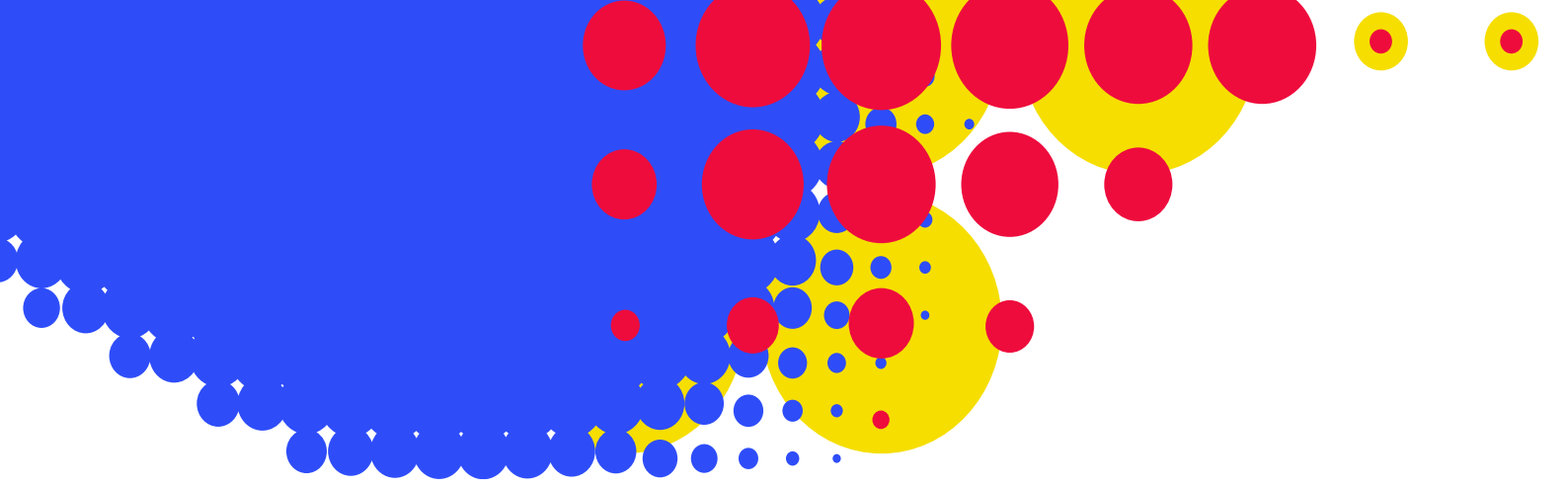




Evaluation of the Integration of Gender Approaches in HIV, TB, and Malaria Programs

Annexes

GF/ELO/2026/03/02
7 October 2026
Geneva, Switzerland

Evaluation of the Integration of Gender Approaches in HIV, TB, and Malaria Programs

Dr. Vandana Sharma
Dr. Aaron Yarmoshuk
Dr. Simukai Shamu
Dr. Rebecca Hémono

Dr. Egidus Kamanyi Rwezahula
Dr. Bienvenu Camara
Dr. Akoua Tano-Kamelan

Dr. Adolphina Addo-Lartey
Dr. Omera Nasser
Ms. Rejoice Chakare

© The Global Fund to Fight AIDS, Tuberculosis and Malaria 2026

This is an independent evaluation published by the Global Fund to Fight AIDS, Tuberculosis and Malaria's Evaluation and Learning Office, based on the work done by an independent evaluation team. This publication does not necessarily reflect the views of the Global Fund to Fight AIDS, Tuberculosis and Malaria and it accepts no responsibility for errors.

This work is licensed under Creative Commons Attribution-Non-commercial 4.0 International.

The user is allowed to copy and redistribute this publication in any medium or format, as well as adapt and transform this work, without explicit permission, provided that the content is accompanied by an acknowledgement that the Global Fund to Fight AIDS, Tuberculosis and Malaria is the source and that it is clearly indicated if changes were made to the original content. You may however not use the work for commercial purposes.

To view a copy of this license, please visit: <https://creativecommons.org/licenses/by-nc/4.0/>.

Adaptation/translation/derivatives should not carry any logo or trademark of the Global Fund, unless explicit permission has been received from the Global Fund. Please contact the Evaluation and Learning Office via the website to obtain permission.

When content published by the Global Fund to Fight AIDS, Tuberculosis and Malaria, such as images, graphics, trademarks or logos, is attributed to a third-party, the user of such content is solely responsible for clearing the rights with the right holder(s).

Any dispute arising out of or related to this license that cannot be settled amicably shall be referred to arbitration in accordance with Arbitration Rules of the United Nations Commission on International Trade Law (UNCITRAL) in force at the time of the commencement of the arbitration. The user and the Global Fund to Fight AIDS, Tuberculosis and Malaria shall be bound by any arbitration award rendered as a result of such arbitration as the final adjudication of such a dispute. The appointment authority of such arbiter shall be the Secretary-General of the Permanent Court of Arbitration. The case shall be administered by the International Bureau of the Permanent Court of Arbitration. The number of arbitrators shall be one. The place of arbitration shall be Geneva, Switzerland. The language used in the arbitral proceedings shall be English.

The designations employed and the presentation of material throughout this publication do not imply the expression of any opinion whatsoever on the part of the Global Fund to Fight AIDS, Tuberculosis and Malaria concerning the legal status of any country, territory or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. The mention of specific companies or products of manufacturers does not imply that they are endorsed or recommended by the Global Fund to Fight AIDS, Tuberculosis and Malaria in preference to others of a similar nature that are not mentioned, or alternatively that their use is discouraged.

This publication is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the user. In no event shall the Global Fund to Fight AIDS, Tuberculosis and Malaria be liable for damages arising from its use.

Table of Contents

6	ANNEX 1. MODULES AND INTERVENTIONS IN THE GLOBAL FUND GC7 MODULAR FRAMEWORK IDENTIFIED AS INTEGRATING GENDER EQUALITY APPROACHES
9	ANNEX 2. EVALUATION MATRIX
12	ANNEX 3. LIST OF DOCUMENTS CONSULTED
16	ANNEX 4. GENDER INTEGRATION SCORE (GIS)
18	ANNEX 5. LIST OF STAKEHOLDERS INTERVIEWED
28	ANNEX 6. COUNTRY INSIGHTS ON KEY THEMES RELATED TO THE INTEGRATION OF GENDER EQUALITY APPROACHES IN HIV, TB, AND MALARIA PROGRAMS
38	ANNEX 7. CARE PATHWAY ANALYSIS

List of Acronyms, Abbreviations, Figures, and Tables

AGYW	Adolescent Girls and Young Women
ANC	Antenatal Care
ART	Antiretroviral Treatment
BDB	Breaking Down Barriers (Strategic Initiative)
CBO	Community-based Organization
CCM	Country Coordinating Mechanism
CHW	Community Health Worker
CLM	Community-Led Monitoring
CRG	Community, Rights and Gender (Dept., Global Fund)
CRS	Catholic Relief Services
CSO	Civil Society Organization
DHIS2	District Health Information Software, Version 2
DOTS	Directly Observed Treatment, Short-course
DR-TB	Drug-Resistant Tuberculosis
FGM	Female Genital Mutilation
FSW	Female Sex Worker
GBV	Gender-Based Violence
GC6	Global Fund Grant Cycle 6
GC7	Global Fund Grant Cycle 7
GEM	Gender Equality Marker
GIS	Gender Integration Score
HMIS	Health Management Information System
HRH	Human Resources for Health
HIV	Human Immunodeficiency Virus
IPV	Intimate Partner Violence
IPTp	Intermittent Preventive Treatment in Pregnancy
ITNs	Insecticide-Treated Nets

KP	Key Population
KPI	Key Performance Indicator
LHW	Lady Health Worker
LLIN	Long-Lasting Insecticidal Net
LOMSHA	Lesotho Output Monitoring System for HIV/AIDS
M&E	Monitoring & Evaluation
MNCH	Maternal, Newborn, and Child Health
MSM	Men Who Have Sex with Men
PAAR	Prioritized Above Allocation Request
PMTCT	Prevention of Mother-to-Child Transmission
PR	Principal Recipient
PrEP	Pre-Exposure Prophylaxis
PUDR	Progress Update and Disbursement Request
ReCo	Community Health Worker/Relais Communautaire
RSSH	Resilient and Sustainable Systems for Health
SBCC	Social and Behavior Change Communication
SBC	Social and Behavior Change
SI	Strategic Initiative
SPI	Specific Prevention Interventions
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
TAP	Technical Advice and Partnerships
TB	Tuberculosis
TRP	Technical Review Panel

Figure 1	Identified Gender Barriers and Interventions along the HIV/AIDS Care Pathway in a Core Country in Southern & Eastern Africa
Figure 2	Identified Gender Barriers and Interventions along the TB Care Pathway in a High Impact Asia Country
Figure 3	Identified Gender Barriers and Interventions along the Malaria Care Pathway in a High Impact Africa 2 Country
Table 1	Gender-Related Modules and Interventions in Global Fund-Supported HIV Programs
Table 2	Gender-Related Modules and Interventions in Global Fund-Supported TB Programs
Table 3	Gender-Related Modules and Interventions in Global Fund-Supported Malaria Programs
Table 4	Revised Evaluation Matrix
Table 5	Gender Integration Scoring Framework
Table 6	List of Stakeholders Consulted
Table 7	Country Insights Related to Gender Integration in Funding Requests and Grant Design
Table 8	Country Insights Related to Budgets for Gender Activities
Table 9	Country Insights Related to Engagement During Country Dialogues
Table 10	Country Insights Related to the Strategic Initiatives
Table 11	Country Insights on Stakeholder Understanding of the Integration of Gender Equality Approaches in HIV, TB, and Malaria Programs
Table 12	Country Insights Comparing Gender in Funding Requests and Implementation
Table 13	Country Insights on Partnerships
Table 14	Country Insights Related to Gender-Relevant Data (High Impact Asia, High Impact Africa 2, Southern & Eastern Africa)
Table 15	Country Insights Related to Gender-Relevant Data (Western & Central Africa, High Impact Africa 1)
Table 16	Country Insights on Successful Gender Equality Approaches in HIV, TB, and Malaria Programs

ANNEX 1. MODULES AND INTERVENTIONS IN THE GLOBAL FUND GC7 MODULAR FRAMEWORK IDENTIFIED AS INTEGRATING GENDER EQUALITY APPROACHES

The following modules and interventions have been identified by the Secretariat as integrating gender equality approaches. They have been categorized as modules and interventions that are gender-targeted, and those that are specifically designed to remove gender barriers in disease programs. HIV modules and interventions are presented in Table 1, TB modules and interventions in Table 2, and malaria modules and interventions in Table 3.

The list was used by the Evaluation team to determine the types of gender-related interventions included in Funding Requests and grant budgets. On review of the modules and interventions, the Evaluation team interprets those activities categorized as removing gender barriers to include both gender-responsive and gender-transformative approaches.

Interventions targeted toward women, girls, transgender populations, and gender-diverse communities (Gender-Targeted)
Prevention Package for Sex Workers, their Clients, and Other Sexual Partners
Condom and lubricant programming for sex workers
Pre-exposure prophylaxis (PrEP) programming for sex workers
HIV prevention communication, information, and demand creation for sex workers
Community empowerment for sex workers
Sexual and reproductive health services, including STIs, hepatitis, and post-violence care for sex workers
Removing human rights-related barriers to prevention for sex workers
Prevention Package for Transgender People and their Sexual Partners
Condom and lubricant programming for transgender people
Pre-exposure prophylaxis (PrEP) programming for transgender people
HIV prevention communication, information and demand creation for transgender people
Community empowerment for transgender people
Sexual and reproductive health services, including STIs, hepatitis, and post-violence care for transgender people
Removing human rights-related barriers to prevention for transgender people
Prevention Package for Adolescent Girls and Young Women (AGYW) and Male Sexual Partners in High HIV Incidence Settings
Condom and lubricant programming for AGYW in high HIV incidence settings
Condom and lubricant programming for male sexual partners of AGYW in high HIV incidence settings
HIV prevention communication, information, and demand creation for AGYW in high HIV incidence settings
HIV prevention communication, information, and demand creation for male sexual partners of AGYW in high HIV incidence settings

Comprehensive sexuality education for AGYW and adolescent boys and young men (ABYM)
PrEP programming for AGYW in high HIV incidence settings
PrEP programming for male sexual partners of AGYW in high HIV incidence settings
SRHS, including STIs, hepatitis, post-violence care for AGYW, and male sexual partners in high HIV incidence settings
Removing human rights–related barriers to prevention for AGYW in high HIV incidence settings
Social protection interventions for AGYW in high HIV incidence settings
Elimination of Vertical Transmission of HIV, Syphilis, and Hepatitis B
Integrated testing of pregnant women for HIV, syphilis, and hepatitis B
Prevention of incident HIV among pregnant and breastfeeding women
Retention support for pregnant and breastfeeding women (facility and community)
Differentiated HIV Testing Services
Facility-based testing for adolescent girls and young women (AGYW) and their male sexual partners programs
Community-based testing for AGYW and their male sexual partners programs
Self-testing for AGYW and their male sexual partners programs
Interventions specifically to remove gender-related barriers (Gender-Responsive and Transformative)
Reducing Human Rights–Related Barriers to HIV/TB Services
Reducing HIV-related gender discrimination, harmful gender norms, and violence against women and girls in all their diversity

