' and define the practical mechanisms through which sectors will jointly plan, finance, implement, monitor and be held accountable.

Key gap

Despite this recognition, multisectoral integration remains underdeveloped and weakly operationalized in many proposals. Linkages with social protection, education, gender, labour and justice systems are often referenced at a high level, but proposals frequently do not define the joint platforms, mandates, referral pathways, financing arrangements, data-sharing protocols or accountability mechanisms needed to make multisectoral collaboration functional in practice.

Risk

Without clearer operational pathways, multisectoral integration may remain rhetorical rather than actionable. This would limit the ability of countries to address structural drivers such as stigma, poverty, gender inequality, exclusion and legal barriers, and reduce the potential of integration to improve equity, access and outcomes for people and communities left furthest behind.

Suggested minimum elements for GC8 proposals

- Practical linkages between HIV and social protection, education, gender and GBV, labour and justice systems, including referral and follow-up pathways.
- Defined joint platforms, mandates, roles and accountability mechanisms for multisectoral collaboration.

- Financing arrangements showing how multisectoral actions will be costed, resourced, coordinated and monitored over time.
- Data sharing, confidentiality and feedback mechanisms that enable coordinated support while protecting rights and privacy.
- Measures showing how multisectoral integration will reduce structural barriers and improve equity outcomes for key and vulnerable populations and other underserved groups.

7 Integration must strengthen equity and rights safeguards, not dilute tailored services.

Across proposals, countries consistently prioritize key and vulnerable populations, including adolescent girls and young women, as well as mobile and hard to reach groups. The emphasis is on reducing access barriers, improving continuity of care and embedding rights-based approaches within integrated service models. However, integration should not assume that general platforms can meet the needs of all populations equally. Stronger proposals combine system-wide efficiency with explicit equity and rights safeguards, population-specific service pathways, confidentiality and data protection protocols, and continued support for peer-led and differentiated models.

Key gap

Despite this strong equity framework, proposals often do not clearly explain how integration will protect tailored services for key and vulnerable populations or prevent service dilution, reduced access, stigma, confidentiality breaches or loss of trust. There is also limited detail on how equity risks will be assessed, mitigated and monitored through disaggregated measures of reach, retention, outcomes and user experience.

Risk

Without explicit safeguards, integration could unintentionally widen existing inequities rather than reduce them. Services may become less acceptable, confidential or accessible for populations facing stigma, criminalization, discrimination, mobility barriers or differentiated service needs, weakening retention, outcomes and trust in integrated systems.

Suggested minimum elements for GC8 proposals

- An equity and rights impact assessment identifying who may benefit, who may be left behind and what mitigation measures are required.
- Population-specific service pathways for key and vulnerable populations and other groups facing access barriers.
- Confidentiality and data protection protocols for integrated records, referrals, reporting and community feedback mechanisms.
- Continued funding for peer-led, community-led and differentiated service delivery models within integrated systems.
- Disaggregated measures of reach, retention, outcomes and user experience to monitor whether integration is reducing or widening inequities.

8 Integration requires phased transformation with explicit readiness gates.

Stronger proposals treated integration as a deliberate, multiyear transformation process rather than a one-off reform. These countries commonly describe phased approaches in which early stages stabilize service delivery and reduce disruption from donor shifts, intermediate stages consolidate and harmonize fragmented systems, and later stages institutionalize integration within governance, financing and routine national systems. Each phase should include explicit readiness gates, with defined entry and exit criteria before expansion to additional facilities or districts.

Key gap

Despite this recognition, proposals often do not define the implementation architecture needed to manage integration as a phased transformation. Accountability and measurement frameworks are frequently underdeveloped, with limited use of indicators or markers of system-level maturity, weak milestones and tracking mechanisms, and little reference to joint performance reviews. Few proposals specify readiness gates, such as minimum staffing, commodity availability, laboratory and data readiness, community acceptance and service-quality thresholds, before moving from pilots to wider rollout.

