Evaluation of Community Engagement in the Global Fund Grant Life Cycle

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Final Report

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Contents

List of acronyms

AIDS	Acquired Immune Deficiency Syndrome
ASP	Additional Safeguards Policy
CAR	Central African Republic
CBO	Community-Based Organization
CCM	Country Coordinating Mechanism
CE	Community Engagement
CE SI	Community Engagement Strategic Initiative
CT	Country Team
CHW	Community Health Worker
CLM	Community-Led Monitoring
CLO	Community-Led Organization
CMO	Context–Mechanism–Outcome
COE	Challenging Operating Environment
CRG	Community, Rights and Gender
C19RM	COVID-19 Response Mechanism
CS4ME	Global Civil Society for Malaria Elimination
CSO	Civil Society Organization
CSS	Community Systems Strengthening
ELO	Evaluation and Learning Office
ER	Eligibility Requirement
ET	Evaluation Team
FGD	Focus Group Discussion
FR	Funding Request
GC	Grant Cycle[1]
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
IDP	Internally Displaced Person
IEP	Independent Evaluation Panel
IL	Implementation Letter

[1] Only used in combination with grant cycle number to refer to a specific cycle.

INGO	International Non-Governmental Organization
IPF	Integrated Performance Framework
ITN	Insecticide-Treated Net
KII	Key Informant Interview
KP	Key Population
KPI	Key Performance Indicator
KVP	Key and Vulnerable Populations
LGBT	Lesbian, Gay, Bisexual, Transgender
NGO	Non-Governmental Organization
NSP	National Strategic Plan
ODA	Official Development Assistance
PWID	People Who Inject Drugs
RfP	Request for Proposals
SWG	Sub-Working Group
TA	Technical Assistance
TB	Tuberculosis
TWG	Technical Working Group
UFE	Utilization-Focused Evaluation
UK	United Kingdom (of Great Britain & Northern Ireland)
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
US	United States of America
WHO	World Health Organization

Executive Summary

The main data collection activities (case studies, document reviews, key informant interviews (KIIs), etc.) for this evaluation were conducted over the period October 2024–early February 2025. The tail end of this period, of course, has marked a moment in time where there have been significant (and ongoing) shifts in the landscape of global health funding and programming. Major bilateral overseas development donors have either paused or announced large-scale cuts to their funding, with other key bilateral donors likely to follow suit in 2025[2].

It is important to recognize the fact that since data collection took place before these events occurred, it does not provide evidence of any immediate impacts of the changes described above. In developing the final report, the Evaluation Team has nonetheless taken this context into account, particularly in the framing of the conclusions and recommendations.

Background and context

The Global Fund's 2023–28 Strategy[3] emphasizes enhancing community engagement (CE) as a Mutually Reinforcing Contributory Objective to improve health interventions for human immunodeficiency virus (HIV), tuberculosis (TB), malaria, health and community systems strengthening, and pandemic preparedness. The Global Fund defines meaningful community engagement (CE) as the process of involving communities most affected by HIV, TB and malaria in decision-making processes that impact their lives.[4] [5] Previous reviews[6] have found that although progress has been made, there is a need for further improvement, particularly in ensuring consistent engagement across the grant cycle.

The Global Fund has commissioned Itad to conduct an evaluation to assess the combination of factors contributing to meaningful CE throughout the Global Fund grant cycle. This cycle comprises three main stages: the funding request, grant making, and grant implementation. During these stages different Global Fund divisions and teams, country-level partners including country coordinating mechanisms (CCMs), civil society organizations (CSOs) and affected communities for human immunodeficiency virus (HIV), tuberculosis (TB) and malaria governments, technical and bilateral partners collectively input into the CE strengthening process.

The evaluation analyzed the effectiveness of current engagement mechanisms, such as the country coordinating mechanisms (CCMs), initiatives led by the Community, Rights and Gender (CRG) Department, which has historically facilitated community participation, and approaches within different contexts, including high-impact and challenging operating environments (COEs). It provides strategic recommendations to improve CE during the grant life cycle stages.

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[2] Brookings Institution (2025) Expanding transparency beyond official development assistance; Government of the Netherlands (2024) First development budget cuts announced: overhaul of grants for NGOs; European Parliament (2024) Committee on Development 04/09/2024.; House of Commons Library (2025) US aid, the UK, and funding for multilateral aid bodies in 2025.

[3] The Global Fund (2021) Fighting Pandemics and Building a Healthier and More Equitable World – Global Fund Strategy (2023-2028), p.13.

[4] The Global Fund (2023) Community Engagement Toolbox. Available at: https://www.theglobalfund.org/media/10734/ccm_communityengagement_toolbox_en.pdf?formCode=MG0AV3

[5] The Global Fund (2025) Strengthening Community Engagement. Available at: https://resources.theglobalfund.org/en/more-topics/technical-cooperation/community-engagement/

[6] The Global Fund (2024) Final Evaluation of the GC6 Strategic Initiative; UNAIDS (2021) Global AIDS Strategy 2021–2026 End Inequalities. End Aids; Technical Evaluation Reference Group (2019): Position Paper - Thematic Review on Resilient and Sustainable Systems for Health (RSSH); MSMGF (2017) Independent Multi-country Review of Community Engagement in Grant Making & Implementation Processes

The evaluation findings inform future approaches, enhance CE processes, and generate organizational learning. The following two evaluation objectives guided the process:

1. Assessment of the effectiveness and adequacy of community engagement processes and interventions.
2. Identification of internal and external factors and the extent to which each category enable and/or /hinder meaningful community engagement.

Methodology

The evaluation design is theory-based, realist-inspired and guided by theory about how the Global Fund achieves its CE objectives. It explores how and why selected CE interventions across the grant cycle have worked or not by opening the 'black box' between intervention and outcomes and examining and testing the causal links between intervention and outcomes.

A broader theory of CE in the Global Fund Grant Cycle, representing how desired immediate CE outcomes are achieved throughout the grant cycle, has been used as an overall framework. Through engagement with a broad range of stakeholders during the inception and data collection stages, including the User Group, the Evaluation and Learning Office, CRG members and key informants, specific areas of that theory have been selected as the focus of the evaluation. For each of these specific areas, hypotheses about how, for whom, to what extent and in what contexts a program might 'work' have been developed. The Evaluation Team (ET) tested and refined these hypotheses through the undertaking of case country studies (number (n)=10) in which existing and new data has been gathered on the achievement (or lack of achievement) of outcomes, aspects of the program context that might impact outcomes, and how these aspects of context shape mechanisms of change. Data has then been analyzed in the form of context–mechanism–outcome (CMO) configurations, and was further tested through a second round of data collection (deep dives – n=2).

The evaluation employed a mixed methods approach, combining qualitative and quantitative data collection methods. Key stakeholders, from communities, civil society, government, technical and bilateral partners and the Global Fund secretariat and where staff have been interviewed to gather insights into their experiences and perspectives on CE. Additionally, document analysis and data from existing monitoring and evaluation systems have been used to provide a comprehensive understanding of the current state of CE. The findings generate actionable insights and drive improvement in CE processes.

Evaluation outcomes

EQ1: How far is the Global Fund achieving meaningful CE outcomes?

1.1 How far is the Global Fund meaningfully engaging communities across the grant cycle?

Of the three grant cycle stages included in this evaluation, the Global Fund is most meaningfully engaging communities during the funding request stage. Across all the countries sampled in this evaluation there was limited engagement during grant making, and mixed levels of engagement during implementation. This evaluation highlighted very high levels of Global Fund engagement at the start of the grant cycle across a majority of countries sampled, including those affected by challenging contextual factors. While the grant making stage is not intended to involve extensive community engagement, the reported very limited levels of meaningful CE are a concern and, for example, community groups reported that little to no information is effectively shared with them about funding decisions during the decision making. During actual grant implementation stage, the

quality of CE was more mixed, with some meaningful engagement observed during oversight activities and some more limited examples of engagement in programmatic revisions.

1.2 For whom are outcomes achieved/not achieved (reach and coverage)?

There were significant differences in the reach and coverage achieved across epidemics, with HIV communities and KPs most consistently engaged across all country contexts. TB-affected populations were engaged where the Global Fund has invested in TA and capacity building for civil society actors representing TB communities and KPs. Malaria-affected communities are the least well-reached among the epidemics. Although there are good examples of successful efforts to engage hardest to reach, most marginalized groups, including sex workers, men who have sex with men and people who use drugs, challenging legal environments and harmful social norms remain challenging barriers. Power imbalances within communities and KPs and their civil society representatives have an inhibiting effect on meaningful reach and coverage of more marginalized, less well-established and smaller KP and community groups.

EQ2: Why is the Global Fund observing different CE outcomes (across countries)?

2.1 What configuration of interventions, processes and approaches is implemented across sampled countries?

Across the sampled countries, the configuration of interventions, processes, and approaches to CE is most developed at the funding request stage, where strong coordination is required due to the complexity of CE interventions. The leadership of the CCM plays a critical role in ensuring effective engagement, with success depending on leadership style, available resources, and the inclusiveness of preparatory consultations. A key tool in this process is the Annex of Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria, which allows CSOs to document their priorities[7]. However, the selection of priorities sometimes favors more experienced partners, limiting broader representation.

TA is a key intervention that strengthens CE by supporting weaker CSOs, fostering peer learning, and helping communities build an evidence base for their priorities. In most countries, TA has successfully mobilized KPs, particularly in restrictive environments. Communities are often excluded from developing TA requirements, however. Beyond the funding request stage, community involvement is primarily structured through oversight mechanisms, such as CSO representation in committees and CLM, which encourage long-term participation. However, there is little structured engagement in programmatic revisions, where CE interventions tend to be ad hoc and limited, despite the requirement for CCM endorsement.

Despite efforts to enhance CE, challenges remain. The presence of civil society representatives in CCM roles whose organizations receive Global Fund funding, or who are implementers, can create perceptions of bias, and a lack of transparency in the grant-making stage undermines the legitimacy of CE efforts. While oversight mechanisms help sustain engagement, the absence of a systematic approach to CE in programmatic revisions weakens community influence in decision-making. Overall, CE relies on strong leadership, inclusive processes, and well-implemented TA, but gaps in transparency and structured participation limit its full impact.

[7] The 'Communities Annex' was newly introduced for the GC7 funding cycle (after being successfully piloted for C19RM in 2022). It is intended to capture and document the highest priority interventions identified by civil society and communities during the country dialogue

2.2 What key adaptations occur in sampled countries, and why?

The key adaptations observed during the evaluation fell into three categories: to mitigate contextual challenges; as a result of identifying capacity gaps; and to respond to the COVID-19 pandemic. The case studies in this evaluation highlight how countries have adopted diverse and innovative approaches to overcome external challenges that could hinder meaningful CE. For instance, Global Fund related outreach in Chad and Ukraine navigated conflict-related disruptions by leveraging partner support and maintaining flexibility in program adjustments. To address the challenge of physical remoteness and stigma, Global Fund related outreach in Ecuador embraced digital tools such as WhatsApp and Zoom to engage marginalized groups, while outreach in Indonesia decentralized governance to empower local decision-making and boost community participation. Global Fund related outreach in other countries, like Cambodia and Zimbabwe, focused on strengthening the capacity of communities and partners to better reach underserved populations. Additionally, many countries adapted their service delivery models during the COVID-19 pandemic, demonstrating agility and responsiveness at the implementation level.

2.3 What contextual factors affected CE in sampled countries? How and how far do key contextual factors affect meaningful CE?

The evidence demonstrated that contextual factors have a clear impact on CE in the sampled countries, influencing the effectiveness of CE efforts. Meaningful CE was nevertheless achieved in countries facing significant barriers. A regionalized (in-country) approach to CE, where decentralizing governance and decision-making supported engagement, proved effective despite geographical and infrastructural difficulties within a country. However, in some cases, contextual challenges were too severe for decentralization to be an effective strategy. Another key mechanism observed was adaptive implementation, with the Global Fund and partners employing flexibility to address specific contextual barriers. In some challenging contexts, the Global Fund's Additional Safeguard Policy – while in place to safeguard against different risks – was reported to have limited adaptive implementation by imposing administrative burdens that restricted flexibility. TA and capacity building were also effective in addressing constraints faced by CSOs due to restricted civic space. Additionally, TA and capacity building played a role in mitigating stigma-related challenges for marginalized KPs and supporting their inclusion in CE processes. However, stigma and entrenched social norms remain difficult to change, particularly where legal frameworks reinforce discriminatory attitudes. The final mechanism identified for addressing contextual challenges was leveraging networks of influential stakeholders, which proved effective in overcoming certain barriers to CE.

Conclusions

The ET has drafted nine conclusions, drawn from the main evaluation findings. These are summarized here.

Conclusion 1: Investing resources and time in targeted mechanisms that maximize opportunities to engage communities in the funding request stage can be a highly effective way of increasing meaningful CE across the disease areas and in subsequent grant cycles.

Conclusion 2: The existence of strong engaged and proactive civil society, the presence of a balanced and deliberate CCM, and the targeted provision of TA to support front loading engagement mechanisms such as those described above, were the three key drivers of meaningful CE, particularly for the most marginalized populations.

Conclusion 3: Global Fund guidance on CE was instrumental in outlining funding and the provision of TA which facilitated meaningful CE. This included guidance in the operations manual, country dialogue during funding request development, available CCM Funding, CE SI TA and the continuous support of the CTs.

Conclusion 4: There is a sense of frustration among communities created by the contrast between significant, front loaded investment in meaningful CE at funding request stage, and limited opportunities for CE in grant making. This threatens the sustainability of CE efforts.

Conclusion 5: The Global Fund's grant making processes do not yet adequately ensure sufficient space for community priorities to influence budget allocations. Other key stakeholders, including government agencies, Principal Recipients, and technical partners, have greater knowledge and involvement at grant making stage than community representatives. Coupled with a lack of transparency about the decision-making process, this further undermines efforts to ensure meaningful CE throughout the grant cycle.

Conclusion 6: The level of meaningful CE varies by disease area. HIV-affected communities and KPs are most engaged, supported by strong civil society and global organizations. TB communities are included where partnerships foster their involvement, but malaria-affected communities are least likely to be meaningfully engaged, with fewer organized, visible partners.

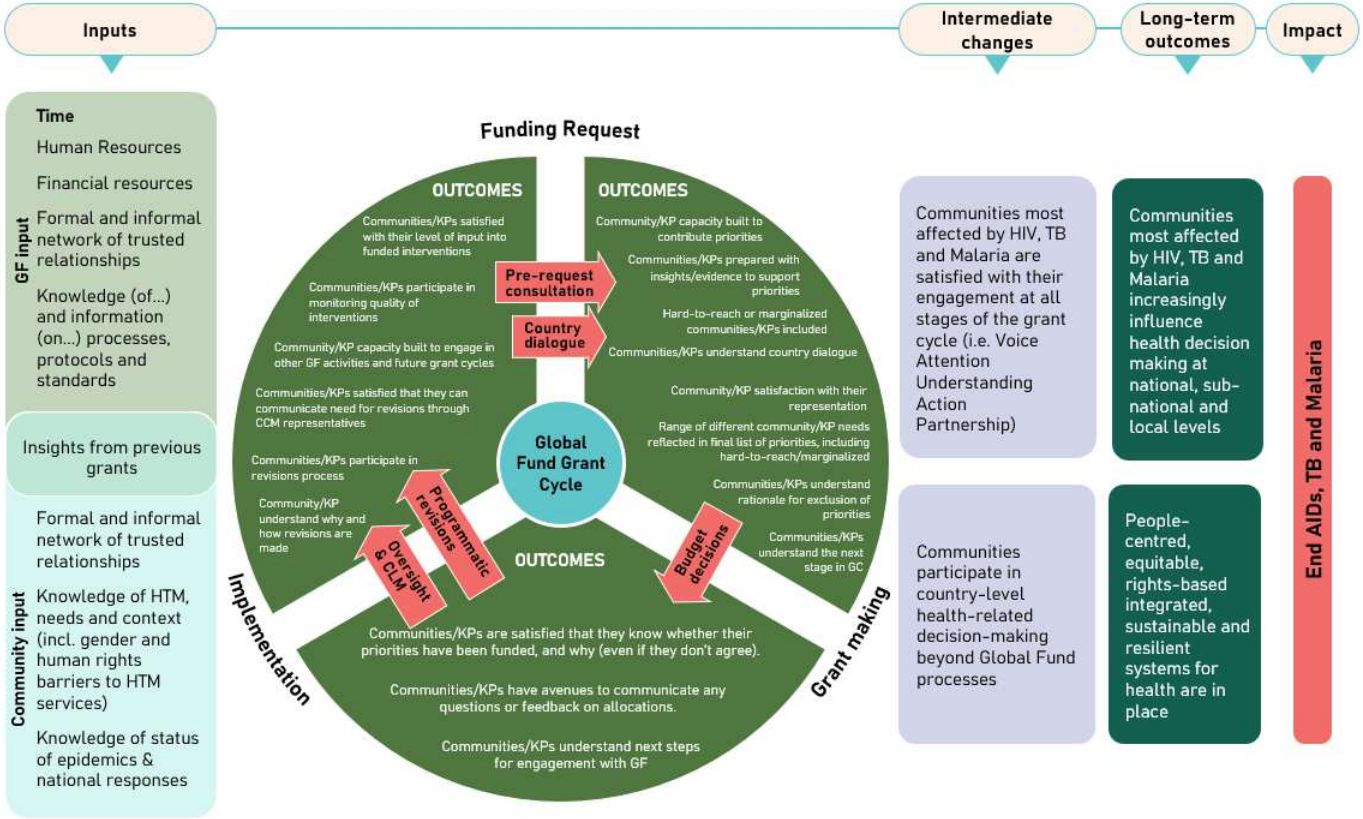
Conclusion 7: Explicitly unpacking and assessing power dynamics among communities, KPs and in CCM representation, and identifying bespoke and targeted solutions to managing and mitigating these dynamics, are closely associated with reported increases in meaningful CE.

Conclusion 8: Achieving meaningful CE through oversight and CLM interventions builds community and KP capacity to engage in the subsequent grant cycle.

Conclusion 9: There are a number of innovations and good practice across the case study countries of a) levers that have been pulled to increase meaningful CE at all stages of the grant cycle, b) successes in increasing engagement reach of some of the most vulnerable groups affected, c) ways to address contextual challenges that can be used to inform future programming.

Program theory

The below diagram presents a high-level roadmap of how the Global Fund and its partners intend to operationalize its commitment to community engagement, and how meaningful community engagement contributes to achieving the organization's broader strategic aims. The diagram highlights the five pathways that the ET explored in depth through the case study methodology (arrows across grant cycle stages).



Recommendations

The ET has proposed nine recommendations which have been developed based on the evaluation's findings and conclusions. These recommendations have been refined and discussed through a facilitated workshop with the User Group and other key Global Fund Secretariat stakeholders, which helped confirm key priorities and ensure their relevance.

The recommendations are presented in line with the program theory presented above and align with the three stages of the grant cycle and the five specific pathways explored in this evaluation.

The grant-making stage presents the best opportunity to enhance meaningful CE. Key recommendations—such as improving transparency (Rec #4 and #5) and keeping communities informed—are low-cost but high-impact. These actions focus on clearer communication and inclusive processes, without requiring significant resources (this also includes Rec #3). In contrast, recommendations for the initial grant stage (Rec #1 and #2) are lower priority due to their higher cost and the fact that there is already strong meaningful CE in the countries sampled. countries. Two recommendations relating to grant implementation (Rec #7 and #8) and one overall recommendation (Rec #9) are classified as important but it is noted their implementation will require an investment of resources and as such suggestions are provided to mitigate this by building on existing mechanisms and processes.

Funding request stage

The following recommendations relate to funding request stage of the grant cycle and specifically the two pathways described in the previous section, namely pathway #1 (Pre-request consultation process) and pathway #2 (Country dialogue and Annex of Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria).

Recommendation 1

Potential consideration

The Global Fund Secretariat, through the CE Strategic Initiative in collaboration with Technical Partners – should update existing guidelines to facilitate improved meaningful CE at the foundation stage of mid-term reviews of disease specific (HTM) national strategic plans and strengthen how the outputs can inform the development of new funding requests for HIV, TB and malaria. The guidelines should:

1) underscore the significance of detailing community responses, engagement and health and community systems strengthening interventions as key national priorities within the NSPs and FRs and reference good practice examples that have been highlighted in this report and elsewhere.
2) include explicit reference to the need for Country Coordinating Mechanisms (CCMs) to develop a detailed Community Engagement (CE) plan that is aligned with the national roadmap for funding request development. This should cover CE in all stages of the funding request, from conceptualization to engagement at grantmaking.
3) focus on strengthening country dialogue processes and the subsequent output i.e. Annex of Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria by revising the template to ensure priorities are evidence based; to support advocacy for their consideration and inclusion into the funding request, and by obligating

the TRP to review the Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria annex.

Recommendation 2

Potential consideration

In collaboration with Technical Partners, the Global Fund Secretariat units, along with CCMs, should strengthen the planning, coordination, procurement, and delivery of technical assistance (TA) during both the funding request and grant-making stages of the grant cycle. To ensure timely identification and procurement of relevant TA, CCMs should make TA for CE, community responses, and systems strengthening a core element of their TA plans. This includes developing generic terms of reference to guide both communities and CCMs. TA planning for CE should recognize that while the funding request and grant-making stages are distinct, they are closely linked and build on one another. Therefore, TA provided during the funding request development stage (such as for country dialogue, proposal writing, and budgeting) should, continue into the grant-making stage, even if at a reduced scale and should be tailored for specific contexts.

Recommendation 3

Important recommendation

The Global Fund secretariat and CCMs should include as a requirement the proactive engagement of CS CCM members as an eligibility requirement. This would formalize the need for representatives to solicit inputs from and provide feedback to their constituencies. This would, in turn, contribute to sound decisions during the funding request development period. This requirement should include updates to CS CCM members on how their priorities detailed in the Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria annex have been considered.

Grant making stage

The following recommendations relate to the grant making stage of the grant cycle and specifically pathway #3 (Selecting interventions and allocating funding).

Recommendation 4

Critical recommendation

The Global Fund should demystify the grant making stage by developing clear guidance for civil society and communities on when and how to engage during grant making. CTs and PRs should be required to enhance transparency and accountability in the grant making process by ensuring that all stakeholders – including community representatives, key civil society, and CCM members – receive clear communication regarding which priorities have been included in the final funding request and budget, as well as the rationale for selection or exclusion. The Secretariat should revise its operational guidance on CE during grantmaking to align with the founding principles of

GF as espoused in the GF Framework Document (2001), particularly principle H, articles 7[8] and 9[9].

Recommendation 5

Important recommendation

The Global Fund should review and improve its guidance relating to CE during grant making to clearly articulate the role of CTs in ensuring greater transparency in the process achieved. The additional provisions should seek to have less focus on outputs (e.g., number of meetings) and more on outcome level (i.e. what the engagement will seek to achieve in terms of CE during the grant making stage e.g. community responses and CSS interventions supported). They should widen the scope of key stakeholders meeting PRs beyond CCM members to include a limited number of technical representatives of CSOs and communities who played significant roles in the writing and costing of the funding requests.

Implementation stage

These recommendations relate to the implementation stage of the grant cycle and specifically the two pathways described in the previous section, namely pathway #4 (Oversight, including community-led monitoring) and pathway #5 (Programmatic revisions).

Recommendation 6

Important recommendation

Through provisions in the modular handbook and other guidance documents for GC 8, the Global Fund secretariat and Partners should mobilize countries to invest holistically in CLM and other reinforcing CSS interventions as an integrated package so that meaningful CE is increased. CLM can be leveraged to build long-term engagement and institutional learning capacity among communities, KPs, CS without requiring significant additional resources.

Recommendation 7

Important recommendation

The Global Fund Secretariat should continue building on the outcomes of CCM evolution notably on oversight and engagement through the IPF. Performance reviews should include relevant issues related to CCMs including those on oversight and engagement, and should be followed up, for example, through management letters.

Recommendation 8

Potential consideration

The Global Fund should review and improve existing guidance to guide the GF Country Teams, PRs and CCMs to strengthen civil society and communities' engagement through CCMs in grant revisions. This guidance (i.e. Operational Policy Manual) should clearly articulate how and when

[8] 'Strengthen the participation of communities and people, particularly those infected and directly affected by the three diseases, in the development of proposals.' (The Global Fund (2001) 'The Framework Document', p.92.)

[9] 'Give due priority to the most affected countries and communities, and to those countries most at risk.' (The Global Fund (2001) 'The Framework Document', p.92.)

CSOs and communities will be meaningfully engaged as a part of the revisions. It should emphasize limiting the number of revisions undertaken without CE through CCMs.

Overarching recommendations

Recommendation 9

Important recommendation

The Global Fund and country teams should strengthen context assessments in key Global Fund-supported countries to systematically analyze power dynamics among communities, KPs, and CCM representation. A differentiated approach is suggested with, for example, greater focus on this issue for countries with restricted civic space and/or diseases with nascent community representation. This assessment should aim to generate nuanced evidence to help identify which groups face the greatest barriers to engagement and recommend targeted, context-appropriate solutions. To avoid additional costs, the process should be integrated into existing assessments, such as the Integrated Performance Framework Review process and/or national strategic planning (NSP) review processes, rather than be a new stand-alone assessment. This assessment should be refreshed and updated throughout the grant cycle, with specific attention to hard-to-reach KPs and TB- and malaria-affected communities, ensuring inclusive and equitable participation.

Next steps

The recommendations above emphasize that the grant-making stage offers the greatest opportunity to strengthen meaningful CE. Two key recommendations (Rec) here—Rec #4 (demystify the grant cycle and improve CS engagement) and Rec #5 (clarify CTs' roles in ensuring inclusive processes)—are ranked as critical and highly important, respectively. Importantly, implementing these does not require substantial resources, as the goal is to improve transparency and communication with communities about grant decisions.

This low-cost, high-impact logic also applies to Rec #3 (systematically update communities on how their input shaped priorities) and Rec #6 (use CLM to support long-term engagement and learning). Like the grant-making recommendations, these focus on transparency and process clarity, achievable without major new investments.

In contrast, two of the three recommendations for the initial grant stage —Rec #1 (enhance meaningful CE in national planning and strategy development) and Rec #2 (strengthen TA planning and delivery)—are given lower priority. While valuable, these would require more investment for limited additional benefit, as meaningful CE levels are already relatively strong during this stage in many countries. A targeted, context-specific approach is therefore recommended.

This evaluation shows that the Global Fund has played a key role in embedding meaningful CE across many countries and across all three diseases, but gaps remain in some contexts and grant stages. The critical and important recommendations offer a roadmap for addressing these gaps with minimal additional investment, leveraging existing mechanisms and partnerships. Strengthening meaningful CE through tailored, practical approaches will help ensure its sustainability in the face of future challenges.

1. Introduction

The main data collection activities (case studies, document reviews, key informant interviews (KIIs), etc.) for this evaluation were conducted over the period October 2024–early February 2025. The tail end of this period, of course, has marked a moment in time where there have been significant (and ongoing) shifts in the landscape of global health funding and programming. Major bilateral overseas development donors have either paused or announced large-scale cuts to their funding, with other key bilateral donors likely to follow suit in 2025[10].

It is important to recognize the fact that since data collection took place before these events occurred, it does not provide evidence of any immediate impacts of the changes described above. In developing the final report, the Evaluation Team has nonetheless taken this context into account, particularly in the framing of the conclusions and recommendations.

The Global Fund to Fight AIDS, Tuberculosis and Malaria ('the Global Fund') Evaluation and Learning Office (ELO) has commissioned Itad to carry out an evaluation of community engagement (CE) throughout the grant cycle under the oversight of the Independent Evaluation Panel (IEP). This cycle comprises three main stages: the funding request, grant making, and grant implementation. During these stages different Global Fund divisions and teams, country-level partners including country coordinating mechanisms (CCMs), civil society organizations (CSOs) and affected communities for human immunodeficiency virus (HIV), tuberculosis (TB) and malaria governments, technical and bilateral partners collectively input into the CE strengthening process.

The primary goal of the evaluation is to assess the factors that contribute to meaningful CE throughout the grant cycle. The findings aim to inform future strategies, enhance CE processes, and generate organizational learning. This final report answers the evaluation questions (EQs) and presents the key findings with the supporting data.

This theory-based evaluation first examines evidence against the evaluation questions, presenting findings and then conclusions. These findings and conclusions lead to a revised program theory – a normative model of how CE is intended to work throughout the grant cycle. Within each stage of the grant cycle, the evaluation isolates pathways to meaningful CE outcomes as shown in the diagram below. This then forms the basis of the recommendations – actions focused on the points in each pathway with the most potential for impact.

[10] Brookings Institution (2025) Expanding transparency beyond official development assistance; Government of the Netherlands (2024) First development budget cuts announced: overhaul of grants for NGOs; European Parliament (2024) Committee on Development 04/09/2024 ; House of Commons Library (2025) US aid, the UK, and funding for multilateral aid bodies in 2025.

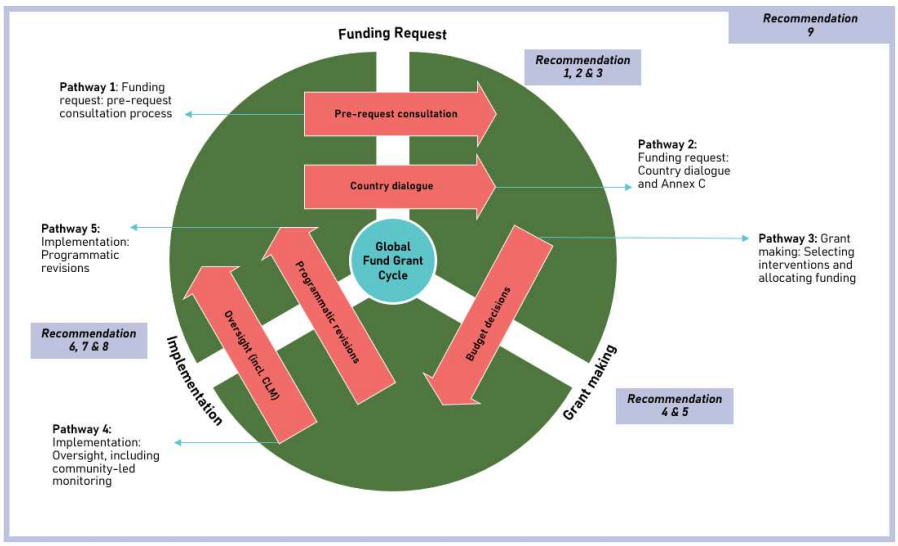


Figure 1. Pathways across the grant cycle.

The report is structured as follows:

- The remainder of Section 1, along with Section 2 and 3, presents the background, methodology, case studies, and structure of the findings section.
- Section 4 presents the evaluation findings, organized by EQs,
- Section 5 presents conclusions
- Section 6 presents the revised Program Theory and corresponding narrative
- Section 7 finally sets out the recommendations.

This is supported by the following annexes, provided separately:

- Annex 1: Evaluation framework
- Annex 2: Methodology
- Annex 2: Additional evidence base
- Annex 3: List of stakeholder groups consulted
- Annex 4: List of references

1.1. Background

Established in 2002, the Global Fund is an international financing partnership that has supported more than 135 countries and saved more than 65 million lives. As the largest multisectoral health funder, its mission is to attract, leverage and invest resources to end these three epidemics, strengthen health systems and support pandemic preparedness, all while advancing the Sustainable Development Goals.[11]

In the Global Fund's 2023–28 Strategy, "*Maximizing the Engagement and Leadership of Most Affected Communities to Leave No One Behind*" is one of the three Mutually Reinforcing

[11] The Global Fund (2024) About the Global Fund.

Contributory Objectives.[12] This is reinforced by the Global Fund Operational Policy Manual, which states that when planning, developing and submitting their funding requests, applicants of Global Fund grants have to put communities at the center, in line with evidence that demonstrates that engagement with communities in the design of programs result in more effective programming and better health outcomes.[13]

By amplifying the role of communities, the Global Fund's objective is to strengthen the leadership and engagement of communities in Global Fund and related national processes, recognizing their unique insights and experiences as valuable contributions to improving health outcomes. The term 'communities' is defined as people living with and/or most affected by HIV, TB and malaria, including key and vulnerable populations (KVP).