Table 1. Gender-Related Modules and Interventions in Global Fund–Supported HIV Programs

Interventions targeted toward women, girls, transgender, and gender-diverse communities (Gender-Targeted)
No modules
Interventions specifically to remove gender-related barriers (Gender-Responsive and Transformative)
Removing Human Rights- and Gender-Related Barriers to TB Services
Reducing TB-related gender discrimination, harmful gender norms, and violence

Table 2. Gender-Related Modules and Interventions in Global Fund–Supported TB Programs

Interventions targeted toward women, girls, transgender, and gender-diverse communities (Gender-Targeted)
Vector Control
Insecticide treated nets (ITNs) - Continuous distribution: antenatal care (ANC)
Specific Prevention Interventions (SPI)
Intermittent preventive treatment (IPT) - In pregnancy
Interventions specifically to remove gender-related barriers (Gender-Responsive and Transformative)
Vector Control
Removing human rights- and gender-related barriers to vector control programs
Case Management
Removing human rights- and gender-related barriers to case management
Specific Prevention Interventions (SPI)
Removing human rights- and gender-related barriers to specific prevention interventions

Table 3. Gender-Related Modules and Interventions in Global Fund–Supported Malaria Programs

ANNEX 2. EVALUATION MATRIX¹

Theme	Evaluation Question	Indicators
Funding Request and Grant Design	1. To what degree are Global Fund HIV, TB, and Malaria grants demonstrating the integration of gender equality approaches into interventions, including human resources for health (HRH)-funded interventions, in their design?	% of Funding Request narratives that include gender-based interventions. Qualitative assessment of the narratives % of Funding Request narratives that address gender-based inequalities (e.g., integrate mechanisms to increase access to services for women and marginalized genders, address harmful gender norms, attitudes, behaviors contributing to reduced access to care) Stakeholder perceptions of the integration of gender equality in intervention design
	2. How are commitments and prioritization to targeting gender equality reflected in grant budgets and performance frameworks?	% of budgets that allocate funding to initiatives that address gender equality % of total budget allocated to gender equality activities % of performance frameworks that include gender-sensitive indicators (indicators that report sex-disaggregated data) % of performance frameworks that include indicators tracking gender equality outcomes (includes indicators focused on gender-specific key populations and/or indicators related to GBV, gender equality, power, and decision-making) Stakeholder reflections on adequacy of gender prioritization in budgeting and M&E frameworks
	3. To what extent were women's and feminist organizations and organizations led by gender-diverse people effectively engaged in country dialogue to identify gender-related barriers and gender-responsive and -transformative interventions in the Global Fund Funding Request? What has facilitated or hindered this engagement?	% of organizations led by gender-diverse staff that agree they were satisfactorily engaged in the country dialogue process % of country dialogues with documented participation of women's, feminist, and gender-diverse organizations Types of organizations involved (advocacy, service delivery, rights-focused) Nature of participation (e.g., consultation, leadership, decision-making roles) Stakeholder perceptions of engagement quality and influence Barriers and enablers to engagement with feminist and gender-diverse organizations (e.g., time constraints, language barriers, political space)
Partnerships and Catalytic Investments	4. In countries that are part of the following Global Fund Strategic Initiatives (SIs), to what extent are the SIs supporting: a) Strengthening engagement of those affected by gender inequalities in advocating for their priorities and influencing decisions? (The Community Engagement SI) b) Efforts to address gender discrimination, harmful norms and gender-based violence in the HIV, TB, and malaria response? (Breaking Down Barriers)?	Documented activities funded under the Community Engagement and Breaking Down Barriers SIs related to gender equality Documented changes in grant design or implementation practices influenced by SI activities Stakeholder perceptions of how SIs have strengthened gender-responsive or transformative approaches within country grants

¹ The full evaluation matrix is available in the Inception Report

Theme	Evaluation Question	Indicators
Grant Implementation and Monitoring	5. How do stakeholders understand integration of gender equality approaches in disease programs and how is this being reflected in program implementation decision-making in Global Fund grants?	Stakeholder definitions and interpretations of gender-responsive and gender-transformative approaches Examples provided by stakeholders of integration into program design and implementation decisions Evidence of decision-making processes that prioritize gender equality considerations (e.g., resource allocation, service adaptation) Differences in understanding and application across stakeholder groups (e.g., PRs vs CSOs vs CCMs)
	6. Are gender equality approaches in HIV, TB, and malaria interventions being conducted as planned in grant design? a) What is facilitating or hindering the implementation of these interventions? b) How does the national enabling environment, including laws and policies, support or mitigate the delivery of Global Fund grants to advance gender equality approaches?	Evidence of implementation of planned gender-responsive and gender-transformative approaches (fidelity to grant design) Identification of challenges, successes, barriers, and enablers in implementation Influence of the national enabling environment (laws, policies, sociopolitical factors) on delivery of gender equality programming
	7. To what extent, and how, are programs supported by Global Fund investments engaging and proactively working with partners at national and community levels to advance gender equality in relation to achieving greater grant impact?	Engagement of women-led and other gender-diverse organizations Documentation of partnerships with national and community-level organizations focused on gender equality Types of partners engaged (e.g., CSOs, women's rights organizations, key population networks) Roles played by partners in advancing gender equality objectives Stakeholder perceptions of the quality and influence of these partnerships on grant activities and outcomes
	8. To what extent is gender-relevant data being advanced and collected by country stakeholders to monitor grant implementation and inform decision-making in programs (including but also going beyond sex-disaggregation)?	% of grants reporting sex-disaggregated data % of grants reporting gender-relevant indicator data beyond basic sex-disaggregation Extent and quality of routine data collection on gender-specific barriers and outcomes Stakeholder perceptions of data quality, reliability, and use for program improvement Evidence of gender data being used to inform program adjustments and decision-making

Theme	Evaluation Question	Indicators
Grant Implementation and Monitoring	9. What gender-equality approaches and specific gender-responsive or gender-transformative approaches in HIV, TB, and malaria interventions are demonstrating an indication of success, and why?	Number and type of gender equality/gender-responsive/gender-transformative approaches that are indicating success (i.e., accessibility, relevance, reach, perceived contribution to improved disease outcomes such as improved access to HIV treatment, etc.) Stakeholder perspectives on what factors contributed to success or adaptation Documentation of lessons learned or adaptive strategies
	10. What good practices, structure, and resources need to be in place to ensure gender equality approaches will drive the sustained impact of HIV, TB, and malaria programs?	Types of good practices, infrastructure, and resources required for sustainability “Good practices” are defined as approaches that are perceived to be effective in contributing to improved disease outcomes, contextually relevant, and demonstrate signs of sustainability or adaptability across settings

Table 4. Revised Evaluation Matrix

A. List of documents reviewed for the portfolio review

1. Country Specific Documents

For each of the 38 grants, the Evaluation team reviewed the following Funding Request-stage, grant and PR reporting documents. In some cases, certain categories of documents were not available for a specific country.

Funding Request-stage Documents:

- Allocation Letters
- Funding Request Form
- Programmatic Gap Table
- Detailed Budget
- Performance Framework
- Funding Landscape Table
- Prioritized Above Allocation Request (PAAR)
- Health Product Management Template (HPMT)
- Implementation Arrangement Map
- RSSH Gaps and Priorities
- Assessment of Human Rights–Related Barriers
- Gender Assessment
- Essential Data Tables
- National Strategic Plan
- Innovative Financing Documentation
- Supporting Documentation Related to Sustainability and Transition
- Secretariat Briefing Note (SBN)
- Funding Priorities from Civil Society and Communities Annex
- Country Dialogue Narrative
- TRP Review and Recommendations Form

Grant Documents:

- Grant Detailed Budget
- Grant Performance Framework

PR Reporting Documents:

- Grant Progress Updates (PU)

2. Global Fund Internal Datasets

- Gender Equality Marker Scores - Numerical data, Time period: 2023–2024
- KPI E3a data by Region and Community, Reporting year: 2025, Allocation period: 2023–2025
- Grant expenditure data, Reporting year: 2025, Allocation period 2023–2025

B. References

1. Technical Brief on Removing Rights-Related Barriers to HIV Services.
2. The Global Fund to Fight AIDS, Tuberculosis and Malaria: Strategic Review, 2017-2022 (SR2023) Final Report, 4 July 2024. Available at: https://www.theglobalfund.org/media/14802/iep_gf-elo-2024-01_report_en.pdf
3. Bhushan A, Mishra S, Orth Z, Riha J. Gender-responsive and -transformative interventions in HIV, TB and malaria programmes: a review of evidence. BMC Public Health. 2026;26(940).
4. The Global Fund Technical Review Panel Observations Report Grant Cycle 7 Windows 1 and 2, October 2023. Available at: https://www.theglobalfund.org/media/13448/trp_2023-observations_report_en.pdf
5. 2020-2022 Technical Review Panel Observations Report July 2022. Available at: https://www.theglobalfund.org/media/12137/trp_2020-2022observations_report_en.pdf
6. Women's Rights in Review 30 Years After Beijing, UN Women, 2025. Available at: <https://www.unwomen.org/sites/default/files/2025-03/womens-rights-in-review-30-years-after-beijing-en.pdf>
7. Progress on the Sustainable Development Goals: The gender snapshot 2025. Available at: <https://www.unwomen.org/en/digital-library/publications/2025/09/progress-on-the-sustainable-development-goals-the-gender-snapshot-2025>
8. How to Strengthen Gender Approaches within the Malaria Response Evidence and Practical Actions to Accelerate Progress Against Malaria, The Global Fund, August 2024. Available at: https://www.theglobalfund.org/media/15055/crg_strengthen-gender-approaches-malaria-response_report_en.pdf
9. Community-led integrated HIV services: The future of a sustainable HIV response. Available at: https://www.unaids.org/sites/default/files/2025-11/PCB57_NGO_Report_EN.pdf
10. Measurement Framework for Advancing Equity, Gender Equality and Human Rights, The Global Fund, June 2024. Available at: https://resources.theglobalfund.org/media/14736/cr_me-measurement-equity-gender-human-rights_framework_en.pdf
11. Key Performance Indicators (KPIs) Handbook for the 2023-2028 Strategy, The Global Fund, April 2024. https://www.theglobalfund.org/media/3skcbxsw/strategy_globalfund2023-2028-kpi_handbook_en.pdf
12. Institute for Health Metrics and Evaluation (IHME). Financing Global Health 2025: Cuts in Aid and Future Outlook. IHME; 2025. <https://www.healthdata.org/research-analysis/library/financing-global-health-2025-cuts-aid-and-future-outlook>
13. The State of Global Health Funding: August 2025. <https://www.thinkglobalhealth.org/article/state-global-health-funding-august-2025>

14. UN Women: “At risk and underfunded: How funding cuts are threatening efforts to end violence against women and girls.” <https://knowledge.unwomen.org/en/digital-library/publications/2025/10/at-risk-and-underfunded-how-funding-cuts-are-threatening-efforts-to-end-violence-against-women-and-girls>
15. UNAIDS: Global AIDS Update 2025. Available at: https://www.unaids.org/sites/default/files/2025-07/2025-global-aids-update-JC3153_en.pdf
16. Her Voice Fund Narrative Report, March 31, 2024.
17. Her Voice Fund Annual Report, 2024-2025.
18. Modular Framework. Handbook Allocation Period 2023-2025, May 2023.
19. 2023-2028 Strategic Performance Summary Report 52nd Board Meeting 20-22 November 2024. Available at: https://archive.theglobalfund.org/media/15297/archive_bm52-02-strategic-performance-2023-2028-summary_report_en.pdf
20. HIV Programming for Adolescent Girls and Young Women Technical Brief, 3 August 2023.
21. HIV Information Note 5, December 2022.
22. HIV Programming at Scale for and with Key Populations, 20 December 2022.
23. Technical Brief Equity, Human Rights, Gender Equality and Malaria Allocation Period 2023-2025.
24. Technical Brief, Community Systems Strengthening Allocation Period 2023-2025.
25. Technical Brief, Removing Human Rights-related Barriers to TB Services. Allocation period 2023-2025.
26. Technical Brief, Removing Rights-Related Barriers to HIV Services. Allocation period 2023-2025.
27. Information Note, HIV Information Note. Allocation period 2023-2025.
28. UNAIDS Gender Assessment Tool, 2025. Available at: <https://www.unaids.org/en/resources/documents/2026/unaids-gender-assessment-tool>
29. Gender and Malaria Evidence Review, Bill and Melinda Gates Foundation, February 2020. Available at: https://mesamalaria.org/wp-content/uploads/2025/03/BMGF_Malaria-Gender-Review_FC.pdf
30. Evaluation of the Global Fund Funding Request and Grant-making Stages of the Funding Cycle. Final Report, 19 December 2024, Available at: https://www.theglobalfund.org/media/15332/iep_gf-elo-2024-04_report_en.pdf
31. Community, Rights and Gender Strategic Initiative 2017-2019: Independent Evaluation, June 2020.
32. Summary Report on Progress to Reduce Human Rights-related Barriers to HIV, TB and Malaria Services. Breaking Down Barriers Initiative, July 2024. Available at: https://www.theglobalfund.org/media/14849/crg_2024-progress-reduce-human-rights-related-barriers-hiv-tb-malaria_summary_en.pdf

33. Mid-term Assessment Summary Report. Global Fund Breaking Down Barriers Initiative, July 2022.
Available at: https://resources.theglobalfund.org/media/14570/cr_2022-breaking-down-barriers-mid-term-assessment_summary_en.pdf
34. Côte d'Ivoire Progress Assessment Global Fund Breaking Down Barriers Initiative, June 2023.
35. Côte d'Ivoire Mid-term Assessment Global Fund Breaking Down Barriers Initiative, December 2020.
36. Kyrgyzstan Progress Assessment Global Fund Breaking Down Barriers Initiative, June 2023.
37. Kyrgyzstan Mid-term Assessment Global Fund Breaking Down Barriers Initiative, December 2020.
38. Community Engagement Strategic Initiative Update, June 2023.

