FRIENDS OF THE GLOBAL FIGHT | AGAINST AIDS, TUBERCULOSIS AND MALARIA

Pharos Global Health Advisors

Protecting Civil Society's Critical Role in HIV and TB Programs During and Beyond Donor Transition

Actions Needed from Congress, the Administration and the Global Fund

May 2026

Summary findings

1

Civil Society Organizations (CSOs) are essential to HIV and TB service delivery. They are not peripheral actors—they drive frontline services and are often the only providers reaching vulnerable populations.

2

U.S. bilateral health agreements focus on commodities and systems but fail to address how CSO-delivered services will be financed after donor withdrawal—creating a predictable gap in prevention and outreach.

3

Evidence shows that abrupt funding losses lead to clinic closures, high user fees and loss to follow-up, putting epidemic control at risk and undermining prior U.S. investments.

4

Sustaining CSO services will require governments to take steps to establish legal authority, budget lines and contracting capacity. Most countries lack at least one of these preconditions, meaning action is needed to sustain CSO services.

5

U.S. government and Global Fund transition processes need to incorporate better reporting on CSO roles, costs and transition readiness—along with explicit plans for CSO financing in MOUs and Funding Requests.

Summary

The tremendous progress made against HIV and TB in low- and middle-income countries over the last thirty years has been driven heavily by civil society organizations (CSOs)—including faith-based organizations—committed to reaching people at elevated risk and those underserved by public-sector health systems. In HIV programs, CSOs often work with key populations who account for a disproportionately high share of new infections and face stigma, criminalization and other barriers to public-sector care.[1] Because HIV epidemics are often concentrated in these key populations, reaching them with prevention and treatment services is vital to reducing overall transmission and sustaining progress against HIV. CSOs also play crucial roles in malaria control and elimination, particularly in engaging communities on prevention (bed nets, seasonal spraying, timely testing) and uncomplicated treatment, although malaria is outside the scope of this analysis.

Despite their critical contributions to national HIV and TB responses, most CSOs remain financially vulnerable due to their dependence on funding from international donors.[2,3,4] If external aid is withdrawn without a planned handoff of CSO contracts to domestic funding mechanisms, many of these organizations are unlikely to survive. Disruptions to CSO-delivered prevention and treatment services can be expected to result, causing a resurgence of new infections and preventable deaths in partner countries—and jeopardizing billions of dollars of U.S. global health investment. Recent evidence from Latin America and the Caribbean and Eastern Europe reveals how poorly managed donor exits can interrupt essential health services. After U.S. foreign aid was suspended in Latin America in early 2025, 87% of community- based organizations surveyed across the region experienced funding freezes that interfered with care for over 156,000 people.[5]

The recent U.S. Government (USG) memorandums of understanding (MOUs) with dozens of countries do not address the issue of CSO contracting. The signed MOUs for Kenya, Ethiopia, Nigeria and Uganda include domestic co-financing targets for health areas like data systems and commodities, but not for CSO contracts.

Going forward, expectations regarding the absorption of CSO contract costs into government budgets should be made explicit and included as a primary element of the country implementation plans that are currently being drafted for each MOU. A primary goal of the transition process, reflected in the implementation plans, should be for partner governments to institutionalize social contracting, in which domestic funds are used to finance CSOs to provide key HIV and TB services.[6]

CIVIL SOCIETY ORGANIZATIONS (CSOs)

CSOs are country-based, locally run organizations that operate independently from the public sector.

They include non-governmental organizations (NGOs), faith-based organizations, community-based organizations, small for-profit health care providers and other non-state actors.

International NGOs and other external implementers are not included in this definition, though they have also played important roles in national HIV and TB responses.

Photo: Gogo is an activist and outreach worker for HIV and women's rights. She established the South African Positive Women Ambassadors Center and is a prominent civil society voice. *The Global Fund/Vincent Becker.*

Objectives and Approach

Objectives: The objectives of this report are to

1. Highlight the critical importance of the CSOs in successful national AIDS and TB programs;
2. Underscore and document their persistent heavy financial dependence on donors;
3. Point to the centrality of maintaining support for CSOs as part of the larger transition agenda in global health;
4. Show that it is challenging to achieve this CSO transition via "social contracting," with many past setbacks but also notable successes, and distill the lessons from these past experiences; and
5. Make recommendations to the US Congress and Administration and to the Global Fund on how they can promote the transition of CSOs from donor to domestic financing over the next five years.

Approach: The transition framework developed by Bao et al. (2015) highlights five core activity areas to facilitate successful global health program transitions including CSOs.[7] The US government, Global Fund and partner country governments should carry out all five of these activities, partly or completely. Given the urgency of the current environment, accelerated progress will be needed in each of the five areas, especially in the first two highlighted in this report:

1. **Create financial sustainability:** Establish predictable domestic financing for CSO-delivered services by creating dedicated government budget lines (or other routine purchasing mechanisms).
2. **Sustain a supportive policy environment:** Secure and document high-level political and legal commitments that allow health ministries and other public entities to contract CSOs for priority services (e.g., clarifying procurement eligibility, addressing legal barriers that prevent contracting).[8]
3. **Develop local stakeholder capacity:** Build the government's technical ability to manage social contracting by strengthening procurement processes, contract management, performance monitoring and technical audit functions needed to oversee CSO providers.
4. **Communicate transparently to all stakeholders:** Maintain structured communication with all stakeholders by developing a written transition plan with timelines and responsibilities, disseminating it at multiple levels.