The Global Fund defines meaningful CE as the process of involving communities most affected by HIV, TB and malaria in decision-making processes that impact their lives.[14] [15] This includes ensuring that communities have a voice in the planning, implementation and evaluation of health programs and policies.[16] Operationally, the Global Fund CE Strategic Initiative (SI) interprets meaningful CE as where the role of communities is consistently and continuously acknowledged in decision-making processes, and where communities' unique perspectives, expertise and lived experiences are sought and valued.[17] [18] The Global Funds' Eligibility Requirements reinforce this value.[19]

At the CCM, which oversees Global Fund grants in countries, CE is reinforced through the CCM Policy (2018),[20] which states that the engagement of key populations (KPs), people living with or affected by HIV, TB and malaria, and civil society is one core principle of CCMs. This is further reinforced by the eligibility requirements (ERs), notably ERs 1, 4 and 5,[21].

The precise definition of meaningful CE and the associated understanding of how it is both operationalized and measured across the grant cycle is not clearcut, and there is currently no established baseline to directly compare objectives and achievements.

The Global Fund launched its first CE SI in 2014. It has since been approved as an CE SI for multiple grant cycles, including GC5, GC6 and GC7, and expanded in scope and scale. The Global Fund credits the CE SI with the establishment of the CE SI Coordination Mechanism to ensure coordinated implementation of short-term and long-term TA for CE. In addition, the Global Fund has implemented the CCM Evolution SI for strengthening of CCMs, and adaptation to the COVID-

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[12] The Global Fund (2021) Fighting Pandemics and Building a Healthier and More Equitable World – Global Fund Strategy (2023-2028), p.13.

[13] The Global Fund (2024) Operational Policy Manual

[14] The Global Fund (August, 2023) CCM Community Engagement Toolbox

[15] Strengthening Community Engagement - Throughout the Cycle - The Global Fund to Fight AIDS, Tuberculosis and Malaria

[16] Community Engagement, a guide to opportunities throughout the Grant Cycle

[17] This definition was adapted by the CRG team from Spieldenner, A., French, M., Ray, V., Minalga, B., Sardina, Cristine., Suttle, R., Castro-Bojorquez, M., Lewis, O., and Sprague, L. (2022) 'The Meaningful Involvement of People with HIV/AIDS (MIPA): The Participatory Praxis Approach to Community Engagement on HIV Surveillance'. *Journal of Community Engagement and Scholarship* 14(2). doi:10.54656/jces.v14i2.26

[18] Technical Evaluation Reference Group (2019): Position Paper - Thematic Review on Resilient and Sustainable Systems for Health (RSSH).

[19] The Eligibility Requirements include: Requirement 3: Recognizing the importance of oversight, the Global Fund requires all CCMs to submit and follow an oversight plan for all Global Fund approved financing. The plan must detail oversight activities, and must describe how the CCM will engage program stakeholders in oversight, including CCM members and non-members, and in particular non-government constituencies and Key Populations.

[20] The Global Fund (2018) Country Coordinating Mechanism Policy Including Principles and Requirements.

21 See Inception Report, p. 9, for details on ERs.

19 pandemic, leveraging opportunities for enhanced CE through initiatives such as the COVID-19 Response Mechanism (C19RM), the C19RM Accelerator, and the CE SI itself. The CCM SI improvements resulted in provision of technical assistance (TA) to support membership renewal for elections of people living with the three diseases and KVP representatives on the CCM, recruitment and maintenance of Oversight Officers within the CCM, and the adoption of an Integrated Performance Framework (IPF) for CCMs through which performance objectives and checks focused on communities and CSOs are reinforced and supported through CCM funding.

In addition, the Global Fund has introduced a key performance indicator (KPI) to measure the degree of CE across the grant cycle. Initial KPI C1 survey results indicate a satisfaction score of 68% among communities regarding engagement in the funding request stage, although this falls short of the target of 75% as is noted in the Request for Proposals (RfP).

The evaluation stems from an acknowledgment during the development of the KPI Framework for the current strategy that KPI C1 alone provides a limited view of satisfaction levels among community members. Hence, a comprehensive evaluation was envisioned to offer rich, contextual insights into what constitutes meaningful CE. In this way the evaluation findings, lessons, and recommendations aim to satisfy the needs of the intended primary audience, which consists of the Global Fund Board, Strategic Committee, Secretariat teams responsible for driving and supporting CE notably the CE SI, the CCM Hub, and the Global Fund Country Teams (GF CTs) who, collectively support CE across the grant cycle. Additionally, the evaluation findings are meant to inform and influence CE within country level stakeholders namely the national programs for HIV, TB, and malaria, CCMs, community-led and based organizations, and communities affected by HIV, TB and malaria. Governance bodies, technical, and bilateral partners also form important audience segments. The following two evaluation objectives guided the process:

1. Assessment of the effectiveness and adequacy of community engagement processes and interventions.
2. Identification of internal and external factors and the extent to which each category enable and/or /hinder meaningful community engagement.

1.2. Framing the evaluation within the wider literature

To frame the evaluation within wider relevant literature, the Evaluation Team (ET) commissioned a rapid review of relevant literature (Annex 2) by an external consultant with support and guidance from one of the ET's expert advisors for realist evaluations. The Global Fund's understanding of CE and its role closely aligns with literature on the topic. There are two broad schools of thought in models CE in recent literature – pragmatic, health system perspective approaches, and ideological or empowerment approaches.[22] The Global Fund defines meaningful CE as a process where "the role of communities is consistently and continuously acknowledged

[22] O'Mara-Eves A, Brunton G, McDaid G, Oliver S, Kavanagh J, Jamal F, et al. Community engagement to reduce inequalities in health: a systematic review, meta-analysis and economic analysis. Public Health Research. 2013;1(4).

Questa K, Das M, King R, Everitt M, Rassi C, Cartwright C, et al. Community engagement interventions for communicable disease control in low-and lower-middle-income countries: evidence from a review of systematic reviews. International journal for equity in health. 2020;19:1-20.

in decision making and processes, and where communities' unique expertise, perspectives and lived experiences are sought and valued."[23] This reflects elements of both schools of thought.

The pragmatic, health systems approaches emphasize the importance of involving patients in decision-making, both as a right and to improve treatment choices, delivery, and outcomes, while also encouraging shared responsibility to identify potential errors. This is founded on the assumption that addressing observed inequalities through stakeholder-engaged interventions leads to more appropriate solutions and ultimately better outcomes.[24] In contrast, ideological or empowerment approaches seek to shift control from established authorities to the community, emphasizing varying levels of empowerment, from consultation through to full citizen control. Rather than targeting individual behavior change, they advocate for addressing social justice and systemic power imbalances, with community empowerment seen as both a means to improving health and an end in itself.[25]

It is clear in the literature that conceptualizing and implementing CE in real-world situations typically combines elements of both schools of thought, and that they can be mutually reinforcing. Pragmatic approaches which include more consultation, co-production and community control will be more likely to empower the community and contribute to inequality reduction. CE can therefore serve dual functions – achieving the objectives of health interventions efficiently and effectively, and providing tangible, empowering benefits for communities to control their own health.[26]

The Global Fund's definition of meaningful CE, and understanding of its role and potential impact, is therefore grounded in recent research. This evaluation seeks to explore how this concept is operationalized, and how well it works for different communities across different GF contexts.

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[23] Arnstein SR. A ladder of citizen participation. Journal of the American Institute of planners. 1969;35(4):216-24

[24] Awasthi KR, Jancey J, Clements AC, Rai R, Leavy JE. Community engagement approaches for malaria prevention, control and elimination: a scoping review. BMJ open. 2024;14(2):e081982.

Genberg BL, Shangani S, Sabatino K, Rachlis B, Wachira J, Braitstein P, et al. Improving engagement in the HIV care cascade: a systematic review of interventions involving people living with HIV/AIDS as peers. AIDS and Behavior. 2016;20:2452-63.

Chavez-Rimache L, Ugarte-Gil C, Brunette MJ. The community as an active part in the implementation of interventions for the prevention and care of tuberculosis: A scoping review. PLOS Global Public Health. 2023;3(12):e0001482.

[25] Kerrigan D, Kennedy CE, Morgan-Thomas R, Reza-Paul S, Mwangi P, Win KT, et al. A community empowerment approach to the HIV response among sex workers: effectiveness, challenges, and considerations for implementation and scale-up. The Lancet. 2015;385(9963):172-85.

Musa BM, Iliyasu Z, Yusuf SM, Uloko AE. Systematic review and metanalysis on community based interventions in tuberculosis care in developing countries. Nigerian Journal of Medicine. 2014;23(2):103-17.

Salimi Y, Shahandeh K, Malekafzali H, Loori N, Kheiltash A, Jamshidi E, et al. Is community-based participatory research (CBPR) useful? A systematic review on papers in a decade. International journal of preventive medicine. 2012;3(6):386.

[26] Atkinson J-A, Vallely A, Fitzgerald L, Whittaker M, Tanner M. The architecture and effect of participation: a systematic review of community participation for communicable disease control and elimination. Implications for malaria elimination. Malaria journal. 2011;10:1-33.

O'Mara-Eves A, Brunton G, McDaid G, Oliver S, Kavanagh J, Jamal F, et al. Community engagement to reduce inequalities in health: a systematic review, meta-analysis and economic analysis. Public Health Research. 2013;1(4).

Questa K, Das M, King R, Everitt M, Rassi C, Cartwright C, et al. Community engagement interventions for communicable disease control in low-and lower-middle-income countries: evidence from a review of systematic reviews. International journal for equity in health. 2020;19:1-20.

2. Methodology

2.1. Evaluation approach

The ET designed the evaluation to be outcome-focused, theory-based and realist-inspired. It is learning-oriented and utilization-focused.

Outcome-focused. Outcomes are defined as "the achievement (or progress in the achievement) of meaningful CE across the stages of the Global Fund grant cycle, or progress towards it".[27] This evaluation focused on the fulfillment of these outcomes and worked backward to determine how and why they came about or not.

'Meaningful CE' is a broad term that runs through interventions, the outputs they deliver, the categories of people they reach, the satisfaction of people who experience the intervention, and the reasons driving this satisfaction, which often include trust and long-term relationships (see Box B in the Inception Report). As a result, agreeing on what level of implementation/change/ time this evaluation conceptualizes as "community engagement outcomes" was a key step for the theory development stage of the evaluation process and framed all the subsequent steps of the evaluation.

Theory-based and realist-inspired. The evaluation is grounded in the understanding that social systems have real effects and people respond differently to interventions in different circumstances. The evaluation design and application are explicitly guided by theory about how the Global Fund achieves meaningful CE. It explores how and why selected CE interventions across the grant cycle have worked or not by examining and testing the causal links between intervention and outcomes.[28] Box A sets out the ET's rationale for applying realist principles in the evaluation.

[27] This differs from traditional definitions of outcomes such as "changes in the behaviour, relationships, actions, activities, policies, or practices of an individual, group, community, organization, or institution" (Wilson-Grau and Britt, 2012: 2). However, the difference is not significant as we still talk about relationships, trust, activities, representation etc.

[28] Morris, L. L. and Fitz-Gibbon, C. T. (1996) 'Theory-Based Evaluation'. *Evaluation Practice* 17(2), pp. 177–184; Coryn, C. L. S. *et al.* (2011) 'A Systematic Review of Theory-Driven Evaluation Practice From 1990 to 2009', *American Journal of Evaluation* 32(2), pp. 199–226. doi: 10.1177/1098214010389321; Chen, H. T. (2012) 'Theory-driven evaluation: Conceptual framework, application and advancement', in Strobl, R., Lobermeier, O., and Heitmeyer, W. (eds) *Evaluation von Programmen und Projekten für Eine Demokratische Kultur*, p. 226. doi: 10.1007/978-3-531-19009-9; Treasury Board of Canada Secretariat (2009). *Theory-Based Approaches to Evaluation: Concepts and Practices.* Retrieved from: https://www.canada.ca/en/treasury-board-secretariat/services/audit-evaluation/evaluation-government-canada/theory-based-approaches-evaluation-concepts-practices.html.

Box A. The rationale for realist-informed evaluation and the ET's application of it

Central to realist evaluation approaches is the idea that programs do not work in the same way for everyone in every location. Context shapes how and why programs contribute, or fail to contribute, to change for different participants in different places. Given the different levels of satisfaction with CE displayed by survey data collected by the Global Fund prior to the evaluation (including among people living with or are affected by HIV, TB and malaria in the same locations) and the variety of contexts in which the Global Fund works, the ET selected realist evaluation because it supports a nuanced analysis of how and why interventions work differently, for different groups of people, in different contexts.

In addition, the evaluation presented a scope to conduct qualitative research with relevant Global Fund stakeholders (remotely) and program participants (through case studies) in order to investigate their perspectives on how and why change happened or did not happen. The approach also includes plans for close engagement with the commissioner to decide and finalize the EQs (to ensure their focus and number), develop theory, and identify priority issues for the evaluation. Both of these elements are often listed among the conditions for realist evaluation.

However, a realist approach "is analytically demanding, and it is rarely possible to look at all dimensions of a complex programme".[29] It can be resource-intensive and time-consuming, and therefore in an evaluation of this scale, it most effectively used to examine priority pathways of change in depth. As a result, this realist investigation focuses on specific pathways within the Program Theory and does not aim to test the entire program theory. This means that, for example, the ET will be able to answer EQ1 only for the specific outcome described in the selected context-mechanism-outcome (CMO) configurations. CMO configurations refer to the interaction between Context (C), Mechanism (M), and Outcome (O). They explain how particular outcomes are generated by specific mechanisms operating in particular contexts, helping to understand what works, for whom, and under what circumstances.

In addition, although a realist evaluation protocol often entails a systematic review[30] and the application of a teacher–learner cycle through realist interviews,[31] the approach does not include those steps, because they would have significantly extended the duration of the theory development stage and require extensive training of in-country data collectors.

Finally, the evaluation is a utilization-focused evaluation (UFE) and is learning-oriented. UFE centers on the identification and engagement of the evaluation's primary intended users.[32] The approach took into account the Global Fund's definitions of meaningful CE and engages program stakeholders earlier on in the process to contextualize it to each stage of the grant cycle. It also included several touchpoints with the User Group, the ELO and other Global Fund key stakeholders, to ensure a responsive learning process based on actionable evidence (during a Preliminary Findings Workshop in January and a Recommendations Workshop in April 2025). The evaluations team's choice of a realist-inspired approach also reflects a learning focus and results from a collaboration between the ET and the ELO, which showed interest in realist evaluation.

[29] Reality bites: Lessons from five years of realist evaluation at Itad | Itad

[30] Pawson, R. *et al.* (2004) 'Realist synthesis: an introduction'. University of Manchester: ESRC Research Methods Programme.

[31] Manzano, A. (2016) 'The craft of interviewing in realist evaluation'. *Evaluation* 22(3), pp. 342–360. Available at: https://journals.sagepub.com/doi/abs/10.1177/1356389016638615.

[32] Utilization-focused evaluation: https://www.betterevaluation.org/methods-approaches/approaches/utilisation-focused-evaluation

The evaluation combined these approaches, implementing them through the model set out in Figure 3 and the steps below.

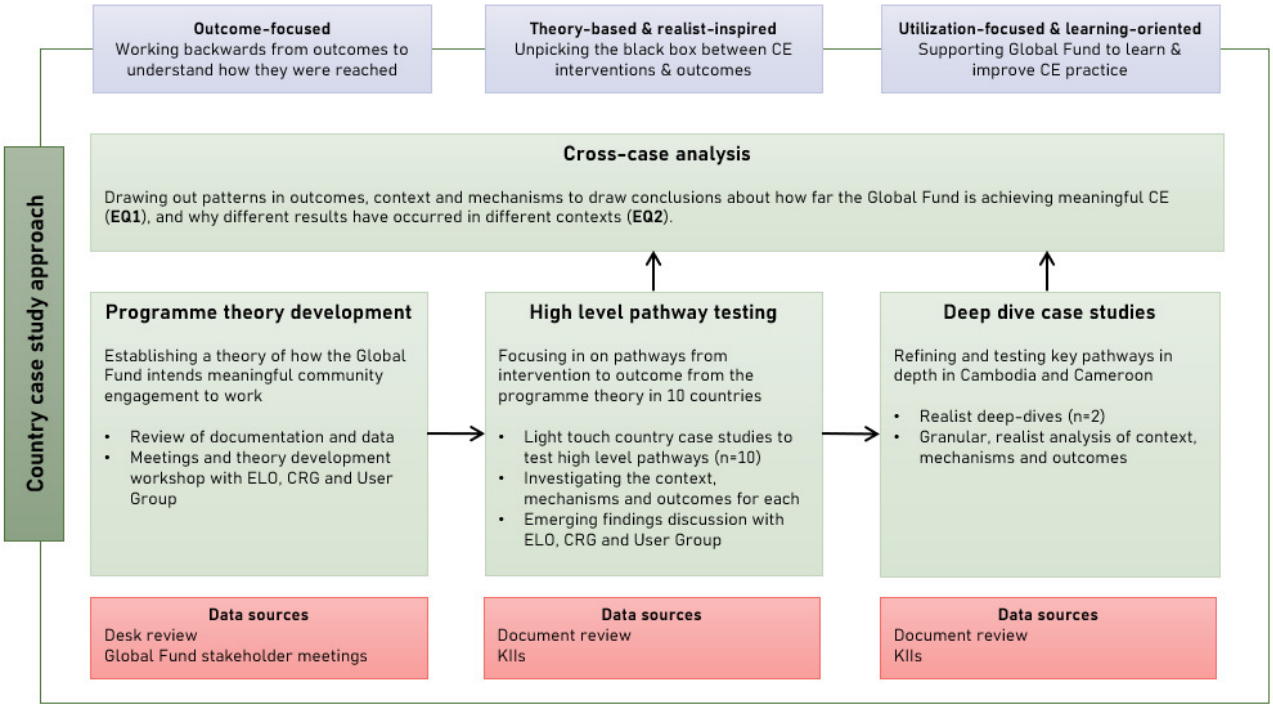

Figure 3. Approach model.

1. **Theory and pathway development.** The ET developed a broad **Program Theory** to set out how desired immediate CE outcomes are achieved through the grant cycle stages. For each stage of the grant cycle, the ET developed **high-level pathways** about how, and for whom, to what extent and in what contexts a program might 'work'.
2. **High-level pathway testing.** The ET tested and refined these high-level pathways through light touch **case study country studies** (n=10). This included sense-checking the pathways with key communities during the case studies. The case studies gathered and analyzed data on the extent to which CE outcomes have been achieved, the structures and processes which drive or impede change, and the contextual factors which influence meaningful CE.[33] The ET then developed this evidence into **high-level CMO** configurations to interrogate each high-level pathway in more detail and to unpack whether and how contextual factors and key mechanisms are linked to specific outcomes.
3. **Deep dive case studies.** The ET tested these findings further through a second round of data collection in Cambodia and Cameroon (n=2). The ET developed **deep dive CMO** configurations for the selected outcome pathways in both countries, using a more fine-grained, realist lens to provide detailed evidence on the combination of contextual factors and mechanisms that led to CE outcomes in both countries.
4. **Cross-case analysis and reporting.** Finally, the ET analyzed the whole database, drawing out patterns in realizing/not realizing meaningful CE outcomes and reflecting on how this works, for whom, to what extent and in what conditions.

[33] Wong, G., Westhorp, G., Manzano, A. *et al.* (2016) 'RAMESES II reporting standards for realist evaluations'. *BMC Med* 14, 96. https://doi.org/10.1186/s12916-016-0643-1

2.2. Engagement of community members in the evaluation and triangulation of data

The ET were committed to engaging community members throughout the evaluation process and clear protocols were developed for doing this during the data collection stages of the evaluation. For all of the ten in depth case country studies, for example, there was very high engagement with community groups and key population members and representatives (see Annex 4). Beyond the data collection stage, civil society and community representatives were involved in the interpretation of information collected through participation in facilitated focus group discussions where initial findings were presented. These discussion were a useful data pint to to inform the generation of recommendations.

The ET combined different approaches to diversify the data sources and triangulate information:

- **Document review and qualitative analysis.** Qualitative evidence was collected through document review, key informant interviews (KIIs) and focus group discussions (FGDs). Where possible (given the need for anonymity), qualitative data has been disaggregated to reflect the perceptions of different groups of stakeholders.
- **Literature review.** The ET conducted an analysis of the relevant literature to underpin the understanding of meaningful CE. By doing so, the ET drew on the expertise of the realist advisor to ensure that the literature review is grounded in the same theoretical context as the overall evaluation.
- **Program Theory iteration.** The ET reviewed and iterated the Program Theory based on conversations/discussions and workshops with the Global Fund's internal key stakeholders during the course of the evaluation. In doing so, the ET deepened their understanding of the grant cycle to develop relevant high-level pathways that informed the active data collection, both remotely and in-country.
- **Remote data collection.** The ET conducted a number of remote KIIs and FGDs with diverse key stakeholders and community representatives in all 10 case countries, pre-selected by the Global Fund. In some contexts, the ET turned to face-to-face data collection, for example in Tajikistan, where remote data collection proved to be hindering and excluding to key informants.
- **In-country deep dives.** The ET conducted two deep dives in-country (in Cambodia and Cameroon) to further explore key aspects of meaningful CE. The deep dives were informed and tailored by the findings of, and observations made during, the remote data collection round.

2.3. Limitations

Like all evaluations of this nature, the approach has both strengths and limitations, mostly shaped around resourcing and time frames, on which the ET reflects below.

Evaluation timeline. The evaluation was conducted within a condensed timeframe, with two months initially planned between the inception report and the first draft of the final report for data collection, analysis, and in-country work. To address this, the evaluation focused on specific grant aspects, complemented by a rapid literature review. Robust and transparent communication with the Global Fund was maintained throughout the process to manage the

scope and jointly address challenges. This collaboration allowed for adjustments to deep dive timing and interim outputs. Additionally, the project timeline was extended to accommodate the substantial data collected and engagement from stakeholders during the Early Observations Workshop.

Challenges in engaging community representatives. The evaluation encountered various challenges in gathering data and engaging community representatives across different settings. These included difficulties in participation due to logistical constraints and limited community resources. The ET collaborated closely with Global Fund Country Teams (CTs) for guidance on navigating local contexts and potential risks, and engaged local consultants with relevant expertise and language skills to facilitate community interaction and address communication barriers. Despite these efforts, the evaluation faced delays in securing key informant interviews and experienced inconsistent stakeholder responsiveness, which ultimately limited the ability to consult with all intended participants. Ongoing communication with ELO allowed for timely adjustments to address these challenges.

2.4. Ethical considerations and mitigations

It is crucial to acknowledge that ethical considerations are paramount when conducting evaluations that involve the engagement of KPs. Potential ethical concerns can arise from power imbalances between researchers or external stakeholders and community members. Stigma and discrimination associated with certain health conditions or KP status can create risks of harm or re-traumatization during engagement processes. Ensuring confidentiality and privacy of participants' information is also an essential ethical obligation. The ET applied mitigation measures to ensure an ethical evaluation process, particularly during data collection. This included obtaining informed verbal consent from all participants, to ensuring they understood the purpose of the evaluation and their rights. Creating safe and inclusive spaces for dialogue where individuals felt comfortable sharing their experiences without fear of judgment or repercussions was vital and gatekeepers within communities were consulted to ensure this. Furthermore, it was important to avoid overburdening communities by making excessive demands on their time or resources. Transparency in the evaluation process, including how data will be used and disseminated, helped to build trust. Finally, the evaluation aims to benefit the communities involved and contribute to positive change regarding meaningful CE.

2.5. Case studies

As outlined above, the ET conducted 10 remote case studies and two deep dives in two of these countries. The countries had been pre-selected by the Global Fund:

- Cambodia (deep dive country, Itad and local consultant)
- Cameroon (deep dive country, local consultant)
- Central African Republic (CAR) (challenging operating environment (COE))
- Chad
- Ecuador
- Ghana
- Indonesia

- Tajikistan
- Ukraine (COE)
- Zimbabwe.

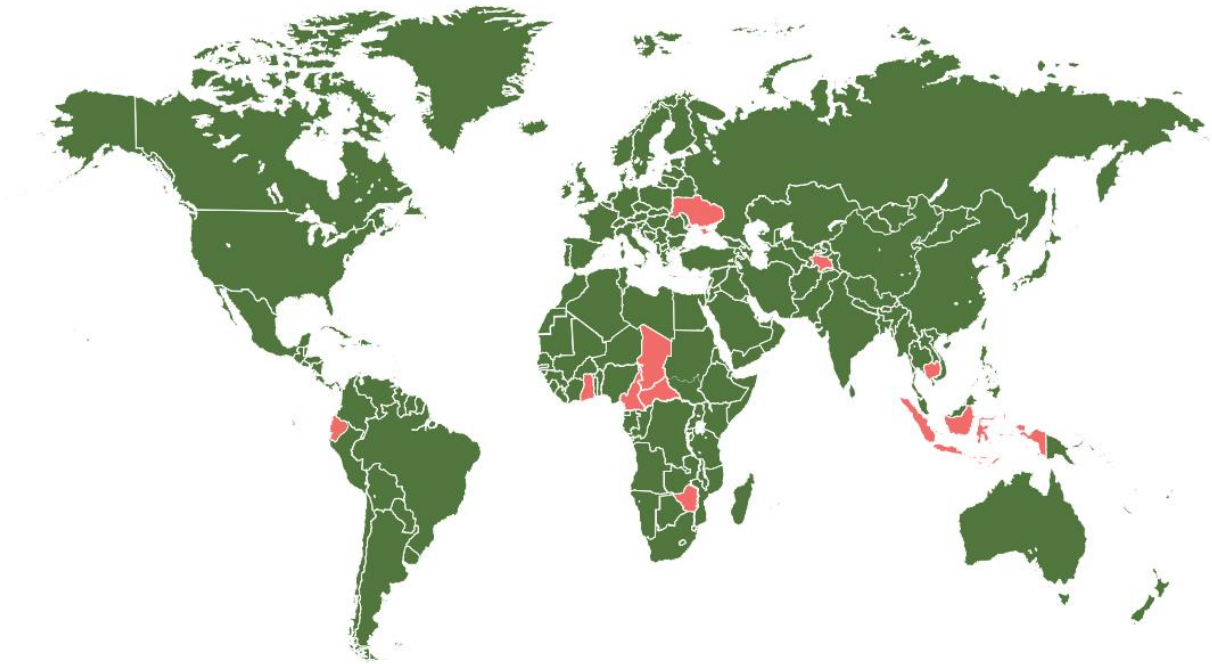

Figure 4. Evaluation case countries.

2.6. Strength of evidence and data triangulation

In line with good evaluation practice, the ET has assessed the strength of the evidence, using the framework shown in Table 1.[34]

Rating	Strength of evidence assessment criteria for conclusions
Strong (1)	Evidence comprises multiple data sources, both internal (e.g. across case study countries) and external (good triangulation from at least two different sources, e.g. document review and KIIs, or multiple KIIs of different stakeholder categories), which are generally of good quality.
Moderate (2)	Evidence comprises multiple data sources (good triangulation across case studies) of lesser quality, or the finding is supported by fewer data sources (limited triangulation, e.g. only documents of KIIs from one stakeholder category) of decent quality.

[34] Assessing the strength of evidence through triangulation of data sources and methods is widely accepted as appropriate in the evaluation literature, drawing on the work of Patton (1999) and Denzin (1978). Communicating the strength of evidence through a rubric-based approach is more recent but also accepted as being in line with best practice in the evaluation literature, as communicated by Aston (2020) and Aston and Apgar (2023).

Limited (3)	Evidence comprises few data sources across limited stakeholder groups (limited triangulation) and is perception-based or is generally based on data sources that are viewed as being of lesser quality.
Poor (4)	Evidence comprises very limited evidence (single source) or incomplete or unreliable evidence. Additional evidence should be sought.

Table 1. Strength of evidence framework for evaluation findings

Triangulation of data refers to the process of using multiple sources of information and methods to cross-verify findings. This approach involves comparing and contrasting data gathered from different sources, such as interviews, document reviews, and insights from different stakeholder groups. By examining evidence from various angles, the ET have scored the strength of evidence supporting each conclusion. Strength of evidence scores have been assigned to all evaluation findings (as per the finding summary tables at the beginning of each section) and the conclusion statements

3. Structure of the findings section

The findings subsection in Section 3 is organized into four main components. First, the ET introduces the key findings. This is followed by an explanation, providing further detail. Next the report provides details on where the finding is observed or not, including the number of countries involved. Finally, report uses the CMOs or additional supporting evidence to substantiate the finding with relevant data and case studies, strengthening the validity of the statement.

4. Evaluation findings

This section presents the ET's findings and supporting evidence, the intersection between findings and the EQs.

4.1. EQ1: How far is the Global Fund achieving meaningful CE outcomes?

1.1 How far is the Global Fund meaningfully engaging communities across the grant cycle?

Of the three grant cycle stages included in this evaluation, the Global Fund is most meaningfully engaging community during the funding request stage. There is limited to no engagement during grant making, and mixed levels of engagement during implementation. Significant Global Fund engagement at the start of the grant cycle has enabled meaningful engagement across a majority of countries, including those affected by challenging contextual factors. In contrast, CE was weakest during the grant making stage. While this stage is not intended to involve extensive CE, engagement of the CCMs by PRs is not perceived to be adequate by communities as there is limited information on how implementation arrangements are finalized including allocation of targets and their related budgets. During the grant implementation stage, the quality of CE was more mixed, with some meaningful engagement observed during oversight activities and some more limited examples of engagement in programmatic revisions. Similarly to the grant making stage, however, there was no evidence of engagement during annual funding decisions and disbursements. The rest of this section sets out in more detail the extent to which meaningful CE occurs across the different stages of the grant cycle.

#	Findings
	Funding request stage
1.1.1	The ET's analysis found that the strongest, most consistent evidence of meaningful CE across all contexts occurred during the funding request stage. All case study countries, even those which faced challenges in achieving meaningful CE across the grant cycle, demonstrated high levels of CE through active consultation and dialogue. This included consolidating programmatic choices for HIV, TB and malaria to inform the funding priorities for the Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria annex, technical writing and costing of the funding requests.
1.1.2	In six countries, the funding request preparations were an effective platform for community groups to advocate for their priorities in a coordinated way. Where this preparatory process of dialogue and consultation was most effective, it was driven by strong and active engagement from support organizations and thoughtful collaboration among partners, TA providers and stakeholders.
1.1.3	Successful community dialogues in these six countries were tailored to different groups within KPs and communities, and therefore facilitated meaningful engagement.
1.1.4	In several countries, the request drafting component of the funding request process undermined previous work to ensure meaningful CE, with community priorities reportedly being left out.
1.1.5	The degree of meaningful CE achieved also varies across diseases. HIV-affected communities and KPs are most meaningfully engaged, supported by strong civil society in many cases. TB

	populations are included in instances where efforts are made to develop partnerships which support their inclusion. Malaria-affected communities are least likely to be meaningfully engaged.
Grant making stage	
1.1.6	The successes in achieving meaningful CE at the funding request stage are not maintained during grant making. Consultation of communities and KPs does not continue, and the process of selecting interventions is restricted to PRs, CTs and some CCM members.
1.1.7	In several countries, there was also a perception that other stakeholders' interests negated community priorities during grant making, with governments and representatives of INGOs or multilateral organizations seen as wielding disproportionate influence.
1.1.8	The poor level of meaningful CE at the grant making stage clearly represents a sharp drop-off in engagement from the funding request stage. This led to reported high levels of frustration at the disconnect between the positive experience of engagement at the funding request stage and the closed-door nature of grant decision making. This in turn resulted in disengagement of community groups from subsequent Global Fund processes.
Grant implementation stage	
1.1.9	In the six countries where the ET assessed the grant implementation stage, engagement was observed during implementation oversight and during programmatic revisions, but not during annual financial decisions and disbursements. The most meaningful engagement during implementation occurred in those contexts which encourage an inclusive process, with strong CCM representatives held accountable by their constituents.
1.1.10	All six countries benefited from capacity building through the CCM evolution strategic initiative, and had key CCM structures in place to facilitate CE during oversight, so some degree of engagement took place across contexts. In the two countries where the CCM leadership (CCM Secretary and Executive Committee) was strong and experienced, CE in oversight took place routinely including joint oversight missions with Programs, with communities represented and actively participating in the process.
1.1.11	There is limited CE in programmatic revisions, with the only avenue for participation being through the CCM Oversight Committee. With short timelines and limited understanding of the processes, communities and KPs are reliant on their CCM representative to influence decision making on their behalf.

