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

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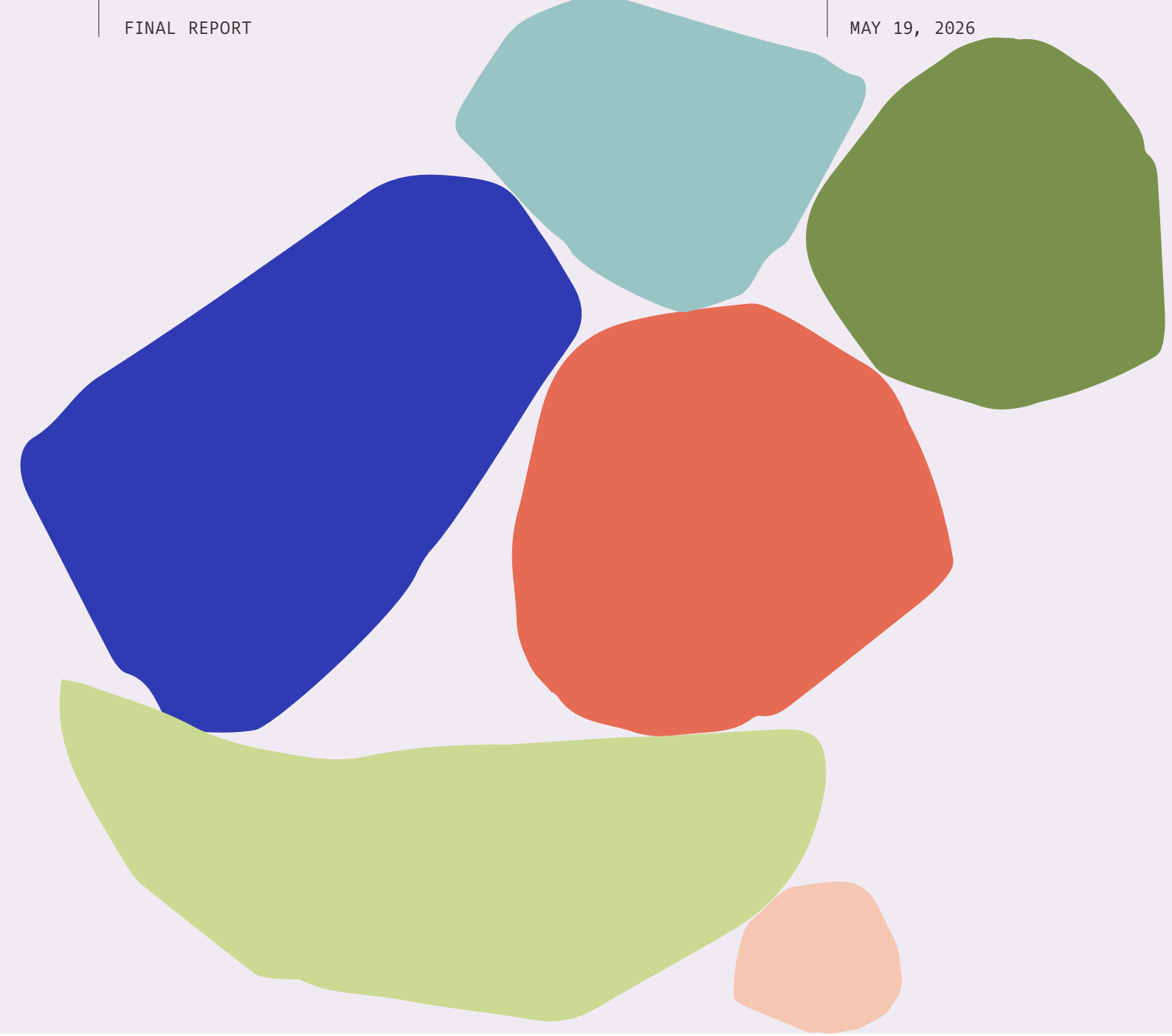

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List of Acronyms, Abbreviations, Figures, and Tables

AGYW	Adolescent Girls and Young Women
AI	Artificial Intelligence
AIDS	Acquired Immune Deficiency Syndrome
ALMA	African Leaders Malaria Alliance
ANC	Antenatal Care
ART	Antiretroviral Treatment
BDB	Breaking Down Barriers (Strategic Initiative)
CBO	Community-based Organization
CCM	Country Coordinating Mechanism
CE-SI	Community Engagement (Strategic Initiative)
CHW	Community Health Worker
CLM	Community-Led Monitoring
CRG	Community, Rights and Gender (Dept., Global Fund)
CSO	Civil Society Organization
DHIS2	District Health Information Software, Version 2
DR-TB	Drug Resistant Tuberculosis
EIL	Equality Insights Lab
ELO	Evaluation and Learning Office
EPI	Expanded Programme on Immunization
EQ	Evaluation Question
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
FSW	Female Sex Worker
GATT	Gender Assessment Tool
GBV	Gender-Based Violence
GC6	Global Fund Grant Cycle 6
GC7	Global Fund Grant Cycle 7
GC8	Global Fund Grant Cycle 8
GEF	Gender Equality Fund
GEM	Gender Equality Marker
GIS	Gender Integration Score
HRH	Human Resources for Health
HMIS	Health Management Information System
HIV	Human Immunodeficiency Virus
IEP	Independent Evaluation Panel
IDIs	In-Depth Interviews
IPTp	Intermittent Preventive Treatment in Pregnancy
IRS	Indoor Residual Spraying
ITNs	Insecticide-Treated Nets
KP	Key Population
KPI	Key Performance Indicator
LGBTQI+	Lesbian, Gay, Bisexual, Transgender, Queer and Intersex
LHW	Lady Health Worker
LLIN	Long-Lasting Insecticidal Net
MEL	Monitoring, Evaluation, and Learning
MSM	Men Who Have Sex with Men
NSP	National Strategic Plan
PAAR	Prioritized Above Allocation Request
PLHIV	People Living With HIV
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PR	Principal Recipient
PrEP	Pre-Exposure Prophylaxis
PUDR	Progress Update and Disbursement Request
RSSH	Resilient and Sustainable Systems for Health
SBCC	Social and Behavior Change Communication
SBC	Social and Behavior Change
SI	Strategic Initiative
SMC	Seasonal Malaria Chemoprevention
SR	Sub-Recipient
SRH	Sexual and Reproductive Health
SSR	Sub Sub-Recipient
STIs	Sexually Transmitted Infections
TA	Technical Assistance
TB	Tuberculosis
ToC	Theory of Change
TRP	Technical Review Panel
TWG	Technical Working Group
UN	United Nations

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Executive Summary

Background and Purpose

This formative evaluation examines how, and the extent to which, gender equality approaches have been integrated into HIV, TB, and malaria programs supported by Global Fund investments in Grant Cycle 7 (GC7) (2023–2025). The Global Fund Strategy (2023–2028) recognizes gender inequality as a barrier to access to HIV, TB, and malaria services (including prevention, diagnosis, treatment, and care services) and increases vulnerability to HIV, TB, and malaria. The Strategy recognizes the importance of gender equality approaches within the context of HIV, TB, and malaria responses. In practice, gender inequality manifests through unequal power relations, exposure to violence, mobility restrictions, stigma and discrimination, economic dependence, and differential health-seeking behaviors, all of which can impede service uptake and retention, and influence disease outcomes.

This evaluation took place during an unstable year for global health financing. Since early 2025, major shifts in bilateral and multilateral assistance, including suspensions, reductions, and restructuring of foreign aid, have introduced volatility into HIV, TB, and malaria responses. These shifts resulted in reprogramming of GC7 grants in response to reductions in country allocations where an aggregate of approximately US $1.43B (~11%) was reduced from grant budgets. Preparations for Grant Cycle 8 (GC8) also commenced during the evaluation period, including around streamlining grant life-cycle processes, with further differentiation for focused portfolios, and discussions on transition pathways, including considerations for accelerated transition in GC8. These dynamics required the evaluation to be flexible in approach and timeline, take into account the rapidly evolving changes in GC7 grants and the implications for forward-looking recommendations.

Defining Gender Equality Approaches Supporting HIV, TB, and Malaria Programs

For the purposes of this evaluation, gender equality approaches are understood to include gender-targeted (addressing specific population groups based on biological vulnerability or differentiated risk), gender-responsive (adapting service delivery models to address social, relational, or practical barriers), and gender-transformative (seeking to shift gender norms and unequal power relations) interventions. The evaluation also separately examined gender-based violence (GBV) prevention and response activities, given their importance in shaping vulnerability, access to services, safety, disclosure, and continuity of care. These approaches aim to improve equitable access to HIV, TB, and malaria services and participation in program design and delivery. No specific modality is inherently superior; rather, different modalities are appropriate for different contextual realities and objectives. However, as per the guidance provided to eligible countries in GC7, at minimum, grants are expected to demonstrate gender-responsive design in line with country epidemiology and to ensure that gender barriers do not undermine access, quality, or equity of services.[1] It is also important to note that the Global Fund operates across highly diverse epidemiological, political, and financial contexts. Country allocations vary substantially in size and scope, reflecting differences in disease burden, and economic capacity. As a result, the scale, form, and ambition of gender equality programming differ across portfolios and disease components. In addition, in most settings, gender-transformative or GBV-focused work may be led by other donors, ministries, or multisectoral platforms outside the Global Fund portfolio. The evaluation did not assess the full landscape of external financing or programming, and findings are therefore limited to what is articulated and financed within Global Fund grants themselves.

Gender and HIV, TB, and Malaria

Gender intersects with the three diseases in distinct ways, shaping both epidemiological risk and disease acquisition and care pathways:

- **HIV** is strongly shaped by gendered power relations, stigma, violence, criminalization, sexuality, and reproductive health dynamics. Gender inequality increases exposure to HIV (e.g., through age-disparate partnerships, limited condom negotiation, and sexual violence) and is a barrier to testing, disclosure, and adherence. Key populations, including women, adolescent girls, and young women (AGYW), transgender people,

[1] Technical Brief Removing Human Rights-related Barriers to TB Services; Technical Brief Equity, Human Rights, Gender Equality and Malaria; Technical Brief on Removing Rights-Related Barriers to HIV Services

men who have sex with men (MSM), and sex workers, experience gendered vulnerability, criminalization, policing, and structural exclusion.

- **TB** reflects gendered patterns of exposure and care-seeking, including delayed diagnosis among men, unpaid caregiving burdens among women, differential stigma, and intra-household decision-making that affects treatment adherence.
- **Malaria** is shaped not only by pregnancy-related biological vulnerability, but also by gendered roles, sleeping arrangements affecting insecticide-treated nets (ITN) use, and gendered patterns of mobility linked to fishing, farming, and informal labor. Programming decisions may prioritize high-incidence groups such as male migrants in some settings, while women's access to prevention and treatment can be influenced by caregiving roles, control over household resources, and social norms affecting mobility and facility access across the life course.

These differences among the diseases influence the types of gender-related[2] interventions that are relevant and feasible for integration into national disease programs. The evaluation is therefore focused on how gender-related considerations are integrated into disease prevention, diagnosis, treatment, care, and health and community system strengthening, rather than on broader gender equality or social transformation outcomes beyond the health sector. While the evaluation primarily focuses on HIV, TB, and malaria programs, it is recognized that gender equality approaches are also relevant across Resilient and Sustainable Systems for Health (RSSH) investments. A small number of RSSH standalone grants related to investments in human resources for health were also reviewed in relation to the evaluation questions.

Evaluation Objectives and Use

The evaluation was designed as a formative evaluation to address three objectives: (1) To assess the extent to which gender equality approaches are being integrated into HIV, TB and malaria disease programs supported by the Global Fund; (2) to identify internal and external enabling and hindering factors, and their causes and effects, for integrating gender equality approaches into Global Fund–supported disease programs; and (3) to identify key lessons and successes that would allow the Global Fund partnership to reinforce, advance, and sustain the integration of gender equality approaches in national health programs. To address these objectives, the evaluation was guided by 10 evaluation questions.

The primary users of the evaluation are the Global Fund Secretariat and Governance bodies. While guidance materials and other key documents are already prepared for the rollout of GC8, this evaluation has the opportunity to inform Funding Request and grant-making processes and GC8 implementation. The evaluation also has longer-term utility as an input into discussions around the next Global Fund strategy period. The secondary users of the evaluation include country stakeholders, including principal recipients (PRs), sub-recipients (SRs), country coordinating mechanisms (CCMs), civil society organizations (CSOs), technical partners, and donors.

Evaluation Methodology and Limitations

The evaluation included a desk-based portfolio review of 38 Global Fund country-components[3] in GC7, representing 24% of the total GC7 allocation, examining Funding Requests, grant documents, and principal recipients' reports. The sample included country-components across all three diseases and from High Impact, Core, and Focused portfolios, providing a sufficiently broad mix to generate useful learning across the portfolio, while not intended to be statistically representative of the full GC7 grant portfolio. The portfolio review also included interviews with stakeholders at the Global Fund Secretariat and with technical partners. The evaluation also undertook in-depth country studies, including interviews, focus group discussions (FGDs), and site visits conducted in Côte d'Ivoire, Guinea, Lesotho, Pakistan, and Tanzania to explore how gender equality approaches are translated into practice within disease programs, the factors shaping implementation, and the role of partnerships, selected Global Fund Strategic Initiatives, and national enabling environments.

A standardized desk review protocol guided the extraction of information from Funding Requests, grants, and other grant-related documents. Components

[2] Gender-related interventions include gender-targeted, gender-responsive, and gender-transformative approaches.

[3] In Global Fund terminology, a country-component refers to the portion of a given country's financing from the Global Fund corresponding to either a disease component (i.e. HIV, TB, or malaria) or to RSSH. It is conceptually distinct from grants as a unit of measurement in that grants are a contractual agreement between the Global Fund and a specific Principal Recipient for a specific program of work. Grants can cover more than one component (i.e. TB and HIV) and in many cases, countries may have more than one grant per country-component (i.e. a Ministry of Health and a Civil Society Organization).

were scored using a Gender Integration Score (GIS)[4] Framework, developed specifically for this evaluation. Findings were triangulated across data sources.

Limitations included limited information on gender and variation in quality and specificity of this information in Funding Request and grant documents, limited implementation data in portfolio documents, as well as the early stage of grant implementation, which meant the evaluation could assess integration, feasibility, and early signals of success, but not effectiveness, or longer-term outcomes. The stakeholder interviews both at the global and country levels may be subject to respondent bias, including selective recall and reporting, variable familiarity with grant processes and/or gender integration, and perspectives shaped by organizational roles and mandates, which may have influenced responses. Various methods and mitigation measures were used to address these limitations including triangulating multiple data sources.

Key Findings Against Evaluation Objectives

Objective 1 – To assess the extent to which gender equality approaches are being integrated into HIV, TB, and malaria disease programs supported by the Global Fund

The integration of gender equality approaches to contribute to disease outcomes is routinely occurring in GC7 Funding Request and grant design and this has increased compared to previous grant cycles. However, the depth, quality, and consistency of approaches vary across disease areas and across the grant cycle.

- Across the 38 GC7 country-components reviewed, 68% included at least one gender-targeted intervention, 71% included disease interventions that had gender-responsive elements, and 40% included interventions that had gender-transformative elements aligned to achieving disease outcomes. In addition, 40% of the country-components included GBV prevention or response activities.
- Gender-targeted and -responsive approaches are common in Global Fund–supported HIV, TB, and malaria programs, while gender-transformative approaches are primarily concentrated in HIV programs.
- The overall average GIS for design was 1.94 (out of 3)[5], with strongest performance in inclusive engagement during country dialogue processes and weakest performance in translating gender analyses into concrete gender interventions.
- HIV programs demonstrate the most mature gender integration across design domains, including use of gender analyses, inclusion of women-led and key population (KP) organizations, and incorporation of gender-responsive and -transformative interventions. TB and malaria programs more often use gender-targeted approaches, and are less likely to include structural or norm-focused interventions. RSSH grants show underdeveloped but important opportunities for gender integration to address systemic barriers and improve equitable service delivery.
- Compared to earlier grant cycles, gender is more visible in GC7 design, including in GC7 Funding Request documentation where gender barriers relevant to disease outcomes are more explicitly acknowledged.
- The GEM[6] has strengthened institutional visibility and systematic consideration of gender integration during Funding Request review. There is an opportunity to further institutionalize its use by enhancing and expanding follow-up mechanisms and country-level visibility.

[4] GIS assesses gender integration across sampled components. The scoring range for GIS is the following: 1 – None/limited; 2 – Moderate; 3 – Strong. For further information, please refer to Annex 4.

[5] Ibid.

[6] The GEM score was developed by the Global Fund Secretariat and introduced in GC7 to assess how gender equality is incorporated into Funding Requests and performance frameworks.

Gender assessments are increasingly used to inform Funding Requests but vary in quality and influence.

- Use of gender assessments has expanded in GC7, with 63% of Funding Requests reviewed including a gender assessment (83% of Funding Requests including HIV modules, 67% for malaria, 45% for TB and 33% for RSSH).
- Gender assessments vary in timing, methodological rigor, and scope; many do not systematically examine barriers across the full disease acquisition and care pathway.
- In several country-components, gender analyses informed the Funding Request narratives but were not consistently translated into grant-stage budgets, performance framework indicators, or implementation plans.

Translation from design into financing and performance frameworks in signed grants remains uneven.

