

Thematic Evaluation on Community Engagement and Community-led Responses Secretariat-led with TERG oversight (CE- CLR)

Global Fund Secretariat
Management Response, Technical
Evaluation Reference Group
(TERG) Commentary, and Final
Report.

June 2023

Secretariat Management Response

TERG Evaluation on Community Engagement and Community-led Responses

Introduction

The Technical Evaluation Reference Group (TERG) is an independent evaluation advisory group, accountable to the Global Fund Board through its Strategy Committee for ensuring independent evaluation of the Global Fund business model, investments and impact. The Global Fund values transparency and publishes TERG reports according to the TERG Documents Procedure approved by the Strategy Committee.

The Board and Strategy Committee (SC) requested that the TERG undertake an evaluation on Human rights, gender and programs for key and vulnerable communities (KVP). The intended purpose was to evaluate the Global Fund's contribution to strengthening human rights and gender and KVP inclusive programs, including through the grant cycle and through country and global governance structures and inform guidance for the next cycle of grants. Recognizing that the proposed review was too broad in scope to be effectively undertaken in a singular assessment, the TERG and Secretariat agreed to refine the focus of the review on the operationalization of Global Fund's support to community engagement (CE) and community-led responses (CLR) through country grants, multi-country grants, and SIs. The review was undertaken as a hybrid assessment with the Secretariat providing oversight of the process under the TERGs guidance.

The Secretariat broadly endorses the key findings and the high-level conclusions from the report and broadly agrees with the recommendations. The Secretariat also appreciates the productive collaboration with the TERG and the Evaluation Team and acknowledges the significant amount of work that was carried out in a short-time frame.

The Secretariat notes that many of the recommendations are already being actioned upon as part of the preparations for Grant Cycle 7 (GC7). Strengthening community engagement and leadership, the role of community led and based organizations in diseases responses, and community systems strengthening, are areas of specific focus in Secretariat planning for operationalization of the 2023-2028 strategy period. Key functional, technical, and operational departments, including grant management, risk, finance, TAP and CRG, have been collaborating to develop collectively owned plans to move forward these strategic priorities.

Areas of agreement

The Summary of Recommendations table at the end of the response presents the seven recommendations from the evaluation report which have been classified by the evaluators as either

'quick wins' (for roll out in GC7) or 'medium term' (for roll out in GC8) or 'long term' (achieve in 2023 – 2028).

Ensure community supported activities are linked to the Global Fund's overarching theory of change for the 2023-2028 strategy to guide the institutionalization of a community-centered, human rights promoting, and gender-transformative culture: The Secretariat should ensure that the overarching theory of change under development for the new strategy clearly articulates how CE and CLR activities under both grants and catalytic funding, contribute to the Global Fund Strategic Objectives. (Recommendation 1)

The Secretariat agrees that any overarching Theory of Change for the Strategy period 2023-2028 should reflect and integrate community engagement, community-led responses, human rights and gender as key domains in contribution to achieving the Strategy's objectives and goals.

It is agreed that roles, responsibilities and accountabilities across the Secretariat, and with partners, should be further clarified to outline the specific contribution that different functions and actors play in promoting and achieving Strategy objectives and outcomes as they relate to CE and CLR.

The 2023-2028 Strategy delivery planning process has been organized and led as cross functional. It has included a focus on capability and capacity needs across multiple Secretariat departments and divisions, as well as identification of activities/actions to be progressed by a range of key functions and process owners.

The Secretariat notes that forward planning for the Strategy has been undertaken as 'holistic' so that all strategy priorities are considered. Decisions on tradeoffs/prioritization, whilst difficult, will be required and will need to consider country context as well as available funding.

Strategy-related change initiatives need to be organized and sequenced (immediate, medium and longer term) in order to effectively drive progress across all imperatives.

Holistic measurement framework: "What gets measured gets done": The Secretariat, in consultation with key partners, should continue to develop a KPI that captures community contribution to Global Fund results for the new strategy 2023-2028, and also ensure that qualitative measures are in place to track progress towards long-term changes in capacities, enabling environments, sustainability and systems. (Recommendation 2)

The draft KPI framework for the 2023-28 Strategy has been developed in consultation with the input of external stakeholders – including technical partners, and independent experts including representatives of key and vulnerable communities. KPIs on community systems strengthening, as well as community engagement are proposed for SC and board consideration.

As noted in the assessment and confirmed through extensive measurement consultations with external partners and experts, including communities, understanding actual CE contribution to results is complex and cannot be meaningfully captured by quantitative measures solely or singularly. To compliment the KPI proposal, periodic qualitative/thematic assessments are proposed on community engagement as part of the future M&E Framework. The Secretariat proposes these assessments be community led and independently managed through the evaluation function. The approach to the proposed KPI on Community Systems Strengthening (CSS) (as specific to community led and based organizations Community- Led Organizations and Community Based Organizations "CLO/CBO" is

similarly presented and includes period thematic/qualitative assessments as complimentary and critical in understanding/measure system needs and the environmental factors that hinder or enable CLO/CBO responses in order to provide a comprehensive view.

Internal process and policy changes are under review as part of strategy delivery planning processes alongside revision to funding request materials, technical information notes and briefs for the GC7 launch.

Evolved methods and approaches through which to monitor and assess implementation arrangements as optimal and inclusive of community led and based organizations across critical intervention areas are in discussion as part of cross functional review and will be rolled out for GC7.

Scale up and integration of CLM mechanisms has been high priority for the Secretariat in the current allocation period and as part of C19RM. This has included a particular focus data use for quality improvement and program monitoring; while building capacity of structures to engage with CLM feedback and data i.e., CCMs and program reviews.

This will remain a focus in forward planning for GC7 and the next strategy period.

Work in these areas is cross functional and includes engagement from TAP, the CCM Hub, SPH, MECA and GMD.

Build minimum community engagement standards into consolidated guidance for each stage of the grant cycle to ensure the meaningful engagement and leadership of most affected communities, with an emphasis on rights, gender and equity considerations. (Recommendation 3)

The Secretariat agrees with this recommendation. GC7 launch and strategy delivery planning has included a specific focus on community engagement across the grant life cycle.

Informed by a broad range of data and evidence, including lessons from C19RM processes, a community engagement minimum expectations framework will be incorporated into the GC7 Funding Request Development process.

Assurance and control points at key stages across the grant life cycle (funding request development, grant making, and grant implementation) have been identified to strengthen meaningful engagement and assess progress.

GC7 funding request and grant making materials and processes, information notes, have been revised and updated to reflect these changes.

Partner consultation and engagement is ongoing and includes discussions with community and CS partners to part of change management pre-planning.

Noting communities are as diverse as the contexts in which they should be engaged and recognized, there is a need to ensure sufficient differentiation to be able to best respond and engage. Criminalization persists in far too many contexts, as does stigma and discrimination. The Secretariat does not then present the proposed changes in processes and policies should not be considered as a panacea, but instead one of many necessary measures and for which the full Global Fund partnership must work towards.

Revise guidance to support earlier and deeper focus on systemic change: Funding guidance should build on lessons learned to emphasize the long-term approach needed to strengthen and sustain community systems and address human- and gender-based barriers to health services. (Recommendation 4)

The Secretariat agrees that guidance, tools and approaches must evolve to better emphasize the critical role and contribution of community actors and community led organizations in disease responses, including and particularly in addressing human and gender related barriers in access to services, as well as responding to inequities, and that a long-term approach is necessary.

Updated guidance, new tools and measurement approaches have been developed for GC7 and which aim to support countries and communities to assess CLR system needs over the longer term and for integration into funding requests and as contributions to overall health sector planning processes. This will include capability development initiatives for writing teams and country partners based on updated guidance and rolled out in collaboration between Resilient and Sustainable Systems for Health and Community, Rights and Gender.

Criteria to select priority contexts is in discussion alongside the development of a catalytic investment stream specifically focused on CSS and CLR.

Setting a specific benchmark for resourcing in these areas is not considered feasible given the diversity of the Global Fund portfolio, including the variable relative contribution of the Global Fund in different context.

Evolve the Global Fund's business model and grant architecture to open up more funding and influencing opportunities for less mature community-led and community-based organizations: The Global Fund Secretariat should consider a differentiated approach in contracting community organizations beyond PRs and SRs to bring in new voices and reach more "last mile" communities. (Recommendation 5)

Alternative engagement and contracting approaches beyond the "PR and SR" model are possible under Global Fund architecture (e.g., service contracts, activity-based contracting, results-based financing), aligned with minimum requirements to demonstrate verifiable delivery of prioritized services and Board approved risk appetite thresholds to drive outcomes and impact.

The Secretariat agrees that these alternatives have not been fully utilized across the portfolio, and that a framework/guidance outlining how the variety of possible approaches should be considered with the specific purpose of providing adequate resourcing for CLOs/CBOs to implement interventions where peer/community led approaches are necessary to achieve program outcomes and impact.

As part of strategy delivery planning, a cross-functional task group is to be established (including representation from risk, GMD, finance, CRG, TAP) to align on changes necessary to move forward this aim.

Greater leverage of political influence to address structural barriers within the Global Fund and enhance full country ownership: The Global Fund at all levels should re-affirm the centrality of the voice of communities to achieving the new strategy and promote country ownership as shared government, private sector, and community ownership, in order to address structural barriers to community engagement. (Recommendation 6)

Better use of the Global Fund's 'diplomatic voice' at all levels is included as specific objective in the 2023-2028 strategy framework. This includes at and via the Board, executive leadership, and at country level (including in-country/regional partners, bi-lateral/multi-lateral partners, networks and implementers).

An approach which outlines where, at what level, through what approaches, and key issues, the Global Fund's influence can be most strategically deployed is in discussion across key functions in the Secretariat, noting the importance of considering country context and the focus of Global Fund support in any given context.

Continuously engage and focus the Partnership to support a stronger role of communities throughout implementation of the new strategy, with clear and accountability for responsibilities at the global and country levels: The Global Fund Board should lead efforts, and delegate to the appropriate body, to convene strategic partners in order to clarify accountabilities for strengthening and supporting the enabling environment for community engagement and community-led responses at the global and country level. (Recommendation 7)

Strong agreement that partnership wide roles, responsibilities and accountabilities should be articulated – with clear alignment at the global, regional, and country levels.

Strengthening the Global Fund partnership is a key priority under the new strategy. While recognizing the extensive and strong collaboration that continues between the Secretariat and key multilateral and bilateral partners, planning for the next strategy period is an ideal opportunity to collectively review roles, responsibilities and accountabilities across the partnership including alignment on respective contributions in support of community engagement, community led and based responses, human rights, gender and equity. The Secretariat believes the Board must be engaged in this discussion to make meaningful progress in this area.

The Secretariats' view is that communities should be meaningfully engaged in the development of any roadmap and that primary accountabilities should be to them.

Agreed that the Secretariat should move to more purposefully and systematically document and share good practices across the partnership.

Conclusions

Several actions are well advanced and will be incorporated into the launch of the next allocation cycle, all of which are aligned with the evaluation recommendations.















A number of these actions are outlined in the Secretariat response to the recommendations. They include application of a community engagement minimum expectations framework across all major stages of the grant life cycle, as well as increased efforts to facilitate access to resources for CLO/CBOs using the range of contracting approaches possible within Global Fund grant architecture, ensuring these are 'fit for purpose' for the diversity of CLO/CBO actors.

Working with external experts, including community representatives, technical and bilateral partners, KPIs have been identified for community engagement as well as community systems strengthening.

Recognizing the limitations of quantitative measures in assessing change and results in these areas, the Secretariat proposes that KPIs are complimented by periodic thematic evaluations.

The Secretariat looks forward to reporting in greater detail progress in these areas and actions against the evaluation recommendations in its detailed report, and planned Board thematic discussions on community engagement, community-led and based responses, CSS as well as a key area of focus in discussion on partnerships.

Summary Recommendations

Recommendation	Timeframe	Level of agreement	Level of control
R1: Ensure community supported activities are linked to the Global Fund's overarching theory of change for the 2023-2028 strategy to guide the institutionalization of a community-centered, human rights promoting, and gender-transformative culture: The Secretariat should ensure that the overarching theory of change under development for the new strategy clearly articulates how CE and CLR activities under both grants and catalytic funding, contribute to the Global Fund Strategic Objectives.	NFM4		
R2: Holistic measurement framework: "What gets measured gets done": The Secretariat, in consultation with key partners, should continue to develop a KPI that captures community contribution to Global Fund results for the new strategy 2023-2028, and also ensure that qualitative measures are in place to track progress towards long-term changes in capacities, enabling environments, sustainability and systems	Next strategy period		
R3. Build minimum community engagement standards into consolidated guidance for each stage of the grant cycle to ensure the meaningful engagement and leadership of most affected communities, with an emphasis on rights, gender and equity considerations.	NFM4, continuing over strategy period		
R4. Revise guidance to support earlier and deeper focus on systemic change: Funding guidance should build on lessons learned to emphasize the long-term approach needed to strengthen and sustain community systems and address human- and gender-based barriers to health services.	NFM4, continuing over strategy period		
R5. Evolve the Global Fund's business model and grant architecture to open up more funding and influencing opportunities for less mature community-led and community-based organizations: The GF Secretariat should consider a differentiated approach in contracting community organizations beyond PRs and SRs to bring in new voices and reach more "last mile" communities.	NFM4, continuing over strategy period		
R6. Greater leverage of political influence to address structural barriers within the GF and enhance full country ownership: The Global Fund at all levels should re-affirm the centrality of the voice of communities to achieving the new strategy and promote country ownership as shared government, private sector and community ownership, in order to address structural barriers to community engagement.	Next strategy period		
R7. Continuously engage and focus the Partnership to support a stronger role of communities throughout implementation of the new strategy, with clear and accountability for responsibilities at the global and country levels: The Global Fund Board should lead efforts, and delegate to the appropriate body, to convene strategic partners in order to clarify accountabilities for strengthening and supporting the enabling environment for community engagement and community-led responses at the global and country level.	On-going		

TERG Commentary: Quality Assessment and Utility of the Evaluation on Community Engagement and Community-led Responses

Report

a) The Technical Evaluation Reference Group (TERG) rated the evaluation of community engagement and community-led responses as:

- | | |
|-------------------------------------|--|
| <input type="checkbox"/> | Fully met or exceeded TERG's standards. |
| <input checked="" type="checkbox"/> | Met TERG's standards with only minor shortcomings. |
| <input type="checkbox"/> | Partially met TERG's standards with some shortcomings. |
| <input type="checkbox"/> | Did not meet TERG's standards with major shortcomings. |

b). General comments

Context

1. In 2021, the Board approved the inclusion of the contributory objective in the Global Fund 2023-2028 Strategy: "Maximizing the Engagement and Leadership of Most Affected Communities to Leave No One Behind". As there had previously been few targeted evaluations on community engagement and with limited scope and results, the Board's Strategy Committee (SC) agreed that community engagement (CE) and community-led responses (CLR) needed to be critically evaluated, and therefore recommended an evaluation to be conducted. This was essential to inform any changes that need to be introduced to the Global Fund's business model and to successfully scale CE and CLR in order to achieve the needed results.
2. The CE and CLR TR was the second independent evaluation led by the Secretariat with TERG oversight, and jointly overseen by a technical oversight committee established with Secretariat and TERG representatives. The TERG welcomes the evaluation of CE and CLR. After reviewing the final report, the TERG felt that the report met the TERG's quality standards with only minor shortcomings, as detailed below.

Quality of the evaluation – detailed comments

3. Overall, this is a high quality, clear and well-structured report. The methods and evaluation framework were clearly articulated and applied. The TOR and scope of work, as defined in the RFP, were met.

4. The limitations of methods were discussed. Country visit was limited, because the agreed workplan for this evaluation was developed at a time when it was not yet possible, or it was difficult to visit countries. When countries became more accessible, the timeframe was too short to change plans for most countries. In addition, as mentioned in the Limitations section of the report, the delays in finalizing country selection for case studies and in accessing key stakeholders for interviews further tightened the timeframe. Mitigation measures were taken and are explained. However, this resulted in less opportunities for the community voices to be heard directly by the evaluators.
5. The evidence was derived from clear primary and secondary data sources, which are laid out in detail. The results are presented in detail, analyzed and interpreted in a systematic and logical way. The evidence compiled, triangulated and synthesized is of good quality, and well structured.

c). Observations on Conclusions and Recommendations¹

6. Each conclusion has clear linkages with several key findings, which were extracted from triangulated evidence, especially from country case studies. The conclusions are presented either at strategic and Secretariat-level, or country-level.
7. The recommendations follow logically from the conclusions, are relevant and actionable and worked out in detail. Recommendations are well prioritized. In addition, they are presented in three stages: Quick wins (for roll out in NFM4), Medium term (for roll out in NFM5), and long term (achieve in 2023 – 2028). This clarifies how the Global Fund Secretariat should implement each recommendation and facilitates the Board and Strategy Committee to monitor the implementation of these recommendations by the Secretariat.
8. The findings, conclusions and recommendations of this evaluation are interrelated to and consistent with findings, conclusions and recommendations of other reviews by the TERG, for example the C19RM evaluation and the evaluation of TB prevention. Cross-fertilization of these three evaluations was facilitated. The TERG strongly urges the Global Fund to revisit those cross-cutting recommendations related to CE and CLR, and to press forward with a cultural shift within the Global Fund Secretariat. It is important that all departments and country teams have a clear understanding of their roles, responsibilities and accountabilities in promoting CE and CLR.
9. The comprehensive findings provided in this evaluation can enrich other ongoing TERG evaluations such as on “Accelerating the equitable deployment and access to innovations”, especially the service delivery approach aspects, as well as the “Country steered review”.

¹ For overview of conclusions and recommendations see annex 1 – executive summary of evaluation report.

10. The TERG notes that the conclusions and recommendations from this evaluation repeat those of other previous reviews and evaluations to a concerning degree. This would suggest that there has not yet been a significant shift in how the Secretariat and the partnership as a whole have facilitated community-driven efforts and embedded community-led response thinking into its approaches across departments. In order to meet the ambitions of the new Global Fund strategy, and increase grant effectiveness, it will be critical to see more concerted effort made to address the shortcomings that have been identified in this and other evaluation/reviews.

Annexes

The following items can be found in Annex:

- Annex 1: Executive Summary of Evaluation Report

Annex 1 – Executive Summary of Evaluation Report

Evaluation scope, objectives and definitions

The Global Fund 2017-2022 strategy recognizes that communities play a critical role in ending epidemics, by promoting and protecting human rights and gender equality (strategic objective 3), which is critical to the fight against HIV, tuberculosis and malaria (strategic objective 1), and by requiring investment in building resilient and sustainable systems for health (strategic objective 2), including community systems. The Global Fund recognizes that greater engagement of communities in decision-making processes results in more effective program design – including more community-led responses – that will accelerate progress towards results. The Global Fund values the ability of diverse communities to reach groups that others cannot – particularly key and vulnerable populations (KVPs) of the three diseases – to adapt and innovate in response to crises, to hold others to account through monitoring, and to advocate for changes to the policy and legal environment that create barriers to people's participation in processes, equitable access to quality services, or their right to lead healthy, safe, and dignified lives. The Global Fund has strengthened its internal capacities, adjusted its processes, created tools and guidance, and directed more grant funding and strategic investments towards supporting communities. Significant progress has been made, strengthening the foundation for the new Global Fund 2023-2028 strategy to be even more ambitious in its efforts to place people and communities squarely at the center of the fight against the three diseases.

In preparation for the implementation of the new strategy, the Global Fund commissioned an evaluation of the support provided to, and the results of community engagement (CE), and community-led responses (CLR) in the 2017-2022 funding allocation periods. In this context, CE is considered specifically in terms of communities' engagement in National Strategic Plan development and review, and Global Fund decision-making processes, including the Country Coordinating Mechanism (CCM), country dialogues related to the Global Fund grant cycle, and related community consultation processes, funding request development, grant making, grant design, grant monitoring and evaluation, and grant review and reprogramming. CLR is defined as interventions that are delivered in settings or locations outside of formal health facilities, and that are specifically informed, managed and implemented by and for communities themselves. CLR includes service delivery, community-led monitoring, and advocacy. The assessment of the impact of community engagement and community led responses on health systems in general, and of interventions implemented by community health workers, are beyond the scope of this evaluation. This evaluation grows out of previous reviews/evaluations undertaken by the Technical Evaluation Reference Group (TERG), reviews from the Technical Review Panel (TRP), and the Office of the Inspector General (OIG) inspections,² which

² For example: TERG Strategic Review 2020; OIG Advisory Report on Resilient and Sustainable Systems for Health; Prospective Country Evaluation Synthesis Reports 2018, 2021 and 2022); OIG Advisory Review: Removing human rights related barriers 2019; Community, Rights and Gender Evaluation 2020; Thematic Review on HIV Primary Prevention 2021; TERG Thematic Review on Sustainability, Transition and Co-financing 2020; TERG Thematic Review on Strategic Initiatives 2021; TRP Lessons Learned Report 2020, and TRP Report on Investment in the 2017-2019 Funding Cycle.

concluded that there was scope for improving CE and CLR in order to achieve the goals laid out in the new Global Fund strategy 2023-2028.

The Technical Oversight Committee, consisting of representatives from the Secretariat and the TERG, provided oversight for this evaluation. The objectives of the evaluation were:

1. To assess the design, implementation, and results of community engagement and community-led responses that have been supported by the Global Fund since 2017 in line with the 2017–2022 strategy, and draw out lessons learned.
2. To assess the contribution of CE and CLR to the achievement of the Global Fund’s results.
3. To draw lessons learned and develop actionable recommendations to guide 2023–2028 investments and implementation strategies, including possible changes to the Global Fund Business Model.

The evaluation used a mixed methods approach, which included extensive document review, interviews with 72 people at the global and regional levels (including ten from communities or civil society), and 158 people at the country level (including 71 from communities or civil society). Ten country case studies were conducted to better understand how support and guidance was playing out on the ground.³ The evaluation was strengthened by structured feedback from the Technical Oversight Committee following submission of findings, conclusions and recommendations and based on discussions during a joint recommendation’s validation workshop. The document review, key informant interviews, case studies, and the validation workshop generated a set of 29 findings to respond to each of the evaluation questions. The findings led to ten conclusions and seven recommendations, presented below.

Key Findings and Conclusions

Strategic and Secretariat level

Strategic and Secretariat-level Conclusions

1. Lack of a shared understanding of community contributions to the Global Fund’s mission.
2. Community contributions are under-recognized.
3. The partnership model is under-utilized.
4. Risk and processes trump communities and complexity.
5. Funding cycles do not sufficiently incentivize efforts to achieve sustainability and long-term change.
6. Gender focus is under-developed.

CE and CLR have been prioritized by the Global Fund, as evidenced by the development of new technical guidance, more open flexible processes to broaden the scope of engagement with community actors, new and evolving strategic initiatives and the use of other catalytic investments, and – critically – an increase in grant investment in communities. These initiatives are all necessary and valuable; however, they are not linked by an overarching understanding of how CE and CLR contribute to the Global Fund’s strategic framework. This has resulted in siloed approaches and accountabilities, and different operational understandings of key terms across the Secretariat and the

³ Case study countries are Côte d’Ivoire, Democratic Republic of Congo, Guinea, Lao PDR, Morocco, Nepal, Paraguay, South Africa, Tajikistan and Togo.

partnership. The absence of a key performance indicator, or a way to disaggregate and understand community-led contributions to the Global Fund's strategy, means that community-specific data is not available at the global level. The Global Fund's tracking of community TB case notifications is an excellent example of collecting and disaggregating data in a way that demonstrates the quantifiable contribution of community-led responses to overall Global Fund results. This is not done for all indicators, however, and as programmatic data is aggregated by the principal recipient, many programmatic results generated by communities are not readily visible at the global level.

Another way in which community-specific data is not available at the global level is the absence of a tracking method for the qualitative work and achievements of communities – particularly in removing human rights and gender-related barriers to health care. Qualitative milestones and results are not readily captured by the Global Fund's quantitative data systems. This results in a lack of adequate data to optimally inform decisions, and a lack of visibility or clear understanding of community results at the global level. Furthermore, the results achieved from grants are not linked with results from related strategic initiatives (e.g., Breaking Down Barriers [BDB]), to generate an overarching picture of the contribution that communities make to Global Fund strategic objectives. In addition, the monitoring and evaluation framework and funding cycle do not allow for meaningful measurement of community-led response over the long-term, as the system focuses on what can be achieved within a funding cycle.

The Global Fund has responded to many lessons learned and recommendations from previous evaluations to improve its work in CE and CLR. Guidance and investments continue to increase and have been strongest in HIV. Understanding of rights and gender-related barriers to TB and malaria is increasing across the Global Fund partnership – with technical partners providing normative guidance on this – and the Global Fund invests in TB and malaria community organizations and networks. Guidance has resulted in changes at country level, to ensure that processes are more inclusive of communities, with 15% of CCM funding dedicated to community and civil society engagement. Other recommendations have been harder to address, particularly those related to underlying structural issues or organizational culture. This is critical, because while more support is reaching more community organizations, processes and incentives in the Secretariat are not always aligned to support or value the dynamic ways that communities work. This particularly impacts less mature community organizations, and especially where they produce longer-term and qualitative results, rather than the short-term quantitative results that the Global Fund's systems were designed to measure.

Another example of the Global Fund's progress in supporting CE and CLR is the increase investment in both between new funding mechanism (NFM) 2 and NFM3, and the development or continuation of catalytic investments, including the Community Rights and Gender Strategic Initiative (CRG SI), BDB, and the Community-Led Monitoring SIs, and the use of matching funds to support some of these initiatives. The COVID-19 pandemic has also renewed interest by governments and global partners in working with communities, as the pandemic afforded an opportunity for communities to demonstrate their ability to provide critical services, and reach communities and KVPs, where others could not.

Still, aspects of the Global Fund's systems and business model have had the unintended consequence of creating barriers to some community organizations becoming funding recipients, and implementation has fallen short of expectations. The Global Fund does not yet have a taxonomy to classify different maturity levels of community organizations, and the capacity assessment is currently applied equally to all. While community sector Principal Recipients are among the best rated by the

Global Fund,⁴ community principal recipients tend to be larger, well-established organizations, and less mature organizations tend not to meet the institutional requirements to manage and report on Global Fund investments. Positive examples were found of Principal Recipients engaging community sub (and sub-sub) recipients, while supporting the capacity development of more nascent organizations, and these can inform best practices going forward. Other forms of contracting – such as service contracts by Principal Recipients, and social contracting by governments remain small-scale and under-utilized, and no examples were found of small-grants programs, but such models offer potential for further development.

Country level

Country-level Conclusions

7. Grant architecture is not conducive to consistently elevating diverse community voices.
8. Enabling environment is key to success.
9. Lack of systems-thinking in approaches to grant design.
10. Country ownership is perceived as government ownership.

While there is an abundance of guidance, many communities still report that they do not understand how the Global Fund works, or how they can access CCMs or Global Fund support, either due to the complexity of the guidance, the language used which may not be adapted to their context, or because they do not receive sufficient support to absorb the guidance. Guidance actively promotes community engagement in CCMs and consultations prior to funding request development, although the meaningfulness of this engagement is contingent on the enabling environment and the ways in which the guidance is interpreted at country level. This affects the extent to which key populations who face criminalization and stigmatization – particularly gay, bisexual and other men who have sex with men, transgender people, sex workers, people who inject drugs, people living with HIV, and people in prison and detention – are able to be included and participate actively in CCMs. Other vulnerable groups – including migrants, mobile and displaced people – also face barriers to engagement that can stem from lack of a representative, compounded by a weak governance environment. Even when these groups are represented on the CCM, power dynamics can result in their engagement being more tokenistic than meaningful, although some positive exceptions to this finding were also found that can be drawn from.

For all communities, however, there is less guidance, and subsequently less engagement in the grant cycle, following the consultation stage. Some communities participate in the funding request writing process, but nearly all lose visibility into the process during finalization. Indeed, while civil society may be represented on the CCM, communities in only one case study country saw the final version of funding request prior to submission, and communities in only two case study countries were aware of the final grant design after the negotiation phase. Among the case study countries, no community received adequate feedback (delivered in a manner they understood) on why some community priorities were not included. The requirement in the COVID-19 Response Mechanism second round of funding to submit community priorities with funding requests resulted in communities feeling more heard by the Global Fund.

⁴ Noting that this category also includes international non-governmental organizations, and international faith-based organizations, who tend to be better rated than local civil society organizations. Although the latter are generally better rated than governments. This is further discussed in Finding 1.

Strong examples were found of community-led responses contributing effectively to the national response, and some national stakeholders reported that it would not be possible to implement country programs without community engagement. This was particularly evident in HIV, which has a longer track record, and is supported by more lessons learned and investment than TB and malaria. With growing recognition of the importance of CLR to reach global targets in technical guidance and global strategies, efforts were also visible of scaling up community-led responses in TB and malaria⁵, although these are relatively nascent with the community structures less mature than in HIV, from which many lessons have been adapted. Overall, CLR implementation and results are variable across contexts and highly dependent on the enabling environment and specific support and involvement by the country teams and partners, including long-term investments in capacity strengthening. The latter is critical, and needs can include support to meet Global Fund reporting and financial management requirements, as well as communication, advocacy or technical skills – including in emerging areas such as community-led monitoring. Capacity and turnover in community organizations are key challenges requiring understanding and support, and efforts to strengthen capacity over the long-term are delivering positive and replicable results.

Other success factors were a combination of the vibrancy and persistence of communities, implementer processes and capacities, technical and bilateral partner involvement, and Global Fund support. Much depends on how support is provided by the Global Fund, and how guidance is interpreted and acted upon in the country. The evaluation also observed that the Global Fund system can create distortions to community engagement by its reliance on principal recipients and CCMs, which can create “in groups” of the communities who sit on the CCM, and “out groups”, who are outside the circle of those who have access to the Global Fund. This is less likely to be the case, however, where communities receive support to organize consultations prior to CCM meetings, and have a mechanism to debrief afterwards.

Community-led responses tend to be more effective when their contribution is understood and valued by the government, particularly when community services and government services are linked (for example from a community referral service to a government treatment center), which also appears to be a key aspect of sustainability. Progress has been made in institutionalizing community engagement in the development of National Strategic Plans in many countries, however beyond this, no examples were found of financial sustainability, nor permanent consultation mechanisms that bring communities and governments together on health issues outside Global Fund-supported bodies. Positive and replicable examples of institutional and financial sustainability exist for community-led response in service delivery, however not in monitoring or advocacy – with the latter unlikely to secure long-term domestic financing. While some community responses have become embedded in national health systems, overall, sustainability is not consistently or adequately planned for, or supported in terms of time and resources.

Limitations

Due to the lack of data collected by the Global Fund or community-specific disaggregation, it was not possible to determine the extent to which the objectives of CLR were achieved globally, nor their specific contribution to national results. It should also be noted that delays in case country selection combined with the short timeframe meant that case study data was not available finalized as analysis was underway.

⁵ For example: the Global Technical Strategy and Targets for Malaria 2016-2030, WHO's End TB Strategy, the Stop TB Partnership's Global Plan to End TB, and the Global AIDS Strategy 2021-26.

Recommendations

Quick wins (For roll out in NFM4)

1. **Ensure community supported activities are linked to the Global Fund's overarching theory of change for the 2023-2028 strategy to guide the institutionalization of a community-centered, human rights promoting, and gender-transformative culture:** The Secretariat should ensure that the overarching theory of change under development for the new strategy clearly articulates how CE and CLR activities under both grants and catalytic funding, contribute to the Global Fund Strategic Objectives. This can guide a cultural shift within the GF secretariat whereby all departments and Country Teams (CTs) have a clear understanding of the important role that communities play in supporting the strategic objectives, and also clarify expectations, roles and responsibilities, and accountabilities within the Secretariat and the partnership. This may require expanding the CT to include a CRG expert, with incentives, authority, support and recognition aligned to demonstrating progress on community engagement, and progress on human rights, gender, and equitable access to services. This process can be linked with the strategy delivery working groups' efforts underway to operationalize the new strategy. This work should be extended to further articulate the roles and responsibilities across the partnership and ensure they are reflected in guidelines accordingly. The process could be launched in NFM4 for full rollout by NFM5.
2. **Holistic measurement framework: "What gets measured gets done":** The Secretariat, in consultation with key partners, should continue to develop a KPI that captures community contribution to Global Fund results for the new strategy 2023-2028, and also ensure that qualitative measures are in place to track progress towards long-term changes in capacities, enabling environments, sustainability and systems. This is necessary to ensure that community-led responses are prioritized in funding requests and that relevant data is collected for monitoring, evaluation, learning and decision-making. This would require: (a) quantitative programmatic grant data to be collected and/or disaggregated by community contribution for all relevant results;⁶ (b) PRs to report financial grant data for analysis by the Secretariat by SR-type; (c) the Secretariat to provide guidance and community engagement minimum standards across the grant cycle for CCMs and PRs to adapt as necessary to the context; and (d) considering the inclusion of community-led monitoring to be included in all grants. Lessons learned and results from the CRG and BDB SIs can provide a baseline to support the development of KPIs, with some key activities from these SIs integrated across more grants. Available data and lessons learned can be analyzed by a task force (for example, including the CRG Department, the Grants Management Department, CCM Hub, M&E team, and Policy Hub), linked to ongoing efforts to develop KPI and updated measurement frameworks for the new strategy.
3. **Build minimum community engagement standards into consolidated guidance for each stage of the grant cycle to ensure the meaningful engagement and leadership of most affected communities, with an emphasis on rights, gender and equity considerations.** Funding and operational guidance could be consolidated and simplified with minimum standards provided for community engagement across the grant life cycle. Community engagement standards could be included in funding request guidance and allocation letters, with a budget provided to facilitate the required engagement. In addition to current requirements, minimum standards should consider: a remunerated communities' representative on the proposal writing team, inclusion of communities' views and questions on each CCM agenda item, a minimum review period for communities before funding request submission, sharing final grant documents

⁶ See for example, "The Case for a Key Performance Indicator on Community Systems Strengthening in the New Global Fund Strategy 2023-2028".

with communities, ensuring that there are guidelines for safeguarding the safety and dignity of communities participating in Global Fund processes such as CCM meetings as well as other public meetings. New processes should also require funding requests to annex communities' priorities with justification for what was or was not included in the final budget, for TRP review. Beyond the grant making phase, community engagement in monitoring and evaluation should be specified, with a clearer mechanism for communities to provide feedback on programs, including through community-led monitoring. CCMs and PRs should be strongly encouraged to bring in new partners from community organizations to reach wider groups, and especially populations who are criminalized, stigmatized or otherwise marginalized, including migrant and displaced populations. This recommendation may inform the strategy delivery working group's current efforts to review processes and guidance in preparation for the NFM4.

4. **Revise guidance to support earlier and deeper focus on systemic change: Funding guidance should build on lessons learned to emphasize the long-term approach needed to strengthen and sustain community systems and address human- and gender-based barriers to health services.** The Secretariat should emphasize the importance of CE and CLR in the funding guidelines and highlighting an appropriate level of investment which could be considered – adapted to the context – to address inequities, the importance of complementary roles between the public and community sectors, and the inclusion of appropriate community-led, gender responsive and transformative service delivery, monitoring, and advocacy. This should include encouragement to build in steps towards long-term sustainability planning in funding requests, with clear milestones to be tracked and built upon in subsequent funding allocations. This approach could be piloted in a number of critical countries in NFM4, results of which could then inform a full roll out in NFM5.

Medium term (For roll out in NFM5)

5. **Evolve the Global Fund's business model and grant architecture to open up more funding and influencing opportunities for less mature community-led and community-based organizations:** The GF Secretariat should consider a differentiated approach in contracting community organizations beyond PRs and SRs to bring in new voices and reach more "last mile" communities. This may involve either (a) relaxing requirements for sub-recipients (SRs) and incentivizing PRs to take on more SRs, with support for supervision and capacity strengthening building on best practices, (b) creating new funding mechanisms that are better adapted to less mature organizations, such as small grants funds, with a focus on program delivery and capacity strengthening support. A technical note could be developed to provide guidance on different models and best practices drawn from both the Global Fund and its technical and bilateral partners. This may also be accompanied by a dedicated platform for communities to meet and be represented on the CCM.

Long term (Achieve in 2023 – 2028)

6. **Greater leverage of political influence to address structural barriers within the GF and enhance full country ownership:** The Global Fund at all levels should re-affirm the centrality of the voice of communities to achieving the new strategy and promote country ownership as shared government, private sector and community ownership, in order to address structural barriers to community engagement. This should be reinforced by the Grant Management Department and other GF high level missions to countries, by holding regular dedicated meetings with communities, and using specific guidance and political influence to ensure that communities, the government and the private sector develop an understanding of their complementary contributions towards shared health goals. In this way, all country stakeholders leverage their comparative advantages while underscoring the criticality of removing

rights- and gender-based barriers to support their work. This will require continuous evidence-based messaging from the GF Secretariat and technical partners throughout the implementation of the 2023-2028 strategy regarding the importance of decriminalizing and destigmatizing KVPs and moving towards gender equality. The GF also needs to reinforce the message that country ownership requires all stakeholders including communities ⁷.

