Evaluation of Community Responses and Systems Strengthening

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Health Management Support Team

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Evaluation team members:

Co-team Leader: Oko Igado
Co-team Leader: Eleanor Brown
Evaluator / Strategic Advisor: Sjoerd Postma
Strategic Advisor: Hind Khatib Othman
Evaluator: Jonathan France
Evaluator: Daniela Rojas Castro
Evaluator: Roy Wakim
Quality Assurance: Lorina McAdam
Data Analyst: Cassidy McGinn

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Executive Summary

Introduction

The Global Fund to Fight AIDS, Tuberculosis and Malaria has consistently recognized the critical role of communities in achieving sustainable health outcomes. Building on its 2023–2028 Strategy, which places communities at the center of systems for health, the Global Fund's Evaluation and Learning Office (ELO) commissioned this evaluation of its approach to Community Responses and Systems Strengthening (CRSS). The purpose of the evaluation was to assess how CRSS is conceptualized, operationalized, and contributing to improved access to HIV, TB and malaria (HTM) services and health system strengthening. The evaluation, conducted by Health Management Support Team (HMST), focuses on Grant Cycle 6 (2020–2022) and early implementation of Grant Cycle 7 (2023), aiming to generate actionable recommendations to enhance how the Global Fund supports community-led responses (CLR) and community systems strengthening (CSS) to contribute to health outcomes, and sustainability.

The evaluation explores four thematic areas: (1) The Global Fund's approach to CRSS; (2) CSS implementation; (3) integration of CRSS with formal health systems; and (4) CRSS contributions to grant performance and HTM access. These are analyzed across four evaluation categories: Design, Relevance & Coherence, Effectiveness & Efficiency, and Sustainability. This document is the final evaluation report.

The evaluation was guided by the Global Fund's definitions of community responses, being those "delivered by community-based or community-led organizations within, partially or completely outside of the formal health system, and CSS as a set of interventions to improve community responses and accelerate in-country results. According to the modular framework, those interventions include community-led monitoring; community-led research and advocacy; community engagement, linkages and coordination; and capacity building and leadership development. CRSS was therefore viewed as where support for community systems strengthens community-led responses, which in turn contributes to improved health outcomes in HIV, tuberculosis and malaria.

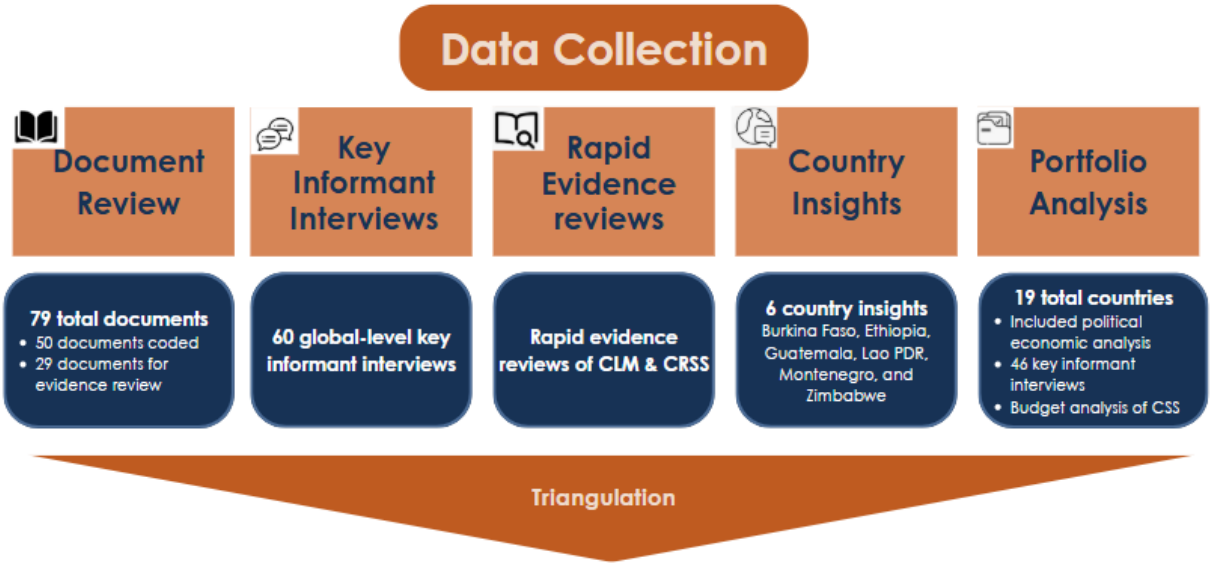
Methodology

The evaluation adopted a mixed-methods, theory-based design combining process evaluation with outcome harvesting and contribution analysis. This approach allowed for tracing pathways of change, identifying enabling and hindering factors, and understanding the contribution of CRSS to HTM outcomes. Data collection included document review, 60 global key informant interviews, six in-depth country insights (Burkina Faso, Ethiopia, Guatemala, Lao PDR, Montenegro, and Zimbabwe), and a portfolio analysis of CRSS investments in 19 countries[1], which included a political economy analysis of 15 countries where sufficient data was available. Data sources were triangulated with document reviews, budget analyses, and monitoring data. Data analysis was supported by an AI-driven tool to enhance thematic coding. The strength of evidence was graded for each finding to inform the robustness of conclusions.

The evaluation also adopted a participatory approach, engaging a Learning Partnership (LP), consisting of representatives of the Regional Learning Hubs to inform the design,

[1] See Table 4 on p. 9.

shape analysis, and review preliminary recommendations. The LP was engaged at specific points to critically analyze emerging findings in critical areas. While ensuring the independence of the evaluation team, this approach proved useful for identifying the utility of the findings within broader aims to strengthen CRSS, and to ensure community voice was represented in shaping recommendations. The LP, for instance, highlighted the need to address legal and regulatory barriers at an early stage to work towards sustainability. This was strongly supported by evidence from the country insight studies.



Limitations included challenges in accessing expenditure data and grant budgets disaggregated below the Principal Recipient level, limited monitoring data on community contributions, low response rates for some country-level validation workshops, and inability to access certain key informants (e.g. government actors in some countries). Due to shifts in the funding landscape, there were substantial adjustments made to the terms of reference and methods used. This included cancelling a global survey, and changes to the portfolio analysis. Several methods were added, including a deeper secondary portfolio analysis with qualitative interviews, evidence reviews and a rapid evaluability assessment. The evaluation team received the recommendations from the concurrent Community Engagement Evaluation at a late stage in the evaluation and was able to check the recommendations for consistency.

Findings

Design

The Global Fund's strategic documents demonstrate a renewed and ambitious commitment to CRSS. The 2023–2028 Strategy articulates a vision of community-centered, people-led systems for health, with specific objectives for scaling up community-led monitoring (CLM), integrating community health strategies, and supporting institutional capacity building. However, the evaluation found that conceptual clarity is lacking. There is no coherent framework that links CLR, CSS, and resilient and sustainable systems for health, and key distinctions (e.g. between community-based and community-led responses, or between community-based organizations [CBO] and community-led organizations [CLO]) are inconsistently applied across Secretariat teams and country stakeholders.

While the strategy is clear, some operational tools (e.g., funding guidance, modules, performance indicators) and their rollout have not sufficiently kept pace (nor are consistently implemented across countries and disease programs). CSS remains under-defined and often misunderstood—frequently reduced to community health worker (CHW) support rather than a broader system of community engagement, leadership, and service delivery. Current Global Fund guidance on CRSS is improved but requires socializing and capacity building across the Secretariat and among country stakeholders, alongside refinements to other tools.

There has been limited adaptation of CRSS to specific contexts such as challenging operating environments (COEs) or rights-constrained settings. Although positive progress has been made in engaging key populations through indirect support, such as funding for civil society organizations (CSOs) and community platforms, more proactive and flexible approaches are needed in environments with shrinking civic space, anti-LGBTQI+ laws, and gender-based barriers.

Relevance & Coherence

The Global Fund employs various levers—notably allocation letters, guidance documents, and catalytic investments (including Strategic Initiatives)—to encourage investment in CRSS. However, investments in community systems are not always aligned to directly support investments in health systems strengthening. Some aspects of CSS, such as CLM receive more attention, funding, and advocacy, than other CSS interventions such as capacity building, and coordination, especially outside the HIV portfolio – although efforts are being made to address this imbalance. This can be perceived as separate from, rather than contributing to national health systems.

Integration of community systems into national strategic plans (NSPs) and community health strategies is uneven across the insight countries. Some countries, such as Zimbabwe and Burkina Faso, show better integration and recognition of community roles, most especially CHWs, while others, such as Guatemala and Ethiopia, reflect weak institutionalization of CSS. In some countries, integration is often driven by Global Fund Country Teams or longstanding CSO networks, rather than being an integral aspect of systemic national planning. This can depend on the discretion of individual Country Teams.

The CSS key performance indicator (KPI S4) introduced in 2023 is not yet generating actionable data. It fails to capture the relationship between community systems and service delivery outcomes and is not used systematically to inform decision-making, particularly to shape investments. Efforts to ensure complementarity between community and formal health services are promising but remain constrained by country systems, with inadequate assessments, planning or investments to address these bottlenecks in most cases. In some contexts, CRSS activities operate in parallel to national services due to unclear integration pathways or limited government buy-in. However, there are also examples of how the Global Fund is able to incentivize and support integration.

Effectiveness & Efficiency

The country insights found that CRSS investments have contributed to increased access to HTM services, particularly for underserved and stigmatized populations. CSO and CLO networks supported by Global Fund grants have expanded service coverage, increased

demand creation, supported treatment adherence, and promoted rights-based service delivery. However, effectiveness varies by context, disease, and maturity of community systems. HIV programming has traditionally seen more structured CRSS investments, with clear pathways from capacity building to service delivery to policy change. In contrast, TB and malaria CRSS components are less developed and receive less funding.

Capacity-building initiatives—particularly under the Community Engagement Strategic Initiative—have helped strengthen organizational governance, financial management, and advocacy skills. This has been achieved both through support provided to specific organizations through long-term capacity strengthening support, as well as through the Regional Learning Hubs. There are examples of where targeted institutional support enabled small CBOs to increase funding eligibility and diversify service offerings, enhancing their sustainability. Yet, many other countries lack such strategic investment, and existing tools are underfunded and underutilized.

CLM, when properly implemented with long-term investment and technical assistance (TA), can lead to service quality improvements and greater accountability. Strong examples were found in the Democratic Republic of Congo, South Africa, and the Philippines, where TA helped streamline CLM tools, reduce duplication, and strengthen stakeholder dialogue. However, CLM has also been introduced in contexts where it may require a different approach or longer lead-in time with more support to ensure that it does not result in duplication, tensions among actors, and/or underutilized data. Its prominence has diverted attention from other CSS priorities in some countries.

Measurement of CRSS outcomes remains weak. Global indicators are poorly aligned with community-level contributions, and country data systems rarely disaggregate or systematically capture CRSS results. This limits the ability to understand or give visibility to community contributions, assess return on investment or learn across contexts.

Sustainability

Despite the Global Fund's strategic intent, current CRSS investments are insufficient to ensure long-term sustainability. CLR interventions are more likely to be sustained where they are integrated into NSPs or linked to community-based service delivery models – such as CHWs, and in limited cases, some prevention services targeting key populations. However, CSS components (e.g. leadership development, network coordination) lack institutional support and are generally funded as time-limited projects, often with limited resources, or not at all.

Integration of community-led approaches into national health systems remains nascent. Many governments view CHWs as the only community health actors, often overlooking the contributions of peer educators, paralegals, and key population networks. Moreover, financing mechanisms for sustained support—such as social contracting or domestic budget allocations—are rare and underdeveloped.

Funding for CSS has decreased in several countries. CSS is often not prioritized in grant-making processes and is at risk of being deprioritized under pressure for short-term service delivery targets. Global and regional CSO platforms have helped maintain visibility of CRSS in regional agendas, but more institutional backing is needed.

Opportunities for improving sustainability include formalizing mechanisms to support the procurement of services by government through civil society and other partners (e.g. social contracting), integrating CRSS into broader health systems strategies, and

leveraging evidence from successful country models. However, these opportunities are not systematically documented or disseminated and to date, implementation of these opportunities, such as social contracting, are limited. Many CSOs remain concerned about the future viability of their contributions once Global Fund support ends.

Conclusions

CRSS is critical to sustainable, people-centered health efforts for the three diseases, as well as for a more integrated, cost-efficient approach. The Global Fund's commitment to communities is evident in its strategy, grant and catalytic investments, and partnerships. However, the current approach to CRSS lacks the clarity, consistency, and the resources needed to fully realize its potential, particularly as it increasingly pursues integration and sustainability. Key challenges include:

- Conceptual fragmentation and inconsistent definitions.
- Over-reliance on CLM at the expense of other needed CSS functions.
- Inadequate measurement resulting in limited visibility of community contributions.
- Limited national integration and sustainability planning, in part reflecting low political will.
- Insufficient and declining funding for community systems strengthening.

CRSS remains a promising but underleveraged pillar of the Global Fund's model. Without stronger alignment across its investments, internal incentives and ways of working, and accountability systems, its contribution to sustainable health outcomes and resilient health systems – including health systems – will remain constrained.

Recommendations

1. Develop a comprehensive framework for CRSS, which links to RSSH and a community/health systems maturity framework. Critical
2. Improve the monitoring and results framework to make community contributions to health outcomes more measurable and visible. Critical
3. Develop a multi-cycle sustainability plan for countries which includes critical community-led responses as part of funding requests, based on the new CRSS framework and the maturity model. Critical
4. Adjust incentives for Country Teams to be accountable to supporting countries adhere to the CRSS framework and make progress on sustainability plans. Critical
5. Update the information note on CLM to provide more explicit guidance on how CLM should be integrated into health systems, appropriate pathways to scale, and better adaptation to context. Important
6. Further invest in light-touch country platforms to create efficiency and provide a basis for sustainability transition, connecting more community actors with diverse but related interests (e.g. health financing) to plan for beyond Global Fund support and CCM representation. Potential considerations
7. Reinvigorate engagement with partners, including with multinational development banks who are engaging with communities, to ensure coordination and resource optimization for CRSS. Potential considerations

The recommendations from this evaluation show points of convergence with the concurrent evaluation on community engagement (CE), as shown in Table 1 below.

Table 1: Convergence between CRSS and CE evaluation recommendations

CRSS Evaluation recommendations	Convergence with the CE evaluation
The CE evaluation recommendations link with CRSS R1, to create an integrated CRSS framework. This would support the CE recommendations to support TA for funding requests (R2), providing a rationale for decisions (R3) and having an assessment to understand dynamics with different groups (R8).	CE evaluation recommendations **2, 3 and 8.**
Recommending a mechanism for communities, KPs and CS to suggest revisions (R7), and investing in initiatives and partnerships to support representation (R9) could link to CRSS R6 on having a country-based platform to support community and civil society communication and coordination.	CE evaluation recommendations **7 and 9.**
The CE evaluation recommends leveraging CLM to support engagement (R5), which could also be addressed in CRSS R5 to update the CLM information note.	CE evaluation recommendation **5.**

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List of Acronyms

AGYW	Adolescent girls and young women
BDB	Breaking Down Barriers Strategic Initiative
C19RM	Covid-19 Response Mechanism
CA	Contribution analysis
CB&LD	Capacity building and leadership development
CBM	Community-based monitoring
CBO	Community-based organization
CCM	Country Coordinating Mechanism
CE	Community engagement
CELC	CSO engagement, linkages and coordination
CE SI	Community engagement strategic initiative
CHW	Community health worker
CHS	Community health strategy
COE	Challenging operating environment
CLM	Community-led monitoring
CLO	Community-led organization
CLR	Community-led responses
CLR&A	Community-led research and advocacy
CRG	Community Rights and Gender Department
CRSS	Community responses and systems strengthening
CSO	Civil society organization
CS&R	Community systems and response
CSS	Community systems strengthening
CT	Country Team
DRC	Democratic Republic of Congo
EECA	Eastern Europe and Central Asia
ELO	Evaluation and Learning Office
EQ	Evaluation question
EVT	Evaluation team
FPM	Fund Portfolio Manager
FR	Funding request
FSW	Female sex workers
GC	Grant Cycle
GMD	Grant Management Division
HEP	Health Extension Program
HF	Health Financing
HMIS	Health management information system
HMST	Health Management Support Team
HRH	Human resources for health
HSS	health systems strengthening
HTM	HIV, TB and Malaria

HTS	HIV testing services
IEP	Independent Evaluation Panel
KII	Key informant interview
KP	Key population
KPI	Key Performance Indicator
KVP	Key and vulnerable populations
LAC	Latin America and the Caribbean
LGBTQI+	Lesbian, gay, bisexual, transgender, queer, intersex, and others
LMICs	Low- and Middle-Income Countries
LP	Learning Partnership
LTFU	Lost to follow-up
M&E	Monitoring and evaluation
MENA	Middle East and North Africa
MOH	Ministry of Health
MSM	Men who have sex with men
NFM	New funding mechanism
NSP	National strategic plan
OH	Outcome harvesting
OM	Outcome mapping
PA	Portfolio Analysis
PE	Process evaluation
PR	Principal Recipient
PrEP	Pre-exposure prophylaxis
PUD	People who use drugs
RAI	Regional Artemisinin-resistance Initiative (Greater Mekong Subregion)
RSSH	Resilient and Sustainable Systems for Health
QoC	Quality of care
SI	Strategic Initiative
SOE	Strength of evidence
SR	Sub-Recipient
TA	Technical assistance
TAP	Technical Assistance and Partnerships Department
TB	Tuberculosis
TERG	Technical Evaluation Reference Group
TGF	The Global Fund
ToC	Theory of Change
ToR	Terms of Reference
TRP	Technical Review Panel
UHC	Universal Health Coverage
USD	United States Dollar
WCA	West and Central Africa

1. Introduction and Background

The Global Fund's commitment to supporting communities is central to its current strategy, which aims to end AIDS, TB and Malaria, working with and to serve the health needs of people and communities.[2] The Global Fund recognizes that sustainable health outcomes can only be achieved when communities are empowered to lead, monitor, and advocate for their health. Yet "communities" are numerous, diverse, and complex in any given country, and this complexity is further amplified across the Global Fund's vast portfolio. The Global Fund has therefore continued to evolve how it supports community-led responses (CLR), and community systems strengthening (CSS), to improve efficiency and effectiveness, and create conditions for sustainability for global health and pandemic preparedness. A call for the Community-led Response and Systems Strengthening (CRSS) evaluation was therefore issued by the Global Fund's Evaluation and Learning Office (ELO) in July 2024 and awarded to Health Management Support Team (HMST) in September 2024.

This document is the final evaluation report, capturing the findings, conclusions and recommendations of the evaluation work undertaken, integrating feedback from the ELO, user group and the Independent Evaluation Panel. This introduction provides some background to the evaluation context, and outlines some of the assumptions to aid in understanding the content. The methodology section explains the approach taken to data collection, analysis and triangulation, as well as the limitations faced. Findings are then presented, including an assessment of the strength of evidence supporting them. This is followed by conclusions based on the findings, and finally, recommendations to respond to the conclusions. The evaluation team (EVT) has attempted to keep recommendations limited in number, clear in focus, and actionable. The recommendations section also shows points of convergence with the recommendations issued by the concurrent evaluation of community engagement.

1.1 Evaluation purpose, objectives and scope

The purpose of this evaluation is to provide the Global Fund and its partners with an assessment of the Global Fund's approach to CRSS and the contribution of community responses to improve access to HIV, tuberculosis and malaria (HTM) services, grant implementation and performance. The evaluation provides learnings on the challenges and gaps, and recommendations as to how the Global Fund can better conceptualize and invest in CRSS. The evaluation is intended to be used by Global Fund Country Teams (CTs), the Technical Advice and Partnership Department (TAP), the Community, Rights and Gender Department (CRG), and in-country recipients of CRSS support.

The evaluation's objectives are:

1. To assess the Global Fund's approach to CRSS and factors that facilitate and hinder progress towards sustainable community systems.
2. To assess the effectiveness of the interventions prioritized by the Global Fund under Community Systems Strengthening.
3. To assess the complementarity and integration of CRSS with the formal health systems at country level.

[2] The Global Fund. (2021). *Fighting pandemics and building a healthier and more equitable world: Global Fund strategy (2023–2028)*. The Global Fund to Fight AIDS, Tuberculosis and Malaria.

4. To assess the contribution of community-led and community-based responses funded by the Global Fund to improve access to HTM services, grant implementation and performance.

The evaluation covers Global Fund's Grant Cycle 6 (GC6) from 2020-2022, and part of Grant Cycle 7 (GC7), for 2023. The evaluation was asked to consider both community responses and community systems strengthening, and it looked at the four interventions of the of CSS: community-led monitoring (CLM), community-led research and advocacy, capacity building and leadership development, and while not included in the original scope, some consideration of engagement, coordination and linkages (avoiding overlap with the concurrent Community Engagement Evaluation). It considered the Global Fund's key performance indicator (KPI) S4. The evaluation looked at the work of community-health workers (CHWs) supported by communities and civil society (those not integrated into public health systems).

The original request for proposals (RFP) identified four themes for the evaluation to explore: (1) The Global Fund's approach to CRSS, (2) CSS, (3) Integration of CRSS with formal health systems and sustainability, and (4) Contribution of CRSS to grant implementation on and access to HTM services. To address these themes in a systematic and practical way, evaluation questions (EQs) were organized into evaluation categories for analysis: Design, Relevance & Coherence, Effectiveness & Efficiency, and Sustainability. EQs were only slightly modified during the evaluation to ensure a clearer flow of the analysis and avoid repetition, without changing the content or scope. The final questions and their categorization are presented in Table 2.

Table 2: Evaluation themes and questions

Evaluation Questions	Sub-questions
Design	
EQ 1. How well conceptualized is the Global Fund's approach to CRSS within its supported disease programs and RSSH?	1.1 How has the Global Fund adapted its approach to CRSS in challenging operating environments (COEs) and in the context of anti-LGBTQI+ and rights movements, gender inequality and violence, and closing civic space? 1.2 How has the Global Fund's approach to CRSS has been adapted?
Relevance / Coherence	
EQ2. How does the Global Fund prioritize, direct investments, and ensure consistency between funding community responses and supporting community systems to deliver CRSS at the country level?	2.1 To what extent are systems-strengthening approaches (such as CLM) aligned with/built into Global Fund HIV, TB, and malaria programs? And to what extent do grant priorities inform CSS? 2.2 To what extent are community responses and systems part of national strategic plans (NSPs) / community health strategies, and how well aligned is the Global Fund's approach to CRSS with these strategies, and operational frameworks for community health? 2.3 How and to what extent does the Global Fund's approach to CRSS ensure complementarity of community-based and community-led services with formal health services?
Effectiveness / Efficiency	
EQ 3. How and to what extent do Global Fund investments in CRSS contribute to grant implementation, grant performance, and overall improvements in	3.1 To what extent do Global Fund investments in CLM lead to improved availability, accessibility, acceptability, and quality of HTM programs? 3.2 How much have the Global Fund investments in CSS contributed to stronger advocacy for resource mobilization and policy change in relation to rights, equity, and health?

Evaluation Questions	Sub-questions
health service delivery and access to HTM services in different contexts?	3.3 To what extent have Global Fund's investments in community capacity building, engagement, coordination and linkages, led to stronger community systems and more effective community responses at the country level? 3.4 To what extent is the Global Funds approach to results and measurement fit for purpose and capturing intended outcomes in CRSS?
Sustainability	
EQ4. To what extent do Global Fund investments in CRSS contribute to sustainability of community systems and responses?	4.1 To what extent are there clear pathways towards sustainable community services and systems at country level (e.g. integration/development of comprehensive community health strategy within national disease response), and why/why not? 4.2 To what extent are Global Fund systems-strengthening investments (such as advocacy and capacity building) enhancing the sustainability of community services within Global Fund HIV, TB, and malaria programs? 4.3 What are the opportunities to strengthen sustainability of CRSS? What are the trade-offs and concerns for sustainability of CRSS for different Global Fund communities?

1.2 Background, Definitions & Language

The Global Fund is recognized as a community-centric donor, reaffirmed in its current strategy, which is recognized as an ambitious and complex undertaking. Its approach has also been the subject of previous evaluations, reviews and assessments – often with a different emphasis (for example, a Community Engagement evaluation was underway concurrently with this evaluation). The evolution of the Global Fund's approach to working with communities will be explored in the findings under the "Design" evaluation category. However, because it has been an evolving process, and because communities are multifaceted and dynamic, it difficult to generalize and categorize them easily. The strategy defines communities as: "Communities living with or affected by HIV, TB and malaria, including key and vulnerable populations." During the evaluation, however, the EVT quickly found that different people or teams – even within the Secretariat – associate different meanings to the term. This was also evident at the country level. In some contexts, there was also conflation between "communities" and "civil society", with an assumption being that CSOs automatically represented communities. Therefore, for the purposes of this evaluation, the following definitions are employed:

- **Communities**: people living at the sub-national level affected by the three diseases.
- **Key populations** (KP): people who can be not only at higher risk of the three diseases, but who can also face stigma and discrimination because of their identify or behavior. In the context of the different diseases, these people can include:
    - HIV/TB: gay men and other men who have sex with men (MSM), sex workers (SW), transgender people, people who use drugs (PUD), people in prisons and other closed settings, and people living with HIV (PLHIV).
    - Malaria: mobile and migrant populations (including forcibly displaced), people working in unregulated or remote worksites , and ethnic minorities.
- **Key and vulnerable populations** (KVPs): KPs, as well as other vulnerable groups in their context, which may include adolescent girls and young women (AGYW), women in general, and forcibly displaced populations.

Questions were also raised regarding the distinction between community-based and community-led, both in the context of organizations (community-based organizations

[CBOs] and community-led organizations [CLOs]) and monitoring (community-based monitoring and community-led monitoring). This distinction was considered important in terms of who is making the decisions: community-based organizations and monitoring can still be directed by people outside of that specific community, whereas community-led implies that members of the community itself are in the drivers' seat and making decisions (whether general population or KP). Where necessary, the evaluation specifies whether an organization or initiative is KP-led, but "communities" is not used as synonymous with KPs to avoid confusion.

CRSS

For many, this evaluation was the first time they had come across the Global Fund's use of the term "CRSS." Indeed, the EVT found no earlier references to it on the Global Fund's website prior to ELO's launch of this evaluation. There was familiarity with CLR (although, as mentioned above, with some inconsistency as to whether "community" referred specifically to KPs, or in some cases, specifically to community health workers) and CSS, and the term "community systems and response" (CS&R) had been observed in some documents from 2022 onwards. This created a challenge for the EVT: evaluating an approach to something where the terminology was not familiar to many stakeholders, even within the Secretariat. Because of this, the EVT sometimes had to refer to CLR and CSS separately. The issue of understanding of CRSS at the country level will be further explored in the Findings section of this report.

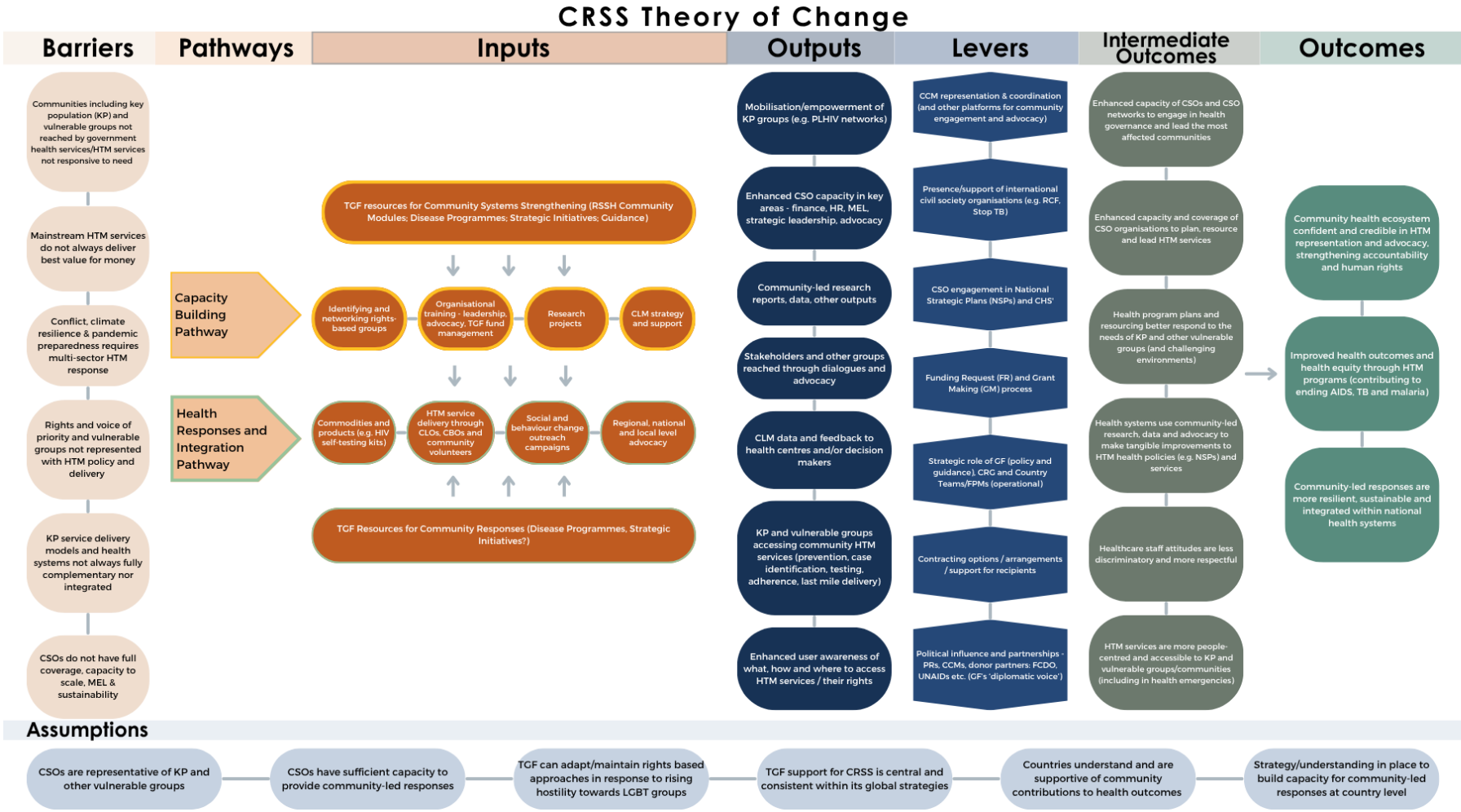
1.3 Theory of change

The evaluation developed a working theory of change which was necessary for the methodology. The evaluation used a strawman ToC during the first phase of the evaluation and worked with key stakeholders at TGF to critique and update the ToC. The final ToC, presented in Figure 1 below, was further developed based on the evaluation's analysis, and using the process evaluation framework. The ToC diagram also presents the assumptions that were tested throughout the evaluation (see below).

The ToC presents the evaluation's findings of how CRSS works in practice. Working from left to right, the ToC presents the most persistent barriers to community responses and systems strengthening in HTM. There are two main pathways in the ToC: the community systems strengthening intervention in the RSSH module, and the capacity-building pathway. This reflects the division which is in the modular framework. The evaluation mapped all interventions and activities related to 'community' in the modular framework, which often duplicates their functions within each module (RSSH and disease modules).