Photo: Community members supported by the NGO BRAC – a Global Fund partner that teaches friends and neighbors to recognize TB symptoms – pose outside their homes in Khulna district, Bangladesh. *The Global Fund/Vincent Becker.*

5. **Align programs:** Integrate donor-supported CSO services into national systems before donors withdraw by aligning reporting procedures, referral pathways and quality standards so that services can continue smoothly under domestic funding.[9]

The rest of this report presents the main findings from our analysis of CSO contracting in the context of rapid global health donor transitions. These findings are based on a detailed review of the literature and our own experience in developing HIV/TB transition plans in more than 15 countries in Africa, Asia and Latin America over the past decade.[a] Our findings are illustrated by case studies that show how domestic financing commitments backed by sound national policies and domestic administrative capacity have resulted in successful transition of CSO services. The report concludes with a set of recommendations for the U.S. Congress, the administration and the Global Fund.

The scale of CSO involvement in national health systems is massive: local CSOs managed nearly 20% ($5.26 billion) of Global Fund grant money from 2017 to 2022, delivering services ranging from mobile TB testing to adherence support for HIV patients enrolled in antiretroviral therapy.

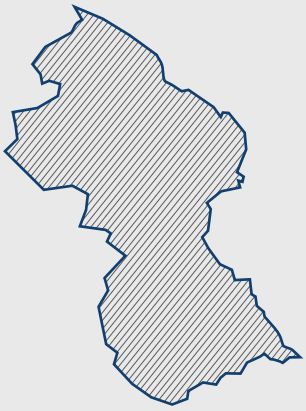
Main Findings

A. CSO-delivered services are foundational to HIV and TB control programs.

Rather than merely supplementing the health system, CSOs in many contexts are the primary drivers of service delivery and infection control. Transition planning that focuses only on public sector actors will miss essential interventions. The scale of CSO involvement in national health systems is massive: local CSOs managed nearly 20% ($5.26 billion) of Global Fund grant money from 2017 to 2022, delivering services ranging from mobile TB testing to adherence support for HIV patients enrolled in antiretroviral therapy.[10] In 2018, CSO providers accounted for nearly 80% of all outpatient visits in Nigeria, and faith-based organizations provided over 50% of all formal healthcare in rural Zambia (including HIV and TB services).[11] Compared to the government health department program, community-based organizations in Costa Rica link a significantly higher proportion of newly diagnosed members of key populations to HIV care within 30 days.[12]

Up to now, the countries transitioning to domestic social contracting have experienced a range of successes and failures. Both contain lessons for future transition planning. The cases below illustrate various approaches to the transition process, detailing the context, trigger and outcome associated with each transition experience. Each case study also highlights which activity areas from the Bao et al. framework emerged as central to the ultimate transition outcome.

a Transition studies performed in Algeria, Angola, Botswana, Cambodia, Colombia, Dominican Republic, Ghana, Guatemala, Honduras, Jamaica, Morocco, Namibia, Tanzania, Tunisia, Zimbabwe



CASE STUDY 1: GUYANA'S MOVE TOWARD SOCIAL CONTRACTING FOR HIV SERVICES

Main takeaway. With sufficient political will, countries can proactively build the architecture for domestic social contracting. Guyana has achieved modest progress and the hard work of scale up lies ahead.

Context. Guyana, an upper-middle-income country since 2016, faces a moderate TB burden and a concentrated HIV epidemic. HIV prevalence rates are significantly higher among key populations compared to the general adult population.[13] A 2017 social contracting analysis carried out by Palladium and Health Policy Plus found that civil society organizations were critical providers of most services for people living with HIV, including members of key populations.[14] Their contribution was described as crucial for HIV counselling, testing, stigma mitigation and home-based care.

Trigger. Large donors have been scaling down funding in Guyana for years, with PEPFAR contributions declining from $28.4 million in 2007 to $6.6 million in 2015. Yet in 2017, at least 80% of the funding for interventions targeting key populations still came from PEPFAR.[15] To address the impending donor transition, the government formed a High-Level Steering Committee for Sustainability to create a National HIV Program Sustainability Plan, which was approved in 2019.

Outcome. In 2018, the Ministers of Health and Finance agreed to contract CSOs to deliver HIV services for key populations, and this commitment was incorporated into the 2019 National HIV Sustainability Plan. In 2019, Guyana launched a pilot program funded through the National AIDS Programme that supported two CSOs targeting vulnerable groups in one region of the country.[16] This partnership model has continued to expand, though domestic social contracting remains incomplete.

Framework tie-in. This case is strong in terms of financial sustainability, capacity building and communication. Guyana used a broad-based Sustainability Steering Committee (which included CSO participation) and multiple assessments to prepare for social contracting, then translated the findings into a pilot outlined in the 2019 National HIV Sustainability Plan. This case also shows progress on the policy environment, since legal and financial analyses and high-level political support created the foundation for financing CSOs with public funds.