C. Internal Documents

The evaluation was also informed by a series of internal documents and materials not in the public domain that were provided to the Evaluation team.

ANNEX 4. GENDER INTEGRATION SCORE (GIS)

Domain	Subdomain	Assessment Criteria	Score 1: None/Limited	Score 2: Moderate	Score 3: Strong
1. Design	A. Gender Analysis	Quality and use of context-specific gender-related data and analysis in Funding Requests; includes consideration of how intersecting identity factors shape risks, roles, and needs	No analysis, or mentions gender but lacks data or contextual analysis to inform selection of gender activities	Partial use of disaggregated data or assessments to inform selection of gender activities	Contextual, data-driven gender analysis incorporated to inform selection of gender activities
	B. Inclusive Engagement	Meaningful involvement of women's organizations, feminist groups, and gender-diverse organizations in shaping program design and priorities	Less than 50% were satisfied with engagement during design (KPI E3a)	50–74% were satisfied	75% and above were satisfied
	C. Identification and Mitigation of Gender Barriers	Program design identifies and addresses gender-related access and equity barriers	Program does not identify or address any participation or access barriers, or barriers are mentioned but none are explicitly addressed in the program activities	At least one key barrier is identified and partially addressed through program activities or delivery methods	Systematic identification and integrated strategies to address gender-related barriers
	D. Intervention Design	Extent and type of gender activities included in the design of programs	No gender activities included	Gender activities integrated in at least one module/program area	Gender activities that specifically address gender-related barriers included in at least one module/program area
2. Budgeting	A. Dedicated Budget Lines for Gender Activities	Presence of specific allocations for gender-related activities	0–5% budget allocation to gender activities	5.1–10% budget allocation to gender activities	>10% budget allocation to gender activities
	B. Scale and Proportionality	Appropriateness of investment relative to stated gender goals	Underfunded relative to gender objectives	Modest investment with some alignment to gender objectives	Budget proportional and aligned with gender integration aims
3. Performance Frameworks	A. Gender-sensitive Indicators and Indicators tracking Gender Equality Outcomes	Includes indicators disaggregated by sex, age, key populations, and other identity factors, and indicators tracking gender-equality outcomes (i.e., that capture gender-related barriers, access, agency, and other outcomes).	Few or no indicators disaggregated by sex, age, or relevant identity factors. No gender equality indicators included	Some relevant indicators are disaggregated, and at least one gender equality indicator appropriate for the grant's gender components is included	Disaggregation is applied to most relevant indicators, and gender equality indicators are included for key program areas, aligned with the grant's gender-related goals
	B. Integration of Gender-Related Indicators Across the Performance Framework	Extent to which gender-related indicators are included across program areas	Gender-related indicators are not included in the performance framework, or included in only one area (e.g., AGYW)	Gender-related indicators are present in more than one module or program area but mostly focused on specific populations or not spread across the framework	Gender indicators are integrated across multiple relevant program areas, reflecting an intentional focus throughout the framework

Domain	Subdomain	Assessment Criteria	Score 1: None/Limited	Score 2: Moderate	Score 3: Strong
4. Monitoring, Evaluation, and Learning (MEL)	A. Use of Gender Data in Decision-Making	Use of gender-related data to inform decisions, adjustments, or learning	No mention of gender data use or reflection processes or general mention of gender data, but no clear mechanism for using it	Some examples of using gender data to inform programs or course correction.	Regular and intentional use of gender and equity data to guide decisions, improvements, or adaptations
	B. Gender in Routine Monitoring Systems	Inclusion of gender indicators in routine monitoring systems and reporting	No or limited mention of gender data in routine monitoring, and no or limited integration into routine systems	Gendered data collection is described for some program areas; partially integrated into national or grant M&E systems	Systematic collection of gender-sensitive and disaggregated data through routine M&E platforms, with feedback loops or reporting structures described
	C. Community Feedback and Gender-Responsive Learning	Mechanisms for gender-sensitive community feedback and adaptive learning	No mention of community feedback or learning mechanisms or some general mention of community engagement, but not specific to feedback or gender	Feedback mechanisms exist with some attention to gender or key populations	Clear, gender-responsive mechanisms to collect, respond to, and adapt based on feedback from affected populations
5. Implementation	A. Implementation of Gender Activities	Extent to which gender activities were implemented as planned	No evidence of gender activities being implemented, or some activities mentioned but delayed, under-implemented, or lacking clarity	Most planned gender activities delivered with some quality or reach	All key gender activities implemented as planned, with good reach
	B. Inclusive Engagement	Meaningful involvement of women's organizations, feminist groups, and gender-diverse organizations in implementation of programs	Less than 50% were satisfied with engagement during implementation (KPI E3a)	50–74% were satisfied	75% and above were satisfied
	C. Use of Gender-Earmarked Funds	Extent to which budget allocation for gender activities is being spent	Gender earmarked budget lines not spent at all or limited or delayed expenditure or major underspends	Most gender-related funds used, with explanations for any delays	Gender-earmarked funds spent as planned and linked to activities delivered in reporting period

Table 5. Gender Integration Scoring Framework

ANNEX 5. LIST OF STAKEHOLDERS INTERVIEWED

#	Location	Organization	Position	#	Location	Organization	Position
1	Global	Global Fund	Manager, KPI reporting	145	Tanzania	Tanzania National Country Coordinating Mechanism (TNCM) – Secretariat	TNCM Executive Secretary
2	Global	Global Fund	Specialist, Data Use for Action, Gender Monitoring, Evaluation and Country Analysis	146	Tanzania	Ministry of Health – Geita District Council	Malaria Focal Person
3	Global	Global Fund	Technical Advisor, Gender	147	Lesotho	Ministry of Finance – PMU	Director
4	Global	Global Fund	Manager, Thematic Cluster for Human Rights	148	Lesotho	Ministry of Finance – PMU	Program Manager
5	Global	Global Fund	Technical Advisor, Gender	149	Lesotho	Ministry of Finance – PMU	Senior AGYW Program Officer
6	Global	Global Fund	Senior Technical Advisor, Human Rights	150	Lesotho	Ministry of Finance – PMU	M&E Manager
7	Global	Global Fund	Senior Technical Advisor, Community Engagement	151	Lesotho	Lesotho Country Coordination Mechanism	Executive Secretary
8	Global	Global Fund	Senior Program Officer, Gender Equality, Strategic Initiatives	152	Lesotho	Ministry of Gender, Youth and Social Development	Gender Officer
9	Global	Global Fund	Technical Advisor, CRG Regional Investment Support	153	Lesotho	Ministry of Justice – Lesotho Correctional Services	Senior Assistant Commissioner
10	Global	Global Fund	Technical Advisor, CRG Regional Investment Support	154	Lesotho	Ministry of Justice – Lesotho Correctional Services	LCS HIV/TB Coordinator
11	Global	Global Fund	Technical Advisor, CRG Regional Investment Support	155	Lesotho	Ministry of Health – DHMT	District Medical Officer
12	Global	Global Fund	Senior Disease Advisor, Technical Advice and Partnerships (TAP)	156	Lesotho	Ministry of Health	National TB and Leprosy Program Manager
13	Global	Global Fund	Senior Disease Advisor, Technical Advice and Partnerships (TAP)	157	Lesotho	Ministry of Health	TB/HIV Coordinator
14	Global	Global Fund	Senior Specialist HRH and SRH Integration RSSH	158	Lesotho	Ministry of Health	HIV Manager

#	Location	Organization	Position	#	Location	Organization	Position
15	Global	Global Fund	Senior Specialist Community Health Worker Programming	159	Lesotho	UNAIDS	Country Director
16	Global	Global Fund	TRP Panel Member	160	Lesotho	UNAIDS	Community Support Advisor
17	Global	Global Fund	TRP Panel Member	161	Lesotho	MCA	GBV/GSI Activity Manager
18	Global	Global Fund	TRP Panel Member	162	Lesotho	UNICEF	HIV Specialist
19	Global	Global Fund	TRP Panel Member	163	Lesotho	UNFPA	Programme Analyst – HIV Prevention and Child Protection
20	Global	Global Fund	TRP Panel Member	164	Lesotho	Bacha-Re-Bacha	Executive Director
21	Global	Global Fund	Regional AGYW Specialist, Country Team (Tanzania)	165	Lesotho	Bacha-Re-Bacha	M&E Manager
22	Global	Global Fund	Senior Fund Portfolio Manager (Tanzania)	166	Lesotho	Baylor College of Medicine Children's Foundation	Executive Director
23	Global	Global Fund	Senior Program Officer (Tanzania)	167	Lesotho	Baylor College of Medicine Children's Foundation	Technical Director
24	Global	Global Fund	Senior Fund Portfolio Manager (Lesotho)	168	Lesotho	Care for Basotho	Acting Director
25	Global	Global Fund	Regional AGYW Specialist, Country Team (Lesotho)	169	Lesotho	Care for Basotho	M&E Manager
26	Global	Global Fund	Senior Program Officer (Lesotho)	170	Lesotho	Care for Basotho	Key Population Nurse
27	Global	Global Fund	Senior Fund Portfolio Manager (Côte d'Ivoire)	171	Lesotho	Jhpiego	Director
28	Global	Global Fund	Program Officer (Guinea)	172	Lesotho	Jhpiego	Technical Director
29	Global	Global Fund	Public Health and M&E Specialist (Guinea)	173	Lesotho	Jhpiego	Finance Manager
30	Global	Global Fund	Senior Program Officer (Pakistan)	174	Lesotho	Jhpiego	Programs Manager

#	Location	Organization	Position	#	Location	Organization	Position
31	Global	Global Fund	Public Health and M&E Specialist (Pakistan)	175	Lesotho	Jhpiego	TB Nurse
32	Global	Speak Up Africa	Director of Programs	176	Lesotho	National AIDS Commission (NAC)	Chief Executive
33	Global	Y Plus Global	Director of Programs	177	Lesotho	National AIDS Commission (NAC)	Programs Manager
34	Global	Y Plus Global	Program Officer	178	Lesotho	National AIDS Commission (NAC)	SI Manager
35	Global	African Leaders Malaria Alliance	Principal Director	179	Lesotho	National Drug Service Organisation (NDSO)	Assistant Customer Manager
36	Global	World Health Organization	Unit Head, Rights and Equality across the Life course (REL)	180	Lesotho	National Drug Service Organisation (NDSO)	Procurement Coordinator
37	Global	World Health Organization	Senior Gender Technical Lead	181	Lesotho	National Drug Service Organisation (NDSO)	Supplies Coordinator
38	Global	Stop TB	Country & Community Support for Impact Team	182	Lesotho	Partners in Health	Deputy Director
39	Global	UNAIDS	Former Head of Gender Equality	183	Lesotho	Partners in Health	MDR-TB Program Lead
40	Global	World Vision Haiti	Chief of Party	184	Lesotho	Phelisang Bophelong	Director
41	Global	World Vision Haiti	Deputy Chief of Party	185	Lesotho	Phelisang Bophelong	M&E Manager
42	Global	FOSREF (Haiti)	Executive Director	186	Lesotho	Phelisang Bophelong	Programs Manager
43	Global	Ministry of Health, Mozambique	Unit Coordinator	187	Lesotho	Phelisang Bophelong	Counselors
44	Global	World Vision Mozambique	Chief of Party for the Malaria Grant	188	Lesotho	Riders for Health	Director
45	Global	World Vision Mozambique	Technical Director for the Malaria Grant	189	Lesotho	Riders for Health	Accountant
46	Global	World Vision Mozambique	Provincial Manager for the Malaria Grant	190	Lesotho	Riders for Health	M&E Officer
47	Global	World Vision Mozambique	Country Director	191	Lesotho	Women in Law Southern Africa (WLSA)	Director