The ToC presents the work with communities within a clear logic framework with TGF-supported inputs leading to outputs, inter-mediate and higher-level outcomes. The two pathways can result in a range of intermediate (and measurable) outcomes related to enhanced CSO capacity and networks, more responsive and efficient HTM services and health systems, and enhanced equity for key populations and vulnerable groups, and in turn three types of overall outcome: a resourced, confident and credible community health eco-system; more effective HTM programs, and lastly, community and health systems integration. These outcomes acknowledge that integration or assimilation into health systems is not always a realistic outcome. Work in rights-based advocacy, or with specific groups, such as key populations, may necessitate a degree of separation from the formal health system to be effective.

Figure 1: Theory of Change



The ToC also identified a number of 'levers'. These are factors or elements that the Global Fund can use to widen the influence of communities, or their contribution to results in the logic model. An example of this is the political influence, or diplomatic voice, of the Global Fund (TGF), which can be used to lever support for rights-based advocacy within a context, without directly supporting interventions. These types of 'under the radar' influence can lead to progress in advocacy for rights and inclusion. Similarly, the strength of CSO voices in the Country Coordinating Mechanisms (CCMs) can exert influence to further CRSS goals, for instance, securing more resources for capacity building.

The evaluation also tested underlying assumptions. As Table 3 below shows, most of these assumptions were found to be partially true. As will be discussed throughout this report, this suggests that several areas need to be strengthened for communities to be recognized for their contribution to health outcomes, and to increase their effectiveness of tackling disease outcomes through community partnership.

Table 3: Assumptions underlying the ToC

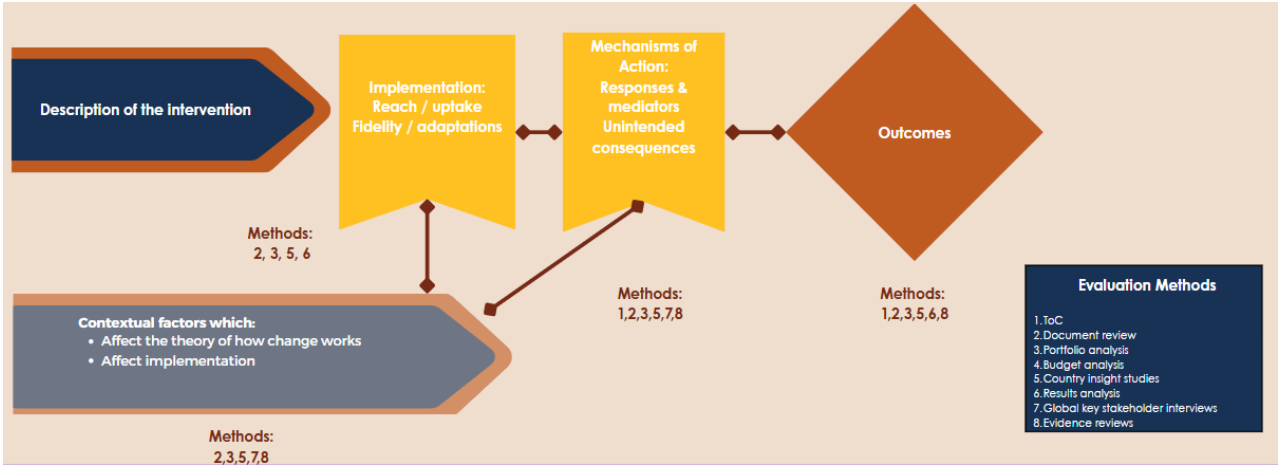
Assumption	Level of validity	Implication for ToC	Report Section
CSOs are representative of KP and other groups	Partially true	TGF support for CSOs plays a critical role, particularly for KPs. Emerging groups, such as CHWs or adolescents, can be under-represented.	Discussed in Sections 3.1 (Design) and 3.2 (Relevance).
CSOs have sufficient funded capacity to provide community responses	Partially true	The evaluation found that investment in CSOs varied by strength of CSO voice, and not by relevance to context, or strength of contribution to outcomes.	Discussed in Section 3.4 (Sustainability) which includes the budget analysis.
TGF can adapt / maintain rights-based approaches in response to rising hostility to LGBTQI+ rights	Partially true	There was strong evidence of adaptation to context, but this is an area of challenge.	Discussed in Section 3.1 (Design).
TGF support to CRSS is central and consistent within global strategy	Partially true	There is strong and central support for CRSS, but consistency could be improved.	Discussed in Section 3.1 (Design).
Country understands contribution to health outcomes	Partially true	In many contexts, and a global level, this assumption was not found to be true.	Discussed throughout the report.
Strategy / understanding in place to build capacity for community responses at country level	Not found to be true	In many contexts, there was not overall strategy for community strengthening or responses.	Discussed in Section 3.1 (Design) and Section 3.4 (Sustainability).

Finally, an implication of the ToC and of this evaluation's findings, is that the strategy for CRSS needs to be clear about different types of CRSS stakeholders, and their potential contribution to different types of outcomes. There are trade-offs to be considered in harnessing the push towards integration for CRSS, for instance, strengthening government support for community-based health actors, but in retaining a focus on wider efforts to strengthen community networks and organizations.

2. Methodology

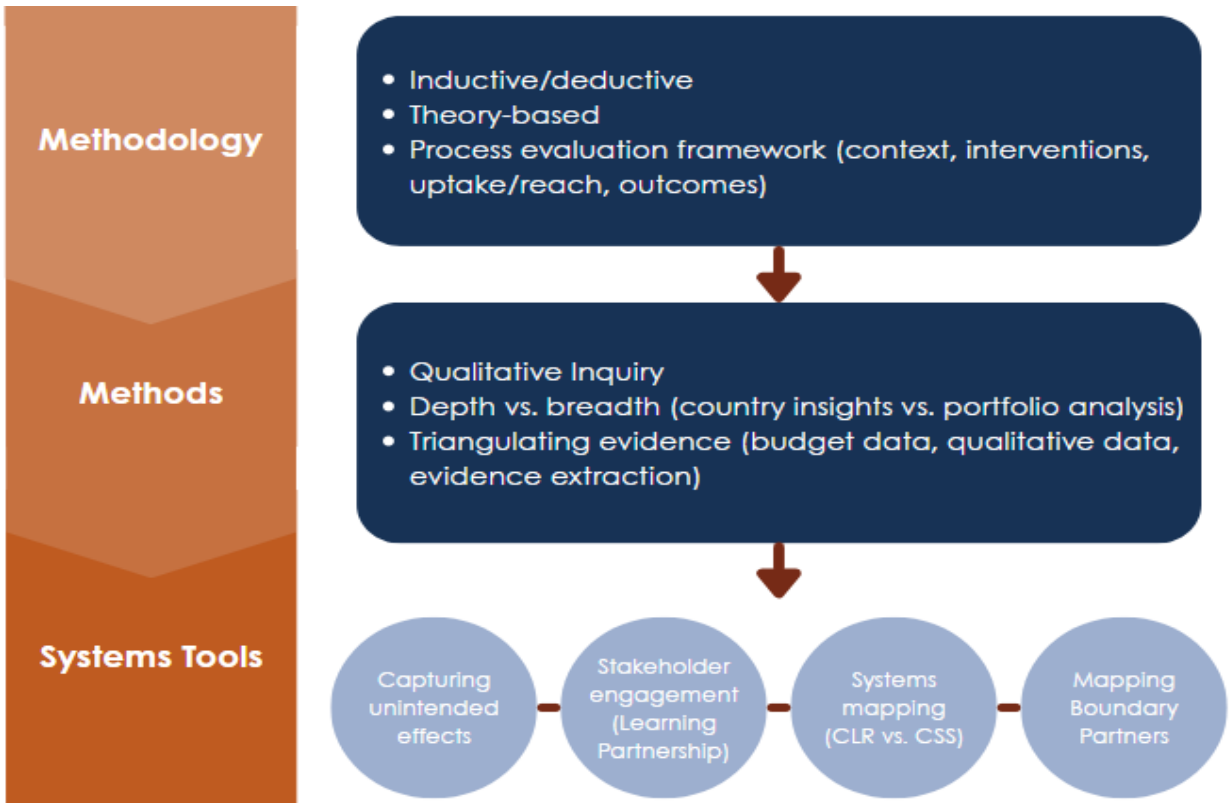
The evaluation approach has been designed to answer both summative (purpose 1) and learning and formative (purpose 2) components of the evaluation. The evaluation was designed to be theory-based and focused on capturing insights and learning. The evaluation methodology used a process evaluation framework (see Figure 2, adapted from the Medical Research Council's framework for process evaluation of complex evaluations) which answers EQs on ***how change*** has been achieved, what role ***contextual factors*** have played, and with ***what types of outcomes***. This framework allows us to conceptually distinguish between the effects of context, design, implementation and outcomes, and also allows further delving into how things are being achieved (*mechanisms of action*). This also strengthens our approach to cross-comparative analysis (e.g. across diseases and country types).

Figure 2: Process evaluation framework with evaluation methods mapped.



The evaluation also used a systems lens, which was designed to: map approaches to working with community systems used by the Global Fund (CSS vs CLR); capture intended and unintended consequences by using qualitative inquiry (as part of a mixed methods approach); map boundary partners and work with a Learning Partnership (LP) to engage community representatives to critically analyze key findings and the implication for policy and practice. The evaluation paid close attention to a political economy analysis to analyze how contextual factors were affecting implementation, and how well the strategy for CRSS was adapting to these contextual factors.

Figure 3: Systems approach to the evaluation



The evaluation methodology used an adapted approach that incorporated outcome harvesting (OH) and contribution analysis (CA). This focused on the mechanisms or 'drivers of change' in different disease and country contexts (challenging/non-challenging operating environments, maturity of community system and Global Fund portfolio classification). OH, is particularly relevant for evaluating CRSS initiatives due to their complex, non-linear nature and the importance of capturing both intended and unintended outcomes. OH, retains the guiding principle of participatory joint analysis of grant results which is characteristic of OH, while also enabling retrospective capturing of unintended outcomes. CA can then be used to map the 'contribution claims' of each outcome and to evaluate the strength of evidence against each claim. This approach was developed into a five-step process (see Figure 3 below).

Figure 4: 5 step process for combining outcome harvesting and contribution analysis

The approach was theory-based and used participatory methods to conduct joint critical analysis of results to inform the recommendations. More in-depth processes were not

possible given time constraints, and the number of outcomes identified. However, this approach identified intended and unintended outcomes against the ToC, to be useful for a cross-comparative analysis.[3] It was also a part of the analysis of how different CRSS components contribute to integration with health systems and enabling service access.

Methodological Glossary
Contribution analysis: contribution analysis is a method which uses methods to assess the extent to which an observed outcome is the result of an intervention. It assesses the strengths of claims of contribution of the intervention to an observed outcome, rather than seeking to establish attribution.
Intended / unintended outcomes: outcomes which are intended are defined as those which are documented in the program's existing logic model or results framework. Unintended outcomes are those which are not planned, but may be positive, negative or neutral.
Outcome harvesting: a method which allows evaluators to identify, verify and make sense of outcomes. Evaluators use methods to identify an outcome, and working backwards, identify what has contributed to that outcome (Evaluation, 2025).
Theory of change (ToC): A comprehensive explanation of how a program or intervention is expected to lead to desired outcomes. It outlines the causal relationships between inputs, activities, outputs, outcomes, and impact.
Theory-based evaluation: An evaluation that uses the ToC to tests the logic model, underlying assumptions, or pathways to effectiveness, rather than just whether the program achieved its intended outcomes.

2.1 Participation and Learning

Our approach was also embedded within a strongly participatory and collaborative learning approach. The evaluation established a 'Learning Partnership' (LP) with CSO members of the Community Engagement Strategic Initiative's Regional Learning Hubs. Members of the LP were engaged from the start of the evaluation, fed back on evaluation design, critically evaluated key evaluation findings, and reviewed evaluation recommendations. The LP thus maintained separation from the evaluation team and evaluation deliverables but supported the analysis of the utility of evaluation findings from communities' perspectives. Members of the Learning Partnership included representatives from *Reseau Access Aux Medicaments Essentiels* (RAME, West Africa), Eastern Africa National Networks of AIDS and Health Service Organizations (EANNASO, Eastern and Southern Africa), *Via Libre* (Latin America) and the Seven Alliance (Asia Pacific).

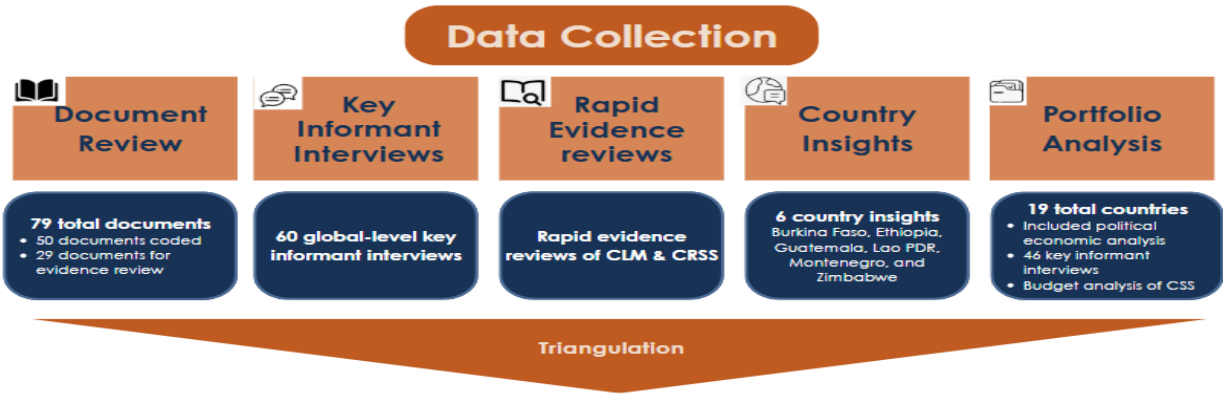
2.2 Methods

This was a mixed method, theory-based evaluation. The methods were designed to enable deeper dives into the Global Fund's work in CRSS, while also being able to capture the breadth of work across different contexts where it operates. Additional methods were added under step 4 of our combined OH/CA approach, to validate emerging findings, or where evidence found for outcomes achieved was not sufficient (see Section 2.3 on limitations). There were substantial adjustments made to the terms of reference (ToR) at the evaluation mid-point, as the funding cuts to global development budgets limited the evaluation's capacity to engage with country stakeholders. Specifically, this resulted in the cancellation of the global survey, which was planned for 21 countries, and was aligned to the portfolio analysis. Instead, the evaluation conducted further in-depth qualitative

[3] To be provided in Vol. II of Annexes.

interviews as part of the portfolio analysis but had to adjust the sample of countries (see below).

Figure 5: Methods used in the evaluation



Methods included:

Development of the theory of change (ToC): a strawman ToC was developed based on a rapid evidence review. This was co-developed with evaluation key stakeholders from the Global Fund Secretariat during online discussions to identify CRSS components, areas of change, and levels of results. The ToC was further developed through the evaluation, as presented in the Introduction above.

Global Key stakeholder interviews: global key stakeholders were identified in collaboration with the ELO and user group and were conducted within the Global Fund Secretariat (18 respondents), partner CSOs (eight respondents) or specialist advisors in CRSS (two respondents). Including the 28 interviews conducted during the inception phase, 60 global level key informant interviews (KIIs) were conducted in total.

Rapid document review and extraction: a rapid document review was conducted at the global level of Global Fund documents which related to CRSS (including policies, guidance, reviews).

Country insight studies: The evaluation also conducted six in-depth country insight studies (see Table 4). Countries were purposively selected to demonstrate a range of country contexts including the maturity of the community health system (KPI S4), and portfolio categorization, grant maturity, geography, and included at least one country categorized as a challenging operating environment (COE). Convenience factors, such as the capacity of the countries to host the evaluation, were also important.

Table 4: Countries selected for the country insight studies

Country	COE	Maturity of community health system (KPI S4)	Portfolio Categorisation	Region
Burkina Faso	Yes	Strong	High Impact	Africa
Ethiopia	No	Weak	High Impact	Africa
Guatemala	No	Weak	Core	Latin America
Lao PDR	No	Emerging	Focus	Asia

Country	COE	Maturity of community health system (KPI S4)	Portfolio Categorisation	Region
Montenegro	Yes	N/A	Focus	Eastern Europe
Zimbabwe	No	Emerging	High Impact	Africa

The country insights provided rich context for the evaluation across all EQs. A cross-comparative analysis across the insight studies allowed for deeper analysis of how contextual factors including the political, social and economic context, were impacting on CRSS (positively or negatively). Country insights methods included rapid document review, extraction of outcomes associated with CRSS, program document review, qualitative interviews and site visits, and evaluation of results in CRSS. Summaries of the country insights are presented in Annex 5, and a cross-comparative table of enabling factors and barriers is presented in Annex 6b.

Portfolio Analysis (PA): Data for 15 countries (see Table 5 below) were shared for inclusion in the portfolio analysis. These were sampled using budget data on CSS, and categorized into high, medium and low levels budgeted for CSS.[4] For the first portfolio analysis, 15 countries were sampled. High-spend countries were over-sampled (six countries), compared to medium (four) and low (five) investing countries (and one country was eventually excluded due to lack of comparable data). This was so that the drivers of higher levels of investment in CSS could be analyzed. The PA used program document review to extract results, outcomes and contextual factors. Relevant documents were insufficient for the PA in four countries, as shown in Column B[5] of Table 5 below. A further round of portfolio analysis that used qualitative interviews with selected key stakeholders was added as a substitute to the planned global survey (Column C, Table 5). The EVT conducted rapid qualitative interviews with representative/s from the Country Team, and from country level stakeholders, such as the Country Coordinating Mechanism (CCM), Local Fund Agent,

Table 5: Countries sampled in the portfolio analysis

Country	CSS budget category (A)	Contextual & political economy analysis (document review) (B)	Contextual and political analysis (in-depth qualitative interviews) (C)
Afghanistan	Medium	Yes	Yes
Algeria	Low	(Yes)	
Azerbaijan	Low	Yes	Yes
Belarus	High		Yes
Bolivia	Low	Yes	Yes
Chad	High		Yes
DR Congo	High	Yes	
The Gambia	Medium		Yes
Guinea	High	Yes	
Honduras	Low	(Yes)	
Indonesia	High	Yes	
Kenya	High	Yes	
Liberia	Medium	Yes	
Mongolia	Medium		Yes
Nepal	Medium	Yes	
Rwanda	High	Yes	
Sri Lanka	Low	Yes	Yes
Sudan	High	(Yes)	
Vietnam	Medium	(Yes)	
Total	**19**	**15**	**8**

[4] Categorization was determined as follows: high - approximately above USD 3 million to USD 54 million; medium - approximately USD 700,001 to USD 3 million; and low – USD 6,600 to USD 700,000.
[5] Note that countries indicated as (Yes) were sampled for the pollical economy analysis, but there was insufficient information to complete the analysis.

Principal Recipients (PRs), and CSO stakeholders (both funded and unfunded). Thirty-one respondents in nine countries were engaged, though only eight countries were included in the analysis[6]. While there was some overlap between the two different portfolio analyses, sampling was impacted by the effects of the budget cuts.

The portfolio analysis also included a budget review. Budget data was requested for all CRSS interventions, using the modular framework to identify community-related activities. However, only budget, and not expenditure data was available (see Section 2.4 below).

Global evidence reviews: The EVT added in global evidence reviews of community systems strengthening and community-led monitoring specifically. This enabled further analysis of how CRSS was intended to 'work' and through which pathways.

Results analysis: Results from the Global Fund's monitoring and evaluation system were extracted by country for the six insight studies and the 15 portfolio analysis countries, and a trend analysis was performed. The EVT also added a rapid evaluability assessment, given the complexities of accessing data on CRSS and to underpin the analysis of the Global Fund's measurement system.

Ethical Norms and Standards

The evaluation was not required to obtain ethical clearance but was conducted in line with both the ELO's 'Evaluation Principles', and UNEG 'Norms and Standards for Evaluation'. This included following procedures for informed consent, prevention of non-deductive disclosure including anonymizing all data, and using strategies to reduce any risk of harm to respondents, especially those at community level (for instance, through re-traumatization).

2.3 Triangulation and Analysis

The evaluation design generated a range of different types of data (including qualitative primary data, budget data, results data, document review data) that formed the basis for the triangulation of data. Our triangulation strategy was comprehensive. Insights and key findings were checked for consistency, and divergency at different levels:

- Data: triangulated by checking for patterns across different types of data
- Respondents: review consistency across different types of stakeholders
- Evaluators: internal analysis checked for consistency and strength of findings across evaluation category leads

The evaluation also ranked the strength of evidence for each finding. Outcomes identified in the OH/CA approach were ranked for strength of evidence, using a strength of evidence (SOE) ranking, and classified using the scale presented in Table 6.

Table 6: Strength of Evidence Assessment

Rating	Assessment of the findings by strength of evidence (SOE)
Strong (1)	The finding is supported by data and/or documentation which is categorized as being of high quality, and the finding is supported by majority of consultations across data sources (KIIs and FGDs) and risk of bias is at a minimum.
Moderate (2)	The finding is supported by data and/or documentation with high or decent quality; and/or the finding is supported by majority of the

[6] The sample reached in Central African Republic was too low and thus it could not be included.

Rating	Assessment of the findings by strength of evidence (SOE)
	consultations across data sources (KIIs and FGDs) and risk of bias is at a minimum.
Limited (3)	The finding is supported by data and/or documentation which is categorized as being of questionable quality; or the finding is supported by only a few consultations (KIIs and FGDs); or the finding is supported by contradictory consultations.
Poor (4)	The finding is supported by data and/or documents which are categorized as being of poor quality; or the finding is supported by few consultations categorized as being of poor quality/biased.

The evaluation used AI-driven software (ATLAS.ti Web, version 5.8.0) to code all qualitative data and global documents. A coding framework was used against the evaluation questions and the theory of change. Further analysis was also done for specific types of data (e.g. key stakeholder interviews). This meant that the coded data was available by evaluation category for analysis. The EVT also held two internal analysis workshops: the first to corroborate and check emerging findings for validity and consistency, and the second to develop preliminary recommendations. The Learning Partnership was also involved in reviewing emerging and key findings and analyzing the utility of these for learning about the Global Fund's support to CRSS and reviewed preliminary recommendations.

2.4 Limitations

The evaluation faced some limitations. This was partly mitigated by including further methods, such as evidence reviews and the qualitative portfolio analysis, but these need to be borne in mind. Some of the limitations also validated some of the evaluation findings.

Key limitations were:

- **Access to data to evidence CRSS was difficult:** The rapid evaluability assessment and country insights found that data to evidence the contribution of communities to disease outcomes was frequently lacking. Even when this data was available, for instance at country level through the health management information system (HMIS), data requests were not responded to.
- **Budget review could only consider intended and not actual investment:** The budget was analyzed for both CSS and the many CLR-related possibilities (with the latter only provided quite late in the process). These are not presented the same way across countries, making analysis difficult. Nor was data available below the Principal Recipient level to understand where investments were going or who was implementing which activities. Significantly, the EVT only had access to signed grant budgets, and not actual expenditure, so final investment could not be assessed.
- **Primary data collection and site visits were limited:** Due to time constraints, primary qualitative data collection covered a limited number of sites. Coupled with the lack of monitoring / quantitative data on community contribution, this undermined how valid wider conclusions were about community impact.
- **Lack of access to government stakeholders:** In some countries, government stakeholders did not respond to requests for interviews, who are important actors especially for the key questions on sustainability.
- **Engagement of country stakeholders in follow-up participatory sessions:** The evaluation intended to engage with country level stakeholders to conduct joint analysis and use outcome mapping tools to map how communities were contributing to change. However, engagement in these planned online group sessions was low and some countries did not schedule the requested sessions.

- **Late change in method resulted in delayed data availability:** The EVT was informed that the originally planned survey would not be possible, and instead the portfolio analysis was expanded. Additional time was also provided to support data collection. However, there was limited time between the data being available (after the initial internal analysis workshop) and drafting the evaluation report.
- **Community Engagement evaluation recommendations were only available at a late stage:** The EVT was able to align its recommendations with the concurrent Community Engagement Evaluation at a late stage, so for instance, alignment was not discussed during the final recommendations workshop. The points of convergence between the two evaluations are discussed in the recommendations section.

3. Findings

This section presents the evaluation's findings organized by the four evaluation categories: Design, Relevance & Coherence, Efficiency & Effectiveness, and Sustainability. All EQs presented in the original RFP have been included but reorganized into the evaluation categories. This allows a presentation of how the Global Fund approaches and conceptualizes CRSS, how it adapts to the country context, the results, and finally, the outlook for integration and sustainability. Findings are then presented against each evaluation question, representing all the issues raised in the request for proposals. When reviewing the data, findings were only retained if the evidence supporting it was deemed to be either strong or moderate or limited (as per the assessment of the strength of evidence presented in Table 6 above), with the color coding reflected in the full list of findings, in Table 7. Following the list of findings, further information is provided explaining the rationale and supporting evidence for each finding.

Table 7: List of Findings

Findings by Evaluation Question	SoE
1. Design	
EQ 1 How well conceptualized is the Global Fund's approach to CRSS within its supported disease programs and RSSH?	
F1.1 The current Global Fund Strategy places renewed emphasis on and is clear on the importance and general role of CRSS within Global Fund disease programs. However, definitions are complex and lack specificity in some important areas, including community-led responses.	1
F1.2. While CSS is conceptually described in the guidance, there is no overall conceptual framework that links CSS with CLR and HSS. This results in a lack of clarity on how communities effectively contribute to health outcomes as part of a country's overall health system, and how they can be supported to do so, at different stages of evolution.	1
EQ 1.1 How has the Global Fund adapted its approach to CRSS in challenging operating environments (COEs) and in the context of anti-LGBTQI+ and rights movements, gender inequality and violence, and closing civic space?	
F1.1.1. The evaluation found limited evidence on how the Global Fund has adapted its approach in the context of COEs and opposition to human rights, although the Global Fund has continued to make good progress in engaging key and vulnerable populations over the period - including via indirect support and advocacy through CSS and strengthening access to service provision.	3
EQ 1.2 How has the Global Fund's approach to CRSS has been adapted?	

Findings by Evaluation Question	SoE
F1.2.1. Global Fund's current strategy for CRSS builds on cumulative experience, thinking and feedback from communities over the years, although there has been less adaptation seen in the tools available to implement CRSS.	1
F1.2.2. The recent emphasis on CLM would benefit from a more nuanced approach, with stronger Global Fund guidance, mediation from the Secretariat in country, and differentiated implementation by national context and disease program.	1
2. Relevance & Coherence	
EQ2. How does the Global Fund prioritize, direct investments, and ensure consistency between funding community responses and supporting community systems to deliver CRSS at the country level?	
F2.1 The Global Fund prioritizes community investments with complementary funding streams. However, support for community-led responses is not consistently aligned with support for strengthening community systems.	1
F2.2 The Global Fund Secretariat adapts to the country context and has discretion in how it influences community investments, requiring different approaches.	1
F2.3 The CSS KPI does not generate the information needed to measure the link between community systems and responses, nor create the incentive to fully support the strategy's intention.	2
EQ 2.1 To what extent are systems-strengthening approaches (such as CLM) aligned with/built into Global Fund HIV, TB, and malaria programs? And to what extent do grant priorities inform CSS?	
F2.1.1. All four aspects of CSS are critical, yet CLM is receiving more attention.	2
F2.1.2. System strengthening approaches are addressed differently in Global Fund HIV, TB and malaria programs, but vary more based on country context and community maturity. This includes CSS being lost or deprioritized within RSSH.	1
EQ 2.2 To what extent are community responses and systems part of national strategic plans (NSPs) / community health strategies, and how well aligned is the Global Fund's approach to CRSS with these strategies, and operational frameworks for community health?	
F2.2.1. Communities are well integrated into national strategic plans (and community health strategies), with their role focused on different aspects of community-based care. Attention to community system strengthening is less consistent.	1
F2.2.2. The Global Fund uses different levers to support communities to shape NSPs, particularly to ensure the inclusion of key populations, and to support CSS.	1
EQ 2.3 How and to what extent does the Global Fund's approach to CRSS ensure complementarity of community-based and community-led services with formal health services?	
F2.3.1. The Global Fund's approach to CRSS encourages complementarity of community-based/led services with formal health care, but some services are easier to integrate than others, integration is easier in some contexts than in others, and Global Fund processes are not always conducive to integration.	2
3. Effectiveness	
EQ 3. How and to what extent do Global Fund investments in community-led and community-based responses contribute to grant implementation, grant performance, and improvements in health service delivery and access to HTM services in different contexts?	
F3.1. Global Fund investments support CBOs/CSOs to deliver improved community health care and increased access to HTM services (across disease testing, treatment, adherence, and prevention) – and particularly for key and vulnerable populations not normally reached by mainstream provision - although there is variation by diseases and context.	1
F3.2. Countries can achieve effectiveness and scale of CSO inputs, with evidence suggesting alignment between stronger performance and enhanced support for	

Findings by Evaluation Question	SoE
community health investments from TGF (within disease programs) - including targeted and sustained support for HIV coalitions (and more latterly TB).	2
F3.3. Key stakeholders globally and nationally recognize the effective (and efficient) contribution that CSOs and CSO networks make to the delivery and success of the Global Fund's country disease programs – although systematic, disaggregated results data is not always available to evidence this	1
F3.4. In some countries, capacity and coverage weaknesses of CBOs and CSOs, and limited integration with formal health systems, limit the contribution of CSOs to improving service access and grant effectiveness. This is compounded by limited budgeted allocations from Global Fund.	1
EQ 3.1 How much have the Global Fund investments contributed to stronger advocacy for resource mobilization and policy change in relation to rights, equity, and health?	
F3.1.1. There are good examples of positive change achieved through CSO advocacy in relation to national policy and Global Fund programming in HIV, in support of access for key and vulnerable populations, following longer-term and/or centralized Global Fund capacity support.	2
F3.1.2. Conversely, the evidence suggests that there are limits to the influence of CSO advocacy – within certain hostile contexts, and in relation to resource mobilization for health – which can be compounded by inflexibility in Global Fund frameworks and monitoring systems.	2
F3.1.3 There is limited to no evidence on how the current approach to CSS under RSSH - with low investment levels - has contributed to stronger advocacy for resource mobilization and policy change.	1
EQ 3.2 To what extent have Global Fund's investments in community capacity building led to stronger community systems and more effective community responses at the country level?	
F3.2.1. There is substantial global evidence demonstrating that investing in the capacity building and leadership development of organizations and coalitions is effective in strengthening community responses and subsequent health outcomes. However, the Global Fund is not prioritizing sufficient funding nor maximizing its existing investments in this area.	2
F3.2.2. Dedicated funds for capacity building, including the CRG/CE Strategic Initiative, have reportedly made more effective contributions to strengthening community systems and community-led responses, and provide learning to inform a needed refresh of the Global Fund's approach to CSS.	2
EQ 3.3 To what extent do Global Fund investments in CLM lead to improved availability, accessibility, acceptability, and quality of HTM programs?	
F3.3.1. Evidence from different countries suggests that when properly implemented, and supported through long-term investment, community-led monitoring can deliver a variety of tangible benefits.	1
F3.3.2. The evaluation also finds several examples of CLM being less effective, e.g. with low acceptance, duplication with other efforts, and data not being used effectively – this creates opportunity costs for countries with other CSS priorities.	1
EQ 3.4 To what extent is the Global Funds approach to results and measurement fit for purpose and capturing intended outcomes in CRSS?	
F3.4.1. Measuring the overall contribution of CRSS to global targets is not possible, due to overall limited direct relevance of national/global targets to community-led responses and community systems strengthening, and high variability across modules	1
4. Sustainability	
EQ 4 To what extent do Global Fund investments in CRSS contribute to the sustainability of community systems and responses?	
F4.1 Current investments in CRSS will not result in sustainability.	1

Findings by Evaluation Question	SoE
F4.2 CRSS investments have been limited in scope and budget	1
EQ 4.1 To what extent are there clear pathways towards sustainable community services and systems at country level (e.g. integration/development of comprehensive community health strategy within national disease response), and why/why not?	
F4.1.1 CLR tends to receive more recognition in NSPs and national health plans and is therefore more likely to be sustainable than CSS.	1
F4.1.2 Integration of some community health interventions into the formal government health sector (beyond CHW cadres) is still limited.	2
F4.1.3 Establishing community health worker schemes is often seen as the single avenue for increasing community health interventions.	2
EQ 4.2 To what extent are Global Fund systems-strengthening investments (such as advocacy and capacity building) enhancing the sustainability of community services within Global Fund HIV, TB, and malaria programs?	
F4.2.1 Funding for CSS is falling in real terms, following the C19RM investment.	1
F4.2.2 CRSS investments are not priorities for countries.	2
F4.2.3 Intercountry CSO platforms have contributed to CSO engagement at the country level.	2
EQ 4.3 What are the opportunities to strengthen the sustainability of CRSS? What are the trade-offs and concerns for the sustainability of CRSS for different Global Fund communities?	
F4.3.1 Opportunities to strengthen the sustainability of CRSS exist, but need to be further documented, institutionalized, and disseminated.	2
F4.3.2 Sustainability concerns affect the outlook of the CSO sector.	1

3.1 Design

EQ 1 How well conceptualized is the Global Fund's approach to CRSS within its supported disease programs and RSSH?