Risk

Without clear sequencing, accountability, decentralization strategies and readiness gates, integration may stall at the level of policy ambition or expand before systems are prepared. This could compromise quality, continuity and equity, make progress difficult to track, weaken learning and course correction, and reduce the likelihood that integration is implemented consistently and sustainably across subnational units and facilities.

Suggested minimum elements for GC8 proposals

- A clear phased implementation pathway with realistic sequencing and explicit transition milestones.
- Defined entry and exit criteria for each phase, including minimum staffing, commodity availability, laboratory and data readiness, community acceptance and service-quality thresholds before expansion to additional facilities or districts.
- Defined integration indicators that measure system-level change, not only programme outputs.
- Mechanisms for tracking progress, joint review, accountability and course correction across programmes and levels of the system.
- A clear strategy for subnational rollout, including readiness at the subnational level, decentralization pathways and implementation support.

Annex 1

Checklist for incorporating suggested minimum elements for GC8 proposals

Insight	Suggested minimum elements for GC8 proposals
1 PHC integration as patient pathway	☐ Defined patient pathway showing entry points, service package, referrals, staffing, records, commodities and follow-up. ☐ Evidence that the model is acceptable to intended users, including key and vulnerable populations. ☐ Measures for waiting time, continuity, quality, retention and HIV/PHC outcomes. ☐ Links to governance, financing, workforce, data and accountability reforms. ☐ Plan for moving pilots or phased approaches to national scale.
2 System readiness	☐ Evidence that workforce, commodity, laboratory and data capacities are ready before additional services are assigned to a platform. ☐ Workforce plan covering roles, task-sharing, supervision, workload, staffing and decision authority. ☐ Supply chain readiness plan covering quantification, forecasting, procurement, stock management and last-mile delivery. ☐ Laboratory and diagnostics readiness plan covering sample transport, networked diagnostics, quality assurance, accreditation and turnaround time. ☐ Data readiness plan covering interoperable records, shared indicators, data quality, data use, financing and performance management. ☐ Measures for efficiency gains, cost savings, quality, workload, stock-outs, turnaround time and value for money.
3 Community-led systems	☐ Formal recognition, financing and connection of community functions to PHC and subnational governance while preserving independence, safety and accountability. ☐ CLM and community platforms embedded in planning, quality improvement and governance without compromising independent accountability. ☐ Institutionalized financing through domestic, pooled, social contracting where feasible, direct funding or pooled civil society mechanisms where needed, and protected financing for key population-led organisations. ☐ Community–facility linkages for referral, follow-up, peer navigation, differentiated service delivery and rights-based accountability. ☐ National-scale social contracting or similar mechanisms for long-term sustainability.

Insight	Suggested minimum elements for GC8 proposals
4 Governance integration	☐ Defined mandates, roles and decision authority for integrated governance platforms at national and subnational levels. ☐ Light governance model linking long-term integration goals with routine decision-making, subnational adaptation, performance review, community feedback and escalation pathways. ☐ Joint planning, budgeting and coordination across diseases and broader health and social sector actors. ☐ Documented resource allocation, bottleneck resolution and accountability decisions. ☐ Plan for strengthening government stewardship and transition from partner-led to nationally owned coordination. ☐ Links to scale up, sustainability, institutionalization, routine performance review, data use and course correction.
5 Financing and sustainability	☐ Costed integration plans showing additional implementation costs and expected recurrent savings or efficiencies. ☐ Transparent evidence, costing methods and assumptions used to estimate savings, efficiencies or value-for-money gains. ☐ Realistic timeframe for when efficiencies may arise, recognizing upfront investment needs. ☐ Alignment of disease-specific financing with national budgets, public financial management systems and UHC financing arrangements. ☐ Pathways to pool or coordinate donor, domestic and insurance funding streams. ☐ Plan to institutionalize and sustain community systems financing beyond donor support.
6 Multisectoral integration	☐ Practical linkages between HIV and social protection, education, gender and GBV, labour and justice systems, including referral and follow-up pathways. ☐ Defined joint platforms, mandates, roles and accountability mechanisms for multisectoral collaboration. ☐ Financing arrangements showing how multisectoral actions will be costed, resourced, coordinated and monitored. ☐ Data sharing, confidentiality and feedback mechanisms that enable coordinated support while protecting rights and privacy. ☐ Measures showing how multisectoral integration will reduce structural barriers and improve equity outcomes.