#	Location	Organization	Position	#	Location	Organization	Position
48	Pakistan	Ministry of NHR&C	Executive Secretary	192	Lesotho	Women in Law Southern Africa (WLSA)	Project Manager
49	Pakistan	World Health Organization	Technical Officer	193	Lesotho	Women in Law Southern Africa (WLSA)	M&E Officer
50	Pakistan	FCDO	Advisor	194	Lesotho	Women in Law Southern Africa (WLSA)	Paralegal
51	Pakistan	Stop TB Partnership	Executive Director	195	Lesotho	Sentebale	Country Director
52	Pakistan	Dareecha	Representative	196	Lesotho	Sentebale	Social, Economic Coordinator
53	Pakistan	APLHIV	Project Manager	197	Lesotho	Sentebale	M&E Manager
54	Pakistan	CMU	Senior Provincial Program Officer	198	Lesotho	Sentebale	Senior Programs Coordinator/ Project Coordinator
55	Pakistan	CMU	M&E Manager	199	Lesotho	Sentebale	Programs Director
56	Pakistan	CMU	Community Support Officer	200	Lesotho	Sentebale	District Coordinator
57	Pakistan	Mercy Corps (TB - Principal Recipient)	Finance Manager	201	Lesotho	Key Affected Populations Alliance of Lesotho (KAPAL)	Project Coordinator
58	Pakistan	Mercy Corps (TB - Principal Recipient)	Gender Focal Person	202	Lesotho	Mosepele Foundation	Project Manager
59	Pakistan	Mercy Corps (TB - Principal Recipient)	M&E Manager	203	Lesotho	Mothers2Mothers	Country Director
60	Pakistan	Association of Social Development. Punjab	Team Lead	204	Lesotho	She-Hive	Programs Director
61	Pakistan	Association of Social Development. Punjab	Team	205	Côte d'Ivoire	World Health Organization	Program Officer
62	Pakistan	Mercy Corps (TB - Principal Recipient)	Director	206	Côte d'Ivoire	Ministry of Health	Gender Permanent Secretariat
63	Pakistan	Greenstar Social Marketing	Team Lead	207	Côte d'Ivoire	Private Sector	Vice Président du CCM

#	Location	Organization	Position	#	Location	Organization	Position
64	Pakistan	Greenstar Social Marketing	Manager Operations	208	Côte d'Ivoire	ROPC-CI	Executive Director
65	Pakistan	Greenstar Social Marketing	Senior M&E Manager	209	Côte d'Ivoire	ROPC-CI	Responsable Gender and Human Rights
66	Pakistan	Greenstar Social Marketing	DDG Technical	210	Côte d'Ivoire	ROPC-CI	M&E Manager
67	Pakistan	Health Services Academy	Vice Chancellor	211	Côte d'Ivoire	COLTMER	Executive Director
68	Pakistan	Shah Abdul Latif Bhittai Welfare Society	President	212	Côte d'Ivoire	COLTMER	Présidente
69	Pakistan	Lady Health Workers (LHWs)	LHWs, Community Members, Influencers	213	Côte d'Ivoire	COLTMER	M&E Manager
70	Pakistan	Youth lead/faith based organization/any other	Community	214	Côte d'Ivoire	COLTMER	Human Rights Focal Point
71	Pakistan	Pireh Male Health Society (PIREH)	Program Manager	215	Côte d'Ivoire	ONG Fromager pour la santé et le social Ss recipient	Superviseur Général des Activités
72	Pakistan	Male Health Alliance	Representative	216	Côte d'Ivoire	ONG Fromager pour la santé et le social Ss recipient	Superviseur du District
73	Pakistan	Bridge Consultant Foundation Sindh	Program Manager	217	Côte d'Ivoire	ONG Fromager pour la santé et le social Ss recipient	Coordonnateur DIC
74	Pakistan	Bridge Consultant Foundation Sindh	Field Implementor/Regional Coordinator	218	Côte d'Ivoire	ADJAH	M&E Manager
75	Pakistan	Bridge Consultant Foundation Sindh	Team	219	Côte d'Ivoire	ADJAH	Executive Director
76	Pakistan	Bridge Consultant Foundation Sindh	Data Manager	220	Côte d'Ivoire	Alliance CI	Executive Director
77	Pakistan	Bridge Consultant Foundation Sindh	M&E Manager	221	Côte d'Ivoire	Alliance CI	Human Rights Focal Point
78	Pakistan	Provincial TB control program Sindh	Finance Manager	222	Côte d'Ivoire	PNLT	Human Rights and Gender

#	Location	Organization	Position	#	Location	Organization	Position
79	Pakistan	Provincial TB control program Sindh	Field Implementor (Sr. Provincial officer)	223	Côte d'Ivoire	Gouvernement	Chargé de Communication
80	Pakistan	Provincial TB control program Sindh	Program Manager	224	Côte d'Ivoire	CCM secteur privé	Suivi Evaluation
81	Pakistan	Provincial TB control program Sindh	provincial LHW TB COORDINATOR	225	Côte d'Ivoire	ENDA SANTE	Human Right and gender
82	Pakistan	Agha Khan University	Researcher	226	Côte d'Ivoire	ENDA SANTE	Coordonnateur programme
83	Pakistan	Punjab Department of Health	Director PTP	227	Côte d'Ivoire	Heartland Alliance	Coordonnateur
84	Pakistan	Pakistan Anti TB Association	President	228	Côte d'Ivoire	RIOF	Coordonnateur
85	Pakistan	PHEONIX	Program Manager	229	Côte d'Ivoire	District sanitaire de Bassam	Directeur
86	Pakistan	Dostana Male Health Society	Program Manager	230	Côte d'Ivoire	PNLS	Directeur Adjoint
87	Pakistan	Baham	Executive Director	231	Côte d'Ivoire	Gouvernement	M&E Manager
88	Pakistan	Active Health Organization (AHO)	Chairperson	232	Côte d'Ivoire	Gouvernement	Executive Director
89	Pakistan	Association of Social Development. Punjab	Program Manager/Team Lead	233	Côte d'Ivoire	Ministère de la Femme, de la Famille et Enfant	Coordonnatrice technique
90	Pakistan	Association of Social Development. Punjab	Finance Officer	234	Côte d'Ivoire	Centre Antituberculeux	Médecin chef
91	Pakistan	Association of Social Development. Punjab	Regional Coordinator	235	Côte d'Ivoire	Alliance CI sous bureau Abengourou	Coordonnateur Alliance Abengourou
92	Pakistan	Association of Social Development. Punjab	Regional Coordinator	236	Côte d'Ivoire	Health alliance	Coordonnateur
93	Pakistan	Association of Social Development. Punjab	ASD TEAM	237	Côte d'Ivoire	ADM	Chargé de suivi evaluation
94	Pakistan	Provincial TB control program Punjab	Senior Finance Officer	238	Côte d'Ivoire	ADM	Directeur coordonnateur

#	Location	Organization	Position	#	Location	Organization	Position
95	Pakistan	Provincial TB control program Punjab	Field Implementor (senior provincial program officer)	239	Côte d'Ivoire	Gouvernement	Directeur
96	Pakistan	Provincial TB control program Punjab	Program Manager	240	Côte d'Ivoire	Gouvernement	Chef de service suivi evaluation
97	Pakistan	Provincial TB control program Punjab	DHIS COORDINATOR	241	Côte d'Ivoire	Secteur Privé	Chef de division
98	Pakistan	Provincial TB control program Punjab	Ex LHW Coordinator	242	Côte d'Ivoire	ONUSIDA	Conseiller pays
99	Pakistan	Mercy Corps-PIU Punjab	Team Lead	243	Côte d'Ivoire	ONG Fromager pour la santé et le social Ss recipient	Members of ONG
100	Pakistan	Mercy Corps-PIU Punjab	Regional Coordinator	244	Côte d'Ivoire	Réseau bénéficiaire	Réseau bénéficiaire
101	Pakistan	Mercy Corps-PIU Punjab	Data Management Officer	245	Côte d'Ivoire	OSC	Members
102	Pakistan	Mercy Corps-PIU Punjab	Assistant Project Officer/ Safeguarding Officer	246	Côte d'Ivoire	Community Leaders	Community Leaders
103	Pakistan	Mercy Corps-PIU Punjab	Team Member	247	Côte d'Ivoire	Community Leaders	Community Leaders
104	Pakistan	Greenstar Social Marketing	Team Member	248	Côte d'Ivoire	Ami Des Hommes (ADH) Sub sub recipient	Members of ONG
105	Pakistan	Baham	Team Member	249	Guinea	Ministry of Health - Department of Community Health	Director
106	Pakistan	CMU	Program Manager	250	Guinea	Ministry for the Promotion of Women, Children and Vulnerable Persons (Regional Office for Women's Affairs)	Head of Childhood Unit
107	Tanzania	Ministry of Health (Mainland) – Global Fund Coordination Unit (GFCU)	MoH GF-Coordination Unit (GFCU)-Coordinator	251	Guinea	Ministry for the Promotion of Women, Children and Vulnerable Persons (District Office for Women's Affairs)	Head of Gender Unit
108	Tanzania	President's Office Regional Administration and Local Government	GF Coordinator	252	Guinea	Ministry for the Promotion of Women, Children and Vulnerable Persons (District Office for Women's Affairs)	Director

#	Location	Organization	Position	#	Location	Organization	Position
109	Tanzania	Ministry of Health	Head of Programs	253	Guinea	National Network of Associations for Malaria Control in Guinea (Réseau National des Associations pour la Lutte contre le Paludisme en Guinée [RENALP-G])	President
110	Tanzania	Ministry of Health (Mainland) – National Malaria Control Programme (NMCP)	Program Manager NMCP	254	Guinea	Women's association Batè Nafadji	Group
111	Tanzania	Ministry of Health (Mainland) – National Malaria Control Programme (NMCP)	Head Finance — NMCP	255	Guinea	Women's association Kintinia	Group
112	Tanzania	Ministry of Health (Mainland) – National Malaria Control Programme (NMCP)	SBC& Advocacy and Community Engagement Coordinator	256	Guinea	Youth association Batè Nafadji	President
113	Tanzania	Ministry of Health (Mainland) – National Malaria Control Programme (NMCP)	GF Coordinator	257	Guinea	Youth association Kintinia	President
114	Tanzania	Ministry of Health (Mainland) – National Malaria Control Programme (NMCP)	Head M&E	258	Guinea	Religion leaders	Imam
115	Tanzania	Ministry of Health (Mainland) – National Malaria Control Programme (NMCP)	Head Vector Control	259	Guinea	Religion leaders	Imam
116	Tanzania	Ministry of Health (Mainland) – National Malaria Control Programme (NMCP)	Head Case Management	260	Guinea	Santé Intégrée	Community Health Specialist
117	Tanzania	Ministry of Health- RSSH	Coordinator RSSH	261	Guinea	Enabel	Sexual and Reproductive Health Rights Expert
118	Tanzania	Ministry of Health CMoH Office - Dodoma City Council Medical Office	HMIS Coordinator	262	Guinea	Expertise France	Gender Specialist

#	Location	Organization	Position	#	Location	Organization	Position
119	Tanzania	Ministry of Health - Dodoma City Council - Makole Health Center	Medical Officer In Charge	263	Guinea	Health centers	Head of Health Center
120	Tanzania	Ministry of Health CMOH Office - Dodoma City Council Medical Office	City Medical Officer of Health (CMoH/DMO)	264	Guinea	Health center of Kintinia	Head of Health Center
121	Tanzania	Ministry of Health - Dodoma City Council - Makole Health Center	Nurse In Charge of ANC	265	Guinea	Village Health Committee (COSAH) of Batè Nafadji	COSAH Members
122	Tanzania	Ministry of Health - Geita Region	Regional Malaria Focal Person	266	Guinea	Village Health Committee (COSAH) of Kintinia village	COSAH Members
123	Tanzania	Ministry of Health - Geita District Council	Acting District Medical Officer	267	Guinea	CHWs/Community relays (ReCos) Batè Nafadji village	CHWs/ReCos
124	Tanzania	Ministry of Health - Geita District Council	HMIS Coordinator	268	Guinea	CHWs/Community relays (ReCos) Kintinia village	CHWs/ReCos
125	Tanzania	Ministry of Health - Geita District Council	Malaria Focal Person	269	Guinea	Representative of the CCM (country level)	SP Coordinator
126	Tanzania	Ministry of Health - Geita District Council - Katoro Health Center	MD/OPD In Charge	270	Guinea	Representative of the CCM (country level)	Member of the Strategic Monitoring Committee
127	Tanzania	Ministry of Health - Geita District Council - Katoro Health Center	RN/RCH In Charge	271	Guinea	Catholic Relief Services (CRS)	Monitoring & Evaluation Technical Advisor
128	Tanzania	Ministry of Health - Geita District Council - Katoro Health Center	Pharmacist/Pharmacy In Charge	272	Guinea	Catholic Relief Services (CRS)	MEAL Manager
129	Tanzania	Ministry of Health - Geita District Council - Katoro Health Center	Pharmacist	273	Guinea	Catholic Relief Services (CRS)	Health Community Technical Advisor
130	Tanzania	Ministry of Health - Geita District Council - Katoro Health Center	Assistant Nursing officer	274	Guinea	Catholic Relief Services (CRS)	Malaria Technical Advisor
131	Tanzania	Ministry of Health - Geita District Council - Inyala Dispensary	RCH In Charge/Enrolled Nurse	275	Guinea	Catholic Relief Services (CRS)	Communication Specialist