7. **Continuously engage and focus the Partnership to support a stronger role of communities throughout implementation of the new strategy, with clear and accountability for responsibilities at the global and country levels:** The Global Fund Board should lead efforts, and delegate to the appropriate body, to convene strategic partners in order to clarify accountabilities for strengthening and supporting the enabling environment for community engagement and community-led responses at the global and country level. The Global Fund can call out present best practices, key findings and recommendations from this evaluation as well as other relevant evaluations (OIG advisory on RSSH, OIG Advisory on Human rights related barriers, TERG Thematic review on STC, TERG Thematic evaluation on HIV prevention CSS evaluation as well as PCE) to inspire and motivate cross-partner sharing and co-designing a way forward. This process may begin in 2023 – 2025 by convening a meeting to develop a roadmap defining roles and responsibilities, including partners such as WHO, UNAIDS, Stop TB, RBM, bilateral donors, and regional organizations, and build on the Partnership enablers Section of the Strategy 2023-2028. This should include further consideration of whether additional partners should also be brought in. This is a long-term effort that should start soon to yield results during the 2023-2028 strategy period.

⁷ See Partnership Enablers in the 2023-2028 strategy.



RFP No TGF-21-117

Final Report

Community Engagement and Community-led Response Evaluation

A Secretariat-led evaluation with TERG oversight

Submitted by **Health Management Support Team**

Resubmitted 15 June, 2022

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Table of Contents

Acknowledgements.....	iv
Glossary of terms in evaluation context	v
Executive Summary	1
Evaluation scope, objectives and definitions	1
Key Findings and Conclusions	2
Strategic and Secretariat level	2
Country level.....	4
Limitations	5
Recommendations.....	5
Abbreviations and acronyms	9
1. Background and Introduction	11
2. Overview of the evaluation	2
2.1 Aim and purpose of the evaluation.....	2
2.2 Objectives of the evaluation	2
2.3 Scope of the evaluation	2
3. Methodology	4
3.1 Desk Review.....	4
3.2 Global Interviews	4
3.3 Country Case Studies	4
3.4 Analysis and Triangulation.....	5
3.5 Quality Assurance.....	5
3.6 Limitations.....	5
4. Findings	6
Pillar 1: Design	12
Pillar 2: Implementation	32
Pillar 3: Results.....	47
Pillar 4: Lessons Learned	53
5. Conclusions	57
6. Recommendations	60

List of Tables

Table 1: Evolution of the Global Fund's support for CE and CLR.....	12
Table 2: Ratings for robustness of key findings.....	6
Table 3: Findings by evaluation question and strength of evidence	7
Table 4: Examples of CE guidance interpretation	25
Table 5: Community engagement overview from case studies	31
Table 6: Community-led response overview of county case studies	33
Table 7: Overview of CLR by disease of country case studies.....	34
Table 8: Conclusions, mapped to findings.....	58
Table 9: Recommendations, mapped to conclusions.....	60

List of Figures

Figure 1: Evaluation scope.....	4
Figure 2: Examples of responses to lessons learned that have strengthened CE and CLR.....	18
Figure 3: Examples of lessons learned where further efforts are necessary	19
Figure 4: CSS investments under RSSH in NFM2 and NFM3	36
Figure 5: Grant Ratings by PR Type 2019-2020	39

List of Annexes (separate document)

1. References
2. List of people interviewed
3. List of guidance documents relevant to CE and CLR
4. Community engagement journey
5. Financial analysis by PR type
6. CRG SI short-term technical assistance tracker analysis
7. Case studies (separate document)

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Finally, the team also appreciates the time and thoughtfulness of the many people who participated in interviews and focus group discussions at the global, regional, and country levels. A list of global interviewees appears in Annex 2, and country interviewees are presented with each case study. Their experience and insights were extremely valuable in informing, balancing, and grounding this evaluation. The evaluators were deeply impressed by the level of dedication, consideration, and commitment that each individual consistently demonstrates to the vision and spirit of the Global Fund.

Glossary of terms in evaluation context¹

Term	Definition
CHW	Community health workers (CHWs) are excluded from the terms of reference of this evaluation, which focuses on community-led responses outside the formal health system. While CHWs may be fully or partially linked with national health systems, and may work closely with community organizations, they are often conflated with community-led cadres, and are referenced in this evaluation that context.
Civil society	The wide array of non-governmental and not for profit organizations that have a presence in public life, express the interests and values of their members and others, based on ethical, cultural, political, scientific, religious or philanthropic considerations (Source: The World Bank)
CLM	Mechanisms that service users or local communities use to gather, analyze and use information on an ongoing basis to improve access, quality and the impact of services, and to hold service providers and decision makers to account. (The Global Fund – for CBM). Or Community-led monitoring is a technique initiated and implemented by local community-based organizations and other civil society groups, networks of key populations (KP), people living with HIV (PLHIV), and other affected groups, or other community entities that gather quantitative and qualitative data about HIV services. The focus is on getting input from recipients of HIV services in a routine and systematic manner that will translate into action and change. (PEPFAR)
Community	Communities living with or affected by HIV, TB and malaria, including key and vulnerable populations (Source: Global Fund Strategy 2023-2028) Broadly, communities are formed by people who are connected to each other in distinct and varied ways. Communities are diverse and dynamic. One person may be part of more than one community. Community members may be connected by living in the same area or by shared experiences, health and other challenges, living situations, culture, religion, identity or values ¹ . This widely used term has no single or fixed definition. (Source: Community Systems Strengthening Technical Brief)
Community-based organization	Those organizations that have arisen within a community in response to particular needs or challenges and are locally organized by community members (Source: Community Systems Strengthening Technical Brief)
Community-based response	Responses that are delivered in settings or locations outside of formal health facilities. They can be provided by a range of stakeholders, including community groups and networks, civil society organizations, the government and the private sector (Source: Community Systems Strengthening Technical Brief)
Community engagement	A process of developing relationships, which are characterized by respect, trust and a common, sense of purpose, that enable stakeholders to work together to address health-related issues and promote well-being to achieve positive health impact and outcomes. For the purposes of this evaluation, it was considered in terms of communities' involvement in Global Fund and national decision-making and processes, including the CCM, National Strategic Plan development and review, country dialogues, and community consultation processes related to the Global

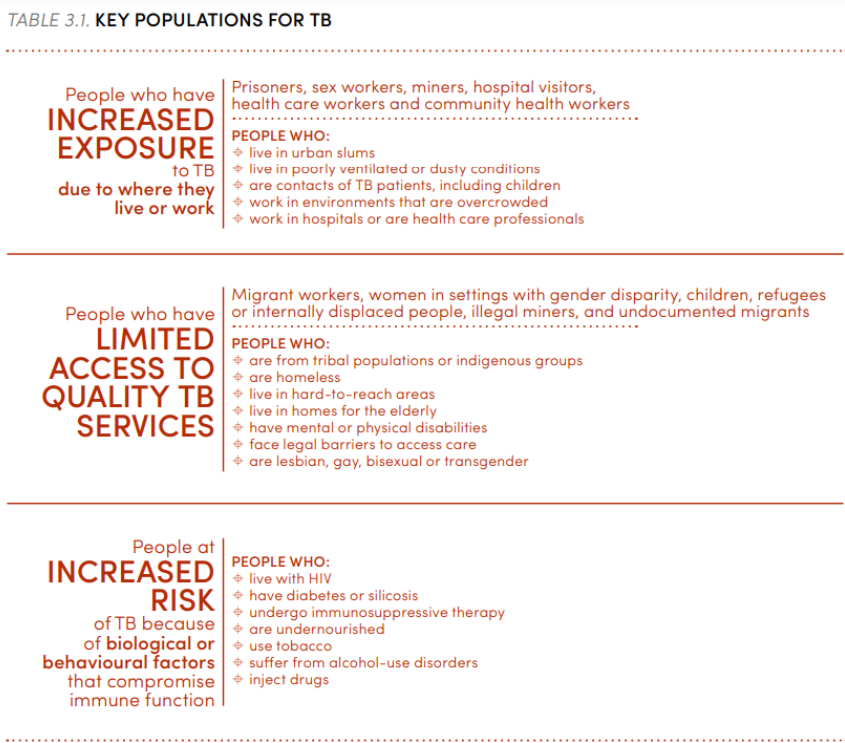
¹ This glossary was compiled with the assistance of the CRG Department.

	Fund business model, from funding request development to grant review and reprogramming.
Community-led organizations, groups and networks	Entities for which the majority of governance, leadership, staff, spokespeople, membership and volunteers, reflect and represent the experiences, perspectives and voices of their constituencies and who have transparent mechanisms of accountability to their constituencies. Community-led organizations, groups and networks are self-determining and autonomous, and not influenced by government, commercial, or donor agendas. Not all community-based organizations are community led. (Source: Community Systems Strengthening Technical Brief) ²
Community-led responses	Actions and strategies that seek to improve the health and human rights of their constituencies, that are specifically informed and implemented by and for communities themselves and the organizations, groups, and networks that represent them. Community-led responses are determined by and respond to the needs and aspirations of their constituents. Community-led responses include advocacy, campaigning and holding decision-makers to account; monitoring of policies, practices, and service delivery; participatory research; education and information sharing; service delivery; capacity building; and funding of community-led organizations, groups, and networks. Community-led responses can take place at global, regional, national, subnational, and grassroots levels, and can be implemented virtually or in person. Not all responses that take place in communities are community led. (Source: Community Systems Strengthening Technical Brief)
Community system	Community-led structures and mechanisms used to interact, coordinate and deliver responses to challenges and needs affecting their communities. (Source: Community Systems Strengthening Technical Brief)
Community systems strengthening	An approach that promotes the development of informed, capable and coordinated communities, and community-based organizations, groups and structures. (Source: Community Systems Strengthening Technical Brief)
Gender equality	Gender equality—or equality between men and women—is a recognized human right, and it reflects the idea that all human beings, both men and women, are free to develop their personal abilities and make choices without any limitations set by stereotypes, rigid gender roles or prejudices. Gender equality means that the different behaviours, aspirations and needs of women and men are considered, valued and favoured equally. It also signifies that there is no discrimination on the grounds of a person's gender in the allocation of resources or benefits, or in access to services. Gender equality may be measured in terms of whether there is equality of opportunity or equality of results. (Source: UNAIDS)
HIV Key Populations (KPs)	Gay, bisexual and other men who have sex with men ³ ; transgender people, especially transgender women; male, female and transgender sex workers; people who use drugs; people living with HIV; people in prison and other closed settings.

² Also note that the definition of community-led responses is under final review for adoption in 2022 by the Global Fund.

³ The use of these terms is not intended to exclude other affirming ways in which people may describe this sexual orientation or behaviour.

HIV Key Populations (KPs)	UNAIDS considers gay men and other men who have sex with men, sex workers and their clients, transgender people, people who inject drugs and prisoners and other incarcerated people as the main key population groups. These populations often suffer from punitive laws or stigmatizing policies, and they are among the most likely to be exposed to HIV. Their engagement is critical to a successful HIV response everywhere—they are key to the epidemic and key to the response. Countries should define the specific populations that are key to their epidemic and response based on the epidemiological and social context. The term key populations at higher risk also may be used more broadly, referring to additional populations that are most at risk of acquiring or transmitting HIV, regardless of the legal and policy environment. (Source: UNAIDS)				
Key Populations	Populations who experience both increased impact from HIV, TB or malaria and/or decreased access to services. While developing a common definition of key populations across the three diseases is not possible, there are several shared characteristics to help clarify who key populations are: <ol style="list-style-type: none"> 1. They experience increased risk or burden of disease due to a combination of biological, socio-economic and structural factors. 2. Access to health services that prevent, diagnose, treat, or care for the three diseases is lower than for the general population. 3. They experience human rights violations, systematic disenfranchisement, social and economic marginalization and/or criminalization. (Source: Community Systems Strengthening Technical Brief) 				
Malaria At Risk and Underserved Populations	Population groups that are at considerably higher risk of contracting malaria and developing severe disease: infants, children under 5 years of age, pregnant women, people living with HIV, as well as people with low immunity moving to areas with intense malaria transmission such as migrants and mobile populations, including refugees and internally displaced persons. (Source: WHO Malaria Factsheet) <div data-bbox="459 1270 1402 1496" data-label="Table"> <table> <tr> <th colspan="2">POPULATIONS MOST IMPACTED</th></tr> <tr> <td> High risk populations* <ul style="list-style-type: none"> ▶ Pregnant women ▶ Infants ▶ Children under 5 years of age ▶ People living with HIV/AIDS ▶ Non-immune groups ▶ Mobile populations ▶ Travelers </td><td> Underserved populations <ul style="list-style-type: none"> ▶ Populations impacted by conflict including refugees and internally displaced persons ▶ Populations living in remote areas facing geographical barriers to services ▶ Women and children from poor settings ▶ Undocumented workers ▶ Indigenous populations ▶ Ethnic minorities </td></tr> </table> </div> <p>Source: Malaria Matchbox Tool</p>	POPULATIONS MOST IMPACTED		High risk populations* <ul style="list-style-type: none"> ▶ Pregnant women ▶ Infants ▶ Children under 5 years of age ▶ People living with HIV/AIDS ▶ Non-immune groups ▶ Mobile populations ▶ Travelers 	Underserved populations <ul style="list-style-type: none"> ▶ Populations impacted by conflict including refugees and internally displaced persons ▶ Populations living in remote areas facing geographical barriers to services ▶ Women and children from poor settings ▶ Undocumented workers ▶ Indigenous populations ▶ Ethnic minorities
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Men who have sex with men (MSM)	Men who have sex with men describes males who have sex with males, regardless of whether or not they also have sex with women or have a personal or social gay or bisexual identity. This includes men who self-identify as heterosexual but who have sex with other men. (Source: The Global Fund)				
People who use drugs	People who use drugs describes people who use nonmedically sanctioned psychoactive drugs, including drugs that are illegal, controlled, or prescription. The term includes drugs that are injected as well as those that are taken in other ways. (For further information, see the INPUD Consensus Statement on Drug Use under Prohibition: Human Rights, Health and the Law [2015]).				

Sex Workers	Sex workers are female, male, and transgender adults and young people (over 18 years of age) who receive money or goods in exchange for sexual services, either regularly or occasionally. Sex work may vary in the degree to which it is “formal” or organized. Sex work is consensual sex between adults, takes many forms, and varies between and within countries and communities. (For further information, see the UNAIDS Guidance Note on HIV and Sex Work [2012].)
TB KP	<p>TABLE 3.1. KEY POPULATIONS FOR TB</p>  <p>53 / Reaching key populations</p> <p>(Source: Stop TB Partnership)</p>
Transgender	Transgender is an umbrella term to describe people whose gender identity and expression does not conform to the norms and expectations traditionally associated with their sex at birth. Transgender people include individuals who have received gender reassignment surgery, individuals who have received gender-related medical interventions other than surgery (e.g., hormone therapy) and individuals who identify as having no gender, multiple genders, or alternative genders. Transgender individuals may use one or more of a wide range of terms to describe themselves. (Source: The Global Fund)
Meaningful community engagement	The evaluation team adopted the working definition of “meaningful community engagement” to be that the role of communities is consistently and continuously acknowledged in decision making and processes, and where communities’ unique expertise, perspectives and lived experiences are sought and valued. (Adapted from Spieldenner et al). This goes beyond the current definition of “Meaningful engagement goes beyond a ‘place at the table’”. It means communities are able to voice their opinions and advocate for their priorities, influencing decisions on how programs are being resourced and delivered.” (Source: Community Systems Strengthening Technical Brief)
Vulnerable populations	See UNAIDS

Executive Summary

Evaluation scope, objectives and definitions

The Global Fund 2017-2022 strategy recognizes that communities play a critical role in ending epidemics, by promoting and protecting human rights and gender equality (strategic objective 3), which is critical to the fight against HIV, tuberculosis and malaria (strategic objective 1), and by requiring investment in building resilient and sustainable systems for health (strategic objective 2), including community systems. The Global Fund recognizes that greater engagement of communities in decision-making processes results in more effective program design – including more community-led responses – that will accelerate progress towards results. The Global Fund values the ability of diverse communities to reach groups that others cannot – particularly key and vulnerable populations (KVPs) of the three diseases – to adapt and innovate in response to crises, to hold others to account through monitoring, and to advocate for changes to the policy and legal environment that create barriers to people's participation in processes, equitable access to quality services, or their right to lead healthy, safe, and dignified lives. The Global Fund has strengthened its internal capacities, adjusted its processes, created tools and guidance, and directed more grant funding and strategic investments towards supporting communities. Significant progress has been made, strengthening the foundation for the new Global Fund 2023-2028 strategy to be even more ambitious in its efforts to place people and communities squarely at the center of the fight against the three diseases.

In preparation for the implementation of the new strategy, the Global Fund commissioned an evaluation of the support provided to, and the results of community engagement (CE), and community-led responses (CLR) in the 2017-2022 funding allocation periods. In this context, CE is considered specifically in terms of communities' engagement in National Strategic Plan development and review, and Global Fund decision-making processes, including the Country Coordinating Mechanism (CCM), country dialogues related to the Global Fund grant cycle, and related community consultation processes, funding request development, grant making, grant design, grant monitoring and evaluation, and grant review and reprogramming. CLR is defined as interventions that are delivered in settings or locations outside of formal health facilities, and that are specifically informed, managed and implemented by and for communities themselves. CLR includes service delivery, community-led monitoring, and advocacy. The assessment of the impact of community engagement and community led responses on health systems in general, and of interventions implemented by community health workers, are beyond the scope of this evaluation. This evaluation grows out of previous reviews/evaluations undertaken by the Technical Evaluation Reference Group (TERG), reviews from the Technical Review Panel (TRP), and the Office of the Inspector General (OIG) inspections,⁴ which concluded that there was scope for improving CE and CLR in order to achieve the goals laid out in the new Global Fund strategy 2023-2028.

The Technical Oversight Committee, consisting of representatives from the Secretariat and the TERG, provided oversight for this evaluation. The objectives of the evaluation were:

⁴ For example: TERG Strategic Review 2020; OIG Advisory Report on Resilient and Sustainable Systems for Health; Prospective Country Evaluation Synthesis Reports 2018, 2021 and 2022); OIG Advisory Review: Removing human rights related barriers 2019; Community, Rights and Gender Evaluation 2020; Thematic Review on HIV Primary Prevention 2021; TERG Thematic Review on Sustainability, Transition and Co-financing 2020; TERG Thematic Review on Strategic Initiatives 2021; TRP Lessons Learned Report 2020, and TRP Report on Investment in the 2017-2019 Funding Cycle.

1. To assess the design, implementation, and results of community engagement and community-led responses that have been supported by the Global Fund since 2017 in line with the 2017–2022 strategy, and draw out lessons learned;
2. To assess the contribution of CE and CLR to the achievement of the Global Fund's results;
3. To draw lessons learned and develop actionable recommendations to guide 2023–2028 investments and implementation strategies, including possible changes to the Global Fund Business Model.

The evaluation used a mixed methods approach, which included extensive document review, interviews with 72 people at the global and regional levels (including ten from communities or civil society), and 158 people at the country level (including 71 from communities or civil society). Ten country case studies were conducted to better understand how support and guidance was playing out on the ground.⁵ The evaluation was strengthened by structured feedback from the Technical Oversight Committee following submission of findings, conclusions and recommendations and based on discussions during a joint recommendations validation workshop. The document review, key informant interviews, case studies, and the validation workshop generated a set of 29 findings to respond to each of the evaluation questions. The findings led to ten conclusions and seven recommendations, presented below.

Key Findings and Conclusions

Strategic and Secretariat level

Strategic and Secretariat-level Conclusions

1. Lack of a shared understanding of community contributions to the Global Fund's mission.
2. Community contributions are under-recognized.
3. The partnership model is under-utilized.
4. Risk and processes trump communities and complexity.
5. Funding cycles do not sufficiently incentivize efforts to achieve sustainability and long-term change.
6. Gender focus is under-developed.

CE and CLR have been prioritized by the Global Fund, as evidenced by the development of new technical guidance, more open flexible processes to broaden the scope of engagement with community actors, new and evolving strategic initiatives and the use of other catalytic investments, and – critically – an increase in grant investment in communities. These initiatives are all necessary and valuable; however, they are not linked by an overarching understanding of how CE and CLR contribute to the Global Fund's strategic framework. This has resulted in siloed approaches and accountabilities, and different operational understandings of key terms across the Secretariat and the partnership. The absence of a key performance indicator, or a way to disaggregate and understand community-led contributions to the Global Fund's strategy, means that community-specific data is not available at the global level. The Global Fund's tracking of community TB case notifications is an excellent example of collecting and disaggregating data in a way that demonstrates the quantifiable contribution of community-led responses to overall Global Fund results. This is not done for all indicators, however, and as

⁵ Case study countries are Côte d'Ivoire, Democratic Republic of Congo, Guinea, Lao PDR, Morocco, Nepal, Paraguay, South Africa, Tajikistan and Togo.

programmatic data is aggregated by the principal recipient, many programmatic results generated by communities are not readily visible at the global level.

Another way in which community-specific data is not available at the global level is the absence of a tracking method for the qualitative work and achievements of communities – particularly in removing human rights and gender-related barriers to health care. Qualitative milestones and results are not readily captured by the Global Fund’s quantitative data systems. This results in a lack of adequate data to optimally inform decisions, and a lack of visibility or clear understanding of community results at the global level. Furthermore, the results achieved from grants are not linked with results from related strategic initiatives (e.g., Breaking Down Barriers [BDB]), to generate an overarching picture of the contribution that communities make to Global Fund strategic objectives. In addition, the monitoring and evaluation framework and funding cycle do not allow for meaningful measurement of community-led response over the long-term, as the system focuses on what can be achieved within a funding cycle.

The Global Fund has responded to many lessons learned and recommendations from previous evaluations to improve its work in CE and CLR. Guidance and investments continue to increase, and have been strongest in HIV. Understanding of rights and gender-related barriers to TB and malaria is increasing across the Global Fund partnership – with technical partners providing normative guidance on this – and the Global Fund invests in TB and malaria community organizations and networks. Guidance has resulted in changes at country level, to ensure that processes are more inclusive of communities, with 15% of CCM funding dedicated to community and civil society engagement. Other recommendations have been harder to address, particularly those related to underlying structural issues or organizational culture. This is critical, because while more support is reaching more community organizations, processes and incentives in the Secretariat are not always aligned to support or value the dynamic ways that communities work. This particularly impacts less mature community organizations, and especially where they produce longer-term and qualitative results, rather than the short-term quantitative results that the Global Fund’s systems were designed to measure.

Another example of the Global Fund’s progress in supporting CE and CLR is the increase investment in both between new funding mechanism (NFM) 2 and NFM3, and the development or continuation of catalytic investments, including the Community Rights and Gender Strategic Initiative (CRG SI), BDB, and the Community-Led Monitoring SIs, and the use of matching funds to support some of these initiatives. The COVID-19 pandemic has also renewed interest by governments and global partners in working with communities, as the pandemic afforded an opportunity for communities to demonstrate their ability to provide critical services, and reach communities and KVPs, where others could not.

Still, aspects of the Global Fund’s systems and business model have had the unintended consequence of creating barriers to some community organizations becoming funding recipients, and implementation has fallen short of expectations. The Global Fund does not yet have a taxonomy to classify different maturity levels of community organizations, and the capacity assessment is currently applied equally to all. While community sector Principal Recipients are among the best rated by the Global Fund,⁶ community principal recipients tend to be larger, well-established organizations, and less mature organizations tend not to meet the institutional requirements to manage and report on Global Fund investments. Positive examples were found of Principal Recipients engaging community sub (and sub-sub)

⁶ Noting that this category also includes international non-governmental organizations, and international faith-based organizations, who tend to be better rated than local civil society organizations. Although the latter are generally better rated than governments. This is further discussed in Finding 1.

recipients, while supporting the capacity development of more nascent organizations, and these can inform best practices going forward. Other forms of contracting – such as service contracts by Principal Recipients, and social contracting by governments remain small-scale and under-utilized, and no examples were found of small-grants programs, but such models offer potential for further development.

Country level

Country-level Conclusions

- 7.** Grant architecture is not conducive to consistently elevating diverse community voices.
- 8.** Enabling environment is key to success.
- 9.** Lack of systems-thinking in approaches to grant design.
- 10.** Country ownership is perceived as government ownership

While there is an abundance of guidance, many communities still report that they do not understand how the Global Fund works, or how they can access CCMs or Global Fund support, either due to the complexity of the guidance, the language used which may not be adapted to their context, or because they do not receive sufficient support to absorb the guidance. Guidance actively promotes community engagement in CCMs and consultations prior to funding request development, although the meaningfulness of this engagement is contingent on the enabling environment and the ways in which the guidance is interpreted at country level. This affects the extent to which key populations who face criminalization and stigmatization – particularly gay, bisexual and other men who have sex with men, transgender people, sex workers, people who inject drugs, people living with HIV, and people in prison and detention – are able to be included and participate actively in CCMs. Other vulnerable groups – including migrants, mobile and displaced people – also face barriers to engagement that can stem from lack of a representative, compounded by a weak governance environment. Even when these groups are represented on the CCM, power dynamics can result in their engagement being more tokenistic than meaningful, although some positive exceptions to this finding were also found that can be drawn from.

For all communities, however, there is less guidance, and subsequently less engagement in the grant cycle, following the consultation stage. Some communities participate in the funding request writing process, but nearly all lose visibility into the process during finalization. Indeed, while civil society may be represented on the CCM, communities in only one case study country saw the final version of funding request prior to submission, and communities in only two case study countries were aware of the final grant design after the negotiation phase. Among the case study countries, no community received adequate feedback (delivered in a manner they understood) on why some community priorities were not included. The requirement in the COVID-19 Response Mechanism second round of funding to submit community priorities with funding requests resulted in communities feeling more heard by the Global Fund.

Strong examples were found of community-led responses contributing effectively to the national response, and some national stakeholders reported that it would not be possible to implement country programs without community engagement. This was particularly evident in HIV, which has a longer track record, and is supported by more lessons learned and investment than TB and malaria. With growing recognition of the importance of CLR to reach global targets in technical guidance and global strategies, efforts were also visible of scaling up community-led responses in TB and malaria⁷, although these are relatively nascent with the community structures less mature than in HIV, from which many lessons have been

⁷ For example: the Global Technical Strategy and Targets for Malaria 2016-2030, WHO's End TB Strategy, the Stop TB Partnership's Global Plan to End TB, and the Global AIDS Strategy 2021-26.

adapted. Overall, CLR implementation and results are variable across contexts and highly dependent on the enabling environment and specific support and involvement by the country teams and partners, including long-term investments in capacity strengthening. The latter is critical, and needs can include support to meet Global Fund reporting and financial management requirements, as well as communication, advocacy or technical skills – including in emerging areas such as community-led monitoring. Capacity and turnover in community organizations are key challenges requiring understanding and support, and efforts to strengthen capacity over the long-term are delivering positive and replicable results.

Other success factors were a combination of the vibrancy and persistence of communities, implementer processes and capacities, technical and bilateral partner involvement, and Global Fund support. Much depends on how support is provided by the Global Fund, and how guidance is interpreted and acted upon in the country. The evaluation also observed that the Global Fund system can create distortions to community engagement by its reliance on principal recipients and CCMs, which can create “in groups” of the communities who sit on the CCM, and “out groups”, who are outside the circle of those who have access to the Global Fund. This is less likely to be the case, however, where communities receive support to organize consultations prior to CCM meetings, and have a mechanism to debrief afterwards.

Community-led responses tend to be more effective when their contribution is understood and valued by the government, particularly when community services and government services are linked (for example from a community referral service to a government treatment center), which also appears to be a key aspect of sustainability. Progress has been made in institutionalizing community engagement in the development of National Strategic Plans in many countries, however beyond this, no examples were found of financial sustainability, nor permanent consultation mechanisms that bring communities and governments together on health issues outside Global Fund-supported bodies. Positive and replicable examples of institutional and financial sustainability exist for community-led response in service delivery, however not in monitoring or advocacy – with the latter unlikely to secure long-term domestic financing. While some community responses have become embedded in national health systems, overall, sustainability is not consistently or adequately planned for, or supported in terms of time and resources.

Limitations

Due to the lack of data collected by the Global Fund or community-specific disaggregation, it was not possible to determine the extent to which the objectives of CLR were achieved globally, nor their specific contribution to national results. It should also be noted that delays in case country selection combined with the short time-frame meant that case study data was not available finalized as analysis was underway.

Recommendations

Quick wins (For roll out in NFM4)

- 1. Ensure community supported activities are linked to the Global Fund’s overarching theory of change for the 2023-2028 strategy to guide the institutionalization of a community-centered, human rights promoting, and gender-transformative culture:** The Secretariat should ensure that the overarching theory of change under development for the new strategy clearly articulates how CE and CLR activities under both grants and catalytic funding, contribute to the Global Fund Strategic Objectives. This can guide a cultural shift within the GF secretariat whereby all departments and Country Teams (CTs) have a clear understanding of the important role that communities play in supporting the

strategic objectives, and also clarify expectations, roles and responsibilities, and accountabilities within the Secretariat and the partnership. This may require expanding the CT to include a CRG expert, with incentives, authority, support and recognition aligned to demonstrating progress on community engagement, and progress on human rights, gender, and equitable access to services. This process can be linked with the strategy delivery working groups' efforts underway to operationalize the new strategy. This work should be extended to further articulate the roles and responsibilities across the partnership and ensure they are reflected in guidelines accordingly. The process could be launched in NFM4 for full rollout by NFM5.

- 2. Holistic measurement framework: “What gets measured gets done”:** The Secretariat, in consultation with key partners, should continue to develop a KPI that captures community contribution to Global Fund results for the new strategy 2023-2028, and also ensure that qualitative measures are in place to track progress towards long-term changes in capacities, enabling environments, sustainability and systems. This is necessary to ensure that community-led responses are prioritized in funding requests and that relevant data is collected for monitoring, evaluation, learning and decision-making. This would require: (a) quantitative programmatic grant data to be collected and/or disaggregated by community contribution for all relevant results;⁸ (b) PRs to report financial grant data for analysis by the Secretariat by SR-type; (c) the Secretariat to provide guidance and community engagement minimum standards across the grant cycle for CCMs and PRs to adapt as necessary to the context; and (d) considering the inclusion of community-led monitoring to be included in all grants. Lessons learned and results from the CRG and BDB SIs can provide a baseline to support the development of KPIs, with some key activities from these SIs integrated across more grants. Available data and lessons learned can be analyzed by a task force (for example, including the CRG Department, the Grants Management Department, CCM Hub, M&E team, and Policy Hub), linked to ongoing efforts to develop KPI and updated measurement frameworks for the new strategy.
- 3. Build minimum community engagement standards into consolidated guidance for each stage of the grant cycle to ensure the meaningful engagement and leadership of most affected communities, with an emphasis on rights, gender and equity considerations.** Funding and operational guidance could be consolidated and simplified with minimum standards provided for community engagement across the grant life cycle. Community engagement standards could be included in funding request guidance and allocation letters, with a budget provided to facilitate the required engagement. In addition to current requirements, minimum standards should consider: a remunerated communities' representative on the proposal writing team, inclusion of communities' views and questions on each CCM agenda item, a minimum review period for communities before funding request submission, sharing final grant documents with communities, ensuring that there are guidelines for safeguarding the safety and dignity of communities participating in Global Fund processes such as CCM meetings as well as other public meetings. New processes should also require funding requests to annex communities' priorities with justification for what was or was not included in the final budget, for TRP review. Beyond the grant making phase, community engagement in monitoring and evaluation should be specified, with a clearer mechanism for communities to provide feedback on programs, including through community-led monitoring. CCMs and PRs should be strongly encouraged to bring in new partners from community organizations to reach wider groups, and especially populations who are criminalized, stigmatized or otherwise marginalized, including migrant and displaced populations. This

⁸ See for example, “The Case for a Key Performance Indicator on Community Systems Strengthening in the New Global Fund Strategy 2023-2028”.

recommendation may inform the strategy delivery working group's current efforts to review processes and guidance in preparation for the NFM4.

4. **Revise guidance to support earlier and deeper focus on systemic change: Funding guidance should build on lessons learned to emphasize the long-term approach needed to strengthen and sustain community systems and address human- and gender-based barriers to health services.** The Secretariat should emphasize the importance of CE and CLR in the funding guidelines and highlighting an appropriate level of investment which could be considered – adapted to the context – to address inequities, the importance of complementary roles between the public and community sectors, and the inclusion of appropriate community-led, gender responsive and transformative service delivery, monitoring, and advocacy. This should include encouragement to build in steps towards long-term sustainability planning in funding requests, with clear milestones to be tracked and built upon in subsequent funding allocations. This approach could be piloted in a number of critical countries in NFM4, results of which could then inform a full roll out in NFM5.

Medium term (For roll out in NFM5)

5. **Evolve the Global Fund's business model and grant architecture to open up more funding and influencing opportunities for less mature community-led and community-based organizations:** The GF Secretariat should consider a differentiated approach in contracting community organizations beyond PRs and SRs to bring in new voices and reach more “last mile” communities. This may involve either (a) relaxing requirements for sub-recipients (SRs) and incentivizing PRs to take on more SRs, with support for supervision and capacity strengthening building on best practices, (b) creating new funding mechanisms that are better adapted to less mature organizations, such as small grants funds, with a focus on program delivery and capacity strengthening support. A technical note could be developed to provide guidance on different models and best practices drawn from both the Global Fund and its technical and bilateral partners. This may also be accompanied by a dedicated platform for communities to meet, and be represented on the CCM.

Long term (Achieve in 2023 – 2028)

6. **Greater leverage of political influence to address structural barriers within the GF and enhance full country ownership:** The Global Fund at all levels should re-affirm the centrality of the voice of communities to achieving the new strategy and promote country ownership as shared government, private sector and community ownership, in order to address structural barriers to community engagement. This should be reinforced by the Grant Management Department and other GF high level missions to countries, by holding regular dedicated meetings with communities, and using specific guidance and political influence to ensure that communities, the government and the private sector develop an understanding of their complementary contributions towards shared health goals. In this way, all country stakeholders leverage their comparative advantages while underscoring the criticality of removing rights- and gender-based barriers to support their work. This will require continuous evidence-based messaging from the GF Secretariat and technical partners throughout the implementation of the 2023-2028 strategy regarding the importance of decriminalizing and destigmatizing KVPs, and moving towards gender equality. The GF also needs to reinforce the message that country ownership requires all stakeholders including communities ⁹.

⁹ See Partnership Enablers in the 2023-2028 strategy.

7. **Continuously engage and focus the Partnership to support a stronger role of communities throughout implementation of the new strategy, with clear and accountability for responsibilities at the global and country levels:** **The Global Fund Board should lead efforts, and delegate to the appropriate body, to convene strategic partners in order to clarify accountabilities for strengthening and supporting the enabling environment for community engagement and community-led responses at the global and country level.** The Global Fund can call out present best practices, key findings and recommendations from this evaluation as well as other relevant evaluations (OIG advisory on RSSH, OIG Advisory on Human rights related barriers, TERG Thematic review on STC, TERG Thematic evaluation on HIV prevention CSS evaluation as well as PCE) to inspire and motivate cross-partner sharing and co-designing a way forward. This process may begin in 2023 – 2025 by convening a meeting to develop a roadmap defining roles and responsibilities, including partners such as WHO, UNAIDS, Stop TB, RBM, bilateral donors, and regional organizations, and build on the Partnership enablers Section of the Strategy 2023-2028. This should include further consideration of whether additional partners should also be brought in. This is a long-term effort that should start soon to yield results during the 2023-2028 strategy period.