Evidence Rating: 1

Finding 1.1 The current Global Fund Strategy places renewed emphasis on and is clear on the importance and general role of CRSS within Global Fund disease programs. However, definitions are complex and lack specificity in some important areas, including for community-led responses.

The Global Fund has put communities at the heart of its work since its inception (see the timeline in Table 9 below, under EQ 1.2), and the 2023–2028 Strategy is its most community-centric yet. The Strategy calls out ten key shifts in the Global Fund's approach, many of which have a community element. Most notably, these include: "*A more systematic approach to supporting the development and integration of community systems for health, recognizing the vital role they play in combatting the three diseases and reinforcing system resilience and sustainability*", alongside a greater focus on prevention, integrated, people-centered health services, strengthening the role and voice of communities, and health inequities. The current Global Fund strategy also emphasizes the role of communities in improving detection and response to new health threats, following Covid-19. This recognition has been greatly appreciated by communities. As one civil society representative explained, "*We understand community-led health systems*

strengthening as the recognition of the community's leadership role—not just as beneficiaries but as protagonists in the health response."

In terms of **community-led responses (CLR)**, the latter includes an implicit key role for communities in improving HTM outcomes and promoting differentiated and equitable access to services, including by:

- Scaling up comprehensive programs and approaches to remove human rights and gender-related barriers across the portfolio.
- Supporting comprehensive sexual and reproductive health and rights programs and their strengthened integration with HIV services for women in all their diversity and their partners.
- Advancing youth-responsive programming, including for AGYW and young KVP and their partners.
- Deploying quantitative and qualitative data to identify drivers of HTM inequity and inform targeted responses, including by gender, age, geography, income and for KVP.
- Leveraging the Global Fund's diplomatic voice to challenge laws, policies and practices that limit impact on HTM.

As part of the Strategy's first contributory objective - '*Maximizing People-centered integrated systems for health to deliver impact, resilience and sustainability*' - **community systems strengthening (CSS)**[7] is key. The Global Fund specifically commits itself to "*strengthen and reinforce community systems and community-led programming, integrated within national health and social systems*." Broken down, this approach is specified as including the following components:

1. Integrate the development of comprehensive community health strategies into national disease responses and grant implementation.
2. Scale up enhanced community-led monitoring (CLM) approaches.
3. Support policy advocacy, reform and innovative sustainability mechanisms.
4. Provide comprehensive and differentiated support for institutional capacity building for community-based and community-led organizations.

By the Strategy's mid-point (three years), the Global Fund hopes to see progress in:

- The advancement of approaches that strengthen the contribution of community health cadres, including key and vulnerable population peers, peer paralegals and treatment supporters, and community health workers employed by CLO/CBOs towards integrated systems for health.
- Strengthened platforms for service delivery through community-led and community-based organizations that allow flexible, people-centered service access options for clients.
- Increased access to funding for community-led organizations, particularly those led by key and vulnerable populations across the three diseases.
- The effective and routine use of CLM data and feedback in program implementation oversight.

The global strategic position is reflected in documents at the country level, where for example in **Ethiopia**, successive funding rounds speak of similar roles for the community and the need for scaling community-led responses and support. Because of this strategic focus, and long track record of investing in community engagement and community-led

[7] The Global Fund. (2022, December 12). *Community systems strengthening: Technical briefing note for the 2023–2025 allocation period*. The Global Fund to Fight AIDS, Tuberculosis and Malaria.

responses, the Global Fund is seen as a leader in this field, not just within the organization but also amongst strategic partners (KIIs).

However, the evaluation found that in practice - across Global Fund documents, country insight work and KIIs - the operational definition of 'communities' is broad and inconsistent, despite the consensus on the value and contribution of community-led responses to supported disease programs (KIIs). For example, it was found that CLR can be associated with the work of community health workers (CHWs) and/or services provided by CSOs to reach KPs (**KIIs, Ethiopia**, **Burkina Faso**), particularly amongst those most closely associated with technical disease response. Such ambiguity is reflected in Global Fund documentation, despite recent improvements. The Global Fund overview document 'Community Systems and Responses (CS&R) in Global Fund GC7 Grants' (2023) identifies a spectrum of community responses, from CHW and other provision formalized under health systems, to community responses outside of the formal health sector. The Technical Brief on Community Systems Strengthening (2022) notes that "some community-based responses are delivered within government health programs and others by independent non-governmental organizations". However, the RSSH Information Note (2023) makes it clear that "*importantly, community systems and the responses they support are based in and led by communities themselves*". The accompanying detailed 'Decision-making Guide for Community Systems Strengthening Interventions in Global Fund Grants' (2023) also emphasizes support for CBOs and CLOs. None of these documents clearly set out the linkages between CSO and CHW-led service provision - including at what point CHWs are considered part of the formal health system (and hence outside of the definition of CLR); their eligibility/ineligibility for different funding steams under CSS and RSSH; alongside definitions of other types of community-led response operatives and their roles, such as peer counsellors. Conversely, neither do the documents set out the lessons to be learned from CHWs on how other cadres of community workers can be supported to expand, professionalize and integrate within health systems.

Given scarce resources (discussed further below) this is important. Country and some global stakeholders would often refer to CSS as the systems and assistance needed to support CHWs only. This is understandable given that ministries of health are seeking to scale access to community health services and expand the range of services that CHWs provide, in line with Universal Health Coverage (UHC) principles. However, a previous evaluation found that, for example, peer community workers (beyond the facility level) provide unique added value, and that a range of different community strategies should be supported to co-exist to ensure maximum reach and effectiveness in HTM services (Global Fund Thematic Review on Community Health, 2022). An earlier review of CSS found that government-led community responses were being funded through the grant more appropriate to health systems strengthening (HSS) (Community Systems Strengthening and Key Populations, 2013), and this appears to have continued under RSSH where the government is the PR.

Secondly, Global Fund conceptual definitions (jointly shared with partners, including WHO and UNAIDS) are perceived to be complex and not always easily or commonly understood. This can be true at the global level, but particularly at the country level, where some concepts may not translate well, or different terms may be used for the same thing. Global Fund documentation from 2021 (*CSR discussion*) provides the following detailed definitions:

1) *Community responses delivered by community-based or community-led organizations within, partially or completely outside of the formal health system;*

2) *Community Systems Strengthening (CSS)that is a set of interventions to improve community responses and accelerate in-country results.*

The introduction of the further distinctions between community based (CBOs) and community-led organizations (CLOs) - explained in more detail in the RSSH Information Note (2023) - and between community-led and community-based responses, adds additional layers of complexity. The Global Fund's Technical Brief on Community Systems Strengthening (2022) defines community-led responses as "interventions led by communities, irrespective of where they are based" whilst community-based responses are "interventions based in communities, irrespective of who leads" (and the focus of CSS is not made explicitly clear). Again, it was found that such definitions are not always consistently applied nor in use across Global Fund countries. One civil society representative reported "*We talk about community systems, but many people don't understand what that actually means. They confuse it with social work or with general support programs.*"

Finally, Global Fund documentation (and hence some Global Fund representatives, including Country Team members at the Secretariat, and in turn CCM members) could be clearer on the overall added-value contribution of CLR to delivering disease outcomes. The Global Fund's Modular Framework Handbook (2022) lists a multiplicity of CLR intervention types (by disease program), yet the rationale for investing in community systems is less clear. These contributions include for example gap filling of state-led health care provision; expanded/decentralized health care access in remote rural or unstable/conflict regions; reaching marginalized communities; engagement and psycho-social support for key and vulnerable populations where disease is most prevalent; community acceptability; and addressing stigma, discrimination and harm reduction - alongside the potential magnitude of the contribution (i.e. to testing, treatment, referrals and preventative services). Limitations or trade-offs could also be more clearly raised and addressed. Some contributions are set out in Global Fund documents such as 'CSR discussion' (2021), but this is not comprehensive, appears underdeveloped in malaria, and does not capture the contextual nuances of where CLR can add most (or more limited) value. The added-value contribution of CLR to Global Fund outcomes, cutting across diseases, is yet to be captured in a comprehensive theory of change, with associated supporting evidence.

These findings on community-led response were reflected in the conclusions of the previous thematic evaluation, which identified significant weaknesses in the Global Fund's approach and guidance: "*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*" (Thematic Review of Community Engagement and Community-led Response 2022).

This lack of conceptual clarity on the modalities and contributions of CLR, amplified by the volume of documentation produced by the Global Fund on CRSS and inconsistent messaging from different teams within Global Fund (KII), is important. As noted above, it can have a direct bearing on country investments in CRSS as well as on the success of advocacy efforts for increased investment in CRSS from country governments, particularly where they are the PR (as observed for example in the case of **Ethiopia** and in Mozambique - KII).

Finding 1.2. While CSS is conceptually described in the guidance, there is no overall conceptual framework that links CSS with CLR (and overall HSS). This results in a lack of clarity on how communities effectively contribute to health outcomes as part of a country's overall health system, and how they can be supported to do so (including through the RSSH grant), at different stages of maturity.

The current four priority areas defined for CSS under the RSSH modular framework are well-defined: Community-led monitoring; Community-led research and advocacy; Community engagement, linkages and coordination; and Capacity building and leadership development. However, the linkages between CSS and CLR, as well as with wider Global Fund health systems strengthening (i.e. RSSH), are not fully articulated in Global Fund guidance. The Global Fund acknowledges that its strategy around community systems is unclear, with a level of disconnect both *within* CRSS and *between* other areas of the Global Fund's work and health systems (KII). "*If we're going to bring CSS into health systems, the first thing, it needs to be looked at as a system and not just a certain output... So, after three years, what is it that needs to be built as a system to support communities to deliver that whole grant? For all diseases, everything...*" (KII).

Firstly, there is a lack of detailed articulated linkages between strengthening CSS and strengthening CLR; for example, detailed examples of how expanding peer counselling services might require strengthened management, training and/or infrastructure support from a central source, how this can be supported by the Global Fund grant or partnerships, and critically, how the outcomes of such capacity building interventions – such as enhanced planning, quality of care (including from CLM) or integration – should be defined and measured (KII, TERG, 2022; GF PCE, 2019). There was a view from global stakeholders, reflected in observations from country insight studies including **Ethiopia**, that this type of analysis is not always undertaken: "*The fund managers don't prioritize it, countries see it as an extra work, extra burden*". (KII)

Limitations within the guidance is further compounded by the dual and potentially competing strategic goals of the Global Fund of promoting better access, quality of care and accountability for marginalized populations, with strengthening the integration of community-level activities within primary health care systems. Early definitions of CSS emphasized the goals of independence and accountability, which lean more towards strengthening parallel systems of delivery, rather than integration: "*CSS... emphasizes efforts to mobilize communities; to increase accountability of governments, donors, and health programs; and to strengthen community advocacy, particularly for marginalized populations... CSS is encouraging for the community sector in general - and key population groups in particular - because it raises the possibility of channeling funds directly to the community sector to support its infrastructure, staff, and agencies that governmental organizations are not always willing to endorse... this was possibly the first time community action was described as a "system" that could be defined and strengthened in much the same way as health systems can" (Global Fund, 2013)*.

The four current modules of RSSH CSS, aimed at strengthening CSO capacity, fit well with this philosophy. However, with only slight modifications to the CSS modular framework, there has been limited development in thinking in this area since the Community Systems Strengthening Framework of 2014. The CSS modules remain disconnected from the WHO's HSS building blocks, which guide other investments in RSSH (KII; previous thematic

evaluation), and support integrated health systems and sustainability[8]. The ambiguities of CSS and its disconnect with health systems were identified as early as 2013 (Community Systems Strengthening and Key Populations). Since then, and within the context of planning for the transition of the Global Fund out of a country, the wider cuts to international aid as well as the emphasis on more resilient health systems (see for example the contribution of CLR during Covid-19), the imperative for closer integration and sustainability of community systems has come to the fore (including within the current Global Fund strategy).

According to one stakeholder (KII): "*The Global Fund was just focused on outputs rather than a long-term building of systems for sustainability... what it's come to now is about looking at building a systematic approach to having a foundation in countries to be able to not only deliver current services but also to continue to deliver once it moves more into a government... more into country ownership rather than a donor kind of program*". Another academic stakeholder reinforced this point, "*When we talk about community systems, the assumption is often that we're referring to NGOs providing services. But it's not just that. It's about people being able to organize, speak, and act collectively on their own health priorities.*"

The current separate modular framework for CSS within RSSH does not fully fit with the Global Fund's evolved strategic approach, and emphasis on integration. Finally, this lack of clarity is exacerbated by expertise and/or responsibility for driving effective CRSS being split across different teams within the Global Fund Secretariat – CRG, TAP, and Country Teams. The evaluation team found a lack of a shared understanding, alignment and vision for CRSS' contribution across these teams - despite the promise of cocreating a joint roadmap for GC6[9].

Such conceptual clarity is important for guiding countries on why and how effective and sustainable CSS should be implemented and prioritized. A civil society representative claimed "*There is still a lack of clarity on what a community-led health system is. It's a nice concept, but people in government don't know how to integrate it in practice.*"

Over time, the competing goals of CSS and integration may converge and become mutually supportive (within the right contexts – see Table 8 below). However, to support this, the Global Fund's guidance and modular approach is currently not adapted to different maturity levels of community health systems to take a longer-term perspective. For example, (i) strengthening CSO leadership and network capacity may be early goals of CSS within more nascent community health systems, before moving to an emphasis on (ii) closer integration with formal health services[10] (including standardized HSS pillars) over the medium-term, and finally (iii) strengthening capacity for CLM and related advocacy once community systems have become established, accepted and with sufficient trust capital in place between sectors/providers. Similarly, the previous evaluation recommended that "funding guidance should build on lessons learned to emphasize the

[8] RSSH focal areas include integrated service delivery, procurement and supply chain management, human resources, monitoring and data systems, strategy alignment, and financial management and oversight.
[9] Finding based on evidence review and global key stakeholder interviews.
[10] Global Fund (2023) provides a useful definition: *Applicants should adequately connect community and public infrastructure through a systems approach to avoid fragmentation and strengthen coordination and sustainability.... Community health systems should be recognized by governments with roles and responsibilities articulated, financing pathways and targets defined and agreements for public-community referrals in place. This may include reinforcing community cadres of all types, harmonizing retention/renumeration and ensuring community data is captured in health information systems, for example.*

long-term approach needed to strengthen and sustain community systems and address human- and gender-based barriers to health services".

Table 8: Political Economy Analysis of Factors Affecting CSS

Key enablers	Key barriers
• Strong political will and supportive legal environments (e.g., Guinea, Nepal) • Targeted investments in CHW programs (e.g., Liberia, Afghanistan) • Meaningful engagement of CSOs in planning and monitoring (e.g., Bolivia, Rwanda) • Intersectoral coordination • Decentralization of health services • Investment in community-based monitoring and surveillance systems • Efforts to reduce stigma and discrimination toward key populations, such as through sensitization and advocacy (e.g., Indonesia, Democratic Republic of Congo)	• Unstable political contexts and weak health infrastructure (e.g., Afghanistan, DRC) • Inadequate or unsustainable financing for community health systems (e.g., Liberia, Rwanda) • Restrictive legal environments limiting CSO operations (e.g., Azerbaijan) • Shortages of trained human resources (e.g., Guinea, Nepal) • Poor integration and interoperability of health data systems • Logistical and supply chain weaknesses • Persistent stigma and discrimination against key populations, limiting access to health services (e.g., Indonesia, Sri Lanka) • Decentralization efforts lacking clear operational plans, leading to role confusion and gaps in service delivery

Source: Portfolio analysis

Alongside adopting this longer-term and maturity-based model for strengthening community systems, what also appears to be specifically missing from the current RSSH CSS modules are interventions or strategies to promote closer integration of community-led responses within the health system itself (and hence protect community investments). An example of this would be developing and piloting models of social contracting. A 2022 Global Fund review found that whilst the Global Fund has supported countries to develop frameworks and regulations for social contracting and to scale up capacity (for example in Ukraine), efforts have been primarily focused on smaller portfolios with interventions in High Impact countries limited.

The Global Fund notes that it will work on an updated framework for CSS. This could take into consideration the findings above, including a CSS Maturity Model to contribute to the RSSH maturity framework and inform future systems-related investments for communities which support sustainability and integration. Alongside better articulation of the theory of change (linking CSS with CLR, HSS and health outcomes), revisions to the modular framework, and strengthened monitoring and guidance, this work could also include detailed case study research on those countries that have shown and registered some success in integrating community-led responses within health systems (for example through social contracting, as reported in South Africa – KII), over the longer-term and with Global Fund support. This would help to strengthen Global Fund guidance on CSS and provide clarity on how the Global Fund can contribute to positive health system strengthening trajectories – whether through disease programs, RSSH or other technical assistance (TA) and advocacy support.

EQ 1.1 How has the Global Fund adapted its approach to CRSS in challenging operating environments (COEs) and in the context of anti-LGBTQI+ and rights movements, gender inequality and violence, and closing civic space?

3

Finding 1.1.1. The evaluation found limited evidence on how the Global Fund has adapted its approach to CRSS in the context of COEs and opposition to human rights, although the Global Fund has continued to make good progress in engaging key and vulnerable populations over the period, including via indirect support and advocacy through CSS and strengthening access to service provision.

The Global Fund has historically played a strong role in supporting the creation and strengthening of LGBTQI+ networks, within the context of support for HIV communities and activist groups and in response to high levels of marginalization, stigmatization and discrimination (as noted by the previous evaluation of CRSS). However, in recent years progress in human rights (and linked access to health services) for some key and vulnerable populations has come under attack, linked to anti-colonial, populist, conservative and/or evangelical political movements. This translates into an ongoing risk of regressive models of HTM service delivery. The Global Fund's current strategy supports community solidarity and action in confronting and taking a stand against laws, policies and practices that put the health, safety and security of key and vulnerable populations at risk, and obstruct progress in the fight against HIV, TB and malaria. This includes "leveraging the Global Fund's voice to challenge harmful laws, policies and practices". Moreover, in conflict and challenging operating environments (such as Ukraine), the Global Fund's partnerships with community-led and civil society organizations are reported to be critical in adapting program responses and ensuring the continuity of life-saving services (Advocacy Roadmap 2023-2025, Global Fund).

The evaluation found limited evidence on how the Global Fund has adapted its approach to CRSS in such contexts. The Secretariat's malaria team reported that they had produced a briefing paper on malaria and gender including relevant activities that could be supported by countries, although also noted that LGBTQI+ community rights issues do not affect malaria as directly as they do HIV. In the **Guatemala** insight study, stakeholders expressed frustration over the Global Fund's rigidity, particularly regarding tailored approaches for gender and language issues, and commented that whilst TB's community engagement strategies with indigenous populations have been adapted in response to piloting, other adjustments such as improving key population monitoring, methodologies in HIV have been slower.

Globally, the reach of gay men and other men who have sex with men and transgender communities within the HIV response has increased over the period, based upon global KPI data (see finding 3.1). Equally, the Global Fund has successfully expanded its work targeting female sex workers and high-risk AGYW, building on the long-term strengthening of HIV coalitions and civil society networks, advocating for inclusion of such groups within National Strategic Plans (NSPs) and Funding Requests (FRs), and operationalizing testing, treatment and preventative programs for these groups (e.g. in **Montenegro**).

One response to mitigating risk has been to shift to more indirect rights-based advocacy (e.g. through leading on HIV and public health messaging – KII, case study insights), as well as continuing to provide access to services through outreach to key populations, and the provision of leadership roles for community representatives (e.g. on CCMs), and CSS (KIIs). In contexts such as **Ethiopia**, the social and political environment remains significantly constrained and direct advocacy for the rights of some groups criminalized by the state (for example female sex workers and people who use drugs) is less viable and even highly

dangerous. Flexible community-led responses however, for example Drop-in-Centers, or other community or village platforms, can increase access to stigma-free services for such groups without overtly targeting them. Similarly, in **Burkina Faso**, the Global Fund has retained a focus on men who have sex with men, despite strong opposition, for example through its focus on CSS and direct funding for CSOs.

Nonetheless, the evaluation also heard about an example in Mozambique where direct intervention from CSOs and the Global Fund Country Team helped safeguard funding for preventative HIV services for the LGBTQI+ community (see Box 6 in section 3 below). This highlights the potential gains where CSOs, the CCM and the Global Fund Secretariat team work together to advocate on behalf of service access for key and vulnerable populations, even in challenging environments. At the time of the evaluation, a national CSO was also in conversation with its Country Team to develop a specific capacity building contract (within the HIV program) to provide technical assistance to smaller CSOs providing services to MSM and the transgender community based upon tailored organizational assessments. This approach of developing a right-based proposal jointly between affected communities and the Global Fund Country Team, before presenting the proposal to the CCM and the PR, was felt to be a unique yet appropriate strategy for gaining the buy-in of national stakeholders in a potentially sensitive area of support. Conversely, it was considered that this would have been difficult to achieve with RSSH resources, perceived to sit with the Ministry of Health and over which the community sector has limited control. Further examples of successful joint CSO-Global Fund advocacy efforts are included under Funding 3.1.1.

EQ 1.2 How has the Global Fund's approach to CRSS been adapted?

Evidence Rating: 1

Finding 1.2.1 Global Fund's current strategy for CRSS builds on cumulative experience, thinking and feedback from communities over the years, although there has been less adaptation seen in the tools available to implement CRSS.

Table 9 details the evolution of the Global Fund's support for CLR and CSS, including how it has used key levers, such as its policies, strategies, guidance, grants and catalytic investments at different times, and further reflects the increasing centralization of CRSS within the Global Fund's strategic approach.

Table 9: Evolution of the Global Fund's support for CLR and CSS[11]

Year	Initiative
2002	The Global Fund was created and required community representatives as members on Country Coordinating Mechanisms.
2004	Board approved adding the Communities delegation as a full voting member of the Board[12].
2007	Board reaffirmed its commitment to strengthening public, private and community health systems by investing to overcome constraints.

[11] This table was adapted from the one presented in The Global Fund. (2023). *Thematic Evaluation on Community Engagement and Community-led Responses: Secretariat-led with TERG oversight (CE-CLR)*, removing community engagement references, and updating it. It was originally compiled from various sources, including a timeline presented in Office of the Inspector General, The Global Fund. (2019, November). *Removing human rights-related barriers: Operationalizing the human rights aspects of Global Fund Strategic Objective 3 (GF-OIG-19-023)*. The Global Fund to Fight AIDS, Tuberculosis and Malaria.
[12] The Global Fund to Fight AIDS, Tuberculosis and Malaria. (2004, June). *Board Decision B08-DP04: Voting Rights for Communities*. https://www.theglobalfund.org/kb/board-decisions/b08/b08-dp04/

2007	The "Accelerating the effort to save lives" strategy included dual-track financing, community systems strengthening, strengthening the role of civil society, and key and vulnerable populations as strategic initiatives.
2008	Board approved the "The Global Fund's Strategy for Ensuring Gender Equality in the Response to HIV/AIDS, Tuberculosis and Malaria ("The Gender Equality Strategy").
2011	Community systems strengthening framework developed.
2013	The Community Gender and Rights Department created.
2014	Community, Rights and Gender (CRG) Special Initiative created.
2016	CCMs required to include a key population representative for each of the three diseases.
2016	The Sustainability, Transition and co-Financing policy emphasized the importance of community systems strengthening to ensure sustainability and smooth transitions, increasing requirements on higher income countries to focus part or all of funding requests on KVPs.[13]
2017	2017-2022 strategy recognized engagement of key and vulnerable communities, and RSSH was included with a CSS component.
2017	CRG Strategic Initiative replaced the CRG Special Initiative.
2018	Breaking Down Barriers Strategic Initiative pilots in 20 countries.
2019	RSSH and Community Systems Strengthening Technical Briefs issued.
2020	Community-led Monitoring Strategic Initiative pilots in 5 countries, 1 region.
2022	The "Fighting Pandemics and Building a Healthier and More Equitable World" 2023-2028 strategy puts communities at the center.
2022	Published Community Systems Strengthening Technical Brief, outlining the four priority areas - including CLM.
2022	Community Systems and Responses in Global Fund GC7 Grants presentation released, providing guidance to applicants for RSSH funding.
2023	Introduction of first CSS Key Performance Indicator.
2023	Updates for the 2023-2025 Allocation Period (GC7) published on Community Systems and Responses (CS&R)
2023	Published "Decision-Making Guide for Community Systems Strengthening Interventions."
2023	Matching Fund Guidelines[14] include incentivizing effective Community Systems and Responses as part of the Global Fund's catalytic investments.
2024	Sustainability, Transition and Co-Financing Policy updated, with key principles to ensure community participation.

The Covid-19 crisis (and before that Ebola in Sierra Leone) provided a further spur to adapting the Global Fund's approach to CRSS, given the important role played by community organizations in reaching at-risk populations. The regional platforms established under the Community, Rights and Gender Strategic Initiative (and later, the regional learning hubs under the renamed Community Engagement Strategic Initiative) pivoted to prioritize sharing timely and accurate information about Covid-19 with community organizations, and how it impacts the Global Fund's work on HIV, TB and malaria. This included sharing information on Covid-19 grant flexibility, and specifically on the Covid-19 Response Mechanism (C19RM). In the first year, USD 357 million was reportedly approved for 95 countries and eight multi-country programs through the C19RM and grant flexibilities (Global Fund, 2020). The platforms also shared solutions to

[13] The Global Fund to Fight AIDS, Tuberculosis and Malaria. (2016, April). *Sustainability, transition and co-financing policy (GF/B35/04 – Revision 1)*. 35th Board Meeting, Abidjan, Côte d'Ivoire. https://www.theglobalfund.org/en/board/meetings/35/

[14] Matching Funds Guidance Document: The Global Fund. (2023, February 23). *Accessing and programming matching funds: Allocation period 2023–2025* (Updated January 9, 2025). https://www.theglobalfund.org/media/14612/core_matching-funds_guidance_en.pdf

service delivery challenges. During the pandemic, C19RM provided a USD 163m boost to CRSS for pandemic preparedness and response, based upon detailed analysis of budget data provided by the Global Fund. However, the TERG Position Paper on Covid-19 Response Mechanism (2023) identifies systematic weaknesses in C19RM reporting, which limits the ability to analyze systematically the achievements of additional community contributions during this period, whilst in some countries the inclusion of CSS within the 2020 and 2021 funding requests was found to be insufficient, including for KPs – the focus of resourcing was rather on infrastructure and health worker training that did not go beyond the national district and facility levels.

The Global Fund (KIIs) also reports a greater focus under GC7 on having community-based organizations being the Principal Recipient and sub-recipients of country grants, compared with previous cycles (although this was not substantiated by other data). Some global stakeholders (KIIs) recognized that this shift reflects wider development in understanding over the last 10 years that the community needs to be part of the disease response, and not just unique to Global Fund.

However, whilst the strategy of the Global Fund has shifted from talking about communities as one part of the strategy to positioning communities at the core of the strategy and thus most activities, some stakeholders also reflected that meanwhile the Global Fund performance framework and modules (for example with regards to RSSH CSS, as mentioned above), which in turn are key to informing funding requests, have not changed significantly: "*To support a strategy that has changed dramatically, you're using the same tools.*"

Finding 1.2.2. The recent emphasis on CLM would benefit from a more nuanced approach, with stronger Global Fund guidance, mediation from the Secretariat in country, and differentiated implementation by national context and disease program.

One significant evolution in approach is the current emphasis on strengthening CLM, as part of CSS, which the Global Fund defines as a*ccountability mechanisms designed, led, and implemented by local community organizations.* However, whilst CLM is useful as an additional tool for strengthening community engagement and the role of (some) CSOs in advocating for improved health care policy (nationally) and practice (locally), the emphasis on CLM could (and some country evidence suggests is, such as in **Burkina Faso** and **Zimbabwe**) be leading to the neglect of other CSS pillars. This includes, for example, diverting resources away from (paradoxically) support for independent advocacy work, and in the case of TB, identified priorities such as strengthening the institutional capacity and leadership of TB community organizations, increasing community-based services across the TB care cascade, and forming national TB survivor networks, as well as integration with national health systems. In malaria, key priorities include empowering and supporting communities, especially the most vulnerable, to participate in national and local structures, platforms, and processes, including in CCMs (Global Fund, 2023). An over-emphasis on CLM also conflicts with Global Fund's commitments under GC7 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*" (Global Fund, Thematic Evaluation on Community Engagement and Community-led Responses Secretariat-led with TERG oversight, 2022). One global stakeholder (KII) suggested that this relates to the lack of clarity on conceptual definitions and implementation of CSS – CLR is easier to understand and may appear more tangible to Global Fund portfolio managers and hence is being prioritized within RSSH funding requests.

Similarly, based upon the country insights, the evaluation finds that CLM may not be fully appropriate in all contexts, depending for example upon the stage of civil society development in each disease area, but also on the level of integration of community-led delivery more generally within national systems (and trust between sectors). **Ethiopia** was found to be at such cross-roads, and evidence from **Zimbabwe** shows that in such contexts, if not properly supported and mediated, the rapid introduction of CLM can result in turf wars between organizations. This is amplified by definitional ambiguities and varying interpretations even within the Global Fund Secretariat itself on who should lead CLM, its purpose and, for example, the use/national digitization of data. In **Guatemala**, data collection remains fragmented, as sub-recipients use different tools and focus primarily on key populations rather than a broader health perspective. Here, a study is planned to assess how CSOs' role in community surveillance could be expanded into a formal CLM mechanism. In many contexts, a more iterative approach to introducing CLM is therefore essential, with additionally the need for CLM weighed up against the range of potentially more pressing capacity and systems integration needs across the community sector (i.e. 1,2 and 4 above) - particularly outside of HIV - and to avoid CLM becoming purely extractive (KII).