B. CSOs provide services that cannot be replaced by governments.

Ministries of health often face legal or cultural barriers to working directly with the affected populations at high risk for HIV acquisition. CSOs have consistently demonstrated their value by successfully implementing peer- and community-based interventions that create environments where members of key populations feel welcome and safe.[17] In several Eastern European countries CSOs have run programs that governments simply could not operate themselves.[18,19] The unique reach of CSOs, and the trust they have engendered within vulnerable communities, is critical considering that members of key populations and their sexual partners accounted for 55% of new HIV infections globally in 2022—up from 44% in 2010.[20]

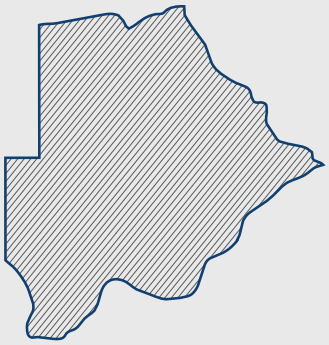
Although some governments have attempted to replace the work of CSOs with state-delivered services, it generally goes poorly. Evidence suggests that care delivery becomes lower quality and narrower in scope when governments take over CSO services.[21] For example, when patients were moved from specialized NGO clinics to state-run facilities in South Africa due to PEPFAR funding cuts, 20% of them dropped out of care entirely.[22]

C. CSOs typically rely heavily on donor financing.

In many countries, CSO service platforms have been built around donor financing models, especially for prevention work and outreach to key populations. Donor funding is often concentrated on community-based interventions critical to preventing new infections, meaning these activities can face rapid contraction when external funding declines. In fact, international aid accounts for 80% of all funding for HIV prevention programs across LMICs. In 2025, only 18 of the 82 countries evaluated by UNAIDS financed more than a quarter of their HIV prevention programs with domestic funds.[23] Considering the heavy involvement of CSOs in HIV and TB prevention programs, these figures point to a significant reliance of CSOs on external support. This creates a precarious dependency where the sudden withdrawal of a single major funder can quickly destabilize a national health system.

Fortunately, some countries have been proactive about addressing the reliance of CSOs on donor funding. A common first step is to develop a roadmap document that identifies the most donor-dependent program areas, assigns institutional responsibility (e.g., to a specific government department or agency), and defines milestones for developing social contracting mechanisms. The Botswana case (Case Study 2) illustrates an “in progress” example of this approach. National health officials in Botswana commissioned a transition readiness assessment and produced a time-bound plan for taking ownership of CSO contracts.

CSOs have consistently demonstrated their value by successfully implementing peer- and community-based interventions that create environments where members of key populations feel welcome and safe.



CASE STUDY 2: TRANSITION PLANNING IN BOTSWANA

Main takeaway. Botswana did not wait for a fiscal crisis to begin planning for donor transition. The process continues with promising early indicators.

Context. Botswana has achieved strong HIV treatment outcomes, but donor dependence remains uneven across the national program. Donors remain the primary funders of several areas that rely on CSO delivery platforms, including HIV testing and counseling (85%) and prevention (59%).[24]

Trigger. In April 2023, the government of Botswana (with support from UNAIDS) commissioned a transition readiness assessment and roadmap to prepare for an anticipated decline in external HIV and TB funding. The roadmap was validated through a stakeholder workshop and presented to the National AIDS and Health Promotion Council.

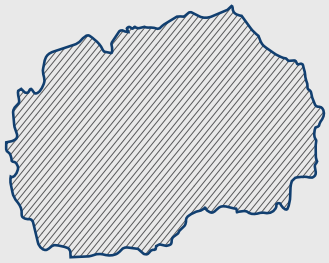
Outcome. The transition roadmap, developed by Pharos Global Health Advisors, found that about 75% of the funding going to CSOs in Botswana for prevention and engagement with key populations is provided by the U.S. government and the Global Fund.[25] Instead of waiting for donors to withdraw, the roadmap argues Botswana should address a practical problem now: CSO funding is split across three funding entities (national government, Global Fund and USG), each with its own reporting requirements, contract systems, etc. The roadmap recommends developing a shared approach for how CSO proposals are requested, vetted, funded and monitored. To achieve this, Pharos proposed the creation of a national oversight committee with separate working groups for critical areas, including CSO coordination. This work is currently ongoing.

Framework tie-in. Bao's activity areas of transparent communication (a published, timebound transition roadmap) and program alignment (explicit steps to harmonize donor and domestic CSO contracting systems) have been a strong focus of Botswana's approach to transition.

D. Some governments have covered CSO services through domestic contracts.

In the most successful transition scenarios, such as the Global Fund transition in North Macedonia (Case Study 3), governments institutionalize social contracting to take full financial ownership of CSO contracts, ensuring that critical services continue without interruption.

CASE STUDY 3: SOCIAL CONTRACTING IN NORTH MACEDONIA AFTER GLOBAL FUND GRANT CLOSURE



Main takeaway. North Macedonia is one of the few countries that completely filled the gap in funding for specific HIV services resulting from the Global Fund's partial exit.