Abbreviations and acronyms

AGYW	adolescent girls and young women
AGYW	adolescent girls and young women strategic initiative
BDB	Breaking Down Barriers strategic initiative
C19RM	COVID-19 response mechanism
CBO	community-based organization
CCM	Country Coordinating Mechanism
CE	community engagement
CHW	community health worker
CLA	community-led advocacy (including community-led research and advocacy)
CLM	community-led monitoring (previously called community-based monitoring)
CLO	community-led organization
CLR	community-led response
CO	community organization
COI	conflict of interest
CRG	community, rights, and gender
CRGD	Community, Rights and Gender Department
CRG SI	Community, Rights and Gender Strategic Initiative
CSS	community systems strengthening
CS&R	community systems and response
CSO	civil society organization
CT	country team
CTE	Core Team of Experts
DAC	Development Assistance Committee
DSD	Differentiated Service Delivery
DTF	dual-track financing
DTL	deputy team lead
EECA	Eastern Europe and Central Asia (Global Fund region)
FGD	focus group discussion
FPM	Fund Portfolio Manager
GAC	Grant Approval Committee
GF	the Global Fund to Fight AIDS, Tuberculosis and Malaria
GMD	Grant Management Department
HF	Health Financing
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HMIS	health management information system
iCCM	integrated community case management
MCG	multi-country grant
MF	matching funds
HMST	Health Management Support Team
HTM	HIV, tuberculosis and malaria
IFBO	international faith-based organization
INGO	international non-governmental organization
IR	inception report
KII	key informant interview
KP	key population
KPLO	key population-led organization
KPI	key performance indicator
KVP	key and vulnerable populations
LAC	Latin America and the Caribbean (Global Fund region)
LLIN	long-lasting insecticide nets
M&E	monitoring & evaluation

MECA	Monitoring and Evaluation and Country Analysis
MENA	Middle East and North Africa (Global Fund region)
NFM	new funding mechanism
NGO	non-governmental organization
NSP	national strategic plan
OIG	Office of the Inspector General
OST	opioid substitution therapy
PCE	prospective country evaluation
PEPFAR	The United States President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
PR	principal recipient
PUDR	progress update and disbursement report
PWID	people who inject drugs
RSSH	Resilient and Sustainable Systems for Health
SC	Strategy Committee
SDG	Sustainable Development Goal
SI	Strategic Initiative
SO	strategic objectives
SR	sub-recipient
SSR	sub-sub-recipient
STC	sustainability, transition, co-Financing
TA	technical assistance
TB	tuberculosis
TERG	Technical Evaluation Reference Group
TL	team leader
TOC	theory of change
TRP	Technical Review Panel
UHC	universal health coverage
UNAIDS	The Joint United Nations Program on HIV/AIDS
USAID	United States Agency for International Development
WHO	World Health Organization

1. Background and Introduction

Communities living with and impacted by the three diseases have been at the heart of the Global Fund's spirit and strategy since its inception. Indeed, it was the grassroots efforts of thousands of communities and civil society groups around the world advocating for increased resources to respond to HIV that inspired the creation of the Global Fund (GF) in 2002. Ever since, communities and civil society have played a role at every level of the GF operations, from governance and strategy development to implementation. At the global level, communities and civil society actively participate on the GF board, and lead advocacy efforts to replenish the GF. At the country level, representatives of communities and civil society participate as members on the Country Coordinating Mechanism (CCM), in country dialogues, as well as implementers. This evaluation adopts the definition of communities provided in the new 2023-2028 Global Fund strategy, of "communities living with or affected by HIV, tuberculosis (TB) and malaria, including key and vulnerable populations" (see glossary). Communities can consist of individuals, community-led or community-based organizations or networks.

The GF is a learning organization and continually evolves its model based on experience and lessons learned. Recent reviews undertaken by the Technical Evaluation Reference Group (TERG), Technical Review Panel (TRP), and Office of the Inspector General (OIG), confirm the pioneering role the GF has played in promoting gender, human rights responsive, and community-led and community-based systems and responses, with a focus on key and vulnerable populations. The 2017-2022 Strategy included a strategic objective to promote and protect human rights and gender equality, which created the framework for increased investment in these areas. In the 2017-2019 allocation period, the GF supported comprehensive programming to reduce human rights-related barriers to HIV and tuberculosis (TB); scaled-up access to prevention services for adolescent girls and young women; expanded global coverage of prevention and treatment services for key and vulnerable populations (KVPs) across the three diseases; and demonstrated its leadership as the largest global funder of harm reduction. These efforts have been supported by strategically targeted investments such as strategic initiatives (SI), matching funds, and multi-country grants; as well as new technical briefs and tools. In particular, the introduction and evolution of the CRG SI, Breaking Down Barriers, Adolescent Girls and Young Women, and Community-Led Monitoring (CLM) SIs – all led by the CRG Department – were all important additions to the GF's toolkit. Considerations for community engagement were also built into the CCM Evolution and Sustainability Transition and Co-Financing SIs. All these efforts have contributed to stronger engagement of communities in GF processes, and growing community leadership in national responses. The Secretariat presents an annual report capturing these achievements.

Despite these gains, however, significant challenges – as well as opportunities for further improvement – remain. For example, although the quality and quantity of human rights and gender analyses included in HIV proposals has improved significantly over the past five years, and the diversity and coverage of GF-supported services for HIV key populations (KPs) (transgender people, sex workers, prisoners, people who use drugs, gay, bisexual and other men who have sex with men, and people living with HIV) has increased in many contexts, investment and programming in these areas remains limited in both scope and scale across the portfolio – including in countries with high disease burden and large allocations. Local non-governmental organizations manage only 9% of total grant investments, although this is not representative of all investments in CLR including community organizations as sub-recipients, which cannot be calculated accurately with the current financial system. While investment in community systems strengthening (CSS) increased by 150% (from USD 35 million to USD 86 million), it represents only 1% of the GF's investment in NFM2 and NFM3. Investment in community-led response (CLR) by 66% between NFM2 and NFM3 (from USD 497 million to

USD 827 million), although at least one quarter of this falls outside the definition of CLR used by this evaluation.¹⁰

Interventions to address gender and human rights issues for TB¹¹ and malaria¹² have increased, but are still nascent, in that there is scope for best practices and lessons learned to be refined into guidance, and the capacity of emerging networks to be strengthened in order for community engagement to have greater influence on program design, and to generate further evidence for more investment in targeted community-led interventions. And, among some stakeholders, there continues to be a lack of clarity regarding the vital role that communities play in designing, delivering and evaluating impactful programming to achieve disease-specific results, and ensure that systems for health are comprehensive, equitable, resilient and sustainable. Across the three diseases, more attention is also needed for other populations that are being left behind, including ethnic minorities, and remote or mobile populations. More investment is also needed to address the persistent drivers of vulnerability, including stigma, discrimination, and violence – without also neglecting those who face socio-economic barriers to health care. Political and cultural barriers to progress for some groups in many countries persist.

Against this backdrop, this evaluation aims to draw lessons from the 2017-2019 and 2020-2022 allocation periods to inform ongoing efforts to operationalize the new strategy. This includes consideration of what was observed during the COVID-19 pandemic – both from the Global Fund and the community's point of view. The 2023-2028 strategy is the Global Fund's most ambitious undertaking from a community perspective, with its commitment to be community- and people-centered, and ensure that the Global Fund 'leaves no one behind', in addition to its commitment to a new evolving objective on pandemic preparedness and response. This evaluation therefore looks backwards to see what can be learned from the extensive efforts to date – as summarized in Table 1 – to adequately prepare for the new challenges ahead. The findings of this evaluation suggest that while the current model has succeeded in bringing the Global Fund its significant successes to date, reaching the next level and last mile, will require new and innovative approaches.

Table 1: Evolution of the Global Fund's support for CE and CLR¹³

Year	Initiative
2002	Global Fund created, and required as members on Country Coordinating Mechanisms
2004	Board approved adding a constituency represented by a representative of an NGO who is a person living with HIV/AIDS or from a community living with tuberculosis or malaria (the "Communities delegation") as a full voting member of the Board ¹⁴

¹⁰ For example, these figures include integrated community case management and community health workers, which are not considered "community-led" for this evaluation. However, these amounts could not be cleanly extracted from the data available. The Global Fund (2021), "Strengthening Community Systems and Responses: Debrief meeting with Peter", presentation, March 2021.

¹¹ TB key populations are Prisoners and incarcerated populations, people living with HIV, migrants, refugees and indigenous populations are all groups that are highly vulnerable to TB, as well as experiencing significant marginalization, decreased access to quality services, and human rights violations (Source: <https://www.theglobalfund.org/en/key-populations/>)

¹² Refugees, migrants, internally displaced people and indigenous populations in malaria-endemic areas (*ibid*)

¹³ Compiled from various sources, including a timeline presented in the Global Fund (2019), "Advisory Review Removing human rights-related barriers: Operationalizing the human rights aspects of Global Fund Strategic Objective 3", GF-OIG-19-023, November 2019 Geneva, Switzerland.

¹⁴ <https://www.theglobalfund.org/kb/board-decisions/b08/b08-dp04/>

2007	The “Accelerating the effort to save lives” strategy began, which included dual-track financing, community systems strengthening, strengthening the role of civil society and the private sector, and key and vulnerable populations as strategic initiatives.
2008	Board approves the “The Global Fund's Strategy for Ensuring Gender Equality in the Response to HIV/AIDS, Tuberculosis and Malaria (”The Gender Equality Strategy”).
2009	Board approves the “Global Fund Strategy in Relation to Sexual Orientation and Gender Identities”
2011	Community systems strengthening framework developed
2012	The 2012-2016 “Investing for impact” strategy included a strategic objective on human rights for first time, with provisions included for funding civil society.
2012	Most at risk population channel created (later closed as funding model evolved from rounds to allocations)
2013	The Community Gender and Rights Department created
2014	Community, Rights and Gender (CRG) Special Initiative
2014	Launch of Gender Equality Action Plan 2014-2016
2014	Launch of Key Populations Action Plan 2014-2017
2015	Establishment of OIG human rights complaints mechanism
2016	CCMs required to include a key population representative for each of the three diseases
2016	The Sustainability, Transition and co-Financing policy requires middle income countries to focus all or part of their funding requests on key and vulnerable populations; and upper-middle income countries to focus 100% on maintaining or scaling-up interventions for key and vulnerable populations. ¹⁵
2016	Technical guidance on human rights in TB and malaria, and improved for HIV
2017	2017-2022 strategy recognizes engagement of key and vulnerable communities , human rights and gender as critical, and RSSH included with a CSS component
2017	CRG Strategic Initiative (previously called CRG Special Initiative)
2018	CCM Evolution Strategic Initiative pilots in 18 countries
2018	Breaking Down Barriers Strategic Initiative pilots in 20 countries
2019	RSSH and Community Systems Strengthening Technical Briefs issued
2019	CRG Strategic Initiative launched
2019	15% of CCM funding allocated to support community participation
2020	Adolescent Girls and Young Women Strategic Initiative pilots in 13 countries
2020	Community-led Monitoring Strategic Initiative pilots in 5 countries, 1 region
2022	In the “Fighting Pandemics and Building a Healthier and More Equitable World” 2023-2028 strategy, a specific strategic objective on community engagement and leadership is included, with a strong focus on equity, human rights and gender equality.

¹⁵ The Global Fund (2016), The Global Fund Sustainability, Transition and Co-financing Policy GF/B35/04 – Revision 1

2. Overview of the evaluation

2.1 Aim and purpose of the evaluation

The overall aim of the evaluation is to understand how community engagement (CE) and community-led responses (CLR) have been supported, and how they have contributed to the Global Fund's strategic objectives and overall mission. The evaluation aims to identify actionable steps to ensure that the key levers at the Global Fund's disposal¹⁶ are best deployed to support CE and CLR in operationalizing the 2023-2028 strategy.

2.2 Objectives of the evaluation

The CE and CLR evaluation has the following objectives:

1. To assess the design, implementation, and results of community engagement and community-led responses that have been supported by the Global Fund since 2017 in line with the 2017–2022 strategy, and draw out lessons learned;
2. To assess the contribution of CE and CLR to the achievement of the Global Fund's results;
3. To draw lessons learned and develop actionable recommendations to guide 2023–2028 investments and implementation strategies, including possible changes to the Global Fund Business Model.

2.3 Scope of the evaluation

The evaluation used the definitions provided in the Global Fund's Community Systems Strengthening Technical brief (2019) as its working definitions of CE and CLR, whereby:

- **Community engagement** is a process of developing relationships, which are characterized by respect, trust and a common, sense of purpose, that enable stakeholders to work together to address health-related issues and promote well-being to achieve positive health impact and outcomes.
- **Community-led responses** are actions, that are delivered in settings or locations outside of formal health facilities, and that are specifically informed, managed and implemented by and for communities themselves.

Specifically, "community engagement" was considered in terms of communities' involvement in Global Fund and national decision-making and processes, including the CCM, National Strategic Plan development and review, country dialogues, and community consultation processes related to the Global Fund business model, from funding request development to grant review and reprogramming. The evaluation team adopted the working definition of "meaningful community engagement" to be that the role of communities is consistently and continuously acknowledged in decision making and processes, and where communities' unique expertise, perspectives and lived experiences are sought and valued.¹⁷

¹⁶ According to the new strategy, these levers are "ongoing country dialogue, grant agreements and financial management improvements, regular progress updates and reviews, reporting, M&E activities, annual funding decisions and reprogramming of savings and any additional funds to strengthen program effectiveness, shepherded by Secretariat Country Teams" (p. 44).

¹⁷ This definition was adapted by the team from Spieldenner, Andrew; French, Martin; Ray, Venita; Minalga, Brian; Sardina, Cristine; Suttle, Robert; Castro-Bojorquez, Marco; Lewis, Octavia; and Sprague, Laurel (2022) "The Meaningful Involvement of People with HIV/AIDS (MIPA): The Participatory Praxis Approach to Community Engagement on HIV Surveillance," Journal of Community Engagement and Scholarship: Vol. 14: Iss. 2, Article 1. Available at: <https://digitalcommons.northgeorgia.edu/jces/vol14/iss2/1> This builds on the definition found in the

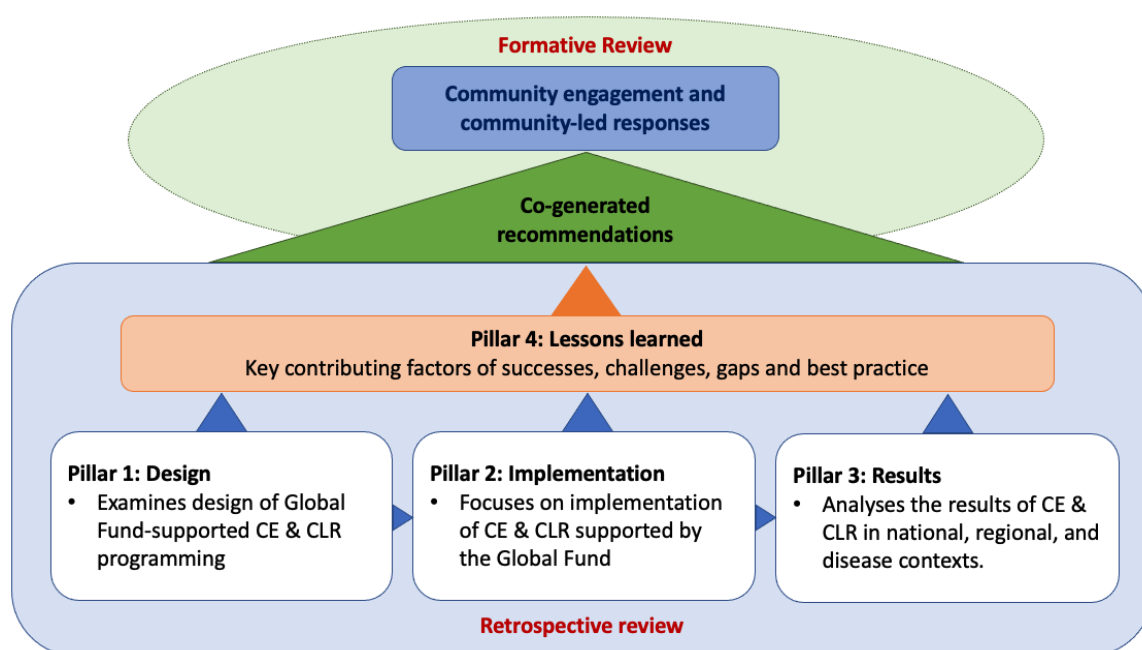
Consideration of CLR included community-led and community-based responses outside of the formal health system, with some consideration of those responses that are “partially captured” under health systems. CLR was taken to include community-led service delivery, monitoring, and advocacy. The evaluation adopted a broad definition of community organizations (COs), which is used to encompass community-led and based organizations (CLOs and CBOs), civil society organizations (CSOs) or networks representing one or more communities, and other non-state community structures or actors, with a particular focus on community-led organizations. “Community-led” does therefore not include international non-government organizations (INGOs), faith-based organizations (FBOs), nor the private sector, as they were considered less representative of the communities affected by the diseases and their interests. The evaluation adopted the definition of “communities” in the 2023-2028 Strategy: “Communities living with or affected by HIV, TB and malaria, including key and vulnerable populations” (KVPs). The definition of KVPs is further explored under findings below.

The evaluation team found that CE and CLR connect to many initiatives and departments of the GF, and that the scope of the evaluation became very broad due to its intersections with other areas of work: human rights and gender, sustainability, systems strengthening etc. The team was guided by the evaluation questions, and focused on the grants and strategic investments considered most directly relevant. The evaluation considered CE and CLR in the context of all three diseases, as well as CSS – the relevant module of resilient and sustainable systems for health (RSSH). In addition to country and multi-country grants, in addition to a number of Strategic Initiatives (SIs): Community Rights and Gender (CRG), Country Coordinating Mechanism (CCM) Evolution, Breaking Down Barriers (BDB), Sustainability, Transition and Co-Financing (STC), Adolescent Girls and Young Women (AGYW), and Community-Led Monitoring (CLM). The evaluation team coordinated key findings with two other ongoing TERG evaluations – TB Prevention and COVID-19 Response Mechanism (C19RM) – to seek complementarity and avoid duplication.

The evaluation approach is grounded in four inter-connected pillars to systematically examine Global Fund-supported programming in CE and CLR, as illustrated in Figure 1 below. The first pillar examines the **design** of the GF’s support for CE and CLR, and the second pillar focuses on the **implementation** of this support. The third pillar considers the **results** of these efforts at the country and global levels, and the fourth and final pillar draws **lessons learned** from the analysis. These findings were shared with the TERG focal points and representatives of the different Secretariat departments to co-create specific recommendations to support the strategic design and implementation of CE and CLR in the context of the Global Fund's 2023-2028 Strategy.

Community Systems Strengthening Brief, whereby ““Meaningful engagement” goes beyond a ‘place at the table’. It means communities are able to voice their opinions and advocate for their priorities, influencing decisions on how programs are being resourced and delivered.”

Figure 1: Evaluation scope



3. Methodology

3.1 Desk Review

The Evaluation Team Leader (TL) and Deputy Team Leader (DTL) reviewed over 100 documents, including previous TERG, OIG and TRP reviews, evaluations, advisories and lessons learned, reports produced by the CRG Department, background and guidance documents on Global Fund Strategic Initiatives and processes, board meeting notes and related reports, and internal presentations. External reports, evaluations and case studies were also reviewed. In some cases, additional data was requested and received, including specific technical assistance and lessons learned trackers, financial data, grant ratings, and iLearn analytics. Documents were reviewed against thematic pillars for triangulation. A complete list of the documents reviewed is presented in Annex 1.

3.2 Global Interviews

The TL and DTL conducted 50 interviews at the global level, with a total of 72 people. These included 48 people within the Global Fund, 11 civil society partners (including representatives of KVP groups, and CRG regional platforms), and 13 technical partners. All but two interviews were held remotely. A complete list of the people interviewed at the global and regional levels is presented in Annex 2.

3.3 Country Case Studies

Ten countries¹⁸ were selected for deeper analysis through a case study, including a diverse mix of regions, focus, funding models, and transition status, allowing different aspects to come

¹⁸ The selected countries were Côte d'Ivoire, Guinea, Lao PDR, Morocco, Nepal, Paraguay, South Africa, Tajikistan and Togo.

to light and be compared. Five country leads covered two countries each, which included a desk review, interviews, and analysis. In total, 158 people were interviewed at the country level, including 71 from communities or civil society, in addition to Principal and Sub-Recipients, CCM members, and government officials. The country case studies are presented in Annex 7.

3.4 Analysis and Triangulation

Due to delays in finalizing country selection and scheduling interviews for the case studies, the global-level analysis advanced before the case studies started. A team analysis workshop held in early April therefore drew primarily on the global desk review and interviews to identify emerging findings, with some input from country-level desk reviews. While drafts of the case studies were received and updates from the country leads were available, the next level of analysis that began to draw out conclusions and recommendations also took place before country case studies were finalized. Data were compiled into thematic tables for review, with findings discussed primarily between the TL and DTL, with input and guidance from the Strategic Advisor and co-writer. Initial findings were shared with the TERG and the Technical Oversight Committee periodically, including a recommendations workshop held prior to the finalization of the report draft, to ground-truth analysis and the draft recommendations.

3.5 Quality Assurance

Quality management and assurance was conducted by the TL, DTL and co-writer by developing quality expectations and a work plan, drawing on best practices from previous evaluations of the entire team. The TL and DTL met regularly, with the TL providing regular updates to the HMST CEO, who oversaw the process and engaged as necessary to ensure adherence to the methodology and timeframe, and the soundness of deliverables. Meetings with the country leads took place to ensure that case studies were progressing consistently, with feedback provided as necessary. The TL and DTL also maintained close communication and coordination with the TERG Secretariat and Technical Oversight Committee throughout the mission.

3.6 Limitations

The evaluation experienced three key limitations and challenges. Firstly, the **scope** of the evaluation is broad and complex, as it includes two distinct concepts, which are covered by several funding mechanisms including country and multi-country grants, matching funds, and a number of SIs, and can be difficult to untangle from related work on human rights, gender, and community systems strengthening. This was challenging in terms of the enormous volume of documentation available, and the potential for wide ranging interviews given the multiple, interconnected issues, as well as each interviewee's own understanding of the topic. The evaluation was therefore challenged to start broadly with the scope, then zoom in on what emerged as the most pertinent issues, without losing the nuance of diversity and intersectionality – such as across diseases or contexts.

Secondly, the **delays** in finalizing country selection for the case studies, and in accessing key stakeholders for interviews amidst many competing priorities (including other ongoing evaluations, as well as a holiday period for most countries) tightened the timeframe. In particular, it required that analysis be rushed, and much of the thinking progressed without completed country case studies on hand. The fact that case study interviews and writing were being completed as the analysis was underway, also limited the country case study leads from fully participating in the analysis process. It should also be noted that while the evaluation

team originally established a set of seven criteria for country selection, following negotiations with country teams, only four of the ten countries met at least four criteria.¹⁹ This may have reduced the opportunity to explore the impact or interaction of SIs, and did not optimize the team's experience and recently collected data.

The third limitation also relates to an evaluation finding, which was the availability of **data**. Some analysis was either not possible, or not reliable, as some financial and programmatic data was either not available, or disaggregated in a way that could be analyzed to draw out community-specific aspects. Some misunderstanding regarding the process to request the Progress Updates and Disbursement Reports (PUDRs), resulted in only some country leads receiving these documents, and usually only for 2020. This limited the evaluation's ability to understand specific aspects of grant progress in some case study countries.

4. Findings

This section presents findings against each evaluation question (EQ)²⁰, organized by pillar. Findings have been assessed for the strength of supportive evidence using the rating system presented in Table 2. Each finding, presented in Table 3, is numbered, with a reference to the pillar and evaluation question number.²¹ Following the summary table of findings, an overview of the evidence and reflection leading to each finding is presented, with additional information included in the annex where necessary. These annexes include an overview of the community engagement journey (Annex 4), further analysis of the financial information received to identify CLR (Annex 5), and a summary of the CRG SI technical assistance trackers (Annex 6).

Table 2: Ratings for robustness of key findings

Rating	Assessment of the findings by strength of evidence (SoE)
Strong (1)	<ul style="list-style-type: none"> Supported by data and/or documentation categorized as being of good quality by the evaluators; and Supported by majority of consultations, with relevant consultee base for specific issues at hand
Moderate (2)	<ul style="list-style-type: none"> Supported by majority of the data and /or documentation with a mix of good and poor quality; and/or Supported by majority of the consultation responses
Limited (3)	<ul style="list-style-type: none"> Supported by some data and/or documentation which is categorized as being of poor quality; or Supported by some consultations and a few sources being used for comparison (i.e., documentation)
Poor (4)	<ul style="list-style-type: none"> Supported by various data and/or documents of poor quality; or Supported by some/few reports only with no data/or documents for comparison; or Supported only by a few consultations or contradictory consultations

¹⁹ Criteria: 1. Country programs included community engagement (10/10 countries); 2. Country programs included community-led response (10/10); 3. Included in the Strategic Initiatives TERG Evaluation, which was also conducted by HMST (1/10); 4. Breaking Down Barriers SI countries (4/10); 5. High Impact country (3/10); 6. Team experience (9/10); 7. AGYW country (1/10). While not a criterion, 2/10 countries included in the CCM Evolution SI.

²⁰ Please note that during a meeting between the evaluation team and the Technical Oversight Committee on 29 April, there was agreement to adjust some of the questions, including clarifying intention, and combining previous questions 3 and 4 under the Implementation pillar, and moving them to lessons learned.

²¹ For example, the finding for the second evaluation question under the Results pillar is marked as EQR2.

Table 3: Findings by evaluation question and strength of evidence

Evaluation Question	Finding	SoE
Pillar 1: Design		
1. How well articulated and emphasized are community engagement and community-led responses in Global Fund internal processes and requirements by country teams and other departments? Is the design of the support for community engagement and community-led responses for the 3 diseases and RSSH well aligned/well-articulated with other related GF support?	Finding 1 (EQD1.1): The GF Secretariat supports CE and CLR with strong technical guidance for communities and countries. However, within the Secretariat itself, internal processes and incentives are not always aligned to a community focus. While many important initiatives and investments have emerged, these efforts are not specifically drawn together in an overarching theory of change with shared accountabilities, a common understanding of key terms, and system-wide connections. As a result, efforts to strengthen CE and CLR are fragmented, and lack the coherence of purpose that would maximize impact.	1
	Finding 2 (EQD1.2): The GF has focused its CE and CLR guidance and efforts where there are the clearest human rights (and to a less extent) gender-based barriers to health services. These are best understood and funded for HIV, increasingly TB, and less so for malaria where there is less experience and fewer community organizations, making it harder for the GF to engage communities in malaria. CSS (RSSH) guidance is strong, and increasingly aligned with the three diseases.	2
2. How are the objectives of the support for community engagement and community-led response defined for the three diseases and RSSH; what performance indicators and targets exist?	Finding 3 (EQD2): The rationale for CE and CLR are well established, and specific objectives of CE and CLR and support for them are defined within SIs. Country-level objectives exist within catalytic funds and specific grants, but are not connected under a broader measure of community results. Consequently, community-disaggregated programmatic and financial data is not routinely collected. In addition, CE and community-led advocacy are best measured qualitatively, while the GF's systems rely on quantitative data.	1
3. To what extent does the current GF support for community engagement and community-led responses reflect lessons learnt from previous evaluations and any contextual change since 2017?	Finding 4 (EQD3). The GF has invested significant effort and increased resources to respond to the numerous lessons learned in previous evaluations related to the business architecture including, CE and CLR, as well as contextual changes, often led by the CRG Department. Lessons learned about underlying issues of organizational structure, incentives and culture have been harder to address – including systematic integration and prioritization of gender equity – and have been more challenging to respond to, as they require an organization-wide reflection.	1
4. To what extent is the approach to support community engagement and community-led responses well explained and fully clear to partners, and community organizations at country level? How is this promoted	Finding 5 (EQD4.1). Guidance on CE and the support available exist and are explained during funding request development, yet still not fully understood by communities. There appears to be more investment where the guidance is better understood and contributions to disease objectives is more explicit. There is less guidance beyond the grant making stage, with promotion of the support dependent on the individual	1

Evaluation Question	Finding	SoE
by country teams and CRG department?	CTs, regional CRG platforms, and partners, and their skills in community, rights and gender issues. Finding 6 (EQD4.2). While technical guidance and support for CLR is available in multiple languages, it is buried in funding request guidance, and is not consistently presented in local languages, nor in a language and style that is easily accessible to community stakeholders. The promotion of CLR is neither systematic, nor systemic in that it is based on individual discretion rather than routine, and can be inadvertently presented as competition, rather than a complement to government efforts to strengthen systems for health and achieve disease objectives.	1
5. To what extent have 'community organizations' been involved and encouraged in the design of grants at country level i.e., funding request and grant making stages? What are barriers for community engagement during grant design?	Finding 7 (EQD5). Considerable effort has been invested in promoting CE in the design of grants, and communities have increasingly been engaged in proposal development. However, it is not consistently sufficient to overcome the many barriers that communities face – particularly KPs and unrepresented groups. Barriers include power differentials between government and community representatives on the CCM, comparative lack of experience in proposal design among community members, human rights challenges that militate against full and safe community representation, and lack of CE in the budgeting process and finalizing the funding request.	1
Pillar 2: Implementation		
1. To what extent has the GF supported community engagement and community-led responses been implemented as planned and as needed to make progress against global targets? a. Describe how the implementation differ by programmatic area (i.e., HIV prevention, malaria, TB, RSSH etc.)? b. How has the situation evolved over time, including effects of COVID-19? c. What have been the main challenges to implementation and providing support at both at country and Secretariat levels? How they have been addressed? What are the lessons learned?	Finding 8 (EQI1). Measuring overall contribution to global targets is not possible due to a lack of explicit linkages between CE and CLR, and global targets, and the lack of disaggregation of data. Furthermore, measuring against plans does not fully capture potential community contributions to global progress, as the GF has limited visibility into community priorities that are not included in grants, unless they are visible from the documentations on the funding landscape that GF receives. Finding 9 (EQI1a). Implementation in HIV is supported by more guidance, investment and experience, and while CE and CLR are less understood and therefore slower to emerge in TB, malaria and RSSH. However, positive examples from all diseases that take a long-term approach can be replicated and scaled up. Finding 10 (EQ1b). Investment in CE and CLR increased between NFM 2 and 3, and community response to COVID-19 has renewed interest in working with communities in the GF and by governments. However, the granularity of data required to measure overall investment in CE and CLR is missing, particularly as financial data is not available below the PR level.	2 1 2

Evaluation Question	Finding	SoE
	Finding 11 (EQ11c). The GF structure and business model – without a differentiated approach and limited systemic capacity or appetite to manage risk, complexity and ambiguity– is not well suited to supporting multiple, diverse community organizations, or results that are not directly quantifiable in the short-term.	1
2. To what extent has the implementation of community engagement and community-led response programs/ activities at country level been timely, efficient, coordinated, monitored, and responsive to needs?	Finding 12 (EQ12). With several successful examples, overall, implementation is variable across contexts and highly dependent on the enabling environment and specific support and engagement by the GMD and partners, including long-term investments in capacity strengthening.	2
a. To what degree have successes been enabled by and challenges been due to Global Fund processes and to implementer processes and capacities?	Finding 13 (EQ12a). Successes have been enabled by a combination of the vibrancy and persistence of communities, implementer processes and capacities, GF and partner support. Yet much depends on how support is provided and guidance is interpreted, which in turn depends on the openness of the enabling environment, which the partners and Global Fund levers are not consistently employed to influence.	3
b. How have challenges been managed? What are the lessons learnt?	Finding 14 (EQ12b). Capacity and turnover in community organizations are key challenges requiring understanding and support, however, efforts in strengthening capacity over the long-term are delivering positive and replicable results.	2
c. What have been programmatic and fiduciary risks in implementing programs by community-led organizations? How can these risks be mitigated?	Finding 15 (EQ12c). Community PRs are among the best rated, yet many community organizations do not meet the capacity requirements to become grant funding recipients. Other forms of contracting – such as social or service contracts – remain small-scale and require further exploration.	3
3. To what extent have community-led organizations been enabled and supported to respond to COVID impacts on HTM programs and how did they contribute? How has the COVID-19 pandemic affected the implementation of the support? What are the lessons learnt for any future design of the approach?	Finding 16 (EQ13). COVID-19 created challenges for CE and CLR, yet the communities' ability to reach the most vulnerable during this time – with services, commodities, support, and accurate information, as well as conduct research and fill critical gaps when the public sector was unable to – highlighted their capacities, flexibility and resilience, generating opportunities and lessons learned on how to more effectively engage communities in national responses, RSSH, and pandemic preparedness and response.	2
4. Is GF sufficiently active in identifying/supporting identification of community actors that could be engaged to maximize community interventions impact?	Finding 17 (EQ14). The Global Fund has made major contributions to identifying and supporting community groups and networks across all three diseases. However, countries are not routinely identifying community actors whose work could contribute to its results – particularly outside the capital cities, or beyond the three diseases. The current PR and CCM-centric model has inadvertently created “in groups” and “out groups” of communities. Partners can offer insights, but this coordination does not consistently occur.	2

Evaluation Question	Finding	SoE
Pillar 3: Results		
1. To what extent have the interventions implemented by communities achieved their intended objectives as mentioned in their plans? a. Are the results different by programmatic areas (HIV, TB, Malaria, RSSH)?	Finding 18 (EQR1). Due to the lack of data collected or appropriate disaggregation, it is not possible to determine the extent to which community objectives have been achieved globally. SR results are integrated by the PR and may not be disaggregated for the GF to monitor. The country case studies, however, suggest that results are largely positive, and while more visible in HIV, they are also emerging in TB and malaria.	3
2. To what extent have these interventions contributed to the results of the national programs of the three diseases and RSSH in general? a. How well have the various community programs supported by the GF at country-level been complementing each other and collectively contributing to achieving country results. How could have the results been improved?	Finding 19 (EQR2). In the case studies, national stakeholders reported that it would not be possible to implement country programs without CE and CLR. However, unless data is disaggregated by community contribution, it cannot be determined to what extent community interventions contribute to national results, or are addressing rights- and gender-related barriers. Where disaggregation exists, there are visible contributions in all three diseases, however complementarity cannot be determined.	3
3. What internal and external factors are contributing the most to a successful community engagement and community-led response?	Finding 20 (EQR3). Global Fund requirements for CCM membership and community representation ensure CE takes place in GF processes, particularly up to funding request design, and notably in countries that would not do this otherwise. CLR tends to be more effective when its need is understood and supported by the government. Both are more successful in a supportive enabling environment, and catalytic funding has been critical to some gains achieved, but has been limited in scale.	3
4. To what extent is sustainability addressed in community engagement and community-led responses (e.g., alignment with any government efforts to establish/strengthen community health program; clearly articulated plans to secure sustainable financing for core activities)?	Finding 21 (EQR4). Progress has been made in establishing institutional, and to a lesser extent financial, sustainability. Positive and replicable examples of institutional and financial sustainability exist for CLR, with more examples of institutional sustainability for CE. Overall, however, sustainability is not consistently adequately planned for or supported in terms of time and resources.	2
5. To what extent have community led responses become integrated and embedded in the national health system e.g., Joint planning, trainings, national strategic planning?	Finding 22 (EQR3). The extent to which community responses have become embedded in national health systems is variable, with positive examples evident where there is a vibrant civil society and supportive enabling environment.	3
Pillar 4: Lessons Learned		

Evaluation Question	Finding	SoE
1. What changes should be introduced to the GF Business Model in relation to GF internal policies, processes-funding request-grant making), implementation – monitoring-grant revisions and reporting) to operationalize the high priority objective given by the new strategy to the community engagement and community-led response	<p>Finding 23 (EQL1). Current systems, incentives, processes and measurements are not as well adapted to supporting diverse organizations, or small, iterative projects that have longer-term and evolving results in complex settings, compared to larger, commodity-based projects with fewer components.</p> <p>Finding 24 (EQL1a). The absence of a way to categorize COs by maturity level and a differentiated risk matrix makes it difficult to make appropriate decisions based on risk for different types of organizations for different types and scales of activities.</p> <p>Finding 25 (EQL1b). Guidance regarding community engagement in grant processes do not set clear enough expectations. While countries should be able to adapt to their context, in the absence of minimum standards or more illustrative examples, this engagement will remain sub-optimal in most contexts.</p> <p>Finding 26 (EQL1c). The drivers of successful community action are highly variable and context-specific but tend to include a combination of individual leadership, organizational capacity and network, and an enabling environment that is open to CE and CLR.</p> <p>Finding 27 (EQL1d). The absence of qualitative or long-term M&E frameworks at the country level is a constraint to meaningfully measuring CE and CLR.</p>	<p>2</p> <p>2</p> <p>1</p> <p>3</p> <p>3</p>
2. How could the processes at global and country-level be improved to facilitate more efficient and effective implementation? Has GF the means to support the community organizations to improve their contributions? What should be done differently to support them better? Have the PRs the right skills and tools to support the community organizations (SR/SSRs)? (Former questions 3&4 under Implementation)	Finding 28 (EQL1). In practice, the current funding-cycle approach favors short-term results, and inadvertently creates competition between sectors – public, private and community – rather than incentivizing long-term investment in the priorities that will contribute most to overall health outcomes, systems strengthening, and cooperation between sectors.	3
3. In addition to changes to GF related processes, what is	Finding 29 (EQL3). Social contracting, service contracts, payment for activities/results, small grants	

Evaluation Question	Finding	SoE
the feasibility and implications of alternative funding approaches, including direct and joint funding with other donors and partners on community engagement?	mechanisms, and pooled funds present opportunities to support more nascent community organizations, however, further exploration is needed.	3

Pillar 1: Design

EQD1. How well articulated and emphasized are community engagement and community-led responses in Global Fund internal processes and requirements by country teams and other departments? Is the design of the support for community engagement and community-led responses for the three diseases and RSSH well aligned/well-articulated with other related GF support?