Table 2. Findings EQ 1.1

Funding request stage

1.1.1 The ET's analysis found that the strongest, most consistent evidence of meaningful CE across all contexts occurred during the funding request stage. All case study countries, even those which faced challenges in achieving meaningful CE across the grant cycle, demonstrated high levels of CE through active consultation and dialogue. This included consolidating programmatic choices for HIV, TB and malaria to inform the funding priorities for the Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria

annex[35], technical writing and costing of the funding requests. Across all case study countries, most evidence of active CE was observed at the funding request stage. Although CE is mandated in Global Fund guidelines[36] [37] during this stage, the evidence nonetheless showed effective practice in implementing engagement activities leading to positive CE outcomes. This finding held in countries where civil space is highly constrained and/or the operating context is very unfavorable (e.g. because of ongoing conflict). Although there were significant variations of level of CE among different community and KP groups and relating to different disease areas, the ET found strong evidence across all the study countries of communities and KPs playing an active part. This included participating in and contributing their priorities to the funding request by engaging in pre-dialogue preparations, contributing to the actual country dialogue processes, and inputting to costing of activities and drafting of the Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria annex.

1.1.2 In six countries, the funding request preparations were an effective platform for community groups to advocate for their priorities in a coordinated way. Where this preparatory process of dialogue and consultation was most effective, it was driven by strong and active engagement from support organizations and thoughtful collaboration among partners, TA providers and stakeholders. All countries held country dialogues to gather community and KP inputs to the Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria annex. Best practice, as observed in three countries, involved a thoughtful series of pre-dialogue consultations, tailored to the needs of diverse communities and KPs. In Cambodia, for example, KPs and TB community representatives representing communities with TB participated in consultations and pre-meetings organized by a health organization.[38] CE SI also provided TA to support the pre-dialogue in Cambodia (see Box B). These consultations served as the primary mechanism for collecting grass roots community input through community representatives collecting, then sharing, constituents' feedback and concerns about treatment access and stigma. The community representatives were provided with information ahead of these consultations, ensuring that they were well informed and able to advocate effectively for their communities. This illustrates the importance of a strong and active representative organization that facilitates effective preparations. Similar successful initiatives to prepare for country dialogues were observed in Chad and Tajikistan. In Chad, funds were provided by different partners, including the CE SI, to sponsor pre-dialogues. The United Nations Children's Fund (UNICEF), the Joint United Nations Program on HIV/AIDS (UNAIDS) and other partners, including youth and women's groups, also supported different constituency groups to conduct dialogues in their own spaces. In Tajikistan a local non-governmental organization (NGO), submitted a request to the Technical Support Mechanism supported by UNAIDS. TA received through UNAIDS TSM was also received by Global Fund related outreach in Ghana, Chad, Zimbabwe, Cameroon. This allowed the involvement of communities in Tajikistan in the process of developing the new funding request, identifying and contributing their own priorities for inclusion in the main national application from Tajikistan under GC7.

[35] This annex is part of the Funding Request.

[36] The Global Fund (2022) *Community Engagement: A Guide to Opportunities Throughout the Grant Life Cycle.*

[37] The Global Fund (2024) *Technical Assistance for Community Engagement: General Overview and Guidelines for Application*.

[38] Khmer HIV/AIDS NGO Alliance.

1.1.3 Successful community dialogues in these six countries were tailored to different groups within KPs and communities, and therefore facilitated meaningful engagement. In the successful examples discussed above, CTs and their partners drew on context-appropriate mechanisms to reach KPs and communities. In Chad, for example, decentralizing dialogues to the community level led to civil society actors identifying solutions, helped educate people about the Global Fund, and actively involved men who have sex with men, sex workers and people who inject drugs, allowing them to voice their needs. In regard to Global Fund related outreach in Ecuador, virtual country dialogues ensured that civil society representatives and KPs could voice concerns, and the inclusion of peer educators fostered trust and engagement within KPs such as people living with HIV. The dialogues helped identify critical gaps in the healthcare system, such as limited access to healthcare services and the stigma associated with HIV testing. Where these mechanisms were not employed, the dialogues did not reach all KPs, and engagement was less meaningful. In both countries these dialogues were supported by TA provided by the CE SI. In Zimbabwe, KPs held capacity building workshop to orient new and young KPs on Global Fund processes, and to undertake community (men who have sex with men, transgender people, sex workers) specific priorities ahead to the broader country dialogue sessions.

Box B. Spotlight on best practice: Meaningful engagement with TB communities in Global Fund related outreach in **Cambodia**

In Cambodia, the Pre-Country Joint TB HIV Dialogue[39] serves as a crucial forum for CE during the funding request stage. These dialogues are organized within the civil society community to identify key issues, agree on priorities for both HIV and TB, and consolidate community demands. They provide a platform for underrepresented groups to participate meaningfully and contribute to the funding request processes.

The dialogues involve a wide range of stakeholders, including representatives from CSOs, people living with HIV, people experienced with TB, KPs, United Nations (UN) agencies, TA providers, and the government entities who are principal recipients in Cambodia. KPs include men who have sex with men, transgender people, entertainment/sex workers, and people who use drugs. These dialogues are designed to gather inputs from communities, which are then shared at the wider country dialogue forum involving stakeholders from government, civil society, and implementing partners.

The Pre-Country Joint TB HIV Dialogue allows for the integration of the needs and priorities of affected communities into the funding request. This inclusive approach ensures that the voices and experiences of those most affected by HIV, malaria and TB shape the programs and services aimed at meeting their needs. For instance, TB representatives actively participated in meetings, including the country dialogue, TB HIV consultative meetings, and TB-Technical Working Group (TWG) meetings, guiding the prioritization of interventions.

Furthermore, these dialogues contribute to developing a holistic, strategic perspective that ensures that disease programs meet the needs of affected communities, particularly among KVP. By incorporating community perspectives at this early stage, funding requests are better aligned with the realities on the ground. The Pre-Country Joint TB HIV Dialogue ensures that funding proposals are responsive to local challenges and barriers to accessing care, such as stigma, accessibility issues, and gaps in education on TB prevention.

[39] Dialogues taking place before the official country dialogues.

1.1.4 In several countries, the request drafting component of the funding request process undermined previous work to ensure meaningful CE, with community priorities reportedly being left out. In these examples, CE effectively stopped during the process of costing and selecting interventions for inclusion into the funding request. In one country, although community groups participated in costing interventions and played an active part in writing the request, they felt they had no substantive influence on whether their interventions would be included either within or above allocation components of the funding request. They reported that other factors overrode their priorities, such as a focus on commodities by both government agencies and the CT; and focus on public sector interventions by heads of program for HIV, TB and malaria, perceived preference among the CT and CCM for new interventions. Similar evidence occurred in two other countries where community organizations reported that they have very little engagement in the crucial exercise of prioritizing interventions suggested by communities and KPs. In one of these countries, for example, despite community-informed issues and coverage gaps being related to poor grant performance, such as drop in TB treatment coverage, which could be explained by: i) stigmatization and discrimination, ii) poor treatment decentralization (only 24 TB treatment centers, iii) insufficient nutritional and psychosocial support, iv) poor therapeutic education, v) and refusal of treatment; and despite the Finding Request calling for an intensification of some programs such as nutrition, the emerging community subcomponent funding did not reflect such intensification.

In the Global Fund's Grant Cycle 7 (GC7) for malaria, out of six proposed vector control interventions, community case management was the only intervention deprioritized. Government-led prevention strategies were retained within the core funding request, while $3.7 million of the $8 million total need for vector control—equating to approximately 47%—was moved to the Priority Above Allocation Request (PAAR), which is not guaranteed to be funded[40].

1.1.5 The degree of meaningful CE achieved also varies across diseases. HIV-affected communities and KPs are most meaningfully engaged, supported by strong civil society in many cases. TB populations are included in instances where efforts are made to develop partnerships which support their inclusion. Malaria-affected communities are least likely to be meaningfully engaged. The clearest evidence of this comes from the seven countries affected by all three epidemics. The ET observed generally strong engagement of communities with HIV and TB, but malaria is mentioned less frequently. HIV communities and KPs are more likely to have strong civil society representation, with more experience of the Global Fund, greater capacity for advocacy, and strong underpinning from global HIV organizations such as UNAIDS. Malaria programs in particular have fewer visible, organized partners, and represent a more generalized epidemic. Across all countries, the level of CE in the funding request stage is more pronounced for HIV and TB compared to that for malaria. In Chad, for example, for HIV, there was an emphasis on engaging young people and KPs, with dedicated workshops held to ensure their voices were heard during the development of the GC6 equivalent) and with improvements noted in GC7. UNAIDS played a vital role in advocating for the continued presence of civil society throughout the grant process. Similarly in CAR, although community consultations were organized involving communities affected by HIV, TB and malaria, evidence suggests that

[40] The Global Fund. (2023a) 'Operational update on GC7 resources, updated C19RM guidelines, and SEAH requirements'.

community leadership and engagement in TB and malaria programs might not be as extensive as in other areas.

Grant making stage

1.1.6 The successes in achieving meaningful CE at the funding request stage are not maintained during grant making. Consultation of communities and KPs does not continue, and the process of selecting interventions is restricted to PRs, CTs and some CCM members. Across all 10 countries, the ET found very little evidence of meaningful CE beyond the involvement of a few CCM members at the grant making stage. This is in contrast to recent data on community satisfaction with the grant making stage, which met or exceeded the expected level. The Global Fund's Operational Policy Manual outlines the expectation for a continued dialogue with the CCM throughout this stage, with appropriate feedback loops to KPs and communities. Although some CCM members are involved, the feedback loops are not working in any of the sampled countries. Communities also argued, that not all CCM representatives are technical, or get meaningfully involved during the funding request writing thus not able to adequately interrogate presentations made to them during the grant making stage. CCM members in few countries, e.g. Ecuador, were able to follow up and influence the grantmaking process favorably. Key informants across many of the case study countries reported that the only community representatives who were able to actively engage with grant making decisions were the CCM chair and another member of a CCM internal committee. Other KP representatives who partake in the CCM mentioned that the grant proposal is approved in the CCM meeting but that barriers within the group limit engagement. This was attributed to tensions and competition among CCM members and resistance toward new CCM members who are not as familiar with CCM processes. The two quotes from Chad and Tajikistan are illustrative.

> *'We were satisfied with the process but not the funding. Many community activities were not funded. Our goal was to decentralize activities, shifting them towards community-led implementation. We justified our priorities, but in the end, the funding didn't reflect our community's needs. […] Our Principal Recipient, […] had a large budget for health systems strengthening, but they allocated very little for community-led activities.'(Chad KII)*

> *'It was expected that with such a well-organized CE process most of the priorities proposed by communities would be included in the FR. Everything seemed fine, and everyone was satisfied until the preparation of the final budget. At that stage [budgeting] many of the proposals from CSOs and communities were not included. Some were moved to PAAR [e.g., proposals related to women living with HIV]' (Tajikistan KII)*

1.1.7 In several countries, there was also a perception that other stakeholders' interests negated community priorities during grant making, with governments and representatives of INGOs or multilateral organizations seen as wielding disproportionate influence. Informants in some cases argued that the end communities had limited influence over funding decisions, despite their formal inclusion in the CCM, as government or INGO/multilaterals representatives dominated discussions. Community representatives were further hampered by technical knowledge gaps, preventing them from participating actively. Grant making was often perceived as a more technical exercise between the PR and the Global Fund. The reliance on TA during the funding request can exacerbate these issues if not managed effectively. In Chad, for example, communities were unable to influence the choice of a Civil Society Principal Recipient to manage the grant. Some respondents found it unusual that communities would advocate for a government principal recipient instead of a community-led one, even considering the Global

Fund's Additional Safeguards Policy. Fear of reprisals from the government dissuaded some community members from calling for a civil society PR. The allegations highlight potential power imbalances between communities, government, within the Country Coordinating Mechanism (CCM), and across other stakeholders involved in the grant-making process, which may have affected funding allocation decisions.

1.1.8 The poor level of meaningful CE at the grant making stage clearly represents a sharp drop-off in engagement from the funding request stage. This led to reported high levels of frustration at the disconnect between the positive experience of engagement at the funding request stage and the closed-door nature of grant decision making. This in turn resulted in disengagement of community groups from subsequent Global Fund processes. As discussed above, the evidence showed that communities and KPs tended to have a significantly more positive experience of CE during the funding request stage. In six of the seven countries where the ET looked at the grant making stage in more detail, KIIs highlighted that there was a significant mismatch between the expectations that they would play a significant part in the implementation arrangements for priorities that were included in the funding requests, that their priorities would have significant targets and budgets to facilitate effective implementation and impact. Although it is clear that in the current funding environment, decisions over budget allocations are challenging to make, the lack of transparency in explaining how and why difficult decisions and trade-offs were made was highlighted as a key concern. Among communities, KPs and partners, this created dissatisfaction with the process, wasted the momentum created by more effective engagement in the funding request stage, and reduced willingness to engage in subsequent stages of the Global Fund activities. The two quotes are illustrative:

'I returned to Tajikistan to work with the CT following the TRP comments [this visit supported by GI]. However, at this stage it was still not possible to incorporate the priorities raised by the communities. As a result, while the process itself may have been appreciated by the communities, they were likely dissatisfied with the final outcome' (Tajikistan KII)

'It was very sad for us as the TB community, because after grant making we found that some of the interventions we defined were not put under the government PR; and some of the interventions, though [they] were in the performance framework, they had zero budget allocation […] if we were represented in grant making as in funding request stage, this could not have happened.' (Ghana KII)

Grant implementation stage

1.1.9 In the six countries where the ET assessed the grant implementation stage, engagement was observed during implementation oversight and during programmatic revisions, but not during annual financial decisions and disbursements. The most meaningful engagement during implementation occurred in those contexts which encourage an inclusive process, with strong CCM representatives held accountable by their constituents. While a full consultation and engagement process is not expected at this stage, common structures and processes exist to facilitate these requirements across countries, with responsibilities sitting with the CCM, specifically the CCM community representatives, CCM sub-committees, PRs and the Global Fund CT. However, in practice, evidence suggests that the functionality and effectiveness of these structures to engage communities to carry out oversight and programmatic revisions (reprogramming) vary according to the inclusivity of how they are implemented, the PRs

involved, the strength of CCM community representatives, and their accountability to constituencies.

1.1.10 All six countries benefited from capacity building through the CCM evolution strategic initiative, and had key CCM structures in place to facilitate CE during oversight, so some degree of engagement took place across contexts. In the two countries where the CCM leadership (CCM Secretary and Executive Committee) was strong and experienced, CE in oversight took place routinely including joint oversight missions with Programs, with communities represented and actively participating in the process. Across all countries, Oversight Officers were key to delivering the oversight function, with the support of the CCM Hub. Across all countries, the composition of the CCMs and that of the Oversight Committee was reported to have been reviewed and updated to ensure that people living with disabilities and KPs for HIV, TB and malaria are represented on the CCM and on the Oversight Committee. However, the evaluation noted that the most effective examples of oversight engagement took place during oversight where joint oversight activities were undertaken. In two countries (Indonesia and Zimbabwe), oversight of Global Fund related outreach was more advanced as joint oversight activities were undertaken between the CCM and the HIV, TB and malaria programs to diagnose and resolve grant implementation challenges together and to prioritize CE.

1.1.11 There is limited CE in programmatic revisions, with the only avenue for participation being through the CCM Oversight Committee. With short timelines and limited understanding of the processes, communities and KPs are reliant on their CCM representative to influence decision making on their behalf. In five countries, the process for programmatic revisions was held by the disease-specific PRs and by CTs, who presented their proposals to the CCMs through the Oversight Committee for review, discussion and endorsement. From respondent feedback it was observed that at the primary level of the programmatic revisions, HIV, TB and malaria communities are not represented. Although community representatives sit on the Oversight Committee and CCM, they are only presented with programmatic decisions to endorse. Because they had not previously been involved in the decision-making process, they reported feeling as though there was no alternative but to approve. It was reported that rarely have proposed programmatic revisions been rejected or returned with substantive amendments before endorsements. This suggests that community representatives do not have enough involvement in this process for CE to occur in any meaningful way. Community and KP members interviewed felt that this did not sufficiently reflect the Global Fund's principle of people-centered approaches as set out in their strategy.

A positive outlier was observed regarding Global Fund related outreach in Zimbabwe, where some decisions were generated by community members during the implementation of the oversight function. One example of this was a programmatic revision which provided resources to pilot interventions for transgender and people who use drugs communities who were previously underreached by services under GC6. These interventions were later scaled up as full modules in GC7, using the experience and lessons from the pilot. Allowing community committee members to propose revisions improved engagement in this part of the implementation process within Global Fund related outreach in Zimbabwe.

1.2 For whom are outcomes achieved/not achieved (reach and coverage)?

There were significant differences in the reach and coverage achieved across epidemics, with HIV communities and KPs most consistently engaged across all country contexts. TB-affected populations were engaged where the Global Fund has invested TA and capacity building for civil society actors representing TB communities and KPs. Malaria-affected communities are the least well-reached among the epidemics. Although there are good examples of successful efforts to engage hardest to reach, most marginalized groups, including sex workers, men who have sex with men and people who use drugs, challenging legal environments and harmful social norms remain challenging barriers. Power imbalances within communities and KPs and their civil society representatives have an inhibiting effect on meaningful reach and coverage of more marginalized, less well-established and smaller KP and community groups.

#	Findings
1.2.1	In all 10 country contexts, HIV KP representatives were most likely to experience meaningful engagement.
1.2.2	The effective reach and coverage of HIV KPs included men who have sex with men and sex workers, even in contexts where these population groups are heavily stigmatized or criminalized.
1.2.3	In almost all countries with TB and malaria-affected populations, CE was less well achieved and less meaningful than in HIV communities.
1.2.4	Two countries provided an example of successful engagement of TB communities. In these cases, TA was used successfully deployed to address the challenges outlined above.
1.2.5	The evaluation also analyzed evidence on the extent of reach and coverage of some of the most marginalized, hard-to-reach groups among communities and KPs. All countries demonstrated some examples of deliberate efforts to address power dynamics to better engage marginalized KPs in planning and implementation of activities across the grant cycle.
1.2.6	The decentralized approach to country dialogues was found to be a key factor in improving meaningful CE and ensuring that remote and hard-to-reach communities were better engaged. However, the success of these initiatives was mixed across countries and between different disease areas and it is noted that this approach requires high investment of resources.
1.2.7	Despite these efforts, transgender people, adolescents, prisoners, forcibly displaced people, and those in rural communities still consistently face barriers to access and participation across different geographical and programmatic contexts. In a majority of countries, this still prevents them from becoming engaged.
1.2.8	A further barrier to effective reach and coverage is created by power imbalances between different community and KP groups. Communities and KPs with more experience of Global Fund processes and with stronger civil society representation tended to crowd out newer, more marginalized groups.
1.2.9	Unsurprisingly, these issues with reach and coverage are exacerbated by contextual factors, including poor infrastructure and conflict. This increases the risk that a few centrally located representatives are the only community or KP members included in CE activities.

1.2.10	Poor reach and coverage of KPs and communities at the funding request stage is particularly significant. KPs or communities not included at the start of the grant cycle tend to remain excluded for the rest of the grant cycle. Communities who are successfully engaged during the funding request process have improved capacity to continue engaging.

Table 3. Findings EQ 1.2

1.2.1 In all 10 country contexts, HIV KP representatives were most likely to experience meaningful engagement. Because the HIV epidemic is concentrated in KPs, some of which have strong civil society representation with long experience of activism and advocacy, they are well equipped to participate. The KPs with aspects of experiences and identity in common, such as people living with HIV, men who have sex with men and sex workers, tended to have the strongest CSOs. They therefore typically have greater capacity to organize and advocate for their priorities, and they have well-established structures for achieving this. Additionally, the HIV sector benefits from strong coordination through the National AIDS Council (NAC) and TWGs, aiding effective coverage of all HIV KPs.

Box C. Global Fund related outreach in **Ecuador**

Within Global Fund related outreach in Ecuador for example, the CCM has made strong progress in involving KPs in the oversight of HIV grants, with men who have sex with men, transgender individuals, sex workers and people living with HIV actively engaged, ensuring that HIV programming is more relevant to these communities. Additionally, consultations with communities helped identify critical gaps in the healthcare system, including limited access to healthcare services and the stigma associated with HIV testing, which was then addressed through mobile HIV testing services, peer education programs, and stigma-reduction initiatives. Peer educators leveraged their lived experiences to engage community members more effectively, and this improved the uptake of HIV services. However, participation is not uniform across all KPs, and people who use drugs remain excluded from oversight mechanisms.

1.2.2 The effective reach and coverage of HIV KPs included men who have sex with men and sex workers, even in contexts where these population groups are heavily stigmatized or criminalized. In seven countries with challenging legal environments, diplomatic advocacy from knowledgeable in-country partners has supported a collaborative working partnership between the Ministry of Health and the relevant government agencies, such as in Zimbabwe. This has enabled the community engagement across the grant cycle of at risk of criminalization, such as men who have sex with men and sex workers, and ensure their inclusion from the start of the grant cycle. Once these communities have participated meaningfully during the funding request stage, evidence showed that this led to better reach and coverage during implementation. For example, in Ghana, key stakeholders continued to partner with community led organizations as SRs in the implementation of men who have sex with men, and sex worker modules for the HIV grant. In Zimbabwe, a national stakeholder has been instrumental in facilitating safe spaces for HIV KPs to both engage, and to implement lifesaving interventions for community members. This enabled engagement with these groups to continue to some extent, even when changes to the law in Zimbabwe criminalized same-sex relations.

1.2.3 In almost all countries with TB and malaria-affected populations, CE was less well achieved and less meaningful than in HIV communities. This disparity arises partly because TB and malaria are often generalized epidemics, resulting in more geographically dispersed communities that do not always possess a strong common identity or robust civil society partners. For instance in Cambodia, although malaria CSOs and communities were engaged in CCM discussions, the disease received less attention than HIV and TB, owing to the declining incidence of malaria cases in recent years, leading to a reduced emphasis on malaria as a public health priority. Even in countries such as Zimbabwe and Ghana, where malaria is still a clear public health priority and they have civil society malaria PR, malaria KPs and institutions tend to be less visible and organized at the community level compared to their HIV counterparts. These less organized communities are typically less engaged in dialogue processes across the grant cycle, impacting their ability to influence funding requests and implementation. Furthermore, in Zimbabwe, the TB and malaria constituencies often lack the representation that supports broader coverage and advocacy seen within HIV communities. Although there are efforts to promote CE in TB, such as through the formation of community-led monitoring initiatives, these may still be less extensive or impactful compared to established HIV engagement mechanisms.

1.2.4 Two countries provided an example of successful engagement of TB communities. In these cases, TA was used successfully deployed to address the challenges outlined above. Concerning Global Fund related outreach in Tajikistan for example, the funding request process included a carefully thought-through series of consultations with KPs, disaggregated by different demographics of TB patients. This ensured that communities were reached that had not previously been well included. Global Fund related outreach in Cambodia was also a positive outlier, where meaningful CE was reported with both TB and malaria communities. Sustained Global Fund investment in the capacity of a key TB civil society partner in Cambodia, was the key driver of meaningful engagement. This supported TB communities' participation in country dialogues and grant proposal development ensures that their specific needs, such as addressing stigma and discrimination, improving access to services, and promoting community-led monitoring (CLM), are integrated into funded interventions. For instance, representatives from an association of TB survivors, actively participated in meetings, including the country dialogue, TB HIV consultative meetings, and TB TWG meetings. Their inputs directly guided the prioritization of interventions, including the development of activities for new modules addressing KPs and human rights and gender barriers. Furthermore, the Global Fund supported initiatives such as a CLM project, which empowered TB-affected individuals to provide feedback on the quality and accessibility of services. This CLM data, along with inputs from pre-dialogue consultations organized by NGOs and CSOs, was crucial in shaping the funding requests to reflect the realities and needs of communities affected by TB.

1.2.5 The evaluation also analyzed evidence on the extent of reach and coverage of some of the most marginalized, hard-to-reach groups among communities and KPs. All countries demonstrated some examples of deliberate efforts to address power dynamics to better engage marginalized KPs in planning and implementation of activities across the grant cycle. The ET observed efforts to engage some marginalized KPs across all countries, largely drawing on targeted TA or on effective civil society partners. These worked to mitigate the power dynamics that acted as a barrier to inclusion. Examples include efforts to support the inclusion of hard-to-

reach KPs, including female sex workers, men who have sex with men, people with TB who live in prisons, and malaria-affected expectant mothers and children. In three countries, TA directly supported this kind of inclusion. For example in Ukraine, an NGO provided TA to the community of organizations representing the interests of people who use drugs in the process of preparing and submitting applications for the Global Fund funding cycle of 2024–26. In Tajikistan, dedicated TA supported a wide range of NGOs working with KPs for HIV and TB, directly engaging community representatives in Global Fund related outreach. This initiative ensured the participation of constituents who might otherwise have been excluded, such as people who inject drugs, including OST[41] patients, sex workers, men who have sex with men, and women living with HIV. Evidence from Global Fund related outreach in Cambodia and Ecuador showed civil society as the key driver of engagement with marginalized populations. Pre-country dialogue consultations organized by NGOs and CSOs provided a platform for underrepresented groups to participate meaningfully in the funding request processes. A national center demonstrated commitment to community engagement, actively involving TB People in various meetings. Country dialogues taking place in Ecuador for GC7 used peer educators to involve men who have sex with men and people living with HIV in shaping HIV grant proposals, leading to the integration of their specific needs, such as mobile HIV testing, peer education, and stigma reduction.

> *'Our NGO held two focus groups: one with PWID [people who inject drugs] and the other with PLHIV [people living with HIV], including women who were either contacts of PWID or widows of PWID who died of AIDS. Without this process PWID, especially those in the regions, would not have had a voice.'* (NGO representative, Tajikistan)

1.2.6 The decentralized approach to country dialogues was found to be a key factor in improving meaningful CE and ensuring that remote and hard-to-reach communities were better engaged. However, the success of these initiatives was mixed across countries and between different disease areas and it is noted that this approach requires high investment of resources. In six case study countries, a decentralized approach to engage KPs and CSOs in country dialogues was observed as a positive key factor. Regarding Global Fund related outreach in Zimbabwe for example, the approach was reported to be very effective in offering an opportunity to cater to the differing needs of different KP groups across different geographies, facilitating capacity building for communities and civil society, to improve their understanding of Global Fund processes and to support their participation, giving communities the space to shape and tailor their priorities in time to contribute them to Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria annex. Similarly, and as mentioned above, in Chad the consultation process was moved from the national to the community level, which significantly increased the breadth of CE and served to generate information that helped better identify and discuss how communities can address challenges. The number of meetings and workshops specifically focused on engaging KPs was increased noticeably, which provided KPs with more opportunities to voice their needs. Besides the successful negotiation for a community-led consortium as a sub-recipient, KPs reported an increase in their confidence in their ability to engage with the Global Fund as a direct outcome of these CE activities.

[41] OST is defined as the administration of a prescribed dosage of opioid medicines to patients with opioid dependence.

1.2.7 Despite these efforts, transgender people, adolescents, prisoners, forcibly displaced people, and those in rural communities still consistently face barriers to access and participation across different geographical and programmatic contexts. In a majority of countries, this still prevents them from becoming engaged. However, despite these efforts, challenges predictably remain in ensuring equitable representation and participation of all marginalized populations and KPs, with stakeholders noting limited involvement of NGOs, CSOs, key community representatives and KPs in the grant making stage, owing to a lack of timely information. Evidence indicates that certain groups including transgender people, adolescents within other KPs, prisoners, forcibly displaced people, people living with disabilities in rural communities, and sex workers often experience the poorest coverage across various settings. In half the countries (n=5), transgender people faced significant barriers to participating in CE activities, owing to a combination of challenging legal environment and regressive social norms around gender. Likewise, forcibly displaced people experienced challenges in engaging meaningfully. For example in CAR, forcibly displaced people are often overlooked, owing to inadequate information and engagement during the funding request process.

> *'One of the things that went wrong was the refugees. We weren't happy about that, because we intended to try to open a space for refugees, but we couldn't be due to lack of information (on required priorities). For a long time, there was an effort to collect this data, but the grant proposals were already finalized. So now we are a little more active, we are conducting some activities directly for the benefit of refugees, but this is indeed an area where there is something to be done […] In addition to this, there are many internally displaced people from the country, but who have had to move from one place to another. There are targets of internally displaced people for whom there would certainly be something to be done.' (CAR KII)*

1.2.8 A further barrier to effective reach and coverage is created by power imbalances between different community and KP groups. Communities and KPs with more experience of Global Fund processes and with stronger civil society representation tended to crowd out newer, more marginalized groups. Evidence from seven countries found that this issue reduced reach and coverage to some degree, with newer, smaller, less well-resourced civil society partners finding it harder to represent their constituents meaningfully. In two countries, for example, informants raised concerns about the lack of inclusivity, with the community organizations involved in GC6 dominating the process of preparing for CG7. These organizations primarily conducted the dialogue with their own constituents, leaving little room for other groups that were not included in the current grant or for community organizations not involved in implementing Global Fund grants. In one country for example, the limited number of active NGOs in the country created a tendency for grants to be awarded to the same organizations in successive cycles, creating a barrier to reaching a more diverse range of less established or geographically dispersed groups. In another country, informants noted that while community engagement in Global Fund processes was generally high, the dialogues were primarily shaped by a small number of well-established civil society organizations with longstanding involvement in Global Fund mechanisms, including two current PRs. While their technical experience and national reach were widely acknowledged as assets, several stakeholders reflected that this concentration of influence may have unintentionally limited the visibility and input of smaller, emerging groups—particularly those representing underrepresented or newer key population constituencies. Power imbalances in other contexts also arose from cultural norms around age and gender. This particularly affected adolescents and women. In two other countries, for example, adolescent

girls within KPs were present at funding request CE activities, but the space to participate was dominated by adults and men across communities and KPs.

1.2.9 Unsurprisingly, these issues with reach and coverage are exacerbated by contextual factors, including poor infrastructure and conflict. This increases the risk that a few centrally located representatives are the only community or KP members included in CE activities. Geography and poor infrastructure impact engagement in Global Fund related outreach in seven countries. For example in Chad, these groups face significant barriers to participation, owing to geographic isolation such as limited road access, making it incredibly difficult to reach communities outside the capital, hindering their consistent participation in the Global Fund grant process. This is particularly acute during the rainy season, when half of the country becomes inaccessible. Conflict also poses significant barriers in four countries. The ongoing war in Ukraine has profoundly impacted CE by disrupting access to services, causing displacement, and creating an environment where security concerns can overshadow participation in public spheres[42]. In CAR, security challenges meant that grant development stages were primarily held outside the country, in Douala, Cameroon, preventing the Global Fund CT from entering the country. This situation inherently limited the reach to communities on the ground within CAR, especially those in conflict-affected zones (e.g. forcibly displaced people). Similarly in Cameroon, underlying conflicts and misunderstandings, along with a fragmented health civil society, hinder effective engagement in regions affected by instability. Because of these constraints, the full inclusion of all affected communities was often not possible, necessitating reliance on a limited number of representatives, sometimes facilitated by partner organizations, to bring the perspectives of those in difficult-to-reach or conflict-ridden areas into the dialogue.