- Alignment between identified gender priorities, budget allocations, and performance indicators is strongest in HIV country-components compared to TB, malaria, and RSSH.
- The total budgeted amount for gender-related activities in signed grants averaged 13.3% of total budgets for HIV programming and 3.8% for malaria programming. There was no clearly identifiable budget amount for gender activities in reviewed TB country-components and RSSH grants.
- Gender-relevant activities embedded within broader modules are often not labeled in budgets, limiting visibility and tracking.
- Grant performance frameworks widely include sex-disaggregated indicators (included in the Funding Requests for 87% of the 38 country-components reviewed), and sometimes include indicators focused on gender-specific key populations and/or GBV, stigma, norms, or decision-making dynamics (included in the Funding Requests for 21% of the country-components reviewed).

Sex-disaggregated data collection in HIV, TB, and malaria programs has improved, but use remains limited, and other types of gender-related data are not routinely collected.

- Routine collection of sex- and age-disaggregated data is widespread in HIV, TB, and malaria programs, but these data are not consistently analyzed or used to inform programmatic decisions.
- Few HIV, TB, and malaria programs systematically collect or analyze data on norms, GBV, decision-making, or structural barriers to accessing disease programs.
- Gender-related data that are collected in programs are not consistently included in grant progress updates or grant performance review discussions between the Global Fund and implementers.

Objective 2 – To identify internal and external enabling and hindering factors, and their causes and effects, for integrating gender equality approaches into Global Fund-supported disease programs

Partnership ecosystems and institutional capacity strongly shape the integration of gender approaches in disease programs.

- HIV programs consistently leverage women-led, feminist, and KP organizations as core delivery partners.
- TB and malaria programs engage community actors but less frequently include gender-specialized expertise.
- Specific strategic Initiatives (Community Engagement Strategic Initiative, Breaking Down Barriers, Gender Equality Fund, Her Voice Fund) are important drivers of reducing gender barriers to access in disease programs by strengthening the capacity and influence of community and feminist actors, and supporting GBV programming and the generation of high-quality gender and human rights data.

Stakeholder understanding of gender and gender barriers to access to HIV, TB, and malaria services influences program ambition.

- Stakeholder Interpretations of gender range from equal access-focused definitions to structural understandings of how norms and power relations impact access to disease services.
- More nuanced understanding correlates with stronger integration of gender equality approaches in HIV, TB, and malaria programs.
- In TB and malaria programs, recognized gender barriers do not consistently shape implementation decisions.
- GBV is most consistently recognized as a core gendered driver of disease outcomes within HIV programs, where stakeholders explicitly link violence to risk, adherence, and service uptake.

Alignment between design and implementation of gender equality approaches in HIV, TB, and malaria grants is shaped by financing dynamics, institutionalization, and enabling environments.

- Embedded service-delivery adaptations responsive to addressing barriers to service access are implemented more reliably than stand-alone or transformative interventions.
- Across contexts, gender activities included in the Funding Requests were sometimes reduced, delayed, or adapted during grant-making and early implementation, particularly under financing volatility.
- In some settings, community-led adaptation during implementation has advanced the integration of gender approaches beyond what was articulated in Funding Requests and grant design.
- Implementation is facilitated where interventions to address gender barriers are embedded in established service platforms and reinforced by experienced gender-specialized partners, technical support, and the use of community-generated evidence to guide adaptive delivery.
- Barriers to implementation of gender equality approaches included financing volatility, prioritization of commodity delivery and service outputs, limited gender-technical capacity, restrictive sociopolitical environments, and weak institutionalization of gender accountability mechanisms.

Objective 3 – To identify key lessons and successes that would allow the Global Fund partnership to reinforce, advance, and sustain the integration of gender equality approaches in national health programs

Different gender equality approaches contribute in distinct ways to achieving disease outcomes.

- Gender-targeted approaches expand reach and coverage for priority populations.
- Gender-responsive approaches, particularly when embedded within routine and integrated service platforms (e.g., ANC, community health workers [CHWs], peer networks, integrated HIV/TB models), are most consistently associated with improved access, retention, trust, and service quality.
- Gender-transformative approaches show indications of success in shifting gender norms, strengthening women's agency, and improving decision-making dynamics affecting access to services. These approaches require sustained financing, specialized expertise, supportive enabling environments, and longer timeframes, often beyond a single Global Fund grant cycle.
- The current evidence on gender-transformative approaches is strongest in HIV programs and is limited in malaria (beyond ANC) and TB contexts.
- Integrated HIV/TB and multi-disease delivery models can have gender-responsive effects by reducing cumulative care-seeking burdens and stigma exposure, creating safer and more acceptable entry points into services, and strengthening linkage and retention, but require deliberate gender-responsive design to avoid obscuring disease-specific gender barriers.

Multilayered, community-led models show the strongest indications of success.

- Approaches combining service delivery adaptation, community dialogue and norms change, GBV response, stigma reduction, and rights-based mechanisms demonstrate the most consistent signals of improved uptake and continuity of care.

Sustained impact depends on institutionalization.

- The integration of gender equality approaches in HIV, TB, and malaria disease programs is more likely to contribute to sustained HIV, TB, and malaria impact when supported by:
  - Visible and sustained financing;
  - Strong partnerships with feminist, women-led, KP, and AGYW organizations, and other gender-focused actors;
  - Gender-relevant data and adaptive management mechanisms;
  - Technical assistance (TA) and governance structures reinforcing accountability.

  These enabling conditions remain uneven across disease areas and national systems.

Conclusions

The findings have led to the following conclusions on how the integration of gender equality approaches in Global Fund–supported HIV, TB, malaria, and RSSH programs progressed in GC7, highlighting the strengths and challenges of ensuring these approaches contribute to disease outcomes.

Objective 1 – Extent of Integration of Gender Approaches in HIV, TB, Malaria, and RSSH Programs

Conclusion 1. The GC7 country components reviewed demonstrate substantial progress in integrating gender equality approaches in HIV, TB and malaria programs, where relevant to epidemiological context, at the design stage. For this progress to contribute lasting improvements in disease outcomes, the integration of gender equality approaches must extend consistently into budgeting, implementation, and monitoring processes across disease programs.

Objective 2 – Enabling and Hindering Factors for Gender Integration

Conclusion 2. The integration of gender equality approaches in HIV, TB, and malaria programs in response to country epidemiology is strongest when design, financing, partnerships, and data systems are mutually reinforcing.

Objective 3 – Lessons and Indications of Success for Sustained Impact

Conclusion 3. Gender-responsive service adaptations embedded in routine HIV, TB, and malaria service delivery platforms, especially when involving community actors, offer the most consistent short- to medium-term returns for achieving disease outcomes, and represent a pragmatic and scalable strategy for strengthening access.

Conclusion 4. Gender-targeted approaches are essential for expanding reach and coverage, but achieving sustained and equitable HIV, TB, and malaria disease outcomes depends on complementing these approaches with interventions that address the context-specific normative, relational, and structural barriers affecting disease risk and vulnerability and access, retention, and continuity of care.

Conclusion 5. Gender-transformative approaches show context-specific potential for longer-term impact on disease outcomes, particularly in HIV programs, but available evidence in TB and malaria (beyond antenatal care [ANC]) remains limited. These approaches require sufficient financial resources, dedicated capacity and partnerships, and high-quality implementation over longer timeframes.

Conclusion 6. The selected Strategic Initiatives examined in this evaluation demonstrated strong contribution to driving the integration of gender equality approaches in HIV, TB, and malaria programs, and their contribution is strongest when learning, evidence, and practices generated through these initiatives are actively taken up within disease programs.

Recommendations

The evaluation generated a set of actionable recommendations for strengthening gender equality integration in Global Fund–supported HIV, TB, malaria, and RSSH programs, in order to improve disease-specific prevention, treatment, and care outcomes, as well as the RSSH responses that support them. In line with Evaluation and Learning Office (ELO) guidance, the recommendations have been categorized as either critical (to be addressed by the Global Fund in the short term), important (to be addressed by the Global Fund in future grant cycles), or for partners (implementing programs supported by Global Fund investments). The recommendations are summarized below; however, recognizing the diversity of the Global Fund portfolio, the report provides specific suggestions on how to concretize each recommendation in Section 6 (Recommendations).

1. Continue to support effective gender-targeted programming, in line with country epidemiology, and strengthen implementation of gender-responsive approaches in HIV, TB, and malaria programs by reinforcing routine and integrated delivery platforms. When resources are constrained, prioritize high-impact barrier-removal interventions.



2. As relevant to the context, continue to support coordinated financing and partnership efforts that implement gender-transformative interventions that address structural drivers of HIV vulnerability and service access. Continue to learn through Strategic Initiatives (SIs) and with partners on how to contribute to addressing these barriers in malaria and TB programs.



3. Strengthen and reinforce the gender components of the Community Engagement SI and Breaking Down Barriers, the Gender Equality Fund, and Her Voice Fund and enhance relationships and learning exchange with disease programs to enable adoption of effective gender interventions and gradual institutionalization of core functions where feasible.



4. Require Funding Requests to be informed by high-quality, recent gender assessments (<5 years old) that systematically examine gender barriers along the disease acquisition and care pathway. These assessments could be disease or RSSH component-specific, or integrated as per the Funding Request but must examine gender barriers to services for all diseases covered in the Funding Request and meet minimum quality standards.



5. Optimize the systematic use of the Gender Equality Marker (GEM) to enhance accountability, strengthen portfolio-level learning, and improve the integration of gender equality considerations at key points in the grant life cycle.



6. Ensure that gender interventions considered during design of HIV, TB, and malaria grants to improve disease outcomes are translated into costed and trackable investments in grants by establishing dedicated and clearly labeled budget lines that include gender-responsive and gender-transformative activities.

Important

7. Adapt Global Fund levers, where relevant, to establish a coherent reporting and learning throughline across the grant cycle stages, to improve visibility and understanding of efforts and progress on the integration of gender approaches in Global Fund Investments.

Important

8. Strengthen the routine collection and use of sex-disaggregated and gender-relevant data across all disease areas, especially malaria, TB, and RSSH, to inform program design, implementation, and course correction.

Countries and Implementing Partners

9. Expand and formalize partnerships with women-led, feminist, and community-based organizations, particularly in TB, malaria, and RSSH, to strengthen the delivery of gender-responsive interventions to improve disease outcomes.

Countries and Implementing Partners

Introduction

This is the final report of the **Evaluation of the Integration of Gender Equality Approaches in HIV, TB, and Malaria Programs supported by the Global Fund.** The evaluation was conducted by Equality Insights Lab (EIL) as an independent external evaluator engaged by the Evaluation and Learning Office (ELO) of the Global Fund Secretariat. This Office is overseen by the Independent Evaluation Panel of the Global Fund (IEP), together forming the independent evaluation function of the Global Fund. This evaluation was designed to address three objectives:

1. **To assess the extent to which gender equality approaches are being integrated into HIV, TB and malaria disease programs supported by the Global Fund.**
2. **To identify internal and external enabling and hindering factors, and their causes and effects, for integrating gender equality approaches into Global Fund–supported disease programs.**
3. **To identify key lessons and successes that would allow the Global Fund partnership to reinforce, advance, and sustain the integration of gender equality approaches in national health programs.**

These objectives are operationalized through 10 evaluation questions (presented in the methodology section), which structure the analysis and findings of this report. Consistent with the objectives, the evaluation was designed as a formative evaluation with a process-oriented analysis of how gender equality approaches are integrated across selected Global Fund country-components.[7] The evaluation was implemented in a rapidly evolving global health financing context. During the first months of 2025, significant uncertainty emerged regarding the sustainability of funding for HIV, TB, and malaria programs, with implications for both program implementation and stakeholder availability to engage in the evaluation. In response, the evaluation adopted a phased and adaptive approach to data collection and analysis, designed to generate robust evidence while minimizing burden on national stakeholders and partners navigating these constraints and who were going through a period of reprogramming in the current grant cycle. Furthermore, additional document review and interview probes were incorporated to explore the effect of the changing funding context on the integration of planned gender equality approaches in HIV, TB, and malaria programs.

This report synthesizes evidence from document review; grant portfolio analysis; interviews with Secretariat staff, technical partners, and country stakeholders; and country-level studies. The key findings section presents findings organized around 10 evaluation questions covering Funding Requests and grant design, budgeting, engagement, implementation, data systems, partnerships, catalytic investments, and sustainability. This is followed by a section on cross-cutting conclusions that draw together patterns across disease areas and contexts. The final section translates these conclusions into recommendations intended to strengthen alignment between gender commitments, financing, implementation, and institutional accountability mechanisms in future grant cycles. The report also acknowledges methodological limitations, including constraints related to data availability, uneven documentation across disease areas, and the evolving external context. These limitations are discussed where relevant to support appropriate interpretation of findings. Examples and lessons are included in country insights boxes in the Annex.

[7] In Global Fund terminology, a country-component refers to the portion of a given country's financing from the Global Fund corresponding to either a disease component (i.e. HIV, TB, or malaria) or to RSSH. It is conceptually distinct from grants as a unit of measurement in that grants are a contractual agreement between the Global Fund and a specific Principal Recipient for a specific program of work. Grants can cover more than one component (i.e. TB and HIV) and in many cases, countries may have more than one grant per country-component (i.e. a Ministry of Health and a Civil Society Organization).

Background and Context

The Global Fund, now in its 23rd year of existence, is a worldwide partnership to defeat AIDS, TB, and malaria and ensure a healthier, safer, more equitable future for all. Since 2002, the Global Fund partnership has saved 70 million lives.[8] Beyond its impact on disease reduction, the Global Fund has been instrumental in supporting communities and countries in advancing human rights and gender equality by reducing barriers to access to health services and ensuring that lifesaving services reach those who need them most. Recognizing that gender inequalities, such as gender norms, power imbalances, stigma, discrimination, and violence, exacerbate health disparities, the Global Fund prioritizes integrating equity and inclusion approaches into HIV, TB, and malaria programming to address disease-specific barriers to access, service delivery, and health outcomes. It understands that the fight against HIV, TB, and malaria cannot succeed without addressing these systemic barriers. To this end, the Global Fund commissioned an independent evaluation of its progress related to gender equality as described in the Global Fund 2023–2028 Strategy.[9]

The Global Fund developed its first standalone gender equality approach in 2008, and a Gender Action Plan during 2014–2016.[10] Building on this, gender was incorporated as a strategy objective in the 2017–2022 Strategy, resulting in a strong focus on adolescent girls and young women (AGYW) and partnerships such as HER Voice[11] and Voix EssentiELLES.[12] However, persistent challenges, such as inconsistent prioritization of gender equality across country disease programs and limited scale-up of gender-related programming, remained during this Strategy period.[13] The Global Fund's 2023–2028 Strategy represents an evolution in its commitment to advancing gender equality to address disease-specific barriers to access, service delivery, and health outcomes.[14] It calls for stronger efforts to address inequalities, and human rights and gender-related barriers, in one of its four strategic objectives (Maximizing Health Equity, Gender Equality, and Human Rights). The strategy outlines an intensified focus on integration of gender equality into disease programs, expansion of data use to identify and respond to inequality, scaling up programs targeting gender-based barriers, and challenging discriminatory laws, policies, and practices.

Under the current strategy, the Global Fund employs the following approaches: (1) integrating gender equality systematically across the entire grant portfolio in line with country epidemiological context and (2) making targeted investments through catalytic initiatives designed to address structural barriers and strengthen community engagement. This includes Breaking Down Barriers (BDB), which combines SI support with matching funds to scale up programs addressing human rights and gender-related barriers, the Community Engagement Strategic Initiative (CE-SI), the Gender Equality Fund (GEF), and the Her Voice Fund. These efforts are complemented by the Gender Equality Marker (GEM), introduced during GC7 to assess how gender equality is incorporated into Funding Requests, guidance on gender integration across the three disease areas, and the introduction of corporate gender equality key performance indicators (KPIs) for board-level tracking, monitoring, and accountability (as discussed in the key findings for Evaluation Question 2).

At the beginning of GC7, a Theory of Change (ToC) was developed to articulate the pathways through which strengthened knowledge, systems, partnerships, and catalytic programming are expected to achieve impact on HIV, TB, and malaria programs. The ToC identifies four key outcomes: (1) Global Fund and partners have increased knowledge, capacity, and political will to address gender inequality within the HIV, TB and malaria response; (2) Global Fund structures and processes better incentivize prioritization of gender equality within the HIV, TB, and malaria response; (3) strengthened partnerships and coordination with existing and new partners at community, national, and international levels to advance gender equality objectives; and (4) high-quality catalytic programming on gender equality supports communities to advance gender equality within the HIV, TB, and malaria response. While the evaluation was not designed to formally test the ToC and its assumptions, the evaluation questions do examine

[8] https://www.theglobalfund.org/en/results/
[9] https://www.theglobalfund.org/en/strategy/
[10] https://www.globalfundadvocatesnetwork.org/wp-content/uploads/2014/10/Publication_GenderEqualityStrategy_ActionPlan_en.pdf
[11] https://www.yplusglobal.org/her-voice-fund
[12] https://voixessentielles.org/en/
[13] https://www.theglobalfund.org/media/14802/iep_gf-elo-2024-01_report_en.pdf
[14] https://www.theglobalfund.org/en/strategy/

many of the mechanisms within it. Some reflections on the alignment of findings with the ToC are included in the conclusions section. Within the Secretariat, the ToC functions primarily as an internal tool for the Community, Rights and Gender (CRG) department. The Global Fund has also commissioned an evidence review[15] to synthesize the evidence on changes to disease- and gender-related outcomes[16] resulting from gender-responsive and -transformative approaches and interventions in HIV, TB, and malaria programs and to inform recommendations for a prioritized package of gender-responsive and -transformative interventions.[17]

For the purposes of this evaluation, it is also important to note that the Global Fund operates across highly diverse epidemiological, political, and financial contexts. Country allocations vary substantially in size and scope, reflecting differences in disease burden and economic capacity. As a result, the scale, form, and ambition of gender equality programming within the context of HIV, TB, and malaria programs differs across portfolios and disease components. The evaluation therefore sought to understand how gender equality is conceptualized, operationalized, and implemented in HIV, TB, and malaria programs across this diversity of contexts, in order to assess progress under GC7 and inform future strategic directions.