The evaluation finds that where CLM has developed more organically and following sustained Global Fund investment, alongside long-term funding and TA support for network development and advocacy efforts (including support to institutions such as research observatories), CLM is more likely to bear fruit (see Finding 3.3.1). In DRC, an observatory articulated how it was able to move from a position where observatories were treated with mistrust to one where health care providers welcome the input as it supports their own requests for additional resources (Global Fund Thematic Review on Community Health, 2022). This was supported by three phases of TA carried out through the CLM Strategic Initiative (SI), first initiated by a mapping of CLM issues, indicators and sites by different Global Fund-supported implementers (which informed decisions by the Country Team to address duplication in sites by different SRs); and a second and third TA focused on assessing the data analysis, sharing and use of CLM by three implementers, a roadmap for transitioning from paper-based CLM data collection to a digital system and finally a review of CLM data collection tools which led to their revision to streamline. In South Africa, TA produced the first-ever mapping of sites and services monitored as well as populations targeted by CLM implementers. This was critical to understand the geographic coverage of CLM in the country funded by different donors and an initial step towards coordination and sharing data by CLM implementers. In several countries (including Lesotho, Mozambique and the Philippines), TA from the SI was also used to help facilitate meaningful dialogue between all CLM stakeholders to resolve tensions and reach a common understanding on the value of CLM (Lessons from the Community-Led Monitoring Strategic Initiative, 2024).

Global Fund guidance and Country Teams could help to better clarify the definitions, purpose and range of contexts in which to invest in CLM, and how it can be operationalized in practice as a mutually supportive platform (using examples of different delivery models), to ensure that the normative vision for CLM is translated into effective practice on the ground. There is also a need to ensure balancing of investments across the range of capacity and systems strengthening needs required to strengthen community-led responses taking a longer-term perspective. Thorough diagnostics of the interlinked needs of community and health systems (as per the example of South Africa

below) as well as better understanding of political economy prior to CLM introduction should underpin this process.

Box 1: Capacity strengthening for CBO/CLO sustainability in South Africa

Country Insight: Capacity strengthening for CBO/CLO sustainability in South Africa
CBOs and CLOs in South Africa are recognized for their role in the HIV response but faced by a shortage of infrastructure, skills, experience, and systems related to governance, leadership, and financial management in addition to poor access to information and reliance on unreliable and/or limited sources of funds. NACOSA (the PR) conducted functional assessments of 134 CLO/CBOs representing eight KP communities and provided sub-grants and differentiated capacity strengthening support related to governance, financial and project management, monitoring and evaluation, resource mobilization etc. As a result of this support, including a small grant component, Rotanganedza Community Care increased its capacity and operational infrastructure, and the Department of Social Development increased their funding base eligibility from USD 1,000 to USD 283,000. This allowed the organization to become more sustainable and provide additional social support services through income generating activities.

Source: Thematic Discussion Communities at the Centre (Global; Fund, 2022)

3.2 Relevance and Coherence

EQ2. How does the Global Fund prioritize, direct investments, and ensure consistency between funding community responses and supporting community systems to deliver CRSS at the country level?

Finding 2.1. The Global Fund prioritizes community investments with complementary funding streams. However, support for community-led responses is not consistently aligned with support for strengthening community systems.

In response to the current strategy, the Global Fund Secretariat has made a concerted effort to direct more resources to supporting communities directly. To understand how the Global Fund prioritizes and directs its grant investments, key levers beyond the grants themselves include: (1) the allocation letter, which provides the funding envelope and non-binding guidance on how a country's budgetary allocation could be used, (2) information notes, to provide guidance to funding applicants, (3) Strategic Initiatives and catalytic investments to provide supplementary and complementary support. The evaluation considered how these levers have been used to guide investments.

1. **The allocation letter**

While the Global Fund is respectful of country ownership,[15] the allocation letter can be used to suggest how the budget will be split across diseases based on the outcomes of

[15] "The allocation methodology does not determine how countries decide to use available funding and there are many levers that guide and influence countries on how to deploy the funds. Different countries will make different decisions, depending on their domestic financing and partner engagement, and the Global Fund should be careful about imposing a decision at the expense of country ownership".

the allocation methodology, and in some cases, who could manage the services funded. This is intended to encourage countries to enable CSOs to access funding, although it is not a requirement. While the allocation methodology is determined at the board level, country-specific changes can be made during qualitative adjustment, and the Country Team is also able to provide guidance, which is taken seriously by the country. The December 2022 **Montenegro** allocation letter, for instance, clearly states that investments are expected to focus on "*interventions for key and vulnerable populations… interventions that respond to human rights and gender-related barriers and vulnerabilities in access to services… and funding civil society organizations' services as necessary, and transition planning and implementation, including securing sustainable domestic funding sources*".[16] This indicates a clear call to strengthen community systems, and community-led responses. Subsequently, nearly all funding was directed to CSOs, in addition to government co-financing also supporting CSOs. However, Montenegro is an upper-middle income country, preparing for transition, which is not representative of most countries. Yet it does demonstrate that the Global Fund can be directive in terms of what and who is funded.

2. Information notes

Different notes are issued by different departments to provide guidance on what the Global Fund would like to see in investments, based on the best available knowledge and experience. These notes are developed by the Secretariat in consultation with partners (and sometimes in consultation with community representatives) to share best practices. Partners and key informants generally agree that these materials are useful and of high quality, however, one challenge identified in some country insight studies and interviews is the number of support tools that need to be digested. The Global Fund Secretariat is aware that the number of guidance notes has expanded to cover different topics in more detail (often as a result of recommendations from evaluations such as this one).[17] However, while useful and despite efforts made to ensure linkages and consistency across the notes, this makes it more complicated for countries – governments and communities – to review all the necessary guidance and develop a coherent approach. Instead, CCMs often have to "divide and conquer" to develop funding requests, rather than adopting an integrated approach (confirmed by a partner and observed in insight studies).

The CSS information note clearly states that "*Members of Country Coordinating Mechanisms (CCMs) and Regional Coordinating Mechanisms (RCMs) are strongly encouraged to include comprehensively designed and adequately budgeted CSS interventions aligned to country and epidemiological contexts and community health strategies into funding requests to the Global Fund*." They are also reminded that technical assistance is available to support country dialogues, making a direct link to the Community Engagement Strategic Initiative (CE SI). The note also outlines the rationale and value of the different CSS modules.

The Global Fund. (2022, May). *Allocation methodology for the 2023–2025 allocation period* (GF/B47/03). 47th Board Meeting, Geneva/Virtual. https://www.theglobalfund.org/media/12301/bm47_03-2023-2025-allocation-methodology_report_en.pdf

[16] The Global Fund. (2022). 2023-2025 Allocation Letter for Montenegro. Global Fund Secretariat

[17] Based on the materials on the Applicant Guidance Materials page of the Global Fund website, there are four essential tools, four core information notes, nine technical briefs and guidance notes, ten HIV-specific tools, six TB-specific tools (including three of which are shared with HIV), an equity tool for malaria, and four RSSH-specific tools (including one that overlaps with HIV and malaria).
The Global Fund. *Applicant guidance materials*. Retrieved from https://resources.theglobalfund.org/en/grant-life-cycle/applying-for-funding/design-and-submit-funding-requests/applicant-guidance-materials/

3. Strategic Initiatives

The Global Fund uses additional resources through Strategic Initiatives to support implementation of core grants and funds. These include the CE SI and the Breaking Down Barriers Strategic Initiative (BDB). Unfortunately, none of the insight study countries were included in the original BDB countries, which addresses rights- and gender-based barriers faced by key populations.[18] Based on baseline assessments, specific interventions are designed and implemented, and a mid-term and endline assessment is conducted to review the change, particularly in areas related to stigma and discrimination. The portfolio analysis revealed a general under-investment in human rights, so this complementary support is critical, and generates lessons learned to share with other countries.

CE SI includes three components that can also support CSS. The first includes short-term technical assistance (TA), which while primarily targeted at supporting community engagement in the grant cycle (e.g. participation in community or country dialogues), can also support community-led research and advocacy. This technical assistance has proven important for many communities, and "The inclusion of key populations in writing teams has shown to directly enable the inclusion of specific priorities in funding requests."[19] However, as TA is on a demand-basis, not all communities in all countries benefit from it, and it can be the countries that already have a capable civil society, or a supportive CT that are able to request the TA that are more likely to access the opportunity. There have been efforts to increase TA to malaria-affected communities, and to increase awareness of the mechanism to encourage its use. However, it can also be the case where TA is requested in a country, but others in the country are not aware of it, which may reduce its effectiveness. The second component is long-term capacity strengthening support to key and vulnerable population networks. The CE-SI currently supports six HIV KP networks, five TB networks, and one malaria network, which is also one of the newer networks to emerge. The third component consists of six regional learning hubs, which contribute to capacity building and engagement, coordination and linkages. These hubs help to share information and connect organizations at the regional level.

Despite these levers, many investment decisions are based on what is considered the best use of limited resources, where the emphasis is on investing in areas that will have a direct impact on indicators and produce measurable results. The impact of investing in CSS to support CLR and its contribution to health outcomes is often less visible, and CLR appears to receive more attention and investment than CSS. We saw in some of the country insight studies that investments were focused on what communities can deliver, but not the capacity challenges they face. As one member of the Secretariat stated in this context, "It's very supply side driven, not the demand side of the system".

This is also reflected in increased investment figures (which will be discussed further in section 3 below). The Global Fund demonstrated responsiveness to Covid-19 with the creation of C19RM as emergency response to the pandemic in 2020. The additional funds

[18] The SI has now expanded to 24 countries, including Burkina Faso in the most recent funding cycle, however this work was too recent to have been captured in the insight study. *Breaking down barriers*. Human Rights - the Global Fund to Fight AIDS, Tuberculosis and Malaria. https://www.theglobalfund.org/en/human-rights/breaking-down-barriers/

[19] The Global Fund. (2020). *The Community, Rights and Gender Strategic Initiative: Engaged Communities, Effective Grants*.

available also increased the focus on CSS in 2021,[20] providing an important opportunity to communities to demonstrate the value of their contribution.

Matching funds can also be an important lever, and in Montenegro, for example, the Global Fund's requirement that the government contribute to funding community-led services proved to be an important step. This requirement was based on lessons learned of the previous transition of the Global Fund out of the country, which resulted in an increase in new HIV infection rates. This time, the Global Fund adapted its approach to plan for a more sustainable transition.

Finding 2.2. The Global Fund Secretariat adapts to the country context and has discretion in how it influences community investments, requiring different approaches.

The Global Fund Secretariat is responsible for overseeing diverse portfolios, and Country Teams also have significant latitude in how they guide or influence a portfolio. The combination of these two factors results in very different approaches to supporting community investments. In adapting to the country context, the Global Fund Secretariat needs to consider:

- the **epidemiological situation** of one to three diseases, which can vary across a country,
- current **health system** strength, both in terms of what the country's health system is capable of, which aspects of the system are un/under-funded or at risk (i.e. the relative needs of laboratory systems, procurement and supply chain systems, information systems, human resource systems, and how each is currently engaging with community systems,
- **fiscal space** of the government, and what resources it may already be investing, or be persuaded to invest,
- government and general **cultural attitudes** to communities, which can be different for different communities (e.g. general "hard to reach" populations compared to stigmatized key populations),
- the **legal context**, in terms of how governments can work with communities,
- the level of openness or **civic space** that communities and civil society have to operate and express themselves freely,
- the **maturity**, capacity, and level of coordination or cohesion of communities and civil society (i.e. capability of community systems),
- the **relationship** between communities and/or civil society with the government,
- the capacity, functioning, and representativity of the **CCM**, and
- **grant maturity and investment priorities**, including how close a country may be to transition away from Global Fund support, noting that maturity varies across functions (for example, procurement systems may be well developed, but community engagement lags).

These country-level factors are often taken for granted, but their importance – and the effort required to understand them – cannot be underestimated (and do not even include the general political situation, respect for the rule of law, gender norms, or the impact of conflict, disaster or displacement). Decisions need to be made on investments based on the understanding and interpretation of these complex factors by the CT/FPM, who will see each factor through the filter of their personal experience, capacity/bandwidth and attitudes. This was observed by some key informants, and confirmed in previous

[20] Advisory Paper on Resilient and Sustainable Systems for Health: Technical Review Panel [Review of Advisory Paper on Resilient and Sustainable Systems for Health: Technical Review Panel]. The Global Fund.

evaluations, and comparisons across country insight studies. For this reason, it is difficult to have or demonstrate consistency in the Global Fund's approach, other being consistent in tailoring investments and support to the context. And the role of the CT/FPM will be a wildcard in the absence of internal guidance on how to respond to the combination of different factors.

Take, for example, the government's attitude to communities. Countries where the community's contribution to health outcomes is understood, recognized, and valued tend to have an easier time securing support for CLR – particularly when the community in question is one that the government would like to reach but cannot. This was observed in the insight studies, where CHWs were seen as the only way to reach some communities due to location (e.g. hard to reach areas in **Chad**, **Burkina Faso** and **Lao**), mobility or cultural-linguistic reasons (**Chad**, **Lao**), or where identity/behavior result in people fearing stigma and discrimination (**Montenegro**). In these cases, people are either unable or unwilling to use public services, and it is recognized that communities/civil society are better placed to provide these services. *As one government PR put it, "To reach our goals, the best way is to through communities, or we will never reach our targets. They are the best epidemiologists – they're the ones who know what's happening at the community level."* However, where the government was less willing to provide resources to a specific community – such as gay men or other MSM or LGBTQI+ people in **Ethiopia** or **Burkina Faso**, it is harder to gain support for CLR, and CSS can even be interpreted as threatening.

In these distinct cases, different approaches may be needed. The former may be supported by a top-down approach (e.g. originating from a National Program or the CCM) or a bottom-up one (e.g. from community level). In **Ethiopia**, it was suggested by a funding partner that attempting to strengthen community infrastructure within the context of a highly centralized and conservative state is a risky strategy, and that it would be more effective to channel funding through CHWs and build support from there. That is, there is a clear dichotomy between supporting CHWs and (KP) CSOs, with each requiring different strategies, but the former potentially being able to create space for the latter.

It is not possible to develop guidance for every community or country context, yet the Global Fund attempts to adjust its investments by bringing different Secretariat teams together to review each country and make collective decisions during the allocation qualitative adjustment process. This allows technical teams, grant management, health financing and other teams to collectively consider relevant factors to inform any needed adjustment to the country allocations. The guidance provided in the allocation letter can provide suggestions on prioritization (e.g. disease components, implementer types) at the country level, but decisions remain the country's. CTs can influence (sometimes significantly) what is funded during the funding request process, and again during grantmaking. A pro-active CT may reach out to colleagues to consult on different issues, but there are no further mechanisms for cross-team collaboration during project implementation or monitoring. Decisions following allocation can be made in silos, partly because consultation can be so time-consuming.[21] The CT also has discretion in terms of how involved they are in ensuring that the country's decisions (a) identify the most appropriate respective roles for government and community responses from a health outcomes perspective, or (b) what support communities need to play their role effectively

[21] Skilled facilitation will also be critical. One Secretariat informant shared "I do think that there needs to be more engagement across the Global Fund, right? So different actors can all get on the same page… it's hard because I feel like the Global Fund is like a Hydra. You know, there's like a million heads. And the minute you think you understand one, it splits into three. And so it's really difficult to figure out who needs to be in that room. I found that the more I can get people in that room, the better. With somebody leading it that is practical, because there's a lot of words and words and words, and then you kind of go away and you're like, I don't even understand what we did there."

to ensure it is responsive to the Global Fund's strategy. In some cases, Secretariat influence can be important if communities themselves have limited influence or the country's analysis under values the community's contribution. This role of the Secretariat to play this role and have this influence is critical. As one community key informant shared, "*Without Global Fund there would be no community interventions from government*." This point was made more explicit by another community KI who requested, "*We would like more support from Geneva, and a consensus steer and decisions across GF, PR, SRs and CSOs through joint meetings*". Indeed, another community representative indicated the CCM was not sufficient to represent community interested, and suggested "*The solution is to create a strong structure to engage and communicate with the Government and PR*."

Finding 2.3. The CSS KPI does not generate the information needed to measure the link between community systems and responses, nor create the incentive to fully support the strategy's intention.

Key Performance Indicators (KPI) are an important accountability tool, signaling the importance of something, and serve as an incentive to perform in that area. The existence of a Community Systems Strengthening KPI is therefore critical to ensure that CSS is measured, tracked, and incentivized. The composition of the current KPI as an index is logical and practical to capture nuanced group of indicators that can provide a picture of community systems and their ability to contribute to national strategies. The criteria and thresholds selected, however, may not adequately capture the key aspects that need to be in place. Some issues identified by the EVT were as follows.

1. **Country has no registration or regulatory restrictions on community service delivery.** This is an appropriate criterion, ensuring that communities can deliver services. It may, however, not go far enough. Based on the Montenegro country insight study, for instance, in addition to not having regulatory impediments to contracting communities, it is also important that the country has procurement mechanisms in place that allow the government to provide contracts or financing directly to CSOs, such as social contracts, or mechanisms to pay CSOs.
2. **Country submitted a National Community Health Strategy with last funding request:** Not all countries currently have a Community Health Strategy, but community health approaches may be integrated within disease NSP. Similarly, the existence of a CHS, therefore, may not be indicative of the status of community systems. Furthermore, as Finding 2.2.1 indicates, some CHS refer to community-based services, without addressing community system strengthening. The current criterion may therefore not provide information on whether community systems strengthening is covered in a national plan. Nor does it provide information on whether communities have the capacity, coordination and position to be able to influence the plans or strategies, which can also be a meaningful indicator of the community's ability to coordinate and advocate.
3. **Country where a Community Sector Principal Recipient has a PR rating of "adequate" as per GF assessment and/or if a capacity assessment of civil society SRs/implementers has been conducted and found to be adequate for at least one implementer.** The capacity of PR/SR may not be a strong indicator of the strength of community systems overall, but rather that of a particular organization. It may also refer to the capacity of international organizations, which are not representative of communities. Communities may also support responses under a government PR, and a country with this system in place would score less well on this index, which would be misleading as to the state and sustainability of health systems in the country. The EVT therefore does not find this criterion to be appropriate for this indicator.

4. **Health facilities include data on referrals by community health workers / community volunteers.** This criterion correctly intends to capture linkages between community health workers/volunteers and the public system. However, it appears to be a very narrow definition and not capture all possibilities for integration and complementarity. By only mentioning referrals, it does not include data related to testing, case detection, or any form of treatment provided by the community. The criterion is also limited to CHWs, whereas some services may be provided by CSOs, who may also share data with health facilities. This criterion therefore does not capture the full range of linkages between community and public services.

Finally, the current indicator does not provide any indication of the likely sustainability of community systems, such as whether the government is currently providing or planning to provide financing to support community services or systems.

EQ 2.1 To what extent are systems-strengthening approaches (such as CLM) aligned with/built into Global Fund HIV, TB, and malaria programs? And to what extent do grant priorities inform CSS?

Finding 2.1.1. All four aspects of CSS are critical, yet CLM is receiving more attention.

The EVT found that all four aspects of CSS included in the modular framework are considered appropriate and valid by partner, country stakeholders, and members of the Secretariat. The classification of community-led research and advocacy, and CLM as CSS can be misleading, however, as both activities can be considered part of a community-led response and contribution, rather than contributing to strengthen community systems per se. That is, part of the community's response is not just delivering services but conducting advocacy. Community-led research and advocacy is critical to ensuring that the right information is available to inform program design that promotes access and quality; capacity building and leadership development is needed to ensure that communities can play their role effectively both in service delivery, influence, and holding decision-makers accountable; engagement, coordination and linkages are needed to ensure that civil society is working well together, and connected to the government; and CLM is needed to allow communities to hold service providers accountable and have influence over the services they receive.

Regardless of where they are classified, all four components are needed to support CRSS, and each is likely to be needed in different ways in different countries, depending on the context – particularly the maturity of communities and civil society. However, there has been increasing emphasis on and investment in CLM. This has been observed in the number of workshops and activities on CLM, and the fact that some countries report that they are being asked to include CLM. This has not been observed with the other three components. Investment in CLM is also increasing, potentially at the expense of community-led research and advocacy (see Figures 7, 8 and 9 in section 3.4 below). While it is not possible to know with the data available, the EVT observes that CLM is being encouraged over and above the other CSS components, without a clear rationale for identifying which CSS components are needed. Country-level stakeholders in at least one insight country (**Ethiopia**) and one portfolio analysis country (**Chad**) were not clear on the need, rationale or value add of CLM in their countries, which they believed already had strong, participatory data collection systems in place. One respondent shared "*the portfolio managers and others just look at what they understand. So that's why community-led monitoring has got the most amount of funding, because they understand CLM, but the other parts they think should be within the disease component and not standalone*…

for a system to work, we need all of those four components… but what happens is countries just will pick one. So right now, community monitoring is the key one that everyone's picking."

CLM has been accompanied by the most additional guidance and assistance (and was its own SI in the previous grant cycle). Yet opinions of CLM vary within the Secretariat, among partners, and at the country level. As will be discussed in the Effectiveness section, CLM can contribute many benefits. In some contexts, however, its purpose and operationalization are less well understood, and in some cases, there may be some overlap with community-led research and advocacy. However, it has risen to prominence within the Global Fund because of examples of success, potentially because donors appreciate that it brings another layer of accountability, and communities recognize it as an opportunity to influence service quality and have a voice. Originally developed for HIV services, its integration into malaria has been slower. However, there is appetite for it – particularly to understand and address barriers in accessing care and understanding why people seek care where they do and supporting that. There remains untapped potential in CLM, and ongoing efforts will be needed to continue to clarify and simplify its operationalization and demonstrate its benefit. However, other CSS components may require prioritization, based on each country's needs. It was also observed that there are only two RSSH/CSS indicators: one related to capacity building ("Number of community organizations that received a pre-defined package of training"), and one related to CLM ("Percentage of health service delivery sites with a community-led monitoring mechanism in place"). The inclusion of an indicator also implies that it will be something that the Global Fund expects to see and will be tracking at a global level.

Finding 2.1.2. System strengthening approaches are addressed differently in Global Fund HIV, TB and malaria program, but vary more based on country context and community maturity. This includes CSS being lost or deprioritized within RSSH.

As discussed in Finding 2.1 above, the EVT found that support for CSS can vary depending on many different factors. Overlaying this, differences can be observed between how CRSS is supported across the three diseases. The Global Fund is aware that historically, HIV CSOs have received more support for capacity building and leadership development; engagement, coordination, and linkages; research and advocacy; and CLM from a variety of technical and financial partners. They subsequently have more capacity and experience, and many of the tools were specifically designed for HIV and the challenges faced by stigmatized KPs. Concerted effort has been made to redress this imbalance by, for example, the CE SI directing more TA and other support at TB and malaria groups, and the Secretariat producing more information notes on equity for these diseases. However, based on both KIIs at the Secretariat level and the country insight studies, more work is needed to ensure that some aspects of CSS – particularly CLM – are better understood in their application to TB and malaria.

Again, there is a distinction between support for community-based care provided by CHWs for populations affected by malaria and TB, where the community's role is recognized and valued, and that of services targeting KPs. Particularly when resources are scarce, CSS activities can be deprioritized at the country level, and service delivery (including commodities) will be prioritized. This can be clear, for example, in having CHWs ensure wider access to malaria testing and treatment services in some countries, and also where there is a strong understanding that a community, or KP-provided service is the best way to reach a particular group. But in some countries, the evidence that would demonstrate what services are needed to increase access to services does not exist, and

there is limited investment in the community-led research needed to generate that evidence. The budget for this type of research is sometimes cut out of grants or prioritized above allocation request.

In addition to CLR being favored over CSS because of its more recognizable contribution grant/NSP indicators, is that the inclusion of CSS in RSSH results in CSS having to "compete" with other important system strengthening priorities. This emerged in several interviews and country insight studies. All aspects of RSSH are important, yet some governments see RSSH as intended to support different aspects of the government's health system. Governments – who can be a dominant CCM member or decision maker (particularly during final grantmaking stages) – may be reluctant to sacrifice strengthening laboratory systems, information systems, procurement and supply chain strengthening, for community systems. There are some exceptions where governments see CHWs as important parts of their health system and approach, but this does not usually extend to the four CSS interventions of the modular framework. This issue is expanded on further in the following finding.

EQ 2.2 To what extent are community responses and systems part of national strategic plans (NSPs) / community health strategies, and how well aligned is the Global Fund's approach to CRSS with these strategies, and operational frameworks for community health?

Finding 2.2.1. Communities are well integrated into national strategic plans (and community health strategies), with their role focused on different aspects of community-based care. Attention to community system strengthening is less consistent.

The Global Fund's commitment to country ownership means that its investments are driven by country-driven National Strategic Plans (NSPs). Efforts are made (particularly through the CE SI) to ensure that NSPs reflect government, private sector and community needs and perspectives, although this varies across countries (and sometimes between communities at the country level). The EVT reviewed the NSPs for the insight study countries that it could locate and found that most include community-led service delivery – particularly by CHWs for malaria testing and treatment, or TB screening, and/or some services targeting KPs by CSOs (the latter mainly for HIV-related services). Some NSPs include community-led research, and there is increasing inclusion of CLM. There appears to be less consistent inclusion of community-led advocacy, or capacity building and leadership development. Similarly, most indicators included in NSPs relate more to service delivery outputs, rather than CSS outcomes, nor make an explicit link between how CSS supports CLR.

Generally, the inclusion of CHWs is common in NSPs of low-income, high-burden countries – particularly for malaria, and to some extent TB – while advocacy and capacity building receive less attention – at least for communities. The role of communities beyond CHWs is also recognized more in HIV than TB and malaria. Some NSPs also refer to integration – both in terms of integrating different health services as well as integration of CHWs into the national health system. This can also be mentioned in Community Health Strategies (CHS), where they exist, as they tend to refer to CHWs in general, rather than disease-specific workers. Of the six insight countries, only **Burkina Faso**, **Ethiopia**, and **Zimbabwe** have a National Community Health Strategy, of which CHWs are key pillars.[22] These strategies can focus more on the general population than being KP-specific. Some CHS also refer to

[22] The evaluation did not find evidence of the Global Fund supporting involvement in the development of CHSs, however, this was not reviewed in detail.

community groups such as women's/mother's groups, youth groups, and local health or development committees, or village savings and loan groups. Governments can see these groups as a way to engage communities, however they tend to feature less in NSPs, and are also less engaged or funded by the Global Fund.

The four pillars of CSS as defined by the Global Fund are more likely to be integrated into NSPs than into CHS. Integration is more clearly reflected in CLR, but more clarity on integration into strategy (such as NSPs) needed for CSS. Investment on CSS can depend on civil society maturity. As one Secretariat respondent said: "*What has given a lot of countries high levels of investment is strong civil society. Without them, no country would invest in CSS. I can promise you that. They would invest in community health workers as one of the community responses, and they would invest in peer approaches programs for sure. But advocacy, CLM, research, capacity development, all of those things would fall through the cracks, and it won't be an area of investment. It only remains an area of investment because of strong, confident agency, community and civil society groups that participate and engage in the process of how these resources are allocated*." Another factor can be civil society's representation and influence on the CCM. Others also believe that civil society's representation and influence on a CCM is important, and how well those representatives are able to advocate for community and frontline worker needs and demonstrate the contribution to health outcomes. One of the Learning Partnership's observations was the importance of Global Fund modules to support this type of advocacy, as the existence of an intervention in the Modular Framework also legitimizes investment into it.

Some NSPs refer to communities in the sense of the general population living in a geographic area, and the use of CHWs is increasingly common to reach people living more than five kilometers from a health center, for example. NSPs can be less clear on how different KPs are included, or in other aspects of CSS. In these cases, the Global Fund Secretariat can have a role to play. As one partner put it, "*So if you're using a national strategy plan and CSS is not in it, it doesn't translate well, right? Because you are adding something that is Global Fund-specific. You may have capacity building, you have advocacy, you have all that within a strategic plan, but it might not be under a category called CSS. So we need the Global Fund Portfolio Manager and others to guide countries to say, this is how it fits into each of these diseases*."

Finding 2.2.2. The Global Fund uses different levers to support communities to shape NSPs, particularly to ensure the inclusion of key populations, and to support CSS.

While NSPs are country-owned documents, the Global Fund has been able to boost the participation of communities to inform the content and priorities of NSPs. Some TA of the CE SI has been used to ensure KPs are involved in NSP development, and there is also clear signaling that broad consultation and participation will be positively viewed when it comes to approving funding requests. This has been important in some countries to ensure groups whose priorities and interests may have previously been excluded, are integrated into plans. This has been particularly important for KPs that face stigma, discrimination or criminalization. Sometimes the wording is adapted for acceptability. In some countries, "vulnerable populations" is often used to refer to MSM or trans people. Despite remaining somewhat invisible, this approach has ensured that the interests of otherwise excluded KPs are supported. In other countries (one insight county), it was reported that some intercultural dialogues that had been included in grant frameworks, were not implemented, which reduced the responsiveness of programs to the needs of Indigenous

and other marginalized communities. The lack of communication contributed to a perceived disconnect between PRs and community stakeholders, leading to misalignment in priorities and missed opportunities for deeper collaboration, and allowing community organizations to shape national health systems, programs and outcomes. As one community stakeholder observed, "*People say there is participation, but it's often symbolic. You're invited to validate a plan already written.*"

Because of the influence it has, there is a symbiotic relationship between NSPs and funding requests prepared for the Global Fund. Many countries timed their NSPs to align with the Global Fund's grant cycle, and many adopt some of the language that appears in Global Fund information notes and the Modular Framework. **Ethiopia**'s National Strategic Plan for HIV/AIDS 2021-2025, for example, includes reference to community-led response, and three out of the four CSS modules. "*Communities are the best way to reach key and priority populations, people living with and affected by HIV. They have the trust of the people they serve, and community-led organizations are the most effective way of reaching people living with HIV and key populations… This NSP will support community level groups to undertake CLM that will diagnose and pinpoint persistent problems, challenges, and barriers to effective service and client outcomes at the site level. Most importantly this collaboration can identify workable solutions that overcome barriers and ensure beneficiaries have access to optimal HIV/AIDS services. … Advocacy and capacity building interventions to implement the domestic resource mobilization strategy will be conducted across the various levels*."[23]

Concern was raised in at least one country that the Global Fund can sometimes exert too much pressure on a country's NSP, and that a balance needs to be found between including KPs and not excluding other community members. In **Guatemala**, for example, the insight study found that there is a top-down approach to defining target populations in the HIV response, resulting in the de-prioritization of certain vulnerable groups. The current HIV programming focuses on trans women, MSM, and female sex workers, but organizations representing women and PLHIV have lost funding and visibility. Many of these groups were foundational in Guatemala's HIV response but have been left out of recent funding cycles, leading to the disappearance of several PLHIV-led organizations. Stakeholders argue that a more inclusive and community-driven approach is needed to ensure that all vulnerable groups receive adequate support. It was also reported in one country that while Global Fund policies are designed with some flexibility, that CTs can impose rigid interpretations of these policies, limiting opportunities to adapt to local realities. There is a perception in some countries that decisions framed as "recommendations" from the Global Fund become requirements, creating tensions with local implementers, and restricting the ability of national programs to innovate and tailor interventions based on evolving needs. While this is example came from one country, it further illustrates the point under Finding 2.2 above on the discretion that a CT can have.

EQ 2.3 How and to what extent does the Global Fund's approach to CRSS ensure complementarity of community-based and community-led services with formal health services?

Finding 2.3.1. The Global Fund's approach to CRSS encourages complementarity of community-based/led services with formal health care, but some services

[23] Federal HIV/AIDS Prevention and Control Office (FHAPCO). (2021). *HIV/AIDS national strategic plan for Ethiopia 2021–2025*. Federal Democratic Republic of Ethiopia. https://hivpreventioncoalition.unaids.org/sites/default/files/attachments/ethiopia-hivaids-national-strategic-plan-2021-25_0.pdf

are easier to integrate than others, integration is easier in some contexts than in others, and Global Fund processes are not always conducive to integration.