Finding 1 (EQD1.1). The GF Secretariat supports CE and CLR with strong technical guidance for communities and countries. However, within the Secretariat itself, internal processes and incentives are not always aligned to a community focus. While many important initiatives and investments have emerged, these efforts are not specifically drawn together in an overarching theory of change with shared accountabilities, a common understanding of key terms, and system-wide connections. As a result, efforts to strengthen CE and CLR are fragmented, and lack the coherence of purpose that would maximize impact.

The Global Fund 2017-2022 strategy called for an intensified focus on human rights and key populations, including increased attention to community engagement (CE) and community-led response (CLR). Three key mechanisms exemplify this trend: (1) increased investment in strategic and targeted catalytic funding specific to communities, human rights and gender, (2) the development and deployment of additional technical guidance (discussed further in Finding 6), and (3) integration of CE and CLR into operational and grant policies and processes. In particular, new strategic initiatives (SIs) – such as the CRG SI, CRG Accelerate, Adolescent girls and young women (AGYW), Breaking Down Barriers (BDB), Community-led monitoring (CLM), and relevant aspects of the CCM Evolution, TB Finding Missing Cases, and Sustainability, Transition, and Co-financing (STC) SIs – were all found to be thoughtfully designed and well-articulated. There is also evidence that matching funds (MF) and multi-country grants were used to advance efforts, and that all investments attempted to build on lessons learned and respond to recommendations of previous evaluations.

Together, these efforts have resulted in funding increases for CE and CLR in grants between NFM2 and NFM3 (see Finding 10), as well as in the SIs. However, because these initiatives are siloed, their collective contribution to the GF's strategy is difficult to ascertain. There is no overarching theory of change that explicitly links efforts to reinforcing CE and CLR to disease- and systems-specific results. It is therefore not clear how catalytic funds interact with grants, nor who has overall accountability, as the owner of the SI – in this case the CRG Department – does not have authority or accountability in terms of grant management and direct country support. Conversely, country team's (CT) – who do have grant management responsibility – are not mandated to oversee the implementation of SIs in their portfolios, in conjunction with their grant oversight role.

Perhaps as a consequence of the lack of understanding about how CE and CLR contribute to disease and systems for health outcomes, there is also inconsistency in understanding key

terms – both within the Secretariat and at country level (including within and across countries). For example, “communities” are sometimes used synonymously with KVPs, and/or with civil society, or in a generic geographic sense. Unlike the current strategy, the 2023-2028 strategy provides a broad, yet clear definition of communities for the GF: “communities living with or affected by HIV, TB, and malaria, including key and vulnerable populations.” This inclusive definition should overcome some of the current issues with different understandings, which can risk conflating and potentially excluding certain groups,²² if it can be consistently adopted and promoted as the GF’s working definition.

Similarly, the GF does not have a clear taxonomy for categorizing community organizations (COs), and this can lead to confused communication and incorrect assumptions. Some Secretariat interviewees interpreted “community organizations” in the sense of the Principal Recipient (PR) “community sector” category, and equated these grants with community-led response. However, this category also includes international non-governmental organizations (INGOs) and international faith-based organizations (IFBOs) – which manage the largest proportion of funding within this category (see Annex 5), yet are not “community” in the sense of the new strategy’s definition. Other PR sub-categories include “Local NGO,” “Local faith-based organization,” and “Other community sector entity.” Even this does not capture the diversity of “local NGOs”. Some community organizations are indeed well established and experienced, with the capacity to successfully manage GF grants, while others are more nascent grassroots organizations with an informal structure, few systems and low capacity, i.e., not suitable as GF PRs or SRs. Some Secretariat interviewees understood “community organizations” to be the latter, while others have a more nuanced view civil society organizations, community-based, community-led, key population-led etc. However, this view does not (yet²³) take into account variations in capacity and experience.

Finding 2 (EQD1.2): The GF has focused its CE and CLR guidance and efforts where there are the clearest human rights (and to a less extent) gender-based barriers to health services. These are best understood and funded for HIV, increasingly TB, and less so for malaria where there is less experience and fewer community organizations, making it harder for the GF to engage communities in malaria. CSS (RSSH) guidance is strong, and increasingly aligned with the three diseases.

The GF’s expertise in community, rights and gender-related programming owes much to the extensive experience and lessons learned from HIV communities and activist groups in response to the high levels of marginalization, criminalization, stigmatization and discrimination they face. As a result, most of the guidance, case studies, and experience has come from HIV. The GF has also invested in supporting HIV COs and networks since the beginning. This process only recently began for TB – particularly through its linkages with HIV KVPs – and is nascent for malaria, where barriers to health care may be less a result of the violation of political rights, but rather equity and socio-economic rights and factors, such as poverty and remoteness. The fact that malaria is an acute rather than chronic disease also does not inspire the same community mobilization as HIV, and there are subsequently fewer malaria- (or TB) specific COs. Where malaria is addressed at the community level, COs may emerge under different guises, such as women’s groups, or community development groups. These groups are less targeted by the GF’s approach to CE and CLR, which tends to focus

²² For example, the evaluation team heard different assumptions about who “communities” included, and at least two global level interviewees raised concerns that conflating “communities” with KVPs risked excluding AGYW, or precluded some non-KVP community organizations from leading responses or receiving the attention they need.

²³ The CRG department is in the process of developing one, and it is recommended that this be done with reference to existing categories used by other organizations, such as USAID.

more on KPs rather than community members who face geographic and socio-economic barriers to health care.

The new GF strategy defines KPs in line with UNAIDS terminology as, “In the context of HIV, KP are gay men and other men who have sex with men, sex workers, transgender people, people who inject drugs, and people in prisons and other closed settings”. While there is emerging recognition of KPs in the context of TB and malaria, this is less well understood or consistently articulated. For example, KPs for TB and malaria are not explicitly included in the new strategy glossary as HIV KPs are. TB tends to refer to “vulnerable groups”, which include PLHIV, people prisoners, health care staff, poor urban populations, and migrants, in addition to contacts of people with TB, or those with other health-related vulnerabilities. Similarly, malaria KVPs include mobile and migrant populations, ethnic minorities, refugees and internally displaced persons in addition to the traditional target groups of children under five and pregnant women – many of whom also face human rights- and gender-based barriers to care.

The relative lack of attention to TB and malaria in CE and CLR was recognized by many interviewees across the Secretariat²⁴ and technical partners, and also evident in the country case studies. There is evidence of growing efforts to strengthen the community voice by investing in TB and malaria networks, and ensuring that there is at least one community representative for each disease on the CCM. This was confirmed by the country case studies, which all reported having community representatives from all diseases on the CCM (with the exception of Morocco, which does not have a malaria grant, and Paraguay, which only has an HIV grant). There is also more guidance available, notably the Malaria Matchbox Assessment Tool, and the Tuberculosis and Human Rights Background Paper, and Gender and Human Rights Technical Briefs for both diseases. The CRG SI has made a concerted effort to respond to the 2019 CRG evaluation finding that more support was needed for TB and malaria organizations,²⁵ and TB has been fully included in the BDB SI.

There is comprehensive guidance around Community Systems Strengthening (CSS), however it is only one of seven components of Resilient and Sustainable Systems for Health (RSSH), with some global interviewees observing that CSS is quickly deprioritized when budgets are tight. The four components of CSS – community-led monitoring (CLM), community-led research and advocacy, social mobilization, and institutional capacity building²⁶ – are well targeted and designed. However, it has not been possible to understand how CSS is prioritized either within RSSH itself (which also includes other critical systems such as integrated service delivery, procurement and supply chain management, human resources, data systems, strategy alignment, and financial management and oversight), and then in terms of how RSSH is prioritized against the three diseases. Nor is there a consistent systems-based approach to tackling the different RSSH components – such as integrating CLM into the data systems component.²⁷

Multidisciplinary CTs are aligned with portfolio requirements, meaning that depending on the grant requirements or classification of a portfolio (focused, core, high impact), not all CTs

²⁴ Including the CRG Department, Disease Experts, and some members of GMD

²⁵ Data provided by the CRG Department showed, however that from 2017-2019 to 2020-2022 (to date), HIV requests constituted 41% and 60% of requests supported. TB increased from 6% to 8% and malaria decreased from 11% to 6%.

²⁶ CLM was formerly known as “community-based monitoring”, and “community-led research and advocacy” was previously known as “community-led advocacy and research”. The former has officially changed, and the latter is being proposed in the updated Modular Framework to better reflect the order that they take place in, according to Secretariat interview.

²⁷ TERG (2019), *Thematic Review to Assess the Current Approach to Investments in Resilient and Sustainable Systems for Health*, the Global Fund: Geneva, Switzerland.

https://www.theglobalfund.org/media/8793/terg_resilientsustainablesystemsforhealthreview_paper_en.pdf

currently have ready access to CRG-specific expertise, and CRG Department staff are not members of CTs, or have direct access to implementers at the country level. Some country teams, however, do have access to knowledgeable CRG staff for support, such as the Tajikistan CT. Emphasis on CE and CLR is inconsistent across CTs, and dependent on different factors including the CT's interest and skill, how much CLR is already included in the grants being overseen, whether communities on the ground are reached by the CRG regional platforms and able to engage, or whether a country has been included in an SI that supports CE and/or CLR. While efforts have been made to provide technical guidance, raise awareness and build capacity internally, there has not been a change in internal GF policies, processes or incentives that drive behavior, such as the risk framework, CT checklists and job descriptions. The implicit (and explicit in the case of FPM job descriptions) emphasis is on risk management, processes and disbursements, with other guidance driven by grant objectives.

In this way, the organizational procedures do not easily accommodate risk, ambiguity, complexity, and unpredictability, although measures and flexibilities are in place to define risk mitigation measures appropriate to the context. Secretariat staff already have heavy workloads and therefore lack the bandwidth to respond to the dynamic way in which communities often work, and risk mitigation also comes with time and resource demands. This results in communities needing to adapt their work in line with GF systems, which can stifle innovation. The need for this flexibility was highlighted in the RSSH thematic review.²⁸ An example of this is the lack of differentiation in the risk matrix, which uses the same tool to assess the risk of a PR or a Sub-Recipient (SR) that will manage a multi-million-dollar commodity-heavy program, or a relatively small social behavior change project.²⁹ This lack of adaption to different types of projects and actors creates a barrier that excludes many COs from becoming PRs and SRs.

Funding requests budgets can be commodity-heavy³⁰, which requires the management skills of high-capacity PRs, and which can also be more suited to the government's role. These PRs are often not suitable to also implement CLR (i.e., if they are governments, multilaterals or international NGOs), which would therefore be included through SRs. This has been done to great effect, for example communities in Tajikistan appreciate UNDP's support for CE and CLR, and similarly Nepalese communities are satisfied with INGO PR expertise. While there is no limit on the number of SRs that can be engaged, it does place additional burden on PRs, who are responsible for selection, management, and any poor performance of SRs.³¹ Implementer guidelines state, "The Global Fund also expects that the PR will restrict the number of SRs to that which is reasonable to achieve maximum impact of the program and prudent management of grant funds [...] The use of a restricted number of SRs avoids unnecessary transaction and management costs and provides stronger assurance."³² The 2022 PCE synthesis also report found that "in some cases, efficiency and/or effectiveness considerations appear to have taken precedence over equity considerations in NFM3 grant

²⁸ TERG (2019), *Thematic Review to Assess the Current Approach to Investments in Resilient and Sustainable Systems for Health*, the Global Fund: Geneva, Switzerland.

https://www.theglobalfund.org/media/8793/terg_resilientsustainablehealthreview_paper_en.pdf

²⁹ The TERG tracker of thematic review evaluation includes this recommendation from the 2017 review on Utilization of Global Fund's M&E investments to improve country data systems: "The TERG encourages the Board and the Strategy Committee to reconsider its level of financial risk appetite and existing policies that may unduly constrain expenditure and to encourage and support the Secretariat's work on flexibility and differentiation in risk management". It was marked as "on track" in 2018.

³⁰ While not analyzed across all grants, as an example from the case study countries, the average component of commodities for HIV grants in NFM3 was 37%, reaching as much as 58% in Togo and 63% in Côte d'Ivoire, with the lowest inclusions in Paraguay and South Africa at 17%.

³¹ "... the PR is responsible for the performance of SRs and its contractors including their actions or omissions as if they were its own, irrespective of whether the SRs have received funding directly from the Global Fund or its agents." *Ibid.*

³² The Global Fund (2015), "Guidelines on Implementers of Global Fund Grants", 24 July.

https://www.theglobalfund.org/media/5663/core_guidelinesonimplementers_guideline_en.pdf

design. For instance, in response to concerns with efficiency, some countries adjusted NFM3 PR and SR implementation arrangements with potentially negative consequences for equity.”³³ As will be discussed under the Implementation pillar, these policies not only prevent communities from receiving funding and leading responses – although other mechanisms may be available to communities for funding – but can also constrain their engagement in grant cycle processes.

EQD2. How are the objectives of the support for community engagement and community-led response defined for the three diseases and RSSH; what performance indicators and targets exist?

Finding 3 (EQD2): The rationale for CE and CLR are well established, and specific objectives of CE and CLR and support for them are defined within SIs. Country-level objectives exist within catalytic funds and specific grants, but are not connected by a broader measure of community results. Consequently, community-disaggregated programmatic and financial data is not routinely collected. In addition, CE and community-led advocacy are best measured qualitatively, while the GF’s systems rely on quantitative data.

The GF’s 2017-2022 Strategy includes an operational objective to promote and protect human rights and gender Equality (objective 3) and to strengthen community responses and systems (under objective 2, to build resilient and sustainable systems for health). It also includes a sub-objective to “Support meaningful participation of key and vulnerable populations and networks in Global Fund-related processes.” Ensuring that communities are strengthened, heard, have access to information, and are recognized as key partners comes through strongly in the current strategy. In particular, “Meaningful engagement is recognized as a necessary step towards increasing investments in evidence-based and rights-based programming which deliver greater impact on the responses to the three diseases and which strengthen local accountability.”³⁴ This has been supported by new technical guidance, changes to CCM guidance, the CCM Evolution SI, and updates to the CRG SI. The latter in particular, provides clear objectives for its support to CE within in a well-defined theory of change. Objectives for CLR were less specific in the strategy, however joint efforts between the CRG, RSSH, Health Financing, and disease teams were made to clarify the objectives of CLR by disease for NFM3.

These efforts came together under a new internal term, community systems and responses (CS&R), which encompasses community responses, and community systems strengthening under the working definition of “working for and with communities on service delivery, community empowerment and accountability”. This effort highlighted the following focus of CLR by disease:

- **HIV:** (1) reach KP and AGYW with prevention package with referral support for early treatment start & SRH services; and (2) improve HIV testing uptake, case finding, and retention on treatment.
- **TB:** (1) Case finding via strengthened awareness, health seeking behavior, contact investigation, active case finding targeting vulnerable and key populations; and (2) Successful treatment of patients with TB/DR-TB (adherence, peer support) and preventive TB treatment for the most at-risk groups (particularly PLHIV & contacts).

³³ The Global Fund (2022), “Technical Evaluation Reference Group: PCE Extension Synthesis Report. TERG Position Paper, Management Response and Final Report”. March.

³⁴ The Global Fund (2022), Fighting Pandemics and Building a Healthier and More Equitable World: Global Fund Strategy 2023-2028, Geneva.

- **Malaria:** (1) Access to quality case management with access and quality of malaria case management in public; and (2) Community based monitoring to hold governments accountable for quality of malaria services for under-served communities.³⁵

Interviewees at the Secretariat level – particularly within GMD – noted that the connection between CE/CLR should be more directly linked to health outcomes and strategic objectives. The evaluation team agrees with the often-shared opinion that if this connection is understood, then government support and investment will follow. The evaluation team heard³⁶ that the TB Finding Missing Cases SI recognized a clear link between community involvement and improving results, which were disaggregated to show community contribution. In the case studies as well, government stakeholders recognized and appreciated the critical role that community organizations play in identifying new cases and supporting treatment access in remote and rural communities. This was the case in Tajikistan, for example. This was also observed for HIV prevention among KPs, and connecting hard-to-reach communities to malaria services. However, the link between investment and results is harder to trace for community-led advocacy efforts, which take time to bear fruit. This can be a deterrent to the GF to invest in advocacy, and this in turn creates disincentives for communities to work on advocacy, when there is more funding available for implementation.

No specific targets for CE were found for how communities “meaningfully” participate in Global Fund processes, and those for CLR tend to be at the grant level, which is not captured at the global level and reflected against strategic objectives and KPIs. Grant guidance itself (e.g.,

“This data is not available, when the GF lives on data. It’s strange that this data is not collected, and it shows level of importance assigned to it.”
(Secretariat interview)

the Modular Framework) does not explicitly identify which interventions can or should be community-led, so not all applicants will necessarily find the available technical guidance or growing number of examples and case studies documented. Critically, while the Board receives regular reports on CRG updates, there is no community-related key performance indicator (KPI), which would signal CE and CLR as priorities. Furthermore, without a KPI, specific data is not collected, nor disaggregated by provider type in a manner that would allow community contributions to be recognized (where these do exist, they are

presented under the Results pillar). More than one member of the Global Fund Secretariat (outside the CRG Department) noted the absence of disaggregated programmatic and financial data to understand the investment and results of CLR.

Two other key constraints for measuring CE and CLR stem from how the GF collects data. The first is the time frame. The GF collects data based on a three-year cycle of funding allocations, yet many CE, CLR and the capacity building and CLM aspects of CSS efforts require a longer time-frame to show results. Currently, the GF does not have indicators to track progress towards on CE or CLR, which would at least capture interim results. The second constraint is that GF systems rely on quantitative data, whereas often community processes and results can only be captured qualitatively. For example, changes to laws, strengthened capacity, improved relationships etc. are difficult to quantify. This could be done using quantitative scales to indicate progress, but capturing qualitative progress or results, for example, against milestones in Workplan Tracking Measures, would provide more accurate data to both inform decision making, and showcase achievements.

³⁵ The Global Fund (2021), “Community Systems and Responses: GMD Directorate Meeting”, PowerPoint presentation, September 2021.

³⁶ From two Secretariat staff members and a technical partner

Experience with RSSH has revealed the complexity of measuring change. While the GF has improved its RSSH guidance, the 2021 PCE, which focused on eight countries, found that it was not consistently followed in the review co-hort. “Despite extensive new guidance, most NFM3 grant performance frameworks do not appear to include many of the new RSSH coverage indicators, suggesting that monitoring RSSH performance and progress toward meeting SO2 remains a challenge. Coverage indicators rarely capture aspects of system strengthening (such as data use for decision-making) and some RSSH investment areas do not map well to available indicators.” The PCE recommended that grants include “more direct measurement of the drivers of inequity and of outcomes of human rights and gender investments”, and specifically, to “ensure performance frameworks incorporate existing data including on human rights and political commitment as well as disease burden and service access amongst different population groups and use this data effectively to monitor grant contribution to both SO3 and SO1 or disease impact.”³⁷

EQD3. To what extent does the current GF support for community engagement and community-led responses reflect lessons learnt from previous evaluations and any contextual change since 2017?

Finding 4 (EQD3). The GF has invested significant effort and increased resources to respond to the numerous lessons learned in previous evaluations related to CE and CLR, as well as contextual changes, often led by the CRG Department. Lessons learned about underlying issues of organizational structure, incentives and culture have been harder to address – including systematic integration and prioritization of gender issues – and have been more challenging to respond to, as they require an organization-wide reflection.

Numerous lessons learned were identified by this evaluation from multiple previous TERG evaluations – including thematic reviews and Prospective Country Evaluations (PCE), Technical Review Panel (TRP) experience, and Office of the Inspector General (OIG) reviews. The number of evaluations received by the consulting team could not all be fully reviewed, and the tracker of these recommendations has not been recently updated due to significant workloads imposed by the COVID-19 pandemic, and it was beyond the scope of this evaluation to follow up on each. Some clear examples of responding to lessons learned were evident, however, including those presented in Figure 2, which were identified as having a positive impact on improving CE and/or CLR.

Figure 2: Examples of responses to lessons learned that have strengthened CE and CLR

- CRG SI, and its extension and subsequent modifications in 2019, specifically to addresses more aspects of the grant cycle beyond the design stage, and to include more focus on TB and malaria (although most of the regional platforms tend to come from HIV background);
- Increase in community-related technical guidance, and increased integration of community considerations across grant documents, including allocation letters;
- Clearer guidance and application process around RSSH, including greater articulation of CSS components;
- Dedication of 15% of the CCM budget to supporting the community participation;
- Requiring that representatives of all three diseases be included on the CCM;
- CCM Evolution SI;
- Breaking Down Barriers SI to address rights-related barriers to HIV and TB;
- CRG Accelerate SI to better work with GMD on CRG-related issues in portfolios;

³⁷ The Global Fund (2021), *Prospective Country Evaluation: Synthesis Report*, TERG: Geneva

- AGYW guidance framework and SI developed to bring attention to this group;
- Service Delivery Innovations SI includes CLM and social contracting to build on early experience and develop best practices;
- Increased focus on KVPs in STC plans;
- Community feedback on the COVID-19 Response Mechanism (C19RM) integrated into the second iteration.

Some of these changes were noted positively during interviews, for example a member of the Secretariat shared, “We don’t often have TB community or TB national program represented on CCM. Most of it’s done by the HIV program and community, which is a problem. But we see it changing now as the requirements change as need disease-specific representative.” Global networks also acknowledged the value of the increased focus on KVPs in sustainability plans (even if the practice falls short of the theory in many contexts). Others mentioned that the inclusion of community consultations in allocation letters also ensures that this actually happens in contexts where it would not have otherwise.

On behalf of the Secretariat, the CRG Department has consistently reported to the Board how it is both generating and responding to lessons learned, demonstrating a thoughtful approach to continual improvement in CE and CLR. However, there is also recognition in parts of the Secretariat that CE and CLR require an integrated approach beyond the CRG department, with greater shared accountability. There are indications that this is being addressed through joint initiatives within the Secretariat, which aim to build on experience from NFM2 to improve grant performance on CS&R, through the following “key enablers:

1. Stepped-up and differentiated practical guidance to CTs;
2. Results-focused, cross departmental approach with joined-accountability for programmatic outcomes;
3. Appropriate resources for further strengthening competencies in CS&R;
4. CS&R indicators linked to programmatic health outcomes and clear metrics to measure CS&R investments;
5. Purposeful partnership agreements and accessible quality TA for community health programs.”³⁸

The results of these efforts were not specifically identified by this evaluation, but this initiative demonstrates internal recognition of the need to shift away from “business as usual,” and that accountability for progress in this area must be shared across the Secretariat. Key recommendations for which evidence was either limited, not found/available, or where further effort may yet be necessary are presented in Figure 3.

Figure 3: Examples of lessons learned where further efforts are necessary

- Differentiating the risk framework (M&E investments evaluation 2017), and continue to address organizational disincentives to proportionate risk-taking (Strategy Review 2020)
- Build country buy in for the inclusion of AGYWs and strengthen gender expertise on the CCM (AGYW evaluation 2018)
- CTs, CCMs and partners to work together for improved integration and coordination on health and non-health platforms to promote AGYWs (AGYW evaluation 2018)
- Exploration of more flexible funding channels to support CSR efforts beyond the PR-SR model with less burdensome reporting requirements (RSSH Evaluation 2019)
- CSR should be seen as part of the main disease control or RSSH effort and conceptualized, planned and programmed as such (RSSH Evaluation 2019)

³⁸ The Global Fund (2021), “Community Systems and Responses: GMD Directorate Meeting”, PowerPoint presentation, September 2021.

- Gradually enhance and support earlier sustainability and transition planning across the GF portfolio (STC Evaluation 2019)
- Intensify efforts to promote domestic or alternative financing of services provided by CSOs (many efforts and increased funding have been noted, yet results are not yet widely felt) (STC Evaluation 2019)
- Ensure that the Secretariat is adequately resourced and working arrangements are in place to meet evolving demand (Strategy Review 2020)
- Develop a Theory of Change to clarify and articulate how the Global Fund partnership will achieve the Strategic Objectives, as well as position the Global Fund to engage in wider global health agenda (Strategy Review 2020).

The HIV prevention evaluation recommended that “the GF should continue to support enhanced KVP engagement through supporting capacity building of these organizations and pushing for the inclusion of Community Based Organizations (CBOs) and KVPs in the implementation, monitoring and review of HIV prevention programs. This should be based on the particular stage of the epidemic in the country. The TERG strongly recommends that the Global Fund play an important role in supporting countries to strengthen national capacity for HIV prevention programs, coordination and delivery platforms and documenting successes with community- led networks. (Secretariat response: Efforts to ensure community systems and improve community-based delivery, including building the capacity of community based and community led implementers was sought within grants, and this has been further prioritized as part of COVID-19 adaptations. HIV prevention guidance will be further updated for the next allocation cycle which will also reflect the direction of the next strategy).³⁹

One lesson learned that has not been fully addressed – which was identified by the TRP and reiterated by the HIV prevention evaluation, yet applicable across all diseases – is an “ongoing weakness in grants is the tendency for siloed community-based and facility-based programmes. This reflects ongoing tensions that in the short term community services may be needed to reach KVPs but in the long term, KVPs need to have access to public services.”⁴⁰ This demonstrates that planning and design are not done from a systems-point of view, but rather as siloed components, which results in sub-optimal design, and poorer linkages, which has implications for sustainability (see Finding 21). Country case studies also observed a siloed approach, however the Côte d'Ivoire case study showed effective support through the CRG SI to support inclusion of CSO voices in the C19RM funding request, an effort that was welcomed by the CCM.

The Secretariat has created ten new working groups to guide the key changes that the 2023-2028 Strategy entails to ensure its delivery. CE and CLR are connected with many of these changes, and in particular the “Service delivery by community-based/led organizations” and “voices for communities.” These working groups are tasked with addressing some of these recommendations in the context of the new strategy, including revising the Modular Framework, and conducting an audit of existing guidance. These efforts were only at early stages during the evaluation period.

EQD4. To what extent is the approach to support community engagement and community-led responses well explained and fully clear to partners, and community organizations at country level? How is this promoted by country teams and CRG department?

³⁹ The Global Fund (2021). *Thematic Review on HIV Primary Prevention: TERG Position Paper, Management Response and Final Report*. Technical Evaluation Reference Group: Geneva.

⁴⁰ The Global Fund (2021). *Thematic Review on HIV Primary Prevention: TERG Position Paper, Management Response and Final Report*. Technical Evaluation Reference Group: Geneva

Finding 5 (EQD4.1). Guidance on CE and the support available exist and are explained during funding request development, yet still not fully understood by communities. There appears to be more investment where the guidance is better understood and contributions to disease objectives is more explicit. There is less guidance beyond the grant making stage, with promotion of the support dependent on the individual CTs, regional CRG platforms, and partners, and their skills in community, rights and gender issues.

Guidance on CE and the support available is well presented on the Global Fund website, with clear links to where additional support can be accessed, such as through the CRG SI. However, the case studies showed that many community representatives, local CBOs and even community SRs, still do not know where to find the guidance, and many do not understand it. Community stakeholders in several of the case study countries reported that they were not familiar with Global Fund guidance, in some cases, such as Tajikistan, due to language barriers.

In Nepal, some community stakeholders reported that they did not access Global Fund guidance themselves, instead relying on the PR to explain it to them. Lack of readily available direct access for communities to the CT or the CRG department, was cited as a challenge by community stakeholders in a number of the case studies.

“We often face language barriers while we want to provide our opinions or comments in the GF grant proposals. Most of the documents are in English and presentations/discussions are also in English during consultations. There are no provisions of interpretations (English-Nepali) – that significantly limits our (community) ability to understand the context and provide useful comments or suggestions on time.” ~ Community representative Nepal

Only two countries (South Africa and Togo) mentioned seeking technical assistance through the SI (although the TA tracker demonstrates that six have received it).⁴¹ This may be due to TA provision being demand driven, promoted by the regional platforms, which in turn, relies on their own networks and reach. Mapping is not routinely done to identify all potential CSOs, which may limit access to this information. Routine training for local CBOs is also not provided. This also suggests that the information is either not easy to find or not user-friendly for communities and that additional effort is needed to support this understanding. In some case studies, community representatives cited language barriers to accessing GF guidance. Another effort to increase access to information and build understanding around guidance was the creation of iLearn – the GF’s online learning platform. Analytics provided to the evaluation team were useful in exploring interest, enrolment and completion, however it was not always possible to recognize communities’ participation, as some may have been included under PR, SR, and CCM categories. From data on participation in the CCM training module, 20% of participants were CSOs, which was the second largest group after CCM members (which also includes CSOs), at 43%. Not enough information is available to interpret the 66% completion rate by CSOs (slightly lower than the average of 69%), and how useful the training was.⁴²

Beyond the CRG SI, the support for CE and CLR by CTs was found to be largely at the discretion of individual CTs, rather than part of institutionalized structures. The current Senior FPM job description, for example, makes no mention of communities, community engagement, or a requirement to consult with CRG experts in the Secretariat – although there

⁴¹ The TA tracker for the two funding rounds was provided by the CRG Department showed that South Africa and Togo requested support for NFM 2; Côte d’Ivoire and Paraguay for NFM 3, and Nepal and Tajikistan requested support for both rounds).

⁴² Analysis of data provided to the consultants by the Ethics team, noting limitations to this analysis due to some participants changing the language they started and completed the course in.

is mention of “ensuring integration of the Human Rights and Gender agenda” in the 2016 version. In 2022, this has been updated to “ensuring integration of the RSSH, human rights, gender and other cross-cutting agendas”. The FPM also “manages partnerships with governmental, non-governmental, civil society, private sector, key affected populations and multilateral partners at country level” – however there is nothing to suggest that these interests need to be protected or prioritized. The FPM’s “Core tasks include effective management of grants and ensuring provision of grant signings, disbursements and renewals,” with an emphasis on risk monitoring and management. There is no requirement for FPMs to have experience or competency regarding community, human rights, or gender.⁴³ Indeed, the competency framework does not include community engagement anywhere, with reference to community only in the context of responses under the human rights/gender/key populations competency, and a mention of CSS under the RSSH organizational competency. The “Country Context” competency also includes, “Knows how these factors may determine ways of engaging country population”. However, “Civil society and advocacy” is included as a functional competency under the GF’s competency framework’s job families of external engagement, communications, disease knowledge, finance, geopolitical and multicultural awareness, negotiations and resource mobilization.⁴⁴

If a CT does not have this expertise, tools could ensure that a community lens is still taken in reviewing and supporting the grant making process. While it is not the CT’s responsibility to assess the quality of country dialogues, the CT Funding Request checklist only requires checking that a key population representative signed the Statement of Compliance⁴⁵ – although it cannot be known under what circumstances that signature was obtained, which was a concern raised in two global interviews.

Finding 6 (EQD4.2). While technical guidance and support for CLR is available in multiple languages, it is buried in funding request guidance, and is not consistently presented in local languages, nor in a language and style that is easily accessible to community stakeholders. The promotion of CLR is neither systematic, nor systemic in that it is based on individual discretion rather than routine, and can be inadvertently presented as competition, rather than a complement to government efforts to strengthen systems for health and achieve disease objectives.

As mentioned in Finding 1, the proliferation of strong new technical guidance produced by the Secretariat has supported CE and CLR– notably from the CRG Department and Resilient and Sustainable Systems for Health team – and the Regional Platforms supported through the CRG SI. Efforts have been made to cross-reference the different guidance available, which tends to be done through hyperlinks (some of which have fallen out of date). This makes guidance appear overwhelming in volume, and difficult to absorb. Despite efforts to ensure that this information is available in multiple languages and accessible to country-level stakeholders – including communities and civil society – there is still a reliance on GF terminology, making it less user-friendly for some CBOs. An example of this is the Community Engagement Toolkit, which was a joint effort of the different regional platforms supported by the CRG SI. It’s a well-presented, comprehensive compilation of tools created for community partners by the regional platforms, which contains links to over 60 different tools (in multiple languages).⁴⁶ In Tajikistan, community representatives reported that absence of guidance in

⁴³ Global Fund job descriptions: Fund Portfolio Manager (March 2016), Senior Fund Portfolio Manager (April 2016 and May 2022)

⁴⁴ The Global Fund, Unified Competency Framework (for 2017-2022 strategy)

⁴⁵ Global Fund Funding Request Country Team Checklist, March 2020.

⁴⁶ CRG Regional Platforms (2020), “Community Engagement Toolbox: Resources from the Regional Communication and Coordination Platforms to support civil society and community engagement in Global Fund-related processes,” https://www.theglobalfund.org/media/10734/crm_communityengagement_toolbox_en.pdf

their languages (or in Russian), which made it difficult for them to access or understand CE. Similarly, the Applicant Handbook, while well-articulated and regularly updated based on lessons learned, it also has numerous links to learning modules, and a large number of technical briefs. A list of these documents available on the GF website is presented in Annex 3, which demonstrates the commendable effort and resources that the GF has invested in improving focus and quality on communities, and priorities in their work around human rights, gender, and key populations.

The Modular Framework also provides additional information on CSS, however, often without clear examples and specifics on many interventions. The CSS intervention with the most detail and most indicators, relates to community health workers (CHW), which fall beyond the scope of this evaluation one they become linked to the health system – but this is also where much CSS investment goes, which may be at least partly as a result of the more specific guidance in the Modular Framework. Much of the guidance lacks specific examples to demonstrate linkages to strategic objectives and results, nor to highlight which activities should be community-led to be more effective in reaching KVPs and hard-to-reach populations. While all these tools are designed to help navigate the GF’s systems and contribute to impactful programming, it is also indicative of how complex it is for communities to engage with the GF, with many communities not understanding the guidance, as discussed in Finding 5.

EQD5. To what extent have ‘community organizations’ been involved and encouraged in the design of grants at country level i.e., funding request and grant making stages? What are barriers for community engagement during grant design?

Finding 7 (EQD5). Considerable effort has been invested in promoting CE in the design of grants, and communities have increasingly been engaged in proposal development. However, it is not consistently sufficient to overcome the many barriers that communities face – particularly KPs and unrepresented groups. Barriers include power differentials between government and community representatives on the CCM, comparative lack of experience in proposal design among community members, human rights challenges that militate against full and safe community representation, and lack of CE in the budgeting process and finalizing the funding request.

The GF has made a concerted effort to ensure that COs are involved in the design of grants at the country level, through the country dialogue process, and in the CCMs. CCM eligibility requirements have gone to considerable effort to ensure that communities affected by the three diseases and KVPs participate in the CCM, and specifically in the funding request development, including to consider safety considerations. CCMs must be able to produce, for example, minutes from meetings, workshops and consultations including showing representation of KVPs (with consideration for the safety of doing so); the list of the writing team members, and copies of the emails and distribution list inviting stakeholders to participate in consultations.⁴⁷

Technical support is available, even if it is not always used - and the appropriateness, quality and timeliness of this support can depend on the Regional Platform, TA provider, the partnering CO, and the general context. The evaluation found that this guidance has been critical to ensuring at least a minimum level of CE in the grant design process in countries where it would not have happened naturally (i.e., where there is already recognition of the important role that communities play, and a culture of openness and cooperation). However, global interviews and case studies found that the requirements to ensure CE can be fulfilled on paper to “check the box” – yet not be meaningful in practice, and no measurement or

⁴⁷ The Global Fund (2020), “Guidance on CCM Eligibility Requirements 1 & 2”.

indicator for this exists. Indeed, the expression “tick” or “check the box” in this context was mentioned in 11 global interviews, including six Secretariat staff members, two technical partners, and three global network representatives, as well as in a number of the case studies. One technical partner observed, “There are a lot of meetings and the people invited to attend aren’t always able to participate effectively, so it feels like a tick-box exercise. There’s no space for contribution.”

The meaningfulness of the engagement then depends on the enabling environment, and the commitment of CCM leadership to ensure effective CE, and/or the communities’ ability to advocate for more space and support. This is particularly true for KVPs. This can impact not only whether or not they are invited, are able to attend meetings, as well as how vocal they are able to be during meetings. Even for non-KVP communities, power dynamics on CCMs often impede effective participation. Yet positive examples were found of where criminalized groups can participate on CCMs, and where KVPs who were not included directly on the CCM ensured that their interests were represented by other KVPs – although this practice was the exception, and most KVP networks strongly advise against “lumping KVPs” together for joint representation.