Context. North Macedonia received about $25 million in Global Fund allocations from 2005 until the country's primary national grant closed 12 years later. Although North Macedonia has continued to receive some support from regional Global Fund grants, 2017 marked the turning point when the government began absorbing the cost of CSO contracts. The country's HIV epidemic is concentrated among key populations, and many prevention and testing services for these communities were implemented by CSOs with Global Fund support. The last national grant provided prior to closeout supported CSOs working with high-risk populations and did not require any domestic co-financing.[26]

Trigger. After the Global Fund country grant closed in 2017, the government shifted toward domestic financing of CSO-delivered interventions to avoid service interruption.

Outcome. The North Macedonia Ministry of Health made a formal commitment in September 2017 to take over financing of the HIV response, including both prevention and treatment services.[27] Since 2018, the government has passed national budgets with specific lines for HIV programs.[28] In 2018 and 2019, domestic resources fully replaced what the Global Fund had been paying CSOs—about $850,000 per year, or half the annual HIV program budget—to deliver prevention and testing among key populations and peer support to people living with HIV.[29] Public financing sources were partially diversified in 2019: 75% came from the basic state budget and 25% from excise taxes on tobacco and alcohol.

Framework tie-in. This case is strong regarding the financial sustainability (a substantial domestic budget allocation immediately after almost complete donor exit) and a supportive policy environment (a clear government commitment and Ministry of Health mandate) aspects of the framework. Program alignment was also achieved thanks to CSOs advocating for their services to be integrated into national and local government programs.[30]

E. Planned and phased transitions help sustain CSO service coverage.

When donors withdraw abruptly, the budget gap is not the only immediate problem. These transitions also require that contracts, supply chains and reporting systems all change simultaneously. Growing evidence therefore emphasizes the importance of early planning, clear accountability mechanisms and monitoring that continues after the donor transition.[31,32]

The main takeaway is that transitions work best when they proceed as a stepwise process with a concrete roadmap, rather than as a sudden shock. The reality, however, is that the USG and the Global Fund have signaled their intention to withdraw funding from many countries where early transition planning has been lacking. In these cases, the USG and the Global Fund need to push partner governments to immediately begin an accelerated planning process. Reviews of PEPFAR and other donor transitions identify a consistent set of steps that can be streamlined when timelines are tight: (1) develop a roadmap; (2) involve stakeholders early; (3) communicate the plan clearly; (4) support midterm evaluations to adjust the approach; (5) strengthen government management capacity; (6) support ongoing monitoring and evaluation.[33] This matters even more for key population services, where domestic political commitment may be weaker and where discriminatory policy environments can limit governments' ability or willingness to contract CSOs for prevention and outreach after donors leave.

The Bao et al. framework offers practical guidance for transition planning. It treats transition as a process that includes a pre-transition phase, active handover and services being sustained beyond the formal transition end date. The Avahan transition (Case Study 4) is one of the best-documented examples of a phased approach that combines detailed preparation with continued learning between transition rounds. Importantly, the Bill & Melinda Gates Foundation—the original project funder—was clear from the beginning about its intention to transition financing responsibility to the Indian government and did not backpedal on this commitment.

Photo: People wait for health services outside a mobile health clinic. Mobile clinics like these provide health services for people living near the front lines in Ukraine. *The Global Fund/Oleksandr Rupeta/VII.*

CASE STUDY 4: PLANNED TRANSITION OF AVAHAN HIV PREVENTION SERVICES TO GOVERNMENT OWNERSHIP IN INDIA

Main takeaway. Avahan's phased handover to the Indian government is the gold standard for planned transitions, but it took years of planning and a funder that was firm and transparent from day one.

Context. Launched in 2003, Avahan was a large HIV prevention initiative funded by the Bill & Melinda Gates Foundation and implemented through CSOs delivering targeted interventions for high-risk populations across six high-prevalence Indian states. By 2009, Avahan reached a quarter of all people "most at-risk" for HIV in India with standard package of services, including condom distribution and clinical treatment for sexually transmitted infections.[34]

Trigger. Beginning in 2009, the Foundation initiated a phased transition in which government agencies took over financing and oversight of targeted interventions, and service delivery largely continued through the same CSOs under government contracts.[35] The transition involved the handover of about 200 separate prevention interventions (i.e., specific projects run by local NGOs providing services like peer education, STI testing, health care provider sensitization, etc.) in three tranches in 2009 (10% of projects), 2011 (20%) and 2012 (remaining 70%).[36]

Outcome. The first transition round in 2009 experienced some friction due to delayed government agreements, which delayed the transition of some initial interventions by up to five months. However, the foundation and the Indian government embraced a model of shared leadership for the later transition rounds, including the establishment of dedicated "transition managers" within the government and formalized a "Common Minimum Programme" to standardize the requirements for a successful transfer.[37] Avahan ultimately dedicated 28% of its total implementation budget to transition-specific activities. Aligning operational aspects of its programs (budgets, team structures, reporting procedures, etc.) with government systems prior to integration helped avoid service disruptions.[38,39] Avahan also aligned its structure with government norms by reducing the overall number of STI clinics while increasing the proportion of less-expensive referral clinics (reduction of STI clinics from 1,820 to 1,401 occurred in 2009–10 without a negative impact on clinical performance).[40]

Framework tie-in. Avahan shows how a phased exit succeeds when several activities from the Bao et al. framework move in coordination. The transition reflected financial sustainability and political commitment when the government assumed financing responsibilities while CSOs continued implementing under new contracts. The program emphasized alignment by adapting its operational procedures to government norms, including reshaping STI clinic models. It also strengthened capacity and communication over successive rounds by enlisting transition managers and adopting a standardized plan for handover expectations.