#	Location	Organization	Position	#	Location	Organization	Position
132	Tanzania	Ministry of Health - Geita District Council - Inyala Dispensary	RN/RCH In Charge	276	Guinea	Catholic Relief Services (CRS)	Global Fund Project Deputy Director
133	Tanzania	CONAMET	Director	277	Guinea	Catholic Relief Services (CRS)	Team Leader
134	Tanzania	KASODEFO	Representative	278	Guinea	Ministry of Health – National Malaria Control Program	Coordinator
135	Tanzania	African Women AIDS working Group	Project Coordinator	279	Guinea	Ministry of Health – National Malaria Control Program	Gender and Equity Officer
136	Tanzania	Gates Foundation's PATH Malaria Control and Elimination Partnership in Africa	Principal Research Scientist	280	Guinea	Ministry of Health – National Malaria Control Program	Monitoring and Evaluation Officer
137	Tanzania	NELICO	CEO	281	Guinea	Ministry of Health – National Malaria Control Program	Partnership Officer
138	Tanzania	Thubutu Africa Initiatives (TAI)	TAI	282	Guinea	Ministry of Health – National Malaria Control Program	Communication Specialist
139	Tanzania	KASODEFO	Simiyu	283	Guinea	Plan International	Communication Officer, Gender Specialist, MEAL Manager, Health Specialist
140	Tanzania	LISAWÉ	Manager	284	Guinea	ChildFund	Protection Senior Specialist Protection – Head of Malaria Project
141	Tanzania	NELICO	Deputy Director at NELICO	285	Guinea	Alliance Promoting Governance and Local Initiatives (AGIL)	Representative
142	Tanzania	LISAWÉ	Manager	286	Guinea	Alliance Promoting Governance and Local Initiatives (AGIL)	M&E Officer, Administrative Assistant, Finance officer
143	Tanzania	African Women AIDS working Group	Tanga	287	Guinea	Organisation Catholique pour la Promotion Humaine (OCPH)	Project Officers (national and regional)
144	Tanzania	Ministry of Health (Mainland) – National Malaria Control Programme (NMCP)	SBC& Advocacy and Community Engagement Coordinator	288	Guinea	Alliance Promoting Governance and Local Initiatives (AGIL)	Field Team

Table 6. List of Stakeholders Consulted

ANNEX 6. COUNTRY INSIGHTS ON KEY THEMES RELATED TO THE INTEGRATION OF GENDER EQUALITY APPROACHES IN HIV, TB, AND MALARIA PROGRAMS

COUNTRY INSIGHTS		
High Impact Africa 1 Country HIV	High Impact Africa 2 Country Malaria	High Impact Asia Country TB
Overall GIS Score for Design = 3 (Strong)	Overall GIS Score for Design = 1.8 (Moderate)	Overall GIS Score for Design = 1 (Limited)
Gender analysis: The HIV grant design drew on sex- and age-disaggregated data, key population (KP) evidence, and recent gender, human rights, and equity analyses. Interview data also suggest that gender analysis helped identify how risks, access barriers, and service needs differed across women, men, adolescents, and transgender populations. This appears to have supported a more differentiated design approach.	Gender analysis: The design process drew on a malaria Matchbox assessment, which provided gender-related evidence on the different barriers faced by groups such as pregnant women, young mothers, and night workers. However, because the assessment was completed late in the funding request process, its influence on design decisions appears to have been limited at the design stage, informing some design discussions. Some stakeholders suggested that Matchbox findings were later used to inform implementation adaptations.	Gender analysis: The funding request reflected limited use of gender analysis. Gender was largely understood through sex-disaggregated data, equal access, and broad references to inclusion, rather than through analysis of how gender norms, stigma, mobility constraints, or decision-making power shape TB access and outcomes. Efforts to strengthen attention to gender and equity through joint reviews and technical assistance were not strongly reflected in the final design.
Inclusive engagement: The design process reflected deliberate inclusion of women's organizations, gender-focused organizations, and KP groups through national dialogue and civil society platforms. Respondents described participant selection as intentionally structured to ensure inclusive representation, and emphasized that women's and youth organizations needed to be present so that their priorities would be reflected in the final design.	Inclusive engagement: Women's organizations and gender-diverse organizations were documented as participating in country dialogue and related consultations, and some respondents felt engagement of women-led organizations was stronger in GC7 than in the previous cycle. At the same time, interview data suggest that participation was variable in both breadth and influence. Some stakeholders noted that relevant women's and feminist organizations were not included, and that broader gender norms affected who felt able to speak and influence discussions.	Inclusive engagement: Country dialogue processes included participation of gender-diverse groups and community actors. However, interview data indicated limited representation of relevant women's and feminist organizations and limited evidence that these perspectives strongly shaped the final design.
Identification and mitigation of gender barriers: The design went beyond identifying vulnerable groups to recognizing concrete gender-related barriers to access, retention, and protection. Stakeholders referred to evidence showing that women's access to care could be constrained by dependence on husbands or fathers, that men were underreached in testing, and that stigma and family rejection created additional risks for key populations. These barriers were linked to strategies such as community screening, human rights interventions, differentiated service delivery, and other measures intended to reduce stigma and improve access.	Identification and mitigation of gender barriers: While the Funding Request emphasized pregnant women and children under five, it did not clearly articulate how gender norms, household decision-making, or male care-seeking patterns shape malaria-related access and prevention. Gender-related barriers were only partially reflected in the design.	Identification and mitigation of gender barriers: The funding request did not clearly identify or systematically respond to gender-related barriers. At the same time, respondents described barriers in practice, including women's limited mobility, dependence on male family members, privacy concerns, discomfort with male providers, and the exclusion of transgender communities from routine service approaches. This suggests that barriers were recognized in implementation, but were not clearly incorporated into design.

COUNTRY INSIGHTS		
High Impact Africa 1 Country HIV	High Impact Africa 2 Country Malaria	High Impact Asia Country TB
Intervention design: The Funding Request included a range of gender-responsive and some gender-transformative elements, including differentiated service delivery, community-based screening, peer support, girls’ empowerment activities, GBV-sensitive HIV support, positive masculinity work, and other approaches tailored to the needs of women and key populations. Interviews suggest that these interventions were valued because they helped reach populations that would otherwise have been missed and improved confidence in service access.	Intervention design: The Funding Request primarily included some gender-targeted approaches. Respondents repeatedly noted that there were no strongly visible or specific gender-related activities in the grant design beyond the focus on pregnant women and other biologically vulnerable groups. The Funding Request briefly references norm change, empowerment, and training-related approaches, but these were not well specified. This suggests moderate integration of gender in intervention design, although with limited detail on how these activities would address identified barriers. In practice, some gender-responsive and -transformative activities are being implemented (e.g., social and behavior change communication activities addressing household decision-making and men’s roles in prevention practices) that were not articulated in the Funding Request.	Intervention design: The design included few clearly specified gender-related interventions. Some practical adaptations were introduced during implementation, including female screeners and health providers, engagement of lady health workers, camp-based outreach, more private service arrangements, and early outreach for transgender communities. However, these were not described as gender-responsive interventions in the funding request.
Implications: This example illustrates that strong gender integration in design was achieved because evidence, inclusive engagement, barrier analysis, and intervention selection were mutually reinforcing. Gender integration shaped how priority groups were understood, which barriers were addressed, and how services were designed and delivered. This resulted in a coherent program design where gender integration helped align priority-setting, barrier analysis, and intervention choices in ways that could improve the reach, accessibility, and responsiveness of HIV services for priority populations. Stakeholders suggested that gender integration strengthened program approaches by improving targeting, expanding differentiated outreach, increasing testing opportunities, reducing stigma-related access barriers, and supporting retention and treatment completion.	Implications: This example suggests that relevant gender analysis was available, but entered too late to fully inform the funding request. This highlights the importance of generating and using gender evidence early enough in the design process to inform both barrier identification and intervention selection. The example also shows that gender analysis can still add value when used later to inform implementation adaptations.	Implications: This example illustrates that without strong gender analysis and design follow-through, the integration of gender approaches to address barriers to access and service use may be limited even when there is some participation of gender-relevant groups and practical adaptations are present.

Table 7: Country Insights Related to Gender Integration in Funding Requests and Grant Design

COUNTRY INSIGHTS			
High Impact Africa 1 Country HIV	Southern & Eastern Africa Country HIV	High Impact Asia Country TB	High Impact Africa 2 Country Malaria
GIS (Budget): 3/3 GIS (Performance Frameworks): 2/3 12% of the budget dedicated to gender-related activities	GIS (Budget): 3/3 GIS (Performance Frameworks): 2/3 15% of the budget dedicated to gender-related activities	GIS (Budget): 1/3 GIS (Performance Frameworks): 1/3 0% of the budget dedicated to gender-related activities	GIS (Budget): 3/3 GIS (Performance Frameworks): 2/3 15% of the budget dedicated to gender-related activities
The HIV grant includes investments in community screening and differentiated services for key populations including transgender people, sex workers, and vulnerable young women; support for women's economic autonomy; psychosocial and GBV-sensitive support (including transit houses for women expelled from their homes after HIV disclosure); and gender and human-rights training for staff. Gender-related activities were financed through both the core grant budgets and Strategic Initiatives. The performance framework shows moderate integration of gender, with sex- and age-disaggregation and several indicators for key populations.	The HIV grant included budgeted activities for groups prioritized in the design, particularly adolescent girls and young women, their male sexual partners, and sex workers. These included condom and lubricant programming, PrEP, prevention communication and demand creation, sexual and reproductive health services, post-violence care, social protection, support to remove human rights-related barriers, and multiple HIV testing modalities for AGYW and their partners. This suggests a strong degree of alignment between grant priorities and funding. The performance framework also included numerous indicators, with sex disaggregation and tracking for specific population groups. It included one indicator related to power (condom use by male partners of AGYW).	The TB grant did not include budgeted gender-related interventions. The few budget lines that were potentially related to gender were limited to community outreach, CSO engagement, and incentives for Lady Health Workers for TB case-finding. These were not identified as gender-related activities. The performance framework showed similarly limited gender integration. While some indicators were sex-disaggregated, there were no gender equality outcome indicators and no indicators related to key populations, power, decision-making, or other gender-related barriers.	This malaria grant included funds for ANC, IPTp, ITNs for pregnant women and children, and SBC and community engagement that often reaches women. However, several of these activities (especially the SBC and community engagement work) were not labeled as gender-related in the budget lines. The performance framework included standard malaria indicators for pregnant women and children under five, along with some sex-disaggregated indicators for the general population.
Implications: This example suggests a relatively high degree of alignment between design and budgeting in the HIV grant, with resources budgeted to a substantive set of gender-related activities for women and key populations. Gender integration was moderate in the performance framework, which included disaggregation and several KP indicators.	Implications: This example shows strong alignment between design and budgeting. There is moderate alignment with the performance framework, which was strong on disaggregation and service coverage, but more limited in its ability to assess gender equality outcomes or change for a wider range of key and vulnerable populations.	Implications: This example suggests that weak integration of gender equality approaches in budgeting and performance measurement reflected a broader weakness in grant design. Because the integration of gender equality approaches was not developed as a substantive design priority, it was also not translated into budget lines or clear indicators within the TB grant.	Implications: This example suggests partial alignment between grant design, budget, and performance frameworks, with all three giving some attention to gender-relevant priorities, especially for pregnant women.

Table 8. Country Insights Related to Budgets for Gender Activities

COUNTRY INSIGHTS		
Southern & Eastern Africa Country HIV	High Impact Asia Country TB	High Impact Africa 2 Country Malaria
Depth of engagement: Engagement of women-led and feminist organizations during GC7 in this country was relatively strong compared to many contexts, particularly for the HIV grant. Established CBOs and youth networks influenced priorities related to GBV, stigma, and gender norms and gender-diverse communities participated primarily through consultations with key populations.	Depth of engagement: Formal country dialogue processes for TB in this country were widely described by CCM and PR stakeholders as open and inclusive; however, participation of women-led, feminist, and gender-diverse organizations was limited in practice. Representation was largely confined to a small number of large NGOs, with minimal involvement of MSM, FSW, transgender, or women's rights organizations.	Depth of engagement: Women-led and gender-focused organizations were formally invited to participate in GC7 malaria country dialogue processes, and consultations were described as inclusive at face value. However, engagement was uneven, with limited meaningful participation by feminist organizations and minimal involvement of gender-diverse groups.
Influence on design: Women-led and feminist organizations helped ensure structural and transformative gender narratives were included within the funding request, particularly on GBV, gender norms, AGYW programming and survivor support. Their influence was most visible in gender-responsive HIV components.	Influence on design: Engagement of gender-focused actors appeared to have limited influence on TB grant design. Gender-related perspectives were not well reflected in program architecture, and consultations were often perceived by community actors as symbolic, and occurring late in the process with limited opportunity to shape priorities or resource allocation.	Influence on design: Despite consultation, women's and feminist organizations had limited influence on agenda-setting and final grant content. Technical and epidemiological discussions were more prevalent and gender and rights perspectives were not systematically reflected in malaria design, resulting in limited translation of engagement into gender-responsive or -transformative programming.