Community engagement on CCMs in practice

The question of CCM composition and appropriate representation of different communities is an ongoing debate within the GF. On the one hand, communities are extremely diverse both across and within those affected by different diseases, and it is not always appropriate or effective to have one group represent another. On the other hand, there is a limit to the number of people who can be on the CCM and still ensure it is an effective oversight body. Nonetheless, the case studies found that communities were generally well represented on CCMs. In Côte d'Ivoire for example, 44% of CCM seats were reserved for community representatives and the CCM vice-chair position is reserved for a key population representative. The GF supports community representation by ensuring that communities elect their own representative – which was confirmed but one of the ten case studies – but

“Today, five years [later], the situation has not changed much. CSOs participating in CCM meetings still do not provide feedback to their respective constituencies. Communities do not routinely meet prior to, and receive updates after CCM meetings.” Côte d'Ivoire

this can result in some representatives advocating for their own organizations or interest group, and other interests not being addressed appropriately. In Cote d'Ivoire, for example, case study interviews found that the majority of CCM members speak on behalf of their own organization, and there is no mechanism for feedback or consultation with constituents.

Among the case study countries, communities in five countries (Nepal, Paraguay, Tajikistan, Côte d'Ivoire and Togo) reported that they meet regularly before CCM meetings and receive feedback afterwards, with two (Côte d'Ivoire and South Africa) reporting that this happens somewhat. In Cote d'Ivoire, civil society organizations organized a Community Dialogue in February 2017 to engage all representatives of the civil society to share their opinions and agree on priority areas and interventions to be brought to the CCM dialogue. The community dialogue gathered about 50 people, representing 36 organizations of key populations, women groups, youth, PLHIV, and community groups. Another model that could be considered for replication is the CSO Platform supported under the Regional Artemisinin Initiative in the Greater Mekong Sub-region, whereby a platform is supported by the GF to ensure that malaria-affected communities and civil society have the opportunity to discuss priorities prior to CCM meetings (or in this case, the Regional Steering Committee), and to research and present advocacy statements and priorities.

Global Fund guidance is clear on the need to include representatives of communities affected by the three diseases, and KVPs on CCMs, and there are checks in place to ensure the participation of appropriate groups. For example, the funding approval process may be stopped if it is found not to be the case. The implementation of this guidance varies across countries, and while implementation indeed should be adapted to the context, this can be at the expense of “meaningful” engagement, as ultimately, much still depends on individual discretion and relationships. For example, while the GF requires that certain groups be included in the funding request process, it does not monitor the extent to which representatives are active in meetings, or the impact of their engagement. The GF requires that a copy of the email be shared as evidence of inviting communities to meetings, but not whether enough time was provided to ensure preparation and participation. This can be country-specific, yet, as one CRG regional platform representative stated, “a lot of countries don’t have democratic political structures in governments. In these countries, despite all declarations of how civil society should be involved and the agreements between government and GF, unfortunately when you look how it works in practice, government representatives on the CCM have much more power and more ability to have the decision-making vote”.

Table 4 compiles actual examples that the evaluation team heard to illustrate how some guidance can enable different levels of engagement on the CCM, and in the funding request development process. Annex 4 also attempts to map out an “ideal” community engagement journey through a grant cycle, compiling inputs from what was heard in terms of best practices. Table 5 at the end of this finding also presents how CE was assessed in the grant cycle in each of the ten case study countries.

Table 4: Examples of CE guidance interpretation

Guidance	Challenging Practice	Positive Practice
CCM membership of people affected by each of the three diseases and KVPs	<ul style="list-style-type: none"> Not all required communities or KVPs are represented due to criminalization or discrimination (MENA, LAC) Communities and KVPs are present, but not briefed or prepared to effectively represent their constituency. Meeting is in a language the representatives are not comfortable in (Morocco, Nepal, Tajikistan). 	<ul style="list-style-type: none"> Community representative is well briefed on GF systems and their role, can bring compelling evidence to the table, and has strong communication skills. Other CCM members value the perspective that communities bring, allowing for plans to be co-designed (Nepal).
Inclusion of KVPs	<ul style="list-style-type: none"> Criminalized KVPs are excluded from CCM and/or denied right to vote. Efforts to contest this are seen as going against country ownership. 	<ul style="list-style-type: none"> Other CCM members recognize that KVPs bring needed perspective to solving public health issues, and can participate equally, despite legal status.
	Alternative case: An “acceptable” KVP represents marginalized KVPs on the CCM through consultation and agreement, continuing to advocate for more space for criminalized KVPs. ⁴⁸ For example, in Morocco, SRs /SSRs put forward KVP as individuals rather than representatives of their communities, because certain KVP are not considered acceptable (MSM, TG, SW, PWID). However, this is very ineffective if imposed from outside the community (Nigeria).	

⁴⁸ Mentioned as a strategy by one KVP global network representative.

Technical assistance via CRG SI	<ul style="list-style-type: none"> • TA opportunities are unknown or not understood, and therefore not applied for. 	<ul style="list-style-type: none"> • TA helps communities collect evidence and facilitate broad participation, to build ownership and capacity.
Represent constituents	<ul style="list-style-type: none"> • No support provided to gather constituents together to discuss, with some COs excluded from process, or insufficient time to fully inform and collect input, or create consensus (Zambia). • Community representative acts as gatekeeper and represents self, own organization, or own interests above constituency. 	<ul style="list-style-type: none"> • Representatives have opportunity to consult with constituents prior to CCM meetings in timely manner to gather input on priorities and messages; and to share back after meetings (Mekong). • Constituents are supported to make an informed choice of their representative through open elections (Colombia).
Meaningful participation	<ul style="list-style-type: none"> • Power dynamics or hierarchical structure are such that community representatives cannot speak up or are not fully heard (Tajikistan) • Meetings are in a location that some KPs have trouble reaching (particularly if unaware of travel allowance) (Uganda) • Some KPs made to feel unwelcome by venue staff or other CCM members (Guyana). • Communities are perceived as not understanding what interventions are appropriate to recommend (Tajikistan). 	<ul style="list-style-type: none"> • Communities are empowered to speak up and share their views as equals (Nepal) • Travel is organized for community representatives, and meetings are held in LGBTQ-friendly venues. • Meeting room organized to protect KPs from being included in photos (LAC).
Communities and KVPs participate in the funding request writing process	<ul style="list-style-type: none"> • Output from community dialogues is not considered by the writing team, deprioritized, and/or under-budgeted (Malawi). • CLR and other activities are proposed in competition to each other, rather than seeking the best strategy to achieve goals. • Consultant/s hired for writing do not consider themselves accountable to communities (Anglophone Africa). • Communities do not receive a copy of the final request submitted, lose visibility of the process after providing input. 	<ul style="list-style-type: none"> • Community analysis and priorities are appropriately integrated into funding request (Kenya). • Activities are designed with CLR complementing public service activities (Colombia), and community perspectives help design public services to ensure appropriateness and acceptability at community level (Vietnam). • Communities participate in responding to questions received from TRP (Guyana).

As a key population global network representative put it, “the allocation letter required community involvement, then you’ll have PRs/CCMs bring the network to tick the box, but when it comes to actual allocation of how money is divided up, there’s not much. How empowered communities feel to input and shape programs, is a gap that needs to be addressed.” It should also be noted that following the funding request preparation, there is even less guidance available on CE, and the majority of country case studies and global interviews confirmed that communities are not routinely consulted in later stages of the grant

cycle, including in the negotiation of the final grant. At this point, global and country community representatives reported that their issues were dropped. This was supported by the TERG HIV Prevention evaluation⁴⁹, and the 2021 PCE, which found that “grant design and budgets did not change significantly during the NFM2 grant making process from the Global Fund’s Technical Review Panel (TRP)-approved funding requests, although proportionally more changes were made to investments in HRG-Equity and RSSH areas. In the majority of PCE countries, investments in reducing HRG-Equity barriers declined during grant making.” While the PCE does acknowledge increases in some RSSH budgets in some countries, it is not known whether this included CSS investments. “Factors that influenced prioritization and changes during grant making included Country Team support and input, catalytic matching funds investments and TRP review and comments, among others.”⁵⁰ These decisions are typically made without community engagement.

Community engagement in country dialogues and community consultations in practice

Beyond the CCM, communities are encouraged to participate in the design of funding requests through community consultations and country dialogues. However, their effectiveness can depend on how they are managed and supported. Barriers to effective engagement can include:

1. Participants’ **understanding** of the process and what is expected of them. Some KVP networks are providing training (including through online platforms) to address this barrier.
2. **Timing**, in terms of (a) notification received to attend a meeting (particularly if travel is required), (b) sufficient time to discuss and develop priorities (particularly if prior data collection is needed), and then (c) to ensure that these inputs feed into the process in time for due consideration. Communities are extremely diverse
3. Participants’ ability to effectively **articulate** their positions in way that will be heard, in the main language. Global KVP networks reported that some groups have limited educational backgrounds and can lack the confidence to speak up in some forums. Some KVP networks are providing training and mentorship to strengthen advocacy and communication skills of representatives.
4. Lack of **support** to participate in meetings, particularly if they are far away, and a bias was noted in the country case studies against CSOs and communities’ representatives located outside capital cities. Online meetings have increased the opportunity to participate – particularly where data packages are provided, but this can create other barriers due to comfort with technology etc.
5. **Safety and protection** of individuals who are criminalized or stigmatized. In some countries, the lack of consideration for the constraints that some groups face, particularly LGBTQI communities, creates a barrier to engagement. This can be addressed through developing some best practices or minimum standards regarding the venue, transportation, as discussed further under the implementation pillar.

The case studies revealed some good practices. In preparation for the most recent funding request in Morocco for example, the participation of key populations, women and people living with HIV and TB began during the preparation of the NSP extension plan, continued during the national dialogue, with the organization of specific workshops and the monitoring of the

⁴⁹ “At the country level, stakeholders report large variations in levels of engagement of KP networks/organisations and communities by CCMs, PRs and SRs. Key reasons underpinning the variable levels of engagement include absence of or low capacity of KVP groups and community organisations to input during CCM and funding request design meetings and less importance accorded to KVPs by decision makers and key partners during the grant design and implementation processes”. The Global Fund (2021). *Thematic Review on HIV Primary Prevention: TERG Position Paper, Management Response and Final Report*. Technical Evaluation Reference Group: Geneva.

⁵⁰ The Global Fund (2021), *Prospective Country Evaluation: Synthesis Report*, TERG: Geneva

process by a CCM Steering Committee including their representatives. In Nepal, community members on the CCM are well informed about the CE guidance and participate actively. Community consultations were found to work well, with community representatives participating in all meetings.

Inclusion of community priorities in funding requests in practice

The funding request writing process varies by country, but is often led by the CCM, PR or the government (or consultant on their behalf) leading the process, rather than a more open, system-wide and collaborative process that reflects a deeper analysis of the problems and an approach to solutions that considers all perspectives, including the most appropriate and complementary role or contribution of government, private sector, and communality. Stakeholders in several of the case studies noted the critical role that external consultants play in writing Global Fund funding requests, and the challenge of engaging communities in that process. The absence of formally contracted or assigned community consultants or representatives in the writing process was a gap noted, for example, in Nepal and global interviews with KVP networks. The impression shared by some global interviewees was that there is a tendency for governments to include commodities first, and other activities will be added afterwards, and often priority given to government implementation, even if it would be more appropriately led by communities. At this point, many community priorities can be lost, particularly where there is no clear minimum requirement for community engagement or responses in implementation, nor a minimum level of funding dedicated to CLR.

Community initiatives, most of which are focused on prevention, awareness creation, and engaging KVPs can be more complex to plan and budget for than commodity-based interventions. For example, the HIV prevention evaluation noted “At the country level, a few challenges which have been noted, including that unit costs for HIV prevention interventions can be particularly difficult to estimate given they are not standardised (e.g. for KP prevention packages which vary in degrees of comprehensiveness, human rights interventions, community empowerment, etc.).”⁵¹ This creates challenges at the budgeting stage, and also during disbursements if the estimates require adjustment.

The GF has invested in many efforts over the years to improve CCMs, including the creation of a dedicated team in the Secretariat. Providing the right balance in guidance to ensure appropriate representation is challenging as it is clearly impossible to fully satisfy all interests in all contexts. One interviewee stated, “I’m rarely in a civil society meeting where the need to improve the CCM doesn’t come up. It came up in the partnership forum, with issues raised around composition, that there are not enough representatives to speak to diversity, the selection of civil society representatives, information sharing, transparency of final decisions – there’s a lot that needs to be addressed. I’m not sure what appetite there is to do this though. People are used to hearing civil society complain about the CCM, and colleagues tune out.” Indeed, Secretariat-level interviews repeatedly mentioned that “there aren’t enough seats” on the CCM. However, there are good examples where community representatives are well prepared, well supported, well engaged with diverse community constituents, communicating effectively, and are being heard. This suggests that rather than focusing on composition, more emphasis is needed on how engagement can be supported to be “meaningful.”

⁵¹ The Global Fund (2021). *Thematic Review on HIV Primary Prevention: TERG Position Paper, Management Response and Final Report*. Technical Evaluation Reference Group: Geneva.

Responsibility to protect community representatives engaging with the Global Fund

While it did not emerge as a significant finding from the case studies, one issue that emerged from the global interviews was deemed important enough to document as a constraint to effective community engagement. The evaluation team heard examples of contexts in which representatives of KVPs can be put at risk by their very participation in GF meetings. At one extreme, this can result in intimidation and violence, at the other, every day lack of consideration can impede effective engagement. As one civil society representative shared that transgender CCM members “came disguised because they had to use public transport, and going in disguise is the only way to use it safely. Then they had to get changed when they came to meeting. But the CCM has five drivers – why didn’t they just pick them up? In some countries, we provide a list of transphobic hotels to CCM – but not all CCMs are willing to listen to these nuances. This makes a difference to participate and participate meaningfully, for example. someone might not drink any water during the meeting if they’re worried about using the toilet, or worried about how to get home safely.” While each situation is different, it was advised that, “The best way to safeguard communities is to ask communities what they need to be safe and participate meaningfully. When we’re in a privileged position, it’s easy to be blind to those who are not. In (one country), the CCM was going to meet, and an official motorcade brought government officials, but communities came on bus or motorbikes. No one asked them. No one even told them they could be reimbursed for a taxi.”

Inclusion of community priorities after funding request development in practice

CE is less visible after funding request development, where there are no requirements for CE. The writing process varies between countries, and many communities do not feel represented at this stage. Once the grant goes into negotiation, discussions only take place between the Global Fund and the PR, and there is no requirement either to share the final grant document nor the outcome of negotiations with the communities. As one KVP network representative put it, “Even in countries where communities seem to have been consulted – dialogues organized, the box is ticked – that’s the community’s last involvement. They never hear about the negotiation process, SR selection. There’s no involvement at all.” Among the case study countries, only one country reported seeing the final funding request prior to submission, and only two were aware of final grant design after negotiation phase. Only two countries felt that communities’ priorities were adequately included in the final funding request, and no community representative from any case study reported that they received an adequate explanation for why their priorities were not included. Reprogramming decisions were also found to typically be complicated processes involving negotiations between the Secretariat at the PR, with the CCM only required to approve and put forward decisions, rather than be

“We were invited at the last stage where the grant proposal was almost finalized, and we could not get sufficient time for inputs or suggestions on this so far. We want our productive engagement from early stage of grant planning processes through a series of consultations along with other CSO networks to have our voices heard.”
~community representative Nepal

meaningfully involved. One regional platform’s views were typical: “There’s no follow up after dialogue. We don’t have access to information. Negotiations happen with PR. It’s a real issue for people as there are a lot of issues that are not being addressed”. These issues were also identified in TRP lessons learned, the Strategic Review 2020, 2018 PCE Report, the 2020 STC Thematic Review, and the 2019 RSSH OIG audit report.

For example, the HIV prevention evaluation also found that “Engagement of KVPs and communities is strong during the design of the funding requests (at times also leading to some challenges), but generally tends to be more limited during the implementation of HIV prevention interventions... mainly because there is are no mechanisms in place to oversee

and review the implementation of Global Fund grants together with a broader set of stakeholders, including KVPs [...] PRs and SRs generally have grant implementation and grant management meetings amongst themselves, and PRs report directly to the CCM, but there is no mechanism in place to also engage with or communicate to KVP networks/organisations on grant implementation. KVP organisations are reportedly often not part of grant review meetings. The new Global Fund initiative of supporting the establishment of community-based monitoring is seen by stakeholders as a useful way to strengthen community engagement during grant implementation.”⁵² This evaluation observes this trend is not limited to HIV prevention grants, but rather a description of business as usual, confirmed by desk review, global interviews, and the case studies.

⁵² The Global Fund (2021). *Thematic Review on HIV Primary Prevention: TERG Position Paper, Management Response and Final Report*. Technical Evaluation Reference Group: Geneva.

Table 5: Community engagement overview from case studies

Case Study Snapshot

Consistently	Somewhat / mixed views	No / Unsatisfactory	n/a	Unconfirmed
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Country finding	CDI	DRC	Guinea	Lao PDR	Morocco	Nepal	Paraguay	SA	Tajikistan	Togo	%
Community engagement											
Communities from 3 diseases represented on CCM (as appropriate to grants)					HIV/TB	Only HIV grant					100%
All affected key populations represented on CCM (even if indirectly)											80%
Communities routinely meet prior to, and receive updates after CCM meetings											40%
Communities had opportunity/support to elect their representative/s on the CCM											90%
All affected communities are aware of GF and how to access information & engage with CCM											10%
CRG SI TA requested and received											20%
Communities believe GF makes effort to ensure their safety and dignity to engage											70%
Communities feel they were "meaningfully" engaged in NSP design (i.e. had influence)											50%
Communities feel they were "meaningfully" engaged in funding request design/development											10%
Communities' priorities adequately included in final funding request											20%
Communities saw funding request prior to submission											10%
Communities received explanation for why, if their inputs were not included											0
Communities were aware of final grant design after negotiation phase											20%
Communities are able to participate in grant monitoring											30%
Communities are able to participate in grant evaluation											30%
Communities have appropriate access to GF staff during country visits											10%
Communities have input into reprogramming decisions											30%
Sustainability plan for CE in place											10%

Pillar 2: Implementation

EQ11. To what extent has the GF supported community engagement and community-led responses been implemented as planned and as needed to make progress against global targets?

- a. **Describe how the implementation differ by programmatic area (i.e., HIV prevention, malaria, TB, RSSH etc.)?**
- b. **How has the situation evolved over time, including effects of COVID-19?**
- c. **What have been the main challenges to implementation and providing support at both at country and Secretariat levels? How they have been addressed? What are the lessons learned?**

Finding 8 (EQ11). Measuring overall contribution to global targets is not possible due to a lack of explicit linkages between CE and CLR and global targets, and the lack of disaggregation of data. Furthermore, measuring against plans does not fully capture potential community contributions to global progress, as the GF has limited visibility into community priorities that are not included in grants, unless they are visible from the documentations on the funding landscape that GF receives.

Measuring CE and CLR contributions to global targets was not possible, as the evaluation learned that data breaking down the role and budget of SRs does not exist at the country level. Nor was it possible to identify specific results against targets, or contributions to national results as data is not collected or disaggregated in this way. The Modular Framework only provides a few indicators that require disaggregation by provider type. Most notably, these include “Percentage of HIV-positive results among the total HIV tests performed during the reporting period,” which requires disaggregation by type of testing, “including Community testing (mobile testing, community VCT)”; “Proportion of suspected malaria cases that receive a parasitological test/first line treatment in the community,”⁵³ “Number of notified TB cases (all forms) contributed by non-national TB program providers – community referrals”. TB also includes community reports as a source of data, which could allow disaggregation by provider type. The Modular Framework is under revision for NFM4, at least for TB to ensure better disaggregation, as one Secretariat member stated, “When we disaggregate contribution of community referral – you can see huge a contribution in some countries, e.g., Bangladesh. We saw a jump in notification in DRC, Mozambique and Nigeria, even during COVID – when see jump, see it’s coming from community.” Yet this level of disaggregation has not been routinely required to date across more indicators, resulting in community contributions being less visible.

Furthermore, while CTs may be aware, the GF does not centrally track to what extent the CE and CLR activities included in the final grants is reflective of community priorities, recommended activities, and requested budgets, as this information is not included in the funding request. As discussed above, many are not included in the funding request, or are dropped during the negotiation stage. Where they were included, often expectations remained high, but activities were under-budgeted. As one KVP network representative observed, “community networks are expected to do all these things, when they get a tiny amount [...] So there are huge expectations, regardless of how much funding is received.” Therefore, assessing plans alone may not fully capture what is actually needed from the community’s perspective. An overview of high-level findings from the country case studies is presented in Table 6, with further insight into each disease presented in Table 7.

⁵³ These indicators are typically used by community health workers, which are largely outside the scope of this evaluation.

Table 6: Community-led response overview of county case studies

Country finding	CDI	DRC	Guinea	Lao PDR	Morocco	Nepal	Paraguay	SA	Tajikistan	Togo	%
Community led response											
Local CSO/s is/are SRs											90%
GF supported local CSO capacity building (technical, operational, foundational)											40%
CLM in place (specify for which disease)					HIV	HIV		HIV and TB		HIV and TB	40%
Local CSOs receive GF funding for advocacy to address barriers											50%
Sustainability plan for CLR in place											10%
Communities report adequate budget for CLR											0
Partners are providing appropriate and effective coordination and support to communities											50%
Communities aware of and use complaints mechanisms											10%
Communities aware of, understand and use technical guidance											30%
Expected contribution of CSS to national strategies/results are clear											30%
Communities believe investment in CSS is adequate and appropriate											0
CSS CLR activities are on track according to plan / targets											20%

Table 7: Overview of CLR by disease of country case studies

Country finding	CDI	DRC	Guinea	Lao PDR	Morocco	Nepal	Paraguay	SA	Tajikistan	Togo	%
Community led response by disease											
Local CSOs deliver services in HIV											100%
Local CSOs deliver services in TB											80%
Local CSOs deliver services in malaria											40%
Expected community-led contribution to national TB results are clear											30%
Expected community-led contribution to national malaria results are clear											10%
HIV CLR activities are on track according to plan / targets											60%
TB CLR activities are on track according to plan / targets											20%
Malaria CLR activities are on track according to plan / targets											20%
Communities work with government and PR to review HIV plans/progress											70%
Communities work with government and PR to review TB plans/progress											40%
Communities work with government and PR to review malaria plans/progress											10%

Another issue that was raised in global interviews, the desk review and the case studies was that the way GF measures results does not fully capture the less tangible aspects or qualitative nature of either the work itself, or the results achieved. This was reported to result in proposed interventions being dropped or significantly under-budgeted if the results could not be adequately quantified. Changes to a policy, an enabling environment, equity, gender equality, or quality of life beyond access to testing etc. are under-valued by existing measures, therefore also under-valuing community interventions. Or as one KVP network representative put it, “Measurement is not designed to capture a holistic approach.” This includes under-estimating the challenges that communities face in implementation and the additional capacity strengthening and moral support they need – yet expectations and scrutiny remains high.

Finding 9 (EQ1a). Implementation in HIV is supported by more guidance, investment and experience, and while CE and CLR are less understood and therefore slower to emerge in TB, malaria and RSSH. However, positive examples from all diseases that take a long-term approach can be replicated and scaled up.

As described under Finding 2, the GF has extensive experience and guidance in HIV, and this is also where the bulk of the GF’s investment is channeled. This partly represents the GF’s investment priorities, for example, in NFM2 and NFM3, USD 13.9 billion, or nearly half of the total USD 28 billion was allocated to HIV programming. This correlates with 47% of all grants being for HIV (followed by 22% for TB, 26% for malaria, and 6% for others). However, we can see increased focus on HIV CLR in the sub-category of Local NGO PRs, whereby HIV accounts for 66% of these grants, 15% for TB, and 19% for malaria (compared to the overall Community PR category, which shows: 54% HIV, 19% TB, and 26% malaria). This focus on HIV increased from 63% in NFM2, to 69% for NFM3. Malaria also increased from 16% to 24%. This occurred at the expense of TB, which fell from 21% of Local NGO PR grants in NFM2 to only 7% in NFM3. This is particularly interesting given that CLR contributions to TB are among the most visible, but there may be many explanations for this that are not evident from the financial data alone.⁵⁴

Another area that more focus on HIV is seen is in the provision of short-term assistance provided by the CRG Regional Platforms, which is demand driven. While responsible for supporting promoting the SI to all communities, most of the platforms have origins in the HIV sector. And while there was a concerted effort to increase demand among TB and malaria communities, this has not been observed from the data shared with the evaluation team. Of the TA requested and provided in 2017-2019, 41% was for HIV, which increased to 60% of all TA requests in 2020-2022. HIV/TB requests fell from 32% to 13%, TB increased from 6% to 8%, and malaria requests fell from 11% to 6%.⁵⁵ Further analysis of this information is presented in Annex 6.

Finding 10 (EQ1b). Investment in CE and CLR increased between NFM 2 and 3, and community response to COVID-19 has renewed interest in working with communities in the GF and by governments. However, the granularity of data required to measure overall investment in CE and CLR is missing, particularly as financial data is not available below the PR level.

With increased guidance and emphasis, there was a 66% increase in funding for CLR between NFMs 2 and 3 for interventions classified as CS&R, from USD 497 million in NFM2, to USD

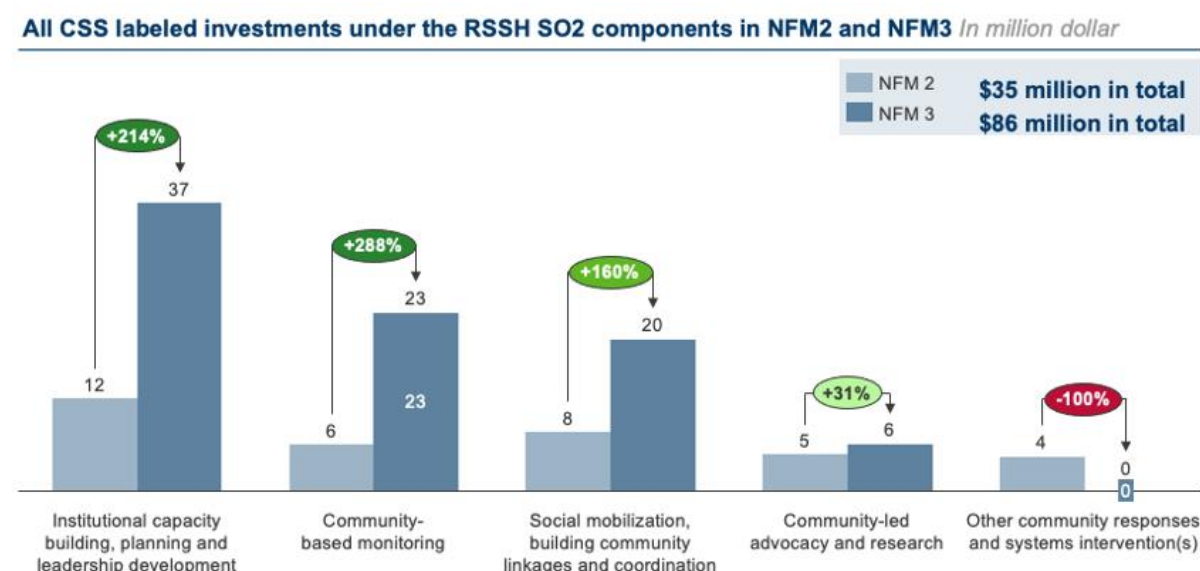
⁵⁴ From data provided to the evaluators by the Finance Team using grant data for NFMs 2 and 3. Further analysis of this financial analysis is presented in Annex 6.

⁵⁵ Based on the TA tracking data provided by the CRG Department.

827 million in NFM3. However, the largest component of CS&R disease funding (USD 165 million) was for integrated community case management (iCCM) and community health workers (CHWs) (USD 108 million) under malaria grants, and the largest component of RSSH funding was also for CHWs (\$14 million). Both of these interventions are typically overseen by the health system (although this cannot be extracted from the financial data), and therefore not “community led” by this evaluation’s definition – yet evidence of the important role that community-level service delivery does play in malaria, and that these efforts have already been integrated into the health system. Other investments in CS&R included HIV behavior change interventions (USD 65 million), HIV community-based testing (\$50 million), HIV/TB behavior change (USD 95 million), and TB community care delivery (USD 29 million).⁵⁶

In NFM2, while 27% of GF resources were invested in RSSH, only 2% of specifically for CSS.⁵⁷ However, the CSS investment increased 150% in NFM3 from USD 35 million to USD 86 million. The largest increase was seen in community-led monitoring (from USD 6 million to USD 23 million, nearly a tripling in investment), with the largest component being institutional capacity building, planning and leadership development, reaching USD 37 million in NFM3. This data is presented in Figure 4. It was also noted that absorption in NFM2 for all categories was far below average (~80%), and was as low as 49% for CLM. Overall absorption in the community sector was 73%, slightly below average. The reasons for this have not been systematically analyzed, but global interviews suggest that this can be due to many CSS-related activities requiring longer mobilization and preparation, particularly for relatively new methodologies. This can be related to capacity issues, but also indicative of an issue with short-term time frames for long-term processes. Low (or slow) absorption can also act as a deterrent from supporting such activities, as internal incentives tend to favor high-disbursement and quick-absorbing grants.

Figure 4: CSS investments under RSSH in NFM2 and NFM3⁵⁸



⁵⁶ The Global Fund (2021), “Strengthening Community Systems and Responses: Debrief meeting with Peter”, presentation, March 2021.

⁵⁷ The Global Fund (2019), RSSH Audit, Office of the Inspector General.

⁵⁸ Taken from The Global Fund (2021), “Strengthening Community Systems and Responses: Debrief meeting with Peter”, presentation, March 2021.

Overall, while funding for CLR is increasing, it still receives less attention than higher-budget (commodity-based) grants, which are both critical, and also tend to ensure higher/faster disbursements, rather than grants with longer-term, less quantifiable processes and results (e.g., capacity building and advocacy, which can be slower to start and show results). However, internal GF analysis into HIV prevention activities found that absorption for HIV prevention interventions was best under the community sector PRs – not only for KVPs, but also for the general population (92% for the community sector, compared to 74% for multilateral and 54% of government).⁵⁹ Beyond the country grants, COVID-19 created challenges for communities, but also saw communities step up and fill gaps in a way that increased recognition of their potential and contribution. Communities demonstrated that they were able to mobilize quickly to develop and implement new interventions – including filling gaps that health systems could not fill. This may also change the way that community implementers are viewed, and open opportunities for increased investment in the future. The impact and opportunities related to COVID-19 are explored further in Finding 16.

Finding 11 (EQ11c). The GF's complex processes inadvertently creates barriers to supporting nascent community organizations, and while alternative funding mechanisms exist, communities feel excluded from influence if they are not a Principal or Sub-Recipient.

The GF's existing business model, and organizational culture – which include elaborate processes to access funding, many of which focus on risk management and mitigation. This can inadvertently create challenges for implementation. This creates issues for: (a) communities' ability to receive funding from the GF, (b) communities' ability to engage in grant implementation if they are not a PR, and (c) communities' likelihood to receive the support and assistance they need address challenges. One of the causes of these issues is the potentially distorting role that the PR can play, as well as the lack of guidance to country teams in terms of supporting communities, which is left to the discretion of individuals, rather than being an institutional requirement. While there are many examples in which community-based organizations are engaged in service delivery, it is also evident that they are not always engaged as effectively as they should be in order to reach KVPs, and that governments may be playing roles that would be better assigned to communities (e.g., TB prevention in Paraguay). Dedicated effort is therefore still required in many contexts to ensure that communities are engaged more appropriately to achieve program goals.

The distorting role of the PR

With the Board Decision to routinely include dual-track financing, the Global Fund has encouraged local entities to serve as PRs, including community organizations, however, the results and perceptions of this policy have been mixed. For NFM 2 and 3, "community" PRs managed 33% of the Global Fund's grants (194 grants), and 26% of total grant funding (USD 7.3 billion). Of this amount, local NGO PRs managed 11% of the grants (67 grants), and were responsible for 9% of total grant funding (USD 2.4 billion). This implies that grant sizes for Local NGOs are on average slightly smaller than those awarded to other types of PRs.⁶⁰ Further breakdown of grants by PR type can be found in Annex 5. Different reasons for this were heard during the evaluation, including the scope of the interventions managed and who is best positioned, lack of clear guidance (regional network interview), the risk of creating parallel systems (that may delay sustainability of interventions), the risk of creating financial

⁵⁹ *ibid*

⁶⁰ Grant analysis data provided by the Finance Team to the consultants.

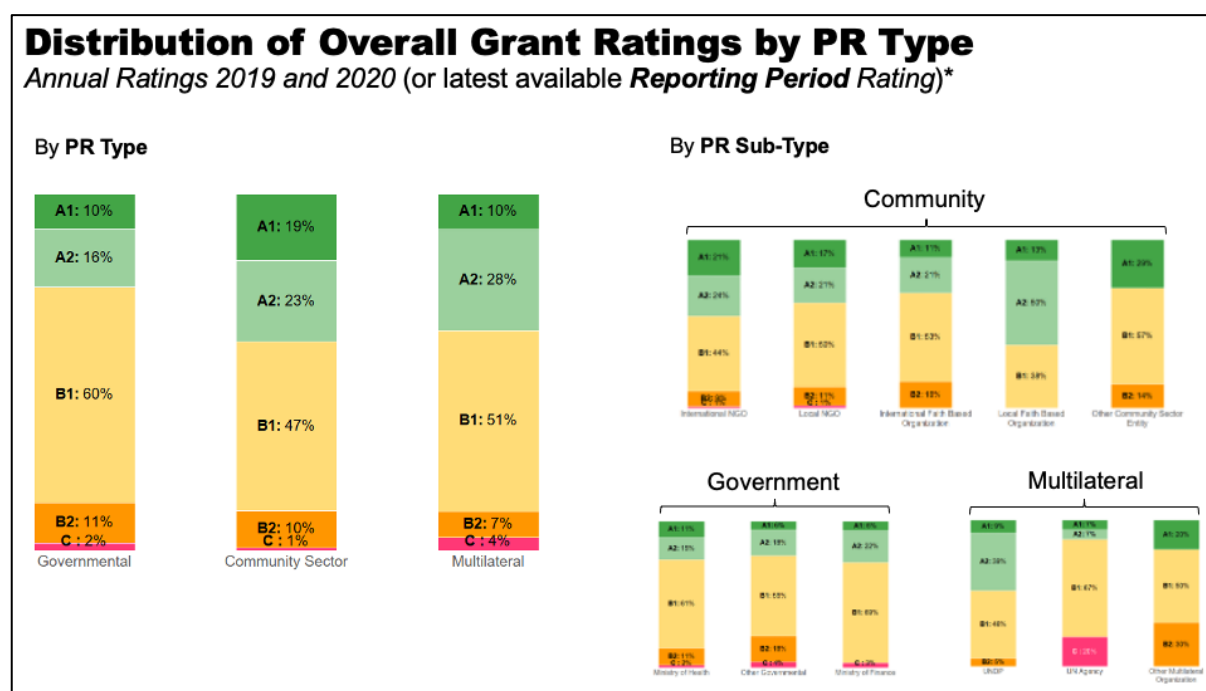
dependency (Secretariat interview), or simply the lack of space afforded to civil society (Secretariat interview). One secretariat interviewee also raised the issue that an alternative could be working with a government PR, who is “forced” to contract civil society in order to begin building the mechanisms and relationships for sustainability and transition. “If we keep it parallel, this process can’t start.” However, the same interview also acknowledged that PR-ship comes with increased visibility and influence that communities also seek.

Another constraint to dual-track financing is either the absence of local NGOs with sufficient capacity (real or perceived) to take on the role of PR – even in countries where civil society have space to operate. While many international NGOs have the capacity and willingness to support CLR with extensive in-country experience with a largely national staff, they are not always representative of communities and KVPs, and one KVP network representative expressed concern that these efforts are not sustained when they leave the country. It is important to note that the GF STC Policy highlights the importance of ensuring that Global Fund financed programs can be implemented through country systems for stronger sustainability. Yet there is not always equal emphasis on ensuring that communities are an integral part of country systems. Low capacity emerged as representing a risk to the GF – particularly in a fiduciary sense – owing to many COs lacking robust financial management and reporting systems and experience.

The GF requires all PRs to undertake a capacity assessment, which determines their capacity, and while capacity-building efforts can be taken, some CCMs may not consider some COs for PR-ship as it is assumed they will not “pass” the assessment. It should be noted that GF data shows that “Community” PRs are the best performing category, with the highest proportion of “A” ratings (see Figure 5)⁶¹. This is slightly lower for the “Local NGO” sub-group within Community PRs, but this group still performs better than government and most multilateral PRs. In this sense, the risk appears unfounded. However, only the more well-established and experienced COs will be able to become PRs, and they are subjected to a high level of scrutiny, as two Secretariat interviewees raised. One stated, “Look at reporting and risk management – it sometimes exceeds what is asked from large organizations and government. They’re asked to account for every last cent. Some investigations have revealed fraud, but they’re also subjected to a higher level of scrutiny.” Another shared an example of a small community group that “received \$5,000 for community action. It was the first time that someone was willing to give them money, and (the representative) was flown to all sorts of nice places and put in nice hotels to speak in meetings. Then when she asked if they could have the money for activities instead, she was told no, because don’t have the capacity to manage it. It is difficult to explain why GF supports representatives to travel to meetings and does not trust them to manage small amounts of funds.”