Furthermore, this evaluation comes at a critical juncture for the Global Fund Partnership. External risks to human rights and gender equality have intensified globally, including increasingly constrained civic space, heightened political resistance to gender equality agendas, and growing fragility in international development financing.[18,19] Against this backdrop, the Global Fund seeks to ensure that its investments are fully leveraging opportunities within the context of HIV, TB, and malaria programming, to address inequalities and strengthen gender-responsive, and where feasible, gender-transformative, health, and community systems.[20] The Global Fund Strategy (2023–2028) explicitly recognizes that without addressing structural gender-related barriers and vulnerabilities, the impact of investments on access to services and health outcomes may be undermined.[21] In settings where such barriers persist, the ability to translate financial commitments into effective and equitable HIV, TB, and malaria responses may be reduced, and sustained improvements in service coverage, quality, and health outcomes may be compromised. It is also important to note that addressing inequalities and advancing gender equality is core to sustainability and to integrated HIV, TB, and malaria service delivery.[22]

At the same time, the global financing environment for health and development has entered a period of heightened instability, with implications for the delivery and sustainability of HIV, TB, and malaria programs.[23, 24] Since early 2025, major shifts in donor funding, including the suspension, reduction, or restructuring of significant bilateral and multilateral assistance, have disrupted established financing flows for global health and increased fiscal pressure across disease programs and health systems, particularly those reliant on external support. These shifts also led to reprogramming of GC7 grants in response to reductions in country allocations where an aggregate of approximately US $1.43B (~11%) was reduced from grant budgets. In this global context, gender-related, community-based, and rights-oriented interventions, many of which are central to addressing social and structural barriers to access, have been vulnerable to reprioritization or budget reductions,

[15] 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).

[16] The report finds evidence for the following outcomes: increased testing and referral to services, increased confidentiality, reduced stigma, increased uptake of services, improved viral suppression rates, improved nonjudgmental care by HCPs, increased self-efficacy of PLWHA, reduced number of sexual partners, lowered rates of men purchasing sex, improved knowledge of HIV status, increased consistent condom use, and increased partner disclosure of HIV serostatus.

[17] Effective approaches to address structural gender inequalities underlying disease prevention and control are multicomponent interventions implemented at multiple levels, with a socioecological lens, with longer duration to improve sustainability of effects.

[18] 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

[19] 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

[20] Global Fund Technical Brief, Gender Equality. Allocation Period 2023-2025.

[21] https://www.theglobalfund.org/en/strategy/

[22] For example: Community-led integrated HIV services: The future of a sustainable HIV response. https://www.unaids.org/sites/default/files/2025-11/PCB57_NGO_Report_EN.pdf

[23] 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

[24] The State of Global Health Funding: August 2025. https://www.thinkglobalhealth.org/article/state-global-health-funding-august-2025

as evidenced by emerging analyses of global funding reductions affecting women's rights organizations, GBV services, and community systems.[25,26] In this increasingly resource-constrained environment, evidence is necessary to inform the prioritization of the most critical and, to some extent, most feasible approaches to integrating gender equality in disease programs and health and community systems. Having a comprehensive understanding of which recent approaches have worked well, and which have not across different disease areas and intervention types, will ensure that future Global Fund investments achieve better results for all.

The evaluation was also completed during the early phases of preparation and rollout for the Global Fund's eighth grant cycle (GC8). As such, it coincides with emerging shifts in strategic emphasis, including a stronger focus on integration of HIV, TB, malaria services in GC8 and around streamlining grant life-cycle processes, with further differentiation for focused portfolios, as well as discussions on transition pathways.

In this context of fiscal uncertainty and strategic transition, the evaluation serves two purposes. It is both formative and forward-looking. It assesses current progress, best practices, and successes in integrating gender equality approaches in HIV, TB, and malaria programs. It also provides evidence and actionable recommendations to inform improvements and decision-making for GC8 and contributes to the development of the post–2028 Global Fund Strategy. In addition to internal learning and accountability, the evaluation aims to contribute to broader global knowledge on how gender equality approaches can be meaningfully integrated into disease programming and to identify practices that should be prioritized. Lessons identified through this evaluation will help inform other actors working at the intersection of gender, health, and human rights.

The primary users of the evaluation are the Global Fund Secretariat and Governance bodies. While guidance materials and other key materials are already prepared for the roll out of GC8, this evaluation has the opportunity to inform Funding Request and grant-making processes and GC8 implementation. The evaluation also has longer-term utility as an input into discussions around the next Global Fund Strategy. The secondary users of the evaluation include country stakeholders, including principal recipients (PRs), sub-recipients (SRs), country coordinating mechanisms (CCMs), civil society organizations (CSOs), technical partners, and donors.

2.1. Concepts and Definitions

This evaluation examines gender equality approaches specifically within the context of HIV, TB, malaria, and RSSH programs supported by the Global Fund. The analysis is therefore focused on how gender-related considerations are integrated into disease prevention, diagnosis, treatment, care, and health and community system strengthening, rather than on broader gender equality or social transformation outcomes beyond the health sector. **Gender-related considerations** refer to the ways that gender norms, roles, and power relations shape health risks, care-seeking, service access, and program delivery. **Gender barriers** refer more specifically to obstacles created by these dynamics that limit individuals' ability to access or benefit from services. While the evaluation recognizes that many drivers of gender inequality, such as education, employment, legal systems, and social protection, lie outside of the health system, it assesses gender equality approaches insofar as they are relevant to, and feasible within, Global Fund–supported health interventions and delivery platforms. Findings and conclusions should be interpreted in light of this programmatic scope. For the purposes of this evaluation, key concepts related to gender and gender equality are defined below to ensure clarity and consistency in interpretation across findings and conclusions. Three types of **gender-related interventions or activities**—gender-targeted, gender-responsive, and gender-transformative—are described here, based on an internal Global Fund categorization of modules and interventions within the modular framework for GC7 (see Annex 1). The evaluation does not assume that one category is inherently superior to another; rather, different approaches are appropriate for different disease contexts, programmatic objectives, capacities, and stages of implementation. The evaluation also separately examined GBV prevention and response activities, given their importance in shaping vulnerability, access to services, safety, disclosure, and continuity of care.

[25] 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

[26] UNAIDS: Global AIDS Update 2025. Available at: https://www.unaids.org/sites/default/files/2025-07/2025-global-aids-update-JC3153_en.pdf

Gender[27]

Gender refers to the socially constructed roles, responsibilities, norms, expectations, and power relations associated with being a woman, man, girl, boy, or gender-diverse person. Gender shapes access to resources, decision-making authority, exposure to risk, health-seeking behavior, and experiences of stigma, discrimination, and violence. Gender operates in interaction with other axes of inequality, such as age, disability, socioeconomic status, migration status, sexual orientation, and gender identity, and influences health outcomes across the life course. Gender differs from biological sex, but sex- and gender-related factors often interact in shaping vulnerability and access to services.

Gender Equality[28]

Gender equality refers to the state in which individuals of all genders have equal rights, responsibilities, opportunities, and access to resources, including health services, decision-making processes, and systems of accountability. In the context of HIV, TB, and malaria responses, gender equality implies that gender-related barriers do not prevent any group from accessing prevention, diagnosis, treatment, care, or support, and that health systems actively work to reduce gender-based inequities.

Gender Integration[29]

Gender integration refers to the systematic consideration and incorporation of gender-related differences, inequalities, and power relations across all stages of the program cycle, including design, budgeting, implementation, monitoring, evaluation, and learning. Gender integration goes beyond the inclusion of women or sex-disaggregated data and involves identifying how gender norms, roles, and structural inequalities affect disease risk, access to services, quality of care, and health outcomes, and adapting programs accordingly. In this evaluation, gender integration is assessed across multiple domains, including program design, financing, data systems, partnerships, and implementation practices. The Evaluation Team developed a novel framework for assessing gender integration (described below).

Gender-Targeted Interventions[30]

Gender-targeted interventions are interventions that explicitly prioritize or focus on specific population groups defined by sex, age, or reproductive status, based on differential biological vulnerability or epidemiological risk. These interventions address who services are delivered to, rather than how underlying gender relations are shaped. Examples include interventions targeting pregnant women through antenatal care platforms, services focused on AGYW, or prevention and treatment services tailored to key populations. Gender-targeted approaches can improve equity of access and coverage, but they do not necessarily address the social norms, power relations, or structural barriers that shape vulnerability. However, when gender-targeted interventions also include efforts to identify and address gender-related barriers to service uptake or use, they would also be considered as gender-responsive.

Gender-Responsive Interventions[31]

Gender-responsive interventions are designed or adapted to account for gendered realities and to remove practical, social, or safety-related barriers to accessing and benefiting from services. These interventions address how services are delivered by recognizing constraints such as time poverty, mobility restrictions, caregiving responsibilities, stigma, fear of violence, or lack of privacy. Gender-responsive approaches

[27] https://www.who.int/health-topics/gender#tab=tab_1

[28] https://www.un.org/womenwatch/osagi/conceptsandefinitions.htm

[29] https://www.international.gc.ca/world-monde/funding-financement/gender_equality_toolkit-trousse_outils_egalite_genres.aspx?lang=eng

[30] See Annex 1

[31] Internal Global Fund Secretariat memoranda

may include adapting service hours, recruiting female health workers, providing privacy-enhancing service layouts, delivering services through community or peer-led models, or aligning outreach with women's and men's daily routines. While gender-responsive interventions improve access, acceptability, and quality of care, they generally work within existing gender norms rather than explicitly seeking to transform them.

Gender-Transformative Interventions[32]

Gender-transformative interventions explicitly seek to challenge and change gender norms, unequal power relations, and structural drivers of gender inequality that affect health risks and outcomes. These approaches aim to shift attitudes, behaviors, institutional practices, and social structures that perpetuate inequality, discrimination, or violence. Examples include interventions that engage men and boys to promote equitable gender norms, address gender-based violence and legal barriers, strengthen women's leadership and collective voice, or reform institutional practices that reinforce discrimination. Gender-transformative approaches typically require sustained investment, specialized expertise, and supportive enabling environments, and their impacts often emerge over longer time horizons than those of gender-targeted or gender-responsive interventions.

2.2. Gender Interventions in HIV, TB, and Malaria Programs

For GC7, the Global Fund developed a series of applicant guidance documents that provide technical guidance on integrating gender considerations into HIV, TB, malaria programming.[33] In addition, an evidence review commissioned by the Global Fund in 2024/2025 examines gender-responsive and gender-transformative approaches across these disease areas, outlining how gender-related barriers can shape exposure, disease acquisition, care seeking, diagnosis, treatment, adherence, and disease outcomes.[34] This review included illustrative care pathways that mapped gender-related barriers at different stages of the pathway and identified corresponding interventions. For the purposes of this evaluation, we have included a simplified table to highlight common barriers and potential intervention examples to illustrate gender-targeted, gender-responsive, and gender-transformative approaches in Global Fund–supported disease programming (see Table 1).

	Gender-Related Barriers	Gender-Targeted	Gender-Responsive	Gender-Transformative
HIV	AGYW face elevated HIV risk due to age–disparate partnerships, limited negotiation power, sexual coercion, and violence	AGYW combination prevention (PrEP, condoms, sexual and reproductive health [SRH] services)	Integrating HIV testing and prevention into ANC/SRH; home-based testing; provider training for respectful care	AGYW empowerment and community mobilization; male engagement addressing norms; GBV prevention and response
TB	Women face delayed diagnosis due to mobility restrictions, stigma, and privacy concerns; men delay care due to norms discouraging care-seeking	Sex/age-tailored screening (e.g., workplace for men; maternal platforms for women)	Community outreach; peer educators; respectful/confidential TB diagnosis; male- or female-friendly clinics; transport/cash support	Community stigma reduction; household engagement to redistribute care burdens; norms change around masculinity and care-seeking

[32] Internal Global Fund Secretariat memoranda.

[33] Technical Brief Removing Human Rights-related Barriers to TB Services; Technical Brief Equity, Human Rights, Gender Equality and Malaria; Technical Brief on Removing Rights-Related Barriers to HIV Services

[34] 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-Related Barriers	Gender-Targeted	Gender-Responsive	Gender-Transformative
Malaria	Pregnancy increases biological vulnerability; household norms shape ITN usage and prioritization; limited women's decision-making power	IPTp via ANC; ITN distribution to pregnant women; occupational prevention for men	CHW delivery of ITNs/ IPTp; ANC integration; male engagement in ITN decision-making; tailored literacy	Community dialogues on household decision-making and women's health; collective participation in community malaria prevention

Table 1. Illustrative Examples of Gender-Related Barriers and Interventions across the Disease Areas

Evaluation Design

3.1. Purpose and Scope

This evaluation examines the extent to which, and how, gender equality approaches have been integrated into HIV, TB, and malaria programs supported by Global Fund investments. For the purposes of this evaluation, gender equality approaches are understood to include gender-targeted, gender-responsive, and gender-transformative efforts to improve equitable access to services and participation in program design and delivery. As a formative assessment, this evaluation not only highlights progress and achievements of these approaches thus far, but also provides actionable recommendations to enhance future Global Fund grant cycles. It is recognized that HIV, TB, and malaria programs and gender programming in many countries are financed through mixed donor ecosystems, including bilateral partners, UN agencies, and domestic resources. This evaluation focuses specifically on gender integration within Global Fund–supported grants, while acknowledging that complementary financing may support additional gender-responsive or gender-transformative activities beyond the scope of individual grants. While the initial purpose, as set out in the terms of reference, was to help identify opportunities for scaling and replicating gender-responsive and gender-transformative interventions, recognizing the threats to funding in this area, the evaluation supports the identification of the gender-integrated approaches that are critical to maintain in national disease programs to achieve the strategy goal of ending AIDS, TB, and malaria. Where gender integration has been limited, the evaluation also explores the underlying reasons and barriers to implementation, including institutional and contextual factors.

While the evaluation primarily focuses on HIV, TB, and malaria programs, it is recognized that gender equality approaches are also relevant across RSSH investments. A small number of RSSH standalone grants, particularly those related to human resources for health, were also reviewed in relation to the evaluation questions.

3.2. Evaluation Approach: Feminist, inclusive, diverse, intersectional, and evidence-informed

This evaluation adopted a feminist approach as outlined in Global Affairs Canada's guidance on feminist evaluations,[35] which emphasizes advancing gender equality and the empowerment of women, girls, and gender-diverse individuals throughout all stages of evaluation. This approach seeks to identify and challenge power imbalances, systemic discrimination, and the root causes of gender inequality. The evaluation therefore aimed to surface power dynamics; center the voices of women, girls, trans, nonbinary, and gender-nonconforming people and gender equality organizations; and prioritize the lived experiences of marginalized groups. To operationalize this, the evaluation intentionally prioritized engagement with community-led, women-led, and lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI+) organizations when possible during the in-country data collection; included data collection and site visits at the community-level; included relevant questions in data collection tools; and ensured safe and confidential participation by groups experiencing stigma, discrimination, or violence. The evaluation was guided by the principles of diversity, inclusion, and intersectionality and aimed to ensure that these principles are incorporated into all stages of the evaluation. It was aligned with the Global Fund's guidance on conducting gender-responsive and intersectional evaluations.[36]

In addition to applying equity principles, the evaluation considers how gender equality efforts are perceived to contribute to broader public health goals. While the evaluation was not intended to assess effectiveness or impact directly, it explored stakeholder views on how gender equality approaches align with evidence-informed public health programming and contribute to improving access, reach, and quality of HIV, TB, and malaria programs as well as disease outcomes.

3.3. Objectives and Evaluation Questions

The specific objectives of this evaluation are:

1. To assess the extent to which gender equality approaches (including both targeted gender-transformative interventions and efforts to improve access and participation of women and gender-diverse groups) are being integrated into HIV, TB, and malaria disease programs supported by the Global Fund.

[35] Global Affairs Canada, 2024. Planning and managing feminist evaluations. Available at: https://www.international.gc.ca/world-monde/funding-financement/planning-planification.aspx?lang=eng#a2

[36] Global Fund. Evaluation Deliverables: Templates and Guidance. Integrating a gender lens to evaluations: Checklist on conducting gender-responsive and intersectional evaluations.

2. To identify internal and external enabling and hindering factors, and their causes and effects, for integrating gender equality approaches into Global Fund–supported disease programs.

3. To identify key lessons and successes that would allow the Global Fund partnership to reinforce, advance, and sustain integration of gender equality approaches in national health programs.

To address these objectives, the evaluation was guided by 10 evaluation questions and the findings in the report have been presented against these questions. Based on the consultations, preliminary document review and input from ELO, the evaluation questions were revised during the inception phase. The final list of evaluation questions is presented in Table 2.

Theme	Revised Question
Funding Requests 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?
	2. How are commitments and prioritization to targeting gender equality reflected in grant budgets and performance 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?
Partnerships and Catalytic Investments	4. In countries that are part of the following Global Fund Strategic Initiatives, 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)
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?
	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?
	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?
	8. To what extent, where programmatically relevant, 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)?
	9. What gender equality approaches in HIV, TB, and malaria interventions are demonstrating an indication of success,* and why?
	10. What good practices, structure, and resources need to be in place to ensure that gender equality approaches will drive the sustained impact of HIV, TB, and malaria programs?

Table 2. Evaluation Questions

*For the purposes of this evaluation, "success" is defined as the perceived effectiveness, relevance, and added value of gender equality approaches in addressing gender-related barriers and advancing equitable participation, access, and outcomes within HIV, TB, and malaria programs. This includes stakeholder perspectives on how these approaches support the goals of more inclusive and effective disease responses. The evaluation does not assess impact or conduct a value-for-money analysis but will explore how success is understood and experienced across contexts.