An objective of the Global Fund Strategy is "Maximizing People-centered **Integrated** Systems for Health to Deliver Impact, Resilience and Sustainability." Integration is therefore at the heart of the strategy; however, no specific definition of "integration" has been found, and it can be used in different contexts. For example, integration may refer to integration of diseases into one approach or service, or it may refer to integration of community services into the government health system. This evaluation defines integration of CRSS in line with the CSS technical briefing note, which refers to integrating community-led or community-based services into the service delivery ecosystem.[24] The intention is to ensure that interventions of different sectors are complementary and collectively address the health needs of all populations, to leave no one behind. The community's unique knowledge of and access to communities also strengthens the community, and community-led efforts can better reach marginalized populations, to promote equitable access to health care. As one KI from the Secretariat put it, "*Ultimately, it really comes down to the trust of the population that's being served in the provider that's serving them*."

Integration of community-based and community-led services into the national system is seen as important to ensure their structural and financial sustainability. However, this is not always possible – typically because of (a) the limited fiscal space that governments have in their health budgets, (b) regulatory issues that may not allow some services to be integrated or for the government to pay a community organization to provide it, (c) unwillingness to integrate certain services, depending on the government's attitude to some key populations and behaviors, and (d) the unwillingness of governments to fund some activities that may not be in their interests, such as advocacy or capacity building – particularly when the government has so many of its own capacity building and leadership development needs.

In cases where community-based services are well accepted by the government – such as testing and treatment of malaria, or TB screening, of populations in remote areas – governments are interested in integrating CHWs into the national system. Even if they are not yet able to afford to pay for them, there are signs of integration, such as the government providing training to CHWs, or using government health facility staff to supervise them. In some countries, CHWs receive some recognition or accreditation from the government. Some are also connected to the national supply chain and use government-provided commodities. Some countries are also integrating – or attempting to integrate – CHW-provided data into national information systems. The main obstacle to CHW integration, therefore, appears to be financial – particularly when coverage targets are ambitious, and CHWs require transport, transportation, supplies, equipment, supportive supervision, and a stipend.

In other cases, the government may be less likely to integrate services either into the national system or the national budget. **Montenegro** is an interesting example, where the government is already providing HIV treatment, and even covers some harm reduction services. It recognizes, however, that HIV testing rates are low among KPs and that CSOs are best placed to reach them. While it has started providing co-financing to CSOs to provide prevention services to KPs, by law, (a) CSOs are not allowed to conduct testing, and (b) there is no mechanism in place for governments to socially contract CSOs. (Legal barriers to contracting CSOs also exist in **Guatemala**.) So, while there is some willingness to

[24] The Global Fund. (2022, December 12). *Community systems strengthening: Technical briefing note for the 2023–2025 allocation period*. The Global Fund to Fight AIDS, Tuberculosis and Malaria. https://resources.theglobalfund.org/media/14248/cr_community-systems_technical-briefing-note_en.pdf

support CSOs to provide some services, legal barriers have not yet been overcome. Nor is the government willing to provide pre-exposure prophylaxis (PrEP) in the country, despite a successful pilot and continued CSO advocacy.

In some cases, commitment to integrate is there, but operationalization needs more support. For example, in **Guatemala**, outreach teams from CSOs test high-risk individuals for HIV in the community and help those who test positive access antiretroviral treatment at government clinics. This collaboration improves continuity of care, but the integration needs to be improved. For example, data from community testing is not always captured in the national Health Management Information System (HMIS), and referral feedback loops are not always effective. The shared interest in better HIV outcomes is clear, but operational integration is still evolving. The overall picture on integration is mixed, and a broader analysis would be required to better understand the status of each country in the global portfolio.

The Thematic Review on Community Health (2020) identified some key factors were supporting integration included: (a) implementers have developed close collaboration and mutual respect between community cadres and health care providers, from local through to national levels (e.g. training, forums, strategy); (b) recognition that parallel options for accessing testing and treatment can maximize the number of people effectively accessing services, by offering alternatives; (c) addressing broader barriers and needs of the population has helped improve engagement with services; (d) investment in community mechanisms for accountability (e.g. CLM) have played a role in improving access to services and treatment by providing early alerts and supporting local responses. It was also noted advocacy based on credible data enhance their effectiveness; (e) the availability of resources to provide the services.[25]

The community health review identified a best practice where there is joint planning and joint working, which needs to be built up over time between CHWs and government health workers. The review observed this in Ghana, and this evaluation observed it in the Regional Artemisinin-resistance Initiative (**RAI**) grant, where there was initially little interest or support for CSOs to support CHWs in early rounds. However, after a pilot study, attitudes changed when data demonstrated their clear contributions. Some governments are now looking at how to integrate more services into CHWs' work and integrate CHWs into the national system. However, the funding mechanism is not always conducive to supporting integration, as limited allocations can sometimes create the situation where communities and governments are competing for limited resources rather than being supported to look for complementarity. While the NSP and the country dialogue process should clearly identify which provider is best suited to provide different services and reach different population groups, this conversation cannot always happen openly in all contexts. Before a complementary system can arise, there is sometimes competition, or potentially parallel systems. It can take several funding cycles for the governments to recognize the value of certain community contributions – particularly if it is not accompanied by the necessary capacity building support.

There is no straight path to integration, as communities – just like governments – are complex. As one partner observed, "*It's all about complexity, like most of this is, it's about dynamics on the ground because you've got relatively small pots of money and large communities who are all very enthusiastic fighting over it because there isn't enough*

[25] ENDA Santé. (2020). *Global Fund Thematic Review on Community Health: Synthesis report*. The Global Fund to Fight AIDS, Tuberculosis and Malaria. https://resources.theglobalfund.org/media/14233/cr_enda-sante-community-health-synthesis_report_en.pdf

money in the system. And so, it's all about politics, it's all about sorting those things. 80% of the energy goes towards that. And those politics tend to predominate."

Despite the challenges, however, partners are glad to see the Global Fund continuing to push in this direction. One partner shared, "*It's super refreshing that it's actually there and that it is prioritized, which is super important. And especially in what is increasingly a resource constrained environment where there's a temptation to drop some of these community-led processes and also of course human rights, gender, community rights and gender issues separately. I do think it's super important and really, a pat on the back that the Global Fund has prioritized this. Some of this comes from Global Fund grants so it's embedded in grants and that's where it's truly beautiful because then it is community owned, and country owned. Some of it because of that resource constrained environment but recognizing it's important comes through separate resources through catalytic initiatives*."

The EVT was pleased to learn that the Global Fund Secretariat is developing a maturity model, which was described in one interview as a "*specific quantitative set of indicators that are used to understand the maturity of the health system, specifically as it relates to community systems and community health workers. Trying to get a quantitative measure on what kind of support do the community groups and community health workers get from the health system in terms of being paid on time, having a written contract, supportive supervision, the engagement of community organizations in the planning, management and operation of health facilities. These are all indicators that are key performance indicators. And our grand performance indicators*."[26] The EVT supports this thinking, and the need to integrate it from the funding request development stage.

3.3 Effectiveness

EQ 3. How and to what extent do Global Fund investments in community-led and community-based responses contribute to grant implementation, grant performance, and improvements in health service delivery and access to HTM services, in different contexts?

Finding 3.1. Global Fund investments support CBOs/CSOs to deliver improved community health care and increased access to HTM services (across disease testing, treatment, adherence, and prevention) – and particularly for key and vulnerable populations not normally reached by the formal health system - although there is variation by disease and context.

Community-led responses (CLR) represent a relatively small (<10%) but growing component of Global Fund grant implementation. Examples of CLR include: i) enhanced case finding and recruitment; ii) increased testing, treatment, and adherence rates (through follow-up services); iii) linking and referrals to health services; iv) prevention activities (in HIV and malaria) - including social and behavior change interventions and other outreach; v) research and advocacy to understand needs and experiences, advocate for improvements in service access or provision, and strengthen governance and accountability. The intervention mechanisms are varied, and include community outreach volunteers, community-based drop-in centers, peer counsellors and 'buddy'

[26] The classification used by the GFF can be viewed in 'The Global Financing Facility Global Expansion Plan to support 50 countries in the period 2018-2023'. The GFF uses country income as the basis for its classification, but articulates the GFF value proposition, value added and implications for ways of working according to four types of countries.

systems, home based and mobile testing and treatment models, social behavior change campaigns, and human rights interventions.

Such interventions are seen to be working well across multiple country insights and portfolio analysis countries reviewed in this evaluation. For example, in **Guatemala**, the evaluation found that the Global Fund's reach into rural and indigenous communities has grown because of partnerships with local NGOs and trained community health workers, demonstrating the deployment of varied mechanisms to boost testing, detection and treatment rates within target populations (see Box 2). In **Lao**, the evaluation found that the Government strongly recognizes the value of the partnership with CSO implementing partners to support the HIV and TB responses. This partnership has resulted in improved efforts in reaching target communities, through enhanced testing, interest in PrEP (MSM and female SW) and retention of PLHIV on treatments (through for example increased home-based ART treatments), as well as through mobilizing communities for TB testing and supporting treatment adherence (including through a home-based case management model for TB-affected patients and a buddy system). The evaluation found that community-based support was working similarly well in other country insights, for example treatment adherence in **Zimbabwe**.

Box 2: Insight from Guatemala – Malaria

Country Insight: Guatemala (Malaria)
In Guatemala, community-led responses are critical to the delivery of all three disease programs, including malaria service delivery, and achieving near-elimination. The presence of community members in delivering malaria services has helped address geographical, social and linguistic barriers, thereby improving both uptake and outcomes. The volunteer collaborators network ensures that remote communities have access (accessibility) to diagnosis and treatment rapidly, which the formal system alone could not guarantee. Community case management through volunteers means diagnostic and treatment services are available even in villages far from clinics. This community-based service delivery is faster, and surveillance quality is high – many malaria cases are tested and treated on the same day in the field, which improves outcomes and interrupts transmission. There are also high treatment completion rates in villages due to follow-up by a neighbor volunteer. Without community-led responses, these services would rely solely on periodic visits from health staff, leaving gaps. The acceptability of malaria interventions (like indoor spraying or taking treatment) is also greater when delivered or mediated by community members who are trusted locally. Quality-wise, volunteers are trained to follow standard protocols. The widespread coverage of volunteers (with ~67% of households aware of a volunteer in their community) demonstrates how far access has been enhanced.

Community organizations are particularly supported to reach specific marginalized key populations, other vulnerable groups and people in hard-to-reach areas, such as rural districts, indigenous communities, and regions affected by conflict (where government health workers cannot always operate). This is highlighted for example in Global Fund indicator data on the reach and coverage of key populations (MSM, TG, SW, PUD, prisoners and other vulnerable groups), and AGYW, with HIV preventative services. This data presented in Table 10 below, related to Global Fund KPIs H4 and H5, shows significant uplift over time.

Table 10: Key Populations and Adolescent Girls and Young Women reached with HIV prevention programs (total, 2021-23)

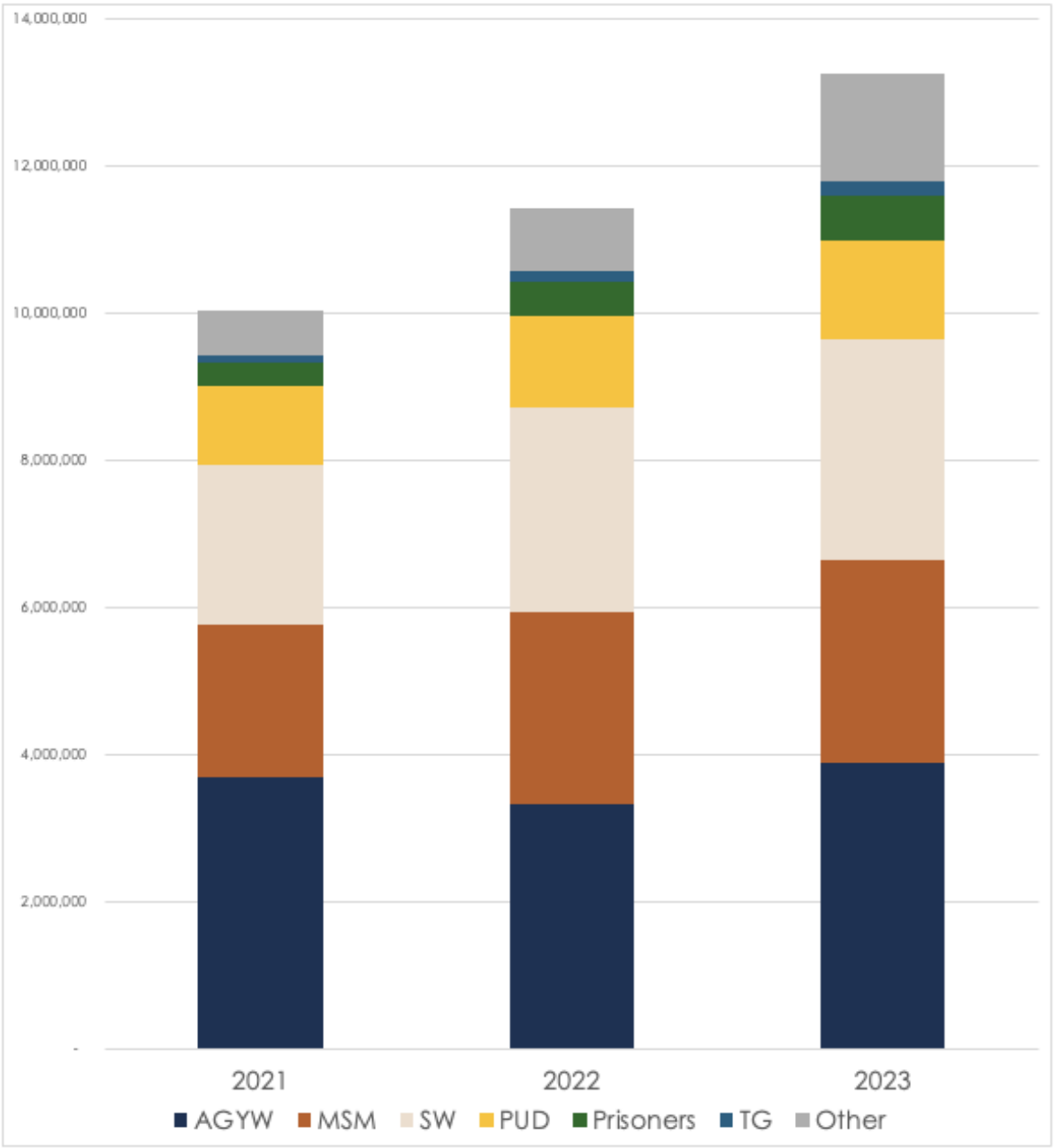
Year	Total reached with HIV preventative services	Total reached with PrEP
2021	10,021,663	88,015
2022	11,417,015	147,257
2023	13,248,704	241,094

Source: Global Fund results data[27]

The combined number of people reached from KVPs with HIV preventative services increased from 10 million in 2021 to 13.3 million in 2023 (latest available data), with the largest gains in absolute terms in MSM (0.7m) and sex workers (0.8m) - see Figure 6. While the number of KVPs reached with HIV preventative services increased in this period by 34%, the number of KVPs reached with PrEP increased by 174%. This reflects (albeit not exclusively) the expansion of community-led responses in HIV targeting key population groups. Coverage of AGYW with preventative services also shows a significant increase from 2.2 million to 3 million, representing a success story for the Global Fund and reflecting concerted attention and advocacy efforts in this area (see also Box 3).

[27] Data includes results reported for AGYW, MSM, transgender people, people who use drugs, prisoners, and other https://data-service.theglobalfund.org/downloads

Figure 6: Key Populations and Adolescent Girls and Young Women reached with HIV prevention programs (by group, 2021-23)



Source: Global Fund results data for the indicators related to "reached with HIV prevention programs services"[28]

These trends in global HIV data were reflected in the evaluation's country insight findings. In Zimbabwe, the team observed particularly strong outcomes for the target group of adolescent girls and young women (although with some gaps including access to PrEP), with 12,767 reached in 2021 rising to 14,855 in 2023 according to KPI data. In Montenegro, the evaluation found that CSO services are effectively reaching female sex workers, MSM and especially people using drugs (with increased population coverage of the latter from 1,261 to 1,454, or around 79% to 100% of the population targeted) with prevention packages and with increased HIV testing. In Guatemala, CRSS has made HIV services more client-centered and acceptable, and extended the reach to marginalized communities, filling critical gaps in availability (see country insight below). These findings

[28] https://data-service.theglobalfund.org/downloads

reflect and amplify findings from the previous thematic intervention (2022) - for example, in Togo it was reported that "most of the people tested by communities were never reached before and this shows how community organizations are unique and essential."

Box 3: Insight from Guatemala - HIV

Country Insight: Guatemala (HIV)
In Guatemala community-led responses have improved the availability and accessibility of HIV services, especially for key populations, by adding innovative approaches. This includes mobile testing units, community drop-in centers, and peer navigation that complement clinic services. This has improved access – key populations can get prevention and testing services and commodities (condoms, needles) through outreach programs that operate in their locales and on their schedules (including in places/times the public sector doesn't reach). Acceptability of services has also increased – peers from the community deliver services in culturally appropriate ways, reducing fear and stigma. For example, transwomen can get tested through a trans-led organization in a stigma-free environment. Outreach by NGOs in Guatemala City's high-risk zones yields hundreds of HIV tests monthly and immediate referral of positives to treatment. The net effect is more people diagnosed and starting treatment than would have been possible with clinic-based approaches alone. Quality of programs is enhanced by community feedback: PLHIV networks flag issues in clinics (stock-outs, mistreatment), prompting improvements (however, there are still gaps in quality consistency).

This reach data reflects the expanded ambition of the Global Fund over the period with regards to KP and other vulnerable groups. More modest gains with regards to expanded coverage (45 to 57%)[29] demonstrates the scale of the remaining challenge (and against which needs to be considered the capacity constraints of CSOs – see **finding 3.3** – alongside the need for ongoing investment in CRSS).

Generally, community-led responses (and hence results) are stronger in HIV than in TB and malaria, which have lower levels of investment and where dedicated community networks, and infrastructure tend to be weaker (see Box 4 on **Ethiopia** below). To some extent this can be justified by the higher barriers faced by HIV KPs, and since broad understanding on the importance of addressing needs of some TB and malaria-affected communities still developing. Nonetheless, there is also growing evidence on the important contribution that community networks and volunteers are making to other disease programs, for example, to TB case finding and scaling of response (reflecting findings from the 2022 evaluation). In **Burkina Faso**, there was evidence of strengthening of community-based care for both PLHIV and TB.

[29] Note that global averages for population coverage hide some differences in how different countries calculate their results for KP1a-1f and YP2, according to Global Fund - for example countries may use sub-national or sub-national population estimates for KP groups as their denominator, depending upon the scale of each programme and/or data availability. Aggregated global figures should therefore be understood as indicative of broad trends in Global Fund coverage only, and considered alongside the cited reach figures.

Box 4: Insight from Ethiopia

Country Insight: Ethiopia

According to Ethiopia's Ministry of Health (MoH), the community-led HIV case management program has directly contributed to an increase in HIV testing in Ethiopia from 85% to 90%. The MoH noted the cost-effectiveness of CSO-led responses, including index case testing administered from a network of Drop-in-Centers (DICs), supported by 900 counsellors deployed across the country and 129 peer led HIV associations. "This is high yield testing", with 70% of clients reportedly returning to care. Consequently, rates of HIV in regions with the highest prevalence (including Gambella) are said to be declining in line with national reductions (4.9% 2019 to 3.15% projected for 2024) - "This is down to many projects, but the Global Fund contribution is huge" (KII, MoH). Overall, around 6% of HIV cases are reported to be served through the Differentiated Service Delivery model, whilst under GC7 around 10% of the HIV program budget is directed towards CSOs. In Ethiopia CSOs are also reported to make a critical contribution to malaria prevention and treatment (e.g. through the distribution of bed nets, training on irrigation) - although their added value was said to be focused on conflict zones and IDPs where Government workers cannot always operate (with the MoH otherwise identifying a limited role and contribution from CSOs in behavior change campaigns). Under GC7, CSOs active in malaria have received a slight uplift in funding allocation, but only to approximately 0.7% of the total disease budget. Within the TB program, the budget allocation for CSOs (0.9%) is similarly small – this is despite data from GC6 showing that 20% of TB cases are now identified/managed by the community (an increase from 14% in the 2019 DHIS). Within GC7, the responsibilities of community organizations are to be expanded from TB advocacy to also include patient support, mobilization, case finding and outreach to slum centers. MoH recognized the important role of CSOs in accessing specific vulnerable groups – those vulnerable to TB due to living conditions and inaccessibility to health services.

As previously mentioned, community-led responses appear to be more effective when their contribution is understood and valued by governments, and when community services and government services are linked - for example from a community referral service to a government treatment center, or through development of combined packages of support. "*That's where it really works well, when the nurse at the health facility sees the value in that community worker, that may be employed by a CSO, and the value that they bring to the health system and to the population's health*" (KII, Global Fund Secretariat). Similarly, the Ghana Country Report from the Community Health Thematic Review (Global Fund, 2022) concluded that the adoption of multi-layered interventions and establishment of a strong continuum between community and facility contributes to improved results from CLR. Other success factors identified included the integration of interventions aimed at reducing barriers to services (such as human rights interventions); a program environment that enables community cadres to be innovative and responsive to community needs; and investment in mechanisms to promote program accountability.

The importance of government buy-in and intersectoral coordination for effective CLR is also reflected in the enablers for effective CSS (Table 8). The previous community engagement and CLR evaluation also found this to be a key aspect of sustainability (see section 3.4). Effective cooperation and linkages between the community and government can depend on the individuals involved and coordination mechanisms in place. However, wider political economy factors are also critical - lack of political will, meaningful engagement processes and supportive legal environments for CSOs, as well

as discriminatory policies and attitudes, can seriously inhibit the development of CRSS in a country (Table 8 and as seen for example in Ethiopia). The previous evaluation concluded that "*the drivers of successful community action are highly variable and context-specific but tend to include a combination of individual leadership, organizational capacity and networks, and an enabling environment that is open to CE and CLR*." The enabling environment and constraining factors are the target of Global Fund advocacy and influence work (see Findings 3.3.1-3).

Finding 3.2. Countries can achieve effectiveness and scale of CSO inputs, with evidence suggesting alignment between stronger performance and enhanced support for community health investments from TGF (within disease programs) - including targeted and sustained support for HIV coalitions (and more latterly TB).

Stakeholders identified improvements in community led responses in HIV and TB over the past 5-6 years and credited long-term support from Global Fund in building platforms for community delivery. In such contexts, CSO networks have effectively managed, delivered and scaled up treatment, care and support services, albeit with heavy Global Fund (and other donor - for example USAID and PEPFAR) investment.

For example, in **Mozambique**, one national CSO and CCM representative reported the successful scaling of services for MSM (and the transgender community) under recent Global Fund grants, expanding from interventions in 20 districts in big cities (Maputo, Beira, Nampula etc.) to 45 rural and other districts in total, following a challenging target set by the Global Fund. This has brought services much closer to vulnerable communities, including two peer educators per district, paralegal support and human rights training for authorities. "*It was something incredible which we did with the Global Fund*".

Other positive country examples from Global Fund included the expansion and national integration of community-led responses to TB in **Tanzania**, where TB care has shifted from exclusively health facility based to now largely within the community, and in **Nigeria**, where it is reported that the proportion of patients who are being diagnosed in the community has increased from less than 20 percent to almost 40 percent in the past five years, as well as registering community-led success in reaching nomadic populations. **Bangladesh** and **India** are also said to have heavily community-based approaches to TB care, where the scale of the populations requires it. This is further illustrated by evidence from Guatemala, where an NGO representative stated, "*Through the support of the Global Fund, we've seen more space open up for civil society to be part of program implementation and even policy discussion*."

Further details on the expansion of Community-led TB responses in **Guatemala** are provided in Box 5. Similarly, the Global Fund's 2020 thematic review found that strong performance on key population programs in HIV (coverage, testing and access to treatment) in **Ghana** coincided with enhanced support to community health investments from the Global Fund, under a civil society PR: "*... 11,105 FSW received HIV testing and results compared to a target for the period of 7,340; and crucially 97.5% of those testing positive were enrolled into care (as compared to 94% in the previous period) ... a significant improvement on the 2016 baselines of 35% ART initiation for FSW*".

The expanded use of CHWs for malaria case management has also produced significant results, both in the elimination context of the **RAI** grant, where cases are increasingly difficult to find, and tend to be in the hardest to reach areas. In high-burden contexts,

CHWs are increasing in scale. In **Chad**, for example, a pilot in two of the country's 23 provinces resulted in CHWs detecting 20% of the entire country's caseload. The Global Fund is now supporting the country to scale this work to eight provinces, which is expected to have a significant impact on malaria case detection and treatment.

Box 5: Insight from Guatemala - TB

Country Insight: Guatemala – TB

The involvement of communities has directly improved case finding and treatment outcomes in TB. Through community interventions (ENGAGE-TB strategy), the availability of TB screening has expanded. This reflects greater accessibility at the community level, not just at health facilities: people are screened in their communities via NGOs, volunteers, and even midwives, overcoming geographic and cultural barriers. As a consequence, there has been an increase in TB notifications from communities that were previously under-detected, and reductions in delays in diagnosis for remote and marginalized populations, in Alta Verapaz and other rural departments. In one district alone, community coalition efforts identified 688 presumptive TB cases in 2023, finding 47 active TB cases that might otherwise have been missed. Community supporters also ensure treatment delivery through directly observed therapy in the community, improving treatment adherence. Acceptability is higher because community agents (including former patients and local leaders) address stigma and support patients; they speak local languages and understand cultural contexts. The quality of TB care has improved with community input – for instance, the National TB Program now includes patient representatives and an Observatorio TB in its regular evaluations to improve "calidez" (humanized care). Patients feel more heard, which improves trust and treatment adherence.

The previous thematic evaluation (2022) identified further countries where community-led responses had become the norm in some service delivery areas, with effective scaling to the national level, including the peer education approach in **Guinea** and key population prevention programs in **South Africa**. In **Morocco**, communities demonstrated both the efficacy and scale of their efforts – whilst community testing was only 10% of the testing undertaken, they were detecting 50% of the HIV cases. Similarly in **DRC**, communities were expected to contribute 26% of all notified cases, yet delivered 31% of results by the end of 2020, with a good follow-up (97%) for treatment success. The 2022 study also flagged the importance of sustained support from Global Fund, country managers and partners - "*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.*"

Both evaluations also find that community-led responses added significant value during the Covid-19 crisis. Many of the community-led responses now proving fruitful build on the additional impetus generated during the funding period under C19RM. The experience of supporting community-led responses using the C19RM grant generated useful lessons for engaging communities more generally in national responses (and RSSH), as well as for pandemic preparedness and response.

Evidence Ranking: 1

Finding 3.3. Key stakeholders globally and nationally recognize the effective (and efficient) contribution that CSOs and CSO networks make to the delivery and success of the Global Fund's country disease programs – although systematic, disaggregated results data is not always available to evidence this.

Most global and country level stakeholders recognize the critical role of CSOs in identifying and responding to health needs and mobilizing marginalized and vulnerable groups, both through community-led service delivery and representation and advocacy. There are also clear and evidential theoretical linkages between improving access to HTM services for key and vulnerable population groups, Global Fund grant performance and results, and positive health outcomes as articulated by several Global Fund stakeholders (KIIs). Sentiments heard from interviews included, "*The more we empower communities to lead, the better our results will be;*" and "*These improved health system outcomes in turn contribute to disease outcomes, be it finding missing cases for TB or screening for women and children in the community*".

More specifically, according to the Global Fund (KII), the recent record numbers of patients diagnosed with TB is attributed to community and private sector interventions, "*which were built and supported by Global Fund*", with more people now on treatment and experiencing better quality of services (since for example people are able to access drugs in their community), less defaulting from treatment, resistance and hence improved treatment outcomes. "*Less people are dying from TB than before because of the support provided by the community… this is some change*".

However, whilst useful anecdotal data was often shared through the country insight visits and KIIs on the contribution of CLOs/CBOs to improving community-based health care and equitable access – e.g. increased HIV testing rate, the percentage of PLHIV returning/enrolled into care, TB detection rates and treatment adherence - these results are not consistently documented and recorded. Global Fund reporting systems (country and global levels) do not produce sufficient data across diseases to systematically measure the contribution of CLR to grant performance. This is principally because grant implementation and service delivery results are not required to be reported in a disaggregated way, by recipient/implementer or type of provider. For example, in **Montenegro**, the country grant measures HIV indicators in line with the NSP, but the contribution is not disaggregated by sector (and furthermore there is no measurement of CSS). As a result, budget and output data pertaining to community responses within each disease program are either incomplete or insufficient to measure the contribution of the sector to grant performance. In **Burkina Faso**, more data is needed on MSM testing and malaria testing to fully evidence the community's contribution. Gauging the true effectiveness of community-led responses proved particularly challenging in **Ethiopia** due to the paucity of relevant data and evaluation reports (including access even to Global Fund program progress reports).

This finding was also echoed within the previous Thematic Evaluation (2022): "*specific data is not collected, nor disaggregated by provider type in a manner that would allow community contributions to be recognized.... it cannot be determined to what extent community interventions contribute to national results or are addressing rights- and gender-related barriers.*" The Global Fund is sensitive to reporting requirements becoming a burden to countries and is understandably reluctant to place more demands on countries.

Examples of partially relevant data collected (since services could be delivered by a range of community-based providers in some contexts) include the percentage of key population groups reached with prevention programs/service package (HIV), and TB cases notified by the community, but with minimal relevant data for malaria. There is also limited data on contribution to Quality of Care (QoC) – e.g. staff attitudes, stockouts etc. - as observed in **Burkina Faso** - or other outcome metrics.

The paucity of relevant data is linked to the requirements of the Global Fund monitoring framework (see below), focus of annual reports, relatively minimal budget allocations, and CSOs' own M&E capacity or systems. The previous evaluation also noted an absence of qualitative or long-term M&E frameworks at the country level, of relevance to measuring the results of advocacy efforts.

Finding 3.4. In some countries, capacity and coverage weaknesses of CBOs and CSOs, and limited integration with formal health systems, limit the contribution of CSOs to improving service access and grant effectiveness. This is compounded by limited budgeted allocations from Global Fund.

Global and country stakeholders also recognize the challenges facing the civil society sector including capacity weaknesses, geographical coverage, delivery against consistent standards, and sustainability. Global stakeholders consulted for the evaluation pointed out gaps in institutional capacity, resource allocation, and governance structures that limit the effectiveness of community-led interventions; perspectives that were confirmed during data gathering at the country level. The positive results described above should be understood within this context.

For example, in **Ethiopia**, recent Funding Requests speak of the weaknesses of community-led responses under GC6: "*Peer education, multi-session social behavioral change communication, and demand creation interventions targeting KPPs were implemented on a very limited scale but were of poor quality*" (HIV). The constraints on effectiveness - limited capacity and coverage – are also highlighted for other diseases. In **Guatemala**, while malaria benefits from an established network of *Colaboradores Voluntarios* (ColVols) who actively contribute to surveillance and response, no equivalent structure exists for tuberculosis. The lack of a community-led TB network provides a challenge for more effective service delivery, particularly for reaching marginalized or hard-to-access populations, in some districts. In **Burkina Faso**, it was observed that whilst QoC inputs were effective, they did not add up to a systems approach – i.e. were less effective in the absence of other health inputs.