F. When governments do not act as donors exit, HIV and TB programs suffer.

Finally, governments may simply fail to take action when donors exit, leading CSOs to reduce or discontinue critical services. In Uganda, patients and providers reported a decline in the quality of HIV care—including disruption to outreach services for high-risk groups—after the government did not step in to replace PEPFAR funding withdrawn from 734 healthcare facilities in 2017.[41] In Nigeria, an $83-million reduction in PEPFAR support forced nearly every clinic surveyed to start charging patients for services that used to be free, while support for tracking patients who missed appointments dropped by more than half.[42] In Kenya, nearly 10% of facilities that provided antiretroviral therapy with PEPFAR support were forced to discontinue the service entirely when the government did not replace withdrawn external funding.[43] Post-transition funding gaps can also lead to issues tracking programmatic and epidemiological data. In Croatia, for example, the regular tracking of HIV cases among the most at-risk groups broke down following the Global Fund's exit.[44] Case study 5 focuses on Montenegro, where the government failed to fund key population services after the Global Fund's partial exit in 2015, and most NGO-run programs were shuttered.[45]

Photo: A MAP Foundation field officer gives a TB awareness presentation and screening to a community of migrant workers from Myanmar near Chiang Mai, Thailand. *The Global Fund/Jonas Gratzer.*

CASE STUDY 5: THE GLOBAL FUND EXIT FROM MONTENEGRO AND THE COLLAPSE OF NGO SERVICES

Main takeaway. Montenegro's case is a cautionary tale of a government that absorbed public-sector HIV services but neglected to cover CSO-delivered interventions after the Global Fund's partial exit.

Context. From 2006 to 2015, the Global Fund helped establish key population services in Montenegro, much of it implemented by NGOs (particularly CAZAS and Juventas).[46] Montenegro's Round 9 HIV grant ended in 2015, marking a major transition point. While Montenegro later benefitted from some regional Global Fund support, total external aid has declined substantially and the period following the withdrawal of country-specific support exposed how ill-prepared the government was for transition.

Trigger. The Global Fund's support ended in June 2015 with the completion of the Round 9 HIV grant, and Montenegro was no longer eligible for further Global Fund support at that time.

Outcome. The Montenegrin government absorbed many public sector components of the HIV and TB programs, including the procurement of rapid tests and services delivered within public health institutions. However, the government did not take over funding for key population services delivered by NGOs, and two of the three NSPs in the country were forced to close.[47] Although two NGOs (CAZAS and Juventas) estimated that together they would need €130,000–€150,000 annually to continue their community outreach to key populations, the government provided only €22,000 in 2015.[48] And while the parliament began allocating money specifically for HIV interventions in 2017 with the State Budget for HIV Prevention, the budget initially covered only a third of service requirements.[49] Montenegro is still receiving funding from multi-country grants focusing on community-led service, but the scope of supported activities has shrunk considerably and the transition to domestic financing for CSO contracts remains incomplete.

Framework tie-in. Montenegro's experience reflects a transition failure across several of the Bao framework activity areas. While the government absorbed numerous interventions delivered through the public sector, there was a lack of political will to take ownership of the contracts for CSOs providing key population services. Moreover, the government faced contracting capacity concerns as it became clear which mechanisms could be used to fund CSO services.[50] The result was a predictable service gap once donor financing stopped, compounded by limited transition planning specifically for NGO-delivered services.

Recommendations

Transition of CSO services from donor to government financing is a core element of sustainability planning. This should be reflected in bilateral global health agreements by the U.S., and CSO transition should also be central to the new round of Global Fund Grant Cycle 8 (GC8) grants. In many countries, CSOs are the sole providers of services to marginalized populations. If donor support declines without a clear plan for governments to contract and pay these organizations, disruptions to essential services are likely to lead to a resurgence of previously controlled epidemics. Philanthropic funders can also play a targeted role in aid transition, including by funding the capacity of CSOs while governments build the systems needed to take over these contracts.

Given what this report shows about how to transition CSOs to domestic funding as donors withdraw, we propose the following recommendations:

U.S. bilateral agreements and global health aid:

- Congress should request the State Department show how it is working with each partner government to move donor-funded CSO interventions into domestic social contracting arrangements.
- Congress should require the State Department to report on the transition readiness of CSO-delivered HIV and TB services in priority countries. At a minimum, this reporting should identify: (1) which CSOs are delivering essential prevention, outreach, testing, treatment and adherence services, (2) the estimated annual cost of these services and (3) the current sources of financing, including external donors and domestic co-financing.
- The State Department should assess whether each partner government has legal authority, contracting mechanisms and financial resources to contract CSOs directly, and how these systems are being leveraged in practice to advance social contracting. Without this level of visibility, Congress cannot judge whether transition planning is sufficient or whether donor withdrawal is leading to a financial cliff.
- Continuity of frontline services is essential. The State Department should leverage APS mechanisms to prioritize integration of CSOs into national systems, including support for social contracting, capacity building and continuity of frontline services during transition.