The evaluation matrix presented in Annex 2 links each evaluation question to its corresponding indicators, ensuring that all evaluation objectives are adequately addressed. Triangulation strategies have been incorporated to strengthen evidence quality and mitigate limitations related to document completeness.

3.4. Evaluation Design and Methodology

To answer these questions, this evaluation was designed as a formative evaluation, using mixed-methods and a process-oriented analysis. It combined (1) a comprehensive desk review–based portfolio analysis of 35 country-components across different diseases and regions plus three RSSH standalone grants (totaling 24% of the GC7 allocation) and (2) in-depth country studies with qualitative interviews in a subsample of seven grant programs in five countries, capturing diverse stakeholder perspectives (see Table 3 for further details).

Phase	Description	Duration	Dates
Inception Phase	Consult stakeholders; refine evaluation questions and methodology	1 month	April 2025
Data Collection Phase – Stage 1: Portfolio Review of 38 country-components	Desk review of existing documents and data from 38 country-components and 29 countries	4 months	May 2025–August 2025
Data Collection Phase – Stage 2: In-depth Country Studies in 5 countries	Qualitative data collection focused on five countries	2 months	September 2025–October 2025
Data Analysis Phase	Systematic analysis, triangulation and interpretation of data/findings from all data streams to answer the evaluation questions; preliminary findings workshop	3 months	October 2025 – December 2025
Reporting Phase	Synthesis of findings into final report; recommendations workshop; submission of draft and final reports, including several rounds of revisions	5 months	December 2025 –April 2026

Table 3. Evaluation Phases

While the evaluation design broadly follows the approach outlined in the inception report, several refinements occurred at two stages of the evaluation process. During the inception phase, the methodology was revised through consultations with the Global Fund ELO to improve feasibility given the country reprioritization exercise and alignment with available data. These revisions included adopting a phased approach to data collection, reducing the number of in-depth country studies from six countries (ten country-components) to five countries (seven country-components), including the removal of Ghana from the sample, revising and streamlining the evaluation questions, discontinuing the initially proposed quantitative survey, and incorporating three RSSH standalone grants into the portfolio review. The revised methodology presented in the inception report reflects these adjustments. During implementation, additional methodological adaptations were made based on early operational learning. In particular, an artificial intelligence (AI)-assisted document analysis approach was piloted for the portfolio review but ultimately discontinued due to limitations in document structure and extraction accuracy, and the analysis was conducted through a structured manual review to ensure analytical validity. In addition, the number of virtual stakeholder interviews at the Secretariat/global level was expanded beyond what was anticipated in the inception report in order to strengthen triangulation and fill gaps not consistently documented in grant materials. These adaptations did not alter the overall objectives of the evaluation but strengthened the feasibility, transparency, and rigor of the final methodological approach.

Stage 1 – Portfolio Review of 38 Country-components

The portfolio review covered 38 country-components implemented in 29 countries, including 35 disease-specific country-components across HIV, TB, and malaria, as well as 3 RSSH standalone grants with relevance to gender integration, particularly in relation to human resources for health. Country-components were purposively selected to ensure variation across disease areas, geographic regions, portfolio categories, and levels of planned gender integration. In total, these

38 country-components had a combined allocation of US $3.097B, representing about 24% of the overall allocation for GC7.[37] The GEM score[38] of disease components was also a critical selection criterion, as only country-components with a score of 0 or 2 were eligible for the evaluation. Only GC7 country-components that had been under implementation for at least 1 year at the time of data collection were included, to allow assessment beyond initial design intentions. The full list of countries and components included in the portfolio review is presented in Table 4.

#	Country	Component	GF Portfolio	Selected for Portfolio Review	Selected for Country Studies
1	Guinea	Malaria	Core	Yes	Yes
2	Côte d'Ivoire	TB	High Impact	Yes	Yes
3	Côte d'Ivoire	HIV	High Impact	Yes	Yes
4	Lesotho	TB	Core	Yes	Yes
5	Lesotho	HIV	Core	Yes	Yes
6	Pakistan	TB	High Impact	Yes	Yes
7	Tanzania (United Republic)	Malaria	High Impact	Yes	Yes
8	Bangladesh	Malaria	High Impact	Yes	No
9	Ethiopia	HIV	High Impact	Yes	No
10	Ghana	Malaria	High Impact	Yes	No
11	Guatemala	HIV	Core	Yes	No
12	Guinea-Bissau	Malaria	Core	Yes	No
13	Haiti	TB	Core	Yes	No
14	Kenya	HIV	High Impact	Yes	No
15	Kyrgyzstan	HIV	Focused	Yes	No
16	Lao (People's Democratic Republic)	TB	Focused	Yes	No
17	Malawi	Malaria	High Impact	Yes	No
18	Mongolia	TB	Focused	Yes	No
19	Mozambique	HIV	High Impact	Yes	No
20	Mozambique	Malaria	High Impact	Yes	No
21	Mozambique	TB	High Impact	Yes	No
22	Papua New Guinea	Malaria	Core	Yes	No
23	Philippines	HIV	High Impact	Yes	No
24	Republic of the Congo	TB	Core	Yes	No

[37] The overall allocation for GC7 was US $13.128B: https://archive.theglobalfund.org/media/12501/archive_bm48-03a-2023-2025-allocation-sources-funds_report_en.pdf. In 2025, total grant allocation was reduced, as described in the Background section of this evaluation report.

[38] The GEM was developed by the Global Fund Secretariat and introduced in GC7 to assess how gender equality is incorporated into Funding Requests. Grants with a GEM score of 1 were excluded to enable a clearer comparative analysis between those with no gender integration (GEM 0) and those with strong gender-transformative approaches (GEM 2).

#	Country	Component	GF Portfolio	Selected for Portfolio Review	Selected for Country Studies
25	Rwanda	HIV	Core	Yes	No
26	Senegal	HIV	Core	Yes	No
27	Sudan	Malaria	Core	Yes	No
28	Suriname	Malaria	Focused	Yes	No
29	Tajikistan	HIV	Focused	Yes	No
30	Zanzibar	Malaria	Focused	Yes	No
31	Ukraine	TB	Core	Yes	No
32	Zambia	HIV	High Impact	Yes	No
33	Zambia	TB	High Impact	Yes	No
34	Zimbabwe	Malaria	High Impact	Yes	No
35	Zimbabwe	TB	High Impact	Yes	No
36	Côte d'Ivoire	RSSH	High Impact	Yes	Yes
37	Mozambique	RSSH	High Impact	Yes	No
38	Haiti	RSSH	Core	Yes	No

Table 4. List of Country-components Selected for Portfolio Review and In-Depth Country Studies

The portfolio review drew on a structured analysis of Funding Requests documents, grant-making stage documents, progress updates, and relevant SI materials where applicable (see Annex 3 for a full list of documents consulted). A standardized desk review protocol guided the extraction of information related to the identification and articulation of gender-related barriers, the design of gender-responsive and gender-transformative interventions, budget allocations and financing arrangements, partnerships with community and civil society actors, and the integration of gender considerations into monitoring and performance frameworks.

The evaluation team explored the use of an AI-assisted model to support the portfolio review by extracting and synthesizing information from portfolio documents. However, during implementation, the model was not used for the document analysis due to challenges related to document structure, variability in formatting, and limitations in extraction accuracy. To ensure analytical rigor and reliability, the portfolio review was therefore conducted through structured manual review of all documents.

In addition, the Evaluation team developed a Gender Integration Score (GIS) framework for assessing gender integration across the sampled country-components. The GIS is designed to assess the extent and quality of gender integration across five core domains of the grant cycle: program design; budgeting; performance frameworks; monitoring, evaluation, and learning (MEL); and implementation. Each domain is divided into defined subdomains, such as gender analysis, inclusive engagement, identification of gender barriers, scale and proportionality of investment, gender-sensitive and gender equality indicators,[39] use of gender data for decision-making, and implementation of gender-earmarked activities, which capture both the presence and depth of gender integration. Each subdomain is scored on a standardized three-point scale (1–3), reflecting limited, moderate, or strong integration based on explicit assessment criteria. Scores were derived through structured document review of Funding Requests, grant-making documents, and available implementation and reporting materials, using a detailed scoring rubric provided in Annex 4. The GIS is

[39] For the purposes of this evaluation, gender-sensitive indicators are defined as indicators that are sex-disaggregated, and gender equality indicators include indicators focused on gender-specific key populations and/or indicators related to GBV, gender equality, power, and decision-making.

intended to support comparative analysis and pattern identification across grants and disease areas, rather than to function as a definitive performance rating, and is used in this evaluation to highlight relative strengths, gaps, and areas for improvement in gender integration across the GC7 portfolio.

Virtual stakeholder in-depth interviews and/or focus group discussions

To complement the document review findings and to capture insights that may not be reflected in programmatic documentation, the evaluation team conducted 31 virtual stakeholder interviews. These interviews primarily focused on Global Fund Secretariat stakeholders and global technical partners. Semi-structured interview and discussion guides, aligned with the evaluation questions, were used to steer conversations while allowing space for participants to raise additional relevant issues. Thematic analysis was conducted to synthesize qualitative findings and triangulate them with desk review results, strengthening the overall robustness of the portfolio review.

Stage 2 – In-Depth Country Studies in Five Countries

Five countries were selected for in-depth studies: Guinea, Côte d'Ivoire, Lesotho, Pakistan, and Tanzania. These countries were purposively selected to reflect diversity across disease areas, geographic regions, sociopolitical contexts, and levels of gender integration, while also ensuring feasibility of data collection within the evaluation timeframe.

Within each country, data collection focused on national and subnational stakeholders involved in funding request development, grant-making, implementation, oversight, and community engagement. Methods included key informant interviews, focus group discussions, and limited site observations where feasible. In addition, detailed activity trackers were completed with stakeholders to document the activities being implemented, the ways in which gender was considered for each activity, early results, and gaps. Stakeholders consulted for the interviews and focus groups included representatives from ministries of health and other relevant ministries, principal and sub-recipients, CCM members, civil society organizations, women-led and community-based organizations, and actors involved in SIs and catalytic investments. Annex 5 includes the full list of stakeholders consulted across all components of the evaluation.

Country/Level	Description	Location	Modality	In-Depth interviews (IDIs)	FGDs	Observational Site Visits
Global	Document Review of 38 country-components from 29 countries	Included initial sample of over 2,000 documents (Funding Request documents, grant-making documents, KPIs, and Progress Update and Disbursement Requests [PUDR] data, etc.) from GC7				
Global	Different stakeholders at Secretariat and technical partners	Global and Geneva[40]	Virtual	31	0	N/A
Tanzania	Malaria component	Dodoma, Geita, Dar es Salaam, Mwanza	In-person (8 virtual IDIs)	38	0	3
Lesotho	HIV and TB component	Maseru, Leribe, Mafeteng, Mohale's Hoek	In-person (12 virtual IDIs)	58	1	4
Guinea	Malaria component	Conakry, Kankan, Siguiri	In-person (Virtual: 4 IDIs, 1 FGD)	32	8	3

[40] Given gaps in implementation information in the document review, PRs in Haiti and Mozambique were interviewed as part of this data collection to capture additional data on implementation.

Country/Level	Description	Location	Modality	In-Depth interviews (IDIs)	FGDs	Observational Site Visits
Côte d'Ivoire	HIV and TB component	Abidjan, Grand Bassam, Abengourou	In-person (1 virtual IDI)	38	6	1
Pakistan	TB component	Lahore, Karachi, Islamabad	In-person (1 virtual IDI)	51	8	8
Total				**248**	**23**	**17**

Table 5. Summary of Data Collected

3.5. Data Analysis, Triangulation, and Strength of Evidence

Qualitative data from interviews and FGDs were analyzed using thematic analysis, guided by a coding framework aligned with the evaluation questions. Analysis focused on identifying patterns related to the design, implementation, financing, monitoring, and sustainability of gender equality approaches, as well as enabling and constraining factors across disease areas. AI-supported tools were used in a limited manner to assist with transcription and translation of interviews and to support cross-checking of manually extracted qualitative data, but all coding, interpretation, and synthesis were conducted by the evaluation team. Findings from the portfolio review, Secretariat interviews, and the in-depth country case studies were triangulated to assess consistency and variation across data sources, countries, and stakeholder groups. Comparative analysis was used to examine differences across HIV, TB, malaria, and RSSH investments, and to identify cross-cutting themes relevant to the Global Fund portfolio as a whole. The strength of evidence for key findings was assessed based on convergence across data sources, diversity of contexts, and consistency across stakeholder perspectives (Table 6). Findings are presented using cautious, proportionate language that reflects the nature and limits of the available evidence. Draft recommendations were developed by the evaluation team based on the synthesis of findings and were presented in a Secretariat stakeholder workshop in Geneva. Participants provided feedback and additional perspectives, which were incorporated into the final recommendations.

Strength of Evidence	Criteria
Strong	• Finding is supported by multiple high-quality data sources (e.g., portfolio review, interviews, surveys), enabling triangulation across at least two distinct methods or stakeholder groups • Evidence is reinforced by consistent patterns across countries and diverse stakeholders (e.g., CSOs, implementers, CCMs)
Moderate	• Finding is supported by more than one data source or stakeholder group, allowing for some triangulation • Data quality is acceptable, although it may be less consistent or of lower quality • May be based on strong evidence from a limited number of countries or stakeholder groups
Limited	• Finding is based on few data sources, limited triangulation, or narrower stakeholder input • Data may be of lower quality, or inconsistently reported • May reflect early signals or emerging insights requiring further exploration

Table 6. Criteria for Strength of Evidence

3.6. Limitations

The evaluation has several limitations. The portfolio review depended on the quality, completeness, and consistency of available portfolio documentation, which varied across countries and components. In addition, most grants had been implemented for a relatively short period at the time of data collection, limiting the ability to observe outcomes or longer-term effects of gender equality approaches. The in-depth country studies primarily relied on qualitative methods, which may be subject to respondent bias. The purposive sampling approach prioritizes depth of understanding and learning rather than statistical representativeness. These limitations were mitigated through triangulation across data sources and stakeholder groups and are taken into account in the interpretation of findings and recommendations. See Table 7 for a detailed list of limitations.

Limitation	Description	Implications for Interpretation
Document availability and completeness	The evaluation relied on Funding Requests, grant-making documents, progress updates, and portfolio materials that were available at the time of review. In some cases, documents had limited information on gender equality intent or implementation.	Findings related to design quality and planned gender integration may underestimate intent or rationale where gender considerations were embedded informally or documented outside core documents.
Variation in quality and specificity of Funding Requests	Funding Requests varied substantially across countries and disease components in how explicitly gender barriers, approaches, and indicators were articulated. Some gender-responsive or transformative intentions were described at a high level without clear operational detail.	Comparisons across countries and disease areas should be interpreted cautiously, as differences may reflect documentation practices rather than substantive differences in intent or commitment.
Limited implementation data in portfolio-level sources	Portfolio review relied on Progress Update and Disbursement Requests (PUDRs) and related Secretariat reporting, which contain limited and inconsistent information on the implementation of gender-related activities.	Portfolio-level analysis provides limited insight into how gender approaches are implemented in practice; findings on implementation therefore primarily rely on in-depth country studies and Secretariat interviews rather than portfolio-wide reporting.
Nonrepresentative allocation coverage	The 38 country-components included in the portfolio review represent approximately 24% of the total GC7 allocation value and were selected to capture diversity across disease areas, regions, and portfolio types, rather than proportional representation by financial weight.	Findings are not statistically representative of the full GC7 portfolio. They illustrate patterns and conditions within the sampled country-components rather than proportional trends across total funding.
Nonrepresentative country sample	Country studies were purposively selected to capture diversity across disease areas, regions, and portfolio types, rather than to provide a statistically representative sample of all Global Fund grants.	Findings are analytically generalizable but not statistically generalizable; they illustrate patterns, mechanisms, and conditions rather than prevalence across the full portfolio.
Predominantly qualitative country-level data	Country-level analysis primarily relied on qualitative methods, including key informant interviews, and focus group discussions. These methods are subject to recall bias, social desirability bias, and variation in respondent perspectives, but were triangulated to address biases. A limited number of site visits were also conducted.	Perceptions of effectiveness, success, or constraint should be understood as indicative rather than causal evidence of impact.