Table 9. Country Insights Related to Engagement During Country Dialogues

High Impact Africa 1 Country HIV			
Context and Strategic Initiative (SI) contribution: During GC6, an SI supported one of the first dedicated assessments of HIV vulnerability and service access among transgender populations in this High Impact Africa 1 country. Interviews highlighted that at the time, transgender communities were largely absent from routine epidemiological data, national strategies, and Global Fund-supported programming.	Influence on GC7 design: Findings from the SI-supported assessment were used to inform GC7 HIV grant design, contributing to the explicit inclusion of peer-led, transgender-run drop-in centers and differentiated service delivery models within the funding request. These interventions represented a substantive shift from prior cycles, where transgender needs were either subsumed under broader KP categories or not addressed at all.	Institutionalization and sustainability: The Ministry of Health has since taken ownership of follow-on analytical work, with the next national HIV assessment incorporating a dedicated transgender component led by government counterparts. This suggests a potential transition from externally supported evidence generation to institutionalized inclusion within national data systems and planning processes.	Implications: This example illustrates how Strategic Initiatives can function as catalytic entry points, introducing politically and technically sensitive gender and human-rights issues, demonstrating feasibility, and enabling eventual uptake by national institutions. In this case, SI-supported evidence moved from pilot analysis to formal program design and onward into routine national assessment practice, strengthening both sustainability and scale.

Table 10. Country Insights Related to the Strategic Initiatives

COUNTRY INSIGHTS		
Southern & Eastern Africa Country HIV	Western & Central Africa Country Malaria	High Impact Africa 2 Country Malaria
How gender integration in HIV, TB, and malaria programs is understood: Stakeholders articulated a relatively sophisticated understanding of gender as power, norms, and structural inequality, extending beyond women and girls to include men, key populations, and institutional barriers. The integration of gender equality approaches in HIV programming was widely described as a determinant of program effectiveness rather than a standalone equity issue. At the same time, understanding was not uniform, and some respondents still framed gender more narrowly.	How gender integration in HIV, TB, and malaria programs is understood: Most stakeholders conceptualized gender primarily in terms of equitable access and inclusion, emphasizing nondiscrimination, reaching vulnerable groups, and sex-disaggregated data. Gender norms and power relations were acknowledged by some actors but rarely framed as explicit targets for intervention.	How gender integration in HIV, TB, and malaria programs is understood: Most stakeholders equated gender equality with treating everyone the same and ensuring universal access, with a strong focus on women as beneficiaries. A smaller group of stakeholders including community actors articulated gender in terms of power, mobility, stigma, and GBV, but this perspective was not common.
How this shaped implementation decisions: This understanding translated into concrete implementation choices, including prioritization of AGYW programming, integration of GBV response and legal support within HIV services, gender-sensitive outreach in prisons and mining communities, and differentiated service delivery models. While gender-transformative ambitions were sometimes moderated by operational constraints, gender-responsive thinking consistently influenced decisions on service design and targeting.	How this shaped implementation decisions: Implementation decisions focused on inclusive coverage strategies, such as prioritizing pregnant women and children, adjusting outreach for mobile populations, recruiting women as community relays, and ensuring gender balance in staffing and training. Gender considerations influenced operational adjustments but rarely extended to deliberate norm change or empowerment strategies.	How this shaped implementation: Malaria implementation decisions were primarily driven by epidemiological risk profiles and supply-side delivery considerations, consistent with prevailing malaria control strategies. However, even where gendered barriers such as women's restricted mobility, men's delayed care-seeking, and stigma were recognized, they were not frequently addressed through complementary programmatic adaptations or resource prioritization aimed at addressing access and uptake. Some CSOs used a stronger understanding of gender to introduce more gender-responsive or -transformative elements in implementation.
Key limitations: Decision-making authority remains centralized within technical and clinical committees, limiting the influence of gender focal persons. Some frontline implementers continue to equate gender integration with women-only targeting.	Key limitations: Community-identified gender norms that impacted disease outcomes and access to services, such as women's limited decision-making power or restrictions on mobility, were managed through practical adaptations rather than systematically integrated into program logic. Gender integration was reflected mainly in targeting, staffing, and service delivery, shaping access and delivery modalities without challenging underlying power dynamics.	Key limitations: Community-level understandings of gender issues, including control over movement, finances, and information, are not strongly reflected in formal decision-making. While some CSOs and individual champions have translated these insights into more gender-responsive implementation choices, gender considerations remain mostly peripheral to implementation choices.

Table 11. Country Insights on Stakeholder Understanding of the Integration of Gender Equality Approaches in HIV, TB, and Malaria Programs

COUNTRY INSIGHTS	
Western & Central Africa Country Malaria	High Impact Africa 2 Country Malaria
Gender equality approaches in the Funding Request (Design): The GC7 malaria Funding Request in this country articulates a relatively expansive gender and human rights agenda. It draws on gender and human rights assessments to identify barriers related to women's decision-making power, social norms, disability, poverty, and access to services. Proposed activities include engaging religious and traditional leaders, promoting positive masculinity, strengthening women's and girls' leadership and voice, and addressing intra-household decision-making. Several of these elements reflect an intention to move beyond biological vulnerability toward norm-focused and potentially gender-transformative approaches.	Gender equality approaches in the Funding Request (Design): The GC7 malaria Funding Request in this country acknowledges that some population groups face greater vulnerability in relation to malaria risk as well as access to prevention and services, particularly pregnant women, children under five, and hard-to-reach populations. The grant design reflects the integration of gender equality approaches largely through gender-targeted and responsive interventions through tailoring SBCC, ensuring gender representation in training and implementation structures, and prioritizing pregnant women, children under five, and hard-to-reach populations. While the Funding Request references gender transformation, this is not clearly defined or linked to specific activities, indicators, or implementation strategies. Gendered power relations, intra-household decision-making, and social norms are not systematically addressed in the design narrative.
Gender equality approaches in reported implementation: In practice, gender integration in this country's malaria programming is concentrated on gender-targeted and gender-responsive approaches. Implementation prioritizes pregnant women and children under five, recruits women as community relays, adapts outreach to mobility and safety constraints, and engages religious leaders to facilitate acceptance of services by male household heads. These strategies are widely perceived as effective in reducing access barriers and increasing uptake, but they largely operate within existing gender norms and authority structures, which may limit the potential for lasting change in malaria prevention and treatment outcomes. The more explicitly norm-transformative activities described in the Funding Request, such as structured male-engagement programming, positive masculinity initiatives, and women's leadership and advocacy components, are not observed in malaria implementation, having been deprioritized during grant-making and shifted to the PAAR, where they were not subsequently funded.	Gender equality approaches in reported implementation: Reported implementation suggests that practice has, in some areas, moved beyond what was articulated in the Funding Request. Implementers describe adapting outreach and SBCC to women's time constraints, caregiving roles, and mobility limitations, as well as engaging men more deliberately around ANC attendance, IPTp uptake, LLIN use, and treatment-seeking. Some respondents linked these adaptations to the malaria Matchbox assessment or related equity/barrier analysis, although this was not consistently reported across implementation partners. Community dialogues and CLM processes have surfaced gendered barriers to access to malaria prevention, diagnosis, and treatment such as permission-seeking, spousal opposition, safety concerns related to travel, and unequal household decision-making, prompting local adjustments in delivery approaches.
Key insight: This example illustrates that the Funding Request articulated a broader approach to how gender affects malaria prevention and service use than was reflected in reported implementation. While the Funding Request reflects broader gender-transformative intent, implementation has prioritized feasible, service-delivery-oriented approaches that improve access but do not systematically challenge underlying gender norms or power relations. Stakeholders attributed this shift to budget constraints and a prioritization of immediate biomedical impact, with gender-transformative elements considered less urgent within the malaria response.	Key insight: While the Funding Request refers to gender integration in broad terms, reported implementation shows more concrete efforts by some frontline actors and CSOs to adapt malaria outreach and service delivery in response to gender-related barriers, including household decision-making, permission-seeking, and women's mobility constraints. However, these adaptations were uneven and weakly institutionalized. Their depth and consistency depended more on local initiative than on the grant design.

Table 12. Country Insights Comparing Gender Equality Approaches in Funding Requests and Implementation

COUNTRY INSIGHTS		
High Impact Africa 2 Country Malaria	Western & Central Africa Country Malaria	High Impact Asia Country TB
Partnership structure and reach: A malaria program involves strong, multilevel partnerships between implementers, district health teams, CSOs, CHWs, facilities, and community governance structures. CHWs are the central interface with households, supported by village- and ward-level committees and regular coordination meetings among NGOs and local leaders.	Partnership structure and reach: Implementation is supported by a dense and functional partnership ecosystem linking government, implementing partners, and community actors including relays, imams, youth representatives, and women's associations. These partnerships are highly trusted and operationally embedded, particularly at the community level.	Partnership structure and reach: TB programs partner extensively with public health actors, the Lady Health Worker program, private providers, and NGOs, including through collaborations between public and private providers that extend community reach. These partnerships support case-finding and service delivery and are appropriately oriented toward biomedical and supply-side TB control strategies. Such strategies are not inherently gender-blind; however, in this country, the partnerships were not structured to engage gender-specialized actors.
Contribution to gender integration in disease program: These partnerships, especially via CSOs and CHWs, are effective at surfacing gender-related barriers during implementation, including partner permission norms, women's mobility constraints, delayed care-seeking, and safety concerns. Community committees can intervene informally when household dynamics block access, and coordination between CHWs and facilities improves targeting of pregnant women.	Contribution to gender integration in disease program: Partnerships have enabled deliberate inclusion of women as community relays, strengthened outreach to remote and mobile populations, and improved equity in service reach. Collaboration with women's associations and community leaders facilitates mobilization of households and identification of vulnerable women and children.	Contribution to gender integration in disease program: Some partnerships enable gender-responsive practices, such as use of female screeners, privacy measures, and female gatekeepers to facilitate women's access. Community-based organizations provide safe spaces and psychosocial support, although often outside TB-funded activities.
Key gaps and limitations: The integration of gender equality approaches to address barriers to access in this malaria program is advanced indirectly rather than intentionally. Partnerships lack formal gender mandates, gender expertise, or mechanisms to escalate identified gender barriers into district or regional decision-making. Gender considerations remain incidental to operational collaboration, limiting their ability to drive systematic or transformative change.	Key gaps and limitations: Partnerships are not strategically designed around gender equality objectives related to reducing barriers to malaria prevention, care-seeking, and access to treatment. Engagement with women's affairs directorates, feminist organizations, or GBV-focused actors remains limited in malaria planning and decision-making processes. Partnerships address gender-related barriers mainly through improving access and participation, rather than through strategies aimed at changing gender norms or addressing rights-related barriers to malaria prevention and treatment.	Key gaps and limitations: Partnerships with women's rights organizations and CBOs led by MSM, FSW, and transgender communities are rare and largely informal. Existing HIV partnership infrastructure with KP-led organizations has not been effectively leveraged for TB. These organizations expressed interest in more formal roles and memoranda of understanding, but reported limited engagement opportunities, particularly for groups working in criminalized or politically sensitive areas. As a result, partnerships that could help address stigma, exclusion, and gendered power dynamics are underused.