CSO contracting in MOUs and implementation plans:

- Congress should require the State Department to demonstrate how U.S. bilateral engagement is securing timebound commitments from partner governments to co-finance and transition CSO-delivered services to domestic ownership.
- The State Department should report on whether the United States has made the transition of these contracts an explicit part of its policy discussions with government counterparts, whether this expectation is reflected concretely in country agreements and implementation plans, and what results have been achieved so far.

Global Fund policies and practices for CSO contracting:

- The Global Fund should continue to report on its support of community and faith organizations for delivering services.
- As part of co-financing expectations and Global Fund's Grant Cycle 8, the Global Fund should ask countries to describe the existing CSO landscape for HIV and TB, including the specific organizations involved, the services they provide, the populations they engage, the size and duration of current contracts, and the mix of financing sources.
- The Global Fund should require countries to state clearly whether CSO contracts supported under prior cycles will be continued, modified or closed out. Funding requests should identify which services now financed through GC7 grants are expected to shift to partial or complete government financial support and should specify both the timeline for that shift and the contracting mechanism to be used. Countries should be asked to explain how they will manage the operational aspects of the transition and maintain uninterrupted care for current patients, particularly members of marginalized populations at high risk of HIV acquisition.
- In their Funding Requests and Cofinancing Commitment Letters, countries should be required to describe specific, quantified plans for increasing domestic co-financing of CSO contracts during GC8.

Conclusion

Transitions of HIV and TB programs will not succeed by default—they will succeed only if they are deliberately built. As both the evidence and experience show, progress across five core areas that ensure the sustainability of CSOs delivering essential HIV and TB services—policy, financing, contracting capacity, communication and system alignment—is not optional; it is the difference between continuity and collapse.

The stakes are immediate. Without clear plans to sustain CSO-delivered services, countries risk losing the very platforms that have driven gains in prevention, treatment and epidemic control. This is not a marginal issue—it is central to whether decades of U.S. and global investment are protected or reversed.

Congress, the Administration and the Global Fund each have a narrow window to act. That means using policy, financing and oversight tools now to secure timebound commitments, build domestic contracting systems and ensure CSOs remain embedded in national responses.

This report was researched and drafted by a team from Pharos Global Health Advisors consisting of Michael Elhardt, Joan Tallada and Robert Hecht. Important edits were made by Friends of the Global Fight.

Endnotes

1 Key populations in this document follow UNAIDS terminology and classifications for groups at heightened risk of HIV acquisition and facing significant barriers to accessing prevention, treatment and care services. https://www.unaids.org/en/topic/key-populations.

2 Krivelyova A, Kakietek J, Connolly H, Bonnel R, Manteuffel B, Rodriguez-García R, N'Jie N, Berruti A, Gregson S, Agrawal R. Funding and expenditure of a sample of community-based organizations in Kenya, Nigeria, and Zimbabwe. AIDS Care. 2013;25 Suppl 1(Suppl 1):S20-9. doi: 10.1080/09540121.2013.764390. PMID: 23745626; PMCID: PMC4003578. https://pubmed.ncbi.nlm.nih.gov/23745626/.

3 Chorna, Y., Lukash, IG., Kalancha, Y. et al. Perspectives on multisectoral accountability framework to end tuberculosis in the Eastern Europe and Central Asia region: a mixed-methods study. BMC Glob. Public Health 3, 20 (2025). https://doi.org/10.1186/s44263-025-00136-y

4 AIDS, crisis and the power to transform: UNAIDS Global AIDS Update 2025. Geneva: Joint United Nations Programme on HIV/AIDS; 2025. Licence: CC BY-NC-SA 3.0 IGO. https://www.unaids.org/en/resources/documents/2025/2025-global-aids-update.

5 Guillén, J.R., Stevenson, M., Talero, M.Á.B., Torres, M.A. and Wirtz, A.L. (2026), Consequences of United States funding suspensions on community-led HIV services in Latin America and the Caribbean: findings of a rapid service provider survey. J Int AIDS Soc., 29: e70081. https://doi.org/10.1002/jia2.70081.

6 Gotsadze G, Chikovani I, Sulaberidze L, Gotsadze T, Goguadze K, Tavanxhi N. The challenges of transition from donor-funded programs: results from a theory-driven multi-country comparative case study of programs in Eastern Europe and Central Asia supported by the Global Fund. Glob Health Sci Pract. 2019;7(2):258-272. https://doi.org/10.9745/GHSP-D-18-00425.

7 Bao J, Rodriguez DC, Paina L, Ozawa S, Bennett S. Monitoring and evaluating the transition of large-scale programs in global health. Glob Health Sci Pract. 2015;3(4):591-605. http://dx.doi.org/10.9745/GHSP-D-15-00221.