Limitation	Description	Implications for Interpretation
Early stage of implementation	Much of the GC7 period assessed corresponds to early implementation, with several activities delayed, adapted, or reprioritized due to funding uncertainty and grant adjustments.	The evaluation is able to assess integration, feasibility, and early signals of success rather than effectiveness, longer-term outcomes or sustainability.
Limitations in gender-disaggregated and gender-relevant data	Routine monitoring systems in TB, malaria, and RSSH largely rely on sex-disaggregation, with limited indicators capturing gender norms, power relations, safety, or GBV-related outcomes. Capacity to interpret and use gender data also varies across programs.	Conclusions regarding gender-transformative effects and norm change are necessarily cautious and based largely on qualitative evidence.
Challenges with AI-assisted portfolio analysis	An AI-assisted approach to analyzing portfolio review documents was initially piloted but discontinued due to limitations in document structure, data quality, and risks to analytical validity. Manual review was used to ensure rigor.	Manual analysis improved quality and contextual interpretation but limited the scale of automated portfolio-wide pattern detection.
Limitations in budget classification and attribution	Budget analysis identified gender-targeted and gender-responsive/transformative expenditures based on CRG classifications of modules and interventions. Gender-relevant activities embedded within broader service delivery or health system modules without explicit gender labeling may not have been captured, leading to potential underestimation of budget amounts of gender activities. Conversely, attributing the full budget of some classified modules to gender may overestimate gender allocations where not all activities are exclusively gender-focused.	Budget findings should be interpreted as indicative of relative prioritization rather than precise accounting of all gender-related spending. Patterns observed across country-components and disease areas remain informative despite limits in financial granularity.
Structural limitations of grant budgeting systems	Global Fund budgets are not designed to systematically tag or track gender-related expenditures, nor to distinguish between gender-targeted, gender-responsive, and gender-transformative approaches.	Constraints reflect structural features of financial reporting systems rather than analytic shortcomings, limiting precision but not the validity of comparative insights.
Limited coverage and depth of RSSH analysis relative to HIV, TB, and malaria	RSSH country-components were not included in the initial sample, but were added during the inception phase. To avoid major increases in scope and resource requirements, three RSSH country-components were added to the portfolio review (compared to 35 HIV, TB, and malaria country-components), and only a small number of RSSH-focused stakeholders were included in Secretariat-level interviews. As a result, the evaluation generated substantially less data for RSSH than for the disease components.	Findings related to RSSH should be interpreted with caution and as illustrative rather than comprehensive. The evaluation may not capture the range of RSSH-related gender work underway in GC7. Lack of depth reflects sampling and data constraints.
Multiple donor financing context	HIV, TB, malaria and gender programs in several countries operate within broader donor ecosystems where gender-related activities are co-financed by bilateral agencies, UN organizations, and domestic resources. The evaluation focuses on Global Fund–supported grants and does not systematically assess the full financing architecture of national gender programming.	Findings related to the scale or prevalence of gender-targeted, responsive, or transformative approaches reflect Global Fund Funding Request, grant design and implementation and may not fully capture complementary gender investments delivered through other funding streams.

Table 7. Limitations of the Evaluation Methodology

Key Findings

This section presents the main findings of the evaluation, organized around the evaluation questions and grounded in triangulated evidence from the portfolio review, in-depth country studies, and global- and country-level stakeholder interviews. Findings reflect patterns observed across 12 HIV, 11 TB, 12 malaria, and 3 RSSH country-components, with attention to variation by disease area, portfolio type (High Impact, Core, and Focused), and national context. Table 8 provides a consolidated overview of all overarching findings and their associated subfindings, along with an assessment of the strength of evidence supporting each finding.

Evaluation Question (EQ)	Overarching Finding	Subfindings	Strength of Evidence†
EQ1. Integration of gender equality approaches in Funding Requests and grant design	**Finding 1**: The integration of gender equality approaches in HIV, TB, and malaria programs is routinely considered in GC7 grant Funding Request and grant design and most country-components demonstrate gender-responsive intent in line with country epidemiology. HIV country-components demonstrate strong gender integration across all four design subdomains (gender analysis, inclusive engagement, identification and mitigation of gender barriers, and intervention design), and across disease areas the strongest performance is observed in inclusive engagement during country dialogues. However, gender equality approaches are unevenly integrated across key design subdomains, with gaps in translating gender analyses and inclusive engagement into interventions. Across country-components reviewed, gender-targeted and -responsive approaches are more prevalent than transformative approaches or GBV activities. Compared to earlier cycles, gender barriers are more explicitly acknowledged in Funding Requests, reflecting progress in institutional visibility and review processes. The increased use of gender assessments and the introduction of institutional review tools such as the GEM have strengthened the visibility and systematic consideration of gender within Funding Request review processes.	**1.1.** Integration of gender equality varies by design subdomain, with the strongest performance in inclusive engagement and the weakest in intervention design; the overall average GIS for design was 1.94 out of 3. **1.2.** Gender assessments are increasingly used to inform design but vary in timing, depth and methodological rigor; 63% of country-components reviewed included a gender assessment in the respective Funding Requests (83% of Funding Requests with HIV modules, and 67% with malaria, 45% with TB, and 33% with RSSH modules). **1.3.** Gender-targeted approaches to expand reach and coverage for affected groups, and gender-responsive approaches that address gender barriers are the most prevalent approaches across country-components, included in 68% and 71% of the 38 country-components reviewed, respectively. Gender-transformative approaches addressing norms and power relations, and GBV-focused interventions are less common, each identified in 40% of country-components. **1.4.** National political, legal, and planning contexts strongly influence gender integration in Funding Requests and grant design. **1.5.** The GEM has strengthened institutional visibility and systematic consideration of gender during Funding Request review. There is an opportunity to further institutionalize its use by enhancing and expanding follow-up mechanisms and country-level visibility.	**Strong**

Evaluation Question (EQ)	Overarching Finding	Subfindings	Strength of Evidence†
EQ2. Reflection of gender commitments in budgets and performance frameworks	**Finding 2:** Gender commitments articulated in GC7 Funding Requests and grant design are not consistently reflected in grant budgets or performance frameworks across disease areas. Where gender-related activities are embedded within broader service delivery or health system modules, the absence of standardized budget tagging limits visibility and systematic tracking of gender investments.	**2.1.** Within Global Fund grant budgets, budgeted amounts for gender-related activities vary across country-components and remain modest relative to articulated gender priorities in Funding Requests; identified gender-related budget amounts averaged 13.3% of total budgets for HIV country-components and 3.8% for malaria components, with no clearly identifiable budget amount for gender activities in the TB and RSSH country-components reviewed. **2.2.** Most identified budget amounts for gender activities support targeted service delivery approaches. **2.3.** Performance frameworks at the Funding Request stage show improved inclusion of sex-disaggregated indicators, with 87% of the 38 country-components including them in their respective Funding Requests. Modular Framework guidance does not include indicators for GBV, norm change, or power-related dynamics, and these indicators are not frequently included in grant performance frameworks. Only 21% of country-components reviewed included indicators focused on gender-specific key populations and/or GBV, stigma, norms, or decision-making dynamics in their respective Funding Requests. **2.4.** Within grants, identified gender priorities in Funding Requests do not consistently include explicit budget amounts or performance indicators. Alignment between gender priorities, budgets and indicators is strongest in HIV country-components. **2.5.** Gender-relevant activities are sometimes embedded within nongender modules and are not labeled in budgets, which limits visibility and tracking. **2.6.** Financial adjustments sometimes reduce the scale or scope of gender-related activities.	**Strong**
EQ3. Engagement of women's, feminist, and gender-diverse groups in country dialogue	**Finding 3:** Formal participation of women's, feminist, and gender-diverse groups is widely documented in GC7 country dialogue documentation, and stakeholders describe increased participation compared to previous cycles. However, formal inclusion did not always translate into substantive influence over grant priorities or design. The extent to which community-identified gender priorities were reflected in final Funding Requests varied across disease areas and national contexts, and was shaped by legal constraints, political sensitivities, and prioritization of core disease control interventions within country decision-making processes.	**3.1.** Formal participation in country dialogue processes has increased, but influence varies widely by disease and context. **3.2.** Power asymmetries, technical and biomedical framing of discussions, linguistic barriers and meeting cultures limit meaningful participation of women's feminist and gender-diverse groups. **3.3.** Structural constraints impede translation of gender priorities into Funding Requests. **3.4.** Strategic Initiatives and targeted support improve participation where present.	**Strong**

Evaluation Question (EQ)	Overarching Finding	Subfindings	Strength of Evidence†
EQ4. Contribution of Strategic Initiatives (CE-SI, BDB)	**Finding 4:** Several catalytic investments examined including the CE-SI, BDB, GEF and Her Voice Fund are drivers of high-quality gender integration across the Global Fund portfolio.	**4.1.** CE-SI strengthens gender-responsive data and community influence in decision-making. **4.2.** CE-SI supports community-led monitoring that captures gendered experiences. **4.3.** BDB strengthens the scale, quality, and durability of gender- and human rights–responsive programming, including GBV response and stigma reduction. **4.4.** The Gender Equality Fund enables grassroots, women-led and feminist organizations to pilot and implement gender-transformative interventions that are often difficult to finance through core grants. **4.5.** The Her Voice Fund strengthens sustained AGYW leadership, collective advocacy, and direct influence in critical decision-making processes. **4.6.** SI reach is expanding beyond HIV into TB and malaria country-components, with variable influence. **4.7.** SI-generated gender data fills gaps in routine systems.	**Moderate**
EQ5. Stakeholder understanding of gender and its influence on implementation decisions	**Finding 5:** Stakeholders interpret gender and gender equality integration through very different lenses, shaping the depth and type of programming across disease areas.	**5.1.** Stakeholders interpret gender and gender integration through equal access-focused, or structural lenses, with variation across roles and disease programs. **5.2.** More nuanced understandings correlate with stronger integration of gender equality approaches in disease programs. **5.3.** In TB and malaria, recognized gender barriers often do not shape implementation decisions. **5.4.** Training and exposure to gender-focused technical support were associated with more nuanced understanding of gender across stakeholder groups.	**Strong**
EQ6. Implementation of gender equality approaches as planned	**Finding 6:** Gender equality approaches to address barriers to access to HIV, TB, and malaria services that were integrated into GC7 grants show partial alignment between grant design and implementation, and gender commitments are sometimes adapted, reduced in scale, or delayed during execution. In some settings, implementation has also advanced beyond design intent, reflecting adaptive, community-led responses to gendered barriers. Implementation is further shaped by financing dynamics, institutional capacity, and the national enabling environment.	**6.1.** Embedded approaches are implemented more reliably than stand-alone components. **6.2.** Implementation varies by disease area, design ambition and partner capacity. **6.3.** In some settings, community-led adaptation has advanced gender integration beyond what was specified during grant design. **6.4.** Implementation of gender-related activities is also shaped by the national enabling environment and broader donor and partner ecosystems. **6.5.** Implementation delays are primarily attributable to administrative, procurement, financing, and operating-environment constraints. **6.6.** Implementation is facilitated where interventions are embedded in established service platforms and reinforced by experienced gender-focused partners, technical support, and the use of community-generated evidence to guide adaptive delivery. **6.7.** Implementation of gender equality approaches is hindered by financing volatility, biomedical prioritization within grant structures, limited gender-technical capacity, restrictive sociopolitical environments, and weak institutionalization of gender accountability mechanisms.	**Strong**

Evaluation Question (EQ)	Overarching Finding	Subfindings	Strength of Evidence†
EQ7. Partnerships for advancing gender equality	**Finding 7:** Partnerships are a major delivery channel for gender equality approaches within Global Fund–supported HIV, TB, and malaria programs. The composition of partnership ecosystems, particularly the inclusion of gender- and rights-specialized partners and actors beyond the health sector, varies by disease area and context, influencing the extent of gender integration in HIV, TB, and malaria program design and implementation by national- and community-level actors.	**7.1.** HIV programs consistently leverage partnerships with women-led organizations, feminist groups, KP networks, and people living with HIV (PLHIV) associations as core delivery mechanisms for gender equality work. **7.2.** TB and malaria partnerships infrequently include gender expertise, limiting the depth and consistency of gender integration. **7.3.** Several SIs strengthen partnership ecosystems by enhancing collaboration with gender and human-rights actors and improving community engagement.	**Strong**
EQ8. Collection and use of gender-relevant data	**Finding 8:** Sex-disaggregated data are now widely collected by country stakeholders, but use is variable; few HIV, TB, and malaria programs systematically collect or analyze data on norms, decision-making, GBV, or gender-specific access barriers.	**8.1.** Sex-disaggregated data are routinely collected but are not consistently used to inform decisions. **8.2.** Routine grant monitoring and national reporting systems rarely capture norms, GBV, or decision-making dynamics. **8.3.** Capacity gaps limit gender data generation, analysis and interpretation. **8.4.** Several SIs generate actionable gender- and rights-related data that fill critical gaps and, in some cases, influence Funding Requests, grant design and implementation. There is an opportunity to strengthen Learning Hubs to enhance translation of knowledge into practice and uptake of successful approaches.	**Strong**
EQ9. Gender approaches demonstrating indications of success	**Finding 9:** An emerging set of gender-targeted, gender-responsive, and gender-transformative approaches in HIV, TB, and malaria programs demonstrates indications of success in contributing to improved disease outcomes. Gender-targeted and -responsive approaches are most effective when embedded within established service platforms and delivered through trusted community actors, whereas transformative approaches require sustained financing, specialized expertise, supportive enabling environments and longer timeframes, often beyond a single Global Fund grant cycle, to achieve deeper shifts in norms and power relations. The most successful approaches are multilayered, community-led, rights-based, and explicitly tailored to gendered realities.	**9.1.** Success of gender equality approaches is primarily defined in terms of disease outcomes. **9.2.** Multilayered approaches show the strongest signs of success. **9.3.** Community-led and rights-based approaches strengthen trust, safety, and continuity of care, contributing to improved uptake and retention. **9.4.** Gender-targeted approaches demonstrate reach and coverage gains; gender-responsive approaches are most consistently associated with improved access, retention, trust, and service quality; and gender-transformative approaches (particularly in HIV) show promise in shifting norms and decision-making when implemented with sufficient resources, high quality and specialized partners. The current evidence base for gender-transformative approaches in TB and malaria contexts is limited. **9.5.** Integrated HIV/TB and multi-disease delivery models function as practical gender-responsive approaches by reducing cumulative care-seeking burdens and stigma exposure, creating safer and more acceptable entry points into services, and strengthening linkage and retention.	**Strong**

Evaluation Question (EQ)	Overarching Finding	Subfindings	Strength of Evidence†
EQ10. Conditions for sustained impact of gender equality approaches	**Finding 10:** Gender equality approaches may be more likely to drive sustained impact of HIV, TB, and malaria programs when they are supported by dedicated financing, strong partnerships, and gender-responsive governance and data systems and TA.	**10.1.** Strong partnerships support more sustained gender-responsive implementation in HIV, TB, and malaria programs. **10.2.** Dedicated funding supports continuity of gender equality approaches in HIV, TB, and malaria programs. **10.3.** TA and gender expertise improve quality and adaptation of gender equality approaches. **10.4.** Gender governance and data systems are viewed as necessary for sustaining gender integration.	**Moderate**

Table 8. Summary of Key Findings and Subfindings and their Associated Strength of Evidence Organized by Evaluation Question

† Strong: Finding is supported by multiple high-quality data sources (e.g., portfolio review, interviews, surveys), enabling triangulation across at least two distinct methods or stakeholder groups; evidence is reinforced by consistent patterns across countries and diverse stakeholders (e.g., CSOs, implementers, CCMs). Moderate: Finding is supported by more than one data source or stakeholder group, allowing for some triangulation; data quality is acceptable, although may be less consistent or of lower quality; may be based on strong evidence from a limited number of countries or stakeholder groups. Limited: Finding is based on few data sources, limited triangulation, or narrower stakeholder input; data may be of lower quality, or inconsistently reported; may reflect early signals or emerging insights requiring further exploration.

Evaluation Question 1

To what degree are Global Fund HIV, TB, and malaria grants demonstrating the integration of gender equality approaches into interventions, including HRH-funded interventions, in their design?

Overarching Finding 1: The integration of gender equality approaches in HIV, TB, and malaria programs is routinely considered in GC7 Funding Requests and grant design and most country-components demonstrate intent to be responsive to addressing gender barriers in line with country epidemiology. HIV country-components demonstrate strong gender integration across all four design subdomains (gender analysis, inclusive engagement, identification and mitigation of gender barriers, and intervention design), and across disease areas the strongest performance is observed in inclusive engagement during country dialogues. However, gender equality approaches are unevenly integrated across key design subdomains, with gaps in translating gender analyses and inclusive engagement into interventions. Across country-components reviewed, gender-targeted and -responsive approaches are more prevalent than transformative approaches or GBV activities. Compared to earlier grant cycles, gender barriers are more explicitly acknowledged in Funding Requests, reflecting progress in institutional visibility and review processes. The increased use of gender assessments and the introduction of institutional review tools such as the GEM have strengthened the visibility and systematic consideration of gender within Funding Request review processes.

Gender Integration in HIV, TB, and Malaria Programs Across Design Subdomains

Component Type	Gender Analysis (max score=3)	Inclusive Engagement (max score=3)	Identification and Mitigation of Gender Barriers (max score=3)	Intervention Design (max score=3)	Overall Score for Integration in Design (max score=3)
Across 38 HIV, TB, Malaria, RSSH Country-components	1.74	2.61	1.97	1.68	1.94

Table 9. Gender Integration in HIV, TB, and Malaria Country-components Across the Four Design Subdomains

While the entry points for the integration of gender equality approaches vary across disease areas, and gender integration may look quite different for HIV, TB, malaria, and RSSH, the Global Fund has articulated a minimum expectation of gender-responsive programming to be applied across all country-components, and the inclusion of gender-transformative elements when possible.[41] To assess this at the Funding Request and grant design stages, the evaluation's GIS scoring framework[42] defines gender-responsive program design to involve application of relevant gender analyses, identification of gender-related barriers across the care pathway, and translation of these insights into program design features and delivery adaptations capable of improving access, quality, and retention for different populations. Findings from the review of GC7 Funding Requests and grant documents indicate that these expectations are inconsistently met, with important gaps in the translation of gender analyses into grant design decisions and in the articulation of gender-responsive and gender-transformative delivery models.

[41] Technical guidance to countries indicates that programs must be gender responsive at a minimum. For example, Technical Brief Equity, Human Rights, Gender Equality and Malaria states (p. 8): "Programs and interventions are designed to be, at a minimum, gender responsive, and ideally gender-transformative to transform gender-related barriers." Technical Brief Removing Human Rights-related Barriers to TB Services states on p. 4 "Ideally, human rights-related barriers should be comprehensively addressed with interventions in all program areas. However, at a minimum, the Global Fund expects national TB programmes to include these program essentials. All TB programming are required to: "Be human rights-based and gender-responsive." The HIV Information Note (Allocation period 2023-2025) states: "Note that all programming must be human rights-based, gender-responsive and informed by and respond to an analysis of inequities."