The previous Thematic Evaluation (2022) also concluded that capacity (and turnover) in community organizations are key challenges requiring understanding and support - including longer-term capacity building and consistent country-level support for interpretation of GF guidance. Whilst capacity weaknesses are observed to some extent across all countries regardless of community system maturity (see Guatemala above), in contexts where the civil society ecosystem is weak or more nascent (generally or disease specific), this evaluation finds that problems are compounded where Global Fund budget allocations do not provide sufficient funding nor direction to build the capacity of CSO networks to support successful community-led responses – despite expectations at the global strategy level.

The Global Fund reports 68% growth in investments in CRSS between NFM2 and 3 - to USD 830 million, and that across the portfolio, regions had on average 10% of their total NFM3 investments in CS&R. However, this calculation includes substantial funding for CHWs and integrated community case management, and includes all provisions funded at the community level, which skews these figures. New analysis undertaken for this evaluation shows that, based upon all grant data for GC6 and GC7, globally, approximately 6% is set aside for community-led response activities and 1% for community systems strengthening, as demonstrated in Figure 8.

This in turn varies by disease program. For example, within the context of relatively weak community structures in **Ethiopia**, a comparatively strong government and Ministry of Health (MoH) (as the sole PR), and limited intervention from the Global Fund to advocate for or support CRSS, the assigned budgets for CRSS appeared relatively small given the recognition and contribution of CSOs to service delivery – particularly within TB and malaria – with funding only registering slight increases between GC6 and 7 (see Box 4 above). Similarly, the previous evaluation found that even where CLR or CSS activities are included in budgets, "often expectations remained high, but activities were under-budgeted".

EQ 3.1 How much have Global Fund investments contributed to stronger advocacy for resource mobilization and policy change in relation to rights, equity, and health?

Finding 3.1.1. There are good examples of positive change achieved through CSO advocacy in relation to national policy and Global Fund programming in HIV, in support of access for key and vulnerable populations, following longer-term and/or centralized Global Fund capacity support.

The Global Fund understands that CSOs advocate for an enabling environment and programming to reduce human rights and gender–related barriers to accessing services, as well as holding leaders accountable to their obligations and commitments. Following from finding 3.2 above, the Global Fund's historic contributions to strengthening HIV coalitions and people living with HIV and LGBTQI+ networks, at the country level, has in turn resulted in greater influence on national HIV policies and programs – and in turn Global Fund investments for disease responses for specific groups – through a variety of mechanisms. Global Fund contribution to advocacy and associated results in other disease areas such as TB care and support is less evident.

In the country insights of Montenegro and Guatemala (see Box 6), there is evidence that long-standing support from the Global Fund and other donors for building the capacity and confidence of civil society organizations working in HIV and TB, enhanced through targeted support from Global Fund for specific advocacy activities, has influenced Government policy. This includes, in **Montenegro**, the inclusion of community-led HIV services in national policy. This has in turn facilitated access to ongoing government funding (circa EUR 200,000 per annum), for preventive services targeting KPs, thereby also supporting sustainability. Community advocacy has also helped shape national harm reduction programs and the country's national drug strategy, following civil society inclusion on Montenegro's National AIDS Council, supported through Global Fund resources. "This process illustrates how tools for engagement can effectively connect community voices with policymaking" (KII).

Box 6: Insight from Guatemala

Country Insight: Guatemala – effective advocacy with Global Fund support
In 2022, Guatemala's National TB Program, influenced by civil society advocacy, incorporated more human-rights-based approaches into its policies. The National TB Strategic Plan (2022–2026) and guidelines now include a patient-centered care model and mandatory anti-stigma training for health providers, representing a shift toward more equitable and accessible TB services nationwide. These changes should in turn result in better case detection, improved treatment adherence and success rates, and lower TB morbidity and mortality over time. The Global Fund supported this work both indirectly, by empowering civil society and patient groups, including a TB survivors network and TB Observatory in Guatemala, which monitor TB services and advocate for improvements, and directly, through funded workshops and dialogues as well as support for the development of the 2022–2026 TB plan itself with technical assistance (and ensuring that community recommendations, like stigma reduction training, were incorporated). More recently, during the development of the 2023–2025 National HIV Strategic Plan, transgender community activists – newly represented on Guatemala's CCM – successfully advocated for the inclusion of gender-affirming care and other trans-specific priorities in the strategy. This marked the first time such issues were integrated into national HIV policy. The Global Fund's CRG efforts laid the groundwork for this outcome. Global Fund grants supported capacity-building for trans advocacy groups and directly financed community consultations for the national strategy. Furthermore, Global Fund policies on CCM inclusivity meant transgender representatives were at the strategy development table in the first place.

In Mali, social mobilization of people living with HIV networks contributed to improved access to ARVs including removal of user fees (Global Fund, 2023). In Myanmar, success in expanding services to PUD was attributed to ambitious target setting, support for improvement in the legal environment including amendments to the drug law of 2018, improved coordination with the Ministry of Home Affairs and the support of peer educators and volunteers at treatment sites through the national HIV program (internal Global Fund analysis, 2021).

Box 7: Insight from Mozambique

Country Insight: Mozambique
In Mozambique, the evaluation team heard how civil society advocacy led to the inclusion of the transgender community within key population groups (alongside MSM, people who use drugs, people who are in prison, and the female sex workers) within the HIV National Strategic Plan, as well as an associated harm reduction program. The evaluation also heard about how advocacy through CSOs was used to safeguard project resources in Maputo, following opposition to the program from a district Governor. This successful outcome was facilitated by civil society's prior involvement in and understanding gained from Global Fund processes and CCM representation. The Global Fund also played an important convening role in bringing parties together and facilitating a country visit to Portugal to view a similar successful intervention. More generally, it should be noted that Mozambique currently represents a generally less hostile environment to the LBTQ+ community than some other neighboring African states.

Centralized programs supported by the Global Fund, as well as partnerships with international NGOs, have also proved effective in strengthening civil society advocacy and associated results for vulnerable groups. For example, the Rights – Evidence – ACTion (REAct) tool, developed by Frontline Aids with support from Global Fund between 2014-18, records, monitors, and responds to human rights violations that happen when people access HIV and health services. Data generated by the tool was used to inform quality human rights-based HIV programming, policy and advocacy at national, regional and global levels. For example, in 2018, evidence generated by REAct was presented in the Lebanese Parliament to advocate for the successful passing of the law for the protection of people living with HIV. The evidence gathered also helped to influence authorities to regulate and sanction breach of confidentiality and ethical practices at state-run health premises. The Global Fund has also worked in synergy with the Robert Carr Foundation to advocate for and increase visibility and accountability for funded directives towards children and youth. This contributed to making children and youth a priority in the Global Fund's modular framework.

Finding 3.1.2. Conversely, the evidence suggests that there are limits to the influence of CSO advocacy – within certain hostile contexts, and in relation to resource mobilization for health – which can be compounded by inflexibility in Global Fund frameworks and monitoring systems.

The Global Fund and its recipients face challenges in supporting human rights interventions within some contexts. Strategic stakeholders (KIIs) recognized that due to the Global Fund's modular framework, there can be some inflexibility with regards to supporting human rights advocacy for key and vulnerable population groups in hostile contexts – where strategic advocacy with policy makers and other duty bearers, and adaptable approaches, can make a difference. There are also challenges in understanding how best to use data on for example, reported human rights violations with national authorities - unlike for example quality of care data generated through CLM. "*We advocate for change, but are we actually influencing national health policies? More advocacy integration is needed*." (Global KII)

Box 8: Community Engagement Strategic Initiative

Community Engagement Strategic Initiative

More recently, the Global Fund has strengthened advocacy platforms, tools and interventions (such as CLM) through the Community Rights and Gender (CRG) Strategic Initiative (2020-22) and through the Community Engagement Strategic Initiative (2023-ongoing). Examples of this include, in Nepal, young people using a CRG Technical Assistance report on cash transfer programs for children living with HIV to advocate for the inclusion of program recommendations in the funding request (2020). In Zimbabwe, the generation and use of community-led data supported successful advocacy and the first-ever inclusion of services for people who use drugs in Zimbabwe's Grant Cycle 7 funding request (with a USD 42k SI grant leveraging up to USD 831k in the FR). The Final Evaluation of the GC6 Community Engagement Strategic Initiative (2024) found that PLHIV communities developed advocacy agendas across Eswatini, Indonesia, Malawi, Moldova, Nigeria and Pakistan, including support for a feasibility study that amplified successful advocacy efforts to introduce opioid agonist therapy. The SI also supports networks of adolescent girls and young women vulnerable to HIV in 13 countries to influence country programs and strategies ("Adolescent and young women... Global Fund is one of the champions for that").

In Nigeria for example, it was reported that SRs had limited budget flexibility in addressing barriers faced by KP groups, with PR approvals reportedly taking a long time (internal Global Fund analysis, 2021). The NFM1 stigma and discrimination module had 0% budget allocated while in NFM2 it had just USD 213,997 from a total budget of USD 10.59M (0.01%) available from the HIV Prevention budget. In **Ethiopia**, it was reported to be extremely difficult to speak openly about and hence directly target certain groups for support including MSM and people who use drugs.

There is more limited evidence of successful CSO advocacy leading to increased allocations for community-led responses overall and/or domestic resource mobilization for health. Advocacy from the Civil Society for Malaria Elimination (CS4ME) is reported to have resulted in the Cameroon Government contributing USD 5m to the GC6 replenishment 2020-22. In Moldova, key populations were trained to make better use of CLM data through the CE Strategic Initiative, leading to successful advocacy for an expanded municipal service package and additional domestic funding.

Box 9: Montenegro

Country Insight: Montenegro
Montenegro provides a good example of the potential and limits to CSO advocacy efforts. Long-term support from the Global Fund strengthened LGBTQ+ networks; influenced understanding and behaviours of health care workers to reduce discrimination and harm and even influenced national policies and programs in HIV (through shaping national harm reduction programs and the national drug strategy through civil society inclusion on Montenegro's National AIDS Council). However, advocacy could not mobilize additional resources/influence funding for CSOs (through changing relevant laws to allow CSOs to provide more services and remove funding caps). Furthermore, whilst PrEP was successfully piloted among MSM through CLR, it was not adopted, despite advocacy efforts.

An important caveat to findings on Global Fund advocacy, as outlined by the previous Thematic Evaluation, is that changes to policies, the enabling environment, equity, gender equality and other measures are under-valued by the existing Global Fund performance framework. This means that that whilst there may be more examples of such successful budget advocacy occurring through disease programs or other mechanisms, these successes are not being captured systematically. The previous evaluation also heard that such under-reporting could result in human rights, gender and equity interventions being dropped or under-budgeted due to lack of quantification.

2

Finding 3.1.3 There is limited to no evidence on how the current CSS module under RSSH – with low investment levels – has contributed to stronger advocacy for resource mobilization and policy change.

Strengthening networks of well-functioning CSOs which in turn supports advocacy outcomes has occurred historically through Global Fund's disease program investments - and more recently through the Strategic Initiative and other central programs. However, there is currently limited to no evidence of the RSSH community module delivering results in this area.

EQ 3.2 To what extent have Global Fund's investments in community capacity building led to stronger community systems and more effective community responses at the country level?

Finding 3.2.1. There is substantial global evidence demonstrating that investing in the capacity building and leadership development of organizations and coalitions is effective in strengthening community responses and subsequent health outcomes. However, the Global Fund is not prioritizing sufficient funding nor maximizing its existing investments in this area.

As outlined in Finding 3.2, countries can achieve effectiveness and scale of CSO-led inputs, with sustained, targeted funding support, including early investments in capacity building. This is evidenced by the growth trajectory of HIV associations and coalitions, underpinned by capacity building support from Global Fund starting 10 – 15 years ago. This is now bearing fruit today in their successful work supporting prevention packages, testing and treatment amongst key population groups, otherwise underserved by formal health services - albeit with relatively substantial ongoing funding from the Global Fund. One community key informant reported, for example, that "*the community coalitions for HIV – self-help groups - were supported through the Global Fund, with support for manuals for establishing coalitions at the community level ... The development of this network was successful. More than 200,000 people are served under this, with links to peer support. This shows what can be achieved from Global Fund in CSS. And many of these people now have a higher quality of life*." However, TB and malaria community systems are now emerging but without the same level of support and investment. Indeed, there appears to be less investment in building community systems at the country level now, particularly once available monies (within the RSSH grant) are split across disease areas and the four different modular priorities.

The Global Fund reports (2021) that community investments within RSSH under NFM3 were relatively small – USD 16M, approximately 3% of total funding (USD 827m), and with most of this funding (90%) channeled to CHWs. Additional analysis by the evaluation team confirms that this position has slightly increased since this period. For the current GC7, Ethiopia has allocated 12% of its RSSH budget to CSS (USD 4.4m); however at least 60% of that budget will fund capacity building of government-supported CHWs.

Overall, using the extensive database of all grant data for GC6 and GC7, globally, approximately 1% in total is allocated for RSSH CSS. The RSSH CSS portion increased from 0.7% in GC5 to 1.2% in GC6 (1.7% if we include the C19RM grants contributions) before slightly reducing to 1.1% in GC7 (but which meant a significant diminution in funding for CSO operations following the Covid-19 crisis). We also found that those three country insights with the highest CRSS capacity-building needs – **Burkina Faso, Ethiopia and Zimbabwe** – have the lowest budget allocations to CSS for GC7 proportionally, ranging from 1 to 0.5% only in Zimbabwe (and where most of the RSSH CSS grant is allocated to CLM).

There is also high variability across allocations by modular area – whereas community engagement linkages and coordination attract by far the largest allocation in **Lao** under GC7 (channeled towards incentivizing community volunteers), this is a much smaller component of all other country CSS budgets.

The Global Fund's Technical Review Panel (TRP) found that these trends are linked to limited understanding of CSS and RSSH within funding requests and interpretation of Global Fund guidance ("*applicants frequently assume investment in community health workers is sufficient, although this is not what is meant by CSS or HSS*"[30]). This is despite the requirement to produce an RSSH Annex to the funding request, and critical reflection on community systems, priorities and the required interventions to respond to identified gaps.

Box 10: Ethiopia

Country Insight: Ethiopia
At a country level, funding for community systems strengthening in Ethiopia, under GC6, was relatively small (estimated at less than 4% of the RSSH and C19RM grants combined), and largely allocated to the Government's Health Extension Program (HEP), with a focus on strengthening Health Extension Workers (HEWs) and on community monitoring (whilst the majority of overall RSSH funds went towards strengthening other aspects of the health system, e.g. supply chains, as per Government of Ethiopia priorities). Within the GC7 allocation, ring-fenced funding for CSS has increased to USD 4.4m for the RSSH module for community systems and responses (from USD 38m overall) – equivalent to 12%. However, this also includes funding support for HEWs - in the FR, at least USD 7m (RSSH plus match funding) is sought for training and supervision of HEWs, compared with USD 4m to be shared across CLM, research and advocacy, capacity building and leadership development, and community engagement, linkages, and coordination for CSOs. Against this can be the substantial range of differentiated capacity challenges facing CSOs in Ethiopia, including financial sustainability of Drop-in-Centers in HIV, strengthening of networks and coverage in TB and malaria, and improved results data, amongst other areas.

Alongside the limited scale of RSSH investment in CSS, the structure (and quality) of the modular activities funded does not necessarily align with the strategic and often functional capacity needs of CSOs (see **Guatemala** below). CLM provides a specific case in point – CSOs lack strong MEL systems to help understand and demonstrate their own contributions to disease goals, yet the objectives of the chosen CLM model – especially when applied across all disease areas - are not necessarily aligned with this specific capacity need. Overall, the Global Fund found that "*Technical support and assistance has not prioritized community organizations with differentiated options to improve programmatic, technical, and institutional capacity and leadership development*" (TERG, 2022). Similarly, the country insight research carried out for this evaluation finds that the CSS modules and budget allocations for activities under RSSH do not always reflect the differentiated capacity needs under each disease program, have funded short-term trainings of limited value, and are not always underpinned by rigorous capacity assessments of community networks (e.g. **Ethiopia**). According to Global Fund (KII), hence even in countries with larger allocations of CSS from RSSH (e.g. DRC, Nigeria, Mozambique, Kenya) inefficiencies in budget disbursement result from the lack of a strategic approach. Strategic stakeholders also commented that whereas there has been some success in scaling and integrating interventions such as CHWs, this is yet to be replicated in other aspects of provision such as peer counsellors.

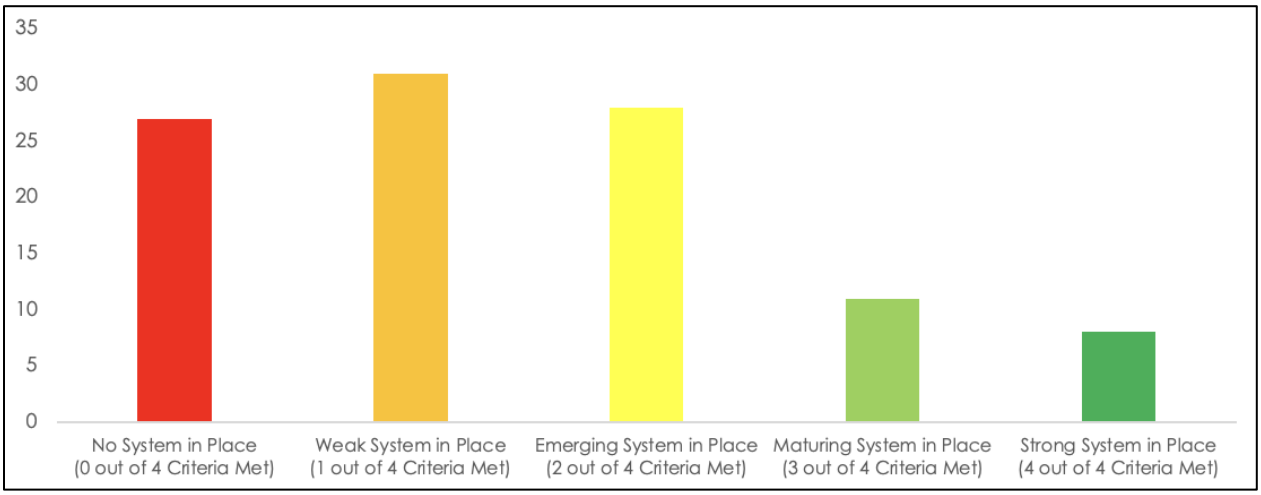
[30] TRP Lessons Learned from Review Window 2 2020-2022 Funding Cycle, October 2020

Box 11: Guatemala community capacity

Country Insight: Guatemala (community capacity)
Global Fund support has significantly strengthened community organizations in Guatemala, improving their capacity, coordination, and response structures. Initially focused on HIV treatment access, interventions have expanded to community-led monitoring (CLM), legal support, stigma reduction, and human rights advocacy. Some community systems, such as ENGAGE-TB committees and malaria volunteer networks, have become more institutionalized, demonstrating long-term sustainability. However, capacity gaps remain, particularly for grassroots groups in rural and indigenous areas, which require continued support in financial management, governance, and leadership development. Smaller CBOs face significant barriers to accessing Global Fund grants directly and as SRs rather than PRs due to limited managerial and financial capacity. While intermediaries like INCAP facilitate fund disbursement to grassroots groups, strict reporting requirements and bureaucratic processes remain a challenge, especially as key guidance documents are often not available in Spanish. Capacity-building efforts exist but remain insufficient, as organizations struggle with low literacy levels, lack of administrative support, and excessive compliance demands. While capacity-building efforts have had a positive impact, some training programs were poorly adapted to the realities of community organizations, emphasizing the need for flexible, co-designed learning approaches.

The overall picture of need is reflected in Global Fund KPI data (KPI S4), as shown in Figure 7, with 19 countries meeting at least 3/4 criteria for sufficient community service delivery (baseline figures for 2022).

Figure 7: Number of countries with systems in place for community service delivery (KPI S4, 2022)



Source: Global Fund, 2025

Nonetheless, the Global Fund reports that currently (2024) 29 countries (28%) have met 3/4 criteria for sufficient community service delivery, suggesting improvement over the period and progress towards the target of 38% by 2028.

Finding 3.2.2. Dedicated funds for capacity building, including the CRG/CE Strategic Initiative, have reportedly made more effective contributions to strengthening community systems and community-led responses, and provide learning to inform a needed refresh of the Global Fund's approach to CSS.

Now in its ninth year, CRG SI partners have supported key and vulnerable populations to effectively engage in Global Fund decision-making through coaching and mentoring, data generation, networking and other activities. Key achievements from GC6 included new community data being generated or used in 27 countries, and key and vulnerable population communities successfully influencing program funding or design in 26 countries (Community Engagement Strategic Initiative Update, June 2024). This included for example in 2020, in Pakistan in HIV, people who use drugs receiving network development support, including the establishment of linkages between network members, other civil society partners, CCM members, and the Global Fund Country Team; (Global Fund, 2020). An evaluation report (2019) found that its six Regional Platforms for communication and coordination resulted in increased capacity among communities to coordinate and work with other communities in the region (68%) and engage more effectively in the Global Fund funding model (60%) and through CCMs (53%). CSO stakeholders in Ethiopia, interviewed five years later, cited Global Fund's regional platforms as good practice, and suggested that the model should be replicated at a country level to strengthen community capacity. However also here, the previous evaluation found that most of the platforms had origins in the HIV sector, and that there was significantly less demand for support among TB and malaria communities (Thematic Evaluation on Community Engagement and Community-led Responses, 2022).

Many global and country stakeholders (KIIs) called for a clearer strategy on how to institutionalize community-led structures within national health systems. There were calls for stronger technical and financial support to improve the functionality of volunteers, local organizations, and peer-led initiatives. Many interviewees also emphasized that strengthening community systems requires not just funding but also policy changes that recognize the legitimacy of community actors. *"It's not just about funding; it's about legitimacy. If governments don't officially recognize community health workers and peer educators, their work remains undervalued and underfunded."*

The TRP has recommended one plan for strengthening HSS including CSS: *Applicants should develop one plan for RSSH that includes a clear picture of the health and community system landscape, an analysis of the prioritized needs/gaps, the sequencing for investments, and what elements would be included in the RSSH requests submitted with each funding request… The lack of a strategy to invest in system strengthening, rather than mere support, results in limited funding for community systems strengthening and missed opportunities to expand the high impact and proven interventions to enhance community ownership and engagement, as well as linking with the formal health system to expand the reach and uptake of most services. In the long run, the sustainability of investments in community systems is limited."*

EQ 3.3. To what extent do Global Fund investments in CLM lead to improved availability, accessibility, acceptability, and quality of HTM programs?

Finding 3.3.1. Evidence from different countries suggests that when properly implemented, and supported through long-term investment, community-led monitoring can deliver a variety of tangible benefits.

CLM is frequently cited by stakeholders as a powerful mechanism for ensuring transparency and accountability in health programs, through monitoring access to appropriate services and helping to ensure program quality. Examples of the benefits from CLM identified in the Global Fund literature include:

- Strengthened community participation and accountability in health.
- Improved availability, access and quality of healthcare services.
- Strengthened Monitoring & Evaluation (M&E) Systems.
- Creation of collaborative frameworks.
- Increased funding and support for community initiatives.

Where successfully implemented, CLM is being used as an important input into advocacy activities: "*Data is power. And the more we can amplify what the community is saying, the better, and especially given the huge lack of any quality of care data.*"

These benefits are seen in a variety of real-life examples of successful CLM supported by Global Fund and have led to the following outcomes – with a focus on access and quality of care. Other examples of successful CLM and related initiatives are included in the section on Advocacy above:

- **Advocacy for strengthening supply chains in Côte d'Ivoire**: CLM data was used to advocate for improvements in ARV supply chains, reducing stockouts and improving treatment continuity.
- **Informing disease programming in Tanzania**: The integration of CLM findings into the annual engagement plan, and its use in feedback meetings with PEPFAR, the Ministry of Health, and Recipients of Care is contributing to greater availability of testing services and expanding access to treatment programs.
- **Advocacy for improved quality of care in Malawi and South Africa:** Comprehensive systems have led to healthcare providers offering PrEP for young women; strategically placing HIV Testing sites for Older Men; proactive ordering of TB treatment medicine; creation of safe spaces and hiring of peer educators to increase HIV testing for sex workers; increased distribution of female condoms; and new equipment for TB diagnoses.
- **Strengthening community-led responses in Ghana:** PLHIV who participated in CLM activities developed a better understanding of Differentiated Service Delivery and its role in improving accessibility and quality of care. As a result, they became more committed to achieving viral suppression and established peer-support groups.

Box 12: Advocacy led to improved access and case detection in DRC

Case study: Advocacy led to improved access and case detection in DRC
The TB/HIV observatory in DRC, managed by a CBO, has been supported by the Global Fund since 2016. It supports the collection of information on barriers to access to care in health facilities, such as stockouts, poor quality, informal payments, stigma and overall satisfaction of service users. The data that is collected forms the basis for direct advocacy with local decision-makers. Stockouts of antiretroviral drugs have reduced significantly in all the provinces where the observatory is implemented, as has overcharging (observatory data flagged incorrect charging of user fees which was subsequently stopped). This led to an increase in TB case detection from 63% in 2021 to 74% in 2022 across three health zones. The observatory has also discovered underlying reasons for some of the behaviors of health care providers – and intervenes with authorities to improve the conditions of health personnel (Global Fund, 2022; Global Fund 2024).

In the examples above, for example in DRC, long-term investments, over multiple grant cycles and with continuous engagement with diverse stakeholders were key to the success of the CLM initiative. In DRC, this included TA support from the CLM Strategic Initiative, which facilitated stronger partnerships between CLM organizations and health districts (with support for integration of CLM data into national systems being a key objective of the SI). The report 'Lessons from the CLM Strategic Initiative' (2024) found that for countries supported by the SI, the TA resulted in strengthened CLM programs which also paved the way for continued (and often, increased) support for CLM under GC7 (e.g. in Côte d'Ivoire, Bangladesh, RAI, Mozambique). Conversely, in countries where such external support was not made available (e.g. Ethiopia) there was a lack of a clear strategy and consensus on how to move forward with developing CLM.

In some of the documents reviewed by this evaluation team (Global Fund, 2020), positive results were reported alongside CLM activities in West and Central Africa and Guatemala and Nicaragua (including recorded stockouts, viral load suppression, reductions in user fees), although it was not always clear how such results could be directly attributed to the research in question.

Finding 3.3.2. The evaluation also finds several examples of CLM being less effective, e.g. with low acceptance, duplication with other efforts, and data not being used effectively – this creates opportunity costs for countries with other CSS priorities.

Several global and country stakeholders (KIIs) commented that community-generated data is often underutilized, or that even when governments confirm commitment to CLM, it is sometimes not known whether CLM data is being used or not – especially in national level advocacy 'beyond the clinic'. It was also noted that CLM success stories of national scale up in countries such as South Africa, Malawi and Uganda are in the minority (although it is similarly noted that CLM in other countries is smaller in scale and at a more nascent stage of development).

In **Montenegro**, CLM is being used to improve CSO services and contribute to advocacy, and the regional grant is supporting a human rights reporting mechanism that links to national systems. The evaluation team found that in some contexts, investments in the community and their services can even exclude rather than engage the district level (including in data flows). In **Zimbabwe**, it was observed that CLM delivered weak systems

gains due to a lack of linkages with district level health services and with wider advocacy efforts. Related capacity challenges included a lack of funding to follow up with advocacy (alongside reduced RSSH funding under GC7). In **Ethiopia**, the CLM model developed through PEPFAR and being scaled through with Global Fund support has been developed in isolation from the MoH (due to tensions over its interpretation) and is largely focused on feedback loops within the network of drop-in-centers, rather than within Ethiopia's HEP. Even in Malawi, it was noted that because data collection is not digitized, it is easier to apply the data at the health facility than to amplify it upwards in national level advocacy.

There is a general consensus that for CLM to be effective, it must remain community-owned and independent while ensuring alignment with national health priorities. However, in some contexts, this dual push can create tensions between different actors, as observed in countries such as Ethiopia, and articulated by several global stakeholders (KIIs):

"CLM should be led by those most affected - people living with HIV and key populations. But in some countries, larger NGOs funded by the Global Fund or governments are leading, creating tensions with grassroots organizations."

"The difficulty with integrating CLM into the health system is all one of semantics. Often the government interprets that to mean the database should sit in a government database, and they should have control over it. That is problematic because community systems need independence to truly hold health systems accountable."

"Governments need to stop seeing CLM as a threat. When done correctly, it actually strengthens the health system by identifying gaps and ensuring services reach those who need them most."

In 'Towards a Common Understanding of Community-based Monitoring and Advocacy' (2020). Global Fund also noted that "*a major challenge is around concerns about the credibility of data collected through CBM*", including lack of familiarity with using qualitative data to inform national level planning, alongside monitoring capacity constraints with CSOs. "*Addressing this persistent challenge requires efforts to increase awareness of the value of CBM as well as changing mindsets*."

Given these weaknesses/tensions, aligned to the limited resource envelope for CSS, there is a potential opportunity-cost from CLM – at least in the short-term, since set-up can be resource intensive, whilst the benefits of CLM tend to manifest themselves in the medium to longer-term. This can be most evident where other community-led research, advocacy or capacity building may be higher priorities (e.g. in Ethiopia, Burkina Faso), and/or where local health systems may already be overwhelmed (for example in Cameroon). The potential high ongoing costs associated with some (stand-alone) CLM initiatives are highlighted by the peer-led tracking of lost to follow-up (LTFU) PLHIV tracking initiative in Indonesia. Whilst reported to have been successful in contributing to an improvement in retention rates among clients on ART, LTFU costs around USD 150,000 per year (in 2019), covering activities in two districts of Jakarta with 10 peer trackers (CSS Overview, Global Fund, 2020).

Stakeholders discussed the need to strengthen CLM efforts by providing adequate resources, training, and supportive policies – including for scale-up and connection of CLM data with health systems and national level policies and programs. This includes guidance on appropriate feedback tools (to complete the monitoring cycle), digitization and integration within national HMIS, incentivization of data use, and greater support for adapting CLM within TB and malaria programs. One CSO claimed "*We were asked to implement CLM but there was no clear methodology, no indicators defined, and no*

follow-up mechanism." Another shared, "*We participate in CLM because it was in the grant, but to be honest, the training was rushed, and we didn't fully understand how to use the data for decision-making.*" Others also did not fully appreciate its potential, reinforcing the need to introduce it carefully. "*In the beginning, we thought CLM was just another reporting task. We didn't know it could be a tool for advocacy and system change.*" It was also noted that CLM should not be pursued in isolation but funded alongside sufficient support for advocacy and coalition building.

EQ 3.4. To what extent is the Global Funds approach to results and measurement fit for purpose and capturing intended outcomes in CRSS?

Finding 3.4.1. Measuring the overall contribution of CRSS to global targets is not possible, due to overall limited direct relevance of national/global targets to community-led responses and community systems strengthening, and high variability across modules.

In general, global KPI data by disease module is not directly (and in the case of TB, even indirectly) disaggregated by community-led responses.

- The HIV module includes two KPIs (and linked indicators) related to percentage of key population groups – MSM, people who use drugs, transgender people, and sex workers (KPI H4) - and high-risk adolescent girls and young women (KPI H5) reached with prevention programs, as well indicators for groups reached with differentiated HIV testing services (HTS 2-3). These KPIs have significant (but not exclusive) relevance to community responses.
- TB and malaria modules contain no KPIs of direct relevance to measuring the contribution of community responses. Within malaria, the constituent indicators cover the proportion of cases identified in the community that receive testing and treatment services (Cm-1b and 2b), which given that the overall share between government and community settings is not known, has limited utility, and furthermore there are no indicators relating to CSO-led distribution of antimalarials, bed nets or other preventative campaigns (which as noted above form an important component of CSO-led work in malaria in some countries).
- Measurement within the TB module is most limited, with no indicators directly relating to testing or treatment within/by the community and only one indicator of tangential relevance to community-led responses (*KVP-2: Number of people with TB notified among key affected populations/high risk groups*).
- It is also noteworthy that none of the disease module nor RSSH KPIs/indicators cover community-led advocacy work.