Table 13. Country Insights on Partnerships

COUNTRY INSIGHTS		
High Impact Asia Country TB	High Impact Africa 2 Country Malaria	Southern & Eastern Africa Country HIV & TB
Data systems and infrastructure: TB programs rely on national TB surveillance systems that collect standard program data including some sex-disaggregated data. A transgender column has reportedly been added to forms, but its routine use in TB reporting was not evident. Interviews noted that data systems are not integrated across TB/HIV/hepatitis platforms, limiting analysis of co-infection or intersecting vulnerabilities.	Data systems and infrastructure: Malaria reporting uses DHIS2 and standard community and facility tools that capture sex disaggregation, pregnancy status, and service volumes. NGOs use digital SBC and community monitoring tools to capture data on vulnerable groups, but these data are not integrated into national systems. Routine malaria reporting and review processes are primarily structured around service delivery and coverage indicators, with limited evidence of systematic gender analysis.	Data systems and infrastructure: This country has a mature national data infrastructure, including DHIS2 for routine health data and LOMSHA for HIV program monitoring. Both support sex- and age-disaggregated reporting. HIV modules include indicators for AGYW and KPs. Some CSOs also use customized tools and databases for community and KP programming. DHIS2 recognizes only binary gender categories, limiting visibility of gender-diverse populations.
Gender-relevant data collected: Beyond sex disaggregation, there was little evidence of routine collection of other gender-relevant data (such as on GBV, stigma, household decision-making, etc.). MSM, transgender people, and FSWs remain largely invisible in TB surveillance; however, collecting such information carries legal and safety risks and could discourage care-seeking if confidentiality cannot be guaranteed.	Gender-relevant data collected: Routine systems capture sex and pregnancy status but not gendered access barriers (e.g., permission norms, mobility constraints, safety concerns). ANC, IPTp, and SBC data provide some gender-relevant data on coverage among women and their service use. CHWs and CSOs observe detailed gender dynamics during home visits and outreach, but these insights are recorded informally in notebooks or verbal discussions.	Gender-relevant data collected: HIV programs collect AGYW participation, PrEP uptake, retention outcomes, and GBV referrals through CSOs, paralegals, and human-rights programming. CLM generates qualitative data on stigma, service quality, provider attitudes, and safety. TB programs collect standard service data but limited gender-relevant data.
Use of gender data: Routine TB indicators are reviewed, but interview evidence provided limited examples of sex-disaggregated data being used to inform tailored responses to gender-related barriers. Gender-related insights raised by community actors, such as women's restricted mobility or men's delayed care-seeking, remain anecdotal and not reflected in planning, targeting, or supervision. Reporting is focused on case numbers and treatment outcomes.	Use of gender data: Reporting and review processes were described as focusing on routine service delivery and coverage indicators and not consistently examining gender differences or norm-related barriers. Some district teams are open to discussing gender barriers, but there is no pathway for translating this into programmatic changes.	Use of gender data: In HIV programming, gender-relevant data are used to identify gaps in retention or service uptake and adjust outreach or differentiated service delivery. CLM data help explain what routine indicators miss on GBV and stigma. Stakeholders reported weak feedback loops and variable use of these data to programming, budgeting, or supervision. Triangulation across health, justice, and social welfare systems remains limited.
Key gaps and constraints: Stakeholders cited discomfort and risk in collecting data on sexual orientation, gender identity, sex work, or violence due to stigma and criminalization. They highlighted limited guidance and capacity to design and use gender-responsive indicators, and no clear institutional ownership of gender analysis.	Key gaps and constraints: HMIS tools do not appear to capture qualitative or social determinants of access, and staff are not trained in gender analysis. Gender-relevant information collected by CHWs and CSOs does not flow upward into planning or decision-making. The system is focused on numeric outputs, while gendered patterns of delay, refusal, or unequal access are not examined at the national level.	Key gaps and constraints: Compared with HIV, TB reporting included less formalized collection and use of gender-relevant and community-generated information. Across both disease areas, stakeholders described variable use of available gender-relevant data in planning, budgeting, and supervision. Information on stigma, safety, power relations, and other barriers generated through community mechanisms was not consistently used in routine systems or decision-making.

Table 14. Country Insights Related to Gender-Relevant Data (High Impact Asia, High Impact Africa 2, Southern & Eastern Africa)

COUNTRY INSIGHTS	
High Impact Africa 1 Country HIV & TB	Western & Central Africa Country Malaria
Data systems and infrastructure: Routine program monitoring draws on national health information and program M&E systems. Additional gender-relevant data are generated through parallel systems including CLM and GBV/FGM service delivery documentation. These data are not integrated into a single platform, and linkages across health, justice, and social services are limited.	Data Systems and Infrastructure: Malaria reporting includes sex-disaggregation and selected equity variables. Routine systems are primarily structured to track coverage, service delivery, and reach and not social or norm-related gender barriers affecting access and uptake.
Gender-relevant data collected: Sex- and age-disaggregated data are routinely collected and the HIV program also collects data disaggregated for key populations. Gender-relevant data are also collected via GBV case records (referrals and follow-up), stigma and discrimination documentation, rights-violation reporting, and FGM-related programming. SI-supported studies have generated deeper gender analyses (e.g., assessments in transgender communities).	Gender-relevant data collected: Sex-disaggregated data are collected more consistently than in earlier grant cycles, and malaria reporting includes pregnancy-related indicators through ANC and IPTp. Program tools also capture some dimensions of vulnerability (including disability) and geographic reach. Data on gender norms, household decision-making, autonomy, GBV, and stigma are not systematically collected.
Use of gender data: In HIV programming, there is evidence that gender-relevant data are used for program adaptation and advocacy. Stigma, GBV, and CLM data are used to adjust outreach and differentiated service delivery, strengthen referral pathways, and engage authorities on barriers and protection risks. SI-funded assessment of transgender communities informed GC7 design, including the introduction of peer-led drop-in centers.	Use of gender data: Disaggregated and equity-oriented data are used for operational planning, including to identify underserved groups and to tailor outreach for remote or mobile populations (including mining areas and flood-prone zones). However, there was limited evidence that routine malaria data were used to analyze or respond systematically to gender-related barriers.
Key gaps and constraints: TB programming relies largely on basic sex- and age-disaggregation. Data streams are fragmented across CSOs, facilities, and social and justice actors, which limits triangulation and learning. Some gender and rights data systems remain dependent on externally funded initiatives, raising sustainability concerns.	Key gaps and constraints: The lack of routine data on norms, decision-making power, and GBV limits the ability to respond to gender barriers affecting malaria prevention and service use. Gender issues are often discussed qualitatively by community leaders and women's affairs representatives but are not captured in formal systems. Routine reporting demands and uneven capacity among implementers and reporting actors to collect and use gender-relevant data limit how far these issues are reflected in malaria reporting and review.

Table 15. Country Insights Related to Gender-Relevant Data (Western & Central Africa, High Impact Africa 1)

COUNTRY INSIGHTS	
High Impact Africa 2 Country Malaria Community-Led Monitoring (CLM)	Southern & Eastern Africa Country HIV AGYW Programming
What the approach enabled: CLM enabled community actors to identify and respond to gender-related barriers affecting malaria prevention and service use during implementation. Through community engagement and follow-up, CHWs adjusted SBCC schedules to align with women's daily workloads, worked with village committees to negotiate with men who blocked women's participation or care-seeking, and supported pregnant women to access ANC-linked malaria services. Collaboration with CSOs with deeper gender expertise strengthened local responses.	What the approach enabled: AGYW initiatives were widely perceived as successful. Stakeholders reported improved school retention, stronger life and vocational skills, increased confidence, and higher uptake of HIV prevention services among girls. Communities viewed the program positively, and AGYW participation in services and support platforms increased. Economic empowerment components were also seen as a promising part of the model, although most were still at an early stage.
Why it was effective: The approach worked because community actors are embedded in the communities they serve and could identify gender-related barriers as they emerged, including permission dynamics, fear of partner backlash, time poverty, transport constraints, and safety concerns. Communities trust CHWs and local actors more than facility staff, making it easier to surface some issues. CLM also strengthened coordination between CHWs, village committees, Regional Health Management Team/Council Health Management Team, and facilities through regular feedback loops, enabling service delivery to respond more directly to barriers affecting women's access to prevention and care.	Why it was effective: Effectiveness was attributed to the focus on girls' lived realities and the creation of supportive, youth-friendly spaces that reduced stigma and improved acceptability. The combination of mentorship, psychosocial support, and service linkages helped AGYW navigate barriers related to confidence, disclosure, and access, contributing to sustained engagement with HIV prevention services.
Additional needs and considerations for success: To strengthen this approach, gender-related barriers identified through CLM need to be more systematically documented and fed into district and facility decision-making. In addition, women community monitors face safety risks, particularly during late travel, and safer working arrangements are needed. Additional training and guidance on responding to gender barriers that are identified and clear referral pathways for GBV disclosures are needed to strengthen and sustain success.	Additional needs and considerations for success: To sustain the gains from this approach, stakeholders emphasized the need for strong coordination, referral, and follow-up systems so that girls can access the full package of mentorship, psychosocial support, HIV prevention, and protection services when needed. The economic empowerment components were at an early stage, with business plans developed but start-up capital not yet disbursed, making outcomes premature to assess. Stakeholders also suggested some related areas, such as male partner engagement, gender-norm change at the community level, gender components in TB programs, and some GBV referral activities, were less developed in practice. These approaches were perceived to be less successful not because the approaches themselves are ineffective, but rather due to limited scale, low participation, weak follow-up and coordination systems, operational gaps, and underfunding.

Table 16. Country Insights on Successful Gender Equality Approaches in HIV, TB, and Malaria Programs

ANNEX 7. CARE PATHWAY ANALYSIS

To further assess whether gender equality approaches are being implemented in ways that respond to the gender barriers identified at the Funding Request and grant design stages, the evaluation developed gendered care pathway diagrams² for each disease area, drawing on in-depth country evidence from a High Impact Africa 2 country (malaria), a High Impact Asia Country (TB), and a country in Southern and Eastern Africa (HIV) (see Figures 1, 2, and 3). These pathways were constructed by mapping gender-related barriers identified in Funding Requests and stakeholder interviews against the interventions reported as implemented through country-level interviews and observational site visits. It is important to note that, in many cases, Funding Requests referenced gender barriers in general terms without clearly specifying their nature. In some cases, this may have been an intentional design choice to allow implementing partners to identify and respond to context-specific gender barriers that arise during implementation. In practice, more detailed articulation of specific gender barriers did emerge more explicitly through country-level stakeholder interviews. While the lack of specificity of the funding requests introduces a limitation in strictly comparing design and implementation, the stakeholder perspectives are used as a proxy for design intent and the care pathway analysis

still helps illustrate where planned gender-related activities appear to align with implementation and where gaps remain. It is also important to note that, as the Global Fund operates through a partnership model, implementation of interventions addressing barriers identified at the Funding Request and grant design stages that were not included in the grant may be taking place through other partners.

Importantly, the care pathways map gender-related barriers encountered at each stage of the care continuum, from prevention and symptom recognition through diagnosis, treatment, and follow-up, and align them with the specific interventions currently being implemented, as per country data, to address those barriers. It should also be noted that at the time of the data collection, GC7 grant implementation had only been underway for on average a year, and some activities were in early stages of rollout.

²These diagrams are adapted from Bhushan A, Mishra S, Orth Z, Riha J. Gender-responsive and -transformative interventions in HIV, TB and malaria programmes: a review of evidence. BMC Public Health. 2026;26(940).

Gender and the HIV/AIDS Care Pathway: Core Country in Southern & Eastern Africa

IDENTIFIED GENDER-RELATED BARRIERS

Stigma, discrimination, fear of violence, women's/girls' economic vulnerability

- Violence and fear of violence
- Unequal power relations shaping sexual decision-making
- Early sexual debut influenced by coercion and inequality
- Limited condom negotiation capacity
- Gender norms supporting multiple partnerships
- Limited access to accurate health information and education

- Normalization of suffering among women
- Fear of violence, blame, and stigma
- Limited sexual health education for AGYW
- Power imbalances in defining illness
- Silence surrounding sexual violence
- Masculinity norms delaying recognition among men

- Fear of violence and relationship disruption
- Unequal decision-making power
- Gendered stigma and moral judgment
- Male partner norms and behavior
- Sexual violence and trauma

- Violence risk
- Power and autonomy constraints
- Stigma
- Caregiving norms
- Confidentiality concerns
- Trauma

- Fear of disclosure, partner violence, or abandonment (particularly for women)
- Persistent stigma and discrimination, especially for key populations
- Limited male involvement in HIV testing, PMTCT, and ongoing care
- Clinic environments perceived as unfriendly to men; Economic, caregiving, and mobility constraints affecting adherence

Prevention (health education, number of sexual partners, age of sexual debut, condom use, violence etc.)

Symptom onset & recognition

Decision to pursue care

Presentation to health facility

Voluntary counseling & testing (VCT) / Testing

Treatment initiation (ART / PMTCT)

Treatment adherence

- Gender-responsive health education and gender-transformative programming (norms change and economic empowerment) for AGYW
- Community-based, women-led prevention outreach
- GBV-integrated prevention services
- Male engagement and norm-change interventions
- Condom negotiation and empowerment interventions
- Gender-sensitive symptom literacy
- Safe spaces for early disclosure and reflection
- Paralegal-supported early response
- Community health worker (CHW) early identification of HIV & GBV
- Stigma-reduction messaging at community level

- Gender-sensitive symptom literacy
- Safe spaces for disclosure
- CHW identification of HIV/GBV
- Stigma reduction

- Integration of GBV response into HIV services
- Legal empowerment and rights awareness
- Confidential entry points
- Community-based referrals
- Paralegal accompaniment
- Women-led outreach and AGYW friendly services
- Trauma-informed care
- KP-friendly service delivery points (e.g. Drop in center-linked referrals)

- Gender-sensitive and confidential testing approaches
- Community-based and women-led testing outreach
- Women-led outreach
- Paralegal-supported referrals
- Youth- and KP-friendly services

- Male engagement and couple-focused strategies
- Accompanied referral and navigation support
- Youth-friendly and gender-sensitive services
- Peer- and community-based ART delivery and adherence support
- Community-facility linkage mechanisms
- Ongoing GBV and psychosocial support
- Community support
- Paralegal support
- Male partner engagement

Community- / peer-based ART and adherence support

Gender-responsive and -transformative approaches, GBV-awareness, Community-based models, Legally supportive approaches, and Engagement of men and households

GENDER-RELATED INTERVENTIONS BEING IMPLEMENTED

Figure 1. Identified Gender Barriers and Interventions along the HIV/AIDS Care Pathway in a Core Country in Southern & Eastern Africa

The HIV pathway in a Core Country in Southern and East Africa identifies gender-related barriers at multiple stages of the care continuum, including prevention, symptom recognition, testing, treatment initiation, and adherence (Figure 1). Barriers such as GBV, intimate partner violence, fear of disclosure, stigma, economic dependence, and unequal caregiving burdens are clearly articulated in the care pathway and in the Funding Request, budget, and stakeholder interviews.