[42] See Annex 4 for the full description of GIS domains, subdomains, and assessment criteria.

Overall, across the country-components reviewed, gender is moderately well integrated into GC7 grant design, with an overall average score of 1.94 (out of 3) across the four design subdomains assessed (the use and timing of gender analyses, the inclusiveness of engagement processes, the identification and mitigation of gender-related barriers, and the translation of these elements into concrete programmatic interventions) (see Table 9). The highest score was observed in inclusive engagement during country dialogues, reflecting documented participation of civil society, KP networks, and women-led organizations during country dialogue processes. However, while participation was frequently evidenced in documentation, stakeholders indicated that the depth and influence of this engagement varied across contexts; the quality and meaningfulness of participation is examined further in subsequent findings. The use of gender analyses to inform Funding Request and grant design was moderate, with not all country-components incorporating these data in the design process. This is discussed in further detail in the gender assessments section. The lowest score was in intervention design, indicating that gender analyses and engagement processes do not always translate into gender-related adapted delivery models, operational strategies, or other approaches. The evidence supporting these findings is **strong**, as a consistent pattern emerges across the portfolio review, in-depth country studies, and global and country-level interviews.

Progress in GC7

Across stakeholder interviews, both at the global-level and in the country studies, there was broad agreement that gender considerations are more explicitly present in GC7 Funding Request documentation than in earlier grant cycles. Secretariat and Technical Review Panel (TRP) interviewees described a shift toward more routine acknowledgment of gender-related barriers in access to disease services in GC7 Funding Requests, driven in part by stronger technical guidance to countries, the GEM, and expanded CRG-related technical support. However, stakeholders were clear that this increased visibility does not necessarily equate to consistent or deep attention to barriers in program design, particularly in TB, malaria, and RSSH country-components.

Gender Assessments

Across the portfolio, gender analyses were present in the majority of Funding Requests, but varied widely in methodological rigor, timing, and influence on design. Overall, Funding Requests for 63% of the reviewed country-components included a gender assessment. Funding Requests for HIV country-components were most likely to draw on a documented gender assessment (83% of HIV country-components), followed by malaria (67%) and TB (45%), while only a third of Funding Requests for RSSH country-components included a gender assessment (see Table 10). When disaggregated by portfolio type, 65% of country-components in High Impact countries, 67% of country-components in Core countries, and 50% of country-components in Focused countries that were reviewed were informed by a gender assessment. Notably, 97% of identified gender assessments had been completed within the last 5 years,[43] indicating that recency was not the primary barrier in GC7. However, review of the available gender assessments for these 38 country-components demonstrated variable quality and inconsistent use of the analyses to inform Funding Requests and interventions.

Secretariat and technical partner interviews noted that more countries undertook gender assessments in GC7 compared to GC6, sometimes in response to TRP feedback or SI-supported TA. For example, gender assessments were supported through TA in Cape Verde, and CRG-focused assessments addressing malaria access barriers were conducted in Thailand. These processes often included community consultation and were intended to inform Funding Request development. TRP members noted, in some cases, strong gender assessments conducted as part of national planning processes or through external partners. Secretariat interviewees and TRP members also emphasized variability in the quality and use of gender assessments and described the following characteristics of high-quality gender assessments:

1. Recent, country-specific analysis
2. Use of disaggregated epidemiological data
3. Analysis of structural drivers of inequality
4. Broad stakeholder engagement, including civil society and women's organizations
5. Explicit linkage between identified gaps and proposed interventions
6. Integration into performance frameworks and monitoring systems

[43] For this evaluation, "recent" gender assessments are defined as those completed within the last 5 years. This threshold was selected to align with the Global Fund's GEM review criteria used during Funding Request reviews and to maintain internal consistency across analyses. The 5-year window also corresponds broadly to common national planning and evidence refresh cycles (e.g., many NSPs span approximately 3–5 years, and key population or household surveys are often conducted on similar intervals). In rapidly changing epidemiological, political, or humanitarian contexts, more frequent updates to gender analysis may be warranted; the 5-year threshold is therefore used as a minimum standard for defining recency in this evaluation.

Component or Portfolio Type	Funding Request Included a Gender Assessment	Gender Assessment was Conducted in Last 5 Years[44]
Across 38 HIV, TB, Malaria, RSSH Country-components	63.2%	95.8%
HIV (12 Country-components)	83.3%	100%
TB (11 Country-components)	45.5%	80%
Malaria (12 Country-components)	66.7%	100%
RSSH (3 Country-components)	33.3%	100%
High Impact (19 Country-components)	63.2%	100%
Core (13 Country-components)	61.5%	87.5%
Focused (6 Country-components)	50%	100%

Table 10. Percent of Country-Components for which the Funding Request Included a Gender Assessment

The evaluation found good examples of gender assessments that were considered effective in informing Funding Requests for HIV country-components through analysis of gender inequalities and broad stakeholder engagement, leading to the inclusion of gender-transformative interventions in the Funding Request (for example, Moldova). However, even among the good examples, the TRP observed that attention to specific key populations was sometimes missing. In contrast, the Secretariat and technical partner interviewees described examples when the malaria matchbox assessment was overly general and insufficiently operational. In those examples, recommendations were reportedly generated from these assessments but without an implementation plan, and most recommendations were not implemented.

The role of technical partners in quality and standardization of gender assessments was also discussed by a number of interviewees. In the TB context, stakeholders described adapting a UNAIDS gender assessment tool, originally designed for HIV programming, for use in TB programming to better understand gender-related barriers for men, women, boys, girls, and transgender populations. UNAIDS has also recently revised a gender assessment tool (GATT), designed to be shorter, more efficient, less jargon-heavy, and more implementation-focused, integrating sustainability, human rights, and disability considerations in collaboration with the Global Fund with the aim of improving uptake in future grant cycles. While these tools provide structured guidance, interviewees did not describe a consistently applied set of minimum quality standards governing how gender assessments are conducted or how methodological rigor is ensured across contexts. Several interviewees also suggested that clearer quality benchmarks and additional guidance or training for consultants carrying out gender assessments could help improve quality and strengthen the practical utility of the assessment findings.

In general, Funding Requests for HIV country-components were more likely to draw on recent gender assessments, KP studies, and sex-disaggregated surveillance data; TB and malaria analyses were more uneven and often referenced gender indirectly through vulnerability groups (e.g., pregnant women, children, mobile or migrant workers) rather than through gender norms, power dynamics, or structural factors. In several cases (particularly in malaria), gender assessments were completed too late to shape Funding Request and grant design decisions. Where assessments were conducted

[44] For the definition and rationale for the 5-year threshold used to define "recent" gender assessments in this evaluation, see footnote 43.

earlier, during country dialogue or aligned with national strategy development, they were more likely to shape programming decisions. Secretariat and technical partner interviews emphasized that assessments conducted early enough to inform country dialogue had greater potential to influence Funding Request content. As described above, the likelihood of inclusion of a gender assessment varied across portfolio types, with fewer gender assessments in focused countries, despite the fact that gender barriers may also be relevant in these contexts.

Across TRP, Secretariat, and technical partner interviews, the most consistent concern was the weak linkage between gender assessment findings and budget allocation. TRP members explicitly noted that there is not necessarily a correlation between inclusion of a gender assessment and seeing corresponding activities or budget allocations in the Funding Request that respond to the barriers flagged in the assessment. Secretariat respondents similarly observed that Funding Requests may reference gender analysis but fail to allocate adequate resources to address identified barriers. Table 11 summarizes the key barriers to translation of gender assessments into programmatic activities identified by stakeholders.

Barrier for Translation of Gender Assessment into Programmatic Activities	Description
Assessments completed too late in the funding cycle	In several malaria contexts, gender assessments were finalized after key module design decisions had already been drafted, limiting their influence on prioritization and costing.
Gender interpreted narrowly (e.g., women included) rather than structurally	Secretariat and TRP stakeholders noted that gender is often associated with the inclusion of women or vulnerable groups rather than analysis of norms, power dynamics, service design, and barriers across the care pathway.
Low-quality assessments, and/ or generic, nonoperational recommendations	Some assessments were described by the TRP as too general and insufficiently specific to inform implementation planning. Without operational clarity, findings could not be translated into design decisions. Document review of the gender assessments suggested variable quality.
Limited political ownership; perception of gender as donor requirement	Several stakeholders indicated that gender approaches are sometimes viewed as requirements imposed by the Global Fund rather than intrinsic programmatic priorities.
Contextual and legal constraints	In some settings, gender and human rights concerns raised during country dialogues could not be fully addressed due to cultural or legal barriers.
Lack of structured accountability for implementation	Stakeholders noted limited mechanisms to verify whether gender-related activities included in Funding Requests were implemented as designed.

Table 11. Barriers to Translation of Gender Assessments into Programmatic Activities

In addition, the evaluation found that identified gender-related barriers were often described broadly in the Funding Requests reviewed, with limited detail on how they manifest along the disease acquisition and care pathway. The evaluation mapped barriers and corresponding interventions using both Funding Request documentation and evidence from in-country interviews and site observations against the care pathways. This analysis shows that gender barriers related to access to prevention, testing, and diagnosis are most commonly identified in grant documentation, while barriers affecting treatment continuation, adherence, household decision-making, and economic vulnerability are less consistently identified. Annex 7 provides further details of this analysis.

Gender-Based Interventions in GC7 Grant Design

Across the country-components assessed, gender-targeted and gender-responsive approaches to address barriers in accessing services were included in most country-components while gender-transformative approaches and GBV-related activities are less common, and there is variability in the extent to which gender barriers were addressed across country-components. Routine expectations for minimum gender-responsive design across all grants as outlined in technical guidance for countries (see footnote 41) have not yet been achieved. As shown in Table 12, 68% of 38 country-components evaluated included gender-targeted elements, 71% included gender-responsive elements and address gender inequalities, 40% included gender-transformative elements, and 40% included GBV prevention or response activities. The relatively high prevalence of gender-targeted approaches reflects sustained attention to populations with distinct biological or epidemiological vulnerabilities; likewise, the relatively high prevalence of gender-responsive elements suggests strong attention toward addressing gender barriers.

Patterns of inclusion of these gender approaches vary by disease component. For example, gender-transformative elements were included in the majority of HIV country-components reviewed, while they were present in about one-third of malaria country-components and were rare in TB country-components. These differences should be interpreted in light of disease-specific contexts, health-sector entry points, and grant scope, rather than as comparative performance across disease areas. In addition, in most settings, gender-transformative or GBV-focused work may be led by other donors, ministries, or multisectoral platforms outside the Global Fund portfolio. The evaluation did not assess the full landscape of external financing or programming, and findings are therefore limited to what is articulated and financed within Global Fund Funding Requests and grants themselves. Findings on the prevalence of targeted versus transformative approaches should therefore be interpreted as country-component-level patterns rather than as an assessment of the full country-level gender response.

Component Type	Includes Any Gender-Targeted Approaches	Includes Gender-Responsive Approaches	Includes Gender-Transformative Approaches	Includes GBV Prevention or Response Activities
Across 38 HIV, TB, Malaria, RSSH Country-components	68.4%	71.1%	39.5%	39.5%

Table 12. Percent of Country-components for which the Funding Request Included Gender Interventions to Address Barriers to Access

Review of the specific gender-related modules and interventions in the Funding Requests, using the list in Annex 1, further illustrates how these patterns manifest in practice. All 12 of the HIV country-components reviewed included gender-targeted interventions, and approximately 67% included at least one gender-responsive/transformative intervention. In two countries, the intervention on reducing HIV-related gender discrimination, gender norms, and violence against women and girls was not included in the Reducing Human Rights–Related Barriers to HIV/TB Services module; however, gender-transformative approaches were described within other modules. Embedding gender-related activities within other modules may reflect efforts to mainstream gender across core programming, but it can also make gender interventions harder to identify, and track through design, budgeting, and implementation. In the 12 malaria country-components reviewed, approximately 67% included gender-targeted modules, and one-third included gender-responsive and -transformative elements. None of the 11 sampled TB country-components included gender-related modules in the Funding Requests. However, four Funding Requests for TB country-components included gender-responsive elements in other TB modules. In RSSH, there are no specific modules or interventions that are tagged as gender-related (See Annex 1). However, review of the Funding Requests indicated that 1 of the 3 actually had gender-responsive elements in the RSSH modules, including community-led monitoring, CHW training with gender elements, and CSO empowerment activities focused on gender integration. GBV-related activities (including response efforts, sensitization, and training) were included in many HIV country-components, and as well in several malaria country-components,[45] but were not included in the TB or in RSSH country-components

assessed. This may reflect the fact that links between GBV and TB outcomes are less well established, although RSSH investments could plausibly provide entry points for GBV integration through health system–strengthening interventions.[46] It is also important to note that the absence of gender approaches in the Funding Requests does not necessarily mean that these approaches were not implemented. In Finding 6 (later in the report), evidence suggests that in some contexts, gender-related activities described in Funding Requests were only partially implemented, while in others, gender-responsive or transformative approaches are being implemented despite limited visibility in the Funding Request.

Findings for Disease Areas and Types of Portfolios

Table 13 shows the gender integration scores separately for each disease area, and for country-components in High Impact, Core, and Focused countries.[47]

Component/ Portfolio Type	Gender Analysis (max score=3)	Inclusive Engagement (max score=3)	Identification and Mitigation of Gender Barriers (max score=3)	Intervention Design (max score=3)	Overall Score for Integration in Design (max score=3)
HIV (12 country-components)	2.75	2.67	2.83	2.67	2.73
TB (11 country-components)	1.09	2.63	1.55	1.00	1.57
Malaria (12 country-components)	1.33	2.4	1.75	1.5	1.75
RSSH (3 country-components)	1.33	3.00	1.00	1.00	1.58
High Impact (19 country-components)	1.84	2.53	2.11	1.74	2.04
Core (13 country-components)	1.77	2.88	2.00	1.85	2.01
Focused (6 country-components)	1.17	2.33	1.50	1.17	1.40

Table 13. Average Gender Integration Scores for Design by Country-component for Disease and Portfolio Type

[45] For example, GBV training for Traditional Birth Attendants (TBAs) and religious leaders and Husband's Clubs are included in one malaria Funding Request from a Core country in Western and Central Africa, and GBV training for health workers was also included in two other countries (one in South East Asia and the other in the High Impact Africa region 2).

[46] GBV is more explicitly linked to disease risk, care engagement, and outcomes in HIV programming than in TB, where the evidence base and policy framing have more commonly emphasized gendered patterns of exposure, diagnosis, and treatment adherence rather than GBV as a direct driver. RSSH investments can plausibly provide entry points for GBV integration through a variety of interventions (e.g., workforce capacity, referral pathways, and service integration).

[47] Global Fund classifies countries as "High Impact," "Core," or "Focused" to tailor levels of investment, support, and portfolio management. High Impact countries receive the largest allocations and intensive strategic support due to high disease burden and programmatic opportunities; Core countries receive substantial investments with more moderate managerial engagement; and Focused countries receive smaller, more targeted allocations aimed at sustaining essential services and maintaining gains.

HIV

Across the portfolio review, HIV grants demonstrated strong gender integration across all four GIS design domains (see Table 13). When comparing portfolio types, country-components in High Impact and Core countries showed stronger integration than country-components in Focused countries. This may partly reflect differences in grant size and scope, as Focused portfolios support a narrower set of prioritized activities within more limited funding envelopes. Several stakeholders noted that country-components with narrower scope or more constrained funding envelopes face greater prioritization pressures, which may limit the extent to which gender interventions are included.

Stakeholders consistently characterized GC7 HIV grants as having a mature approach to gender integration in design, noting relatively routine use of gender analyses, structured engagement with women's organizations and KP networks, and clear articulation of gender-specific barriers and responses. Several stakeholders emphasized that HIV programs have benefited from longer-standing norms around community engagement and gender-targeted and -responsive programming, which have translated into more coherent design choices in GC7. At the same time, gender-transformative program elements, particularly those addressing norms change, are limited and were described as being increasingly scrutinized in relation to cost, feasibility, and the ability to demonstrate measurable results within limited funding envelopes. Interviews with Secretariat stakeholders indicated that norms-change interventions are often perceived as resource-intensive, slower to yield measurable results, and more difficult to link directly to short-term disease outcomes compared to core prevention, diagnosis, and treatment services. Several interviewees noted that, given the Global Fund's emphasis on equity at scale and value-for-money, there is pressure to prioritize interventions that can reach large populations quickly, which can disadvantage gender-transformative approaches that require sustained engagement, community-level work, or longer implementation horizons.

HIV grants reportedly draw consistently on sex- and age-disaggregated epidemiological data, KP studies, and recent gender and human rights analyses, which are more routinely available and institutionally embedded in HIV responses than in other disease areas. In two of the country studies, Funding Requests explicitly linked recent gender analyses and KP studies to differentiated service delivery models, GBV referral pathways, and empowerment programming for adolescent girls and young women. In these contexts, inclusive engagement during country dialogue processes, particularly with women-led organizations, networks of PLHIV, and KP groups, was frequently cited by stakeholders as central to translating analysis into design.

Malaria

Gender integration in the design of malaria grants is modest and variable, with important differences across portfolio types. Overall malaria design scores averaged 1.75 (moderate gender integration in design), with country-components in High Impact and Core countries performing similarly, while those in Focused countries showed more limited integration. Malaria country-components typically prioritize pregnant women and young children through ANC and commodity distribution platforms, an approach grounded in epidemiological risk but not always accompanied by analysis of gender norms, household decision-making, or mobility constraints that affect access to prevention and treatment. In Tanzania (United Republic), for example, the Funding Request focused on ITN distribution through ANC services without explicitly addressing women's decision-making power or men's influence over net use. Implementation data collected as part of the Tanzania country study, however, showed that gender-responsive and -transformative elements, such as Social and Behavior Change Communication (SBCC) activities targeting household decision-making, were introduced during early grant implementation. This suggests that some gender-responsive and -transformative elements were incorporated during implementation, even where they were not detailed in the original Funding Requests and grant design or directly prompted by TRP or Secretariat feedback.