Insight	Suggested minimum elements for GC8 proposals
7 Equity and rights safeguards	☐ Equity and rights impact assessment identifying who may benefit, who may be left behind and mitigation measures required. ☐ Population-specific service pathways for key and vulnerable populations and other groups facing access barriers. ☐ Confidentiality and data protection protocols for integrated records, referrals, reporting and community feedback mechanisms. ☐ Continued funding for peer-led, community-led and differentiated service delivery models. ☐ Disaggregated measures of reach, retention, outcomes and user experience.
8. Phased transformation and readiness gates	☐ Clear phased implementation pathway with realistic sequencing and transition milestones. ☐ Entry and exit criteria for each phase, including staffing, commodity availability, laboratory and data readiness, community acceptance and quality thresholds. ☐ Integration indicators that measure system-level change, not only programme outputs. ☐ Mechanisms for tracking progress, joint review, accountability and course correction. ☐ Subnational rollout strategy, including readiness, decentralization pathways and implementation support.

Annex 2

Integration investment matrix: translating integration priorities into fundable actions

Domain	Suggested priority investments	What the investment should enable	Key implementation considerations	Core measures and safeguards
1 Governance, financing and accountability	Joint planning, budgeting and accountability; costed integration and transition plans; social contracting and public financing for community-led responses.	Integration decisions that are costed, financed, governed and accountable across national, subnational and community levels.	Name the accountable institution; have a clear decision authority; map recurrent cost; clear domestic uptake milestones; links to public financial management, UHC or pooled financing arrangements; social contracting safeguards.	Budget allocation and execution; domestic financing milestones; performance review process; protection against unfunded transfer of responsibilities or premature budget reductions
2 Integrated services and workforce readiness	PHC-based HIV service integration; patient pathway redesign; differentiated service delivery; task sharing, multidisciplinary delivery, training and supportive supervision.	HIV services that are delivered through PHC and related platforms without reducing quality, confidentiality, retention or tailored access.	Define service package, entry points, referral and follow-up model; conduct a facility and workforce readiness assessment; ensure staffing, protocols, supervision and role clarification across facility and community levels.	Coverage, waiting time, retention, viral suppression, quality and user experience; safeguards for confidentiality, equity and differentiated access.
3 Commodities, laboratories, data and digital systems	Integrated forecasting, procurement, logistics, laboratory networks, sample referral systems and secure interoperable information systems, including community data.	Integrated delivery supported by reliable commodities, diagnostics, secure data flows and interoperable systems.	End-to-end commodity, diagnostic and data workflow; maintenance and quality-assurance plan; interoperability approach; data governance, confidentiality and data quality processes.	Stock-outs, turnaround time, data completeness and use of data for decisions; privacy, safety and service-continuity safeguards.

Domain	Suggested priority investments	What the investment should enable	Key implementation considerations	Core measures and safeguards
4 Community systems, feedback loops and rights	Community-led delivery, peer navigation, adherence support, community–facility linkages, CLM, legal support and feedback loops for service quality and programme improvement, and legal and enabling environment reforms that support community registration, safe operation, funding access and accountability.	Communities financed, recognized and empowered to deliver, monitor and improve services while protecting rights and independence.	Define formal community roles; put in place payment and contracting mechanisms; referral, escalation and feedback protocols; responsible decision-makers; safety and independence safeguards.	Community coverage, predictable financing and proportion of CLM issues resolved; protection of community independence, confidentiality and security.
5 Multisectoral and equity-focused integration	Selected, high-impact linkages with TB, sexual and reproductive health and rights, maternal and child health, non-communicable diseases, mental health, nutrition, GBV, social protection, education, gender and justice systems.	High-impact linkages that address structural barriers and improve access, uptake and outcomes for people most at risk of being left behind.	Define target population, priority funded actions, referral pathway, joint lead and shared indicator(s); equity and rights impact assessment with population-specific service pathways.	Referral completion, benefit uptake, reach, retention and disaggregated outcomes; avoid unfunded coordination and preserve tailored services.