⁶¹ Data provided by the DASH team to the consultants, using data extracted from the Global Fund corporate warehouse database as of 2nd May 2022

Figure 5: Grant Ratings by PR Type 2019-2020



This is due to the fact that the GF risk matrix does not easily accommodate more nascent organizations from being funding recipients, as discussed under Finding 2. The other avenue to having more community PRs and SRs, is to build their capacity. There are excellent examples of this, however, it does not happen consistently. This capacity strengthening role is mentioned in GF guidance, but not required. For example, “The Grant Agreement with a non-national entity PR may include plans for developing the capacity of one or several local entities and a timeline for passing PR responsibility to them.”⁶² While the potentially never-ending nature of capacity strengthening was raised by two secretariat staff members, it was also noted that these efforts need to focus on effectiveness, and strengthen capacity for a specific end. The capacity assessments can result in a mitigation plan that includes capacity strengthening, and this process could be adapted to not just current contenders for PR/SR-ship, but aspiring ones.

Even as SRs, the HIV prevention evaluation also found that “reportedly Global Fund pre-requisites can sometimes preclude KVP-led organisations from being able to qualify for becoming an implementing organisation (SR or Sub-Sub-Recipient (SSR)), as KVP organisations may lack the required capacity (e.g. to deliver services, manage funds and monitor results). As a result, in a number of countries such as Botswana and Ethiopia, KVP-led organisations are only indirectly involved in programme implementation. Whilst the Global Fund requirements are important to manage risks, some stakeholders have queried whether the required SR/ SSR standard is too high and may create instances where some community-based organisations (CBOs) who have been working in communities for an extended period of time are not selected to implement, which may mean that the SR who is selected is not best placed to adequately reach the KPs targeted, and existing CBOs miss out on opportunities for further capacity building and strengthening.”⁶³ As mentioned above, PRs can be deterred from

⁶² The Global Fund (2015), “Guidelines on Implementers of Global Fund Grants”, 24 July.

https://www.theglobalfund.org/media/5663/core_guidelinesonimplementers_guideline_en.pdf

⁶³ The Global Fund (2021). *Thematic Review on HIV Primary Prevention: TERG Position Paper, Management Response and Final Report*. Technical Evaluation Reference Group: Geneva

contracting SRs who may be deemed higher risk, given that they will be held accountable for any performance or management issues. This is particularly concerning for some programs, which can require a larger number of implementers to reach different KVPs in different areas – yet many PRs are disincentivized for doing so. This also requires effective coordination among implementers, which not all PRs may be well positioned or skilled to facilitate.⁶⁴

It should also be noted that the emphasis on PR-ship is not only financially motivated, but because of the GF model, it is also where the influence lies. As mentioned in Finding 7, after funding request submission, the most substantial communication between a country and the Global Fund occurs between the PR and the FPM. Many who are not in this position, or who are not represented on the CCM, can feel cut off from the Global Fund. This was reported both in global interviews, and evident in communities' experiences in case studies.

Critical role of country teams

The CTs play a critical and extremely challenging role in the GF model, with multiple responsibilities, and many competing priorities. The workload – acknowledged within the secretariat, by global technical and KP partners, and stakeholders at the country level – is extremely high. There is widespread recognition of the multiple demands on CTs' time and attention. Additionally, some CTs may be responsible for multiple counties, while others are dedicated to one, and thus have greater bandwidth to engage with communities. However, CTs also have considerable discretion in determining what to prioritize and advocate for. Two of the four key population networks mentioned how important the CT's role is, yet how variable it can be. "Support of the CTs is crucial. When you have that support it makes a difference. It doesn't mean that the CT will tell them what to do, but just making introductions goes a long way – even just an email can open doors. Not all CTs are open to doing that... For a long time, it's been left as a personal thing – it depends more on personal opinion than policy." "It's the action – if a CT tells someone to stop interfering or says a country is not ready to have a KP on a CCM, and then they fail to deliver, it makes countries complacent. Culture cannot be an excuse."

Inconsistency was also found in how CTs are engaged in the work of the CRG SI in the country. One platform reported, "The role of CT is crucial in the whole process. When we identify a need from community, we communicate with the CCM and CT Portfolio manager to see what their recommendations are. It would be weird for us to submit a request without that discussion." But in the other regional platforms interviewed, the relationship was described as "not so strong," or non-existent when developing a CRG SI TA request. Similarly, it was understood that the design of some SIs and the selection of participating countries could also happen without CT involvement. This is problematic if the SI is seen as an additional responsibility by the CT, rather than as an active complement to supporting a country, resulting in fragmented oversight.

EQI2. To what extent has the implementation of community engagement and community-led response programs/activities at country level been timely, efficient, coordinated, monitored, and responsive to needs?

- a. To what degree have successes been enabled by and challenges been due to Global Fund processes and to implementer processes and capacities?***
- b. How have challenges been managed? What are the lessons learnt?***

⁶⁴ The Global Fund (2021). *Thematic Review on HIV Primary Prevention: TERG Position Paper, Management Response and Final Report*. Technical Evaluation Reference Group: Geneva.

c. What have been programmatic and fiduciary risks in implementing programs by community-led organizations? How can these risks be mitigated?

Finding 12 (EQI2). With several successful examples, overall, implementation is variable across contexts and highly dependent on the enabling environment and specific support and engagement by the GMD and partners, including long-term investments in capacity strengthening.

Given the diversity of contexts and grants, it is difficult to assess overall implementation of CE and CLR at the country level, which depends on many different factors. The different elements of this question were observed as follows.

Timely

As mentioned above, CLR-activities can experience implementation delays, particularly in start-up. This was also observed by the 2021 PCE, which found “that early implementation delays disproportionately affected RSSH and HRG-Equity activities and absorption remained particularly low in some RSSH and HRG-Equity related investment areas. However, regular progress reviews and grant coordination meetings among key stakeholders helped accelerate implementation of the grants.”⁶⁵ The timeliness of some longer-term efforts – such as strengthening capacity, advocacy, and preparing for sustainability – is sometimes lacking. These efforts can require implementation over many funding rounds to achieve results, which is not happening systematically (addressed in Finding 21). The current funding cycle can encourage short-term thinking, i.e., prioritizing results that can be realized and measured in a three-year time frame, however, this is not adequate to produce systemic change.

Efficient

Some CLR efforts are showing that they are able to reach targets/groups of people in ways other implementers cannot, and sometimes with greater efficiency. For example, HIV prevention absorption has been higher for community PRs than other implementers (as mentioned in Finding 10). It was found, however, that in the case study countries, Local NGO PRs have higher management costs on average compared to other PRs, which may be a result of a lack of alternative and complementary funding sources, and community resources.⁶⁶ Data was not found see whether these costs come down over time as capacity is built etc. There is also some evidence to suggest that the GF’s emphasis on efficiency and effectiveness may come at the expenses of community considerations, even when a focus on equity was prioritized. The 2021 PCE found, “evidence of NFM3 funding requests being designed with explicitly more focus than in NFM2 on improving equitable access to health services and allocating resources to intervention approaches that are known to contribute to greater programmatic sustainability. However, in some cases, efficiency and/or effectiveness considerations appear to have taken precedence over equity considerations in NFM3 grant design. For instance, in response to concerns with efficiency, some countries adjusted NFM3 PR and SR implementation arrangements with potentially negative consequences for equity.”⁶⁷ This implies that the GF may need to be more flexible when it comes to efficiency, if greater equity is to be achieved.

Coordinated

Coordination issues were identified at the country level, and between the countries and the GF. This is particularly evident in terms of coordination between SI efforts and grant activities.

⁶⁵ The Global Fund (2021), *Prospective Country Evaluation: Synthesis Report*, TERG: Geneva

⁶⁶ Data provided to the consultants from the financing team for the ten case study countries showed that government PR management costs averaged under USD 3 million, around USD 7 million for international NGOs, and over USD 8 million for local NGOs.

⁶⁷ The Global Fund (2021), *Prospective Country Evaluation: Synthesis Report*, TERG: Geneva

Some SIs were developed and countries selected without CT or country level engagement, and were therefore not widely known, locally-owned, and subsequently, not fully valued (e.g. Nepal). Furthermore, without the CT being consulted in their development, the SIs may not receive the same attention by the CTs, even though the FPM is the main point of contact with countries, rather than the SI owner. Coordination can also be limited if the PRs (where there are multiple) do not coordinate, or where there is a competitive, rather than cooperative relationship between the sectors. Government and community activities can be developed in parallel rather than as complements, resulting in less coordination. However, good practices include where there is a clear link in services, for example, between a community-led prevention and counseling service, to government or facility-led treatment, then back to community-led adherence support. For example, in Nepal, stable methadone clients (who have attended services for at least one year) at government facilities can be referred to and access methadone at community sites.

Monitored

Monitoring can be guided by the indicators that exist, which can be guided by the Modular Framework, and corporate KPIs. As discussed under Findings 8 and 18, there are few community-specific or community-disaggregated indicators. Furthermore, many community processes and results require qualitative measures, which current GF systems do not support. Another monitoring limitation can be the lack of data available. The 2021 PCE made a connection between the effectiveness of grants targeting KVPs, and the access to quality data, whereby monitoring this data would support improved programming. It reported “better-quality and/or more recent data on KVPs during NFM3 compared to NFM2... enabled grants to set up new interventions to target KVPs more precisely or widen the geographical distribution of places that KVPs would receive services. However, the quality of data (particularly the accuracy of KVP population size estimates) continues to constrain these decisions and overall allocative efficiency.”⁶⁸

Responsive to needs

Responsiveness to needs should also be considered in the context of whether communities needs were adequately considered during the NSP and funding request development in the first place, as discussed in previous findings. However, where CLR has been included, they have found to be responsive to needs of communities and KVPs. Needs, however, can change over time, and it was reported that grants cannot change as quickly as necessary. While flexibility exists, the reprogramming process can be cumbersome, and there are no requirements that communities be consulted in that process, which takes place largely between the PR and the CT, unless either party chooses to include communities. Among the case study countries, only three reported having input into reprogramming decisions (Côte d'Ivoire, Morocco and Togo. No community access to this process was reported in DRC, Lao, and Tajikistan), even though civil society were involved or consulted, this was not always representative of communities. However, examples of good practice were found in some countries, such as community-based ART in Nepal (funded by USAID/PEPFAR).

Finding 13 (EQI2a). Successes have been enabled by a combination of the vibrancy and persistence of communities, implementer processes and capacities, GF and partner support. Yet much depends on how support is provided and guidance is interpreted, which in turn depends on the openness of the enabling environment, which the partners and Global Fund levers are not consistently employed to influence.

⁶⁸ The Global Fund (2021), *Prospective Country Evaluation: Synthesis Report*, TERG: Geneva

Where things work well, GF guidance contributes to an open process where communities engage equally with other partners to contribute to improved program design. This design would include a balanced approach between public, private, and community actors, each drawing on their strengths to jointly contribute to shared disease and health system goals. Global interviews and case studies confirmed that success in reality relies on a combination of contributing factors – both within and outside the GF’s control or influence. The most critical is a vibrant, active, vocal and persistent civil society with the space to operate openly – and particularly where they have experience, capacity in advocacy, communication, and implementation, with strong networks and relationships. In particular, a mutually respectful relationship with the government – or at least one that recognizes the value and contribution of each other’s role – also contributes to success. That is, CE and CLR are more likely to be successful where there is a supportive enabling environment. GF guidance and support can help shape this environment, although efforts to do this in different contexts can depend on individual CTs, partners, and other GF efforts to address underlying issues. A regional network representative made this connection: “There is always national ownership in grant related process, and this depends country to country. In countries without democratic political structures, despite all declarations of how civil society should be involved and the agreements between government and GF, unfortunately when you look how it works in practice, government representatives on the CCM have much more power.”

The GF’s country ownership principle is an important one, however, this can mean that the GF sees the enabling environment as not just outside its sphere of control, but also its sphere of influence. As one Global Fund interviewee stated, “Because it’s a country driven process and country ownership model, the GF been reluctant to be more engaged. If we truly want to promote equity, rights and CE, there will be areas that the GF needs to do more as the GF. There’s still country ownership, but there needs to be a voice for those principles at the country. I’m not sure GF is doing this as loudly as it could.” A Secretariat interviewee noted, “Country ownership terminology is a little dated. Of course, it’s there. It’s their country, their MOH. But we use it as a cover when we have a lot of soft influence, or it could be the voice of a partner in the country. We should be accountable in how we do it. We leave a lot to individual discretion”. Another Secretariat staff member mentioned that “something we’re not doing enough of and that would have big impact is for CTs to have in their job descriptions to visit communities, just like do for ministries when on mission. If do that, switches narrative from country ownership being government to country ownership being government and communities – as highlighted in Partnership Enablers in the new strategy. This would help change perceptions, understandings and attitudes.” As discussed in Finding 11, a supportive CT is an important success factor.

The role of partners can also play an important role here, particularly as they are on the ground and therefore have direct knowledge and influence. There are successful examples of joint efforts that have enabled successes and progress, for example, in South Africa where the funding request learned from experience in CLM supported by PEPFAR, to then obtain GF support to scale it nationally. Similarly, in Nepal, PEPFAR/USAID-funded on-line feedback system of CLM has now been accepted at the national level, and is now in the process of integration into the Global Fund supported program, under C19RM funding. In Togo, USAID West Africa established a CLM system in May 2021 to monitor stigma and access to testing and treatment services. The provision of TA by partners, as well as through the CRG SI, has also contributed to success, for example in generated necessary data to inform decisions, ensuring broader community engagement in country dialogues and funding request development, as well as in strengthening capacity of key organizations and networks.

Finding 14 (EQI2b). Capacity and turnover in community organizations are key challenges requiring understanding and support, however, efforts in strengthening capacity over the long-term are delivering positive and replicable results.

COs can face many internal challenges, not only within each organization, but also between them as their diversity means that they do not always agree and cannot speak with one voice. A stark example of the challenges that some CBOs can face was identified in Tajikistan by the HIV prevention evaluation where systemic discrimination and harassment actually reduces the lifespan of people living with HIV, who are also responsible for delivering HIV prevention services. Other challenges stem from GF's current model with its conservative approach to risk, and internal incentives and processes that prefer clear-cut, large-scale, fast spending grants with quantifiable results, implemented by proven organizations. In this sense, the GF funding CLR is a square-peg/round-hole situation. However, innovative solutions have been found, particularly where there is a commitment to strengthening capacity and connection of COs. "For example, in 2017 the Kenya civil society PR, the Kenya Red Cross, provided support to CBOs during the development of funding requests. As a result, a number of Kenyan community groups are now well-established implementers and some even managed to obtain PEPFAR funding during following years for additional programme implementation. Similarly, reportedly CSOs have provided useful and cost-effective South-South collaboration, such as Frontline AIDS bringing together Ukrainian civil society HIV prevention specialists working with Kenyan HIV prevention CBOs to build capacity for harm reduction programming in Kenya."⁶⁹ A regional platform added that that Red Cross has prioritized developing the capacity of KP organizations, by taking a long-term perspective. "Many CBOs don't get funded because don't pass the due diligence test. So Red the Cross took a grant cycle to work with these groups to support capacity, so by the second funding round, they could take them on as SRs. Understanding and replicating these successes both strengthens capacity, while support country-led initiatives and relationship building."

Kenya was cited as a good practice example in a number of interviews,⁷⁰ even though the process is not a smooth nor linear one (see Box). Global Fund and external interviewees noted the importance in investing in standout leaders - preferably more than one - who can engage with the GF process effectively, while bringing their constituents along. This also included providing not just training, but mentorship, which led to greater engagement over time – from NSP development, funding request narrative development, as well as the budgeting process. Kenya was also cited as effectively using virtual engagement to “democratize processes”, which then allowed engagement that could brought “insight and perspective that was translated into project design, budget and targets.” Kenya was also cited as being able to organize KPs not only around GF processes, but more broadly, indicating a deeper level of capacity and maturity. Kenya has made good use of available GF tools and the support available, such as requesting TA to better understand the Malaria Matchbox Tool. They also developed their own Kenya-specific guidelines of some KP-specific tools, to ensure that they were well-adapted to the context, which supported understanding and country-level accountability.

“Kenya started with a lot of noise from the community, but translated that to balance noise with program design, and they understood programming and could carve out those parts of the program that they could perform... It was organic – not necessarily a continuum.”
(Secretariat interviewee)

“Kenya is an example of KPs organizing using CCM as part of their organizing without necessarily organizing around the CCM. They have quite an inclusive and advanced narrative on the importance of involvement.” (KVP network interviewee)

⁶⁹ The Global Fund (2021). *Thematic Review on HIV Primary Prevention: TERG Position Paper, Management Response and Final Report*. Technical Evaluation Reference Group: Geneva

⁷⁰ Ten interviews cited Kenya as a good example: four Secretariat, four KVP networks, one technical partner, and one regional network

Another challenge raised by global and country interviewees is that there are instances of where capacity is strengthened, these staff may leave the CO for more stable or influential alternatives. This contributes to staff turnover in COs, and investments in capacity strengthening are lost to that organization. One cautionary note was shared by a technical partner regarding the challenge of finding the right balance between capacity strengthening, and disconnecting COs from their communities: “We’ve had a cadre of strong individuals who are so literate in GF, it’s almost taken them away from communities. They are now experts in jargon, politics, dynamics – which is different from what’s needed on the ground. I wonder if there’s been unintentional professionalization, taking them away from their work, to more global level think that that’s more cerebral than practical.” Good practice includes ensuring that multiple people are trained, and receive sufficient incentive to stay with their CO.

Finding 15 (EQ12c). Community PRs are among the best rated, yet many community organizations do not meet the current capacity requirements to become grant funding recipients. Other forms of contracting – such as social or service contracts – remain small-scale and require further exploration.

As discussed under Findings 11 and 14, community PRs – including local NGOs – are among the best rated grants in terms of performance. Yet many COs are not selected because they are considered too low capacity/high risk. However, the current capacity assessment and risk approach may take a differentiated approach in theory that can weigh up relative risks against a planned project or budget – but the capacity assessment tool is the same for all. Many CO grants can be quite small scale, running low-risk activities, with minimal procurement etc., hence they should not be held to the same systems standards as PRs who will be managing large volumes of commodities. Furthermore, the LFA may decide interpret requirements strictly, and PRs may be unwilling to take on many SRs, particularly if they have concerns about risks that they will be held accountable for. Much of this can depend on the PR’s own appetite and capacity to provide support to SRs, and as the Kenya example from Finding 14 shows, these risks can be mitigated through a longer-term approach to strengthening capacity.

Current perceptions suggest that in practice, the GF places greater emphasis on financial than programmatic risk. This is understandable given the reputational risk it faces in the case of fraud or financial mismanagement. Risk mitigation and reporting requirement also place a heavy reporting burden on PRs, which can be overwhelming for smaller organizations who may be less well set up from a staffing perspective to meet GF expectations. Alternative funding mechanisms do exist that can both (a) reduce the need for a capacity assessment, (b) reduce onerous reporting requirements. These include social contracting (discussed more under Finding 21), service contracts, or performance-based contracts, such as payment for activities, or payment for results. These models require that services be provided or results delivered, while minimizing the financial risk to the GF. They can, however, be accompanied by different management requirements, higher transactional costs for the Secretariat, and may again depend on a willing PR.

EQ13. To what extent have community-led organizations been enabled and supported to respond to COVID impacts on HTM programs and how did they contribute? How has the COVID-19 pandemic affected the implementation of the support? What are the lessons learnt for any future design of the approach?

Finding 16 (EQ13). COVID-19 created challenges for CE and CLR, yet the communities’ ability to reach the most vulnerable during this time – with services, commodities, support, and accurate information, as well as conduct research and fill critical gaps when

the public sector was unable to – highlighted their capacities, flexibility and resilience, generating opportunities and lessons learned on how to more effectively engage communities in national responses, RSSH, and pandemic preparedness and response.

GF and external interviews were generally enthusiastic about the capacity, resilience and innovation that communities demonstrated in response to the COVID-19 pandemic. Many COs and their constituents faced not only a health crisis, but also an economic one – particularly when reliant on volunteers or part-time staff who may have lost a source of livelihood. Communities – particularly KVPs – faced additional challenges to access their treatment, and in some cases, also enough food to meet their nutritional needs. Nevertheless, many COs stepped up both support COVID-19 responses in terms of providing accurate information and distributing personal protective equipment, as well as filling service gaps to ensure that KVPs were not cut off from critical treatment. For example, in Morocco, community-led organizations delivered ARVs and methadone directly to KVPs, allowing them to stay home rather than exposing themselves to risk by going to the hospital. In Paraguay, CSOs distributed some food and essential items that were needed by communities (even though such activities were not eligible for C19RM funding).

The shift to more remote support and engagement created less contact and insight into what is happening on the ground, and CTs reported feeling cut off from their countries. Yet at the same time, more virtual events but also allowed for more participation in meetings, webinars, training etc. The CRG SI provided data packages to ensure that communities could join online meetings, which overcame one of the barriers that many faced. Although issues with remote access was inevitably an issue. Like the rest of the world, communities and the GF learned how to improve virtual communication, and even now as travel becomes possible again, some of the advantages of virtual participation may result in a hybrid approach being used.

Some lessons were also learned that will be useful for the GF's evolving pandemic preparedness and response objective under the 2023-2028 strategy. This includes the importance of involving communities earlier in data collection and planning phases, in order to ensure that there is a good understanding of the impact on KVPs, and to ensure appropriate community mobilization is built in quickly. The GF's own response through the COVID-19 Response Mechanism (C19RM) also demonstrated rapid learning and adaptation in response to a survey conducted among civil society. This revealed greater satisfaction with the second iteration than the first, which included more and earlier CE, as well as more transparency.

EQI4. Is GF sufficiently active in identifying/supporting identification of community actors that could be engaged to maximize community interventions impact?

Finding 17 (EQI4). The Global Fund has made major contributions to identifying and supporting community groups and networks across all three diseases. However, countries are not routinely identifying community actors whose work could contribute to its results – particularly outside the capital cities, or beyond the three diseases. The current PR and CCM-centric model has inadvertently created “in groups” and “out groups” of communities. Partners can offer insights, but this coordination does not consistently occur.

While in some contexts, the GF has done an excellent job of reaching out to different communities to ensure their inclusion in processes, in others, this may not be done broadly or often enough to ensure sufficient identification of community actors. In some countries, involvement can be based on “who you know”, or which networks a CO is connected to. Regular mapping – for example, prior to each funding cycle, is not a requirement, so there may not be the pro-active inclusion of fresh faces. Networks also tend to extend to COs that

focus on HIV, TB and malaria, and a wider scope may be necessary. This may include organizations working on sexual and reproductive rights and health, gender, human rights, UHC, and the sustainable development goals. Some countries already do this pro-actively, and it can help overcome a limitation faced by the only being able to engage organizations that already exist. This has been a constraint in malaria, for example, where there has been less community mobilization, or perhaps more specific groups that may have difficulty organizing, such as prisoners and ex-prisoners, and displaced people. A consistent mapping could also help identify these gaps, and GF has had success in supporting COs and networks to fill them.

In addition to who is included, it was also noted in the case studies (e.g., DRC, Paraguay), that COs based in the capital cities are more likely to be included and invited to meetings. Although countries such as Nepal were better at reaching out. Supporting community actors outside cities and in provinces can be more challenging – even for national networks – as it's harder for them to attend meetings (particularly on short-notice), and even internet access can be a barrier to remote participation. Often the regular interaction from proximity can help build the trust and relationships necessary to ensure cooperation.

One of the challenges raised with engaging the right COs is the risk – and reality in many countries – of the formation of “in groups” and “out groups”. The “in groups” include those on the CCM or PR/SR/SSRs. There may be a wider circle of their allies and natural partners, but many COs feel cut off from the Global Fund. Some countries referred to a “circle of friends”, where CCMs tend to include the same people who have an incentive to remain on the CCM, which may conflict with their role of representing the community if they are not willing to rock the boat. While there is guidance around term limits, it has also been raised that it can take time to build sufficient understanding and capacity to be effective on the CCM, so it is a delicate balance to strike between becoming experienced, and becoming entrenched.

Pillar 3: Results

***EQR3. To what extent have the interventions implemented by communities achieved their intended objectives as mentioned in their plans?
Are the results different by programmatic areas (HIV, TB, Malaria, RSSH)?***

Finding 18 (EQR1). Due to the lack of data collected or appropriate disaggregation, it is not possible to determine the extent to which community objectives have been achieved globally. SR results are integrated by the PR and may not be disaggregated for the GF to monitor. The country case studies, however, suggest that results are largely positive, and while more visible in HIV, they are also emerging in TB and malaria.

CRG reports to the Board share strong examples of the results that CLR can deliver. However, due to the way in which data is collected and reported (e.g., lack of disaggregated of SR and SSR data in PR reports, or lack of disaggregated results by sector), it is difficult to go beyond the anecdotal to a more general understanding of community results. The evaluation team also did not have access to all the necessary data to do a systematic review of results against targets. Therefore, most information in this finding remains anecdotal. (It is also worth remembering that, as discussed in Finding 12 above, as not all community priorities are included in final grants, plans may not correspond with needs).

In South Africa, the key benefits of CLR were identified as the expansion of HIV prevention interventions – particularly for KVPs and AGYWs. Community-based monitoring is also scaling up, including social accountability monitoring for sexual and reproductive health and rights.

CLR is also generating additional data on HIV and TB services, including using digital tools. The case study also found that collaborative policy advocacy actions are addressing HIV and TB service challenges faced by KVPs and AGYW). Capacity strengthening and community mobilization are also important aspects of these interventions.

In Morocco, communities demonstrate both the efficacy and scale of their efforts. While community testing is only 10% of the testing done in Morocco, they are detecting 50% of the HIV cases, indicating effective targeting. Similarly in DRC, communities were expected to contribute 26% of all notified cases, and delivered 31% of results by the end of 2020. In the first half of 2021, the result was 32% with a good follow-up (97%) for treatment success. The country is currently planning to increase community targets to reflect this success. In Togo, key informants in HIV reported that: *“Most of the people tested by communities were never reached before and this shows how community organizations are unique and essential.”*

In some countries, the CLR works closely with government. For example, in Nepal, a community representative observed “We are supporting or complementing the government to reach the national targets and serving our communities. In this case, they (government) should think this as complementarity – and value our strength as network working for and by the community.” However, in other case studies, the CLR contribution to national targets was muted. For example, in Cote d'Ivoire, stakeholders reported that community engagement in HIV service provision is minimal. “The communities must be at the center of the fight, but in Côte d'Ivoire the clinic still seems to be predominant. Today, in the fight against HIV, everything is centralized at the level of the national Program, including the management of condoms: how can key populations (SW, MSM, Transgender, etc.) come to the PNLs when they need condoms without the risk of being stigmatized? How can confidentiality be guaranteed in this situation?”

EQR2. To what extent have these interventions contributed to the results of the national programs of the three diseases and RSSH in general? How well have the various community programs supported by the GF at country-level been complementing each other and collectively contributing to achieving country results. How could have the results been improved?

Finding 19 (EQR2). In the case studies, national stakeholders reported that it would not be possible to implement country programs without CE and CLR. However, unless data is disaggregated by community contribution, it cannot be determined to what extent community interventions contribute to national results, or are addressing rights- and gender-related barriers. Where disaggregation exists, there are visible contributions in all three diseases, however complementarity cannot be determined.

Case study data shows that in most cases, national stakeholders believe that CLR makes a vital contribution to the national response. For example, TB government representatives in Tajikistan reported that the community contribution was absolutely critical to identifying new cases, because community organizations have the capacity to reach remote or other difficult-to-reach vulnerable communities, and that community organizations have significantly improved the impact of the TB program. The case studies also revealed a tendency, however, to conflate CLR with CHWs or village volunteers, particularly in the case of malaria⁷¹. In these cases, key informants report that CHWs make an important contribution to the malaria response. For example, in Lao, when discussing the contribution of CLR to national programs,

⁷¹ The evaluators acknowledge that community organizations can employ or deliver services through CHWs, or peers (a sub-set of CHWs), however as CHWs in general are outside the evaluation scope, this was not explored, although peer educators were considered.

key informants reported that village health workers and volunteer village malaria workers increased access to health services – including HIV and TB services – particularly in remote villages and among key population groups, improved adherence to treatment, and increased the quality and coverage of sexual and reproductive health services.

“GF has made a significant contribution to strengthening civil society, particularly in terms of governance, grants monitoring, human rights through the Observatory; accountability inviting civil society organizations to report not only to the GF but also to national authorities” - Togo

CLR has also shaped the national response in some cases. In Guinea, for example, the peer educator approach utilized by CLR interventions became the national norm. In South Africa, CLR has driven expansion of the AGYW, harm reduction and key populations HIV prevention interventions. In Nepal, CLR supported by the Global Fund is the backbone

of the harm reduction program for PWID, with all HIV prevention services for PWID provided by COs, and community-based opioid substitution therapy (OST) is also provided in community settings, (in addition to government clinics), while USAID/PEPFAR supports CLR interventions with sex workers and the LGBTI community. In DRC, data from the TB program shows that community case finding met and even exceeded targets. The support of or coordination with partners can be a strong contributor to success and scale, as mentioned in Finding 13 above, with the GF able to build on the CLM efforts initiated by PEPFAR.

EQR3. What internal and external factors are contributing the most to a successful community engagement and community-led response?

Finding 20 (EQR3). Global Fund requirements for CCM membership and community representation ensure CE takes place in GF processes, particularly up to funding request design, and notably particularly in countries that would not do this otherwise. CLR tends to be more effective when its need is understood and supported by the government. Both are more successful in a supportive enabling environment, and catalytic funding has been critical to some gains achieved, but has been limited in scale.

Global Fund CE requirements have played a catalytic role in ensuring communities are actively engaged in critical processes, especially during development of the funding request. In Lao, community dialogue fed directly into funding request development and in Nepal, communities and their representatives engaged in all aspects of funding request development. Conversely, in some cases, communities felt that their ability to input meaningfully into funding request development was minimal, despite Global Fund CE requirements. For example, in Tajikistan, communities reported that the formal requirements of CCM engagement – such as the need to submit questions in advance of the meetings, and the need to respect the “chain of command,” a prohibition on observers attending CCM meetings, and severe stigma and discrimination (for the LGBTI community) – made it challenging for communities to contribute in the context of CCM discussions.

The evaluation identified a fascinating study in Cote d'Ivoire⁷² that tracked CCM members' participation in meetings by analyzing the number of speeches from each sector. Although the method does not take into account either the duration of the interventions or their quality, and was based on manual note taking, it did identify important trends: It showed that CCM discussions were dominated by international cooperation representatives (PEPFAR, Coopération Française, UNAIDS, WHO, UNICEF, PAC-CI and independent observers), with an estimated 50% speaking time, while civil society representatives participated in 14% of the

⁷² Anne Bekelync (2019), Côte d'Ivoire, a case study of power relations: PEPFAR - Global Fund,

exchanges, which were mainly due to its two members serving as Vice-Presidents in the Executive Bureau and 6% of the national public sector.

Weak community engagement in CCM meetings was also noted in the case of Togo, where community representatives reported that civil society representatives on the CCM were not vocal enough, generally due to capacity gaps. *“Civil society is characterized by great diversity in skills and understanding. Some associations are neither sufficiently formed nor structured. The technical capacities of these associations are relatively weak. There are people with a low basic education”.*

Requirements for CE in Global Fund processes have also had positive spill-over effects into national processes. For example, in DRC, the CSO SANRU actively participated in the developing and implementing national plans (malaria and community health). Similarly, in Nepal, CSOs actively participated in the HIV National Strategic Plan development in the context of national and regional consultations that engaged communities together with the range of stakeholders across all of Nepal's seven regions. In Togo, community organizations were closely engaged throughout the NSP development process, identifying priority areas, implementation challenges, developing recommendations and target setting. In other countries, however, community engagement in NSP development remains sub-optimal. For example, one community SR in Côte d'Ivoire reported, *“During the development of the NSP, our CSO did not take part directly in the development. Our views and opinions are collected by email by Alliance Côte d'Ivoire. Similarly, during the national dialogue, it is Alliance Côte d'Ivoire that participates and shares information with us by email. In the future, we want to participate as individuals to ensure that our opinions are indeed taken into account. We believe it is important to identify communities at all levels of decision-making.”*

EQR4. To what extent is sustainability addressed in community engagement and community-led responses (e.g., alignment with any government efforts to establish/strengthen community health program; clearly articulated plans to secure sustainable financing for core activities)?

Finding 21 (EQR4). Progress has been made in establishing institutional, and to a lesser extent financial, sustainability. Positive and replicable examples of institutional and financial sustainability exist for CLR, with more examples of institutional sustainability for CE. Overall, however, sustainability is not consistently adequately planned for or supported in terms of time and resources.

Sustainability is recognized as a challenge across the board, as is inevitable when significant donor funding is relied upon for years, yet it was not a part of the GF's architecture until systems, habits and expectations were already well established. As funding requests aim to support NSPs, long-term thinking should be evident, however preparing for sustainability can also span multiple plans. The funding cycle does not actively support or encourage countries to take a long-term approach to sustainability planning and domestic resource mobilization. This has since changed and the GF's STC policy has required increased focus on and domestic funding for KVPs in transitioning countries since 2016. However, the focus of these efforts has been more on transitioning countries, rather than building these considerations in from the beginning.

The 2020 STC thematic review came to the same conclusion and also observed that also found that “Most KVP [key and vulnerable population] and human rights interventions are funded through external sources, regardless of proximity to transition, and are at risk of neither being scaled-up nor sustained.” And “Existing governance structures (e.g., Global Fund CCMs) may constrain sustainability”.⁷³ This implies that COs may be forced to focus on survival rather than their mission, and they risk losing their influence when the GF leaves, as

“The huge dependence on external funding is likely to constitute an obstacle to the sustainability of the fight. In 2016, GF funding represented 95% of all funding received by Alliance Côte d'Ivoire. This proportion had slightly decreased and was 82% in 2019. With COVID-19, dependency GF funding represents more than 90%. We are aware that such dependence will not allow us to envisage the sustainability of the activities we have undertaken.” – Cote d'Ivoire

the CCMs are often the only forum in which communities have a voice. The CCM Evolution SI introduced updated guidance in 2020 on Positioning, which “encourages all countries to build on their national structures, wherever possible, and to position the CCM and/or CCM functions within existing health platforms to contribute to central coordination of health programs and investments.” This is an excellent initiative, although specific examples of its implementation were not found.⁷⁴

This evaluation approached sustainability from both a financing, and institutional perspective. For financial sustainability, there are some good examples of countries increasing their contributions to supporting KVPs, even prior to transition (e.g., the Dominican Republic), which should be celebrated and learned from. It also suggests that sustainability planning does not need to wait until transition is imminent. The GF is also strengthening its experience in social contracting, and some good practices have been identified – particularly for service delivery. From these examples, best practice is where long-term scenario planning is used to develop each cycle of funding requests, to progressively build community capacity, government mechanisms, and the necessary trust and relationships over multiple grant cycles. A key ingredient for successful social contracting is the government’s recognition of the importance of the CLR to public health goals. Once this is clearly established, the rest – developing an accepted package, and ensuring an appropriate contracting mechanism is in place – may happen by the government itself, or can be done with additional technical assistance. These lessons also highlight the importance of focusing not strengthening community capacity – including to communicate effectively with the government – but the evaluation agrees with one Secretariat interviewee who stated, “if we’re serious about building sustainability [...] we need some complementary investment in government to make sure that communities are given more space and opportunities to engage, invited to the table, and a deliberate attempt to really build a campaign approach so that community voices and perspectives are sought out and recognized as important contributions to health impact.”

Best practice suggests therefore that community-government capacity and cooperation is built over multiple funding rounds. Examples of this happening were cited most often in HIV – particularly prevention, treatment and support for adherence, with some examples in HIV treatment, and TB screening and diagnosis. No social contracts were identified in malaria (although growing institutionalized sustainability of iCCM and CHWs are the equivalent of the government supporting community-based – although not necessary community-led approaches, and financial sustainability is not yet in sight). There are currently no known social contracts for CLM, however, that could be an appropriate service for the government to contract to communities, particularly if it contributes to its own health management information system (HMIS). One Global Fund interviewee suggested that the GF could help build the habit

⁷³ The Global Fund (2020), Thematic Review on Sustainability, Transition and Co-financing (STC) Policy: Position Paper, Management Response and Report, Technical Evaluation Reference Group: Geneva.