Some malaria country-components in High Impact and Core countries demonstrated more deliberate attempts to identify and address gender barriers, often supported by short-term TA or SIs. In Cape Verde and along the Thai–Myanmar border, for instance, community assessments supported by SIs informed more contextually grounded malaria interventions, including outreach strategies tailored to mobile populations and women's caregiving roles.

TB

TB grants show limited integration of gender equality in design across all portfolio types, with overall scores clustering between 1.13 and 1.55 and minimal differentiation between High Impact, Core, and Focused country-components. TB programming remains strongly

oriented toward universal access, with limited attention to gendered patterns of risk and care-seeking, such as men's delayed diagnosis or women's unpaid caregiving burdens. In Pakistan, one notable exception involved mobile chest screening services explicitly targeting women and stigmatized populations, reflecting a gender-responsive adaptation in a program that was otherwise gender-neutral in objectives, budgeting, and performance frameworks. Secretariat stakeholders also provided a few examples of targeted efforts in some settings to reach men with TB screening, diagnosis, and treatment support. However, such examples were not typically described in Funding Request documents reviewed or systematically embedded across TB portfolios. TB stakeholders described increased awareness of gender issues in GC7 TB grants and noted that gender and stigma assessments are increasingly commissioned. They highlighted that TB modules in Funding Requests often continue to frame access challenges in universal terms rather than designing differentiated strategies that respond to gendered patterns of risk, care-seeking, and unpaid caregiving. Several Secretariat stakeholders highlighted that intense competition for limited fiscal space in country allocations, combined with a strong focus on diagnostics and treatment scale-up, restricts the inclusion of gender-responsive or transformative interventions at the design stage. As a result, TB modules within Funding Requests frequently remain gender-neutral in structure, even when assessments acknowledge gendered barriers.

RSSH

RSSH grants, including modules related to human resources for health, present significant potential for gender integration but gender-related barriers and opportunities are not systematically analyzed or explicitly incorporated into RSSH design. In some countries, stakeholders described efforts to integrate gender considerations into HRH planning, such as through gender balance in recruitment, or incorporating community-led monitoring mechanisms that can surface gender-related access barriers. However, these efforts were inconsistently reflected in Funding Request documentation. Secretariat stakeholders viewed GC7 as presenting unrealized potential for gender integration in design. Interviewees described gender as conceptually central to health workforce planning, community health worker models, and service delivery sustainability, but noted that Funding Requests with RSSH modules rarely include systematic gender analysis or explicit gender-responsive design features. Where gender considerations were present, they were often indirect or embedded within broader discussions of equity, without clear articulation of how gender-related barriers to accessing services would be addressed through RSSH investments.

Influence of Contextual Factors on Design

National political, legal, and planning environments strongly shape the degree and nature of gender integration in Funding Requests and grant design. Countries with gender-responsive national strategies, robust sex-disaggregated data systems, and prior gender assessments tended to demonstrate stronger integration across all portfolio types. Conversely, in contexts where sexual and gender minorities are criminalized or heavily stigmatized, Funding Requests often avoided explicit reference to these populations even when they are central to disease transmission dynamics. These constraints shape both what can be included in grant design and the extent to which Global Fund TA can influence national priorities. Several stakeholders noted that while gender-related TA sometimes succeeds in introducing formal commitments, such as the inclusion of gender focal points in national plans, these commitments are not always operationalized in practice.

The GEM and Gender Integration in Design

The introduction of the GEM[48] in GC7 has strengthened the systematic consideration of gender at the Funding Request stage and signaled that gender integration is a core expectation of Global Fund–supported programs. The GEM is applied during Funding Request review to systematically assess whether gender considerations are reflected in Funding Request content for a specific component. It provides a structured framework for examining whether a recent gender analysis has been conducted (within the last 5 years), whether gender-responsive activities are included, and whether monitoring frameworks incorporate sex- and/or gender-

[48] The GEM is applied at the Funding Request design and review stage to assess the extent to which gender equality is integrated into Funding Requests. The GEM is adapted from the OECD-DAC gender equality policy marker and uses a three-point scoring system: 0 (not targeted), 1 (significant focus), and 2 (principal focus). To receive a score of 1 for a requested component, Funding Requests must demonstrate that a recent gender assessment (within the last 5 years or as part of the most recent NSP process) has been conducted, that its findings informed the requested modules for that component, that at least one intervention for the respective component explicitly advances gender equality, and that sex- and/or gender-disaggregated data are used and committed to in performance monitoring for that component. To receive a score of 2, a country-component must meet all score 1 criteria and additionally demonstrate multiple gender-transformative interventions, clear ambition to advance gender equality as a central objective, and systematic use of sex- and/or gender-disaggregated indicators across the majority of interventions for that component.

disaggregated indicators. In this way, it standardizes expectations for gender integration across portfolios.

However, it is not a country-led assessment tool, nor does it function as a funding conditionality mechanism. Multiple TRP members clarified that the GEM score itself is not referenced in formal TRP funding recommendations and does not serve as a decision threshold. While it informs internal review discussions, it does not trigger rejection, revision, or conditional approval. Several stakeholders characterized the GEM as primarily an internal tool used by the Secretariat to structure assessment and generate portfolio-level tracking, rather than as a negotiation instrument with countries.

Despite this, stakeholders agreed that the GEM has increased institutional visibility of gender. One stakeholder described the GEM as "game changing" in ensuring that gender is explicitly considered during Funding Request review, particularly by drawing attention to the presence (or absence) of gender analyses and gender-related content in Funding Requests. Prior to its introduction, there was no systematic way to track whether Funding Requests included gender analysis or gender-responsive elements. The GEM has enabled portfolio-wide tracking and comparison across funding cycles, providing a baseline against which progress can be assessed. Secretariat stakeholders described the tool as supporting internal advocacy by normalizing gender as a routine dimension of review. Its impact has been largely institutional rather than programmatic: it has embedded gender into internal systems and review processes.

At the same time, stakeholders characterized the GEM as a blunt tool, with limited ability to capture some of the nuance and quality of gender integration in program design. Specific limitations raised included its threshold-based structure, limited sensitivity to disease-specific and contextual variation, and insufficient attention to funding allocations for gender-related interventions. In addition, several TRP members discussed that some refinement to the GEM occurred during the GC7 review process to address an initial overreliance on whether a gender assessment had been conducted, rather than whether gender data meaningfully informed programming. TRP members noted that while low GEM scores could signal weaknesses in gender integration, the score itself does not trigger formal remedial actions. There are no automatic consequences, conditionalities, or required revisions for a low GEM score, which TRP members felt limited its utility and power.

Secretariat stakeholders, in contrast, described instances where low GEM scores informed follow-up support. One stakeholder described a process in which letters were sent to all CCMs summarizing findings from the GEM assessment. These letters were intended to provide structured feedback but the process was described as labor-intensive. In some instances, low GEM scores also prompted more substantive follow-up, including targeted TA and the development of gender action plans with selected countries. However, these cases appeared to be dependent on interest from country stakeholders, available technical support, and the timing of broader grant cycle processes. In addition, despite the provision of these letters, data from the in-depth country studies showed limited awareness of the GEM at country level, including among CCM members and PRs. This suggests that the GEM feedback was likely not communicated in an optimal way. This represents a missed opportunity for countries to use GEM feedback to strengthen subsequent submissions.

Finally, despite some critiques of the GEM methodology, CRG stakeholders cautioned against significant methodological changes in the immediate term. Maintaining comparability between GC7 and GC8 scores was described as essential to preserving the tool's value as a longitudinal tracking instrument. Substantial revisions to scoring criteria or structure would limit the ability to assess progress over time. While stakeholders identified potential refinements, including greater nuance, expanded criteria, and improved sensitivity to context, there was general recognition that methodological continuity is necessary to protect baseline integrity.

Taken together, these perspectives suggest that while the GEM has been instrumental in elevating gender within review processes, its utility is constrained by uneven follow-up mechanisms, limited country-level visibility, and the absence of a systematic pathway linking scores to corrective or supportive actions.

Annex 6 presents additional country insights related to gender integration in GC7 design.

Evaluation Question 2

How are commitments and prioritization of gender equality reflected in grant budgets and performance frameworks?

Overarching Finding 2: **Gender commitments articulated in GC7 Funding Requests and grant design are not consistently reflected in budgets or performance frameworks across disease areas. Where gender-related activities are embedded within broader service delivery or health system modules, the absence of standardized budget tagging limits visibility and systematic tracking of gender investments.**

While gender equality considerations are visible in the majority of GC7 Funding Request narratives reviewed, their translation into resourced grant-stage activities and measurable performance indicators is inconsistent across the portfolio. Across disease areas, budgeted investments[49] prioritize gender-targeted service delivery for women, girls, and gender-diverse populations, with minimal allocation to interventions addressing structural gender barriers or transformative change. The evidence supporting this finding is **strong**, drawing on consistent patterns across the portfolio review, analysis of budgets and performance frameworks, in-depth country studies, and stakeholder interviews at both Secretariat and country levels.

Budgets

The portfolio review and country studies showed that formal budget labeling does not fully capture the extent to which programs are addressing gender barriers to service in practice. In several contexts, gender-responsive or transformative activities were embedded within broader service delivery or health system interventions. Because explicit gender tagging is not required in budgets, there is limited visibility and systematic tracking of gender investments; the reasons explicit gender tagging is not currently used are discussed further below.

In HIV country-components, grant budget analysis shows a notable share of resources directed to gender-related activities (on average 13.3% of the total budget for HIV country-components; mean GIS score 2.58 out of 3) (see Table 14). This reflects established practices within HIV that support gender-responsive work including engagement with women-led and gender-focused organizations, use of sex- and age-disaggregated data, and the presence of programmatic modules that accommodate gender-responsive work. Stakeholders noted that these institutional features make it easier to convert gender analyses into funded activities linked to differentiated service delivery, empowerment programming for AGYW, and GBV response. However, the majority of HIV resources were dedicated to gender-targeted approaches, with only a small proportion of the gender-related budget being directed to barrier-removal or structural interventions.

In malaria, gender-related activities represented an average of 3.8% of the total budget for malaria country-components (GIS budget score 1.33). Secretariat stakeholders, technical partners, and country stakeholders emphasized that during grant-making, commodity-driven budgeting in malaria grants created limited fiscal flexibility for social and structural programming, even when gender barriers are acknowledged in Funding Requests. Financing for malaria modules related to gender in grants primarily supported gender-targeted approaches such as ANC-based service delivery and ITN distribution for pregnant women, while responsive interventions, such as SBCC addressing household decision-making, were less prominent.

In TB, no dedicated budget amounts for gender activities were identified in the grants for the 11 country-components reviewed (GIS budget score 1). Secretariat stakeholders, TRP members, and TB-focused technical partners highlighted that during grant design, competition for diagnostics, treatment commodities, and health system costs leaves limited perceived space for gender-responsive investments, reinforcing a longstanding pattern of gender neutrality in TB budgeting despite recognition of gender-related access barriers.

[49] Amounts in grant budgets for modules and interventions related to (1) gender-targeted activities (e.g., intermittent preventive treatment [IPT] - in pregnancy or condom and lubricant programming for AGYW in high HIV incidence settings), and (2) gender-responsive and -transformative activities (e.g., removing human rights and gender-related barriers to vector control programs). See Annex 1 for the full list of modules and interventions in each category.

Component	Total % of Country-component Budget for Gender Activities†	% of Country-component Budget for Gender-Targeted Activities	% of Country-component Budget for Gender-Responsive and -Transformative Activities	Gender Integration Score (Budget) (max score=3)
HIV	13.33	13.15	0.21	2.58
TB	0	0	0	1
Malaria	3.81	3.43	0.38	1.33
RSSH	0	0	0	1

Table 14. Average Percentage of Country-component Budget Dedicated to Gender Activities

†Calculated by totaling budgeted amounts for modules and interventions related to: (1) Gender-targeted activities (e.g., IPT in pregnancy or condom and lubricant programming for AGYW in high HIV incidence settings), and (2) gender-responsive and -transformative activities (e.g., removing human rights and gender-related barriers to vector control programs) within each country-component. This amount was then divided by the total budgeted amount for the relevant disease component in that country to determine the percentage of the budget allocated to gender-related programming. The percentages were then averaged across all country-components for each disease. See Annex 1 for the full list of modules and interventions in each category.

Similarly, the three RSSH country-components reviewed did not include explicit budget amounts for gender-related activities (GIS budget score 1). Secretariat stakeholders noted that while RSSH is well-positioned to support community systems, participation, stigma reduction, and rights-related interventions, these activities were often embedded within broader modules without explicit gender tagging.

The absence of standardized gender tagging in grant budget or dedicated budget lines limits visibility and tracking of gender investments, weakens accountability for resourcing identified priorities, and constrains learning on what levels and types of investment support stronger implementation. At the same time, the Global Fund has historically chosen not to introduce thematic budget tagging, including for gender, following internal analysis and governance-level deliberations that weighed the potential reporting benefits against risks related to data quality, additional burden on country teams and PRs, and management costs. As part of this evaluation, some Secretariat stakeholders emphasized concerns that activity tagging could be applied inconsistently, and that poor-quality tagging could undermine rather than strengthen accountability. In addition, they noted that in some contexts, especially where gender issues are politically or socially sensitive, explicit tagging of gender-related activities may not be feasible or desirable. Other Secretariat stakeholders felt that standardized budget tagging for gender is feasible and the benefits would outweigh the costs.

Performance Frameworks

Performance frameworks at the grant stage mirror these grant budget patterns. HIV country-components achieved a high average GIS score for performance frameworks of 2.33 out of 3, reflecting routine inclusion of sex- and age-disaggregated indicators and, in some cases, indicators linked to GBV response, stigma reduction, or community engagement. TB country-components had an average GIS score of 2.0, but the inclusion of gender-relevant indicators was uneven, with some country-components demonstrating strong integration and including indicators for stigma and discrimination and others relying almost exclusively on basic sex-disaggregation. Malaria and RSSH country-components had an average score of 1.4 and 1.0, respectively, indicating limited incorporation of gender-relevant indicators beyond sex disaggregation. Table 15 provides the percentage of country-components that included sex-disaggregated data in any of their grant performance frameworks, as well as the percentage that included gender equality outcomes (indicators focused on gender-specific key populations and/or indicators related to GBV, gender equality, power, and decision-making). HIV country-components were more likely to include these gender equality indicators in grants, usually focused on key populations. Across all disease areas, indicators rarely captured changes in gender norms, power relations, safety, or decision-making dynamics, and there are no standard indicators for these in the Global Fund Modular Framework. For example, Lesotho grant performance frameworks for HIV modules included an indicator on condom use by male partners of AGYW, several country-components had indicators related to discrimination, and at least one had a GBV indicator. Secretariat stakeholders noted that sometimes when gender-related activities were included in a grant, monitoring relied on process indicators embedded in workplan tracking measures rather than outcome-oriented indicators capable of assessing gender equality progress. Several stakeholders highlighted that while workplan tracking measures sometimes include relevant process indicators for gender activities, these are rarely

elevated within formal performance assessment or portfolio discussions.

At the Secretariat level, two Strategy KPIs measure progress to advance gender integration efforts in HIV, TB, and malaria programs. This includes E3a[50] and E3b,[51] which monitor satisfaction of women and gender-diverse communities with their engagement in the grant cycle and performance on selected gender-tagged indicators drawn from grant performance frameworks. Secretariat interviews confirm that these indicators are incorporated into grant performance assessments and Principal Recipient reviews, meaning that underperformance on gender-tagged indicators requires explanation within routine oversight processes. However, because KPI measurement relies on existing grant indicators, and standard performance indicators for GBV, norm change, or empowerment were largely absent from the GC7 Modular Framework,[52] strategy KPIs tend to reflect service coverage and sex-disaggregation rather than other gender equality outcomes.

Component	% of Country-components for which at least 1 Grant Performance Framework includes Gender-Sensitive Indicators†	% of Country-components for which at least 1 Grant Performance Framework Tracks Gender Equality Outcomes††
All (38 country-components)	86.8%	21.1%
HIV (12 country-components)	100%	66.7%
TB (11 country-components)	100%	0%
Malaria (12 country-components)	83.3%	0%
RSSH (3 country-components)	0%	0%

Table 15. Inclusion of Gender Indicators in Grant Performance Frameworks

†Specifically defined as indicators that are sex-disaggregated

††Includes indicators focused on gender-specific key populations and/or indicators related to GBV, gender equality, power, and decision-making

Prioritization and Adjustments

A recurring challenge across country-components is the translation of identified national gender priorities into activities and indicators in signed grants. These challenges emerged at multiple points in the grant life cycle, including during GC7 grant design, grant-making, and the 2025 GC7 reprioritization exercise. For example, even when gender assessments or consultations identified specific barriers, these priorities were sometimes moved from the allocation request to the Prioritized Above Allocation Request (PAAR)[53] or reduced during grant design or grant-making to accommodate fiscal constraints. A review of PAAR[54] indicates that 18 of the 38 country-components reviewed (47.4%) included at least one gender-related intervention in the PAAR. Gender-related PAAR activities were most common for HIV country-components (10 of 12 country components), followed by TB (5 of 11) and malaria (3 of 12), while none of the RSSH country-components reviewed included explicit gender-related interventions in the PAAR. The interventions most frequently included in the PAAR were KP prevention packages, AGYW-focused activities, and GBV-related initiatives such as legal literacy, paralegal support, and discrimination reduction measures. These were predominantly gender-targeted or gender-responsive components, with fewer explicitly gender-transformative interventions. Country data also support this finding. In one country, stakeholders described how several planned gender-responsive behavior change interventions including communication campaigns were shifted to the PAAR during grant design and grant-making to preserve core malaria commodities. Similar dynamics related to other country-components were

[50] KPI E3a measures the quality of engagement of women and gender-diverse communities across the grant cycle, based on stakeholder surveys.