Some examples exist at country level of where testing/treatment data is further disaggregated by sector/provider to demonstrate the community's contribution to service delivery and Global Fund results (e.g. **RAI**, where results data - testing and treatment - is disaggregated by which sector contributed; and TB cases detected by the community in **Ethiopia**), but once aggregated to a global level (e.g. KPI T1: TB notifications) this detail is lost. This was also a finding of the 2022 evaluation. Other countries highlight gaps in CLR data, for example in **Burkina Faso**, where more data is needed on testing MSM and on malaria to evidence community contribution. In **Montenegro**, the country grant measures HIV indicators in line with the NSP, but the contribution is not disaggregated by sector (and whilst community responses are partially measured, CSS is not measured at all).

Furthermore, the current focus of Global Fund reporting provides limited to no visibility on how CRSS investments are used, as well as what outcomes they are contributing to (a general challenge within the sector). This reflects findings from the previous evaluation, as well as recommendations from the TRP: "*Applicants should consider greater engagement, strengthening and contracting of CBOs to collect data on and monitor key population programs and ensure CBO and private sector data is integrated into program-useful information systems*".

The 2022 evaluation recommended resolving this at the Global Fund level simply by "*ensuring that the indicators included in the modular framework require disaggregation by community provider*". The 2021 Prospective Country Evaluation also recommended that "*performance frameworks (PFs) 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 strategic objectives and disease impact]*." We understand that improvements in disaggregation are planned for GC8.

Changes arising from CSS have a more comprehensive set of measures in place – although they are not measured consistently nor always documented in a way that can effectively inform decision-making. RSSH KPIs include KPI S4, which measures the percentage of countries with systems in place for community health service delivery - however this has the potential to either be useful or misleading for measuring outcomes, depending upon the definition of community health service delivery (e.g. inclusion/exclusion of formal provision such as CHWs, inclusion/exclusion of qualitative alongside quantitative assessments)[31].

Other modular framework indicators relate to specific components of CSS (coverage) and provide potentially useful measures, although following a data request to Global Fund, uptake of these indicators and availability of data appears to be patchy, and especially for the latter two RSSH indicators:

Table 11: Community System Strengthening Indicators

RSSH module	Relevant CSS indicators
Under RSSH/Community Systems Strengthening	CSS-2: Number of community organizations that received a predefined package of training (disaggregated by type of organization)
	CSS-3: Percentage of health service delivery sites with a community-led monitoring mechanism in place (disaggregated by type of CLM mechanism)

[31] Global Fund guidance is slightly contradictory in this respect. The Global Fund report "2022 Baseline for KPI S4: Reinforcing Community Systems for Service Delivery" notes that "the KPI has broad relevance across RSSH strategic objectives by integrating both formal (CHW) and informal (CSO) community service providers". However, there is a separate KPI (S5) for measuring systems readiness for CHWs. Otherwise, KPI S4 includes a reasonable set of assessment criteria: "(i) Laws, regulations or policies provide for the operation of community service providers; (ii) National health strategies include community-led and community-based service providers; (iii) Community service providers have adequate capacity to deliver HIV, TB and malaria services; (iv) Data from community service providers is fed into national health information systems". A further problem arises in the indicator currently assigned to key measure (iii) - Number of countries with a Community Sector Principal Recipient with a programmatic rating of C or higher. Many countries will not have a CSO PR; hence it is imperative to also supplement this measure with a broader capacity assessment of civil society SRs/ implementers (conducted and found to be adequate for at least one implementer) as specified in the KPI Handbook (April 2024), in order to ensure meaningful measurement of KPI S4.
The Global Fund. (2023). *KPI S4 2022 Baseline Report (updated August 2023)*.

RSSH module	Relevant CSS indicators
Under RSSH/Health Financing Systems	HFS-5: Percentage of civil society organizations contracted by public entities for provision of community-based services to key populations (disaggregated by source of financing, disease type, type of key population)
Under RSSH/Monitoring and Evaluation Systems	M&E-4.1: Percentage of service delivery reports from community health units integrated/ interoperable with the national HMIS
	M&E-4.1: Percentage of service delivery reports from community health units integrated/ interoperable with the national HMIS

2024 analysis from the Global Fund found only seven countries with CSS-2 in their PFs (10% of total countries - N=68 - with signed CSS grants in GC7), and 22 countries with CSS-3 in their PF (32% of total countries). The 23 countries with CSS indicators account for just over 50% of CSS GC7 HTM funding. Of the 20 highest CSS-funded countries, seven do not have a CSS indicator (India, Zambia, Ukraine, Senegal, Russia, Burundi, Mali).

One further KPI (C1) measures community engagement across the Global Fund grant cycle, aiming to assess the effectiveness of the Global Fund in supporting and realizing community engagement, but this is a process measure rather than focusing on service delivery or outcomes. As a newly created KPI there is no available data for the period 2020-2024.

Looking beyond monitoring data, some global stakeholders (KIIs) also emphasized the need for better measurement of outcomes (health systems and diseases) – both magnitude and mechanisms, the need for more robust impact assessments, as well as for Improving data collection methodologies to capture both quantitative and qualitative impact. Given that most indicators available for community-led responses are output based, this does not demonstrate contribution to disease outcomes – in turn potentially weakening advocacy efforts: "*We need to move beyond activity-based reporting to real impact measurement. What difference did we actually make?*" One suggestion was the use of surveys to capture more behavioral outcomes.

3.4 Sustainability

EQ 4 To what extent do Global Fund investments in CRSS contribute to the sustainability of community systems and responses?

1 **Finding 4.1 Current investments in CRSS will not result in sustainability.**

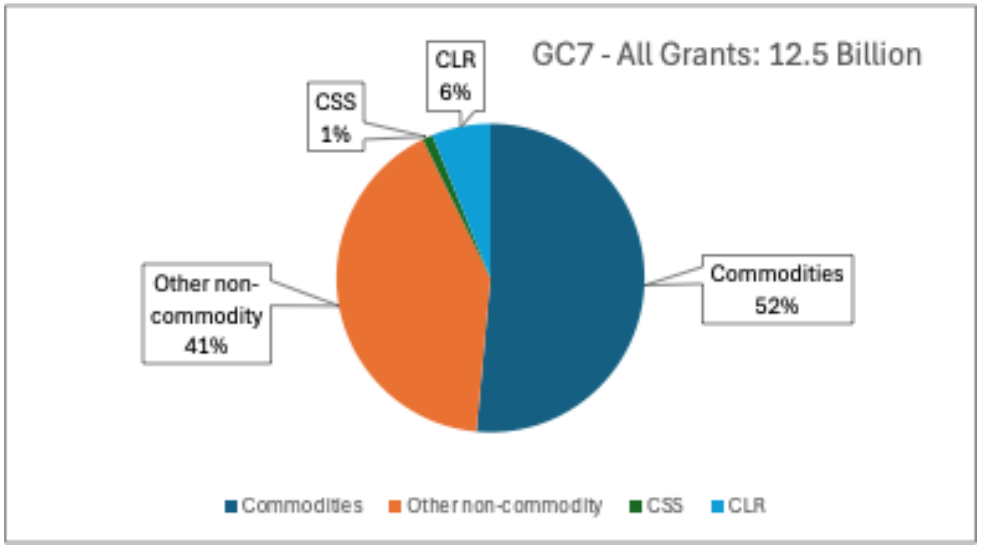
From the country insight studies and the portfolio analysis, it was found overall that Global Fund investments in CRSS, though laudable as grant activities, have contributed little to the longer-term sustainability of community systems and responses. As one CSO representative shared, "*Sometimes I wonder if what we're doing is really sustainable. When the funding ends, everything ends. That's not strengthening, that's dependency.*" Several reasons were identified, which are further described below under the sub-evaluation questions.

2 **F4.2 CRSS investments have been limited in scope and budget.**

CRSS elements are reflected in national strategic plans for diseases, rather than national health sector plans, often as separate projects, hence relying on external funding by international donors[32], limiting their sustainability. Experience from LAC and EECA shows that when there is no longer funding from the Global Fund, CSOs can disappear[33].

CRSS funding has been small in quantity and limited in scope/use. Investments for CSOs focus on identification/surveillance, testing, (limited) treatment, and follow-up of affected people; it provided limited funding for capacity building of CSOs regarding individual or organizational development and resource mobilization[34]. With the emphasis on commodities and financing of national systems, there is limited funding for CSOs and CRSS. Figure 8 below that shows the CLR and CSS budgets as part of all the CG7 grants as of January 2025[35]. The RSSH CSS investments are small compared to CLR activities implemented by CSOs and communities. Key informants frequently mentioned that GF support for CSO activities is too fragmented across the different disease modules, under RSSH/CSS, as part of CRG activities and under the various strategic initiatives (with often projectivized activities), which are usually so little coordinated among the different stakeholder groups that a common, sustainable approach is challenging to develop. Indeed, the EVT heard many community requests for ring-fenced funding. For example, *"The Global Fund must give clear guidance on the contribution of civil society organizations and how governments should work with them, and who should be PRs, including the percentage allocations for CSOs."*

Figure 8: GC7 investment allocation to CSS and CLR



Other health systems elements also point to limited integration and sustainability of community systems:

- **Health Information systems**: Community data systems are often not integrated with national M&E systems; CLM is being introduced as an alternative and often a one-off activity (Guatemala, Burkina Faso, Lao)
- **Human Resources for Health**: Community workers, while in some cases funded by the government (Burkina Faso, Ethiopia, Lao), are in most cases not necessarily part of the national HRH system; there is a sensitivity between 'real' volunteer and 'paid' volunteers (often introduced by the Global Fund and other external funders)

[32] Country insight studies
[33] KII-TAP/RSSH
[34] KII-CSOs
[35] From the budget review; explanation and further description in Annex 4. CRSS Budgets Review

- **Health care financing**: Domestic financing, including co-financing, is geared towards sustaining treatment (commodities, diagnostics), not to CSO-led prevention programs (Guatemala, Lao). The exception is Montenegro, where the government has increased its contribution, but only to about half of what is necessary, and it is unclear whether this will be sustained after the Global Fund transitions out again. Several countries have used social contracting as part of their HTM response, primarily well-established programs in middle-income countries and above, as part of a transition plan. The implementation and effectiveness of social contracting vary based on a country's legal framework, political will, and the capacity of NGOs and CSOs. Limited evidence supports that the Global Fund is addressing these barriers.

These are further explored under the sub-evaluation question sections below.

EQ 4.1 To what extent are there clear pathways towards sustainable community services and systems at the country level (e.g., integration/ development of a comprehensive community health strategy within the national disease response), and why/why not?

Finding 4.1.1 CLR tends to receive more recognition in NSPs and national health plans and is more likely to be sustainable than CSS.

From the review of NSPs, national health plans and GF grant applications, there is growing recognition of community systems supporting the health sector; however, few describe explicitly the strengthening of community systems. As much as community roles are often well described in national documentation (for TB and HIV), this does not necessarily lead to operationalization and integration efforts (Guatemala, Burkina Faso).[36]

Also, there are currently very few community health strategies; globally, only 19 countries (eight in Africa, five in Asia, and six in the Americas, covering half the global population) have a formal community health strategy as part of their primary health care system, and they are not always up to date[37]. CRSS activities are often reflected in national disease programs rather than as community health activities, even when there is a community health strategy, as this allows for funding by the Global Fund or other external donors (Burkina Faso, Zimbabwe).[38]

On the other hand, there is growing evidence from the GC7 grant applications that a solid process of CSO consultations has taken place, both for NSP development and the grant application processes, which suggests that the CSO sector is increasingly recognized as an essential stakeholder, which could eventually lead to further discussion about integration. However, the budget review (see Annex 4) showed that at this stage (GC7), very little funding is available for CSO activities, primarily for operational community-led response activities, separate from those of the government.

Finding 4.1.2 Integration of community health interventions into the formal government health sector is still limited.

There are several good practices where CSOs/CBOs and community workers are working in complement to government systems. For example, in **Guatemala** and **Lao**, CSOs have

[36] Country insight studies
[37] Internal evidence review – March 2025
[38] Country insight studies

been engaged to reach out to key populations and those in remote areas or ethnic minorities.[39]

Still, many countries report weak integration of community systems with mainstream health systems, particularly in data reporting, staff capacity development, and limited government financing to pay for CSO services[40]. Several countries also reported that even the first step of integration, i.e., the coordination of government and the CSO sector, is often lacking or is only cursory at best (annual meeting attendance, a CCM meeting).

It was also reported that TB programs are considered very bio-medically orientated, with little scope for prevention and not having specific key populations other than those identified as having TB and their immediate families (Guatemala, Lao, Burkina Faso) that there is little scope for CSO involvement apart from bringing those from remote areas to regular health services for sputum testing and treatment.[41]

Key informants queried whose role it is to ensure integration of the CSO-led response activities into the national health system. "*Is it the role of the Global Fund to ensure integration, or can we leave it to in-country partners*"[42]. If CSOs are to be integrated into national health systems, then "it requires development of the social contracting model within the public financial management structures in the countries." But there are often no clear pathways on integration: "*transitions don't consider things like social contracting or other kinds of guarantees that community, civil society and other people can be in the conversation means that as the Global Fund we fail a little bit if we just say, okay, we're out, the government has the power, plan now. And next thing you know, very vulnerable communities or rural communities or already marginalized communities just fall off the agenda completely. And the government's very happy they are carrying on with what they want to do. But all that work that we had done to make sure that the, you know, that the poorest were prioritized, etc., will have come to naught in a way, and that community voice will disappear*".[43]

In **Zimbabwe**, the government oversees social contracting with little influence from the Global Fund[44]. Key stakeholders emphasized that this allowed greater flexibility in how they worked with specific communities for specific health goals (for instance, targeting mining communities, or adolescent girls and young women). The Zimbabwe example demonstrates the utility of social contracting for clearly defining government priorities. However, it also highlights the lack of political willingness in some areas, specifically to work with key populations.

Finding 4.1.3 Establishing community health worker schemes is often seen as the single avenue for increasing community health interventions.

Several countries have established community (health) worker schemes, some funded by the government and others primarily relying on external funding, which raises questions about integration and sustainability. In **Ethiopia**, the health extension program is a government-funded community health program that supports integrating health services at the community level. However, TB and HIV still need to be integrated at that level, as they have been thus far separately funded by the Global Fund. The CBOs that address HIV and TB work in isolation with little oversight from the government, and therefore, there

[39] Country insight studies
[40] Country insight studies and Portfolio analysis
[41] Country insight studies
[42] KII-CRG
[43] KII-TAP/RSSH
[44] Zimbabwe country insight study

seems to be no direction or incentive to have them integrated with existing health systems.[45]

In each of the **RAI** countries[46], "*the number of malaria program volunteers, the services offered, position titles, and their status within health structures vary. This complexity has created a scenario where, in some instances, there are inequities in pay and provision of incentives to volunteers, or where some volunteers are working for multiple vertical and integrated volunteer programs. This complicates discussions around integration and sustainability as not all key stakeholders shared a common understanding of who the volunteers were, their remit, and how they are managed*"[47].

In **Ghana**, "*the recognition of certain community cadres in national frameworks and policies and the strong reliance of health facilities on them suggests a high level of commitment to sustaining them even though they are funded on a project basis rather than as core elements of the health system*"[48].

Guatemala is an exception where the Malaria CRSS program is well integrated with the national malaria program in Guatemala (see Box 13).

[45] Ethiopia country insight study
[46] Cambodia, Lao, Myanmar, Thailand and Vietnam.
[47] Health Management Support Team. (2022, December 30). *Advisory report on village malaria workers for RAI4E*. Submitted to the RAI Independent Monitoring Panel
[48] Greenall, M., with support from Duodu, J. (2020, March 12). *Global Fund thematic review on community health: Ghana country report*. Global Fund.

Box 13: Malaria Program Sustainability in Guatemala

Country Insight: Malaria Program Sustainability in Guatemala

Community engagement is explicitly built into Guatemala's malaria elimination strategy and plans. The Malaria Transition Plan 2021–2025 (and the updated 2025–2030 plan) and the official Transition Plan devote considerable attention to the community level. For example, they outline actions to strengthen the "*Estrategia Nacional de ColVol*" (National Volunteer Collaborator Strategy) to adapt volunteer roles in the context of elimination and prevention of re-establishment. This includes regular training, supervision, and inclusion of community data in the health information system. There are established mechanisms like semi-annual meetings with community leaders and municipal health authorities to coordinate efforts (as noted in the Transition Plan). Many malaria volunteers are linked to local clinics for reporting and supplies. Because of this integration, community actions (like fever surveillance, use of rapid tests, and treatment initiation by volunteers) are sustained as a routine part of the health system in high-risk areas. This alignment of NSP and on-the-ground practice means the community response is relatively well institutionalized in malaria compared to HIV/TB.

Malaria investments in CRSS have trained and organized the ColVols network, which does case detection, treatment, and health education at the village level. This has made the malaria response highly decentralized and resilient. Even in remote areas, volunteers ensure surveillance and quick treatment, which is crucial for elimination. These sustained community efforts are a cornerstone of keeping malaria in check and are a lasting asset beyond the project timeframe. CRSS funding also empowered local structures, e.g., village health committees and indigenous leaders, which were engaged in malaria awareness and home spraying campaigns. Community members have skills and ownership over malaria outcomes (many volunteers have served for years). This local capacity is a sustainable outcome: even if funding fluctuates, the knowledge and social capital remain in the community. However, keeping these volunteers motivated (through incentives or recognition) is critical to sustain the system, a point frequently raised by malaria stakeholders.

A positive development is the notable shift away from singular disease community health workers to multi-disciplinary/tasking health workers in several countries (Lao, Guatemala, Ethiopia, Burkina Faso, Zimbabwe), particularly with a growing focus on UHC. However, as mentioned above their formal adoption as part of the civil service is often lacking.[49]

EQ 4.2 To what extent are Global Fund systems-strengthening investments (such as advocacy and capacity building) enhancing the sustainability of community services within Global Fund HIV, TB, and malaria programs?

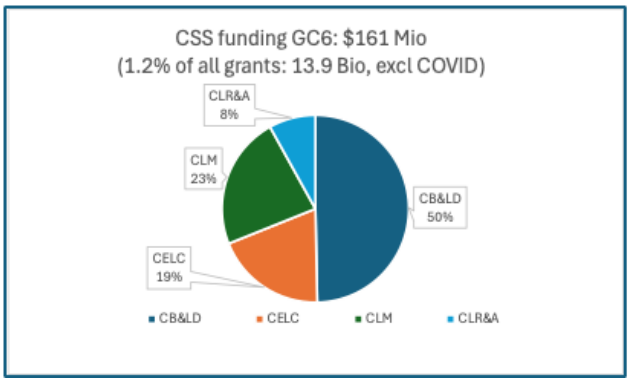
Finding 2

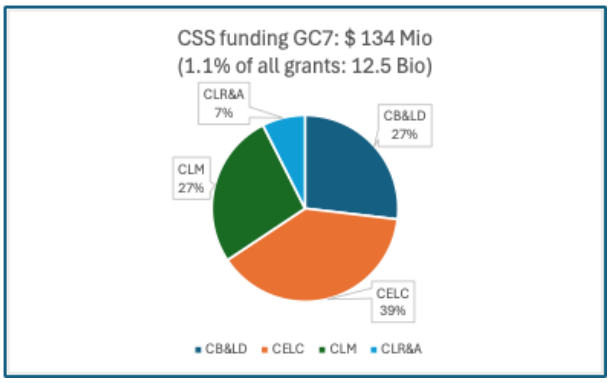
Finding 4.2.1 Funding for CSS is falling in absolute terms.

The RSSH/CSS budget of all grants has steadily increased from 0.7% (GC5) to 1.2% (GC6) and reduced to 1.1% for GC7[50]. However, comparing GC6/GC7 in absolute USD terms, shows an overall reduction of CSS investment of 17%, with a halving for capacity building and leadership development (CB&LD), an increase for CSO engagement, linkages and coordination (CELC) and a similar amount in the two grant cycles for Community-led/based monitoring (CLM/CBM) and community-based research and advocacy (CLR&A). However, the total for the latter was only about USD 10 million, or an average of USD 60,000 per grant per year. See the two graphs below in Figure 9.

[49] Country insight studies
[50] Budget review see Annex 4. CRSS Budgets Review and the graphs

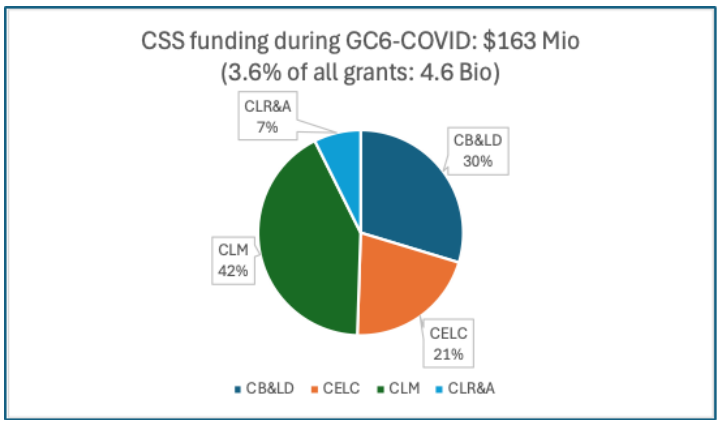
Figure 9: CSS Funding in CG6 and CG7





However, the additional C19RM funding provided a similar amount, USD 163 million, for RSSH/CSS activities, which increased the CSS investment to about 17% of all grants during the GC6 period; see Figure 10. Even then, many CSOs feel that they do not receive adequate support to do their work effectively. One implementer said "*We have to do the minimum and make concessions everywhere. We can't cover every province, but we have to prioritize the highest prevalence. We're only covering a fifth of the communities' needs.*" Another explained "*Community organizations are doing the work on the ground, but we struggle to access even small funding to support our activities.*" As a result, some expressed feeling more like "*we are just subcontractors, without influence*".

Figure 10: CSS funding in GC6 and C19RM



2

Finding 4.2.2 CRSS investments are not priorities for countries

At the country level, CSO budgets are not included in many countries' national health budgets. Even the Global Fund Secretariat suggested 30% (or 50% in some cases[51]) of the provided grants for community investment were not implemented (RAI), even though this was seen by many of the interviewed CSOs as the key path to sustainability.[52]

Countries (Ethiopia, Lao, Burkina Faso) reported limited Global Fund investments in strengthening community and health systems to ensure the sustainability of community services. The country budget review confirmed this (see above and Annex 4).[53]

[51] Reported in KIIs related to an earlier grant cycle.
[52] KII-CSOs and KII-RSC
[53] Country insight studies

Guatemala's health system has long prioritized tertiary care over primary prevention, with underfunded rural clinics and a lack of culturally competent providers. The Global Fund's CRSS investments have partially filled these gaps. Still, they are constrained by centralized budgeting of the grants allocated to the Ministry of Health, often for hospital infrastructure rather than community-led programs, and a fragmented approach to coordination (i.e., competing priorities between NGOs, the state, and different donors dilute accountability). It was also reported that capacity development came too late and too little in Guatemala, as the country is transitioning soon. [54]

In **Ethiopia**, there was no Global Fund funding to build the capacities of CSOs to do their own fundraising. There was earlier capacity development investment in the CSO sector in **Montenegro**, but that has dissipated, and only a few of the more established NGOs are left. In Lao, CSO funding for TB/HIV under the World Bank-funded blended financing program has become so tiny that it marginally pays for the operational expenses of a limited number of community outreach workers, with no funding for institutional or capacity development. Furthermore, CLM as a priority CSS element during GC7 is seen as creating a parallel system to already existing government and CSO monitoring systems, and its introduction is seen as a one-time event rather than an effort to be systematically integrated into the national monitoring system (Guatemala, Lao, Zimbabwe)[55].

In some cases, partners (e.g., Robert Carr Fund) are picking up the costs for key personnel, capacity development, and other institutional development, where the Global Fund provides for the operational costs and commodities[56]. Although the future of continued support is now in doubt.

It was reported that only faith-based and private sector organizations remain when CSOs disappear after Global Fund funding has ceased. However, there is still little experience within the Global Fund to engage and/or tap those resources meaningfully: "*This is a shame, as 60-70% of the people attend the private sector in the first instance. As there is no longer experience in the RSSH team on the private sector, even the briefing note on private sector engagement may be shelve*"[57].

Finding 4.2.3Intercountry CSO platforms have contributed to CSO engagement at country level.

On the other hand, the GF support for regional (such as the CSO Platform, supported by the **RAI** grant) and international platforms (such as CS4ME, supported by the CE SI) has contributed significantly to the engagement of CSOs at the country level, particularly in capacity development and the development of advocacy strategies. They have increasingly supported CSOs to be part of NSP and grant application processes, through in-country and regional meetings to prepare for country disease strategy development and the GC7 grant application process.[58]

In the Mekong region, over 50 CSOs allied with and implementing the **RAI** project stay in touch through a dedicated platform that allows them to communicate, promote best practices, develop advocacy strategies, monitor implementation, harmonize and

[54] Guatemala country insight study
[55] Country insight studies
[56] KII-Partner
[57] KII-TAP/RSSH
[58] KII – CSO platform, Vice Chair and CSO Representative on RAI/RSC

coordinate activities, and share experiences[59]. Continued financing of the RAI CSO platform would ensure capacity development and CSO engagement at the highest levels, which is looking to expand beyond malaria[60].

In three countries (Cameroon, Niger and Nigeria), where the CS4ME platform supported by the Global Fund has been active, members engaged with decision-makers before and during the grant application process to advocate for – and in some cases achieve - greater engagement with CSOs as well as an increased mobilization of national resources for the fight against malaria, HIV/AIDS and TB[61].

In Georgia, Global Fund grants have supported the formation of a strong CSO platform. However, the sustainability of CSOs is uncertain, especially in terms of social contracting, legal and regulatory frameworks for their work, CSO financial support, and the need for further capacity building for CSO institutional management (see also concerns in the next section)[62].

EQ 4.3 What are the opportunities to strengthen the sustainability of CRSS? What are the trade-offs and concerns for the sustainability of CRSS for different Global Fund communities?

Finding 4.3.1 Opportunities to strengthen the sustainability of CRSS exist, but need to be further documented, institutionalized, and disseminated.

Besides the experience with the inter-county CSO platforms as mentioned above and pool procurement, in-country CSOs mentioned several other opportunities to increase their engagement in HTM control and elimination[63]. Countries frequently referred to the previous dual-track financing, which provided them with more flexibility and ownership than the current, often activity-based contracting modality (Lao, Guatemala, Ethiopia). In addition, 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[64].

Countries advocated for a more explicit role or description of CSO service provision vis-à-vis government services (Lao, Guatemala, Ethiopia). This includes ringfencing budget for the CSO sector (Ethiopia) or making them part of the Government budget (Guatemala), through social contracting as well as expansion of technical tasks, or task shifting, in testing and treatment and capacity development for resource mobilization. One community key informant stated that "*Budget allocation for RSSH must be a key priority to allocate to civil society*."

With the Global Fund's support over the last decade and a half, there has been a move away from verticalization towards a more horizontal, integrated approach of disease

[59] The Global Fund. (2024, December). *Eliminating malaria in the Mekong: Regional Artemisinin-resistance Initiative (RAI)*. The Global Fund to Fight AIDS, Tuberculosis and Malaria.
[60] KII – CSO representative on RAI/RSC
[61] CS4ME Secretariat. (2023). *CS4ME 2023 Annual Report: Ensuring that the needs of vulnerable populations are included in malaria programs*. Civil Society for Malaria Elimination (CS4ME).
[62] Technical Evaluation Reference Group. (2019). *Position Paper – Thematic Review on Resilient and Sustainable Systems for Health (RSSH)*. The Global Fund.
[63] Country insight studies
[64] The Global Fund. (2023). *Thematic Evaluation on Community Engagement and Community-led Responses: Secretariat-led with TERG oversight (CE-CLR)*.

management. However, this continues to need substantial support from external partners while ensuring subnational coordination that includes CSOs.

The existence of CHW structures (and their funding) as part of the national HRH structures in Burkina Faso and Ethiopia is seen as an opportunity to expand the scope of the tasks for CHWs. The Global Fund's inputs into blended financing arrangements, such as World Bank projects in Burkina Faso and Lao, could further support this, although queries exist about whether this was a good use of loan financing.

Lastly, new tools and technologies, a stronger focus on program prioritization, and better tailoring programs to the local context offer opportunities for strengthened impact[65]. Country health systems differ in maturity/progression and weaknesses; systems support and strengthening interventions should be tailored according to country-specific constraints and opportunities[66].

Finding 4.3.2 Sustainability concerns affect the outlook of the CSO sector.

However, key concerns remain. CSOs raised concerns about sustained funding for their operations and a dwindling scope when the epidemic burden is reduced. In countries close to transition (Montenegro, Lao), there are fears that as the Global Fund leaves (and the CCM disappears as well), the government will no longer finance the CSO sector (as previously required as part of co-financing). In **Montenegro**, the government increased the funding for HIV prevention programs, though only to about 50% of what is potentially needed to provide a comprehensive cover. CSOs fear it will discontinue once the Global Fund co-financing requirements are no longer there. A marginalized CSO sector would particularly affect service provision for key populations. A Mozambican CSO representative shared that this is already happening: '*We as a CCM member, we have the power as a CCM member, but sometimes I feel that we look like, let's say, a lion without teeth. We have the name as members, we are the ones who should make the decisions, but in reality, what I have seen does not look like this. Once the primary recipient signs a contract with the Global Fund, we are just left out"*[67]. Similar sentiments were heard in other countries.

All insight countries referred to the fact that there are draft transition plans or an intention to have a transition plan. However, there is little incentive to operationalize them, as there was still Global Fund and other partner funding to support the HTM activities. This lack of transition planning and/or operationalization, as well as limited budgets, leaves the CSO sector unprepared. This is particularly the case when some of the changes needed to prepare for transition will likely require more than one grant cycle to prepare for.

In **Guatemala**, there was a concern of increasing tension between paid and non-paid volunteers, leading to a loss of long-term 'social capital' in the communities; such community members need further/continued motivation. At the same time, uncertain economic outlooks and US policies towards international development assistance were frequently mentioned by government and CSO key informants as concerns for the future if the Global Fund and thus, CSO support; particularly for CSO-led activities, such as CLM[68].

[65] The Global Fund. (2021). *Fighting pandemics and building a healthier and more equitable world: Global Fund strategy (2023–2028)*. The Global Fund to Fight AIDS, Tuberculosis and Malaria.
[66] TERG - Global Fund Mapping Health Systems Strengthening (HSS) Component of the Resilient and Sustainable Systems for Health (RSSH) Investments
[67] KII-CSO Mozambique
[68] County insight studies, particularly KIIs with CSOs and Government representatives.

An overall negative trade-off is the Global Fund's focus on commodities for testing and treatment to sustain services; this often deters funding availability for the CSO sector – although communities are also important channels for providing access to those commodities. KIIs implied that current approach appears to favor a "commodities first, the rest second" approach rather than adopt a holistic view of strategic priorities to improve health outcomes.