1.2.10 Poor reach and coverage of KPs and communities at the funding request stage is particularly significant. KPs or communities not included at the start of the grant cycle tend to remain excluded for the rest of the grant cycle. Communities who are successfully engaged during the funding request process have improved capacity to continue engaging. There was no evidence that CE activities outside the funding request stage brought in new constituencies or supported the inclusion of previously excluded groups. Any evidence of this occurring takes place in the funding request stage. Where funding request engagement is achieved, however, they are more likely to stay engaged.[43] In four countries, evidence showed that engagement during the funding request built capacity to participate in implementation. As a result of engaging in the funding request processes, and supported by the modular handbook, community representative organizations became implementers of explicit KP-related modules. In Ukraine, Ghana, Cameroon and Cambodia, this was as SRs or SSRs. For instance, in Ukraine, robust community participation shaped funding applications, helping to ensure they reflected community priorities. This also built their capacity for engaging in CE activities during implementation. This highlights the importance of early and meaningful engagement in the

[42] It should be noted that the war in Ukraine has in some respects rallied the communities together, for example to ensure uninterrupted provision of essential health services to KPs. Apart from the national grant, provision of long-term CE SI TA was reprogrammed to ensure that KPs have funds allocated to emergency humanitarian assistance, supporting continuity of ART and take-home OST across the country.

[43] As noted in the inclusion of FR CE as an activity in the Community engagement, linkages and coordination intervention in the CSS Module under RSSH.

funding request stage, underpinned by regular CS mapping, to foster the capacity for communities to take on implementing roles throughout the grant cycle.

4.2. EQ2: Why is the Global Fund observing different CE outcomes (across countries)?

2.1 What configuration of interventions, processes and approaches is implemented across sampled countries?

Across the sampled countries, the configuration of interventions, processes, and approaches to CE is most developed at the funding request stage, where strong coordination is required due to the complexity of interventions. The leadership of the CCM plays a critical role in ensuring effective engagement, with success depending on leadership style, available resources, and the inclusiveness of preparatory consultations. A key tool in this process is the Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria annex, which allows CSOs to document their priorities. However, the selection of priorities sometimes favors more experienced partners, limiting broader representation.

TA is a key intervention that strengthens CE by supporting weaker CSOs, fostering peer learning, and helping communities build an evidence base for their priorities. In most countries, TA has successfully mobilized KPs, particularly in restrictive environments, yet its development and allocation often exclude community input. Beyond the funding request stage, community involvement is primarily structured through oversight mechanisms, such as CSO representation in committees and CLM, which encourage long-term participation. However, there is little structured engagement in programmatic revisions, where CE interventions tend to be ad hoc and limited, despite the requirement for CCM endorsement, including from CSO representatives.

Despite efforts to enhance CE, challenges remain. The presence of civil society representatives in CCM roles who receive Global Fund funding can create perceptions of bias, and a lack of transparency in the grant-making stage undermines the legitimacy of CE efforts.[44] While oversight mechanisms help sustain engagement, the absence of a systematic approach to CE in programmatic revisions weakens community influence in decision-making. Overall, CE relies on strong leadership, inclusive processes, and well-implemented TA, but gaps in transparency and structured participation limit its full impact.

#	Findings
2.1.1	Across all countries and grant sizes, the largest Global Fund investment in CE takes place at the funding request stage. Because the funding request therefore has a more complex configuration of interventions, the CCM leadership is key to ensuring their coordination.

[44] As also noted in The Global Fund. Technical Review Panel Observations Report: Grant Cycle 7 Windows 1 and 2. October 2023. Available online at: https://www.theglobalfund.org/media/13448/trp_2023-observations_report_en.pdf

2.1.2	Meaningful CE at the funding request stage was dependent on the CCM leadership's approach, available resources, and the structure of the country dialogue process, particularly the inclusiveness of preparatory pre-dialogue consultations.
2.1.3	The Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria annex was universally flagged as a key document for CSOs and communities to detail their priorities and to inform the funding request. The process of prioritizing requests for inclusion was sometimes biased in favor of more experienced civil society partners.
2.1.4	In addition to a strong CCM leadership and effective use of the Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria annex, strong civil society partners drove meaningful CE in the funding request stage.
2.1.5	TA is another key pillar of meaningful engagement during the funding request stage. This took three main forms: supporting weaker or less experienced CSOs; supporting peer capacity building among partners; and providing support to develop an evidence base for community priorities. Across a majority of sampled countries (n=8), TA had a positive impact on supporting and mobilizing community and KP participation. In particular, this was a key intervention in contexts with repressed civic space.
2.1.6	There is also more limited evidence of civil society partners providing TA and capacity building support to less experienced CSOs and NGOs. This in turn supported the participation of newer, more marginalized groups to participate.
2.1.7	The final main use of TA was support to communities and KPs to develop an evidence base to support inclusion of their priorities in the final funding request. This supported communities to articulate their priorities and advocate for their inclusion in the Global Fund funding request process.
2.1.8	Communities were often not involved in the development and selection of TA, and in some cases, stakeholders expressed concerns about the appropriateness and allocation of this support.
2.1.9	Throughout the funding request stage, the involvement of civil society representatives in CCM roles who receive Global Fund funding can create perceptions of bias and favoritism. This is compounded by the lack of transparency in the grant making stage, which reduces the legitimacy and meaning of CE.
2.1.10	Community involvement in oversight is the principal approach taken to CE in the majority of countries (n=6). This is achieved through the inclusion of CSO representatives in the oversight committee and CLM initiatives. Communities and KPs involved in CLM are more likely to engage in subsequent grant cycles.
2.1.11	In contrast, evidence suggests that communities find it challenging to engage in programmatic revisions and interventions to involve them tend to be ad hoc, minimal or too late. This tendency reduces the degree to which communities are engaged at these key decision-making moments.

Table 4. Findings EQ 2.1

2.1.1 Across all countries and grant sizes, the largest Global Fund investment in CE takes place at the funding request stage. Because the funding request therefore has a more complex configuration of interventions, the CCM leadership is key to ensuring their coordination. As per ER 1, CCMs have the mandate of coordinating the development and submission of the funding request to the Global Fund. CCMs established development committees or task forces to champion this process. These task forces were supported by the CCM Secretaries and CCM executive, and they provided leadership, notably in terms of mobilizing TA and developing roadmaps to organize key events, including country dialogues contributing to the completion of the Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria annex. CCM leadership also provided for the representation of communities in funding request writing teams. Evidence showed that this took place across contexts.

2.1.2 Meaningful CE at the funding request stage was dependent on the CCM leadership's approach, available resources, and the structure of the country dialogue process, particularly the inclusiveness of preparatory pre-dialogue consultations. Where CCM leadership took an approach that prioritized and resourced in-depth country dialogue processes, CE was more meaningful. The most effective approach was when CCM leadership curated a careful series of orientation, capacity building and consultation events to prepare different communities and KPs for the final country dialogue meetings. This allowed for coverage of a more diverse range of participants and for a more meaningful process of contributing and selecting priorities for inclusion in the Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria annex. For instance in Zimbabwe, KPs had orientation and capacity building workshops covering Global Fund processes, followed by their own KP priority setting sessions with supporting evidence, before engaging in the CCM-organized country dialogue sessions at national and decentralized levels. They adopted this style based on training on developing an 'evidence-based priorities charter'. In contrast, in three countries who lacked sufficient resources and leadership, focus on in-depth preparation was limited. They attempted to achieve national coverage through single-day country dialogue sessions for HIV, TB, malaria and Community Systems Strengthening (CSS) in limited locations, owing to a lack of resources. This resulted in lists of priorities without adequate supporting evidence, which negatively affected their influence on the funding request. The risk of token representation also increased if

Box D. Spotlight on best practice: Global Fund related outreach in **Cambodia**

Global Fund related outreach in Cambodia is an example of incorporating pre-dialogue consultations to enhance community input during the funding request stage. Before the country dialogue, NGOs and CSOs facilitated pre-dialogue consultations, enabling underrepresented groups affected by HIV, malaria and TB to share their experiences and shape funding priorities. For instance, UNAIDS supported a HIV/AIDS committee in organizing a pre-country dialogue within CSOs and the HIV community to identify and agree on key asks and priorities for TB and HIV for the funding request. These pre-dialogue initiatives aimed to familiarize participants with the New Funding Model and the overall process of funding request development. KPs, such as men who have sex with men and transgender people in Cambodia, expressed challenges in gaining a good understanding of disease epidemiology, policy, strategy, programmatic issues and social matters, which could affect their full engagement in the country dialogue process. Additionally, a lack of necessary skills, including documentation, technology use, case story writing and advocacy skills, was identified as a barrier to prioritizing their issues.

community leaders participating in less structured dialogues did not fully understand the process or lacked adequate support for advocating community needs.

2.1.3 The Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria annex was universally flagged as a key document for CSOs and communities to detail their priorities and to inform the funding request. The process of prioritizing requests for inclusion was sometimes biased in favor of more experienced civil society partners. The use of community annexes for gathering community priorities during the funding request stage was explicitly mentioned in six countries and across different contexts. The annex was seen as a valuable tool, making the funding request stage more inclusive and ensuring that communities could formally record their priorities. Despite the annex typically not containing costing or expected outcomes, and despite standard modules and interventions being described in narrative format not aligned to the Modular Framework or consistently costed, one interviewee in Ukraine described the annex as a 'structured and effective document'. Stakeholders in Ukraine recognized the annex application as an effective tool for future grant planning. During the development of the annex, all community organizations participated in working groups and were given the opportunity to convey their priorities and needs, including during the grant application process. Likewise in Tajikistan, 151 community and NGO representatives participated in focus groups and meetings to draw up and agree on the final list of 20 community priorities to be included in the annex. However, concerns were raised that the Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria annex was often presented as an overly ambitious wish list, dominated by the priorities of the strongest community organizations. In the case of one country, it was reported that several community groups were unsuccessful their advocacy for their candidate as PR as some other communities chose to support the government to gain the government's favor. This resulted from power imbalances between communities and KPs, as discussed above.

2.1.4 In addition to a strong CCM leadership and effective use of the Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria annex, strong civil society partners drove meaningful CE in the funding request stage. In three countries with strong civil society, partners were key to effective funding request stage engagement. In Cambodia, Ghana and Ukraine, civil society partners with strong technical and programmatic leadership were able to ensure that their constituents were included effectively in the country dialogue, and therefore in the final funding request. Countries with strong civil society partners demonstrated several positive outcomes. In Cambodia, pre-dialogue consultations organized by NGOs and CSOs provided a platform for underrepresented groups to participate and contribute to funding request processes. The Cambodia CCM made efforts to address feedback provided by the Technical Review Panel effectively.[45] In Ghana, CCM members engaged in country dialogue consultations informed the consolidation and prioritization of their respective priorities for the three diseases alongside community systems strengthening. This led to the partial inclusion of civil society and communities' priorities into funding requests and improved programming and implementation arrangements for communities, notably KPs. Global Fund related outreach in Ukraine similarly had a clear system where communities are clearly involved in policymaking

[45] Feedback was provided in the October 2023 Observations Report.

and decision making, making them visible politically, programmatically and socially to the government and international partners.

2.1.5 TA is another key pillar of meaningful engagement during the funding request stage. This took three main forms: supporting weaker or less experienced CSOs; supporting peer capacity building among partners; and providing support to develop an evidence base for community priorities.

Across a majority of sampled countries (n=8), TA had a positive impact on supporting and mobilizing community and KP participation. In particular, this was a key intervention in contexts with repressed civic space. All countries had access to TA through the CCM Hub. The CE SI, UNAIDS, among other TA providers, were able to access TA. This was particularly important in contexts of repressed civic space, because strong civil society partners were not able to drive meaningful CE. In Tajikistan, Chad and CAR for example, this helped ensure that some KPs who would not otherwise have been included in Global Fund related outreach were able to participate (e.g. women who use drugs). In Tajikistan, CCM Hub TA involved constituents who would not otherwise have been part of the process, partially addressing the gaps created by less developed CS partners, although meaningful CE was not ensured during the finalization of the country funding request. In Chad, partners such as UNAIDS played a crucial role in advocating for the continued presence of civil society throughout the process, which likely facilitated their meaningful participation. In CAR, UNAIDS played a crucial role in supporting a KP CSO umbrella platform, enabling it to coordinate and engage effectively in Global Fund processes. UNAIDS They provided TA and capacity building to enhance PCOS's understanding of Global Fund procedures, strengthened coordination among member organizations, and supported advocacy for the needs of communities and KPs.

2.1.6 There is also more limited evidence of civil society partners providing TA and capacity building support to less experienced CSOs and NGOs. This in turn supported the participation of newer, more marginalized groups to participate. Three countries offer useful examples of this kind of peer learning. In Cameroon, civil society created a 'Community Volunteer Expert' role, where more experienced individuals supported the broader civil society delegation in the grant development process. In Chad, platforms for dialogue and task forces were established to coordinate and share information among civil society actors. In Zimbabwe, a partner organization provided dedicated funding for more experienced KPs and their CSOs (men who have sex with men, sex workers and LGBTQ+ groups) to hold capacity building workshops on Global Fund processes for the transgender, people who use drugs and adolescent KPs and communities. Additionally, another organization dedicated resources to support civil society and community representatives' participation during the various writing residential workshops for the funding request. This enabled these newer groups to meaningfully engage and articulate themselves in various forums during the funding request development process.

2.1.7 The final main use of TA was support to communities and KPs to develop an evidence base to support inclusion of their priorities in the final funding request. This supported communities to articulate their priorities and advocate for their inclusion in the Global Fund funding request process. TA from various partners , including UNAIDS and the Global Fund, and specific initiatives such as CRG and the CE SI were utilized to support communities and KPs. This TA was focused on supporting communities and KPs to understand how best to prioritize requests for inclusion in the Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria annex, how to articulate them effectively, and how to substantiate them with relevant evidence. Evidence from four countries showed that this improved the quality of community submissions to the funding request process. In CAR, TA provided by UNICEF, UNAIDS and another partner allowed communities to participate in the writing process. In Tajikistan and Ukraine, interviewees reported that TA encouraged more effective advocacy and communication of KP requests. In Zimbabwe, TA was used within Global Fund related outreach to train women living with HIV to conduct their own research. This allowed them to generate documentary evidence to support advocacy of their priorities in the funding request.

> *'The [women living with HIV-led] research generated documentary evidence that is useful evidence to support advocacy of priorities in the funding request and during grant making. Lack of documentary evidence is the greatest disadvantage of communities because they tend to base their priorities on hearsay whilst government and public sector base it on evidence. So this is a step in the right direction.' (Key informant, Zimbabwe)*

2.1.8 Communities were often not involved in the development and selection of TA, and in some cases stakeholders expressed concerns about the appropriateness and allocation of this support. Although TA was a significant component of the funding request stage and was generally viewed as beneficial for capacity building and enabling community participation, there were some issues as to its relevance. Evidence showed that this was caused by the lack of community input in its design. In three countries, this was reported to affect the quality of support offered, with a risk of communities becoming disengaged. Respondents engaged in Global Fund related outreach in Zimbabwe, for example, noted the lack of involvement of CSOs and communities in the development of the Terms of Reference for TA and the related selection of consultants. This lack of involvement adversely affected the quality of TA selected to support them during the dialogue and funding request development process.

2.1.9 Throughout the funding request stage, the involvement of civil society representatives in CCM roles who receive Global Fund funding can create perceptions of bias and favoritism. This is compounded by the lack of transparency in the grant making stage, which reduces the legitimacy and meaning of CE. Interviewees from six countries cited issues around the legitimacy of decision making. In four countries, this related to the PR wielding disproportionate influence over selection of priorities where they occupied a powerful CCM position, such as chair. They felt that PRs, and other civil society representatives receiving funding, sometimes placed the interests of their organization over those of the community of KPs they were representing. In two countries, although a clear multistakeholder process took place, some decisions were made by smaller, less transparent teams within the CCM, limiting the degree of scrutiny and CE. As discussed in EQ1.1 above, there are no clear processes for involving communities in grant making, often leaving them uninformed about which priorities from the Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria annex were funded and why. This can erode trust in Global Fund processes and can negatively impact engagement.

> *'People and organizations are represented, including those who then become sub-recipients. We involve communities, but they expect to receive grants. And when people have these two roles, they behave differently. It's one thing to get funding for what the community really needs, and another thing to maintain your organization, pay your employees, etc.' (Interviewee, Ukraine)*

2.1.10 Community involvement in oversight is the principal approach taken to CE in the majority of countries (n=6). This is achieved through the inclusion of CSO representatives in the oversight committee and CLM initiatives. Communities and KPs involved in CLM are more likely to engage in subsequent grant cycles. Evidence showed good practice in engaging through oversight and CLM in six countries. This engagement builds understanding and knowledge of Global Fund processes, and develops capacity for advocating and articulating priorities. Evidence across countries showed that communities and KPs involved in implementation of GC6 were then better able to engage in GC7. In Chad, Cameroon and Indonesia for example, communities participated

Box E. Spotlight on programmatic revisions: Ghana

Within Global Fund related outreach in Ghana, programmatic revisions were used to redress both gaps in the original funding request, and to adapt to evolving community and KP needs.

After the grant making stage in GC7, it became clear that some TB CSO and community interventions and activities either lacked sufficient funding, or had not been allocated any funds. After review of these interventions, it was determined that these were key interventions for TB-affected communities. The revision ensured funding for interventions including active case finding activities (ACF), monitoring and supportive supervision, refresher training for community cadres and review meetings for validation of data and information for all 15 demonstrative regions.

Another programmatic revision related to the repurposing of funds badged for C19RM. A national program was the key driver of this change. It enabled community distribution of HIV self-test kits. Future revisions continue to be considered under GC 7, reallocating budget for resilient and sustainable systems for health (RSSH) interventions, which to date has a low absorption rate to make more funds available for CSS and HIV interventions.

in oversight through the inclusion of CSO representatives in oversight committees and CLM initiatives. In Chad and Cameroon, CLM reports were included in the documentation reviewed by the oversight committee. The malaria component of the CCM in Cameroon has established an organization that collects, analyses and distributes information to CCM commissioners, PRs and SR, ensuring civil society's genuine involvement. In Indonesia, KPs are reported to be well represented at the CCM during the oversight of implementation, with initiatives such as CLM playing a critical role in adapting implementation. The CCM in Indonesia, which includes community representatives, conducts regular field oversight visits. KPs such as men who have sex with men, transgender individuals, sex workers and people living with HIV actively engage through their involvement in the Ecuadorian CCM, influencing HIV program planning, implementation and evaluation. In CAR, KPs and people affected by diseases are included in the Oversight Committee, although logistical barriers can limit broader engagement. In Zimbabwe, CSOs and communities are represented in relevant TWGs in areas such as KPs, prevention, and CLM, particularly within the HIV sector.

2.1.11 In contrast, evidence suggests that communities find it challenging to engage in programmatic revisions and interventions to involve them tend to be ad hoc, minimal or too late. This tendency reduces the degree to which communities are engaged at these key decision making moments. Reports from community groups located in Cameroon, Ecuador, and Ghana, for example, highlighted that when programmatic revisions are proposed there is not clear opportunity for CSOs and communities to meaningfully participate. CE was limited to responding to revisions that are presented to the oversight committees and CCMs for review and endorsement. However, these revisions are often presented by the PRs very late and this as reported to result in the fact that community groups have little room for input in to these proposals which nevertheless endorsed. Global Fund related outreach in Zimbabwe offered a rare positive example of engagement during programmatic revisions where the transgender community successfully engaged with the Key Populations Technical Group to advocate for, and gain, expanded funding under GC7.

2.2 What key adaptations occur in sampled countries, and why?

The key adaptations observed during the evaluation fell into three categories: adaptations made to mitigate contextual challenges; adaptations made as a result of identifying capacity gaps; and adaptations made to respond to the COVID-19 pandemic. The case studies in this evaluation highlight how countries have adopted diverse and innovative approaches to overcome external challenges that could hinder meaningful CE. For instance, Global Fund related outreach in Chad and Ukraine navigated conflict-related disruptions by leveraging partner support and maintaining flexibility in program adjustments. To address the challenge of physical remoteness and stigma, Global Fund related outreach in Ecuador embraced digital tools such as WhatsApp and Zoom to engage marginalized groups, while in Indonesia governance was decentralized to empower local decision-making and boost community participation. Global Fund related outreach in other countries, like Cambodia and Zimbabwe, focused on strengthening the capacity of communities and partners to better reach underserved populations. Additionally, many countries adapted their service delivery models during the COVID-19 pandemic, demonstrating agility and responsiveness at the implementation level.

#	Findings
2.2.1	Global Fund related outreach in Chad and Ukraine offer differing examples of successful responses to COEs, relying on support from partners and on flexibility and agility in programmatic revisions.
2.2.2	Global Fund related outreach in Ecuador and Indonesia adopted different approaches to the challenges posed by physical remoteness of some communities and KPs, adapting their processes to use digital tools (Ecuador) or a more devolved system of decision making (Indonesia).
2.2.3	The use of technologies by Global Fund related outreach in Ecuador, such as WhatsApp, Zoom and online forums, also encouraged the participation of groups that often remain hidden for fear of stigma and persecution.
2.2.4	The decentralization of governance by Global Fund related outreach in Indonesia empowered local communities, fostering greater inclusivity and strengthening their participation in decision-making processes. This adaptation has proven effective in creating a more enabling environment for CE.
2.2.5	The next category of adaptation arose from identifying and responding to capacity needs among communities, KPs and partners. This supported engagement of some of the harder-to-reach communities and KPs in Global Fund related outreach in Cambodia and Zimbabwe.
2.2.6	The final category of adaptations observed was service delivery-oriented during the implementation stage of the COVID-19 pandemic; these adaptations were evident in a majority of countries.

Table 5. Findings EQ 2.2

2.2.1 Global Fund related outreach in Chad and Ukraine offer differing examples of successful responses to COEs, relying on support from partners and on flexibility and agility in programmatic revisions. In Chad, where civic space is highly repressed, influential INGOs and multilaterals (e.g. UNAIDS) were able to advocate with the government for the involvement of national CSOs in the funding request process. These influential actors leveraged their relationships with the Chadian government to safeguard CSO engagement with KPs despite initial resistance. This allowed space for the same organizations to provide TA to community organizations. National CSOs and community organizations then created safe spaces for dialogue and decision making with their respective constituencies, enabling their inclusion. Although this did not fully overcome the significant contextual challenges faced in Chad, this approach still fostered meaningful engagement in this conflict-affected, resource-scarce environment. In Ukraine, the Global Fund and partners took a flexible approach to CE activities, combining them with humanitarian interventions in response to the volatile situation. The team made use of the programmatic revisions process to achieve this, reallocating funds and mobilizing new resources to address

> *'We really appreciate the fact that Global Fund, despite all the rigor and strict policies and procedures, was open to it and understanding. Flexibility is important, flexibility and really open-mindedness – these helped saving a lot of lives back then. We did struggle, of course, with reporting and we did have to even return some of the funds used back then, but to [a] large extent those efforts were supported.'* (Key informant, Ukraine)

emerging humanitarian needs, while seeking to center community participation within all new interventions. This adaptable approach helped ensure the continuation of the funding request process and sustained service delivery even amid the ongoing war. The Global Fund's openness and understanding of the challenging context were crucial in allowing for necessary adjustments to programs.

2.2.2 Global Fund related outreach in Ecuador and Indonesia adopted different approaches to the challenges posed by physical remoteness of some communities and KPs, adapting their processes to use digital tools (Ecuador) or a more devolved system of decision making (Indonesia). Global Fund related outreach in Ecuador utilized digital platforms such as WhatsApp groups and online surveys to sound out and facilitate broader participation from communities and KPs in hard-to-reach areas, which also partially addresses the risks associated with widespread violence, and during the C19RM period. These digital mechanisms proved instrumental in reducing logistical barriers that often prevented the engagement of individuals, such as Indigenous populations, who might otherwise be excluded from crucial dialogues. People living with HIV in remote areas utilized these platforms to voice their concerns regarding treatment accessibility and adherence. During the preparation of Ecuador's GC7, these participatory digital tools were key in amplifying community voices and fostering dialogue, ultimately identifying specific healthcare priorities such as the need for mobile HIV testing and stigma-reduction training. Because of the decentralized governance by Global Fund related outreach in Indonesia, where local governments have considerable autonomy and diverse capacities, engaging all CSOs across the country is challenging. Moreover, There are wide disparities of resources and CSO's capacities across the country, where CSOs in the eastern part of Indonesia (particularly in Papua) is less advanced in resources due to the geographic and infrastructures challenges. Nevertheless, by leveraging technologies (Zoom or WhatsApp) some CSOs (although only a few) in the remote areas can be involved in the funding request or grant making process.

2.2.3 The use of technologies by Global Fund related outreach in Ecuador, such as WhatsApp, Zoom and online forums, also encouraged the participation of groups that often remain hidden for fear of stigma and persecution. By driving the country dialogues through community-based organizations (CBOs) and peer educators, men who have sex with men and people living with HIV were actively involved in the needs prioritization process of Global Fund related outreach in Ecuador. The evaluation team identified that engagement of sex workers and transgender women was limited, owing to gender norms, stigma, and logistical challenges. Drug users were also not consulted as a stand-alone group during the country dialogues, which is a direct result of them not being a prioritized group under the current grant. However, some representatives of other KP groups in the CCM also identify as drug users. During the COVID-19 lockdowns, Global Fund related outreach in Ecuador conducted country dialogues virtually, ensuring that civil society representatives from KPs such as transgender women and sex workers could continue to contribute to decision-making processes by voicing their concerns. Relying on digital tools did create other barriers to participation, however, linked to inequitable Internet access.

2.2.4 The decentralization of governance by Global Fund related outreach in Indonesia empowered local communities, fostering greater inclusivity and strengthening their participation in decision-making processes. This adaptation has proven effective in creating a more enabling environment for CE. In Indonesia, the Global Fund and partners were able to capitalize on the increasing autonomy of local governments. They have worked with these key local government actors to support CE interventions at the local level. In regions such as Bali Province, with stronger commitment and resources toward HIV control, local governments have taken the SR role and have worked with other Global Fund partners to implement key initiatives in integrating CE into their own health plans and activities. Furthermore, the decentralization fostered increased community participation in decision making through mechanisms such as the Deliberation Development Planning (Musrenbang), which actively encourages citizen input at various levels of governance. To further enhance inclusivity, CCM Indonesia established TWGs and sub-working groups (SWGs) to engage a broader range of communities and KPs beyond the official CCM membership, allowing for more inclusive implementation oversight activities and joint field visits. The CCM also made targeted outreach efforts to smaller CSOs in eastern Indonesia, ensuring that voices from remote areas were incorporated into the decision-making processes, reflecting a commitment to equitable distribution of representation. Despite all the efforts, some parts of eastern Indonesia, particularly in Papua or island around Maluku, continue to face significant challenges/barriers in accessing health care/public service. These challenges stem from a geographic, infrastructure or limited resources that disproportionately affect remote and island communities. Consequently, engaging communities or CSO in these areas are still a challenge.

2.2.5 The next category of adaptation arose from identifying and responding to capacity needs among communities, KPs and partners. This supported engagement of some of the harder-to-reach communities and KPs in Global Fund related outreach in Cambodia and Zimbabwe. In both countries this involved adapting the preparation for the funding request preparation process to support with developing and articulating community priorities. For example, HIV KPs in Zimbabwe engaged in pre-funding request development capacity building and in internal KP priority setting and collation of supporting evidence in readiness for the CCM-led country dialogue, consolidation and prioritization sessions. The TA consultants who worked on the TB National Strategic Plan (NSP) review and the development of the CRG Action also supported the TB community in drafting the TB section of the funding request, thus ensuring consistency in the priorities identified into the final funding request. Additional efforts were made by Global Fund related outreach in Cambodia to understand and respond to gendered barriers to CE for women with TB through a CRG assessment. In Ghana, representatives of marginalized communities were intentionally engaged in Global Fund activities before the funding request stage began. This additional engagement and capacity building led to better engagement of some of the most stigmatized HIV KPs: young men who have sex with men, sex workers, transgender people and people who use drugs.

2.2.6 The final category of adaptations observed was service delivery-oriented during the implementation stage of the COVID-19 pandemic; these adaptations were evident in a majority of countries. The pandemic and other contextual factors created space for communities to become more involved in-service delivery through task shifting, and there was a greater reliance on

community health workers (CHWs) and local leaders in, for example, changes in existing arrangements to distribute insecticide-treated nets (ITNs). Additionally, the involvement of the HIV KP peer educators ensured continued access to services and HIV prevention commodities throughout the shutdown period.

2.3 What contextual factors affected CE in sampled countries? How and how far do key contextual factors affect meaningful CE?

The evidence demonstrated that contextual factors have a clear impact on CE in the sampled countries, influencing the effectiveness of CE efforts. Meaningful CE was still achieved in countries facing significant barriers. A regionalized (in-country) approach to CE, where decentralizing governance and decision-making supported engagement, proved effective despite geographical and infrastructural difficulties. However, in some cases, contextual challenges were too severe for decentralization to be an effective strategy. Another key mechanism observed was adaptive implementation, with the Global Fund and partners employing flexibility to address specific contextual barriers. In some challenging contexts, the Global Fund's Additional Safeguard Policy – while in place to safeguard against different risks – limited adaptive implementation by imposing administrative burdens that restricted flexibility. TA and capacity building were also effective in addressing constraints faced by CSOs due to restricted civic space. Additionally, TA and capacity building played a role in mitigating stigma-related challenges for marginalized KPs and supporting their inclusion in CE processes. However, stigma and entrenched social norms remain difficult to change, particularly where legal frameworks reinforce discriminatory attitudes. The final mechanism identified for addressing contextual challenges was leveraging networks of influential stakeholders, which proved effective in overcoming certain barriers to CE.

#	Findings
2.3.1	The evidence showed that the contextual factors cited as influential in the literature on CE had an observable effect in the sampled countries.
2.3.2	Despite these challenges, there are examples of meaningful CE achieved in contexts negatively affected by all these factors.
2.3.3	Six countries took a regionalized (in-country) approach to CE. Decentralizing decision making and governance supported engagement despite challenging geography and/or poor infrastructure.
2.3.4	Some countries or communities, however, face contextual challenges too significant for this mechanism to be effective. Evidence for this came from three countries.
2.3.5	The second mechanism observed in the evidence related to adaptive implementation. In four countries, the Global Fund and partners took a flexible approach to adapting CE activities in order to address contextual challenges.
2.3.6	In some more challenging contexts, however, Global Fund structures can limit a country's ability to work in an adaptive way, since they are subject to the Additional Safeguard Policy. The added administrative burdens restricted the use of adaptive implementation as a mechanism.

2.3.7	TA and capacity building form the third effective mechanism for addressing contextual challenge, serving to bolster CSOs limited by repressed civic space (n=3).
2.3.8	TA and capacity building were also used to mitigate the impacts of stigma on some marginalized KPs (n=9) and support their inclusion (n=10).
2.3.9	It should be noted that as per the literature, stigma and social norms are notoriously persistent and hard to address, particularly where the legal environment reinforces harmful norms.
2.3.10	The final key mechanism identified for addressing contextual challenges is drawing on a network of influential stakeholders. This has been effective in two countries facing significant contextual challenges.

Table 6. Findings EQ 2.3

2.3.1 The evidence showed that the contextual factors cited as influential in the literature on CE had an observable effect in the sampled countries. Conflict and insecurity affected four countries; physical geography and infrastructure posed significant challenges in six. The degree of civic space and the strength of civil society impacted all countries, as did sociocultural norms, particularly around gender and sexuality. These factors affected CE throughout the grant cycle; there was not an observable difference between the different stages.

2.3.2 Despite these challenges, there are examples of meaningful CE achieved in contexts negatively affected by all these factors. The analysis discusses the mechanisms identified which can mitigate the challenges created by contextual factors, enabling more meaningful engagement. These include: taking a regionalized (in-country) approach; adaptive implementation; capacity building and TA; and networks of influential stakeholders.