⁷⁴ The Global Fund (2020), “Country Coordinating Mechanism Guidance Note: Positioning”

of the government and communities working together by requiring that funding requests include an appropriate mix of service providers, rather than just the government – to build ownership over time.

Across the case study countries, growing interest among governments to support communities was evident. In Cote d'Ivoire, the government has set up a matching fund for CSOs, and a “Cell in charge of support for CSOs” has been set up by MoH to provide financial support for community activities. In Paraguay, a study on social contracting has been completed and a pilot will start soon, however, no community key informants believed they would succeed in accessing support via social contracting. Similarly, in Nepal, while social contracting was in place until 2015 when it was discontinued, a feasibility review is now underway and there are plans to re-start social contracting. In Tajikistan, social contracting is in place in both HIV and TB.

The case for sustainable community engagement is more complex. There are examples of communities now being integral parts of the NSP development process – as is the case in Nepal, which institutionalized the role of communities in health systems. However no other examples were found for continuous engagement, or coordination/decision-making bodies outside of the CCM that communities will be able to play a role in after the GF. No indications were found for the sustainability for community-led advocacy, and it is unrealistic to expect governments to pay for their own watchdogs. This may, however, be an important role for partners to play, to ensure that this role continues. The issue of country ownership also arises as a potential limitation to sustainability if this is understood to mean government ownership.

As one regional network explained, “Georgia had a perfect transition plan: it had a budget, M&E plan, it was detailed, civil society was involved, and they did an analysis on whether civil society needs were addressed – so the process was good. But it got stuck when it needed to be approved as a guiding document for the country. It was considered by the Ministry of Health and the Ministry of Finance, not as a GF-related activity through the CCM, but government ownership. And it didn’t happen in Georgia.” Once again, the enabling environment can trump GF processes,

“We’re not challenging country ownership by ensuring that things we care about are taken on board. Hiding behind country ownership is like saying they can steal the money because it’s their money – it’s the same thing. We should be watching them just as carefully on the programmatic side if we’re not getting what we want. We’re doing it because it gets us to where we need to be, and the data is telling us that. It’s a programmatic imperative.”
(Secretariat interviewee)

and the government can overrule civil society, particularly where decisions are made outside the CCM. In short, the GF can use its guidance and partners to encourage an earlier and sharper focus on sustainability – at least for CLR for service delivery and CLM – with partners having a role to play to address advocacy and continuous community engagement.

EQR5. To what extent have community led responses become integrated and embedded in the national health system e.g., Joint planning, trainings, national strategic planning?

Finding 22 (EQR5). The extent to which community responses have become embedded in national health systems is variable, with positive examples evident where there is a vibrant civil society and supportive enabling environment.

As with most findings, the extent to which community responses have become embedded in national health systems varies with the context, specifically, the enabling environment and the capacity of communities to deliver appropriate responses that deliver visible results, and then again, the enabling environment’s openness to these processes and results. The country that

was cited the most often in global interviews in terms of integration was Ukraine. This is a country that has received significant long-term and concentrated GF attention and support in the form of grant funding, and SI support, including Breaking Down Barriers supporting advocacy and networks. Civil society also received long-term capacity strengthening funding from other donors to strengthen its network of community advocates. Over time, the government increased its domestic funding of KVP activities, and the country took over more service delivery which is open to bidding.⁷⁵ A Secretariat interview observed, that the number of NGOs in Ukraine increased from one to hundreds organized in an elaborate network – mostly funded by the GF. This is now considered well entrenched to the point that “the culture has changed in Ukraine.” This is largely because CBOs are recognized as bringing a specific expertise that the government needs, but doesn’t have.

It should also be remembered also that potentially the best example of a community-led or community-based initiative that has been embedded in national systems are iCCM and CHWs, typically to provide malaria prevention, diagnosis and treatment services – yet these are outside this evaluation’s scope. It was also noted that with some exceptions, these are still struggling to be fully integrated into national systems, with some positive examples emerging of more self-organizing CHWs. It does demonstrate, however, that there is a pathway to integration when the government recognizes the value (either programmatically and/or financially) of community efforts. A clear example of this was the community-led effort to reach hard-to-reach populations with malaria services in and around remote forest areas of Cambodia, particularly near the Lao and Vietnam borders. The creation of mobile malaria workers (MMWs) – who were best placed to know where and how to find these groups who may not have wanted to access government services – proved so successful in identifying and treating malaria cases in drug resistant areas, that they were integrated into the national health system.⁷⁶

There is also evidence that more CLR is being included in national health system processes, such as inclusion in national strategic planning, the integration of community-generated data into HMIS. One of the objectives of the CLM SI is to develop best practices to integrate CLM-data into HMIS for scale-up and replication, which this evaluation fully endorses.

Pillar 4: Lessons Learned

EQL1. What changes should be introduced to the GF Business Model in relation to GF internal policies, processes-funding request–grant making), implementation – monitoring- grant revisions and reporting) to operationalize the high priority objective given by the new strategy to the community engagement and community-led response

- a. What conditions (in line with the adapted risk appetite) should diverse community organizations meet at different levels to be supported?***
- b. How can the inclusion of communities during the development of funding requests/grant making be further enhanced?***
- c. What are the key factors that drive successful community action that could be highlighted in Global Fund guidance?***

⁷⁵ As an aside, the Secretariat interviewee who raised this mentioned that as service delivery is now market driven, the community aspect of it can be diluted – presenting a dilemma for prioritization between community-led or market-driven services.

⁷⁶ For example, S. Canavati *et al*, “Village malaria worker performance key to the elimination of artemisinin-resistant malaria: A Western Cambodia health system assessment”, *Malaria Journal*, Volume 15, Issue 1, 20 May 2016, Article number 282. <https://research-portal.najah.edu/migrant/16554/>

d. Are there M&E plans on community engagement and led responses? What needs to improve in terms of meaningful indicators and approaches?

Finding 23 (EQL1). Current systems, incentives, processes and measurements are not as well adapted to supporting diverse organizations, or small, iterative projects that have longer-term and evolving results in complex settings, compared to larger, commodity-based projects with fewer components.

The GF is in the difficult position of needing to limit its overhead and management costs, and be fully transparent and accountable, while fulfilling its commitment to equity, CE, and supporting CLR. Through job descriptions, checklists and general messaging, the current emphasis appears to be on (financial) risk mitigation and following processes, which places a heavy burden on Secretariat staff and implementers – while also creating barriers for communities to receive more support. The following findings propose revisions to existing guidance that may create more opportunity for CE and CLR, while also providing a level of accountability.⁷⁷ However, changes in policy must be

“We need to include the messiness of communities... when it becomes less messy, it becomes less community. We’re dependent on third parties to know this. Donors in country see things differently from looking from outside, and they have the capacity to inform us.” (Global Fund)

accompanied by a shift in mindset that is more open to accepting a greater degree of ambiguity, being willing to work through complexity, and respond to dynamic situations. It may also require engaging more directly with partners to better understand and respond to evolving contexts. In short, it may require that more GF Secretariat staff shift from an administrative to an advocate mindset.

This evaluation also sees potential for greater integration of key elements of the BDB and CRG SIs into all grants, including ensuring that the necessary data is in place to support funding request design. This was also recommended by the 2021 PCE recommendation to build on “the success of strategic initiatives and/or matching funds in incentivizing grant investments in reducing equity, human rights and gender related barriers to accessing services, prioritize scaling up across the portfolio and incentivizing such investments through mainstream grant management operations.”⁷⁸ There are many design elements and lessons learned that can be included in funding request guidance to signal that these are priority investments.

Finding 24 (EQL1a). The absence of a way to categorize community organizations by maturity level and a differentiated risk matrix makes it difficult to make appropriate decisions based on risk for different types of organizations for different types and scales of activities.

The evaluators recommend that the GF develop a differentiated risk matrix based on (a) the type and value of intervention proposed, and (b) the type of organization. As mentioned in Finding 1, the CRG Department is currently developing a taxonomy of different COs, based on their maturity level, and this can be used to manage expectations and transparency around what types/levels of COs are suitable to carry out which type of intervention/budget level, with which level of scrutiny. This taxonomy may, for example, classify COs as “nascent”, “developing”, “mature”, “established”, based on their longevity, systems in place, reputations etc., with each level being considered appropriate for certain interventions/budgets. Regional platforms could establish mentoring relationships between more developed and more nascent

⁷⁷ Please note that due to the framing of the evaluation questions, these findings tend to blur with recommendations, which was accepted by the Technical Oversight Committee.

⁷⁸ The Global Fund (2021), *Prospective Country Evaluation: Synthesis Report*, TERG: Geneva

COs to facilitate south-south learning, as occurred successfully with a Côte d'Ivoire PR coaching an emerging PR in Mali. This taxonomy will also give the GF a clear language to discuss COs, beyond CLOs, CBOs, KPLOs, NGOs, etc., which do not necessarily reveal anything about their capacity.

Finding 25 (EQL1b). Guidance regarding community engagement in grant processes do not set clear enough expectations. While countries should be able to adapt to their context, in the absence of minimum standards or more illustrative examples, this engagement will remain sub-optimal in most contexts.

“Tick the box” requirements for CE have not resulted in meaningful CE in contexts where the enabling environment is not supportive. While the CCM Secretariat orients new and existing community members, and some budget is available to support this, additional minimum standards could be considered, such as training for prospective CCM community representatives – including orientation on the GF, their role, and potentially even communication and advocacy training.” Some partners have done this effectively and could be engaged to support this, and these best practices could be considered by the CCM Evolution SI, which is currently developing training on using CLM data at the CCM. Meeting agendas may include an item to ensure that community has the opportunity to speak up. The process guidance could also include requirements that: (a) communities – via the CCM representatives – receive a copy of the final funding request prior to submission with an opportunity to ask questions, (b) the PR provide a response as to why any community requests were not included, and (c) communities receive a copy of the final grant document after negotiations, with any further explanation as to why their inputs may have changed.

Additional consideration of CE is also required after funding request development. At a minimum, communities should be consulted – through a platform, dialogue, or even online meeting – prior to reprogramming decisions. This should be used to seek communities’ feedback on the program, its progress and results, and recommendations for reprogramming. Communities should also receive a copy of the revised grant. At best, guidance should also be provided to ensure that communities have an opportunity to engage in grant monitoring – either through their CCM representative or through a feedback mechanism created by the PR – as well as evaluation. Evaluation teams could include a representative of the affected communities, or at least ensure they are fully consulted during data collection, and have an opportunity to review the evaluation findings and recommendations prior to finalization.

Finding 26 (EQL1c). The drivers of successful community action are highly variable and context-specific but tend to include a combination of individual leadership, organizational capacity and network, and an enabling environment that is open to CE and CLR.

The evaluation team believes that the most effective changes that the GF can make are to (a) focus on influencing the enabling environment in small and large ways, and (b) ensure that capacity strengthening needs are understood, and the priorities supported. While influencing the enabling environment is a long-term endeavor, CTs can be very influential in this by continually speaking up for and requesting space for communities’ voices to be heard and respected, and taking time to visit different communities during country visits. Job descriptions and trip plans could be adjusted to reflect this as a priority. Best practices from some of the strongest FPMs in this area could be taken as models (Colombia and the Greater Mekong Sub-Region were called out as excellent examples).

Secondly, while capacity strengthening is often raised as a barrier and constraint, and there are investments in it, there does not appear to be a capacity strengthening strategy whereby the different needs of different communities can be understood and strategically supported. Capacity strengthening may be technical, organizational, financial, or related to reporting, communication, research, advocacy, mobilizing, or using data effectively. Working with partners on the ground and/or regional platforms to understand which aspect of capacity is the most significant impediment to progress, performance or trust would be a clear first step to using available support strategically. A capacity building component may be built into each allocation to support this, with clear objectives for each funding cycle.

Finding 27 (EQL1d). The absence of qualitative or long-term M&E frameworks at the country level is a constraint to meaningfully measuring CE and CLR.

Country level M&E plans need to better capture qualitative contributions that communities make to national results. This could be achieved by ensuring that the indicators included in the modular framework require disaggregation by community provider (as is currently required by some indicators as described in Finding 8). Secondly, the GF needs to include qualitative indicators in M&E frameworks that map to larger results. Rather than just being anecdotal, this may be done by mapping progress against milestones outlined in the performance framework, or a country-level theory of change. The GF may consider developing its expertise in evaluation methodologies that are adapted to understanding change in complex environments, which still allows for attribution of results.⁷⁹

In addition, current M&E frameworks are cycle-specific, while many of the changes that countries are working for are longer-term efforts. Rather than using this as a reason not to support something, grant M&E frameworks should map against longer-term strategies, such as sustainability plans, and be held accountable to realistic progress in a three-year period, rather than expecting ten-year goals to be achieved in one grant cycle.

EQL2. How could the processes at global and country-level be improved to facilitate more efficient and effective implementation? Has GF the means to support the community organizations to improve their contributions? What should be done differently to support them better? Have the PRs the right skills and tools to support the community organizations (SR/SSRs)? (Former questions 3&4 under Implementation)

Finding 28 (EQL2). In practice, the current funding-cycle approach favors short-term results, and inadvertently creates competition between sectors – public, private and community – rather than incentivizing long-term investment in the priorities that will contribute most to overall health outcomes, systems strengthening, and cooperation between sectors

The current funding request development process was described to the evaluation team as different partners or sectors going to their corners to plan how they can get the largest slice of a limited pie. Government priorities – including commodities – can absorb a large slice in many countries, either due to the high need or low government capacity to pay, with other priorities and actors tussling over what is left. Many countries referenced the power of the person or group who writes the proposal. Where this group includes communities' representative (such as in Nepal), the inclusion of communities' interests and priorities appears to be higher. The

⁷⁹ For example, validated methodologies such as [outcome harvesting](#) or [most significant change](#).

design of a funding request need not be a competition between actors, but an opportunity for system-wide thinking about (a) what the problems are, (b) how to address those problems, (c) who is best positioned to provide the solution. The writer/s could therefore play more of a facilitation role to support co-design between the different actors, so that each develops a shared understanding of the situation, and recognizes their own – and each other's – critical and complementary role. While idealistic, such an approach should also support strengthening systems for health and contribute to developing the cooperative relationships necessary for a smooth sustainability and transition plan. Indeed, where transition works best, is where it begins early to create the mechanisms and relationships, based on an appreciation of communities' unique contributions.

The best examples of PRs who support CE and CLR are those who invest in strengthening the capacity of COs to engage as SRs, or even to eventually replace them as PRs. PRs typically feel accountable to the GF, yet they also need to be held accountable to the communities that the grants support. Each should be required to create a feedback mechanism appropriate to the context. One suggestion heard was for PRs to be required to hire a community KVP representative to provide mutual capacity strengthening and greater connection between the PR and communities, who are otherwise largely excluded.

The current capacity of PRs to do this varies, and is more common in community PRs, to some extent with multilateral, and to lesser extent government. However, it could be something that is required and built into grants and budgets – even if a government PR needs to engage a community PR to facilitate. Examples from PRs who have performed well (e.g., Kenya, Côte d'Ivoire) in this area could be developed into implementation guidance.

EQL3. In addition to changes to GF related processes, what is the feasibility and implications of alternative funding approaches, including direct and joint funding with other donors and partners on community engagement?

Finding 29 (EQL3). Social contracting, service contracts, payment for activities/results, small grants mechanisms, and pooled funds present opportunities to support more nascent community organizations, however, further exploration is needed.

As discussed under Finding 21, social contracting is a feasible alternative funding approach. The evaluation also sees potential for service contracts and other types of contracting with fewer barriers to entry, and minimal reporting requirements. However, these practices were not evident enough in the case study for the evaluation to identify strong findings, other than the need for further exploration. It is recommended that a study be commissioned to identify the different contracting mechanisms in use – both by the Global Fund and its PRs, as well as its partners – to identify the advantages, disadvantages and costs of each, and in which context or to what end each would be best suited.

Another area that the evaluation identified under-utilized potential is the role of partners in supporting CE and CLR – technically, politically, and financially. For example, joint strategy development could identify longer-term (multi-cycle) goals, a sustainability and transition plan, and a clear role for each partner's contribution. While the CCM can play this role to some extent, it is usually specifically focused on GF-funded activities, and while information on other donor efforts is required in funding requests, these efforts do not always sufficiently consider the longer-term strategy, and may not specifically address CE and CLR aspects.

5. Conclusions

Table 8: Conclusions, mapped to findings

Conclusions	Map to Finding
Strategic and Secretariat level	
C1. Lack of a shared understanding of community contributions to Global Fund's mission. Inconsistent understanding of how community engagement and community-led responses contribute to progress against diseases, pandemics, and systems strengthening, results in fragmented guidance, unaligned use of different investments, unclear or a lack of accountability, and ultimately under-investment. It has also resulted in attention to community voices and support for community are not institutionalized across the secretariat, but dependent on individual skill or interest.	F1 F3 F6
C2. Community contributions are under-recognized. The absence of a KPI that captures community contribution to Global Fund results leads to a lack of visibility and recognition of the community's role, as essential programmatic and financial data is not available to inform decision making, either at the country or global level. Furthermore, much of the community's work and achievements that are progressive and qualitative in nature are currently not captured at all, further contributing to a lack of recognition of their efforts and achievements.	F3 F8 F10 F18 F19
C3. The partnership model is under-utilized. As the partnership model continues to evolve under the current strategy, many global technical and peer partners collaborating to advancing gender equality, addressing human rights related barriers, and expanding services and uptake for KVPs across the three diseases. However, this is not done systematically or consistently at the country level, and roles and expectations need further clarification and harmonization to address barriers to CE and CLR, particularly at the country level.	F5 F17 F12 F29 F13
C4. Risk and processes trump communities and complexity. Global Fund systems and internal incentive structures are more aligned to manage risk and follow processes than to support innovation and rapid iteration. This particularly impacts smaller community organizations, who may present more of a risk as a funding recipient, and require mitigating measures, including long-term capacity strengthening in Global Fund systems. Internal incentives favor fewer, large, straightforward, grants that produce short-term quantifiable results, rather than many, smaller and more complex projects that work towards long-term change.	F1 F15 F4 F23 F11 F24
C5. Funding cycles do not sufficiently incentivize efforts to achieve sustainability and long-term change. The current time frame of the Global Fund's funding as well as the reporting requirements for performance-based financing do not adequately capture the qualitative or long-term progressive and iterative nature of many community efforts and results, particularly in investing in indigenous partners, strengthening systems, influencing the enabling environment, and working towards sustainability in line with the STC policy.	F3 F14 F23 F27
C6. Gender focus is under-developed. While the AGYW Strategic Initiative is laudable, it is largely limited to HIV in Southern and Eastern Africa and insufficient to ensure that the different needs of people of all ages and genders across the gender spectrum are fully considered and addressed across all Global Fund investments, and prioritized in community efforts.	F2 F4 F5 F19
Country level	

<p>C7. Grant architecture is not conducive to consistently elevating diverse community voices. While community engagement requirements are clear leading up to funding request development, most communities – particularly KVPs – have limited to no access to grant making, monitoring, evaluation and reprogramming. This is partly due to the lack of guidance or standards at these stages, but also because reliance on CCMs and PRs has unintentionally created a closed circle in some countries, and communication regarding grants directly between GMD and PRs. This has been ameliorated in countries where more support is provided to communities to meet in preparation for CCM meetings, and to ensure that feedback is provided to communities after meetings.</p>	<p>F5 F17 F24 F25 F29</p>
<p>C8. Enabling environment is key. The enabling environment, that is, the legal, cultural, and political context, is the single most important determinant of the quality of community engagement, and the likelihood that community-led responses will be supported, and able to become sustainable. The context guides how Global Fund policies are interpreted, so policies alone are not enough to ensure meaningful community engagement.</p>	<p>F4 F7 F12 F21 F13 F22 F20 F26</p>
<p>C10. Country ownership is perceived as government ownership. While country ownership is a critical principle, it is used as a rationale for the Global Fund for not being more assertive in promoting communities' rights. and meaningful participation. This inadvertently signals that "country ownership" is "government ownership", rather than promoting shared government, community, as called for in the new strategy.</p>	<p>F1 F21 F28</p>

6. Recommendations

Table 9: Recommendations, mapped to conclusions

Quick wins (For roll out in NFM4)	Mapped to conclusion
<p>R1. Ensure community supported activities are linked to the Global Fund's overarching theory of change for the 2023-2028 strategy to guide the institutionalization of a community-centered, human rights promoting, and gender-transformative culture: The Secretariat should ensure that the overarching theory of change under development for the new strategy clearly articulates how CE and CLR activities under both grants and catalytic funding, contribute to the Global Fund Strategic Objectives. This can guide a cultural shift within the GF secretariat whereby all departments and Country Teams (CTs) have a clear understanding of the important role that communities play in supporting the strategic objectives, and also clarify expectations, roles and responsibilities, and accountabilities within the Secretariat and the partnership. This may require expanding the CT to include a CRG expert, with incentives, authority, support and recognition aligned to demonstrating progress on community engagement, and progress on human rights, gender, and equitable access to services. This process can be linked with the strategy delivery working groups' efforts underway to operationalize the new strategy. This work should be extended to further articulate the roles and responsibilities across the partnership and ensure they are reflected in guidelines accordingly. The process could be launched in NFM4 for full rollout by NFM5.</p>	C1
<p>R2. Holistic measurement framework: "What gets measured gets done": The Secretariat, in consultation with key partners, should continue to develop a KPI that captures community contribution to Global Fund results for the new strategy 2023-2028, and also ensure that qualitative measures are in place to track progress towards long-term changes in capacities, enabling environments, sustainability and systems. This is necessary to ensure that community-led responses are prioritized in funding requests and that relevant data is collected for monitoring, evaluation, learning and decision-making. This would require: (a) quantitative programmatic grant data to be collected and/or disaggregated by community contribution for all relevant results;⁸⁰ (b) PRs to report financial grant data for analysis by the Secretariat by SR-type; (c) the Secretariat to provide guidance and community engagement minimum standards across the grant cycle for CCMs and PRs to adapt as necessary to the context; and (d) considering the inclusion of community-led monitoring to be included in all grants. Lessons learned and results from the CRG and BDB SIs can provide a baseline to support the development of KPIs, with some key activities from these SIs integrated across more grants. Available data and lessons learned can be analyzed by a task force (for example, including the CRG Department, the Grants Management Department, CCM Hub, M&E team, and Policy Hub), linked to ongoing efforts to develop KPI and updated measurement frameworks for the new strategy.</p>	C2

⁸⁰ See for example, "The Case for a Key Performance Indicator on Community Systems Strengthening in the New Global Fund Strategy 2023-2028".

<p>R3. Build minimum community engagement standards into consolidated guidance for each stage of the grant cycle to ensure the meaningful engagement and leadership of most affected communities, with an emphasis on rights, gender and equity considerations. Funding and operational guidance could be consolidated and simplified with minimum standards provided for community engagement across the grant life cycle. Community engagement standards could be included in funding request guidance and allocation letters, with a budget provided to facilitate the required engagement. In addition to current requirements, minimum standards should consider: a remunerated communities' representative on the proposal writing team, inclusion of communities' views and questions on each CCM agenda item, a minimum review period for communities before funding request submission, sharing final grant documents with communities, ensuring that there are guidelines for safeguarding the safety and dignity of communities participating in Global Fund processes such as CCM meetings as well as other public meetings. New processes should require funding requests to annex communities' priorities with justification for what was or was not included in the final budget, for TRP review. Beyond the grant making phase, community engagement in monitoring and evaluation should be specified, with a clearer mechanism for communities to provide feedback on programs, including through community-led monitoring. CCMs and PRs should be strongly encouraged to bring in new partners from community organizations to reach wider groups, and especially populations who are criminalized, stigmatized or otherwise marginalized, including migrant and displaced populations. This recommendation may inform the strategy delivery working group's current efforts to review processes and guidance in preparation for the NFM4.</p>	C4, C7
<p>R4. Revise guidance to support earlier and deeper focus on systemic change: Funding guidance should build on lessons learned to emphasize the long-term approach needed to strengthen and sustain community systems and address human- and gender-based barriers to health services. The Secretariat should emphasize the importance of CE and CLR in the funding guidelines and highlighting an appropriate level of investment which could be considered – adapted to the context – to address inequities, the importance of complementary roles between the public and community sectors, and the inclusion of appropriate community-led, gender responsive and transformative service delivery, monitoring, and advocacy. This should include encouragement to build in steps towards long-term sustainability planning in funding requests, with clear milestones to be tracked and built upon in subsequent funding allocations. This approach could be piloted in a number of critical countries in NFM4, results of which could then inform a full roll out in NFM5.</p>	C5
<p>Medium term (For roll out in NFM5)</p>	
<p>R5. Evolve the Global Fund's business model and grant architecture to open up more funding and influencing opportunities for less mature community-led and community-based organizations: The GF Secretariat should consider a differentiated approach in contracting community organizations beyond PRs and SRs to bring in new voices and reach more "last mile" communities. This may involve either (a) relaxing requirements for sub-recipients (SRs) and incentivizing PRs to take on more SRs, with support for supervision and capacity strengthening building on best practices, (b) creating new funding mechanisms that are better adapted to less mature organizations, such as small grants funds, with a focus on program delivery and capacity strengthening support. A</p>	C7

technical note could be developed to provide guidance on different and models and best practices drawn from both the Global Fund and its technical and bilateral partners. This may also be accompanied by a dedicated platform for communities to meet, and be represented on the CCM.	
Long term (Achieve in 2023 – 2028)	
R6. Greater leverage of political influence to address structural barriers within the GF and enhance full country ownership: The Global Fund at all levels should re-affirm the centrality of the voice of communities to achieving the new strategy and promote country ownership as shared government, private sector and community ownership, in order to address structural barriers to community engagement. This should be reinforced by the Grant Management Department and other GF high level missions to countries, by holding regular dedicated meetings with communities, and using specific guidance and political influence to ensure that communities, the government and the private sector develop an understanding of their complementary contributions towards shared health goals. In this way, all country stakeholders leverage their comparative advantages while underscoring the criticality of removing rights- and gender-based barriers to support their work. This will require continuous evidence-based messaging from the GF Secretariat and technical partners throughout the implementation of the 2023-2028 strategy regarding the importance of decriminalizing and destigmatizing KVPs, and moving towards gender equality. The GF also needs to reinforce the message that country ownership requires all stakeholders including communities ⁸¹	C8, C10
R7. Continuously engage and focus the Partnership to support a stronger role of communities throughout implementation of the new strategy, with clear and accountability for responsibilities at the global and country levels: The Global Fund Board should lead efforts, and delegate to the appropriate body, to convene strategic partners in order to clarify accountabilities for strengthening and supporting the enabling environment for community engagement and community-led responses at the global and country level. The Global Fund can call out present best practices, key findings and recommendations from this evaluation as well as other relevant evaluations (OIG advisory on RSSH, OIG Advisory on Human rights related barriers, TERG Thematic review on STC, TERG Thematic evaluation on HIV prevention CSS evaluation as well as PCE) to inspire and motivate cross-partner sharing and co-designing a way forward. This process may begin in 2023 – 2025 by convening a meeting to develop a roadmap defining roles and responsibilities, including partners such as WHO, UNAIDS, Stop TB, RBM, bilateral donors, and regional organizations, and build on the Partnership enablers Section of the Strategy 2023-2028. This should include further consideration of whether additional partners should also be brought in. This is a long-term effort that should start soon to yield results during the 2023-2028 strategy period.	C3, C8, C10

⁸¹ See Partnership Enablers in the 2023-2028 strategy.



RFP No TGF-21-117

Preliminary Report

Annexes

Community Engagement and Community-led Response Evaluation

A Secretariat-led evaluation with TERG oversight

4 June, 2022

List of Annexes

Annex 1: References.....	2
Annex 2: List of people interviewed (chronological order)	7
Annex 3: List of guidance documents relevant to CE and CLR	10
Annex 4: Community engagement journey in the grant cycle	12
Annex 5: Financial analysis.....	13
Annex 6: CRG SI short-term technical assistance analysis.....	20

Annex 1: References

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Annex 2: List of people interviewed (chronological order)

#	Title	Department, organisation
1	Head of CRG Department	CRG, Global Fund Secretariat
2	Senior Technical Coordinator - Policy and Strategy	CRG, Global Fund Secretariat
3	Technical Advisor, Community Systems and Responses	CRG, Global Fund Secretariat
4	Senior Program Officer (long-term TA)	CRG, Global Fund Secretariat
5	Senior Program Officer (short-term TA)	CRG, Global Fund Secretariat
6	Manager, Political and Civil Society Advocacy	External Communications, Global Fund Secretariat
7	Manager	CCM Hub, Global Fund Secretariat
8	Specialist, Project Manager	CCM Hub, Global Fund Secretariat
9	TRP, Vice-Chair, Gender & Rights Expert	TRP
10	Head, AELAC Department (LAC, EEC, Central Asia)	GMD, Global Fund Secretariat
11	Head, Africa & MENA (WCA, ESA, MENA)	GMD, Global Fund Secretariat
12	Chief of Staff / Acting Head SIID	Global Fund Secretariat
13	Head High Impact Africa 2 Department (MZ, TZ, UG, ET, KE)	GMD, Global Fund Secretariat
14	Special Advisor, Community Mobilisation	UNAIDS
15	Director, Science, System and Services for All Department	UNAIDS
16	Senior Advisor, HIV integration & Community Led response	UNAIDS
17	Consultant, Community Mobilization	UNAIDS
18	Director, Equal Rights for All Department	UNAIDS
19	Senior Strategy & Policy Advisor	Strategy and Policy Hub, Global Fund Secretariat
20	Team Leader Country and Community Support for Impact	Stop TB Partnership
21	Community, Rights and Gender Advisor	Stop TB Partnership
22	Head High Impact Africa 1 Department (NI, BF, DRC, IC, GH)	GMD, Global Fund Secretariat
23	Senior Advisor	RBM Partnership to End Malaria
24	Access to Funding	Global Fund Secretariat
25	HIV Prevention	Global Fund Secretariat
26	LAC Sustainability and Transition (now FPM)	Global Fund Secretariat
27	Deputy Head	Health Finance Department, Secretariat

28	Senior Specialist (High Impact Africa)	Health Finance Department, Secretariat
29	Chief Risk Officer	Global Fund Secretariat
30	Head Country Risk Management	Global Fund Secretariat
31	Senior Disease experts - Malaria	Global Fund Secretariat
32	Senior Disease experts - Malaria	Global Fund Secretariat
33	Head	Health Finance Department, Secretariat
34	Senior Advisor C19RM	TAP, RSSH Secretariat
35	Senior Specialist, CBO/CSO Service Delivery	TAP, RSSH Secretariat
36	Head	Technical Advice & Partnerships Department
37	Manager Programmatic Results and Impact	SI Department
38	Manager Data and Analytics	DASH Team
39	Senior Specialist M&E	RSSH TAP
40	Data Analyst	RSSH TAP
41	Senior Advisor TB	Global Fund Secretariat
42	Senior Specialist Community Health Program	RSSH TAP
43	Head of Grant Portfolio Solutions and Support	Global Fund Secretariat
44	STC EECA	Global Fund Secretariat
45	STC SEA	Global Fund Secretariat
46	Manager, KPI Reporting	Global Fund Secretariat
47	Senior Advisor Key Populations	CRG
48	Senior Tech Coordinator	CRG
49	Via Libre	Via Libre - LAC CRG Platform
50	Senior Specialist, Finance	Finance Team
51	Manager, Finance	Finance Team
52	Associate Specialist, Finance	Finance Team
53	Senior Technical Coordinator AGYW	CRG
54	Interim Executive Director	EANNASO - Anglo Africa CRG Platform
55	Executive Director	MPact (MSM network)
56	S&T Advisor, CRG Platform Program Coordinator	EHRA
57	TERG Chair / Strategy Committee member	Global Fund

58	Executive Director	INPUD (PUD network)
59	Interim Executive Director / Director of Programs	GATE (trans network)
60	National Coordinator	ACT Africa (TB network)
61	Technical Director	Expertise France
62	Regional Coordinator	GFAN AP
63	Technical Coordinator	BACKUP Health, GIZ
64	Senior Advisor, VfM	Health Finance Department, GF
65	Advisor (key populations focal point)	WHO
66	Coordinator, Regional Platform	ITPC-MENA
67	Deputy-Director, External Relations and Communications Division and Head	Donor Relations Department, GF
68	Senior Manager, Strategic Initiatives	TAP, GF
69	Head of Grant Management	GMD, Management Committee
70	Alternate member, Communities Delegation	GF Board
71	Global Coordinator	NSWP (sex worker network)
72	Member, Private Foundations Delegation	GF Board

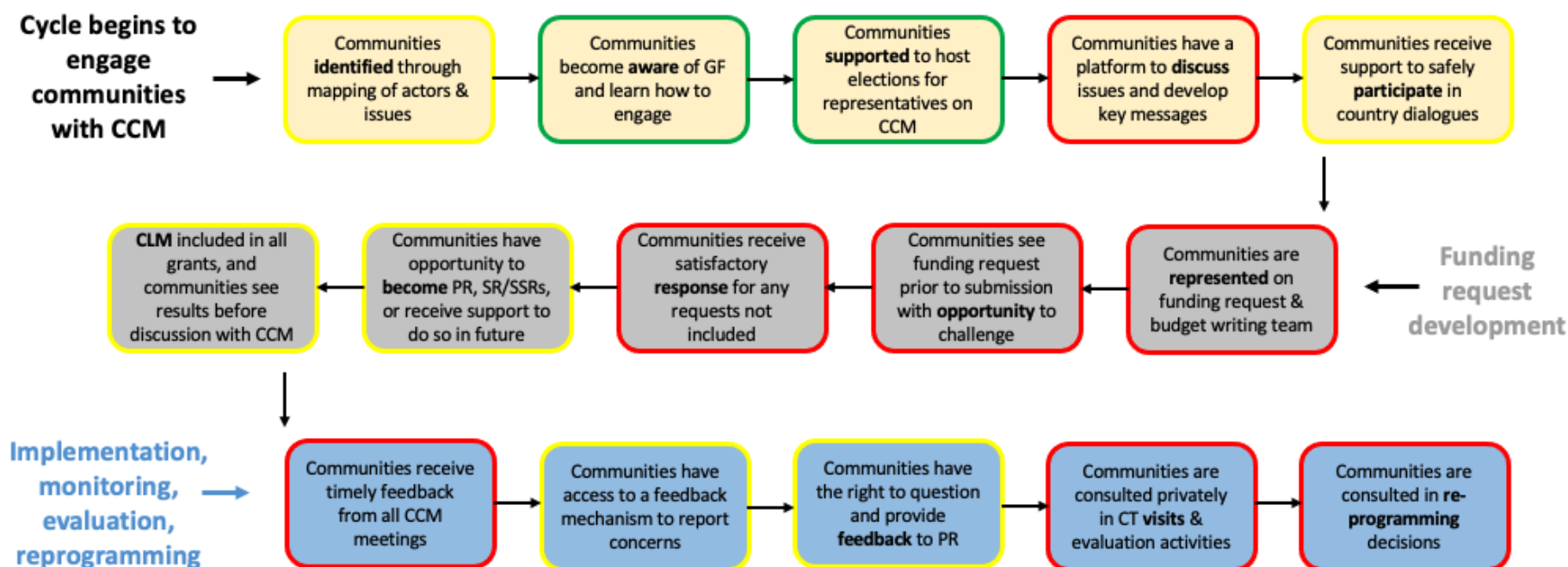
Annex 3: List of guidance documents relevant to CE and CLR

1. Achieving Quality in Programs to Remove Human Rights- and Gender-Related Barriers to HIV, TB and Malaria Services
2. Addressing HIV and TB in Prisons, Pre-Trial Detention and Other Closed Settings Technical Brief
3. A Practical Guide: Implementing and Scaling up Programs to Review Human rights Barriers to HIV Services
4. Community-Based Monitoring: An Overview
5. Community, Rights and Gender Strategic Initiative 2017-2019: Independent Evaluation
6. Community, Rights and Gender Strategic Initiative Update
7. Community Systems Strengthening Framework
8. Community Systems Strengthening Technical Brief
9. Engage! Practical Tips to Ensure the New Funding Model Delivers the Impact Communities Need Guide
10. Ensuring that programs to remove human rights-related barriers to HIV, TB and malaria services are gender responsive and gender transformative. A guidance document.
11. Factors that Contribute to Favourable MDR-TB Treatment Outcomes in Eastern Europe/Central Asia
12. Focus on the Crucial Role of Communities: Strengthening Responses to HIV, Tuberculosis and Malaria
13. Focus on Ending HIV Among Adolescent Girls and Young Women
14. Focus on Human Rights
15. Funding Request Case Studies
16. Gender Equality Strategy Action Plan
17. Gender Equality and Key Populations: Results, Gaps and Lessons Learned from the Implementation of Strategies and Action Plans Report
18. Gender Equity Technical Brief
19. Guidance for Sustainability and Transition Assessments and Planning for National HIV and TB Responses
20. Guidance Note for Developing a Resilient and Sustainable Systems for Health Funding Request
21. Harm Reduction for People Who Use Drugs Technical Brief
22. HIV, Human Rights, and Gender Equality Technical Brief
23. HIV Programming for Adolescent Girls and Young Women in High-HIV Burden Settings Technical Brief
24. How We Engage: Stories of Effective Community Engagement on AIDS, Tuberculosis and Malaria

25. Human Rights complaints procedure
26. Human Rights and Gender Programming in Challenging Operating Environments Guidance Brief
27. Human Rights and the Global Fund: How does a Large Funder of Basic Health Services Meet the Challenges of Rights-Based Programs?
28. Integration of HIV Programming in the Latin America and Caribbean Region
29. Investing in the Future: Women and Girls in All their Diversity
30. Key Populations Action Plan 2014-2017
31. Malaria, Gender and Human Rights Technical Brief
32. Malaria Matchbox Tool – An equity assessment tool to improve the effectiveness of malaria programs
33. Niger, Madagascar, Senegal and Mauritania Country Dialogue Country Experience
34. Programming at Scale with Sex Workers, Men who have Sex with Men, Transgender People, People who Inject Drugs, and People in Prison and Other Closed Settings
35. Strategy in Relation to Sexual Orientation and Gender Identities
36. Sustainability, Transition and Co-Financing Guidance Note
37. Thematic Review on Community Health
38. Towards a Common Understanding of Community-based Monitoring and Advocacy
39. Tuberculosis, Gender and Human Rights Technical Brief
40. Tuberculosis and Human Rights: Background Paper

Annex 4: Community engagement journey in the grant cycle

“Communities” include representatives of people affected by the three diseases. While it is understood that it is not possible to include representatives of all key populations on the CCM, there are good examples of where community platforms are supported by the Global Fund to ensure that the elected CCM members can meet with other community representatives to debate and agree on messages and priorities to present to the CCM. These forums also serve to provide feedback from the CCM back to communities. The following outlines what an “ideal” journey for communities may look like in the grant cycle based on best practices observed in different countries, with the border color signifying urgency to address (red being the most urgent).