8 Gotsadze et al. The Challenges of Transition from Donor-Funded Programs. 2019.

9 McDade, Kaci Kennedy and Schäferhoff, Marco and Ogbuoji, Osondu and Bharali, Ipchita and Dixit, Siddharth and Mao, Wenhui and Bandara, Shashika and Yamey, Gavin. Transitioning Away from Donor Funding for Health: A Cross Cutting Examination of Donor Approaches to Transition. The Center for Policy Impact in Global Health., Duke Global Working Paper Series No. 21, April 2020, Available at SSRN: https://ssrn.com/abstract=3575681.

10 The Global Fund to Fight AIDS, Tuberculosis and Malaria. The Global Fund's funding for community and civil society organizations: an analysis of Grant Cycle 5 and Grant Cycle 6. Geneva: The Global Fund to Fight AIDS, Tuberculosis and Malaria; 2024 Jul 19. https://www.theglobalfund.org/media/14830/cs_funding-community-civil-society-organizations_report_en.pdf.

11 Friends of the Global Fight Against AIDS, Tuberculosis and Malaria. The Global Fund and faith-based organizations: a growing $3.5 billion partnership. Washington (DC): Friends of the Global Fight Against AIDS, Tuberculosis and Malaria; 2024 May. https://www.theglobalfight.org/issue-brief-the-global-fund-and-faith-based-organizations/.

12 Marano-Lee, Mariette, et al. Contributions of the Community-Based Organization Program Funded by the Centers for Disease Control and Prevention to Linkage to HIV Medical Care. Public Health Reports, vol. 139, no. 6, 31 May 2024, pp. 662–668, https://doi.org/10.1177/00333549241252579.

13 United Nations Development Programme (UNDP). Using social contracting in national HIV responses: country case studies from Africa, the Caribbean, Eastern Europe and Latin America. New York: UNDP; 2019.

14 UNDP. Using Social Contracting in National HIV Responses. 2019.

15 UNDP. Using Social Contracting in National HIV Responses. 2019.

16 Pan Caribbean Partnership against HIV and AIDS (PANCAP). Best practices of civil society organizations' models of resource mobilization in selected Caribbean countries. June 2021. https://pancap.org/pw/pcc/media/pancap_document/Best-Practices-of-Civil-Society-Organizations-Models-of-Resource-Mobilization.pdf.

17 Gotsadze et al. The Challenges of Transition from Donor-Funded Programs. 2019.

18 European Monitoring Centre for Drugs and Drug Addiction. North Macedonia: a summary of the national drug situation. Lisbon: EMCDDA; 2013 Sep. https://www.euda.europa.eu/publications/country-overview/2013/north-macedonia/html_en. https://www.euda.europa.eu/publications/country-overview/2013/north-macedonia/html_en

19 European Monitoring Centre for Drugs and Drug Addiction. Bulgaria country drug report 2019. Lisbon: EMCDDA; 2019 Jun 6. https://www.euda.europa.eu/publications/country-drug-reports/2019/bulgaria_en.

20 Korenromp EL, Sabin K, Stover J, Brown T, Johnson LF, Martin-Hughes R, Ten Brink D, Teng Y, Stevens O, Silhol R, Arias-Garcia S, Kimani J, Glaubius R, Vickerman P, Mahy M. New HIV Infections Among Key Populations and Their Partners in 2010 and 2022, by World Region: A Multisources Estimation. J Acquir Immune Defic Syndr. 2024 Jan 1;95(1S):e34-e45. doi: 10.1097/QAI.0000000000003340. Epub 2024 Jan 4. PMID: 38180737; PMCID: PMC10769164. https://pmc.ncbi.nlm.nih.gov/articles/PMC10769164/.

21 Zakumumpa H, Paina L, Wilhelm J, Ssengooba F, Ssegujja E, Mukuru M, Bennett S. The impact of loss of PEPFAR support on HIV services at health facilities in low-burden districts in Uganda. BMC Health Serv Res. 2021 Apr 1;21(1):302. doi: 10.1186/s12913-021-06316-4. PMID: 33794880; PMCID: PMC8017884. https://pmc.ncbi.nlm.nih.gov/articles/PMC8017884/.

22 Katz IT, Bogart LM, Cloete C, Crankshaw TL, Giddy J, Govender T, Gaynes MR, Leone D, Losina E, Bassett IV. Understanding HIV-infected patients' experiences with PEPFAR-associated transitions at a Centre of Excellence in KwaZulu Natal, South Africa: a qualitative study. AIDS Care. 2015;27(10):1298-303. doi: 10.1080/09540121.2015.1051502. Epub 2015 Aug 24. PMID: 26300297; PMCID: PMC4548805. https://pubmed.ncbi.nlm.nih.gov/26300297/.

23 UNAIDS. Global AIDS Update 2025. 2025.

24 Pharos Global Health Advisors. Botswana: sustainability and transition readiness assessment and roadmap for HIV and TB. Gaborone: Botswana National AIDS and Health Promotion Council; April 2024. https://pharosglobalhealth.com/projects/botswana-hiv-sustainability-and-transition-roadmap/.