2.3.3 Six countries took a regionalized (in-country) approach to CE. Decentralizing decision making and governance supported engagement despite challenging geography and/or poor infrastructure. Devolving governance and focusing CE activities at community level enabled some engagement to take place in Global Fund related outreach in Cameroon, Indonesia and Chad, helping to mitigate the difficulties posed both by the vast terrain and, in Chad, by security and infrastructure challenges. In Zimbabwe, Chad and Tajikistan, this also supported inclusion of more marginalized groups facing stigma and/or criminalization. Devolving activities to the community level helped ensure that activities such as pre-funding request consultations were tailored to their needs and took place in safe, familiar spaces.

2.3.4 Some countries or communities, however, face contextual challenges too significant for this mechanism to be effective. Evidence for this came from three countries. The security situation in CAR was too volatile for grant making to take place within the country at all, making CE almost impossible during this stage. Similarly, faced with wartime constraints and limited access to physical spaces, Ukrainian stakeholders adopted a range of virtual engagement mechanisms—

including a platform, CLM digital tools, and remote consultations—to ensure sustained participation of community groups throughout the grant cycle.

In Chad, despite concerted efforts from the Global Fund and partners, infrastructure prevented inclusion of more remote communities and KPs, particularly during the rainy season. This had a particular impact on forcibly displaced communities, and on people with disabilities. As one KI reported:

> *'There has been much attention paid to community engagement development specifically by the Global Fund and its broad successes. My major concern, because they have been developing something that seems to be working. […] I have seen that almost all communities are developing a CLM mechanism. I mean, it's impressive and at the same time due to the context, to the actual context, it's highly uncertain that it will be able to function or to keep functioning'.*

2.3.5 The second mechanism observed in the evidence related to adaptive implementation. In four countries, the Global Fund and partners took a flexible approach to adapting CE activities in order to address contextual challenges. Four countries pivoted to working through CHWs and networks of peer educators during the COVID-19 lockdowns, enabling CE activities to continue. Combining CE with humanitarian response activities similarly enabled some continued engagement within Global Fund related outreach in Ukraine, even in very challenging situations. A different expression of the willingness to flex and adapt was observed within Global Fund related outreach in Ecuador, where the team developed new approaches to engagement, utilizing networks of peer educators to support virtual country dialogues. This mitigated some of the barriers posed by the country's physical geography.

2.3.6 In some more challenging contexts, however, Global Fund structures can limit a country's ability to work in an adaptive way, since they are subject to the Additional Safeguard Policy. The added administrative burdens restricted the use of adaptive implementation as a mechanism. In Zimbabwe, the programmatic and funds flow mechanism under C19RM and GC6 for KPs was reported to be United Nations Development Program (UNDP)– United Nations Population Fund (UNFPA)– a national committee – KPs , and for TB communities UNDP–TB Program–TB SR. This long loop, mandated by the Additional Safeguard Policy (ASP), coupled with administrative and logistical delays, was reported to contribute to delays in implementing CE. While it is clear that the ASP is a necessary risk management tool, it does restrict flexibility. The challenge has since been discussed by all national level stakeholders and the Global Fund, and the flow for KPs is now UNDP– a national committee –KPs as SSRs, with the country (through the CCM) advised to prepare to have a CS PR under dual track financing under GC8.

2.3.7 TA and capacity building form the third effective mechanism for addressing contextual challenge, serving to bolster CSOs limited by repressed civic space (n=3). TA regarding Global Fund related outreach in Chad, CAR and Tajikistan was employed to address capacity gaps in civil society partners operating under repressive political and legislative regimes. In Chad and Tajikistan, this involved supporting local CSOs and NGOs with funding to carry out CE activities, and in CAR it took the form of supporting with administrative and logistical work, such as preparing budgets. In all three cases, this widened the range of civil society partners involved and supported the inclusion of their constituencies.

2.3.8 TA and capacity building were also used to mitigate the impacts of stigma on some marginalized KPs (n=9) and support their inclusion (n=10). In all countries, social stigma and fear of violence affects KPs, including sex workers, people who use drugs, men who have sex with men, and LGBTQ+ community members. It is one of the barriers to engaging with people who use drugs. Three countries showed examples of using capacity building to support some degree of participation. In Ukraine and Zimbabwe, organizations representing people who use drugs received TA to represent their constituencies more effectively. In Ecuador, peer educators worked with men who have sex with men and people living with HIV to support their capacity to engage in Global Fund activities in culturally appropriate ways, sensitive to the ways in which stigma affects them. In Cambodia, it was noted that women from communities and KPs were not sufficiently involved in country dialogues. Gender sensitivity training was therefore used to raise awareness of this issue with civil society partners, with the aim of improving ongoing engagement with women.

2.3.9 It should be noted that as per the literature, stigma and social norms are notoriously persistent and hard to address, particularly where the legal environment reinforces harmful norms. Examples from Global Fund related outreach in five countries show that despite efforts of the kind described above, stigma and social norms still acted to prevent engagement with some KPs. Adolescents, particularly those living with HIV, were not well engaged in four of the sampled countries, with social stigmas cited as a key factor in their exclusion. In Cambodia, young people hide their HIV status, owing to concerns about finding a life partner and fear of discrimination, with some even wanting to abort babies if they are HIV-positive. In Chad, despite efforts to engage young people, their visibility creates discomfort, owing to prevailing discriminatory attitudes. Similarly in Tajikistan, adolescents, including those living with HIV, did not participate in dialogues. In Indonesia, young people from all KPs were less engaged. The same applies to sex workers and transgender people in a majority of countries (four out of five for both sex workers and transgender people). In Cambodia, factory workers with HIV hide their status to avoid taking time off for treatment, and villagers discriminate against sellers with HIV. Transgender individuals and female sex workers in Cambodia are hard to reach regarding Global Fund related outreach, sometimes facing stigma and discrimination. In Chad, sex workers face societal stigma, and transgender individuals were not specifically targeted in CE activities. In Tajikistan, sex workers face administrative penalties and high levels of stigma, hindering their participation. Transgender people in Tajikistan face significant challenges, lack official recognition, and could not speak openly in meetings due to stigma. In Ecuador, sex workers face high levels of stigmatization, making them a difficult group to connect with, and transgender women encountered significant barriers to participation in dialogues, owing to stigma. For example, some respondents flagged a violent incident during the interviews of a transgender women experiencing targeted police violence in her home. The respondents linked this incident directly with the woman's involvement in community engagement activities which increased her public visibility as a transgender woman. Similarly, multiple key informants reported that they face stigma and customers avoiding them when their HIV diagnosis becomes known. This not only reported by sex workers but also by women who live with HIV and have varying jobs. In Indonesia, while the 2024 stigma index showed a decline in stigma key populations still avoid accessing HIV services because of many forms of stigma, including self-stigma. According to

UNAIDS, for example female sex workers are not comfortable reaching out to health facilities because of afraid of being judged, mainly in more conservative districts/provinces while MDR TB patients often face discrimination at work, for instance many cases of they were unfairly dismissed from their jobs. In CAR, CSOs working with men who have sex with men and sex workers face legal challenges and societal stigma. While transgender communities were represented in Global Fund related outreach in Ukraine and participated in country dialogue and technical committees, interviews revealed that stigma, especially from medical professionals and public institutions, continued to hinder broader community engagement and service uptake. Similarly, regarding Global Fund related outreach in Zimbabwe, stigma and discrimination toward KPs influenced their access to services, especially in rural areas.

2.3.10 The final key mechanism identified for addressing contextual challenges is drawing on a network of influential stakeholders. This has been effective in two countries facing significant contextual challenges. In Chad and Zimbabwe, the Global Fund and its partners have cultivated effective working relationships with relevant ministries and government agencies, working within an otherwise challenging political context to demonstrate the utility and urgency of the Global Fund's work. In Chad, this has enabled them to continue working through civil society partners in a context where civic space is heavily repressed. In Zimbabwe, this has helped ensure some continuation of CE activities with groups at risk of criminalization, such as men who have sex with men and sex workers.

5. Conclusions

The ET has drafted nine conclusions, drawn from the findings articulated in the section 3.1. For each conclusion the ET provides a headline statement and then supporting text. Specific examples (drawn from case studies conducted under this evaluation) are referenced. Full descriptions of these examples are provided in the findings section.

Conclusion 1: Investing resources and time in targeted mechanisms that maximize opportunities to engage communities in the funding request stage can be a highly effective way of increasing meaningful CE across the disease areas and in subsequent grant cycles.

Strength of evidence[46]

			Strong

Front-loading efforts to engage communities with targeted, well-planned and well-resourced outreach, going beyond the running of isolated community dialogue events, were shown to deliver high levels of reported meaningful CE across the countries studied (including those affected by challenging contextual factors) and across disease areas. Initiatives to engage communities in the pre-dialogue stage (such as TB community representative outreach in Cambodia, or the sponsoring of pre-dialogue activities for Global Fund related outreach in Chad and preparatory orientation, and prioritization workshops for HIV KPs in Zimbabwe) were particularly well recognized as promoting and facilitating meaningful CE, including with some groups previously not engaged. Initiatives that tailored outreach to different groups within KPs and communities and, for example, deployed people with detailed contextual understanding of these groups (such as peer educators in Ecuador and the Pre-Country Joint TB HIV Dialogue in Cambodia) or ensuring that consultations were undertaken in contexts where participants felt safe (such as youth and women groups in Chad moving around the country to conduct dialogues directly with communities in their own spaces) were also very effective in fostering trust and engagement within KPs. This facilitated their meaningful engagement. Mechanisms to decentralize dialogues to the regional and district levels were also well recognized to increase engagement, and where this happened (e.g., as part of Global Fund related outreach in Chad, Zimbabwe, Cambodia and Indonesia) the quality of engagement and insights generated from this engagement was very high, offering an opportunity to cater to the differing needs of different KP groups across different geographies, facilitating capacity building for communities and civil society, to improve their understanding of Global Fund processes, and to support their participation giving communities the space to shape and tailor their priorities in time to contribute them to the Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria annex. The ET found numerous examples of innovation and adaptation strategies in these outreach efforts across the countries studied, including encouraging virtual engagement through online platforms and social media (e.g., Global Fund related outreach in Ecuador, Chad and Tajikistan).

[46] See section 2.6

Conversely, in countries where insufficient resources were invested in in-depth planning and preparation during the funding request, levels of meaningful CE were, not surprisingly, far more limited. Attempts to achieve national coverage through single-day country dialogue sessions for HIV, TB, malaria, and CSS in limited locations resulted in lists of priorities without adequate supporting evidence, which negatively affected their influence on the funding request (e.g., regarding Global Fund related outreach in Cameroon, Chad). The risk of token representation also increased if the community leaders that participated in these less structured dialogues did not fully understand the process or lacked adequate support for advocating community needs. For example, in Ghana, the country dialogue consultations were led by CCM members from civil society and communities, and the TA was only available during the prioritization, consolidation and the development of the Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria annex. These sessions were held without adequate pre-planning, resulting in the majority of participants attending without prior review of relevant documentation or consensus on their sub-community priorities. Consequently, many priorities were deprioritized, with only a limited few making it into the integrated priorities charter.

Conclusion 2: The existence of strong engaged and proactive civil society, the presence of a balanced and deliberate CCM, and the targeted provision of TA to support front loading engagement mechanisms such as those described above, were the three key drivers of meaningful CE, particularly for the most marginalized populations.

Strength of evidence

			Strong

Strong civil society partners with technical and programmatic leadership were essential for effective funding request engagement and inclusive country dialogues. Countries with active civil society participation saw better representation of community priorities, improved programming, and stronger implementation arrangements. In Cambodia, NGOs and CSOs organized pre-dialogue consultations, amplifying underrepresented voices and influencing funding requests. In Ghana, country dialogue consultations helped consolidate and prioritize community needs, leading to partial inclusion of civil society priorities and improved programming for key populations. Regarding Global Fund related outreach in Ukraine, a clear engagement structure ensured that communities were actively involved in policymaking and decision-making, boosting their visibility to both the government and international partners. Conversely, where CSO was weak (e.g., for malaria in many countries) or was facing constrained civic space (Tajikistan), reported levels of meaningful CE were, not surprisingly, significantly lower, and resultant ownership and engagement in the grant process amongst communities were also reduced.

An effective CCM was a key driver of meaningful engagement when CCM leadership prioritized an inclusive, well-prepared country dialogue process. Best practice drew on in-depth knowledge of the complexities and diverse needs of affected communities and KPs, and of the contextual challenges and constraints. This knowledge was then used to manage country dialogues in an adaptive way to meet needs and address challenges, even in very difficult or volatile situations. In Cambodia and Tajikistan, leadership curated a series of pre-funding request dialogue and

consultations, catering to the needs of different disease-affected communities and KPs, and adjusted their process to adapt to challenges. Without clear leadership planning, the process became truncated, and meaningful engagement reduced, such as in examples of Global Fund related outreach in Cameroon, and Zimbabwe.

TA was often focused on capacity building, for example, supporting communities and KPs to understand how best to prioritize requests for inclusion in the Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria annex, how to articulate them effectively and how to substantiate them with relevant evidence. This TA support encouraged more effective advocacy and communication of KP requests to the funding request process (e.g. regarding Global Fund related outreach in Tajikistan and Ukraine) and to actively participate in the funding request writing process (e.g. CAR). Expert TA support also successfully facilitated meaningful CE of some of the most vulnerable KPs and was particularly successful in contexts of repressed civic space, because strong civil society partners were not able to drive meaningful community engagement. In Tajikistan, Chad and CAR, for example, this helped ensure that some KPs who would not otherwise have been included were able to participate (e.g. women who use drugs). Importantly TA provision was not always successful, and the evaluation identified a number of instances where TA selection processes had not adequately involved the communities involved (e.g., in Global Fund related outreach in Zimbabwe) and/or the quality of the TA provided had been suboptimal.

Conclusion 3: Global Fund guidance on CE was instrumental in outlining funding and the provision of TA which facilitated meaningful CE. This included guidance in the operations manual, country dialogue during funding request development, available CCM Funding, CE SI TA and the continuous support of the CTs.

Strength of evidence

			Strong

The Global Fund provides a range of technical guidance on CE to CTs, eligible countries, communities, CSOs and consultants to use. This is accompanied by the support available through CCMs and through the Global Fund secretariat. This access for CTs, the CCM Hub and the CE SI focal points collectively contributed to CE across the grant cycle, notably in the funding request stage of the cycle. Since community representatives on the CCMs are critical to achieving meaningful CE, this guidance is particularly important for them. All this information is on the Global Fund website, and periodically updated in line with developments or any changes made.[47]

[47] Some of the key guidance documents include: the operational policy manual, and the applicant handbook 2023-2025 Allocation Period which both elaborate on country dialogue and CE across the grant cycle; available guidance on CCMs including on country dialogue and oversight, and details of the availability of CCM funding to support the recruitment of oversight officers, the budget for both oversight, and constituency engagement including the elections for CSOs.

Conclusion 4: There is a sense of frustration among communities created by the contrast between significant, front loaded investment in meaningful CE at funding request stage, and limited opportunities for CE in grant making. This threatens the sustainability of CE efforts.

Strength of evidence

			Strong

Across the case studies the ET found a number of occasions where CE stalled during intervention costing and selection for the Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria annex. Despite participating in consultations and drafting funding requests, community groups felt they had little influence over final intervention choices that went in the funding request (e.g., in Zimbabwe, Cameroon). Agreed-upon community priorities were frequently excluded without explanation, and organizations reported minimal involvement in the crucial process of prioritizing interventions (e.g. in Tajikistan and Cameroon). Not surprisingly, in these cases high levels of discontent and frustration were expressed by community members about the process and some expressed reluctance to maintain engagement in ongoing Global Fund processes. A common theme in these cases is the reported lack of transparency in final funding request decisions, and poor communication about the process.

This is compounded by the finding that after the funding request stage, there is a complete change in the approach to CE. Meaningful CE drops sharply during grant-making, exacerbating frustration and disengagement. Across almost all case studies, communities and KPs reported a disconnect between meaningful involvement in the funding request stage and the 'closed-door' nature of grant decisions. They highlighted a mismatch between expectations and reality, with communities excluded from decisions about which priorities were funded. Intervention selection is limited to PRs, CTs, and a few CCM members, with little evidence of broader community involvement across all 10 countries. Although Global Fund policy calls for ongoing dialogue and feedback loops with communities, these mechanisms were not functioning in any sampled country. The evaluation found that although no interventions are intended to support meaningful CE during the grant making stage, there is a gap in informing communities about which priorities from the Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria annex were funded and why, despite minimum expectations that feedback meetings will take place. During the mandatory grant making CCM meeting only high-level documents are presented - i.e. summary budget and not detailed budget – which do not enable meaningful inputs from stakeholders. Although budget constraints are inevitable, the lack of transparency around trade-offs and communication about decisions was a major concern. This eroded trust, wasted momentum from earlier engagement, and reduced willingness to participate in future Global Fund processes.

Conclusion 5: The Global Fund's grant making processes do not yet adequately ensure sufficient space for community priorities to influence budget allocations. Other key stakeholders, including government agencies, Principal Recipients, and technical partners, have greater knowledge and involvement at grant making stage than community representatives. Coupled with a lack of transparency about the decision-making process, this further undermines efforts to ensure meaningful CE throughout the grant cycle.

Strength of evidence

		Moderate	

Without a dedicated funding split that protects or guarantees adequate financial resources for essential community activities, their eventual funding remains uncertain despite all the efforts and investments in community engagement earlier in the grant cycle. Despite strong community engagement during the funding request stage, communities are largely excluded from meaningful participation in the grant-making process, resulting in a lack of transparency, diminished influence over funding decisions, and reduced alignment of grants with community priorities.

Key insights supporting this conclusion include the sharp decline in engagement, lack of transparency in decision-making and limited influence over final allocations in Global Fund related outreach in Cameroon, CAR, Chad, and Tajikistan. First, while communities play an active role in identifying priorities during the funding request stage, their involvement significantly drops during grant-making, where critical funding and programmatic decisions are made. Secondly, communities often have little to no insight into how financial allocations are determined, leading to frustration and disengagement when their priorities are deprioritized or omitted without clear justification. This was true for Global Fund related outreach in most countries, including Ghana and Zimbabwe. Grant-making processes are dominated by government agencies, Principal Recipients, and technical partners, leaving community representatives with minimal decision-making power despite their frontline expertise. In Ukraine, for example, community involvement in Global Fund related outreach was robust during the funding request stage, with consultations and participatory mechanisms reported across all key populations. However, several stakeholders noted a drop in influence during grant-making, where technical decisions were often made by state actors or expert committees with limited community representation. Even in cases like Global Fund related outreach in Tajikistan where TA for grant making was provided, they were reportedly not involved of the final decision-making process.

Therefore, even with improved engagement structures, targeted TA, and adaptive strategies, community-led activities still face underfunding, bureaucratic barriers, and implementation challenges. Power imbalances between governments, major donors, and community organizations persist, often limiting the extent to which community-identified priorities are reflected in final grant agreements.

This implies that without a dedicated funding split and transparent process that protects or guarantees financial resources for community activities, their eventual funding remains uncertain despite all the efforts and investments in community engagement earlier in the grant

cycle. This is even more critical in countries with constrained civic space, where government and institutional actors may deprioritize community initiatives, leading to further marginalization of affected populations. As a result, without a structural financial safeguard for community-led interventions, their sustainability and impact remain in jeopardy, ultimately undermining the Global Fund's commitment to inclusive, community-centred health responses.

Conclusion 6: The level of meaningful CE varies by disease area. HIV-affected communities and KPs are most engaged, supported by strong civil society and global organizations. TB communities are included where partnerships foster their involvement, but malaria-affected communities are least likely to be meaningfully engaged, with fewer organized, visible partners.

Strength of evidence

			Strong

Across all case study countries CE for TB and malaria lags behind HIV, partly because of more dispersed populations, weaker common identities, and fewer organized civil society partners. For example, Cambodia's declining malaria incidence reduced its public health priority, and in Zimbabwe and Ghana, even where malaria remains a priority, community-level organizations are less visible and engaged than HIV groups and the extent to which these organizations are representative of the broad spectrum of constituents was raised as a concern. TB and malaria communities often lack the representation and advocacy structures seen in HIV, limiting their influence on funding and implementation.

However, successful engagement examples exist in both TB and malaria. Concerning Global Fund related outreach in Tajikistan, for example carefully structured consultations reached previously excluded TB patient groups. In Cambodia, sustained Global Fund investment in a key TB civil society partner, drove meaningful engagement. TB survivors actively participated in dialogues, influencing intervention priorities, including human rights and gender barriers and supported initiatives such as a CLM project, which collected community feedback to shape funding requests based on real needs. These efforts ensured that TB communities had a voice throughout the grant cycle.

In Cameroon, a positive example of CE of malaria-affected communities occurred during the development of the GC7 grant cycle. With technical and financial support from the Global Civil Society for Malaria Elimination (CS4ME), CSOs and communities affected by malaria were meaningfully engaged in the process. This strong engagement led to the incorporation of their priorities into the GC7 concept note through close collaboration with the a national program and the CCM. As a result, activities such as strengthening the capacities of community organizations and supporting CHWs were included in the GC7 budget.

Conclusion 7: Explicitly unpacking and assessing power dynamics among communities, KPs and in CCM representation, and identifying bespoke and targeted solutions to managing and mitigating these dynamics, are closely associated with reported increases in meaningful CE.

Strength of evidence

		Moderate	

Power imbalances among communities and KP, and within the CCM have a profound effect on reach and coverage of CE interventions and on communities' view of the legitimacy of decision making. This starts with CCM representation and how the power dynamics between different communities are managed and who has the right to represent certain communities. Where the PR is on the CCM, there is a clear added power imbalance. In all countries where this was the case, there were perceptions of bias and questions over the fairness of decisions around funding allocations. The tension for CCM members between representing their organization and their constituents was also identified as a challenge, with perceptions that organizational needs sometimes overrode community and KP needs.

Existing power dynamics also lead to unequal participation of KP groups and communities. Long-established groups have better understanding and capacity, and can crowd out other voices. This can exclude very vulnerable KP minority groups, such as transgender people and adolescents within KPs, as well as large less coherent KP groups, particularly malaria-affected groups. Where stigmatized groups have strong civil society partners, they can overcome significant barriers to engagement.

Both within the CCM, and among communities and KPs, power dynamics and imbalances will always be a key factor. Best practice involves clear awareness among CCM leadership that this is a dimension to consider, leading to a thoughtful, in-depth assessment of the context and actors to understand where the problems are. The CCM Hub, for example, works closely with the GF Ethics Office to deliver awareness sessions on ethics and COI, and provides guidance in navigating the issues. However, this support is not taken up across all countries and, by definition, is very sensitive work. Increased awareness and understanding of the issues can then inform actions to mitigate and address harmful power dynamics, to the extent possible. For example, in Cambodia a CRG assessment helped to analyze how and why gendered barriers prevented women from engaging in the country dialogue process. This is informing adaptations to practice.

Conclusion 8: Achieving meaningful CE through oversight and CLM interventions builds community and KP capacity to engage in the subsequent grant cycle.

Strength of evidence

		Moderate	

Evidence on who is most meaningfully engaged in the funding request process makes clear that civil society partners, communities and KPs have stronger capacity to participate when they have previously been involved in Global Fund activities. This indicates a positive feedback loop; being involved in implementation feeds better engagement in the subsequent cycle. Because evidence also showed that the Global Fund has good mechanisms for CE in oversight, including CLM, this part of the grant implementation process offers the opportunity to involve communities and KPs in a more gradual way, building up capacity over time. This is valuable, because it takes time for capacity building to filter through to civil society constituencies.

There are some good examples of this taking place, as in Global Fund related outreach in Ghana and Indonesia. Implemented effectively, as in these examples, CLM has been important for developing an evidence base for programs and policies, and is valued by KPs as building their capacity. This is an area that could be capitalized on more, and more intentionally, in terms of including hard-to-reach, or marginalized KPs.

Conclusion 9: There are a number of innovations and good practice across the case study countries of a) levers that have been pulled to increase meaningful CE at all stages of the grant cycle, b) successes in increasing engagement reach of some of the most vulnerable groups affected, c) ways to address contextual challenges that can be used to inform future programming.

Strength of evidence

		Moderate	

The evaluation identified from the case studies a number of innovations and examples of good practice across the grant cycle that could be used to inform future Global Fund design and approach across countries. The ET has categorized these examples across three areas, as listed below.

a) Levers to increase meaningful CE in grant cycle

Examples include

- Well-planned and resourced support to pre-dialogue engagement in funding request stage (Global Fund related outreach in Cambodia, Cameroon)
- Targeted TA to build capacity community groups to engage in funding request activities (Global Fund related outreach in Tajikistan, Chad, CAR)
- Creation of a Community Volunteer Expert role, where more experienced individuals supported the broader civil society delegation in the grant development process (Global Fund related outreach in Cameroon)
- Communities participating in oversight through the inclusion of CSO representatives in strategic oversight committees (Global Fund related outreach in Chad, Cameroon, Indonesia)
- Creation of a body that that collects, analyses, and distributes information to CCM commissioners (Global Fund related outreach in Cameroon)
- Representation of CSOs and communities are represented in relevant TWGs (Global Fund related outreach in Zimbabwe)

b) Successes in reaching vulnerable groups

Examples include

- Decentralized approach to country dialogues (Global Fund related outreach in Zimbabwe, Cambodia, Chad, Ecuador)
- Diplomatic advocacy from knowledgeable in-country partners, which has supported a collaborative working partnership between the Ministry of Health and the relevant government agencies (Global Fund related outreach in Zimbabwe)
- Dedicated TA supporting a wide range of NGOs working with key populations for HIV and TB, directly engaging community representatives (Global Fund related outreach in Tajikistan, Zimbabwe)
- Informal engagement of community representative groups in planning and delivering interventions (Global Fund related outreach in Ghana)
- Effective civil society partners to engage KPs in funding request processes (Global Fund related outreach in Cambodia, Ukraine, Ecuador)
- Use of technologies, such as WhatsApp, Zoom, and online forums, encouraging participation of groups that often remain hidden for fear of stigma and persecution (Global Fund related outreach in Ecuador).
- Engaging representatives of marginalized communities in Global Fund activities before the funding request stage begins (Global Fund related outreach in Ghana)
- Use of networks of peer educators to support country dialogues and ongoing engagement (Global Fund related outreach in Ecuador, Ukraine)

c) Addressing contextual challenges

Examples in include

- Adoption of different approaches to the challenges posed by physical remoteness of some communities and KPs, adapting their processes to use digital tools (Global Fund related outreach in Ecuador) or a more devolved system of decision making (Global Fund related outreach in Indonesia).
- Influential INGOs and multilaterals advocating with government for the involvement of national CSOs in the funding request process where civic space is highly repressed (Global Fund related outreach in Chad)
- Adopting a highly flexible approach to CE activities and combining them with humanitarian interventions in response to volatile situations (agile programmatic revisions, reallocating funds and mobilizing new resources to address emerging humanitarian needs, while seeking to center community participation within all new interventions (Global Fund related outreach in Ukraine).

Adaptations in service delivery during the implementation stage of the COVID-19 pandemic period (Global Fund related outreach in Ukraine, Ecuador).

6. Program theory, narrative and pathways

This section presents the program theory – a theory setting out how the Global Fund can achieve meaningful community engagement throughout the grant cycle, based on the analysis of the evidence base in this evaluation. The theory is set out as a series of diagrams with accompanying narrative, and is a normative view of meaningful CE within the grant cycle. Normative in this context means that it sets out how CE is intended to work, based on the evidence of what's working and what's not in current practice.

The ET first takes an overall view of CE across the grant cycle. This situates each cycle and its CE interventions and outcomes within the broader scope of the Global Fund's longer-term ambitions for engaging its communities and KPs. The team then focused in on the grant cycle, breaking out the pathways to meaningful CE within each stage. This allows us to zero in on the key considerations within that specific pathway, based on evidence of what works to promote meaningful engagement. Within each pathway, the ET also traced how it is intended to contribute to the next part of the cycle, and pinpoint key interventions Global Fund can focus on to move current practice closer to the normative pathway.

The theory has been developed based on the findings section above and is closely linked to the recommendations made in section 4.2 below. Development has also been in consultation with the Global Fund, and has been iterated further through the report drafting process.

6.1. Overarching theory of CE

The below diagram presents a high-level roadmap of how the Global Fund and its partners intend to operationalize its commitment to community engagement, and how meaningful community engagement contributes to achieving the organization's broader strategic aims.

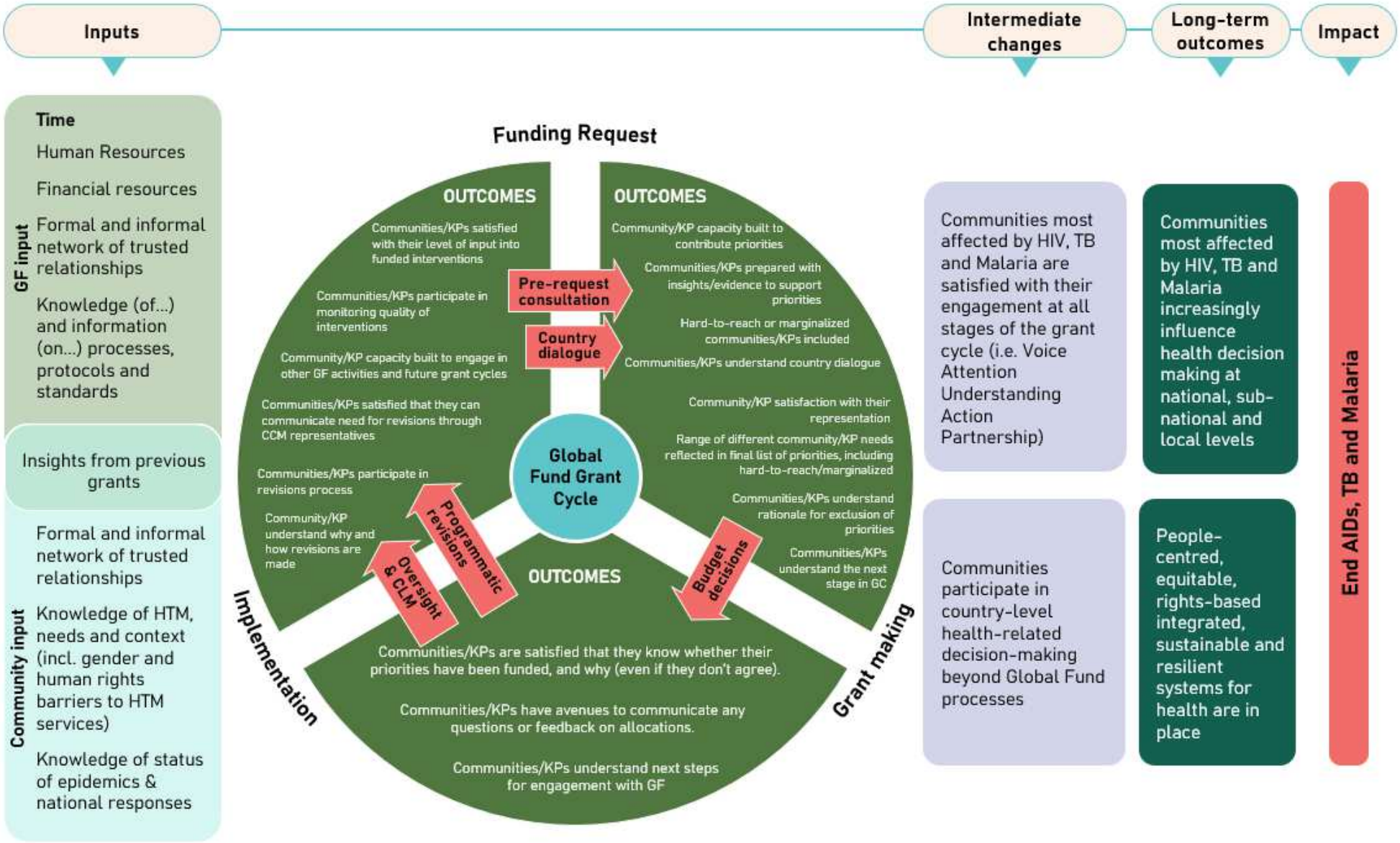

Fig. 3. Overarching theory of CE

It begins on the left-hand side with the inputs brought by both the Global Fund and communities themselves – the skills, experience and knowledge which underpin engagement throughout the process. The grant cycle itself is then represented this circular way, frontloading engagement at the start of a new cycle to catalyze engagement throughout, through investing resources in communities and KPs during the funding request stage.