The TRP[69] notices that there were missed opportunities to facilitate comprehensive RSSH landscape mapping and coordination of stakeholders involved in health and community systems strengthening. The TRP recognizes that, for maximum programmatic impact to be realized, RSSH planning and implementation must include civil society and community health systems actors as well as government actors. Similarly, the question of optimizing CSS investments to expand community-led service delivery in hostile and challenging operating environments was also raised. The current guidance is limited on this, apart from commodity provisions to keep services going.[70]

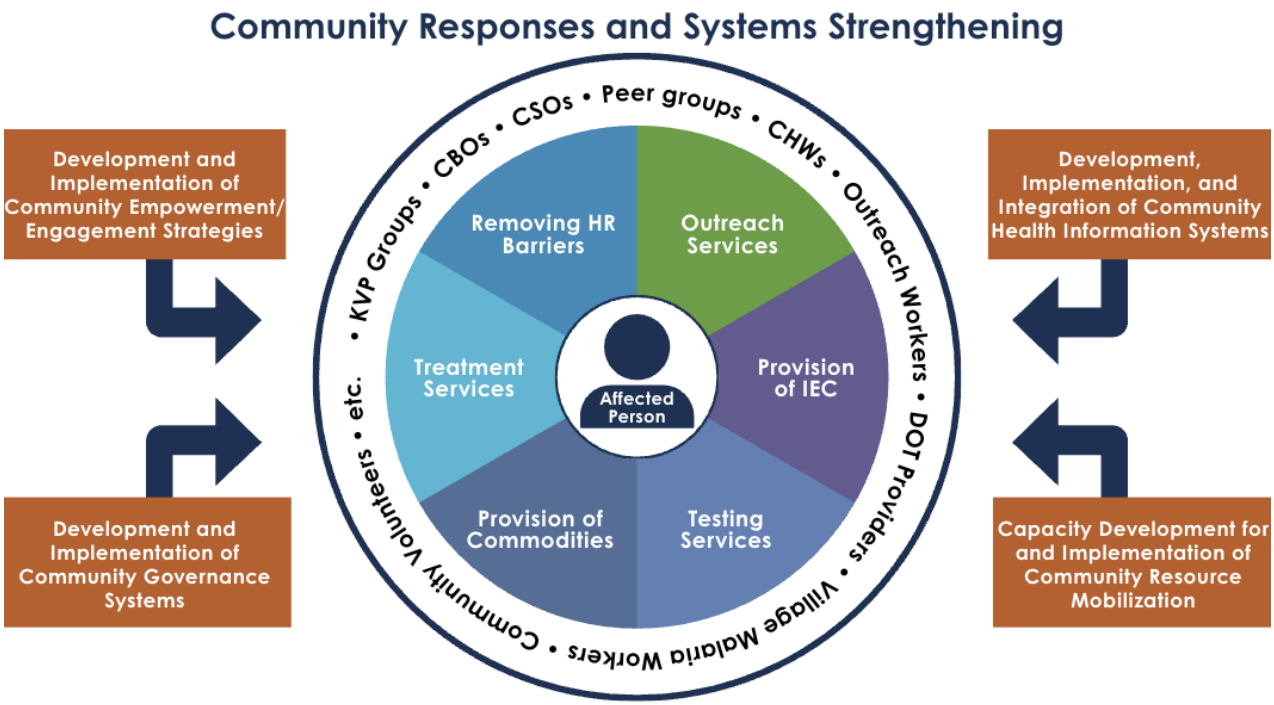
As much as the positive experience with the regional[71] capacity development platforms, it is challenging for regional projects to deliver scaled-up services to key populations in multiple countries (**RAI**, **Montenegro**). National and local key population organizations would benefit significantly from additional opportunities to obtain CSS or direct key population-focused funding. However, for example, SI projectization has minimized the impact in some of the supported countries, and not all countries sought or were given SI opportunities.

3.5 A draft for an integrated framework for CRSS and RSSH

The evaluation findings point to a concerning conclusion, whether by design or interpretation of the design in practice, approaches to working with communities lack a strategic focus or are not comprehensive enough. Figure 11 presents a strawman module for CRSS that identifies the six key functions (operational enablers) that communities, community-based health workers, and community organizations are expected to undertake to support affected persons and thereby contribute to reducing the HTM burden. In addition, four comprehensive strategic enablers build and support communities, community health workers and organizations to do so and build their long-term capacity or strengthen their systems.

[69] Technical Review Panel (TRP). (2024). *TRP RSSH Deep Dive 2024 Report*.
[70] Global Fund applicant guidance note.
[71] Global Forum on MSM & HIV (MSMGF). (2013, October 3). *Community systems strengthening and key populations: A policy discussion paper*.

Figure 11: Strawman integrated CRSS Framework



This was developed by compiling all instances of community interventions across the Disease and RSSH modules in the current (2023 version) modular framework handbook. More than 70 interventions (and substantially more potential activities) were identified, making it difficult for countries to select the appropriate interventions or to decide under which module (disease or RSSH) they should do so. This mapping enabled the evaluators to gain a comprehensive overview of activities undertaken by communities, community workers and organizations. The mapping found that interventions were often duplicative. The EVT grouped all community interventions, de-duplicated them and simplified them into common CRSS functions, further divided as operational or strategic. These were then linked to health or health systems outcomes. The mapping with selected sample interventions is provided in Annex I.

As the figure above illustrates, the mapping shows operational functions that community actors and organisations may play and how further strategic development partners or government support may complement these operational activities. These may differ depending on the context, identified needs, and stage of a country's health system maturity. For instance, CLM may be appropriate in a context where accountability may function as a lever to improve quality of care, but not in another context where community health information systems are already well developed and cost-effective. With the increasing emphasis of domestic resource mobilisation, integration and achieving UHC, this would permit analysis of where CRSS is a 'best fit'. The strawman could also be further developed by stage of health system maturity. For instance, in a context where there is greater health systems maturity, it would be expected that CSOs and community groups would still retain a role in health systems governance and accountability.

Options for further use of this strawman framework by TGF include:

- A standalone CRSS module in the modular framework (the above has brought the CLR and CSS intervention from the disease and RSSH modules together under one module). This would also allow a CSO dual-track partner to be engaged for one comprehensive CRSS module only.

- A framework for selecting a CRSS approach in each country's context or responding to a specific high disease burden.
- The links to health and health systems outcomes would need testing and monitoring in each context but would enable a clearer justification for investments in operational or strategic enablers.

4. Key conclusions

SOE	Conclusions	Map to Findings
Strategy & Approach		
	1. **Admirable commitment to putting communities at the center**. The Global Fund's current strategy demonstrates its recognition of the important role that communities play in fighting the three diseases, and the need to support community-led responses, and community system strengthening. There is also general consensus that the four intervention areas that the Global Fund targets for CSS are generally the right ones.	1.1, 1.1.1, 2.2.1, 2.2.2, 3.3
	2. **Lack of overarching CRSS framework.** The lack of an integrated framework connecting community system strengthening to community-led response, and its contributions to health outcomes (and a common definition of "communities") has led to inconsistent approaches to CRSS, with investment in CLR favored over CSS. This is also related to the internal organization of the Global Fund Secretariat, whereby different aspects of CRSS are managed by different teams, who do not necessarily come together to reflect on a country-level approach. Decisions on how to support CRSS can therefore be dependent on the discretionary decisions of Country Teams.	1.1, 1.2, 2.1, 2.2, 2.1.2
	3. **Inconsistent understanding of communities and CLR.** "Communities" appear to be understood either as affected populations in some contexts, or specifically as key populations in others. Depending on this understanding, CLR may be understood as either the work of community health workers (CHWs), or the services provided by civil society organizations to key populations, which can include efforts to address human rights and gender-based barriers. Both are necessary for a comprehensive approach to the three diseases, yet not all stakeholders understand them in the same way, which creates confusion.	1.2, 2.1.1, 4.1.3
	4. Communities contribute to a wider variety of health outcomes than appears to be commonly recognized. The evaluation identified numerous roles that communities and civil society play in providing services and supporting elimination of the three diseases. Yet these were not consistently known by many involved in developing national responses.	1.2, 3.1, 3.2, 3.3
Investment		

	5. **Investing in Community Systems Strengthening is critical to the Global Fund having impact, yet difficult to do effectively**. Designing effective investments is challenging due to the complex set of interconnected and hard-to-measure factors to inform prioritization and costing, and alignment with community health strategies. This is compounded by the lack of data on the effectiveness of CSS to impact health system strengthening or integrating community systems with formal health systems to impact health outcomes.	1.1, 1.1.1, 2.2, 3.1, 3.1.3
	6. **Underinvestment in communities and CSOs.** Given the critical role that communities and civil society play in fighting epidemics, there is insufficient investment in them to have significant impact. This is particularly true in countries where governments are struggling to reach some key populations (particularly gay men and other MSM), and leave this to civil society, without providing the needed resources.	3.3, 3.1.3, 3.2.1, 3.4, 4.1, 4.2, 4.2.1
	7. **Investment in CLR is not fully supported by investment in CSS**. While the Global Fund has increased its investment in CRSS, most of this increase has been towards CLR, with CSS representing only 1% of investment in GC6 and GC7 grant budgets, compared to 6% (GC6) and 7%(GC7) for CLR.	3.2.1, 4.1, 4.2.1, 4.2.2
Operationalization		
	8. **CSS is de-coupled from CLR in practice.** The inclusion of CSS in RSSH can result in an artificial de-coupling of CSS from CLR and can create more competition for scarce resources between communities and other RSSH modules, which typically support the government.	2.1, 2.2.1, 3.2.2, 4.1.1
	9. **Community system maturity is not systematically considered**. Communities and CSOs are diverse and complex, and a large organization like the Global Fund is not set up to respond to this nuance across multiple countries. All Global Fund grants attempt to adapt to the context, yet there is a lack of tools to support consistent design and decision making, resulting in individual discretion determining what CSS support is needed to support what CLR.	1.2, 1.2.1, 2.1.2
	10. **Lack of measurement results in lack of evidence.** Despite the increasing investment in CRSS, there is a lack of clear evidence of how investment in CSS supports CLR – nor how CRSS contributes to health outcomes. This is not because is it not having an impact, but because the necessary data is not systematically collected, reported or analyzed. Current indicators are not all mandatory nor designed to provide the needed information. Service delivery results are generally not disaggregated by sector, rendering the communities' contribution invisible.	2.3, 3.1.2, 3.1.3, 3.4.1

	11. **Lack of assessment and sustainability or integration planning.** Planning and preparation for sustainability of CLR is not consistently prepared for early enough in advance to address the legal, structural, relational and capacity needs that will take multiple cycles to change. Nor is an assessment conducted to understand the current community system, in terms of the government's readiness to support community efforts, nor the community's capacity to deliver services, in order to develop a coherent plan or track changes over time.	2.3.1, 4.2, 4.1.1, 4.1.2, 4.3.2
	12. **Community Engagement Strategic Initiative complements grant investments.** The Community Engagement Strategic Initiative is filling important gaps in CSS; however, its reach is relatively limited and not always consistently aligned with CLR efforts.	3.2.2, 4.2.3
	13. **Community-led monitoring requires a more tailored approach.** CLM is working well in some contexts but requires more careful consideration, assessment, and support for adaptation in others. CLM appears to be encouraged over and above other needed CSS interventions without an appropriate assessment, sometimes resulting in duplication or lack of linkages with other initiatives.	1.2.1, 1.2.2, 2.1, 3.3.1, 3.3.2
	14. The current model is not designed for integrated efforts. With diminishing resources, it will be increasingly necessary to seek efficiency and savings through the integration of efforts and more horizontal management of diseases, e.g. through CHWs. This is currently not supported by the Global Fund's current structure or tools.	4.3.1, 4.2.2
	15. Abundant, high-quality but scattered guidance. Country stakeholders find the large number of different guidance documents produced by different teams difficult to navigate. Nor does the guidance support a clear CRSS approach, despite efforts to link and cross-reference guidance. Similarly, CSS is presented more as a community responsibility, rather than linked to the government systems that can support it, in terms of a conducive operating environment.	1.1, 1.2.1
	16. **Limited community-level coordination in countries.** The current approach to funding request development can create competition rather than cooperation between communities and civil society, particularly with limited representation on the CCM. Where social capital has been built among communities and civil society, it may not be sustainable beyond Global Fund support.	2.2, 4.3.2
	17. **Cooperation needed with others working with community systems.** The Global Fund partnership works well across traditional technical and financial partners, however, in the current restricted funding environment, opportunities may be missed for optimal resource use by not connecting with other significant investors who work with communities, such as the multilateral development banks.	Non-EQ related, cross-cutting observation

5. Recommendations

The following table presents the evaluation's recommendations, linked to the evaluation's conclusions, which are in turn, drawn from the findings based on the evidence presented above. Below, further details are provided on each recommendation, included who each recommendation is addressed to, the priority level, the recommended timeframe, and guidance on operationalization.

Table 12: Summary Recommendations mapped to conclusions and findings

Recommendations	Map to Conclusion	Map to Findings
1. Develop a comprehensive framework for CRSS, which links to RSSH and a health systems maturity framework.	C2, C3, C4, C5, C9	1.1, 1.2, 1.2.1, 2.1, 2.2, 2.1.1, 2.1.2, 3.1, 3.2, 3.3, 4.1.3
2. Improve the monitoring and results framework to make community contributions to health outcomes more measurable and visible.	C8, C10	2.1, 2.3, 2.2.1, 3.1.2, 3.1.3, 3.2.2, 3.4.1, 4.1.1
3. Develop a multi-cycle sustainability plan for countries which includes critical community-led responses as part of funding requests, based on the new CRSS framework and the maturity model.	C12, C17	2.3.1, 4.2, 4.1.1, 4.1.2, 4.2.2, 4.3.1, 4.3.2
4. Adjust incentives for FPMs to be accountable to supporting countries adhere to the CRSS framework and make progress on sustainability plans.	C2, C9	1.2, 1.2.2, 2.2
5. Update the information note on CLM to provide more explicit guidance on how CLM should be integrated into health systems, appropriate pathways to scale, and better adaptation to context.	C14	1.2.1, 1.2.2, 2.1, 3.3.1, 3.3.2
6. Further invest in light-touch country platforms to create efficiency and provide a basis for sustainability transition, connecting more community actors with diverse but related interests (e.g. health financing) to plan for beyond Global Fund support and CCM representation.	C13, C15	2.2, 4.2.3
7. Reinvigorate engagement with partners, including with multinational development banks who are engaging with communities, to ensure coordination and resource optimization for CRSS.	C16	4.3.1

Recommendation 1:

Develop a comprehensive framework for CRSS, which links to RSSH and a health systems maturity framework.

Level of priority:	**Timeframe:**
Critical	Immediately

Intended Audience:
The Global Fund Secretariat

Operationalization:

- The framework aims to serve as a tool that allows the Secretariat and countries to think through and recognize community contributions to the national strategies and establish a clearer link between CSS and CLR, demonstrating their inextricable nature, as well as the specific contribution that communities make to health outcomes.
- The framework will integrate the Global Fund's existing CSS strategy and decision-making tool and use an integrated theory of change to link CSS to CLR. That is, it will demonstrate possible pathways from the four CSS approaches (community-led research and advocacy, community-led monitoring, capacity building and leadership development, and community engagement and coordination), and how they support the different community-led responses (i.e., the multiple interventions included under the disease components of the Modular Framework), and how these responses in turn contribute to community impact on health outcomes in the three diseases (with the potential to build in integrated approaches and a greater focus on primary health care).
- The framework will use a clear differentiated model, detailing how different community entities – community health workers, CSOs, and others – contribute to strengthening health outcomes.
- The framework would also consider the maturity module currently under development by the CRG team.
- The framework will be accompanied by a monitoring approach that makes community contributions more explicit in specific health domains (e.g. HIV prevention and testing, TB identification and referral of suspected cases, malaria case management).
- The framework will incorporate a rights-agenda and build rights to access care, demonstrating the change that can occur when access barriers are removed and the contribution to health outcomes.
- The framework will use terms that foster understanding with wider partners and actors, by drawing on language commonly seen in national strategic plans, and more consistent with WHO guidance.
- The framework will be a tool that can facilitate decision-making on what kinds of community entities and systems both at the Secretariat and country levels. As part of the roll-out of the CRSS framework, pilot (a) cross-departmental meetings at the Secretariat to review key countries, and (b) multi-sectoral meetings at the country level to review the Framework and adapt it to the country. The purpose of these meetings is to inform preparation of (a) the allocation letter at the Secretariat level, and (b) the Funding request, at the country level. The latter may be facilitated by the CT with the CCM upon delivery of the allocation letter, and prior to the country dialogue.

Trade-offs:
The tool may be used for greater alignment of work with CSOs to the RSSH and disease modules. This could lead to working in more consolidated ways with community actors, but with a risk of changing the funding allocations between CSO and government actors. It also risks requiring additional time to review the country context and shift attitudes regarding appropriate roles of communities and CSOs.

Recommendation 2:

Improve the monitoring and results framework to make community contributions to health outcomes more measurable and visible

Level of priority: Critical	**Timeframe:** Before GC8

Intended Audience:
The Global Fund Secretariat

Operationalization:

- Ensure that specific indicators where community contributions are high, such as: provision of prevention services, testing, identification and referral, community-based observed treatment, are disaggregated by delivery sector (e.g. government, private, community). This should be linked to government information systems as appropriate, consistent with the aid effectiveness agenda.
- This already occurs in the RAI, for example, where malaria testing and case detection are reported and recorded by sector, clearly demonstrating the community's contribution. In some cases, sector disaggregation is required by WHO reporting, indicating that government M&E systems are able to manage this type of information. Global Fund reporting templates may need to adapt in order to capture the results of different recipients separately to allow for disaggregation prior to reporting. This information will also help governments identify the most effective service providers.
- Adapt reporting requirements and support Recipients to collate and disseminate evidence on task shifting which demonstrates the cost effectiveness of working with community actors. Task shifting is already underway in some countries but is not reported on in a way that generates the necessary evidence to both contribute to country ownership, and to demonstrate the effectiveness of this practice. It may include, for example, an indicator of how many health center tasks have been shifted to CHWs (evidenced by CHW terms of reference), or how many CHWs have been trained to perform tasks previously performed by health center staff.
- Improve the tracking of quality-of-care indicators where community-based interventions, such as CLM, are present to reduce duplication of indicator measurement, and track whether CLM is having any impact on quality of care improvements.
- Adjust the CSS KPI to better capture country readiness for supporting CLR in terms of: (a) having a community health strategy and sustainability plan, (b) having an appropriate legal structure in place (e.g. for social contracting), (c) integration and linkages between community and government systems, and (d), and progressive government funding.

Trade-offs:
The recommendation will require some investment in updating the monitoring and results framework and changing data collection and reporting requirements. This will require adjusting reporting formats and additional training, without overburdening

countries and respecting national systems and ownership. However, improved measurement of community contributions will have greater utility for country level actors, the Secretariat's own understanding of community contributions, and for sustainability discussions.

Recommendation 3:

Develop a multi-cycle sustainability plan for countries which includes critical community-led responses as part of funding requests, based on the new CRSS framework and the maturity model.

Level of priority: Critical	**Timeframe:** Before GC8

Intended Audience:
The Global Fund Secretariat

Operationalization:

- The maturity matrix under development can be used to determine how far ahead sustainability planning could reasonably begin, and in which aspects.
- Sustainability plans should use the new CRSS framework to map expected sustainability pathways for community actors, including CSOs, CHWs, and other community-based entities which are critical to improving health outcomes
- Sustainability plans should be explicitly linked to different levels of health system maturity, and to levels of co-financing and domestic financing.
- Sustainability plans should identify opportunities for optimizing integration and efficiency, as well as integrating community strengthening programming in areas where communities add clear strengths to tackling HTM (governance and over-sight, community health information systems, advocacy, addressing rights-based barriers).

Trade-offs:
Alignment to clearer sustainability pathways may entail stronger engagement with national governments on co-financing arrangements, and to a different set of priorities in terms of community systems strengthening.

Recommendation 4:

Adjust incentives for Country Teams to be accountable to supporting countries adhere to the CRSS framework and make progress on sustainability plans.

Level of priority: Critical	**Timeframe:** Before GC8

Intended Audience:
The Global Fund Secretariat

Operationalization:

- Use the updated monitoring and results framework to track progress in adherence to sustainability plans
- Make levels of budget allocations to CRSS available so that FPMs and others can track a) allocations to CRSS as a whole, b) spend against allocations
- Coordinate with partners, and where available, use budget allocation and expenditure tracking to measure progress in supporting CRSS in sustainability plans.
- Develop incentives, such as performance indicators, to measure adherence to sustainability plans which include CRSS.

Trade-offs:
Incentives may result in a shift to prioritize or emphasize CRSS investments, which will necessitate increased coordination with partners and higher partnership transaction costs. There is a possibility of more complex grant negotiations, and investment in internal systems needed to make activity budgets more visible.

Recommendation 5:

Update the information note on CLM to provide more explicit guidance on how CLM should be integrated into health systems, appropriate pathways to scale, and better adaptation to context.

Level of priority:	**Timeframe:**
Important	Before GC8

Intended Audience:
Global Fund Secretariat

Operationalization:

- Guidance should include a decision-making tool to provide deeper justifications for when CLM is appropriate.
- Measurement of CLM should be aligned to measurement of quality of care and tracked to measure whether CLM is resulting in improving QoC.
- CLM should be explicitly aligned – and not duplicative of – other community-based systems.
- Guidance on CLM will detail how it can support other quality of care mechanisms and be required to link to sub-national decision-making and planning.
- CLM guidance will need to demonstrate how to maintain equitable use of scarce resources in fragile health systems and prevent consolidating resources where CLM is active and community voice is strong. Specifically, to guard against a risk of displacing human resources to health facilities with active CLM.
- Guidance needs to provide the necessary methods and tools to enable operationalization. Guidance should clarify issues encountered when scaling CLM interventions.
- Use evidence on whether CLM improves QoC to initiate technical discussions on how CLM can be integrated and scaled as part of a health systems approach.

Trade-offs:
Increased alignment of CLM to RSSH and quality of care may result in a more streamlined approach and in cases where CLM is duplicating existing functions, may result in less funding of CLM.

Recommendation 6:

Further invest in light-touch country platforms to create efficiency and establish a basis for sustainability and transition.

Level of priority: Potential considerations	**Timeframe:** GC8 and beyond

Intended Audience:
Global Fund Secretariat

Operationalization:

- The purpose of this recommendation is twofold. Firstly, to expand the breadth of community actors that are aware of the Global Fund's work but are not currently engaged, including existing sustainable structures (such as mothers' groups, youth groups, health committees, savings and loan groups, or platforms supported by other partners), and create connections between them. This may include connecting health advocates with health finance advocates to help them work and learn together. This will help strengthen and maintain the social capital that has been built among Global Fund civil society and community partners, while connecting them with other initiatives. Secondly, to ensure that a platform exists for connection and engagement to help facilitate civil society engagement in planning for sustainability and transition.
- A platform can be any mechanism that provides an opportunity for connection and engagement. An excellent example of a CSO platform is the RAI-supported CSO platform, however, this is also resource intensive. A light-touch platform could be as simple as a WhatsApp community for community or civil society representatives to share updates, provide input on CCM agendas or reactions to CCM meeting report-outs, links to resources, tips and lessons learned, to foster connection and collaboration.
- This recommendation would be in line with and support the operationalization of the Sustainability, Transition and Co-Financing Policy (updated November 2024), which recognizes the need to support communities to plan for sustainability, maintain community involvement in health planning processes to address structural barriers and ensure different needs are met, and to be able to continue advocacy.[72]
- Be explicit about the different roles and functions that CSOs can play at country level and clearly distinguish between those who have a program performance monitoring or capacity-building or network management function, and those more directly involved in delivery. A role may also be to demonstrate the potential risks and losses that will occur if CSOs and community-led responses are not sufficiently supported (for example, the increase in new HIV infections after the Global Fund withdrew from Montenegro).
- Platforms can a) support coordination between communities and CSOs (and CHWs), (b) represent more communities on the CCM following consultation, and (c) seek sustainability of coordination and the social capital built through the work supported by the Global Fund to date.
- To be included in the next iteration of the Community Engagement Strategic Initiative, in collaboration with the Learning Hubs. For instance, expanding mailing lists and connecting with more diverse groups to connect with other initiatives.

[72] https://www.theglobalfund.org/media/14383/core_sustainability-transition-cofinancing_policy_en.pdfThe Global Fund to Fight AIDS, Tuberculosis and Malaria. (2024). *Sustainability, transition and co-financing policy*.

Trade-offs:
A light-touch approach is proposed but will need further work in defining how the Global Fund Secretariat can support medium to long-term community leadership. It may require upfront effort to work with countries to identify existing mechanisms and to find appropriate ways to connect them. A focus delineating the roles of CSOs – with a clear separation of functions – may result in further streamlining and changing funding for CSOs.

Recommendation 7:

Reinvigorate engagement with partners, such as multinational development banks, lead UN agencies (UNICEF, WHO), and other global health partners who are engaging with communities, to ensure coordination and resource optimization for CRSS.

Level of priority: Potential considerations	**Timeframe:** GC8 and beyond

Intended Audience:
Global Fund Secretariat and Partnership

Operationalization:

- Clarify the language being used to describe CRSS, and align it with that being used by global partners
- Be explicit about what types of community entities are being referred to, and how these link to development efforts in different ways
- Ensure coordination and resource optimization where possible, and on a country-by-country basis, specifically for organizational strengthening and long-term sustainability plans
- Encourage community systems strengthening within wider efforts to achieve universal health care coverage.

Trade-offs:
Greater alignment with development partners may yield efficiencies across partners to support CRSS but will necessitate coordination at both global and national levels.

The Evaluation Team also reviewed these recommendations against the recommendations from the Community Engagement evaluation (which were only received after both the first draft of the report was completed and the recommendations workshop). The Community Engagement (CE) evaluation took place at a similar time to this evaluation, meaning that data was collected in 2024, yet analysis and writing was completed in early 2025 in a very different context. Both evaluations were acutely aware that the recommendations needed to be adapted to a significantly constrained funding environment. This context enhances the need for the recommendations of the two evaluations to be as harmonized in a way that supports cost effective implementation.
Some points of convergence were observed, which may contribute to streamlined implementation, as noted in the table below.

Table 13: Convergence between CRSS and CE evaluation recommendations

CRSS Evaluation recommendations	Convergence with the CE evaluation
The CE evaluation recommendations link with CRSS R1, to create an integrated CRSS framework. This would support the CE recommendations to support TA for funding requests (R2), providing a rationale for decisions (R3) and having an assessment to understand dynamics with different groups (R8).	CE evaluation recommendations **2, 3 and 8.**
Recommending a mechanism for communities, KPs and CS to suggest revisions (R7), and investing in initiatives and partnerships to support representation (R9) could link to CRSS R6 on having a country-based platform to support community and civil society communication and coordination.	CE evaluation recommendations **7 and 9.**
The CE evaluation recommends leveraging CLM to support engagement (R5), which could also be addressed in CRSS R5 to update the CLM information note.	CE evaluation recommendation **5.**

6. Learning

The evaluation generated rich insights and learning in CRSS and identified some areas for further exploration. Some of the key areas of learning included:

In several country contexts, lack of precision on the language around 'communities', fierce competition for resources, and duplication of roles and responsibilities fueled inefficiencies in how CSOs, and other community-based entities, are supported on a sustainability pathway. Learning from other contexts, such as the RAI, have demonstrated that even light-touch investments in coordination and alignment can yield a more focused and streamlined approach to working with communities, and specifically, the CSOs which represent them. Clarity in roles and responsibilities, for instance, over which entities manage and coordinate CSO networks, verify and track program progress, and deliver services, has reduced duplication and improved collaborative approaches, and thus efficiencies. In addition, CSOs funding which does not cover core costs hampers CSOs to strengthen their leadership. This learning suggests that approaches to building 'community leadership' need to consider wider CSO landscape factors to be effective, and not just rely on an inputs-based (e.g. providing training) approach.

Related to this point, in the new era of severely reduced funding, there is renewed pressure to focus on the alignment agenda, particularly as it relates to improving work with CRSS. The portfolio analysis showed that even in countries facing severe shortfalls in health budget spend (such as Afghanistan), there were still opportunities to increase the efficiencies of how communities, and the CSOs which represent, are supported. Multiple partners are supporting the same CSOs with similar aims. Greater coordination around capacity-building and leadership development could reduce these inefficiencies.

The evaluation also found that rising hostility and anti-LGBTQ+ movements present a danger to TGF's work, especially in HIV prevention. The response needs to be nuanced, coordinated with a wider rights-based movement, and adapted to context.
In several contexts, rising hostility to LGBTQ+ groups were driven by right-wing populism, traditional norms and anti-colonial movements. But the evaluation also learnt that TGF's own positioning within the landscape, lack of clarity over roles and access to funding, and fierce competition among CSOs, contributed to backlash. It is also observable that the LGBTQ+ rights movement itself has a stronger identity as a rights-based advocacy movement, de-linked from health and service provision. In these difficult and challenging contexts, TGF plays a vital role in being a bastion of support for groups who are marginalized on the basis of sexual identity, but the evaluation's learnings highlight the importance of recognizing politically savvy tactics in these environments. These include leveraging influence, working 'behind the scenes', and coordinating with partners who have better access to political decision-makers (beyond health). The evaluation's ToC highlights the importance of 'levers' that may amplify these tactics, and for thinking about types of support beyond funding projects.

The evaluation generated a lot of learning and insights on CLM in multiple contexts, and how to improve CLM's adaptation to context, links to quality of care, and scaling pathway. As the sampling for the evaluation was based on sampling across the portfolio and not based on positive deviance or capturing models of 'success', the evaluation learnt a lot about how CLM is implemented in more typical contexts. The learning on CLM is that while the global evidence on CLM shows that it can lead to improvements in health services, there are also practical issues around scaling CLM, linkages to quality of care and health systems strengthening, and adaptation to context. CLM worked very well in some contexts (e.g. adolescent girls in Zimbabwe) but may be less adapted in other contexts. CLM

advocates tended to over-claim the effects of CLM on quality of care. The evaluation learned that CLM tends to affect specific aspects of QoC (e.g. drug stock-outs, staff attitudes) and its wider impacts are less certain. Linkages to existing QoC systems tended to be weak, as well as to sub-national planning. CLM is framed as a community empowerment tool, which leads to strong ownership by implementing CSOs. When CLM had ambitions to achieve national scale, issues of ownership in terms of methods, rights to implement, and use of data became contentious. There is also the possibility that CLM can create perverse incentives, for instance, by increasing inequitable allocation of staff to high functioning facilities, at the cost of others. This learning suggests that the design of CLM, and accompanying guidance, needs to consider these issues in detail, particularly in an era of reduced funding.

There was strong consensus that social contracting offers a potential route to learning how governments' capacities to work with CSOs can be built, even though current government co-financing is low. Learning from social contracting so far indicates that it provides substantial benefits in terms of understanding how government health leaders conceptualize the advantages of working with communities in HTM. Government stakeholders favor this approach as they view it as more tailored to context and risk groups. This suggests that this approach could be fruitful in terms of improving allocative efficiency, and optimizing how to work with communities, while creating a more collaborative relationship. In many contexts, government leadership was equated with less funding for CSOs, and social contracting could find ways to improve how governments work with CSOs in the longer-term. However, governments in many contexts may continue to resist work with important groups, such as KPs and MSM.

The evaluation identified opportunities for the Global Fund to substantial contributions to CRSS that will support the movement to achieve universal health care coverage (UHC), through its support to community health workers. This work with communities was often highly valued by government and other stakeholders, as part of improving linkages to communities. However, despite this high value, sustainability pathways for CHWs were often under-supported, and many remain disease-specific, rather than offering integrated services.

The portfolio and budget analysis learned that country allocations to CSS were based on existing government commitment and the strength of the voice of CSOs in advocating for resourcing. This learning suggests that investment strategies for CRSS are not reflective of where they could make the most difference, for instance, in task shifting, or investing in more efficient ways to identify, test and treat.