25 Pharos Global Health Advisors. Botswana HIV and TB Sustainability and Transition Roadmap. 2024.

26 UNDP. Using Social Contracting in National HIV Responses. 2019.

27 UNDP. Using Social Contracting in National HIV Responses. 2019.

28 United Nations Development Programme. Social Return on Investment for HIV services. Policy brief. May 2021. https://www.undp.org/eurasia/publications/social-return-investment-hiv-services.

29 UNDP. Using Social Contracting in National HIV Responses. 2019.

30 UNDP. Using Social Contracting in National HIV Responses. 2019.

31 Gotsadze et al. The Challenges of Transition from Donor-Funded Programs. 2019.

32 Ozawa S, Singh S, Singh K, Chhabra V, Bennett S (2016). The Avahan Transition: Effects of Transition Readiness on Program Institutionalization and Sustained Outcomes. PLoS ONE 11(7): e0158659. doi:10.1371/journal.pone.0158659. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0158659.

33 Vogus A, Graff K. PEPFAR Transitions to Country Ownership: Review of Past Donor Transitions and Application of Lessons Learned to the Eastern Caribbean. Glob Health Sci Pract. 2015 Jun 17;3(2):274-86. doi: 10.9745/GHSP-D-14-00227. PMID: 26085023; PMCID: PMC4476864. https://pmc.ncbi.nlm.nih.gov/articles/PMC4476864/.

34 Sgaier SK, Ramakrishnan A, Dhingra N, Wadhwani A, Alexander A, Bennett S, Bhalla A, Kumta S, Jayaram M, Gupta P, Piot PK, Bertozzi SM, Anthony J. How the Avahan HIV prevention program transitioned from the Gates Foundation to the government of India. Health Aff (Millwood). 2013 Jul;32(7):1265-73. doi: 10.1377/hlthaff.2012.0646. PMID: 23836743. https://doi.org/10.1377/hlthaff.2012.0646.

35 Bennett S, Singh S, Rodriguez D, Ozawa S, Singh K, Chhabra V, et al. (2015). Transitioning a Large Scale HIV/AIDS Prevention Program to Local Stakeholders: Findings from the Avahan Transition Evaluation. PLoS ONE 10(9): e0136177. https://doi.org/10.1371/journal.pone.0136177.

36 Bennett, S., Rodriguez, D., Ozawa, S. et al. Management practices to support donor transition: lessons from Avahan, the India AIDS Initiative. BMC Health Serv Res 15, 232 (2015). https://doi.org/10.1186/s12913-015-0894-0.

37 Bennett et al. Transitioning a Large Scale HIV/AIDS Prevention Program to Local Stakeholders. 2015.

38 Sgaier et al. How the Avahan HIV Prevention Program Transitioned from the Gates Foundation to the Government of India. 2013.

39 Bennett et al. Transitioning a Large Scale HIV/AIDS Prevention Program to Local Stakeholders. 2015.

40 Sgaier et al. How the Avahan HIV Prevention Program Transitioned from the Gates Foundation to the Government of India. 2013.

41 Zakumumpa et al. The Impact of Loss of PEPFAR Support on HIV Services in Uganda. 2021.

42 Banigbe B, Audet CM, Okonkwo P, Arije OO, Bassi E, Clouse K, et al. (2019) Effect of PEPFAR funding policy change on HIV service delivery in a large HIV care and treatment network in Nigeria. PLoS ONE 14(9): e0221809. https://doi.org/10.1371/journal.pone.0221809. https://doi.org/10.1371/journal.pone.0221809

43 Rodríguez DC, Mohan D, Mackenzie C, Wilhelm J, Eze-Ajoku E, Omondi E, Qiu M, Bennett S. Effects of transition on HIV and non-HIV services and health systems in Kenya: a mixed methods evaluation of donor transition. BMC Health Serv Res. 2021 May 13;21(1):457. doi: 10.1186/s12913-021-06451-y. PMID: 33985482; PMCID: PMC8117613. https://pmc.ncbi.nlm.nih.gov/articles/PMC8117613/.

44 Gotsadze et al. The Challenges of Transition from Donor-Funded Programs. 2019.

45 Golubovic V. The impact of transition from Global Fund support to governmental funding on the sustainability of harm reduction programs: a case study from Montenegro. Eurasian Harm Reduction Network; 2016. https://icaso.org/wp-content/uploads/2016/10/Montenegro-Case-Study.pdf.

46 Golubovic. The Impact of Transition from Global Fund Support to Governmental Funding on the Sustainability of Harm Reduction Programs. 2016.

47 Golubovic. The Impact of Transition from Global Fund Support to Governmental Funding on the Sustainability of Harm Reduction Programs. 2016.

48 Golubovic. The Impact of Transition from Global Fund Support to Governmental Funding on the Sustainability of Harm Reduction Programs. 2016.

49 Ministry of Health of Montenegro. National drug situation overview 2023. European Union Drugs Agency; 2024. https://www.euda.europa.eu/drugs-library/national-drug-situation-overview-2023-montenegro_en.

50 Golubovic. The Impact of Transition from Global Fund Support to Governmental Funding on the Sustainability of Harm Reduction Programs. 2016.