The cycle diagram includes engagement throughout, with normative CE outcomes identified at the end of each stage which feed into and strengthen engagement at the next stage. These end-of-stage outcomes are based on evidence of what works currently, and where the ET's recommendations suggest Global Fund could adjust and improve its practice. Similarly, each cycle should then bolster engagement in the subsequent one, with capacities for engagement and knowledge of the Global Fund improved for all actors within the system.

The ET has also highlighted key moments where Global Fund interventions can make CE more meaningful; levers to pull which bring current practice closer to normative pathways, and therefore improved CE outcomes.

6.2. Overview of pathways

This section now breaks the theory down into pathways within each stage of the grant cycle. This allows us to narrow in on what works at each stage. The ET has developed the pathways based on the evaluation's realist principles. This means the team presents the Global Fund intervention, the key contextual factors to consider, the mechanisms which drive change, and the CE outcomes which result.

To achieve this, each pathway diagram first sets out the pathway, the part of the cycle where there is an opportunity to push forward meaningful CE. The ET then sets out **levers** – the key activities Global Fund can implement to promote CE. These are the opportunities to capitalize on, where the Global Fund's influence on the process is most meaningful, as per the analysis of the evidence base. The team next lists key **contextual factors** which have an influence on this specific pathway. It should be noted that there are, of course, high level contextual factors which will always shape and influence the operating environment (e.g. conflict, geography). The team instead has focused in on the factors which are most important to consider, and have the largest influence in each pathway.

The diagram then sets out the **normative mechanisms** which influence CE within the pathway. In other words, if the Global Fund designs and implements the levers set out, in a way that addresses the contextual factors, these mechanisms should be the outputs, which in turn promote meaningful CE. The ET finally presents the intended pathway-level **CE outcomes**, based on three main considerations. These outcomes firstly relate to community and KP satisfaction and participation with their engagement in that pathway. Secondly, they are outcomes the lay the foundation for the next part of the grant cycle, and next pathway. Finally, they are the CE outcomes that, over time, contribute to the higher-level CE outcomes displayed on the right hand side of the overarching program theory.

The next section sets out each of the five pathways in more detail.

Pathway 1: Funding request stage: Pre-request consultation process

As made clear in the findings, meaningful CE in the funding request stage is highly dependent on the quality of pre-request preparations. This is therefore a key pathway for establishing effective engagement throughout the grant cycle.

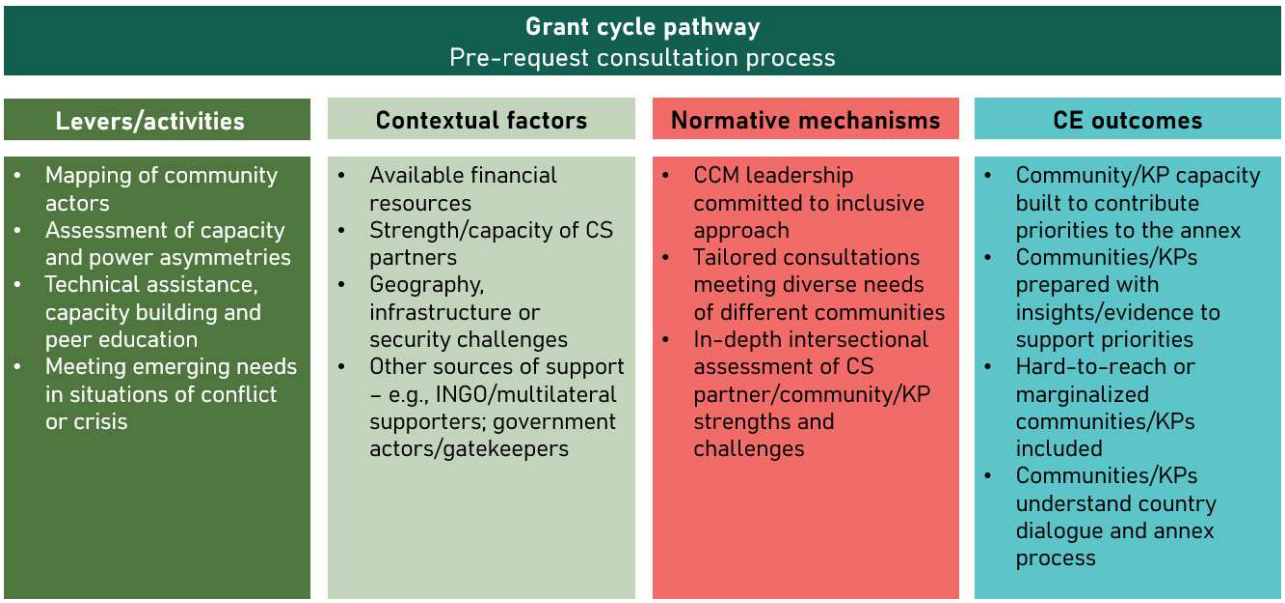

Figure. 5. Grant cycle pathway – Pre-request consultation process (annex refers to the Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria annex)

Levers: This should start with assessing the capacity and power dynamics within communities, KPs and CS partners. This will chiefly be based on existing expertise and knowledge of the context and actors, rather than a formal assessment. This will enable CTs and CCM leadership to understand what communities and KPs need to engage in consultations. This includes both capacity strengths and weaknesses, and power dynamics that will affect their engagement. This is particularly important for hard-to-reach and marginalized communities and KPs. This allows for targeting of appropriate technical assistance, capacity building or peer education to address identified gaps or inequities. In crisis situations, this understanding will support with including these consultations in necessary interventions to meet basic needs (finding 2.2.1[48]) This is an area of strength in current Global Fund practice, with good evidence of all these levers being used effectively (findings 1.1.1[49], 1.1.2[50], 1.1.3[51]).

Contextual factors: This consultation process obviously needs to take place within financial and resource constraints, and the ET acknowledges this is likely to become an even more limiting factor in the short to medium term. Evidence showed that Global Fund investment in this

[48] Global Fund related outreach in Chad and Ukraine offer differing examples of successful responses to COEs, relying on support from partners and on flexibility and agility in programmatic revisions.

[49] The ET's analysis found that the strongest, most consistent evidence of meaningful CE across all contexts occurred during the funding request stage. All case study countries, even those which faced challenges in achieving meaningful CE across the grant cycle, demonstrated high levels of CE through active consultation and dialogue. This included consolidating programmatic choices for HIV, TB and malaria to inform the funding priorities for the Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria annex , technical writing and costing of the funding requests..

[50] In six countries, the funding request preparations were an effective platform for community groups to advocate for their priorities in a coordinated way. Where this preparatory process of dialogue and consultation was most effective, it was driven by strong and active engagement from support organizations and thoughtful collaboration among partners, TA providers and stakeholders.

[51] Successful community dialogues in these six countries were tailored to different groups within KPs and communities, and therefore facilitated meaningful engagement.

pathway is an effective use of resources, though, since it's foundational to achieving meaningful CE later on (finding 1.2.10[52]). A further factor is the capacity of CS partners, and the extent of civic space. In contexts of strong civic space, CS partners can lead consultations, with considerations of instances where more experienced CS partners can crowd out newer colleagues (finding 1.2.8[53]). In weaker or repressed civic space, it may be necessary to draw more heavily on the TA lever. Another factor to consider is other sources of support to bolster weak or constrained CS partners (such as technical or bilateral partners), or to shore up government support for the process where needed (government contacts). Context should also inform the mode of consultations, so that they are appropriately adapted to geography, infrastructure or security challenges.

Normative mechanisms: Within this pathway, the mechanisms which drive meaningful engagement include a CCM leadership committed to an inclusive approach which informs how they organize consultations. This mechanism is most evident where they have clear understanding of intersecting vulnerability and power dynamics within the context. This allows them to design and implement diverse community and KP-specific consultations.

CE outcomes: When these factors interact as intended, this pathway should build community and KP capacity to participate in the final country dialogue, developing their understanding of the Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria annex. Communities should be prepared to contribute their priorities with the right supporting evidence, based on this understanding. Some marginalized, hard-to-reach groups should have contributed their priorities. There are already some good examples of this taking place within the evidence base (finding 1.2.5[54]). Crucially, however, communities and KPs should also understand understanding of what happens next – know country dialogue and the Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria annex, which is not completely clear in all contexts (finding 1.1.6[55], 1.1.7[56], 1.1.8[57]).

Pathway 2: Funding request stage: Country dialogue and Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria annex

As per Global Fund processes, getting this part of the funding request right involves ensuring diverse community and KP voices are reflected in what's funded. This helps ensure the right

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[52] Poor reach and coverage of KPs and communities at the funding request stage is particularly significant. KPs or communities not included at the start of the grant cycle tend to remain excluded for the rest of the grant cycle. Communities who are successfully engaged during the funding request process have improved capacity to continue engaging.

[53] A further barrier to effective reach and coverage is created by power imbalances between different community and KP groups. Communities and KPs with more experience of Global Fund processes and with stronger civil society representation tended to crowd out newer, more marginalized groups.

[54] The evaluation also analyzed evidence on the extent of reach and coverage of some of the most marginalized, hard-to-reach groups among communities and KPs. All countries demonstrated some examples of deliberate efforts to address power dynamics to better engage marginalized KPs in planning and implementation of activities across the grant cycle.

[55] The successes in achieving meaningful CE at the funding request stage are not maintained during grant making. Consultation of communities and KPs does not continue, and the process of selecting interventions is restricted to PRs, CTs and some CCM members.

[56] In several countries, there was also a perception that other stakeholders' interests negated community priorities during grant making, with governments and representatives of INGOs or multilateral organizations seen as wielding disproportionate influence.

[57] The poor level of meaningful CE at the grant making stage clearly represents a sharp drop-off in engagement from the funding request stage. This led to reported high levels of frustration at the disconnect between the positive experience of engagement at the funding request stage and the closed-door nature of grant decision making. This in turn resulted in disengagement of community groups from subsequent Global Fund processes.

interventions are funded to meet diverse needs and sustain diverse engagement as the grant cycle continues.

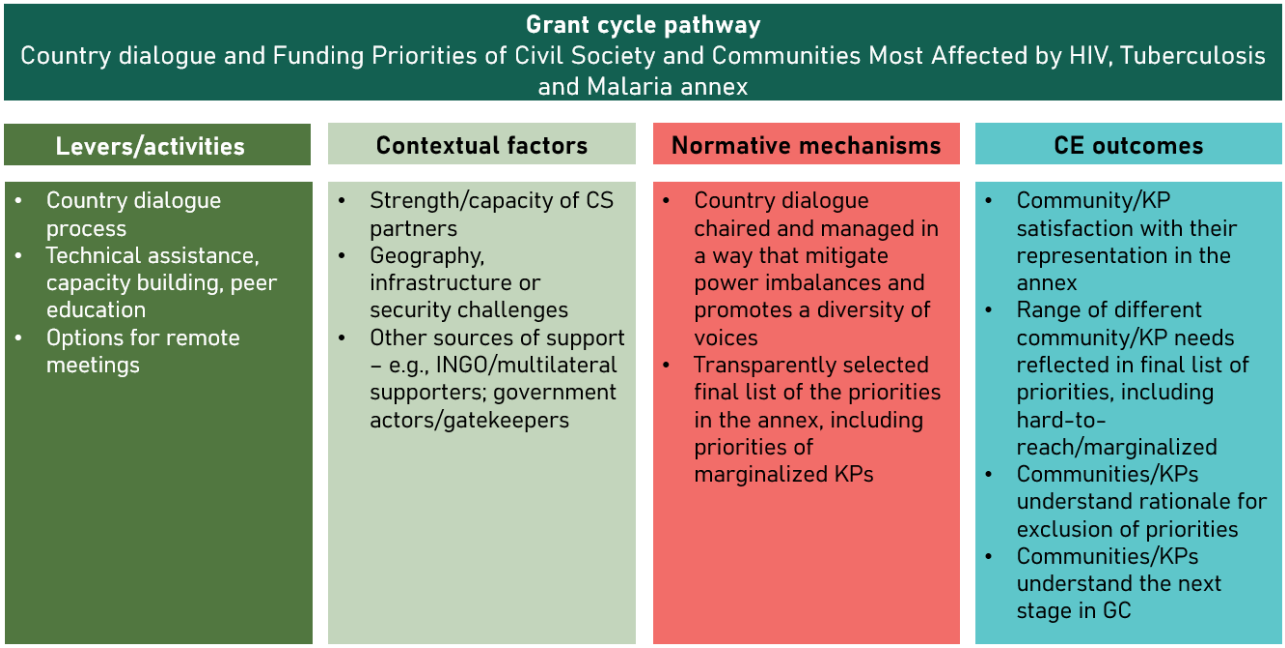

Figure 6. Grant cycle pathway – Country dialogue and Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria annex

Levers: The main lever here is the country dialogue process itself, supported by technical assistance, capacity building or peer education as needed. In this case, the process continues to draw on the assessment of strengths and weaknesses conducted in the pre-request pathway; again, there are good examples of this in the evidence (finding 2.1.2[58]). An adaptive approach will continue to be needed to mitigate any major contextual challenges (finding 2.2.1[59], 2.2.2[60], 2.2.3[61], 2.2.4[62], 2.2.5[63], 2.2.6[64]).

Contextual factors: Similar key factors apply here as in the previous pathway. At this stage when final decisions are made about which priorities are included, there is an amplified need for awareness of which voices are loudest, and of the potential influence of other actors, conflicting

[58] Meaningful CE at the funding request stage was dependent on the CCM leadership's approach, available resources, and the structure of the country dialogue process, particularly the inclusiveness of preparatory pre-dialogue consultations.

[59] Global Fund related outreach in Chad and Ukraine offer differing examples of successful responses to COEs, relying on support from partners and on flexibility and agility in programmatic revisions.

[60] Global Fund related outreach in Ecuador and Indonesia adopted different approaches to the challenges posed by physical remoteness of some communities and KPs, adapting their processes to use digital tools (Ecuador) or a more devolved system of decision making (Indonesia).

[61] The use of technologies by Global Fund related outreach in Ecuador, such as WhatsApp, Zoom and online forums, also encouraged the participation of groups that often remain hidden for fear of stigma and persecution.

[62] Decentralization of governance by Global Fund related outreach in Indonesia empowered local communities, fostering greater inclusivity and strengthening their participation in decision-making processes. This adaptation has proven effective in creating a more enabling environment for CE.

[63] The next category of adaptation arose from identifying and responding to capacity needs among communities, KPs and partners. This supported engagement of some of the harder-to-reach communities and KPs in Global Fund related outreach in Cambodia and Zimbabwe.

[64] The final category of adaptations observed was service delivery-oriented during the implementation stage of the COVID-19 pandemic; these adaptations were evident in a majority of countries.

with community and KP voices (finding 1.2.8[65]). This is a key aspect to consider how to mitigate or work within.

Normative mechanisms: The central mechanism in this pathway is a well chaired and managed dialogue process. This builds on the thorough knowledge of communities, KPs and CS partners established during the consultations, with keen awareness of power dynamics and readiness to mitigate those to the extent possible. A further key mechanism is transparency – it should be clear which priorities are included, which are not, and why. There should be a focus here on marginalized, hard-to-reach groups. The final key mechanism is to conduct the final selection of priorities with the grant making stage in mind, and to prepare communities and KPs with a realistic view of what the budget allocation process is likely to make possible, rather than compiling a very long wish-list (finding 1.1.4[66]).

CE outcomes: This should result in community satisfaction, with a range of different needs included, including some hard-to-reach, marginalized groups. The evidence shows good examples of this happening, even in very challenging circumstances (finding 1.2.5[67]). Other outcomes should be that communities understand the rationale for the exclusion of any of their priorities, and what happens next – crucially, that not everything will be funded. This will become increasingly important in the current funding context. This has been a key point of weakness across countries at grant making stage, but the foundations for addressing this challenge lie in this pathway.

Pathway 3: Grant making: Selecting interventions and allocating funding

This is a key point in the grant cycle for the Global Fund to improve current practice, across all contexts. It's clear that there isn't space or resource for full consultation or engagement at this stage. Equally, it's the reality that difficult decisions have to be made, and will become more challenging given increasing funding constraints. This pathway therefore sets out changes to improve transparency and communication with communities and KPs about what decisions are made, by whom, based on what rationale.

[65] A further barrier to effective reach and coverage is created by power imbalances between different community and KP groups. Communities and KPs with more experience of Global Fund processes and with stronger civil society representation tended to crowd out newer, more marginalized groups.

[66] In several countries, the request drafting component of the funding request process undermined previous work to ensure meaningful CE, with community priorities reportedly being left out.

[67] The evaluation also analyzed evidence on the extent of reach and coverage of some of the most marginalized, hard-to-reach groups among communities and KPs. All countries demonstrated some examples of deliberate efforts to address power dynamics to better engage marginalized KPs in planning and implementation of activities across the grant cycle.

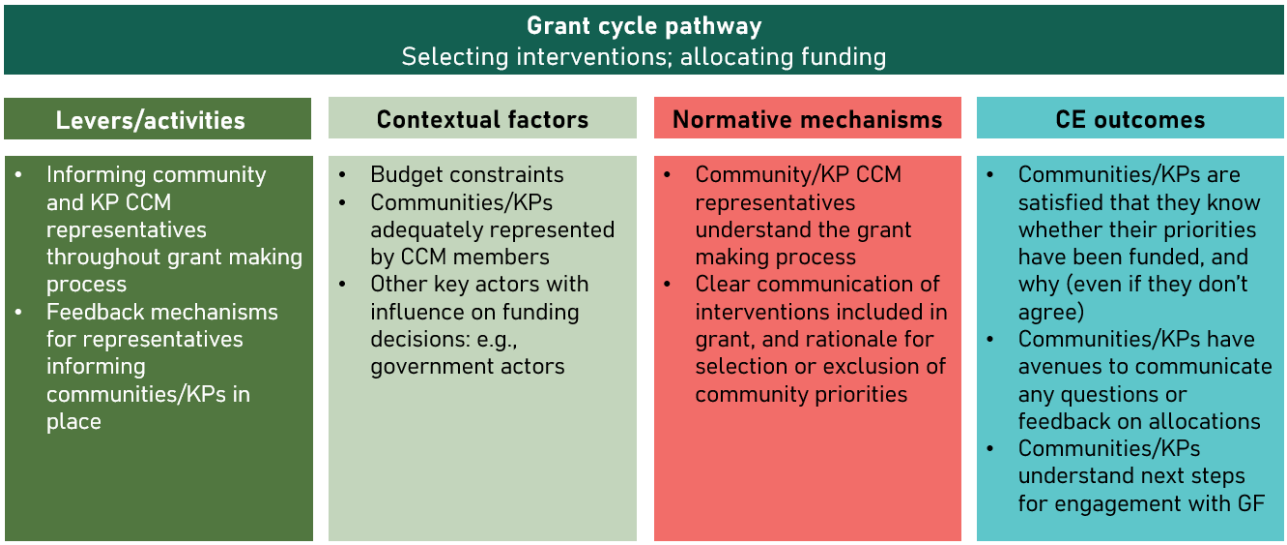

Figure 7. Grant cycle pathway – Selecting interventions; allocating funding

Levers: Current practice does not include any levers for engagement in this pathway (finding 1.1.8[68]). The evidence suggests the first effective lever would be a clear process for informing CCM community and KP representatives what is happening during grant making. This should include who makes the decisions, which interventions have been funded and the rationale for this. The second lever is a clear feedback loop for community and KP CCM representatives to share this with their constituents. The priority for this should be informing communities and KPs who were involved in the funding request process. This represents the final step in the Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria annex process – to know whether and why things have been funded.

Contextual factors: These levers rely firstly on adequate representation within CCM membership; this is something to monitor and adjust on an ongoing basis. The evidence also showed that this is a stage in the cycle where key stakeholders, including PRs, CTs and LFA can influence funding decisions. Understanding the importance of those stakeholders, and their relationships and influence with the Global Fund, will be key to planning for transparent, appropriate communication of their involvement in the process to communities and KPs.

Normative mechanisms: This would lead to clear understanding from CCM representatives of the grant making process. Current evidence shows only limited understanding in a couple of cases (finding 1.1.6[69]). Clear, transparent communication of final funding decisions, and supporting rationale, would mitigate the current disconnect between funding request and grant making (finding 1.1.8[70]).

CE outcomes: In contrast to the current evidence, this would mean communities and KPs know the outcome of their involvement in funding request and development of the Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria annex. They

[68] The poor level of meaningful CE at the grant making stage clearly represents a sharp drop-off in engagement from the funding request stage. This led to reported high levels of frustration at the disconnect between the positive experience of engagement at the funding request stage and the closed-door nature of grant decision making. This in turn resulted in disengagement of community groups from subsequent Global Fund processes.

[69] The successes in achieving meaningful CE at the funding request stage are not maintained during grant making. Consultation of communities and KPs does not continue, and the process of selecting interventions is restricted to PRs, CTs and some CCM members.

[70] See footnote 69

would know whether their priorities have been funded and why, helping to maintain engagement, even if they don't agree. Having clear feedback loops would give CCM representatives space to take feedback and clarify questions. Again, this would support communities and KPs understanding of the cycle, and knowledge of the next steps.

Pathway 4: Implementation: Oversight, including community-led monitoring

Oversight is a key part of the implementation stage for engagement, chiefly through CCM members representing communities and KPs in the oversight committee, and through CLM. Both these avenues represent crucial moments to sustain meaningful CE over time, albeit in a less intense, less resource-heavy way than during the funding request stage.

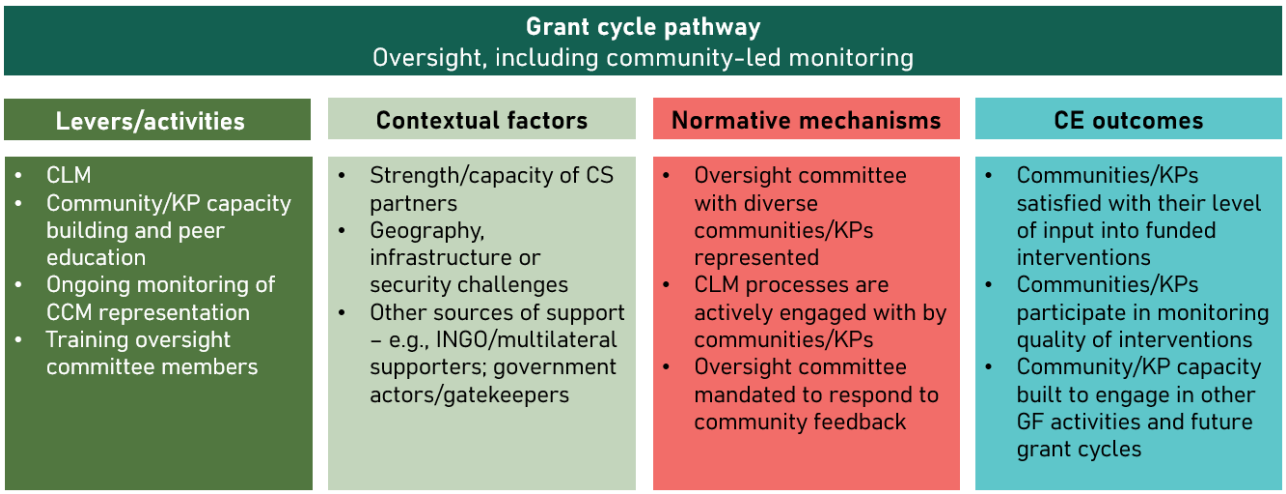

Figure 8. Grant cycle pathway – Oversight, including community-led monitoring

Levers: CLM itself is a key way to move forward meaningful engagement. It acts as a vehicle for capacity building, not only to support community involvement in monitoring but also implicit or hidden capacity building. This second type of capacity building relates to involvement in itself builds experience and knowledge of Global Fund processes for communities and KPs, and develops the Global Fund's own understanding of, and links with communities and KPs. This applies for CCM members, partners and the Global Fund itself. Community representation in the oversight committee also builds capacity more gradually, enabling community and KP representatives on that committee to act as a more effective bridge between their constituents and the Global Fund and partners. As in earlier pathways, this is highly dependent on ongoing monitoring of CCM representation to ensure the diversity within communities is represented by oversight committee members, to the extent possible.

Contextual factors: Factors with an influence at this stage include the skills of CS partners, and the extent to which they can support involvement in CLM (finding 2.1.4[71], 2.1.10[72]). Also important are any external sources of support to draw on during this process, particularly those which

[71] In addition to a strong CCM leadership and effective use of the Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria annex, strong civil society partners drove meaningful CE in the funding request stage.

[72] Community involvement in oversight is the principal approach taken to CE in the majority of countries (n=6). This is achieved through the inclusion of CSO representatives in the oversight committee and CLM initiatives. Communities and KPs involved in CLM are more likely to engage in subsequent grant cycles.

create space for peer sharing/mentoring, and support adaptive management of challenges (finding 2.1.6[73]).

Normative mechanisms: This pathway is driven by effective, diverse representation within oversight committee. This supports the inclusion of a range of communities and KPs in oversight mechanisms, including CLM (finding 2.1.10[74]). Capacity building should, over time, ensure that communities understand CLM processes, are equipped to engage with them. Oversight should in turn be ready to respond to CLM feedback (finding 2.1.10[75]).

CE outcomes: Communities should be participating in oversight activities, with a diverse range of KPs represented. Over time, communities and KPs should build capacity to engage in other Global Fund activities and interventions, in turn better equipping them for the subsequent grant cycle. This should contribute to a virtuous cycle, where future interventions are more likely to support their needs. As at every stage, some hard-to-reach or marginalized groups should be included in, and benefit from, these outcomes.

Pathway 5: Implementation: Programmatic revisions

Programmatic revisions provide the second opportunity for engagement within implementation. Since the evidence suggests engagement is currently limited, the analysis suggests this pathway through which engagement with communities and KPs can be more consistent and meaningful.

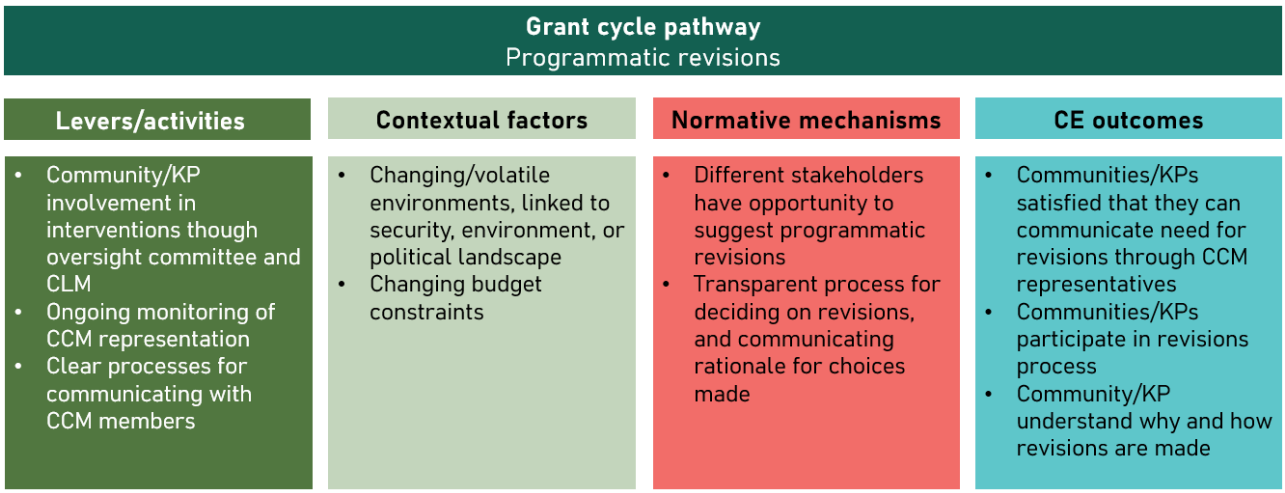

Figure 9. Grant cycle pathway – Programmatic revisions

Levers: Levers for this pathway work in complementary way with the oversight pathway. Where communities, KPs and their CCM representatives engage with and know what's going on with implementing interventions, by extension they also know what revisions might be needed. This works best when communication processes function effectively, including use of automated messages for CCM members. Again, ongoing monitoring of representation is vital to ensure a diverse range of people can contribute to this process.

Contextual factors: Context is clearly a strong driver of need for revisions and the rationale for approving or denying them; the Global Fund and partners need to respond to changes in the

[73] There is also more limited evidence of civil society partners providing TA and capacity building support to less experienced CSOs and NGOs. This in turn supported the participation of newer, more marginalized groups to participate.

[74] See footnote 73

[75] Ibid.

contexts (finding 2.2.1[76], 2.2.2[77], 2.2.3[78], 2.2.4[79], 2.2.5[80], 2.2.6[81]). Also key to this pathway is a knowledge of changes in budgetary environment, and consequent understanding of the extent to which revisions are possible.

Normative mechanisms: To make CE work more consistently in this pathway, there is a clear opportunity for different stakeholders to raise the need for revisions. There is currently little evidence that this comes from communities and KPs (finding 2.1.11[82]). Creating space for them to make suggestions, and provide rationale, and to offer feedback on revisions suggested by other stakeholders would ensure more meaningful engagement. As the grant making stage, it's clear that it's not resource efficient to have an extensive consultation with communities and KPs to make final selection of what is funded. It is, however, crucial to communicate decisions clearly, with transparency about how and why decisions are made.

CE outcomes: This would help ensure communities and KPs can contribute suggested revisions, and provide feedback on others' suggestions. Having a strong understanding of what revisions are made and why helps to maintain engagement throughout implementation.

This program theory therefore provides a framework for more sustained engagement throughout the grant cycle. The normative pathways achieve this in a way that builds on the successes of CE from the previous stage or grant cycle, while preparing communities and KPs for the next stage or grant cycle. The ET fully acknowledges that processes and resources don't allow for full involvement from all communities and KPs at every point. The pathways instead take a pragmatic view of the intended level of engagement, setting out what's reasonable and achievable within each pathway, while driving Global Fund's commitment to meaningful CE.

[76] Global Fund related outreach in Chad and Ukraine offer differing examples of successful responses to COEs, relying on support from partners and on flexibility and agility in programmatic revisions.

[77] Global Fund related outreach in Ecuador and Indonesia adopted different approaches to the challenges posed by physical remoteness of some communities and KPs, adapting their processes to use digital tools (Ecuador) or a more devolved system of decision making (Indonesia).

[78] The use of technologies by Global Fund related outreach in Ecuador, such as WhatsApp, Zoom and online forums, also encouraged the participation of groups that often remain hidden for fear of stigma and persecution.

[79] Decentralization of governance by Global Fund related outreach in Indonesia empowered local communities, fostering greater inclusivity and strengthening their participation in decision-making processes. This adaptation has proven effective in creating a more enabling environment for CE.

[80] The next category of adaptation arose from identifying and responding to capacity needs among communities, KPs and partners. This supported engagement of some of the harder-to-reach communities and KPs in Global Fund related outreach in Cambodia and Zimbabwe.

[81] The final category of adaptations observed was service delivery-oriented during the implementation stage of the COVID-19 pandemic; these adaptations were evident in a majority of countries.

[82] In contrast, evidence suggests that communities find it challenging to engage in programmatic revisions and interventions to involve them tend to be ad hoc, minimal or too late. This tendency reduces the degree to which communities are engaged at these key decision-making moments.

7. Recommendations

This section presents the ET's recommendations, developed based on the evaluation's findings and conclusions. These recommendations have been refined and discussed through a facilitated workshop with the User Group, which helped confirm key priorities and ensure their relevance.

The recommendations have been presented in line with the program theory presented above in section 5 and specifically maps recommendations against the three stages of the grant cycle and the pathways outlined in this section (Figure 10).