There is strong alignment between what was designed in the Funding Request and budget and what is being implemented with respect to GBV/IPV response. Planned activities included IPV screening integrated within HIV, TB, and malaria programs and SRH services, legal literacy and paralegal support, referral pathways to social and protection services, and stigma-reduction efforts. Stakeholder interviews confirm that these mechanisms are operational: GBV screening is conducted, paralegals are active, referral systems are functioning, and peer-based accompaniment supports survivors in accessing care. However, activities focused on the primary prevention of violence, including interventions to address underlying gender norms, were more limited in the grant design, and implementation similarly places greater emphasis on response than on prevention. Community dialogues, comprehensive sexuality education, and gender-transformative language, particularly within KP programming, were included in the planned activities. However, clearly defined, evidence-based primary prevention models focused on sustained community-level norm change or structured transformation of harmful masculinities were not included in the design. Implementation mirrors this approach: prevention activities largely consist of awareness raising, service-linked engagement, and community sensitization rather than long-term, multilevel norm-transformation programming.

Economic vulnerability is explicitly identified in the Funding Request as a driver of HIV risk among AGYW, and planned activities include a continuation of socioeconomic strengthening and social protection interventions targeting high-risk districts. Implementation evidence confirms that vulnerability assessments have been conducted, beneficiaries have been identified, vocational training has been delivered, and business plans have been developed in line with the proposal. However, stakeholders report that the economic empowerment component remains at an early stage of rollout. While business plans have been prepared, start-up capital has not yet been disbursed in several sites, and mentorship structures are still being operationalized.

Male engagement and couple-focused strategies are included in the Funding Request, particularly through prevention programming for male sexual partners of AGYW, comprehensive sexuality education for adolescent boys and young men, and community engagement activities. Implementation evidence confirms that male partners are reached through SBCC, PrEP programming, and referral mechanisms, consistent with the design. However, these strategies are primarily service-linked and prevention-oriented rather than structured masculinity transformation or sustained couple-based power interventions. This reflects the scope of the original design rather than an implementation gap.

Gender and the Tuberculosis Care Pathway: High Impact Asia Country

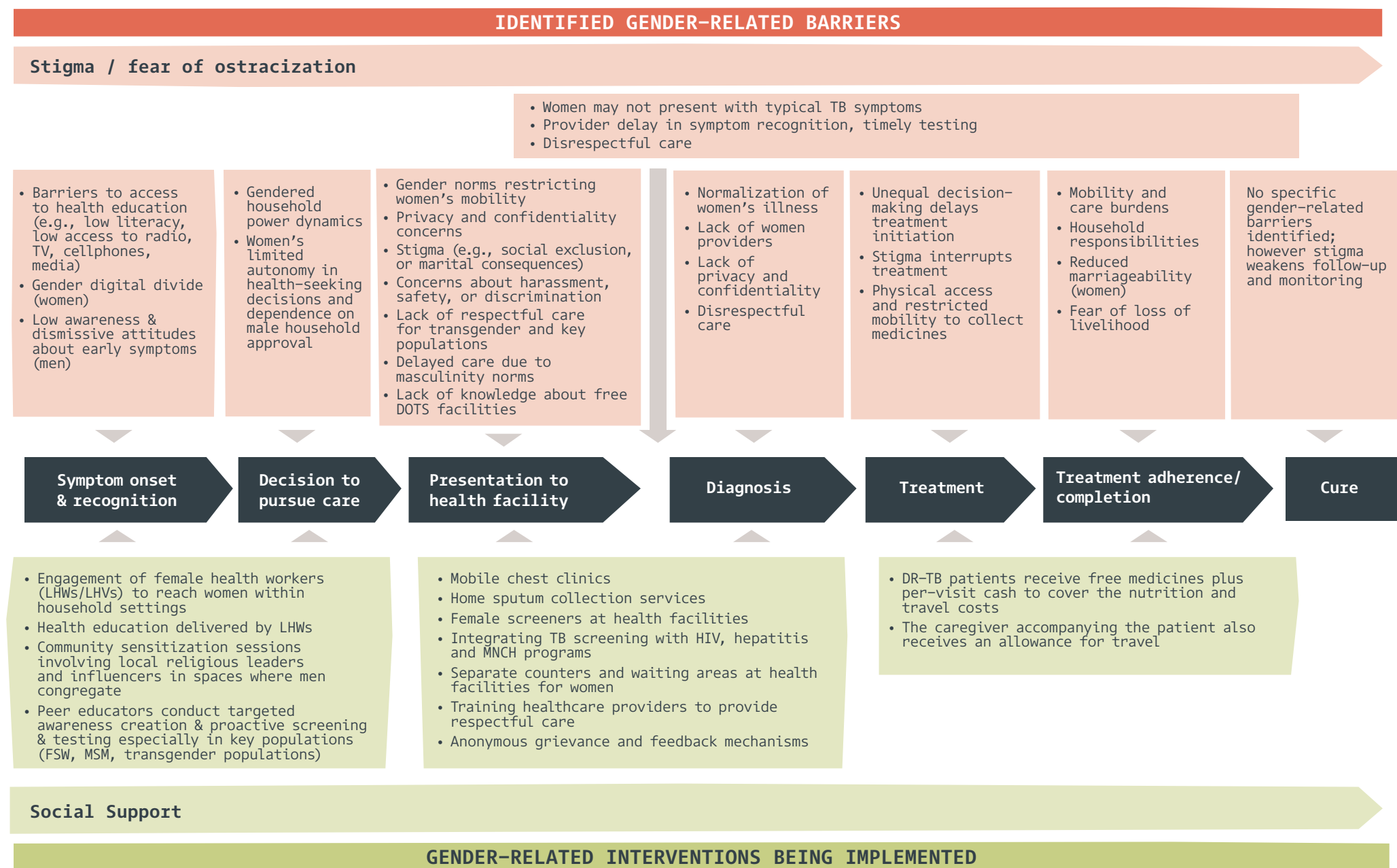


Figure 2. Identified Gender Barriers and Interventions along the TB Care Pathway in a High Impact Asia Country

In this High Impact Asia country, the pathway reveals that many interventions are concentrated around diagnosis, reflecting both the design emphasis of the Funding Request and the way activities are being implemented (see Figure 2). Barriers during symptom recognition and decision-making, including low health literacy, stigma, fear of ostracization, and women's limited autonomy are clearly identified in both the Funding Request and stakeholder interviews, but are only indirectly addressed through outreach by female health workers and community influencers as per the original grant design. There are few interventions, either at the design or implementation stage, that systematically support early symptom recognition among women or men, particularly in contexts where TB symptoms are normalized or hidden due to stigma. While diagnostic barriers are relatively well addressed through mobile clinics, female screeners, privacy adaptations in camps and facilities, and respectful care initiatives, downstream barriers are less developed in both planned activities and in practice. These include unequal decision-making power affecting treatment initiation, mobility constraints for medicine collection, and the

caregiving burdens placed on women during prolonged treatment. The pathway highlights the absence of structured gender-responsive follow-up mechanisms. While routine treatment-monitoring systems are in place, neither the planned activities nor current implementation includes gender-specific strategies to address adherence, treatment completion, or the longer-term social consequences of TB, indicating a design-level limitation rather than an implementation gap. While the Funding Request explicitly recognizes stigma, financial hardship, and the economic costs of long-term treatment as barriers to TB care, and includes community engagement and limited travel or treatment support measures, the scale and structure of these responses remain modest; neither the design nor current implementation includes comprehensive social protection, livelihood support, or sustained stigma-reduction programming commensurate with the magnitude of the barriers identified. Overall, gender equality approaches in HIV, TB, and malaria interventions are being largely implemented as designed under GC7.

Gender and the Malaria Care Pathway: High Impact Africa 2 Country

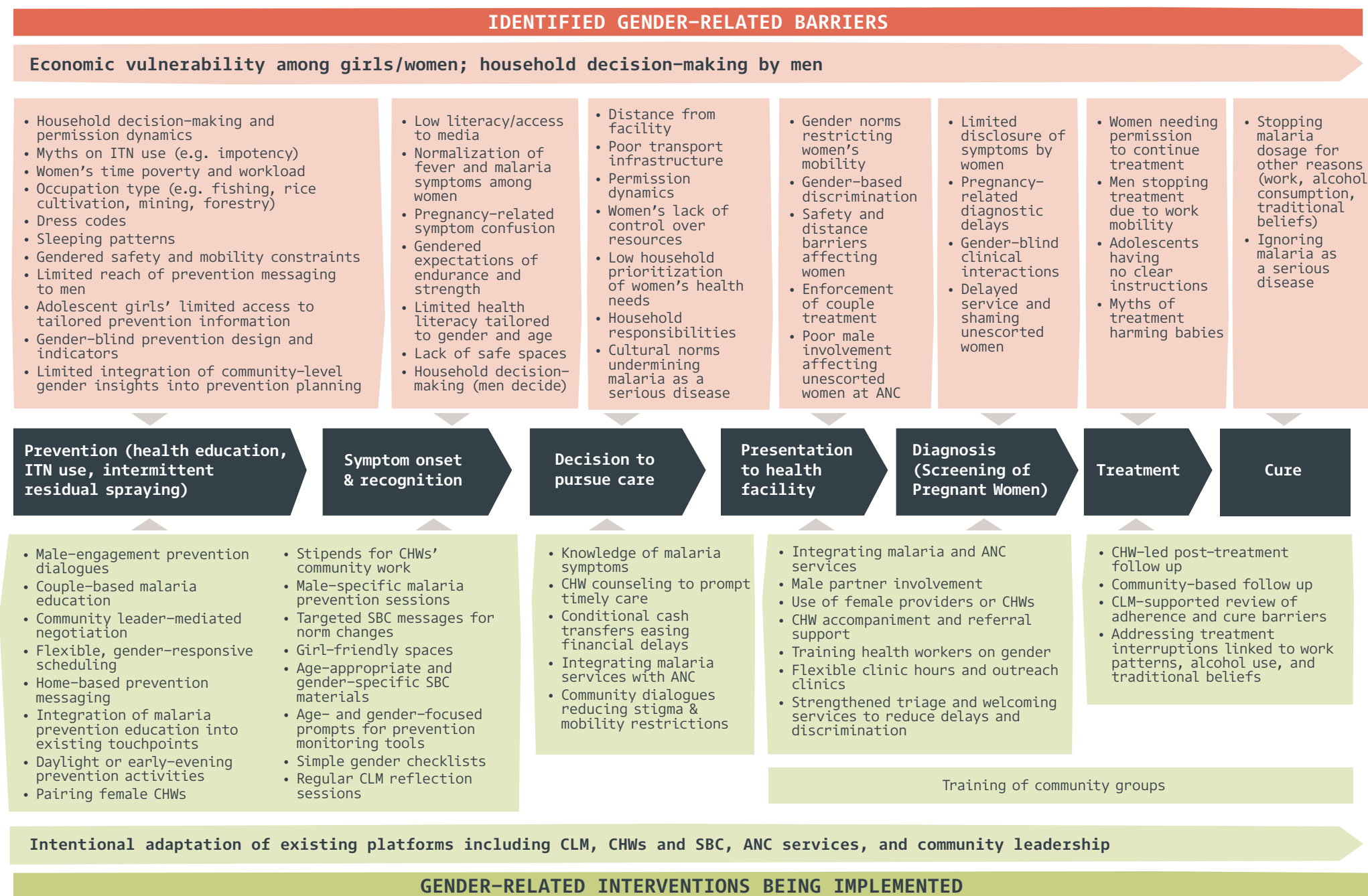


Figure 3. Identified Gender Barriers and Interventions along the Malaria Care Pathway in a High Impact Africa 2 Country

The malaria care pathway in this High Impact Africa 2 country shows strong alignment between the gender-responsive elements articulated in the Funding Request and budget and what is being implemented, especially in the early stages of prevention and diagnosis (see Figure 3). The grant design prioritized biologically vulnerable groups, especially pregnant women and children under five, through ITN distribution via ANC, IPTp, school-based net distribution, and integration of malaria services into routine maternal and child health platforms. It also included gender-balanced CHW deployment and community-based SBC approaches informed by equity considerations. Stakeholder interviews confirm that these activities are operational: ITNs are distributed through ANC and mass campaigns, CHWs are recruited with male–female pairing at village level, and community outreach targets pregnant women, caregivers of young children, and other vulnerable groups. In these areas, implementation closely reflects the planned modules and interventions.

However, several barriers are weakly addressed. Stakeholder interviews do reference economic vulnerability, particularly in relation to transport costs, women’s limited financial autonomy, and delayed care-seeking, but this is not acknowledged or addressed in the grant design and there are no interventions that directly reduce women’s financial dependence or address income loss

associated with seeking care in the grant. Safety risks for women, particularly those associated with travel to facilities or participation in evening activities, are acknowledged but not matched with systematic protections or transport solutions. At later stages of the pathway, gendered barriers related to treatment continuation, dosage completion, and household control over treatment decisions were described, but interventions focus largely on health education rather than on structured gender-responsive adherence support or interventions to address household-level power dynamics related to partner permission or financial support. These gaps reflect the scope of the original design rather than gaps in implementation.