Bibliography

57th Programme Coordinating Board meeting: Global AIDS Strategy 2026–2031. Geneva: Joint United Nations Programme on HIV/AIDS; 2025 (PCB57_Global_AIDS_Strategy_2026-2031.pdf).

Communities Delegation to the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria. Integration that works for communities: A community-centred framework for integrated HIV, TB and malaria investments on the path to domestic sustainability. Community policy paper submitted as an advocacy contribution to the GC8 funding request development process. 2026.

Community-led AIDS responses. Geneva: Joint United Nations Programme on HIV/AIDS (Community-led AIDS responses — Final report based on the recommendations of the multistakeholder task team).

Gurung B, Prabowo H. A community guide to integration in the Global Fund Grant Cycle 8 (GC8): what to protect, push for, and how to engage? Bangkok: Asia-Pacific Regional Learning Hub (APRLH), Seven Alliance; 2026.

Equity in the HIV response: Assessing progress and charting a way forward. Geneva: Joint United Nations Programme on HIV/AIDS; 2024 (Equity in the HIV response: Assessing progress and charting a way forward | UNAIDS).

Fighting pandemics and building a healthier and more equitable world: Global Fund strategy (2023–2028). Geneva: Global Fund to Fight AIDS, Tuberculosis and Malaria; 2021 (strategy_globalfund2023-2028_narrative_en.pdf)

Global AIDS Strategy 2026–2031: United towards ending AIDS. Geneva: Joint United Nations Programme on HIV/AIDS; 2026.

Global HIV target setting for 2030: Global task team on 2030 targets recommendations. Geneva: Joint United Nations Programme on HIV/AIDS; 2025 (Global HIV Target Setting for 2030 — Global Task Team on 2030 Targets Recommendations — Live document as of 28 March 2025).

Grant Cycle 8 (GC8) prioritization guidance: Resilient and sustainable systems for health. Geneva: Global Fund to Fight AIDS, Tuberculosis and Malaria; 2026 (cr_gc8-rssh-prioritization_guidance_en.pdf).

HIV integration in West and Central Africa: From service delivery to system embedding. Draft report. Dakar: UNAIDS West and Central Africa Regional Office; February 2026.

HIV prevention and care as part of universal health coverage. WHO Bull. 2020 (HIV prevention and care as part of universal health coverage).

HIV response sustainability primer. Geneva: Joint United Nations Programme on HIV/AIDS; 2024 (HIV response sustainability primer).

Integrating health services: brief. Geneva: World Health Organization; 2018 (Integrating health services: brief).

Kiplagat J, Huschke S. HIV and primary health care integration in Africa: the challenges and opportunities. BMC Public Health. 2021;21:2013. doi:10.1186/s12889-021-12019-8.

Primary health care and HIV: convergent actions: policy considerations for decision-makers. Technical document. Geneva: World Health Organization; 2023 (Primary health care and HIV: convergent actions: policy considerations for decision-makers).

Proctor EK, Powell BJ, McMillen JC. Implementation strategies: recommendations for specifying and reporting. Implementation Sci. 2013;8:139. doi:10.1186/1748-5908-8-139.

Quality of care in fragile, conflict-affected and vulnerable settings: taking action. Geneva: World Health Organization; 2020.

Sweeney S, Obure CD, Maier CB, Greener R, Dehne K, Vassall A. Costs and efficiency of integrating HIV/AIDS services with other health services: a systematic review of evidence and experience. Sex Transm Infect. 2012;88(2):85–99. doi:10.1136/sextrans-2011-050199.

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UNAIDS
Joint United Nations
Programme on HIV/AIDS

20 Avenue Appia
1211 Geneva 27
Switzerland

+41 22 595 59 92

unaids.org