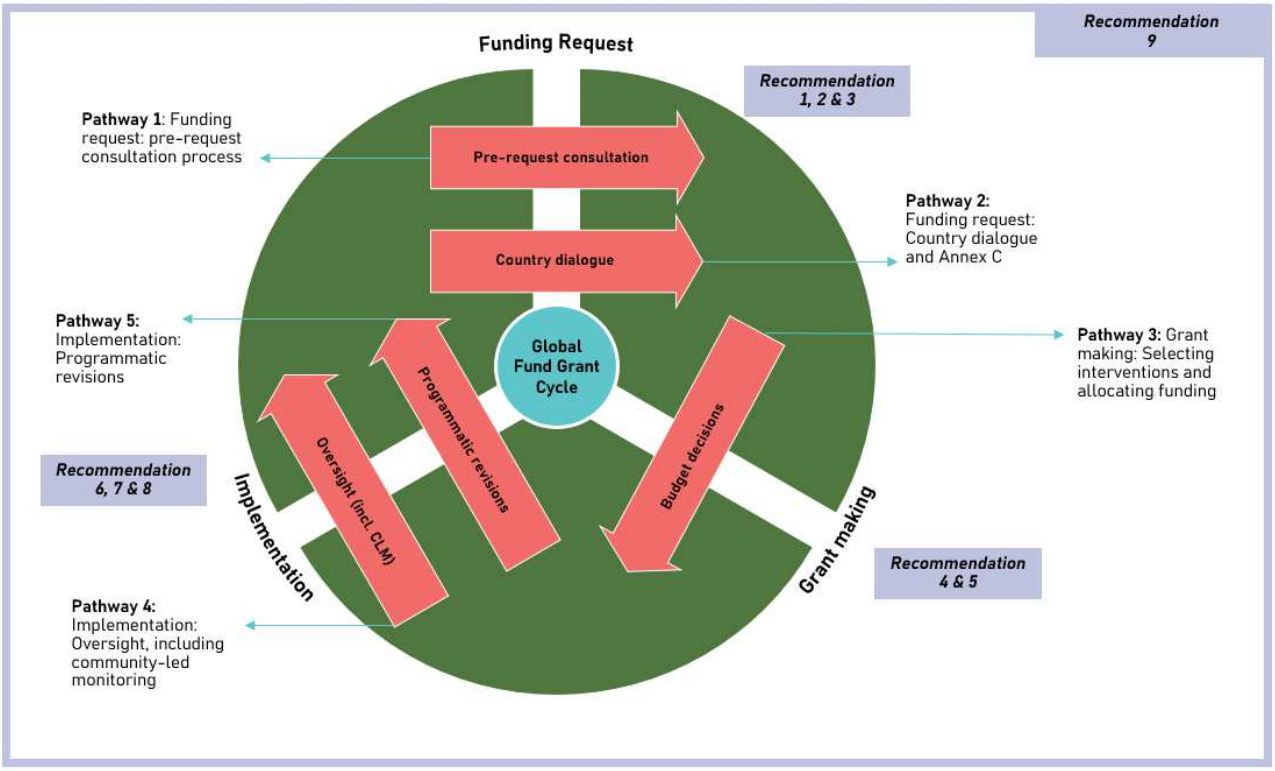

Figure 10. Recommendations across the grant cycle.

For each recommendation a brief high-level rationale has been provided that draws on the conclusions presented in section 4..

For each specific recommendation we have specified who it is targeted for (i.e., who should own the recommendation) and have also provided an 'importance rating' as per the following categories provided by the Global Fund ELO (see Figure 11).

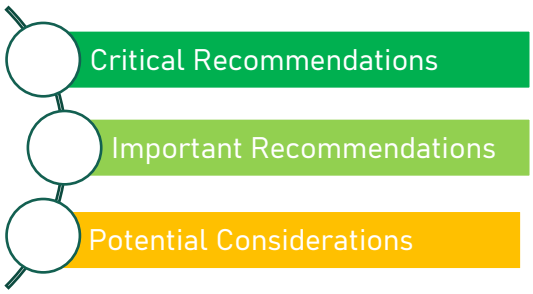

Figure 11. Global Fund rating for recommendations

The grant-making stage presents the best opportunity to enhance meaningful CE. Key recommendations—such as improving transparency (Rec #4 and #5) and keeping communities informed—are low-cost but high-impact. These actions focus on clearer communication and inclusive processes, without requiring significant resources (this also includes Rec #3). In contrast, recommendations for the initial grant stage (Rec #1 and #2) are lower priority due to their higher cost and the fact that there is already strong meaningful CE in many countries. Two recommendations relating to grant implementation (Rec #7 and #8) and one overall recommendation (Rec #9) are classified as important but it is noted their implementation will require an investment of resources and as such suggestions are provided to mitigate this by building on existing mechanisms and processes.

7.1. Funding request stage

The following recommendations relate to the **funding request stage** of the grant cycle and specifically the two pathways described in the previous section, namely pathway #1 (Pre-request consultation process) and pathway #2 (Country dialogue and Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria annex).

Recommendation 1

Potential consideration

The Global Fund Secretariat, through the CE Strategic Initiative in collaboration with Technical Partners – should update existing guidelines to facilitate improved meaningful CE at the foundation stage of mid-term reviews of disease specific (HTM) national strategic plans and strengthen how the outputs can inform the development of new funding requests for HIV, TB and malaria. The guidelines should:

1) underscore the significance of detailing community responses, engagement and health and community systems strengthening interventions as key national priorities within the NSPs and FRs and reference good practice examples that have been highlighted in this report and elsewhere.
2) include explicit reference to the need for Country Coordinating Mechanisms (CCMs) to develop a detailed Community Engagement (CE) plan that is aligned with the national roadmap for funding request development. This should cover CE in all stages of the funding request, from conceptualization to engagement at grantmaking.
3) focus on strengthening country dialogue processes and the subsequent output i.e. Annex of Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria by revising the template to ensure priorities are evidence based; to support advocacy for their consideration and inclusion into the funding request, and by obligating the TRP to review the Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria annex.

Rationale: The evaluation found strong examples of meaningful CE at this stage, achieved across diverse contexts, including very challenging environments. Fine tuning and improving the guidance provided to build on this success and utilizing existing expertise among CTs and partners to support other countries to improve their practice would make this good performance more consistent across Global Fund-supported countries.

Recommendation 2

Potential consideration

In collaboration with Technical Partners, the Global Fund Secretariat units, along with CCMs, should strengthen the planning, coordination, procurement, and delivery of technical assistance (TA) during both the funding request and grant-making stages of the grant cycle. To ensure timely identification and procurement of relevant TA, CCMs should make TA for CE, community responses, and systems strengthening a core element of their TA plans. This includes developing generic terms of reference to guide both communities and CCMs. TA planning for CE should recognize that while the funding request and grant-making stages are distinct, they are closely linked and build on one another. Therefore, TA provided during the funding request development stage (such as for country dialogue, proposal writing, and budgeting) should, continue into the grant-making stage, even if at a reduced scale and should be tailored for specific contexts.

Rationale: The evaluation found that technical assistance (TA) was available to communities during the funding request (FR) stage and played a significant role in supporting meaningful CE. However, it also revealed a disparity in support during the grant-making stage. While consultants engaged by the CCM—such as lead writers and costing consultants—were available to assist the Country Team (CT) and Principal Recipients (PRs) during grant-making, the consultants who supported communities were generally not included in this stage. In most cases, TA was procured exclusively for the funding request stage, despite the fact that the funding request process is only finalized at the end of grant-making with the signing of the grant agreements. Additionally, the evaluation found that most communities were not given the opportunity to review the terms of reference for their TA or to participate in the selection of consultants. In some cases, TA provided through partner organizations and global networks arrived late in the process, when funding request development was already well advanced.

Recommendation 3

Important recommendation

The Global Fund secretariat and CCMs should include as a requirement the proactive engagement of CS CCM members as an eligibility requirement. This would formalize the need for representatives to solicit inputs from and provide feedback to their constituencies. This would, in turn, contribute to sound decisions during the funding request development period. This requirement should include updates to CS CCM members on how their priorities detailed in the Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria annex have been considered.

Rationale: The evaluation found that communities were often not informed about what happened after the country dialogue and submission of the Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria annex. Many assumed their priorities would be included in the funding request. Some were unaware of which priorities made it into the annex, while others only learned late in the process that certain priorities had been deprioritized or excluded. These communication gaps created unrealistic expectations, leading to disappointment and reduced community engagement in future grant processes.

7.2. Grant making stage

The following recommendations relate to the **grant making stage** of the grant cycle and specifically the pathway described in the previous section, namely pathway #3 (Selecting interventions and allocating funding).

Recommendation 4

Critical recommendation

The Global Fund should demystify the grant making stage by developing clear guidance for civil society and communities on when and how to engage during grant making. CTs and PRs should be required to enhance transparency and accountability in the grant making process by ensuring that all stakeholders – including community representatives, key civil society, and CCM members – receive clear communication regarding which priorities have been included in the final funding request and budget, as well as the rationale for selection or exclusion. The Secretariat should revise its operational guidance on CE during grantmaking to align with the founding principles of GF as espoused in the GF Framework Document (2001), particularly principle H, articles 7[83] and 9[84].

Rationale: Evidence strongly indicates that the current grant-making process is opaque and poorly understood, even by experienced CCM members. This lack of transparency undermines the successes of CE at the funding request stage, reducing motivation among communities to participate in later grant stages. Providing more structured and accessible guidance on how decisions are made will enhance trust, efficiency, and long-term participation.

Recommendation 5

Important recommendation

The Global Fund should review and improve its guidance relating to CE during grant making to clearly articulate the role of CTs in ensuring greater transparency in the process achieved. The additional provisions should seek to have less focus on outputs (e.g., number of meetings) and more on outcome level (i.e. what the engagement will seek to achieve in terms of CE during the grant making stage e.g. community responses and CSS interventions supported). They should widen the scope of key stakeholders meeting PRs beyond CCM members to include a limited number of technical representatives of CSOs and communities who played significant roles in the writing and costing of the funding requests.

Rationale: As one of its founding principles as a financing mechanism, GF was mandated to ensure community engagement in reaching funding decisions (Global Fund Framework Document (2001). This evaluation found that across sampled countries there is a sharp decline in community engagement after the funding request stage, and this is a recurring challenge. During grant-making, communities are often excluded, and there is little to no consultation on decisions regarding budget allocations.

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[83] 'Strengthen the participation of communities and people, particularly those infected and directly affected by the three diseases, in the development of proposals.' (The Global Fund (2001) 'The Framework Document', p.92.)

[84] 'Give due priority to the most affected countries and communities, and to those countries most at risk.' (The Global Fund (2001) 'The Framework Document', p.92.)

7.3. Implementation stage

These recommendations relate to the **implementation stage** of the grant cycle and specifically the two pathways described in the previous section, namely pathway #4 (Oversight, including community-led monitoring) and pathway #5 (Programmatic revisions).

Recommendation 6

Important recommendation

Through provisions in the modular handbook and other guidance documents for GC 8, the Global Fund secretariat and Partners should mobilize countries to invest holistically in CLM and other reinforcing CSS interventions as an integrated package so that meaningful CE is increased. CLM can be leveraged to build long-term engagement and institutional learning capacity among communities, KPs, CS without requiring significant additional resources.

Rationale: Evaluations show that where CLM was effectively implemented, communities and KPs developed a deeper understanding of Global Fund processes and strengthened their capacity for meaningful engagement. However, CLM and other CRSS efforts remain largely underutilized, and their potential for reinforcing each other is not fully realized. Embedding and integrating CLM within CSS frameworks will create a cost-effective, sustainable model for capacity-building, information-sharing, and grassroots advocacy.

Recommendation 7

Important recommendation

The Global Fund Secretariat should continue building on the outcomes of CCM evolution notably on oversight and engagement through the IPF. Performance reviews should include relevant issues related to CCMs including those on oversight and engagement, and should be followed up, for example, through management letters.

Rationale: The evaluation observed that all countries benefited from capacity building through the CCM evolution SI on oversight and engagement. However, the support to facilitate improvements was reported to be largely initiated and delivered through the CCM Hub, with country teams having a minimal role in the follow up. Enhanced follow up on key areas such as engagement, addressing conflict of interest and ethics concerns, amongst others will accelerate improvements and strengthen how CCMs including community representatives address CE internally, within their relevant constituencies, and in grant oversight.

Recommendation 8

Potential consideration

The Global Fund should review and improve existing guidance to guide the GF Country Teams, PRs and CCMs to strengthen civil society and communities' engagement through CCMs in grant revisions. This guidance (i.e. Operational Policy Manual) should clearly articulate how and when CSOs and communities will be meaningfully engaged as a part of the revisions. It should emphasize limiting the number of revisions undertaken without CE through CCMs.

Rationale: The evaluation established that grant revisions were routinely undertaken to adapt existing grants and maximize efficiencies. The revisions are largely discussed by PR and CTs, and

ultimately endorsed by oversight committees and CCMs. However. CCMs, including CSO and communities, highlighted that in most cases they had little opportunity to either initiate or influence proposed grant revisions.

7.4. Overarching recommendation

Recommendation 9

Important recommendation

The Global Fund and country teams should strengthen context assessments in key Global Fund-supported countries to systematically analyze power dynamics among communities, KPs, and CCM representation. A differentiated approach is suggested with, for example, greater focus on this issue for countries with restricted civic space and/or diseases with nascent community representation. This assessment should aim to generate nuanced evidence to help identify which groups face the greatest barriers to engagement and recommend targeted, context-appropriate solutions. To avoid additional costs, the process should be integrated into existing assessments, such as the Integrated Performance Framework Review process and/or national strategic planning (NSP) review processes, rather than be a new stand-alone assessment. This assessment should be refreshed and updated throughout the grant cycle, with specific attention to hard-to-reach KPs and TB- and malaria-affected communities, ensuring inclusive and equitable participation.

Rationale: Evaluations indicate that power dynamics and inequities contribute to the exclusion of marginalized communities, particularly hard-to-reach KPs and those affected by TB and malaria. This has resulted in lower engagement levels, even in contexts where engagement is prioritized. A context assessment embedded within national planning processes would help identify these dynamics and inform appropriate responses, such as targeted technical assistance (TA) or alternative mechanisms for community representation. In contexts of restricted civil space this is even more important since CS representatives have less space and capacity to advocate for their constituents. Avoiding additional TA layers while leveraging existing frameworks would ensure cost-effectiveness without increasing administrative burdens.

7.5. Next steps

The recommendations outlined above and the prioritization of these make the case that the component of the grant cycle where the most potential for making a significant impact in terms of increasing meaningful CE is in the grant making stage. The two recommendations (Rec) articulated under this stage (Rec #5: demystify the grant cycle and tighten guidance to allow for greater CS engagement in the grant-making stage and Rec #6: improve the existing guidance on CE during this stage to clearly articulate the role of CTs in ensuring a transparent and inclusive process) are both accorded critical and highly important respectively.

Importantly, the implementation of both these recommendations will not require a high investment of resources since the basic concept being proposed here is to find ways to more openly communicate with community stakeholders on how and why key decisions have been taken around grant allocations. This is a key consideration to take in to account as the Global Fund and it partners face the need to make decisions that will require tradeoffs around resource allocation.

The same logic around low investment/ potentially high returns also applies to Rec #3 (proactively engage and more systematically update community stakeholders on how their priorities detailed in the Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria annex have been considered) as well as Rec #6 (Leverage the CLM to build long-term engagement and institutional learning capacity among communities, KPs, CS). As with the grant cycle recommendations, these recommendations are focused on increasing transparency and clarity of process and finding ways to engage communities better in key pathways in a way the does not necessarily requiring significant additional resources.

Conversely, two out of the three recommendations (Rec #1: update existing guidelines to facilitate improved meaningful CE from the foundation stage of mid-term reviews and development of national strategic plans and funding requests for HIV, TB and malaria and Rec #2: strengthen the planning, coordination, procurement, and delivery of TA) that have been presented for the first stage of the grant cycle, have been accorded lower importance (i.e. 'potential consideration'). These recommendations will require a higher level of investment while the potential return on this effort will likely be marginal – because this evaluation found that levels of meaningful CE in many countries are already high during this initial stage. For these recommendations, the expectation is that a more differentiated approach will be more appropriate within key countries, for example using resources (such as TA) in a more targeted way that is dependent on context.

This need for a differentiated approach to both the recommendations and the broader findings of this evaluation is indeed an important framing to flag by way of conclusion. For example, the best practices and mechanisms identified in the country case studies that we identified as contributing meaningful CE across the grant cycle (see conclusion #9) should be leveraged in ways that account for geographical and contextual differences, as well as the specific characteristics of the disease area being addressed.

As global and country-level resources to support the work of the Global Fund come under increasing pressure, the role of civil society and communities in promoting accountability, advocacy, and crucially to help inform necessary trade-off decisions becomes even more critical. It is therefore crucial that the Global Fund maintains its commitment to meaningful CE. While cost-saving measures may be necessary, they must not undermine the inclusivity and effectiveness of meaningful CE.

This evaluation has highlighted how in many countries and in many contexts the Global Fund has been a key driver in promoting and embedding meaningful CE in country responses to the three diseases. However, in some contexts and in certain key stages of the grant cycle, meaningful CE remains underdeveloped and more work is needed to address these gaps through the implementation of tailored approaches that reflect country-specific constraints and trade-offs. The critical and important recommendations outlined in this report provide a possible pathway to doing this even in light of the increasingly constrained funding environment, highlighting how the Global Fund can build on its critical and foundational work, and implement changes that leverage existing mechanisms and best practice to further strengthen meaningful CE, without the need for significant additional resources. This work combined with the Global Funds key role in leveraging its partnerships and negotiating power to catalyse the embedding of meaningful CE within national and sub-national governance structures could help ensure meaningful CE is sustained well into the future despite the key challenges ahead.

Annexes

1. Evaluation framework

This evaluation framework maps each EQ and sub-question to the analytical methods used to respond to the question, the judgment criteria which are used to assess the question, and the detailed data sources. This evaluation framework guided the development of tools for data collection. Also delineated are the preliminary types of data and information that were sought.

Overarching EQs	Sub-EQs	Program theory focus (high-level CMO)	Areas of inquiry	Methods/analysis	Data sources
1. How far is the Global Fund achieving meaningful CE outcomes?	1.1 How far is the Global Fund meaningfully engaging communities in the grant cycle?	**Outcomes:** levels of satisfaction with CE activities	Selected priority areas in the ToC, agreed in collaboration with the User Group Subgroups defined as part of clustering (e.g., for people in specific locations, with specific personal or contextual characteristics, key populations). This will also probe on how the subgroups are identified and facilitated (funding, technically, etc.) to realize meaningful CE as per Global Fund expectations	Light touch country case studies (n=10) Gathering evidence on the type and extent of outcomes achieved Deep dive case studies (n=2) Adding a layer of realist evidence on the type of outcome achieved Cross-case analysis Drawing out patterns in type and extent of outcomes	Desk review of CCM Threshold Analysis and Integrated Performance Framework—civil society engagement indicators GC5 and GC6 Reports; Partner Reports (See list of References); Stigma Index; CCM meeting minutes; CCM membership list (or CCM representation); Funding Request Dialogue Report and Annex, CCM Engagement Scorecards; among others, CRG/CE SI and CCM Evolution reports, consultants providing CE TA to countries Key informant interviews and focus group discussions with CE Implementers, community leaders and members, country teams, CCM Hub, CRG, CE Program Managers, GMD, Health Department, CE Implementers (CCMs, PRs, SRs and communities); partners
	1.2 For whom are outcomes achieved/not achieved (reach and coverage)?	**Outcomes:** degree of reach and coverage of CE outcomes among different groups of people		Light touch country case studies (n=10) Deep dive case studies (n=2) Exploring reach and coverage in detail Cross-case analysis Drawing out patterns in reach and coverage	
2. Why is the Global Fund observing different CE outcomes (across countries)?	2.1 What configuration of interventions, processes and approaches is implemented across sampled countries?	**Mechanisms:** approaches, structures, processes used to implement CE activities	Minimum expectations Key in-country adaptations to 'standard' GC engagement (and the contextual features and internal factors that drove them) Country-level support to population groups and TA: CE SI Impediments to meaningful CE across sampled countries Complementarity of interventions (original EQ4) Coordination among Global Fund entities (original EQ7) (as discussed) Adequacy of interventions (dosage)	Light touch country case studies (n=10) Gathering evidence on the impact of different resources and support for CE activities, including processes and structures. Deep dive case studies (n=2) Exploring resources and support in more depth Cross-case analysis Analyzing the impact of different configurations	Desk review of policy documents; GF Documents, GC7 Costing Key informant interviews and focus group discussions with Regional Hubs, Community Leaders; CCM Hub, CRG, CE Program Managers, GMD, CS PR and SR; Health Department, Community Leaders, CE Implementers (CCMs, PRs, SRs and communities) and CE partners at global and country level, consultants providing CE TA to countries
	2.2 What key adaptations occur in sampled countries, and why?	**Mechanisms:** shifts in approaches, structures and processes		Light touch country case studies (n=10) Gathering evidence on shifts in approaches and their impact on CE Deep dive case studies (n=2) Exploring adaptations in more detail Cross-case analysis Analyzing patterns in adaptations	
	2.3 What contextual factors affected CE in sampled countries? How and how far do key contextual factors affect meaningful CE?	**Context:** extent and nature of influence of key contextual factors on meaningful CE	Coherence at Global Fund partnership as one of the contextual factors Civic space Composition/strength of civil society Coordination Type of epidemic (concentrated vs generalized) Geography health policy landscape, legal/political environment	Light touch country case studies (n=10) Gather data on relevant variables within each country and investigate how they affect CE Deep dive case studies (n=2) Exploring these factors in greater depth in country contexts Cross-case analysis Drawing overall conclusions about how key contextual factors influence CE	Desk review of policy documents; GF CE Documents, UNDP, UNAIDS and Country Legal Environment Assessments, Stigma Index, Stop TB React tool, GC7 Community Costing TA Reports, partner analyses, e.g., PEPFAR Sustainability Index Tool; Social Contracting Policies (where available); CCM Oversight Reports and Minutes; IPF/CCM Threshold tool positioning indicators; civil society (Civicus Civic Space report, Open Society); reports on Additional Safeguard Policy and CoE among others. Key informant interviews and focus group discussions with CRG, CE SI partner network, CCM Hub, Health Officials, Dual Track PRs, country teams and community leaders, partners, consultants supporting CE and CCM TA

2. Methodology

2.1 Overview of the approach

The overall evaluation design is outcome-focused, theory-based and realist-inspired. It is learning-oriented and utilization focused. To ensure a feasible scope (within timeline and resources) it leverages the priorities of the Global Fund to draw boundaries around the scope of the evaluation.

The evaluation design is outcome-focused. For the purpose of this evaluation, outcomes are defined as "the achievement (or progress in the achievement) of meaningful CE across the stages of the Global Fund grant cycle, or progress towards it".[85] This evaluation focuses on the fulfilment of these outcomes and works backward to determine how and why they came about or not.

However, as detailed in Box A, meaningful CE is a broad term that runs through interventions, the outputs they deliver, the categories of people they reach, the satisfaction of people who experience the intervention, and the reasons driving this satisfaction, which often include trust and long-term relationships.[86] As a result, agreeing on what level of implementation/ change/ time this evaluation conceptualizes as "community engagement outcomes" was a key step for the theory development phase of the evaluation process.

Box A. Defining "meaningful community engagement outcomes"

'Immediate outcomes' are the focus of this evaluation. According to Global Affairs Canada (as referenced in the RfP for this evaluation) **immediate outcomes** are changes that are expected to occur once, or more outputs have been provided or delivered by the implementer.[87] They happen in the short term and usually relate to "changes in capacity, such as increased in knowledge, awareness, skills, abilities or access to (…) among intermediaries and/or beneficiaries." The emphasis on these immediate outcomes for this evaluation means that data collection and analysis focuses on, for instance, whether, how and why CBOs have increased knowledge about the Global Fund decision-making processes and understand advocacy entry points[88], provided that those actions are *partly* in response to (i.e., a result or consequence of) the actions of the project/programme"[89].

The Global Fund's analysis of survey results recognizes that "satisfaction with CE" can be interpreted in different ways and it is likely to express degrees of fulfilment of the following aspects:

- **Capacity:** The extent to which communities are capacitated and facilitated for meaningful CS

[85] This differs from traditional definitions of outcomes such as "changes in the behaviour, relationships, actions, activities, policies, or practices of an individual, group, community, organization, or institution" *(Wilson-Grau and Britt, 2012: 2).*

[86] Vincent R, Kamuya D, Adhikari B, *et al*. Community engagement and the centrality of 'working relationships' in health research *BMJ Global Health* 2024;**9:**e015350; Schiavo, R. (2021). What is true community engagement and why it matters (now more than ever). *Journal of Communication in Healthcare*, 14, 91 - 92. https://doi.org/10.1080/17538068.2021.1935569; Turin, T., Kazi, M., Rumana, N., Lasker, M., & Chowdhury, N. (2023). Community Ecosystem Mapping: A Foundational Step for Effective Community Engagement in Research and Knowledge Mobilization. *Journal of Primary Care & Community Health*, 14. https://doi.org/10.1177/21501319231205170.

[87] https://www.international.gc.ca/world-monde/funding-financement/results_based_management-gestion_axee_resultats-guide.aspx?lang=eng#a5_3_c

[88] These outcomes are taken from the Cameroon section in the document *Community Engagement Strategic Initiative (CE SI) KVP Networks: Country And Regional Overview (GC7 CE SI WCA engagement plan summary CMR).*

[89] https://thomasmtaston.medium.com/thats-an-output-not-an-outcome-b34cf23eb734

- **Participation & Advocacy:** Whether a communities are able engage from an informed perspective, hold duty bearers accountable and advocate for their respective issues to be taken into account by those making decisions that affect them
- **Attention:** Whether communities experience decision-makers as listening to what they are expressing with their voice.
- **Understanding:** Whether communities experience decision-makers as trying to understand their perspective.
- **Action:** Whether communities experience decision-makers as valuing their voice and using their input to adjust a course of action (decision-making).
- **Partnership:** Whether the experience of the community and the decision-maker interacting has built a durable improved understanding and provides a foundation for further relationship.

The evaluation design is theory-based and realist-inspired. It is grounded in the understanding that social systems have real effects and people respond differently to interventions in different circumstances. The evaluation design and application are explicitly guided by theory about how the Global Fund achieves meaningful CE. It explores how and why selected CE interventions across the grant cycle have worked or not by opening the 'black box' between intervention and outcomes and examining and testing the causal links between them.[90] Box B sets out the rationale for applying realist principles in the evaluation.

Box B. The rationale for realist informed evaluation and the application of it

Central to realist evaluation approaches is the idea that programs do not work in the same way for everyone, in every location. Context shapes how and why programs contribute or fail to contribute to change for different participants in different places. Given the different levels of satisfaction with CE displayed by survey data collected by the Global Fund prior to the evaluation (including among people with different diseases in the same locations) and the variety of contexts in which the Global Fund works, the ET selected realist evaluation because it supports a nuanced analysis of how and why interventions work differently, for different groups of people, in different contexts.

In addition, the evaluation presented a scope to conduct qualitative research with relevant Global Fund stakeholders (remotely) and program participants (through case studies) in order to investigate their perspectives on how and why change happened or not. The approach also includes close engagement with the commissioner (ELO, User Group, CRG Investment Advisors) to decide and finalize the evaluation questions (to ensure their focus and number), develop theory and identify priority issues for the evaluation. Both of these elements are often listed among the conditions for realist evaluation.

However, a realist approach "is analytically demanding, and it is rarely possible to look at all dimensions of a complex programme"[91]. It can be resource-intensive and time-consuming, so not

[90] Morris, L. L. and Fitz-Gibbon, C. T. (1996) 'Theory-Based Evaluation', *Evaluation Practice*, 17(2), pp. 177–184; Coryn, C. L. S. *et al.* (2011) 'A Systematic Review of Theory-Driven Evaluation Practice From 1990 to 2009', *American Journal of Evaluation*, 32(2), pp. 199–226. doi: 10.1177/1098214010389321; Chen, H. T. (2012) 'Theory-driven evaluation: Conceptual framework, application and advancement', in Strobl, R., Lobermeier, O., and Heitmeyer, W. (eds) *Evaluation von Programmen und Projekten für Eine Demokratische Kultur*, p. 226. doi: 10.1007/978-3-531-19009-9; Treasury Board of Canada Secretariat (2009). *Theory-Based Approaches to Evaluation: Concepts and Practices.* Retrieved from: https://www.canada.ca/en/treasury-board-secretariat/services/audit-evaluation/evaluation-government-canada/theory-based-approaches-evaluation-concepts-practices.html.

[91] Reality bites: Lessons from five years of realist evaluation at Itad | Itad

appropriate to apply it in full in this. As a result, the scope of the realist investigation is limited to a few pathways on the ToC and does not test the entire program theory.

In addition, while a realist evaluation protocol often entails a systematic review[92] and applying a teacher-learner cycle through realist interviews[93], the approach does not include those steps, which would significantly extend the duration of the theory development phase and require extensive training of in-country data collectors.

Finally, the evaluation is utilization-focused (UFE) and learning-oriented. UFE centers on the identification and engagement of the evaluation's primary intended users.[94] The approach takes into account the Global Fund's definitions of meaningful CE and engages program stakeholders earlier on in the process to contextualize it to each phase of the grant cycle. It also includes several touchpoints with the evaluation User Group, ELO and other Global Fund key stakeholders to ensure a responsive learning process based on actionable evidence. The choice of a realist-inspired approach also reflects a learning focus and results from a collaboration between the evaluation team and the ELO, which showed interest in realist evaluation.

2.2 Implementing the approach

The evaluation combined these approaches, implementing them through the model set out in Figure 1 and the steps below:

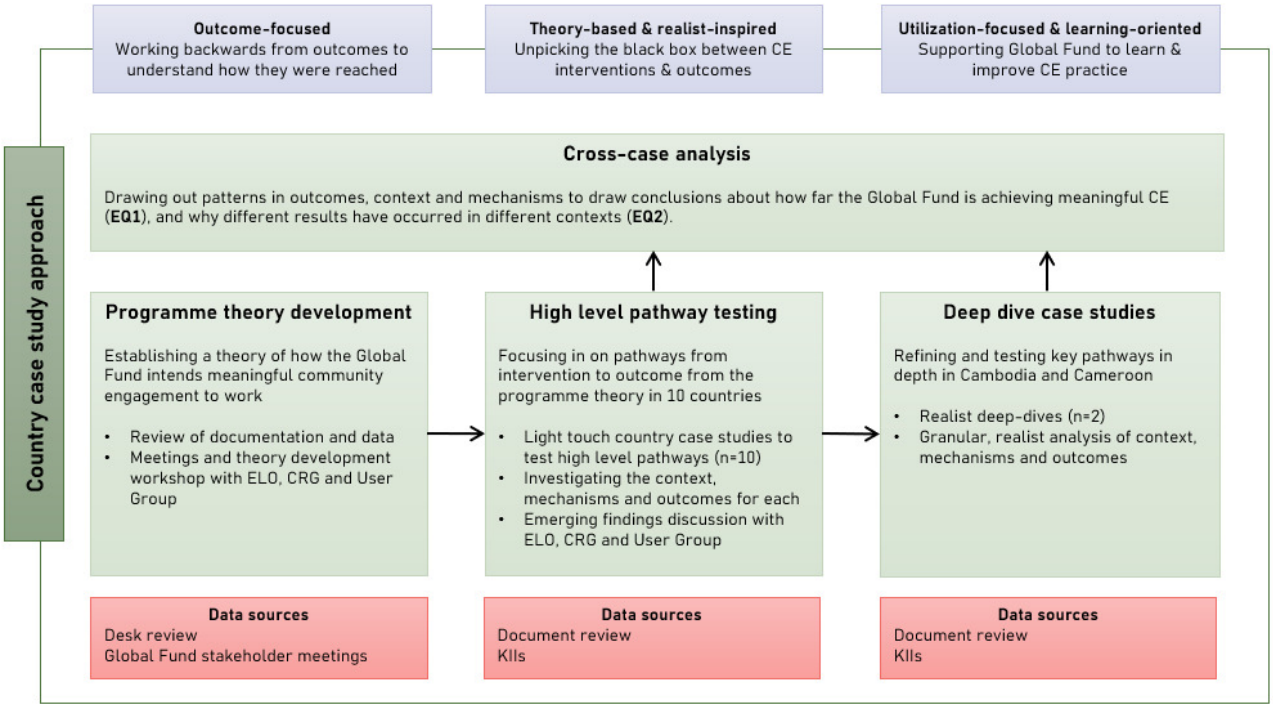

Figure 1. Approach model.