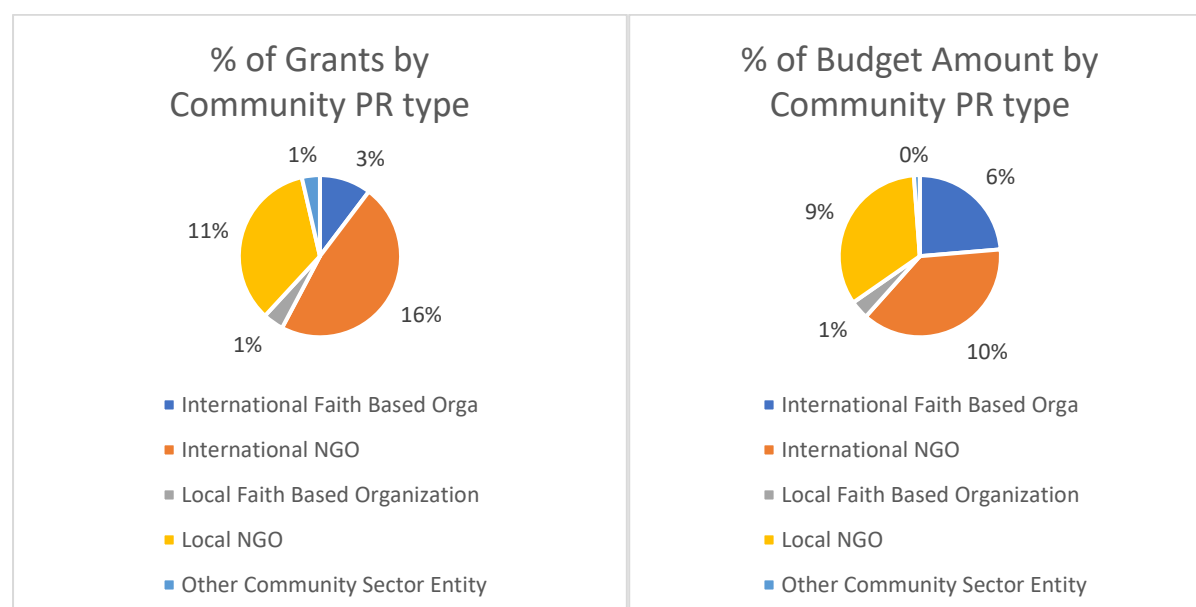
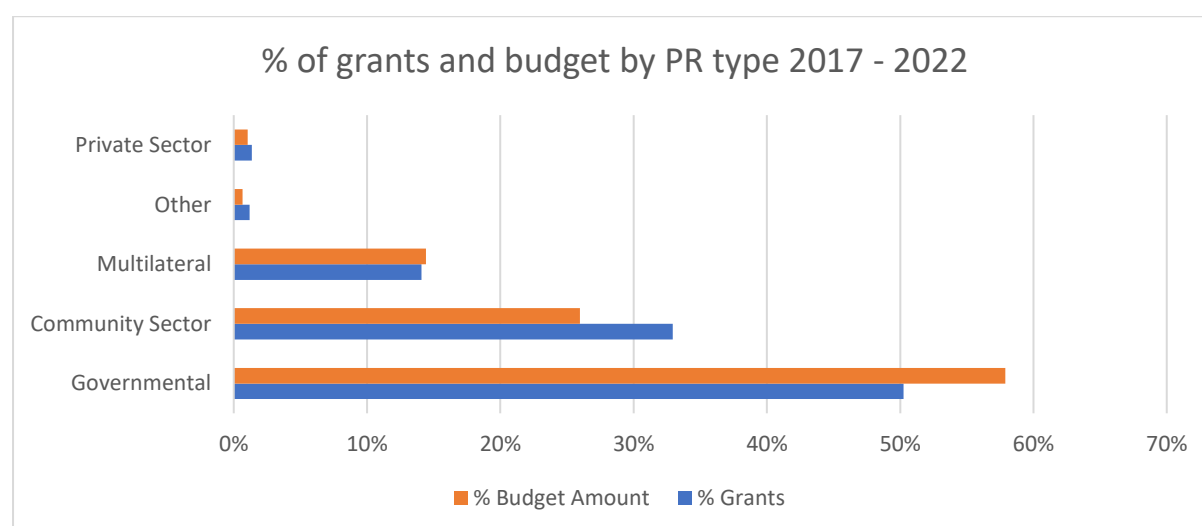


Annex 5: Financial analysis

Country Grant Financial Analysis¹ 2017 – April 2022

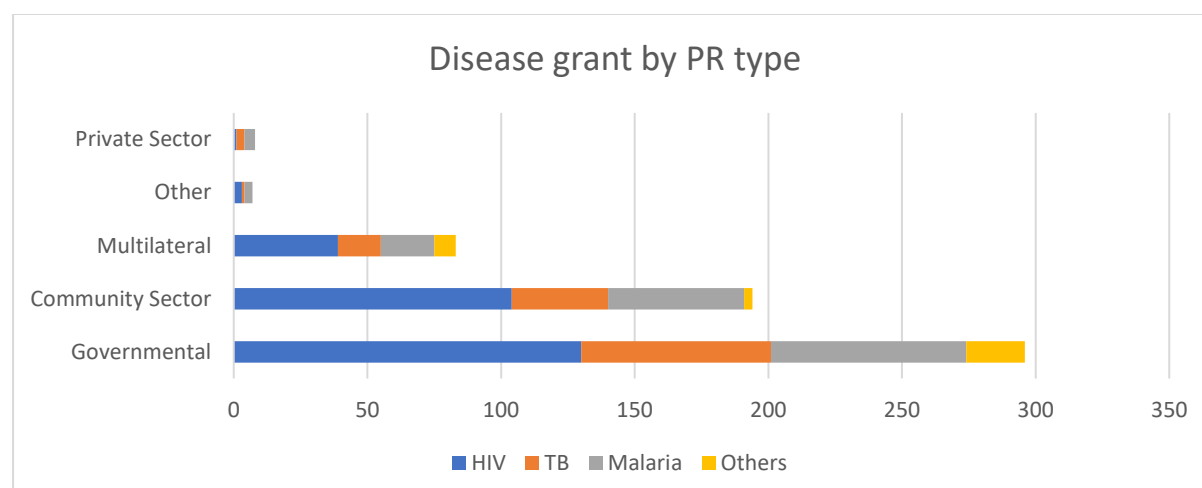
Financial analysis by PR type

For NFM 2 and 3, “community” PRs managed 33% of the Global Fund’s grants (194 grants), and 26% of total grant funding (USD 7.3 billion). Of this amount, local NGO PRs managed 11% of the grants (67 grants), and were responsible for 9% of total grant funding (USD 2.4 billion). This implies that grant sizes for Local NGOs are on average slightly smaller than those awarded to other types of PRs.

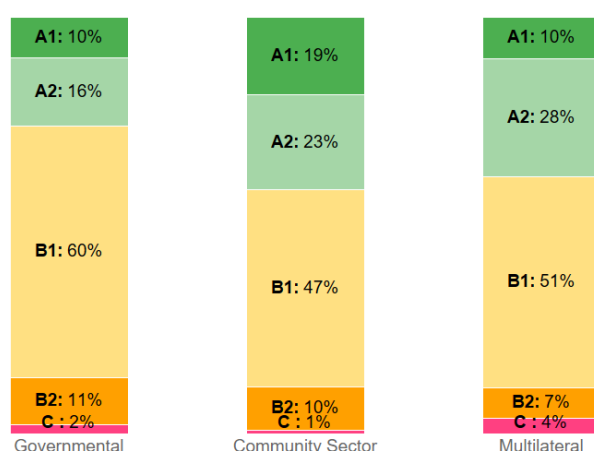


¹ Based on data provided by the finance team to the evaluators.

According to the module-level financial data provided to the consulting team for the ten case study countries, local NGO grants included 44 HIV grants (16% of all HIV grants), 10 TB grants (8% of all TB grants), and 13 malaria grants (9% of all malaria grants).

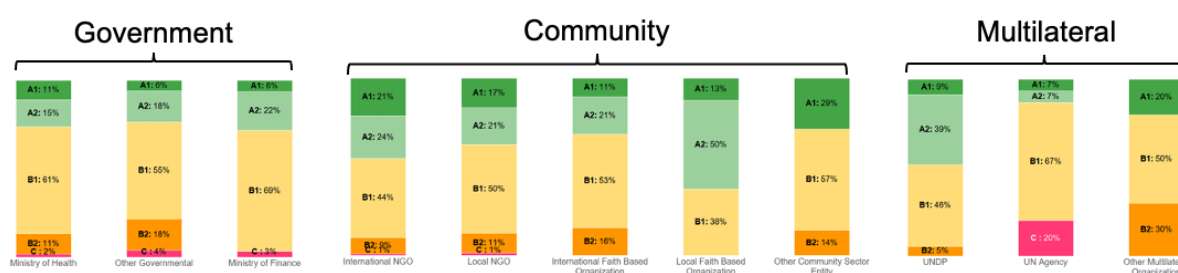


Local NGO PRs are most prevalent in Africa (21%), followed by Asia (34%), EEAC (8%), and LAC (7%). There are no Local NGO PRs for country grants in MENA.



In terms of performance, Community Sector PRs are the best performing, according to Annual Ratings provided by the DASH team in May 2022.

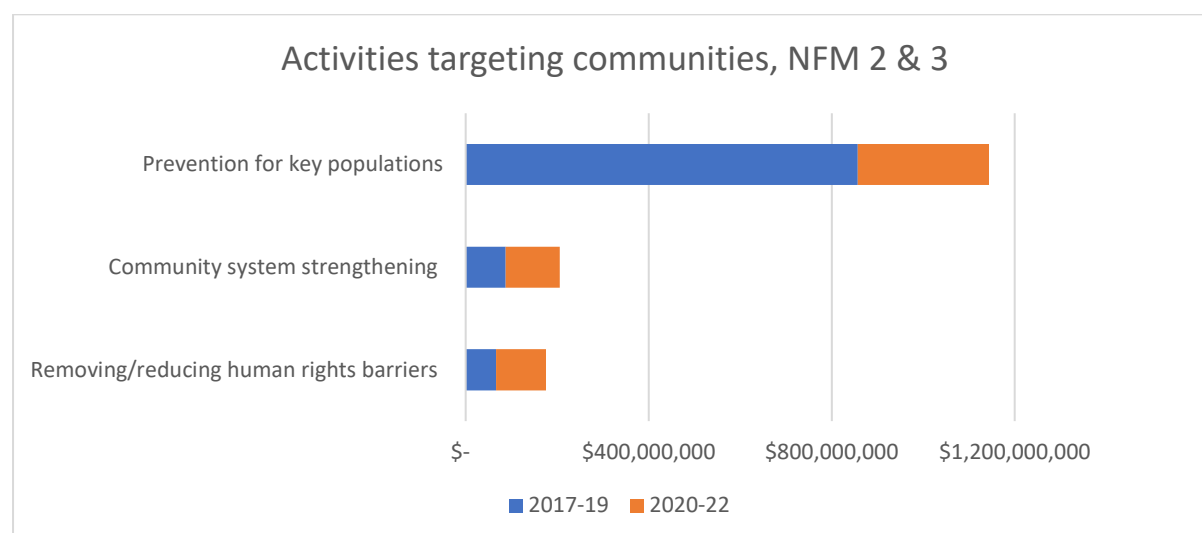
However, while Local NGOs are not the best performing PRs among the Community Sector (which are local faith-based organizations), they are still out-performing government PRs, and many multilateral PRs, with 38% being rated as A1 or A2, and only 1% rated at C.



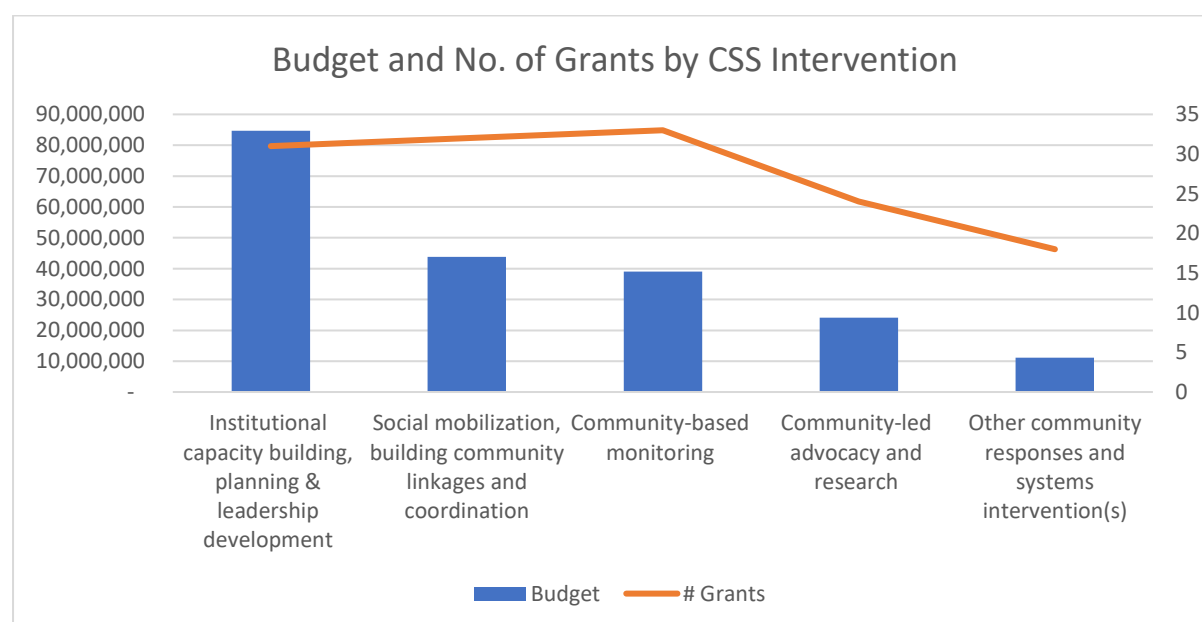
Source: data provided by the DASH team for the evaluation team.

However, not all funding for communities is provided through grants managed by Local NGO PRs. Interventions supporting communities and key populations were included under grants by all PR types. Between NFM 2 and 3, an increase in funding was observed for community system strengthening (36% increase), and activities targeting the removal or reduction of human rights-related barriers (64% increase). Activities targeting prevention among key populations appear to have reduced, but this may be due to the different classification of

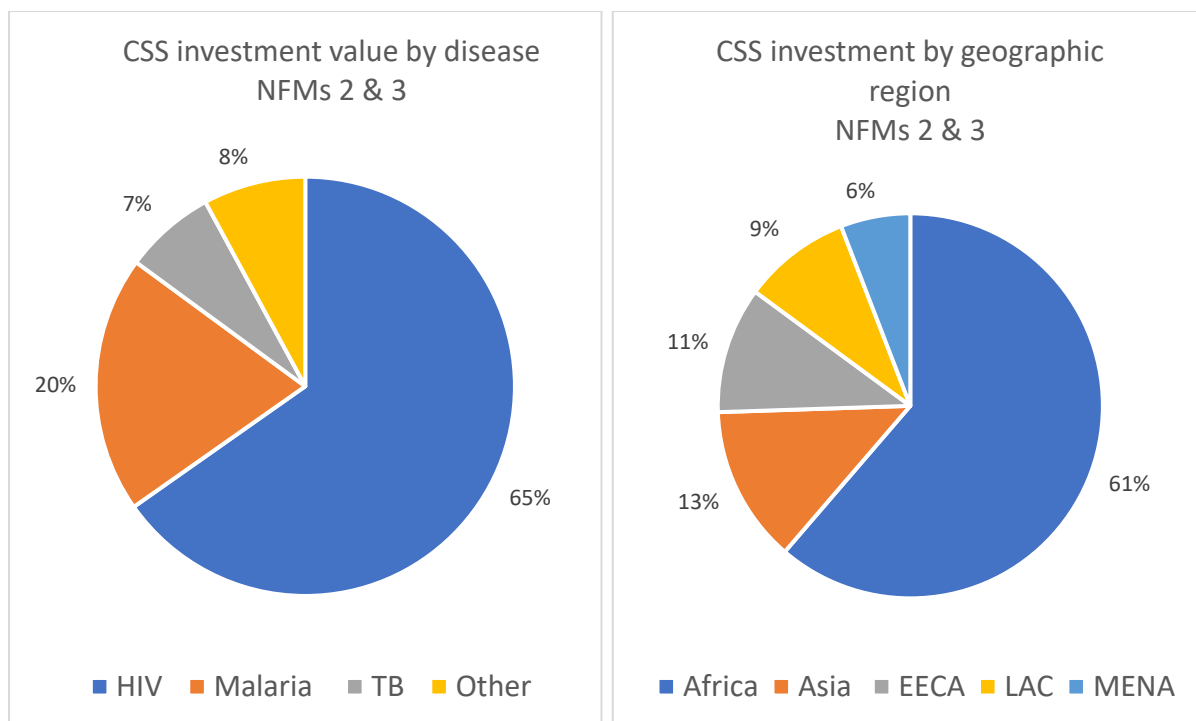
prevention activities in the accounting system between the two rounds, which complicates comparison.



CSS funding constituted 1% of Global Fund’s investment in NFM 2 and 3 (USD 203 million). Breaking down the CSS interventions between 2017-2022, the largest investment and number of grants has been in “Institutional capacity building, planning and leadership development (USD 84.7 million), followed by “Social mobilization, building community linkages and coordination” and “Community-based monitoring” (USD 43.8 million and USD 39 million respectively). “Community-led advocacy and research” is less funded, with 24 interventions (USD 24 million).

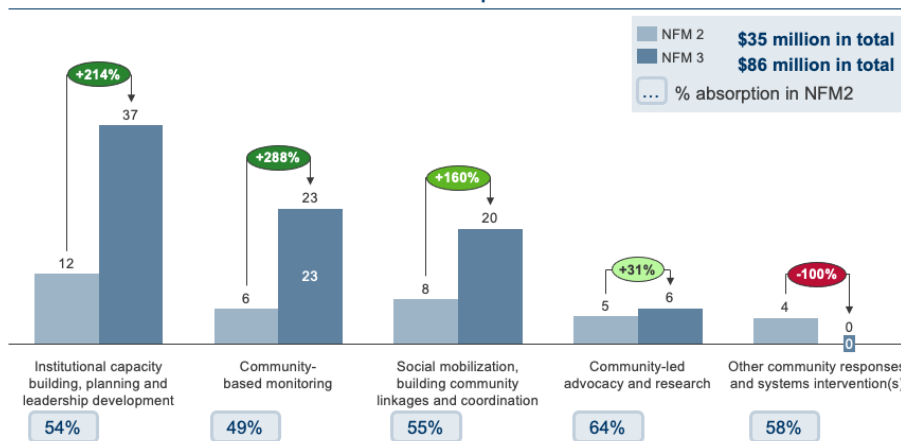


Most CSS investment has been linked to HIV grants (USD 132 million), followed by malaria (USD 40 million). Africa is responsible for over 60% of CSS investments (USD 126 million), with Asia and EECA following distantly (USD 27 million and USD 22 million respectively). There are only two CSS grants in EECA, three in LAC, and four in EECA.



NFM3 signed grants in the RSSH module on CSS increased to ~\$86 million, 1.5 times larger vs NFM2

All CSS labeled investments under the RSSH SO2 components in NFM2 and NFM3 In million dollar



TheGlobalFund

NB: Size of investments is based on equal comparison of NFM2 and NFM3, including only countries with signed grants for both NFM2 and 3

Key take-aways:

- Includes all investments with CSS intervention label, under the RSSH SO2 components
- Overall ~\$86 million in CSS investments in NFM3
- Significant growth: CSS investments increased 1.5 times comparing NFM2 and NFM3, with an absolute increase of ~\$51 million
- Largest increase seen in community based monitoring, with 2.8 times and ~\$17 million
- Absorption** in NFM2 for all categories far below average (~80%), with lowest for community based monitoring at 49%

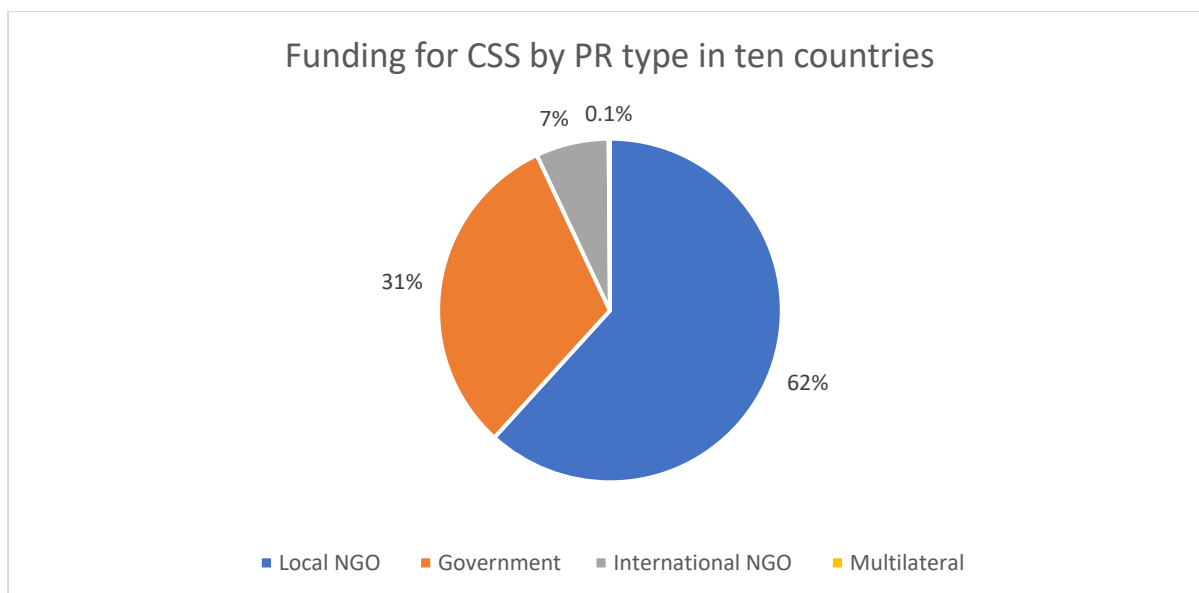
Source: The Global Fund (2021), "Strengthening Community Systems and Responses: Debrief meeting with Peter", presentation, March 2021

Case study country financial analysis

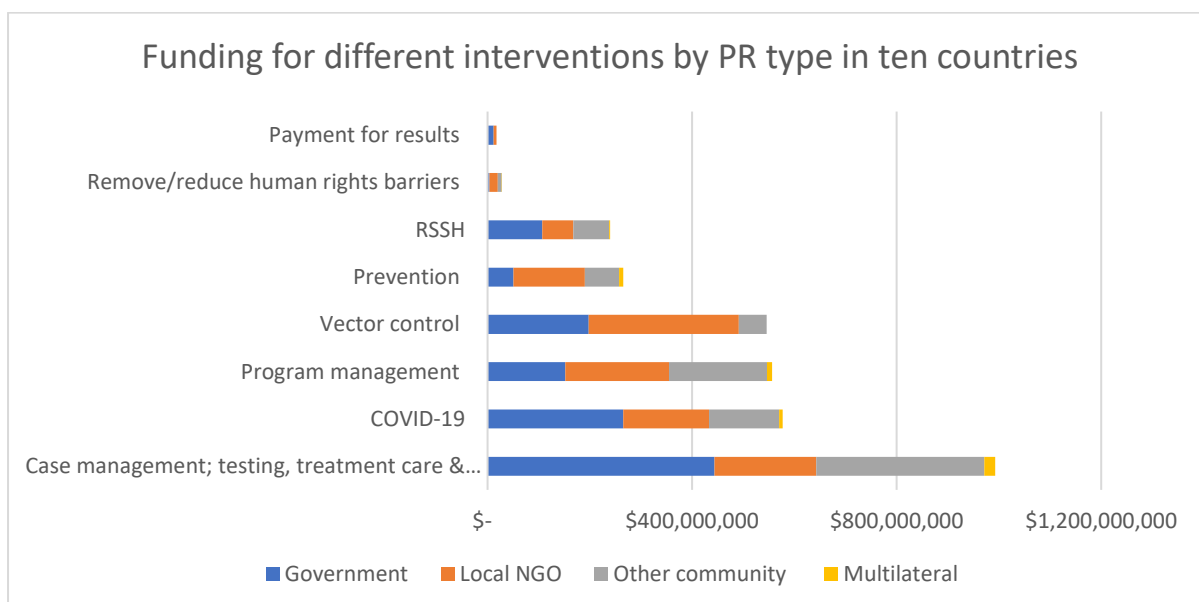
For the ten case study countries, the most common modules included in grants with local NGO PRs were for COVID-19, followed by RSSH, and comprehensive programs for key populations (HIV). The largest average value of grants is for malaria case management and vector control, which include commodity procurement. Grants supporting key populations, including the removal or reduction of human rights barriers are lower value. Only one Local NGO PR grant was found for Payment for Results, for an HIV grant in South Africa.

<i>Grants managed by local NGO PR by module</i>	<i># Grants</i>	<i>Average value</i>	<i>Total value</i>
COVID-19	76	\$2,208,439	\$167,841,390
RSSH	62	\$987,544	\$61,227,738
Comprehensive programs for KPs (HIV only)	61	\$604,711	\$36,887,396
Prevention (HIV)	55	\$1,670,725	\$91,889,852
Removing/reducing HR barriers to HIV	29	\$559,763	\$16,233,122
Program management (all diseases)	24	\$8,461,945	\$203,086,668
Treatment, care and support (HIV)	19	\$730,498	\$13,879,470
TB care and prevention	14	\$470,893	\$6,592,505
Case management (malaria only)	12	\$14,679,462	\$176,153,541
Differentiated HIV testing	7	\$283,863	\$1,986,854
Vector control	5	\$58,775,232	\$293,876,158
MDR-TB	3	\$31,378	\$94,133
Specific prevention interventions (malaria)	3	\$3,705,385	\$11,116,156
TB/HIV	2	\$195,156	\$390,312
Payment for results (HIV)	1	\$5,575,370	\$5,575,370
Total	373	\$2,913,755	\$1,083,830,665

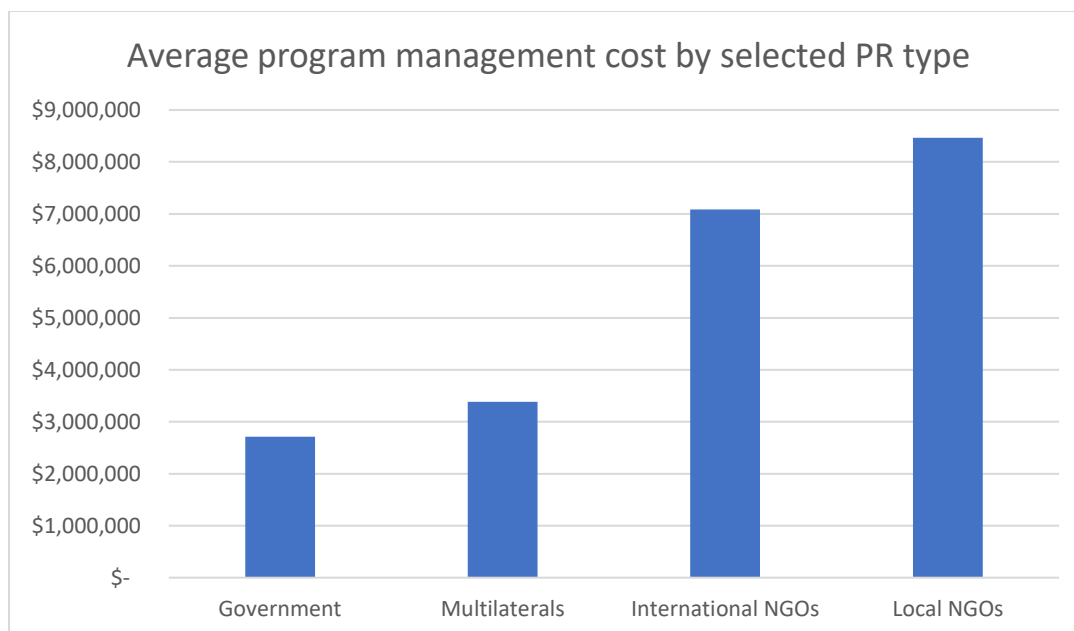
Community-focused activities were not only implemented by Local NGOs, but included in grants managed by international NGO, international faith-based organizations, government and multinational PRs. For example, in the ten case study countries, 62% of grant funding for CSS was managed by local NGOs, and almost a third by government PRs.



Broken further into module groups, Local NGO PRs can be seen as most present in HIV prevention (which includes specific outreach to KPs). The high contribution of local NGO PRs to vector control is due to DRC's large grants for bed net distribution, which would otherwise appear as zero.

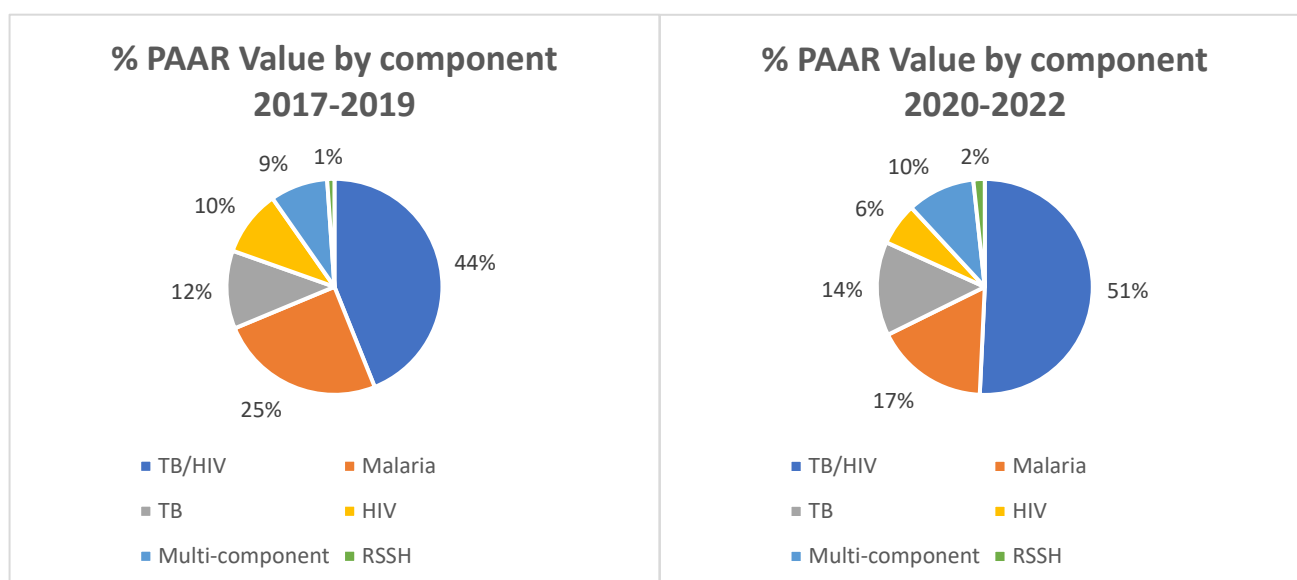


It was also noted that average program management costs were highest for local NGOs, compared to the main other categories of PRs, and compared to international NGOs. This can be indicative of local NGO dependence on the Global Fund to cover overhead costs.



PAAR Analysis 2017 – 2019 and 2020-2022

Noting that some of the categorization of grants varied slightly between the two rounds, we can see that requests above allocation increased significantly from USD 3 billion in NFM 2 to USD 5.3 billion in NFM 3. The charts below show that TB/HIV were the largest inclusions, followed by malaria. The requests for RSSH activities increased from one to two percent between the rounds. Of this, requests for interventions classified under Community Response & Systems (NFM 2) and Community System Strengthening (NFM 3) increased from USD 40.6 million (1.4% of total) to USD 62.5 million (1.2% of total). This is not, however, to draw conclusions about how PAAR is used to either fund or de-prioritize community activities.



Annex 6: CRG SI short-term technical assistance analysis

2017 - 2019	#	%	2020 - 2022	#	%	2017 - 2022	#	%
Total	125		Total	48		Total	173	
CCM members	45	36%	CCM endorsement	40	83%	CCM member/endorsement	85	
Stage			Stage			Stage		
Funding request development	43	34%	Funding request development	11	24%	Funding request development	54	31%
Grant implementation	50	40%	Grant implementation	27	60%	Grant implementation	77	45%
Grant-making	25	20%	Grant-making	5	11%	Grant-making	30	17%
NSP	7	6%	NSP	2	4%	NSP	9	5%
Component			Component			Component		
HIV	51	41%	HIV	29	60%	HIV	80	46%
HIV/TB	40	32%	HIV/TB	6	13%	HIV/TB	46	27%
TB	8	6%	TB	4	8%	TB	12	7%
Malaria	14	11%	Malaria	3	6%	Malaria	17	10%
All	12	10%	Other (combo, incl. RSSH)	6	13%	Other (combo, incl. RSSH)	18	10%
Value			Value			Value		
Total	\$4,488,424		Total	\$1,656,749		Total	\$6,145,173	
Average	\$34,404		Average	34,516		Average	34,460	
Platform / Region			Platform / Region			Platform / Region		
Anglophone Africa	47	38%	Anglophone Africa	14	29%	Anglophone Africa	61	35%
Asia Pacific	16	13%	Asia Pacific	5	10%	Asia Pacific	21	12%
EECA	16	13%	EECA	7	15%	EECA	23	13%
Francophone Africa	22	18%	Francophone Africa	8	17%	Francophone Africa	30	17%
LAC	17	14%	LAC	12	25%	LAC	29	17%
MENA	7	6%	MENA	2	4%	MENA	9	5%
Key TA			Key TA			Key TA		
Situational analysis and needs assess	55	44%	Situational analysis and needs assess	25	52%	Situational analysis and needs assess	80	46%
Engagement in the country dialogue	56	45%	Engagement in country dialogue pro	25	52%	Engagement in country dialogue pro	81	47%
Supporting program design	78	62%	Supporting design and implementati	21	44%	Supporting design and implementat	99	57%
Support oversight and monitoring o	27	22%						
Support engagement in sustainabilit	17	14%						
National Strategic Planning	18	14%						
CRG Component			CRG Component (includes combos)			CRG Component (includes combos)		
Gender	61	49%	Gender	12	25%	Gender	73	42%
Human Rights	66	53%	Human Rights	12	25%	Human Rights	78	45%
Community responses & CSS	23	18%	Community responses & CSS	6	13%	Community responses & CSS	29	17%
Harm Reduction	5	4%	Harm Reduction	5	10%	Harm Reduction	10	6%
Key Pops	68	54%	Key Pops	25	52%	Key Pops	93	54%