5. **Theory and pathway development:** The ET developed a broad **Program Theory**. This theory sets out how desired immediate CE outcomes are achieved through the grant cycle stages. For each stage of the grant cycle, the ET focused in on how CE is intended to work,

[92] Pawson, R. et al., 2004. Realist synthesis: an introduction, University of Manchester: ESRC Research Methods Programme.

[93] Manzano, A., 2016. The craft of interviewing in realist evaluation. Evaluation, p.1356389016638615-. Available at: http://evi.sagepub.com/cgi/content/long/1356389016638615v1.

[94] Utilization-focused evaluation, https://www.betterevaluation.org/methods-approaches/approaches/utilisation-focused-evaluation

developing **high-level pathways** about how, and for whom, to what extent, and in what contexts a program might 'work'. These pathways allow to focus on particular aspects of the grant cycle, managing the scope of the evaluation while looking across the whole grant cycle.

6. **High level pathway testing:** The ET tested and refined these high-level pathways through light touch **case study country studies** (n=10), including sense checking the pathways with key communities during the case studies. The case studies gathered and analyzed data on the extent to which CE outcomes have been achieved, the structures and processes which drive or impede change, and the contextual factors which influence meaningful CE.[95] The ET then developed this evidence into **high level context-mechanism-outcome (CMO)** configurations for each case study country. These allowed the ET to interrogate each high level pathway in more detail, and to unpack whether and how contextual factors, key mechanisms are linked to specific outcomes.
7. **Deep dive case studies:** The ET then tested these findings further through a second round of data collection in Cambodia and Cameroon (n=2). The ET developed **deep dive CMO** configurations for the selected outcome pathways in both countries, using a more fine-grained, realist lens to provide detailed evidence on the combination of contextual factors and mechanisms led to CE outcomes in both countries.
8. **Cross-case analysis and reporting:** Finally, the ET analyzed the whole database, drawing out patterns in realizing/not realizing meaningful CE outcomes and reflecting on how this works, for whom, to what extent, and in what conditions. Findings were linked to the wider literature[96] on meaningful CE in grant making processes.

The table below sets out a glossary of key terminology and how they are used in this evaluation:

Terminology	Definition
Program theory	An overall theory of how Global Fund intends its CE work to lead to positive outcomes and impacts for program participants.
High level pathway	A broad causal pathway within the Program Theory, describing how CE activities within a stage of the grant cycle are intended to lead to meaningful CE outcomes.
Context	Factors in the context which influence CE throughout the grant cycle.
Mechanism	Structures, processes and mechanisms which influence the design, implementation and outcomes of CE.
Outcome	The degree of achievement of or progress towards meaningful CE, including the extent of reach and coverage of CE activities (for details see Box B).
High level CMO (context-mechanism-outcome)	An analysis of the evidence on the contextual factors, mechanisms and outcomes within a high level pathway.
Deep dive CMO (context-mechanism-outcome)	A granular realist analysis of the evidence on the contextual factors, mechanisms and outcomes within a pathway.

[95] Wong, G., Westhorp, G., Manzano, A. *et al.* RAMESES II reporting standards for realist evaluations. *BMC Med* **14**, 96 (2016). https://doi.org/10.1186/s12916-016-0643-1

[96] *Ibid. (Item 18)*

3. Additional evidence base

3.1. Literature review

3.1.1. Overarching review question:

What does the literature tell us about how to achieve meaningful community engagement in public health interventions?

What types of interventions, processes and approaches have been observed to achieve meaningful community engagement?

Approaches/types of interventions

O'Mara-Eves *et al.* conducted an extensive systematic review to assess how CE approaches reduce inequalities in health, for whom they work, under what circumstances, and with what resources [1]. Although this review is >10 years old, it has several key findings which are directly applicable to the questions outlined in the ToR. The ET has further added additional findings from more recent literature and literature focused on the key populations highlighted by the Global Fund to supplement the findings.

Engagement with communities encompasses a broad spectrum of activities—ranging from those with very limited engagement, such as exchanging information or leading consultations, to more involved approaches including developing and participating in interventions and policies, delivering services, taking action to achieve change, and becoming empowered. The ideal level of engagement should be empowerment, which requires the ceding of power/control to people who traditionally lack this power. The ET highlights the Global Fund's definition of meaningful CE as "where the role of communities is consistently and continuously acknowledged in decision making and processes, and where communities' unique expertise, perspectives and lived experiences are sought and valued." This goal is closely related to concepts of empowerment, and aligns well with Arnstein's well-known (i.e., with more than 19,000 citations) ladder of participation [2]. Although this model is over 50 years old, it provides guidance on participation that centers communities and emphasizes the need to move away from superficial methods of participation—moving from non-participation (manipulation, therapy) and degrees of tokenism (informing, consultation, placation) to degrees of citizen power (partnership, delegated power, citizen control).

Similarly, O'Mara-Eves *et al.* note that empowerment considers the social determinants of health, social justice and structural change. Through empowerment, communities can begin engagement and can take control of their own destinies and health; however, notably, most CE efforts do not start with the community but rather involve an academic/intervention/health system initiating the CE for utilitarian reasons to make interventions more effective. Engagement can serve both functions—as a means to achieve the objectives of interventions efficiently/effectively and as an end in itself, by providing tangible benefits for communities to control their own health. O'Mara-Eves *et al.* (2013) categorize models (the processes) in these two categories, which the ET describes below and supplement with additional literature.

1) **Utilitarian/pragmatic or health system perspective approaches to CE.** Broadly, this includes examples such as: involving patients into decision-making processes to select the most appropriate treatment, delivery and outcomes; involving patients because they

have a right to be included; and sharing responsibility to provide opportunities to identify mistakes. The theory of change includes: (1) observed inequality; (2) intervention designed to reduce inequality; (3) the views of stakeholders are sought; (4) intervention is now more appropriate than before, owing to stakeholder engagement; (5) implementation of intervention; (6) outcomes (which are better than they would have been without the engagement). Ultimately, this engagement increases the acceptability, take-up and effectiveness of the interventions**.** According to a recent scoping review, most malaria CE efforts would fall into this category of 'informing' or 'consulting' [3].

   a. **Peer or lay community members delivering an intervention** are a related, although distinct, method of engagement. In this approach, the intervention is delivered by lay people because they are seen as more credible, effective and persuasive. The theory of change includes: (1) observed health problem; (2) intervention designed to address the problem; (3) peers deliver the intervention; (4) outcomes, better than they would have been without the peer delivery. Such approaches have been widely used for HIV [4].

   b. **Related models address social inequalities more broadly rather than specific health problems.** Originally proposed by Margaret Whitehead, these models include tackling larger inequalities rather than a specific health problem by: (1) observing health inequality; (2) perceiving causes of inequality; (3) identifying policy goals to address causes; (4) establishing theories about how/why interventions would work; (5) designing intervention program; (6) outcome.

      i. **Individual empowerment is included in these models** and includes addressing gaps in individuals' knowledge, skills, etc. (a deficit model) or acknowledging strengths and skills (a capability model).

      ii. **Community strengthening** within this model acknowledges that isolating can affect health negatively and encourages strengthening connections between communities.

2) **Ideological perspectives for CE.** This set of models does not focus on engaging with the community to improve effectiveness, acceptability, etc. but rather concerns itself with the movement of control from the group which is currently in position of it to another group (the community). Within this, there are different levels of community empowerment along the continuum, ranging from 'citizen power', meaning that power is completely within the community (e.g., partnership, delegated power, citizen control) to other, less participatory methods (e.g., non-participation which includes manipulation, therapy, tokenism which includes informing, consultation, placation). Notably, many of these approaches advocate to move away from individualistic approaches focused on behavioral change and toward addressing social justice and wider power structures which contribute to oppression and injustice. By empowering communities, they are able to increase their own capacity to improve their own health (this is an outcome in itself). These models can be combined with the earlier set of utilitarian models, noting that approaches which include more co-production and community control will be more likely to empower the community and contribute to inequality reduction.

The ET has included 'Figure 13: The wheel of participation' from the publication in the Appendix; this figure provides details on the different types of activities that could be undertaken to

increase participation. Given the Global Fund's goal of meaningful CE, activities which fall within 'empowerment' are the most relevant, and include entrusting control and devolving decision making to communities and facilitating community groups to provide services.

A recent scoping review of TB CE found that most efforts involved the community during one specific element of the health program (i.e., identifying the problem; identifying solutions; implementing solutions; managing resources for interventions; monitoring and evaluation of interventions), with only 3% of studies engaging the community in all five elements. Most efforts included the community to supervise treatment [5]. This finding is well aligned with O'Mara-Eves *et al.*'s conclusion that most interventions are informative/consultative and utilitarian—rather than aiming to radically change social inequalities.

When trying to understand approaches further, the ET reviewed a recent systematic review CE interventions for communicable disease in low and middle-income countries (LMICs), which summarizes approaches, effectiveness, mechanisms, and factors influencing success [6].

They highlight several approaches in the following categories, some of which are closely aligned to the above categories:

- **Community/social mobilization [6]:** Cornish *et al.* (2014) [7] define community as the collective resources that exist at the community level (not the individual level), and that mobilization is the process of capitalizing on these strengths and connections to generate action ideas. A few specific examples relevant to the Global Fund are: community mobilization to recruit men to take up medical male circumcision to reduce HIV [8]; community mobilization to recruit participants through outreach or inform culturally appropriate materials [9]; and community mobilization to change power relations, including among female sex workers [10].
- **Participatory community interventions [6]:** In the context of HIV prevention, Skevington *et al.* state that this approach aims to empower women and men to enhance control over their relationships (sexual and emotional) in their context (sociocultural, economic, and political) [11]. They describe examples where different age groups are paired together intensively to build knowledge, reflect on motivation, and review factors which affect lives and behavior over months. Through this intensive process, several different age groups are then equipped with skills to reduce vulnerability to HIV in their own and their communities' lives.
- **Community empowerment [6]:** Example approaches include community mobilization (defined as capitalizing on community connections to generate new ideas) efforts of sex workers or other marginalized communities [12].
- **Community-based ART delivery or malaria treatment [6]:** volunteers trained to administer rapid malaria tests and administer ART or malaria treatment; similar community-based initiatives (e.g., family/friend cantered approaches, peer led interventions, community-based ART adherence) have been utilized for HIV/AIDS.
- **Lay community health workers [6]:** community health care workers, health aids or similar are identified and chosen by the community to facilitate the delivery of TB [13] or other care.
- **Peer education [6]:** the sharing of education about HIV or other diseases in groups or one-to-one between peers [14].

- **Community-based participatory research [6]:** communities involved in the design and conduct of research. This has been successfully demonstrated for STIs and HIV/AIDS [15].
- **Sensitization [6]:** this involves raising awareness about the health intervention before the intervention begins, to provide an opportunity for engagement. It relies on local knowledge and skills to identify useful resources, issues or individuals or to design the intervention package.
- **Community participation for malaria** [6]**:** This is presented as a separate category because the literature for approaches for malaria is largely divided into two categories—top-down approaches and bottom-down approaches.
    - **Top-down approaches [16]:** policymakers and professionals develop plans to convince communities to engage in program implementation, and this can be seen as a way to improve the efficiency of planning and implementing large-scale programs. However, this approach (like the utilitarian approach from O'Mara-Eves *et al.*) comes across as paternalistic and can lead to resistance from communities, particularly if the diseases are not a high priority [17].
    - **Bottom-up (or 'horizontal') approaches [16]:** Engagement and support of communities to establish their own priorities for their health and make democratic decisions about resource allocation, which the policymakers/professionals then support. Although this is seen as a way to create sustainable and positive change, it requires substantial time and resources and is often incompatible with larger agendas for selective disease control or national programs (such as the Global Fund).

Although Questa *et al.* highlighted that most studies indicate that communities were actively involved in several components of the programs (i.e., design, delivery, content of the interventions) rather than passively receiving information about the interventions, they also note that there were few details on the level of 'citizen control' [6]. None of the included reviews used a community empowerment model to frame their findings, limiting the ability of this review to understand if/how the control was ceded from traditional parties and transferred to the community (the goal of community empowerment approaches).

Although the primary focus of many community empowerment efforts is to improve health outcomes/the effectiveness of programs (e.g., utilitarian/pragmatic models) [1] and most measure the final health outcomes (HIV/STI incidence/prevalence, maternal mortality, etc.) and proximal behavioral outcomes (e.g., increased condom use, reduced risky behavior, improved immunization), some reports also described psychosocial outcomes, which could be used to measure or understand the success of CE efforts. For example, two studies found that there was a significant improvement in the distribution of power in the community [7, 16]. Atkinson *et al.* showed that when traditional kinship systems were combined with community-directed interventions, there was significantly less control over decision making by leaders [16], leading to improved behavioral and health outcomes. CE also has significantly improved attitudes toward people affected by communicable disease [11, 15] and reduced stigma. Similarly, social cohesion (e.g., increased networking and building trust), social capital, and CE (or 'collective self-efficacy') increased.

Notably, the indicators or definitions are not universally reported or described in detail (as they would be with other effectiveness or behavior change interventions). For example, the

Farnsworth (2014) evidence on CE to enhance child survival noted that several studies noted increased social cohesion, that social capital was built, trust increased between health workers, and legitimacy was established [18]. Other approaches to increase the sense of belonging and ownership over the intervention were successful. Trust was measured only in two of the primary studies [18] but has also been shown to be critically important in other contexts and disease areas.

For example, the World Health Organization (WHO) published a "WHO CE Framework for Quality, People-Centred and Resilient Health Services", which summarizes both successes and areas for improvement in CE during the Ebola virus outbreaks in Guinea, Liberia and Sierra Leone, and highlights how critical trust building is for any CE efforts. In this report they present a framework which outlines enabling conditions, capacity development for implementation, and outcomes across several functions of CE (governance, peace, democracy, dialogue, and participation). This framework aims to shift the paradigm that is often seen in CE of 'educating, telling, and selling', noted as the most limited forms of engagement in O'Mara-Eves *et al.* [1]

Closely related to this, United Nations Children's Fund (UNICEF) led many CE efforts during the outbreak and conducted an assessment to gather lessons for other contexts/disease areas/emergencies, which are relevant for the Global Fund [19]. They recommend approaches which were highlighted above, including:

- **A decentralization strategy:** developing a strategy with communities at the center, funding and resources specifically for CE. During the Ebola outbreak, initial responses were negative, and communities were not provided with information adequately, so they needed to identify influential sources of information and adapt the response to the context (i.e., urban and rural communities have different methods of communication and information needs).
- **Coordination:** Coordinate CE in a timely and relevant fashion with the right authorities and ensure that the CE has standard operating procedures. The standard operating procedures should not undermine the adaptation/contextual considerations for CE but can help to make sure that the efforts are well coordinated and consistent.
- **Entering and engaging communities:** communities should be listened to and building trust is essential; addressing stigma/discrimination, particularly if working with marginalized groups. Local community members should be mobilizers and strengthen connections and communication with the overall community and subgroups. These individuals will have insights and greater community trust to facilitate CE.
- **Messaging:** tracking and adapting messages and trying to minimize rumors/ misinformation. Messaging should not be static but change as the situation changes, particularly in the context of an outbreak.
- **Partnerships:** building broad partnerships, including with religious leaders, radio, and other partners. This may involve partnerships with other international organizations who are working with similar diseases/populations/areas.
- **Capacity building:** consider management and capacity building of staff, which can address challenges with retention, and ensure that the responses/programs are consistent and of high quality.

- **Data and performance monitoring:** collect data and conduct research; develop indicators for CE/M&E. This can include both qualitative and quantitative data to understand real-time issues such as misinformation and longer-term impacts of the CE.

Processes/mechanisms

On mechanisms, the ET notes that most articles simply list factors/effects, without going into detail about the precise mechanisms, combinations of mechanisms, and how change is achieved in a certain context. Questa *et al.* described the specific mechanisms in which CE interventions lead to improvements in health in the following categories (listed below), but note that of the included reviews in Questa *et al.*, only seven [7, 12, 14, 16, 18, 20, 21] discussed mechanisms:

- increasing critical consciousness
- increasing sense of ownership, autonomy and leadership by the community
- developing social cohesion by building social capital and trust and increasing networking
- building capacity of action/collection action, e.g., through women's learning and action groups, which allowed women to better organize and advocate for their health [20]
- engaging with wider partners
- changing social norms/attitudes/beliefs, e.g., after acquiring new knowledge or new norms, may lead to behavior change [18]
- changing health behaviors and care seeking.

O'Mara-Eves *et al.* include a theory of change describing pathways from CE to health improvement in Figure 14 (see Appendix), which shows how the more limited forms of engagement (e.g., informing, consultation) can only lead to improvements in health by providing more appropriate and accessible services and improving uptake, while more empowerment-focused engagement (e.g., community control, delegated power, coproduction) may operate through mechanisms such as impacting social capital, enhancing community empowerment, and improving social and material conditions.

Much academic literature, including the O'Mara-Eves *et al.* review [1], describes communities as the site of interventions, rather than the community-level interventions. This reflects a broader issue that most community-level and empowerment initiatives focus on the individuals rather than the communities, because the measurement is more straightforward for individual-level outcomes versus community or capacity-building outcomes.

Although it is older (2006), Wallerstein *et al.* describe the mechanisms operating on individual and community levels more clearly, and they highlight health and community capacity outcomes, which are relevant for understanding mechanisms [22]. A couple of notable individual-level empowerment outcomes which are highlighted include psychological empowerment, including collective efficacy (the belief that people together can make a difference), political efficacy (the belief that one can influence the political process, organizations, and communities), outcome efficacy (the belief that one's actions produce results), critical thinking skills/ability, and participatory behavior. These empowerment outcomes are related to the sense of community (i.e., how people connect and bond with their social networks and place of residence). Communities which have a strong sense of community are more likely to participate and facilitate CE and achieve the psychological empowerment outcomes listed above. Empowerment

measurements at the community level include community bonding measures such as neighborhood cohesion, social capital, neighborhood influence, community capacities/assets, and community-level measures of participation (e.g., the extent of civic organizations). Similarly, closely related to mechanisms, the ET also notes that the Global Fund goal for meaningful CE is also closely related to collaborative governance. In a 2021 publication, Emerson *et al.* [23] developed a framework which describes some dynamics (principled engagement, shared motivation, capacity for joint action) in a cyclical fashion with considerations of the broader context and drivers. For example, principled engagement, where individuals with differing relational, content and identity goals work across borders (e.g., of institutional, sectors, jurisdictions), is described through an interactive process of discovery (i.e., revealing shared interest), definition (i.e., efforts to build sharing meaning, goals, and objectives), deliberation (i.e., reasoned communication), and determination (i.e., making joint decisions). Emerson *et al.* highlight that these processes generate and sustain principled engagement and highlight similar processes for shared motivation and capacity for joint action—all of which relate to the Global Fund focus on meaningful CE and co-governance.

Although outside of the scope of this ToR given that they focus on research, several publications which may have translatable findings include: (1) the Minkler and Wallerstein book on Community-Based Participatory Research (CBPR) [24]; (2) the Vincent *et al.* realist review of CE in research [25]; the Oetzel article on CBPR [26]; and the Jagosh article on partnership research [27]. These publications provide substantially more information on causal processes which may be relevant, regardless of the research focus.

3.1.2. What are the key contextual factors that can affect CE efforts? How can CE interventions, processes and approaches be adapted to address these contextual factors?

Contextual factors

Numerous contextual factors were noted by Questa [6], including:

- Existence of wider partners, such as non-governmental organizations, that can have a positive influence or lobby for the community.
- Place and social structure—such as whether the CE takes place in rural or urban areas, because several studies have shown greater impacts on rural areas with existing social networks that have poorer health outcomes, and the local infrastructure/ accessibility impact participation rates.
- Nature of the health issue; prevalence of issue—meaning that if there were many negative pre-existing beliefs or misinformation, the that would impact CE. If the condition was prevalent, there are greater levels of participation.
- The community-level sociopolitical context (stigma, marginalization of some groups, uneven power structures, particularly regarding gender).
- The state-level sociopolitical context (e.g., national or larger decisions can affect degree of collectivism within society, trust, and the resources available for health and CE; political/legal components such as the banning of sex work or same sex relationships can deter individuals from collective organizing).

- Collective action/social cohesion; communities with pre-existing cohesion benefits from CE interventions.

In the systematic review for malaria interventions, Atkison *et al.* also describe factors which affect participation in CE across four levels (individual, household, community, and government/civil society levels), listed below.

- Individual-level influences include knowledge/perceptions of disease, vulnerability, stigma, incentives, acceptability of programs.
- Household-level influences include gender roles and power relationships, cultural norms and social mechanisms, access, and urban/rural implementation differences.
- Community-level influences include community characteristics, disease epidemiology, complexity of intervention, process by which communities are engaged, and congruence of external targets and local priorities.
- Government/civil society influences include the political environment, government advocacy and support, decentralization of power and resources, and financial/human resources.

They also evaluated how many of the primary studies included in the review mentioned each of the factors, finding stark differences between some factors (e.g., 70% of studies mentioning household-level access affecting participation but only 15% of studies mentioning that stigma might affect participation). Incentives were mentioned across studies and included both monetary incentives (e.g., paying regular/full-time employees) and non-monetary incentives (e.g., training programs or free healthcare for village-level volunteers). Another noted factor was the characteristics of the implementation organizations, whereby those that support rather than direct are more likely to have greater levels of engagement.

Although a bit older and therefore outside of the scope of the ToR, two books which describe the contextual factors in more depth include chapters 4 and 10 in Hickey, S. and Mohan, G. (2004) From Tyranny to Transformation? Exploring new approaches to participation in development, and Cornwall, A. and Coelho, V. S. (eds) (2007) Spaces for change?: the politics of citizen participation in new democratic arenas (Vol. 4). Zed Books. The first describes broader networks and organizations with specific agendas relevant for governance, beyond tokenistic forms of participation. The second book describes factors which affect whether CE is successful or constrained in a given context.

3.1.3 How can CE efforts engage different vulnerable or marginalized population groups?

Vulnerable and marginalized population groups

The ET notes that given the disease area focus of this review, several of the aforementioned studies and reviews were among disadvantaged groups and demonstrate a greater impact on these groups. This greater impact is hypothesized to be linked to their shared collective identity. For example, among sex workers, they have greater group cohesion as they are facing several similar barriers (e.g., laws deterring sex work). Marginalized communities face many challenges and the need and urgency of addressing the social determinants is more obvious, which may mean that mobilizing a subgroup, rather than the entire community, may be more achievable.

Cyril *et al.* (2015) conducted a systematic review to understand which approaches maximize effectiveness, acceptability, and feasibility among disadvantaged populations. They consider any group which might be disadvantaged by facing a disproportionate burden of disease because of structural, cultural or social barriers, limited access to care, financial barriers, poor literacy, and other factors. Successful approaches included ensuring cultural adaptability and acceptability of the program for the community, conducting a needs assessment to identify community-specific barriers which the programs could address, and identifying community-specific barriers (e.g., breastfeeding barriers among Navajo tribal women). In addition to improved health outcomes, Cyril *et al.* also describe other outcomes, such as improved awareness and knowledge of health concerns, improved participation in health programs, increased awareness of health issues (e.g., teen pregnancy), and cultural adaptations of programs to increase future involvement. Some evidence from specific vulnerable populations follows:

- **Sex workers:** a wealth of evidence demonstrates the impact of various CE efforts, such as sex worker-led outreach, peer education, community-led drop-in centers, and advocacy efforts. These efforts focus on ensuring rights of sex workers, including the rights to health, and such approaches have been part of many large-scale HIV prevention programs. Example programs include: The Durbar Mahila Samanwaya Committee, a community-driven initiative to increase safe sexual practices and decrease HIV in Kolkata, India; The Avahan India AIDS Initiative, which developed and implemented multi-level intervention package for sex workers across several Indian states; Compromiso Colectivo (Collective Commitment) and, later, Abriendo Puertas (Opening Doors) in the Dominican Republic; Project Encontros in Brazil; Project Shikamana in Tanzania; and others in Kenya and South Africa. Each of these programs involves the acknowledgment of sex work as work and the causes of vulnerability and marginalisation, in order to facilitate collective action among this group which may have limited reach/impact owing to the legal and policy environment.
- **Men who have sex with men:** There are several individual studies on programs for CE with men who have sex with men; for example in Taiwan, among a population of men who have sex with men living with HIV/AIDS, they assessed factors associated with CE and found that age, involvement with AIDS service organizations, and AIDS knowledge were associated with CE (either community events or HIV-related community action). Existing organizations for HIV care played an important role in improving/organizing CE [28].

In addition to these specific and potentially criminalized sources of identity, it is worth noting that HIV, TB and malaria affect poor and marginalized communities across contexts—these populations may differ in terms of age, urban/rural status, access to health and other services, and other components. For this purpose, thinking more broadly about the social determinants of health in CE may be beneficial. Although it is older (2007), Popay *et al.*'s is a useful resource which reviews the impacts and processes of CE to address social determinants of health. They note that CE has been shown to contribute positively to health (e.g., physical, mental) and has socioeconomic benefits (e.g., education, employment) and social benefits (e.g., social/relational such as improved cohesion and networking, feelings of empowerment). Closely related to this, the literature on intersectionality can provide guidance on how to think about interactions between different social stratifiers. Although such framing is more commonly used in high-resource settings, a recent review focused on the concept in low and middle-income countries

LMICs [29] and may be worth considering as a potentially more innovative approach to CE, unlike most of the governance-oriented approaches taken by the Global Fund.

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4. List of stakeholder groups consulted

The ET consulted a range of representatives from different groups and categories during the evaluation. It is important to highlight the instrumental role that the Evaluation and Learning Office (ELO) and in-country contacts have been playing to support the evaluation team. Many potential key informant interview (KIIs) at the global and country level have been shared with the team, which was used to identify key informants for interviews, covering the groups below. Additionally, the ELO has worked to raise the profile of the evaluation with key stakeholders by sharing introductory letters for the CCMs in the respective languages, and John Grove (CELO) provided a high-level letter to stakeholders.

Given the sensitive nature of the evaluation, consulting with people affected by (in some contexts) stigmatized diseases, the ET excludes names from key informants spoken to in the countries.

Group	Level	Description
Global Fund (internal)	Global	Continuing the ET's engagement with Global Fund stakeholders from the Inception Phase to sense-check and test the Program Theory, identified pathways and CMOs.

Global Fund partners	Global, regional and/or local (country level)	External stakeholders who engage with the Global Fund through structured partnerships, e.g., grantees, providers of technical assistance.
Community representatives/civil society organizations	Local	Representatives of most affected communities (HIV, TB, malaria)/civil society organizations that engage with the Global Fund directly or indirectly by being involved in the grant cycle to some capacity. The evaluation team only engaged with adult representatives, to avoid putting minors at risk.
CCM leadership/members	Local	CCM members in the ten countries, including CCM secretaries and chairs.
Donors	Global	Stakeholders who support the Global Fund by pledging and providing amounts of money to be distributed to countries.

Within the Global Fund, the ET has spoken to the following individuals during the evaluation process:

Category	Position
CELO	CELO
ELO/UG Secretariat	Senior Specialist
ELO	Team Coordinator
ELO/UG Secretariat	Specialist
IEP	Vice-Chair
	Voting Member
UG member	Principal Legal Counsel
	Senior Specialist, PHME MENA Team
	Senior Program Officer. High Impact Asia Department (GMD)
	Associate Specialist, CCM Hub Officer
	Senior Technical Advisor, CRG
	Manager, Thematic Cluster for Key Populations. CRG
Tajikistan case	Program Officer
	Technical Advisor, CRG Regional Investment Support
Cambodia case	Senior Fund Portfolio Manager (SFPM)
	Senior Program Officer (SPO)
	Technical Advisor, CRG Regional Investment Support
	Senior Fund Portfolio Manager (SFPM)
RAI	Senior Program Officer
Cameroon case	Senior Program Officer (SPO), West and Central Africa
	Senior Fund Portfolio Manager (SFPM), WCA
	Senior Program Officer (SPO), WCA

	Technical Advisor, CRG Regional Investment Support, CRG
	Specialist, Public Health and M&E, Grant Management Division, WCA
CRG and CCM Hub	Associate Specialist, CCM Hub
	Manager, CCM Hub Team
	Associate Specialist, CCM Hub Officer
	Senior Technical Advisor, Community Engagement, CRG
	Manager, Thematic Cluster for Key Populations, Community Engagement and Responses, CRG
	Technical Advisor, Community Engagement, CRG
Ghana case	Senior Program Officer (SPO), High Impact Africa 1 Department HIA1
	Senior Program Officer (SPO), HIA1
	Specialist PHME, HIA1
	Technical Advisor, CRG Regional Investment Support, CRG
Central African Republic (CAR) case	Senior Fund Portfolio Manager (SFPM), WCA
	Specialist, PHME, WCA
	Program Officer (PO), WCA
	Senior Program Officer (SPO), GMD
	Technical Advisor, CRG Regional Investment Support, CRG
Chad case	Senior Fund Portfolio Manager (SFPM), WCA
	Senior Program Officer (SPO), GMD
	Senior Program Officer (SPO), GMD
	CRG Specialist, GMD (Region), Africa and Middle East Department

Additionally, the ET spoke to the following individuals on the global level during online focus group discussions:

Organization	Position
Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)	Technical Advisor
Stop TB Partnership	Community, Rights and Gender Advisor
WHO	Senior Adviser to Director of Global Malaria Programme
	Team Lead: People-centered care and community engagement for TB
Joint United Nations Programme on HIV/AIDS (UNAIDS) TSM	Manager
Global Civil Society for Malaria Elimination (CS4ME)	Executive Director
TBEC	Executive Director
ACT Asia Pacific	Project Coordinator

LAC Learning Hub	Coordinator
EECA Learning Hub	Coordinator
Francophone Africa Learning Hub	Coordinator
GNP+	Co-Executive Director
Y+ Global	Executive Director
Frontline AIDS	Lead, HIV & health financing
RAI Civil Society Organization (CSO) Platform	Project Manager

During the data collection (remote and deep dive), the evaluation team spoke to the following stakeholders in countries[97]:

Country	External stakeholders who engage with the Global Fund, e.g., grantees, providers of technical assistance.	Representatives of most affected communities (HIV, TB, malaria).	CCM members in the ten countries, including CCM secretaries and chairs.	Others (e.g. government bodies)
Chad	3	6		
Cambodia	33	20		13
Cameroon	4	11	5	1
CAR	3	4		
Ecuador		8	1	
Ghana	7	5	3	1
Indonesia	3	3	6	1
Tajikistan	7	5	2	1
Ukraine	5	4	1	4
Zimbabwe	2	1	1	

5. List of reference groups

The ET received and a great number of different documents for consultation, belonging to the following groups of documents:

- **Global Fund** internal documents, such as strategies, general reports, relevant initiative documents, handbooks, Funding Request guidelines, etc.
- **Global** documents, such as official Funding Request application forms, presentations, surveys.
- **External** documents, such as reviews, reports, evaluations.
- **Evaluation Function SOPs**, such as flowcharts.

[97] External stakeholders, representatives of KPs and CCM members are often part of more than one group. The allocation here is therefore based on the capacity in which the informant was interviewed.

- **Country case selection**, such as indicators.
- **Country specific documents** relating to all case countries, such as latest Funding Request Applications and Annexes, Response Forms, CCM documents, etc.

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