[51] E3b tracks performance on selected gender-specific or gender-tagged grant indicators across the portfolio.

[52] It is noted that a performance indicator related to GBV has been added to the GC8 Modular Framework https://resources.theglobalfund.org/media/mbmbjftc/cr_gc8-modular-framework_handbook_en.pdf

[53] PAAR refers to components or interventions included in a Funding Request that exceed a country's allocated funding amount. PAAR items are prioritized by the country for potential funding if additional resources become available, but they are not guaranteed to be financed within the approved grant envelope. Once approved as an unfunded quality demand by the TRP, these activities can then be funded during grant-making or implementation without further review by the TRP.

[54] There were some inconsistencies between allocation and PAAR documentation. In several cases, interventions appeared simultaneously in both the main allocation and the PAAR or were inconsistently labeled (e.g., marked "Yes" in one document and "Partial" in another), creating ambiguity in prioritization and costing.

reported during interviews with Secretariat, TRP, and in-country stakeholders, who also emphasized that gender-responsive and structural interventions were more vulnerable to reduction than core biomedical commodities and treatment costs, even when gendered access barriers were acknowledged.

Across four of the five countries where country studies took place, gender-related activities were reported to have been modified, reduced, or partially deferred during GC7 grant-making or during the 2025 reprioritization process, most often to preserve essential commodities or core biomedical interventions. These findings are primarily based on interviews with in-country and Secretariat stakeholders conducted while reprioritization decisions were still underway; in most cases, changes had not yet been fully validated through finalized budgets at the time of data collection. While biomedical interventions can be delivered in gender-responsive ways, in-country stakeholders noted that the adjustments specifically affected activities such as norms-change and SBCC activities, community empowerment and outreach efforts, stigma reduction, and rights-related interventions, often by reducing their scale, frequency, or geographic coverage.

For example, in several contexts, stakeholders described specific examples of gender-related activities being adjusted during grant-making or reprioritization. These included reduced paralegal coverage for GBV-related support, male engagement and women's empowerment activities being scaled back or shifted out of the allocation amount, and norm change or community engagement work continuing at lower intensity or in fewer geographic areas. In two countries, issues related to dedicated gender focal point roles were also noted during this period: in one, a gender advisor position funded by another partner was discontinued due to external donor funding changes, and in another, a planned gender focal point role was not filled, delaying a planned consultation on gender-related priorities.

Overall, stakeholders noted that the changes introduced during grant-making or reprioritization were not uniform, and in some cases, gender-related activities were entirely retained. Several country and Secretariat stakeholders noted deliberate efforts to preserve at least a minimal set of gender-responsive activities during financial adjustments. Nonetheless, while GC7 reprioritization guidance emphasized protecting equitable access to essential services and did not direct countries to reduce gender-related investments, country stakeholders in some countries noted that the effect of the reprioritization decisions was to reduce the scale, intensity, or transformative potential of gender-related interventions. The evaluation did not assess whether reductions to gender-related activities were disproportionate compared to cuts in other program areas, and findings should therefore be interpreted as reflecting reported patterns of adjustment rather than comparative magnitude of cuts. In addition, the analysis was conducted prior to final reprioritization decisions.

Annex 6 presents additional country insights regarding budgets.

Evaluation Question 3

To what extent were women's and feminist organizations and gender-diverse groups effectively engaged in country dialogue? What facilitated or hindered this engagement?

Overarching Finding 3: Formal participation of women's, feminist, and gender-diverse groups[55] is widely documented in GC7 country dialogue documentation, and stakeholders describe increased participation compared to previous cycles. However, formal inclusion did not always translate into substantive influence over grant priorities or grant design. The extent to which community-identified gender priorities were reflected in final Funding Requests varied across disease areas and national contexts, and was shaped by legal constraints, political sensitivities, and the prioritization of core disease control interventions within country decision-making processes.

Across the portfolio, inclusive engagement during GC7 country dialogue processes was documented with most country-components demonstrating high scores on formal measures of participation (such as data from country-specific stakeholder surveys completed for reporting on KPI E3a[56]). Based on review of community dialogue documents, women's organizations, feminist groups, and, to a lesser extent, gender-diverse actors were formally represented in national consultations, CCM processes, and technical working groups (TWGs) in the majority of country-components reviewed (see Table 16). While KPI E3a does not permit direct comparison with earlier grant cycles, interviews with Secretariat staff, technical partners, and country stakeholders consistently described greater visibility and formal inclusion of gender-focused civil society actors in GC7 relative to previous cycles. This reflects stronger Global Fund requirements for multistakeholder dialogue, expanded CRG-related investments, and greater normalization of civil society participation in Funding Request development. However, the extent to which formal participation translated into meaningful influence over grant priorities and grant design varied substantially across disease areas and contexts. Based on the review of the country dialogue data for 38 country-components, engagement was most substantive for HIV components, where established AGYW platforms and KP networks are embedded in national responses, and weakest in TB and malaria components, where gender remains less integrated into technical framing and decision-making processes. The evidence supporting this finding is **strong**, drawing on consistent patterns across the portfolio review, country studies, and interviews with Secretariat staff, technical partners, and community stakeholders.

Component	Women's Organizations	Feminist Organizations	Gender-Diverse Organizations
All (38 country components)	73.7%	81.6%	76.3%
HIV (12 country components)	83.3%	83.3%	83.3%
TB (11 country components)	72.7%	100%	72.7%
Malaria (12 country components)	75.0%	66.7%	83.3%
RSSH (3 country components)	0%	33.3%	0%

Table 16. Percent of Country-components with Documented Participation of Women's, Feminist, and Gender-Diverse Organizations during the Country Dialogue Process for that Component

While formal inclusion in country dialogue has improved, meaningful influence on final Funding Request content remains inconsistent. In multiple settings included in the country studies, community and feminist actors actively participated in consultations but reported limited ability to shape priorities, intervention choices, or resource allocation. This gap was particularly pronounced in TB, malaria, and RSSH country-components reviewed, where gender-related inputs were often acknowledged at the level of discussion but did not result in substantive

[55]Gender-diverse groups include those representing transgender and nonbinary people.

[56]KPI E3a measures the meaningful engagement of women and gender-diverse communities across the grant life cycle. This reinforces Global Fund's commitment to promoting the role of women and LGBTQI+-led organizations in the design and implementation of programs. Data comes from a survey based around a set of minimum expectations for community engagement administered to each country to assess level of satisfaction at each stage of the grant life cycle. https://www.theglobalfund.org/media/3skcbxsw/strategy_globalfund2023-2028-kpi_handbook_en.pdf

changes to Funding Requests. Stakeholders consistently emphasized that participation alone does not guarantee influence, especially where gender considerations are not perceived as central to disease control strategies. A review of country dialogue documentation further illustrates variation in the depth of gender prioritization across disease areas (see Table 17). Across all 38 country-components, gender issues were discussed in 73.7% of dialogues. However, only 52.6% included clearly defined gender-based interventions in CSO-stated priorities related to that component. Gender-targeted interventions were most commonly articulated (68.4%), followed by gender-responsive approaches (55.3%), while explicitly gender-transformative interventions were identified in only 23.7% of dialogues for a given country-component. This variation is particularly pronounced across disease areas, reinforcing qualitative findings that the depth of prioritization and ambition related to gender varies substantially by disease area.

Component	Gender Issues Discussed	Clear Gender-based Interventions Included in Priorities Related to the Component	Gender-Targeted Interventions Included in Priorities Related to the Component	Gender-Responsive Interventions Included in Priorities Related to the Component	Gender-Transformative Interventions Included in Priorities Related to the Component
All (38 country-components)	**73.7%**	**52.6%**	**68.4%**	**55.3%**	**23.7%**
HIV (12 country-components)	100%	91.7%	83.3%	91.7%	58.3%
TB (11 country-components)	72.7%	54.5%	72.7%	45.5%	9.1%
Malaria (12 country-components)	50%	41.7%	83.3%	33.3%	8.3%
RSSH (3 country-components)	66.7%	33.3%	66.7%	33.3%	0

Table 17. Percent of Country-Components Where Gender Issues were Discussed and Gender Interventions were Included in CSO Priorities Related to the Respective Component during the Country Dialogue Process

Power asymmetries, technical barriers, and meeting cultures emerged as significant constraints on effective engagement across contexts. Even when formally included, many women's and feminist organizations lacked the technical preparation, financial resources, or institutional standing required to engage confidently in highly technical discussions dominated by epidemiological data, budgeting frameworks, and performance metrics. Hierarchical meeting formats, limited speaking time, and fast-paced drafting processes further limited participation, particularly for smaller or grassroots organizations. Gender-diverse groups faced additional barriers, including limited visibility within TB and malaria programming and inconsistent representation within CCM and country dialogue processes. Evidence from the in-depth country studies suggests that these groups were not actively excluded, but that their participation was often limited by a lack of proactive outreach and deliberate engagement efforts. Participation frequently depended on existing civil society networks, organizational visibility, and prior involvement rather than structured mechanisms to ensure representation. For example, in two of the country studies, CCM representatives described country dialogue processes as formally open, while civil society stakeholders in the same countries noted that inclusion of gender-diverse organizations primarily relied on broad invitations and umbrella CSO structures rather than targeted outreach. These issues often resulted in participation that was consultative rather than deliberative, reinforcing existing power imbalances within national decision-making structures.

Structural and contextual factors further limited the translation of gender priorities into Funding Requests. Across countries, community consultations and dialogue processes frequently identified clear gender-related barriers, including GBV, stigma, mobility constraints, and unequal household decision-making. However,

these priorities were not consistently reflected in final grant designs due to restrictive legal and political environments, prioritizing commodities and core clinical packages during prioritization negotiations, weak or absent feedback mechanisms to communities that limited accountability for how consultation inputs were taken forward, and sometimes the shifting of gender-responsive activities into unfunded PAARs. These constraints were particularly salient in settings where advocacy by women's rights or LGBTQI+ organizations is politically sensitive or legally restricted, narrowing the scope of what could be explicitly included in Funding Requests regardless of consultation outcomes.

The enabling conditions and barriers that shaped whether the participation of women's, feminist, and gender-diverse groups moved beyond formal inclusion to meaningful influence on Funding Requests and grant design are summarized in Table 18. These factors should be understood as enabling or limiting conditions rather than determinants, and their presence did not automatically result in meaningful engagement. In addition, Annex 6 presents selected country insights from three countries, highlighting variation in the depth of engagement, the extent to which participation influenced Funding Requests and grant design, and the specific enablers and barriers shaping outcomes in each context.

Enablers of Meaningful Engagement	Barriers to Meaningful Engagement
• Clear Global Fund requirements for inclusive, multistakeholder country dialogue and civil society participation • Presence of strong, established, women-led, feminist, and KP organizations with technical expertise • Strategic Initiative efforts to increase women's and AGYW's participation in decision-making • Dedicated TA to support civil society engagement in grant design and negotiation • Reserved CCM seats for civil society and key populations • Early and sustained engagement across multiple stages of the Funding Request process • Strong coordination platforms linking civil society, technical partners, and implementers • National commitments to gender equality and enabling policy environments	• Patriarchal norms and meeting cultures that limit women's voice and constrain participation, particularly in mixed-gender and highly formal decision-making spaces • Technical, linguistic, and educational barriers, including the use of highly technical language or epidemiological and biomedical framing that does not adequately incorporate how gender and inequities shape health risks, access, and outcomes, which disadvantages feminist, grassroots, and community-based actors, especially in TB and malaria • In some contexts, civic space is constrained and women's rights and LGBTQI+ groups face legal and security risks • Limited financial support for participation (travel, time, preparation), particularly for grassroots groups • Engagement occurring late in the process, after key design decisions are made • Country dialogue processes in which community-identified gender priorities are not consistently reflected in final Funding Requests, and feedback to communities on how inputs were used is limited or absent • Weak or absent feedback loops, leaving community actors uncertain about whether or how their inputs were incorporated into grant design. • Mediated participation through large networks or umbrella organizations, which can narrow representation and exclude informal, rural, or less-established women's and feminist groups • Narrow stakeholder mapping and reliance on a small pool of "usual" NGOs

Table 18. Enablers and Barriers of Meaningful Engagement by Women's, Feminist, and Gender-Diverse Groups in Country Dialogues

Evaluation Question 4

In countries that are part of the following Global Fund Strategic Initiatives, 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 GBV in the HIV, TB, and malaria response? (Breaking Down Barriers)

Overarching Finding 4: Several catalytic investments examined including the CE-SI, BDB, GEF, and Her Voice Fund are drivers of high-quality gender integration across the Global Fund portfolio.

Strategic Initiatives, including the CE-SI, the BDB component of the Human Rights and Gender SI including matching funds, the GEF, and the Her Voice Fund, play a critical role in advancing gender-responsive and gender-transformative approaches across HIV, TB, and malaria programs. Table 19 provides an overview of the specific SIs examined in this evaluation, including their objectives, and country coverage. While these initiatives differ in structure and scope, they share a common function of filling critical gaps, particularly in relation to gender analysis, community engagement, accountability, and rights-based programming. The evaluation finds that these initiatives consistently generate high-quality gender and human rights data, strengthen the capacity and influence of community and feminist actors, and enable forms of accountability, learning, and norm change that are otherwise weakly institutionalized within disease programs. The evidence supporting this finding is **moderate**, drawing on portfolio review findings, a limited number of in-depth country studies where SIs were active, and a smaller set of stakeholder interviews focused specifically on SI design and implementation. While the consistency of themes across these sources is strong, the relatively narrow empirical base limits generalizability across the full Global Fund portfolio.

Catalytic Investment	Description	Countries
Community Engagement Strategic Initiative (CE-SI)	CE-SI aims to strengthen meaningful community engagement across the Global Fund portfolio by supporting community-led assessments, building the capacity of civil society and community actors, and enabling their effective participation in country dialogue, CCMs, and TWGs. CE-SI supports community-led monitoring systems and generates evidence on access barriers, stigma, discrimination, and gender norms that are often missing from routine systems. CE-SI is delivered through multiple components, including long-term technical support in 25 countries, targeted TA available to all countries eligible for Global Fund allocations, and six regional learning hubs that facilitate peer learning and cross-country exchange.	For the long-term support focus, CE-SI operates in 25 countries across multiple regions, with a strong presence in High Impact and Core HIV countries and expanding support in TB and malaria contexts, including Azerbaijan, Bolivia, Cameroon, Central African Republic, Republic of the Congo, **Côte d'Ivoire**, Ghana, Guatemala, **Guinea**, Kenya, Kyrgyzstan, Moldova, Mongolia, Mozambique, Namibia, Nepal, Niger, Nigeria, **Pakistan**, Peru, **Tanzania**, Uganda, Ukraine, Zambia, and Zimbabwe

Breaking Down Barriers (Human Rights and Gender Strategic Initiative) (BDB)	BDB focuses on reducing human rights- and gender-related barriers to HIV, TB, and malaria services. It supports GBV response, legal literacy, paralegal services, stigma reduction, and rights-based service delivery, alongside periodic assessments and scorecards to track progress on structural barriers over time. BDB is implemented through a combination of dedicated catalytic funding and required matching funds from country allocations, reinforcing country ownership and incentivizing the integration and scale-up of rights- and gender-responsive interventions within core HIV, TB, and malaria programs.	BDB operates in 24 countries with significant rights-related barriers, including Bangladesh, Benin, Botswana, Burkina Faso, Cameroon, **Côte d'Ivoire**, Democratic Republic of the Congo, Ghana, Honduras, Indonesia, Jamaica, Kenya, Kyrgyzstan, Mozambique, Nigeria, Nepal, the Philippines, Senegal, Sierra Leone, South Africa, Thailand, Tunisia, Uganda, and Ukraine
Gender Equality Fund (GEF) (within CE-SI)	The GEF, launched in 2023, provides direct funding to women-led, feminist, and community-based organizations to support gender-responsive and gender-transformative interventions, community-led monitoring, and advocacy. GEF complements CE-SI by enabling grassroots organizations to implement and sustain gender-focused activities.	GEF is active in the following 9 countries: Nigeria, **Lesotho**, Eswatini, Zambia, Uganda, Burkina Faso, **Côte d'Ivoire**, Mozambique, and **Tanzania**
Her Voice Fund (within CE-SI)	The Her Voice Fund focuses on strengthening the leadership, participation, and influence of women and adolescent girls, particularly AGYW, in HIV responses and broader health decision-making. It supports capacity building, advocacy, and engagement in national and Global Fund processes.	The fund actively supports groups in 13 countries across sub-Saharan Africa including Botswana, Cameroon, Eswatini, Kenya, **Lesotho**, Malawi, Mozambique, Namibia, South Africa, **Tanzania**, Uganda, Zambia, and Zimbabwe

Table 19. Overview of the Strategic Initiatives Selected for Review in this Evaluation

Across data sources, SIs were described as important mechanisms for translating gender commitments into actionable evidence, meaningful dialogue, and sustained implementation. Collectively, they contribute by strengthening the availability and use of gender-responsive evidence, supporting gender expertise and community voice within planning and oversight processes, and filling critical gaps that are not consistently addressed through grant activities. These contributions are particularly relevant in contexts where routine national health information systems do not capture data on gender-, rights-, or norm-related barriers. In some cases, SIs have helped fill critical gaps. For example, a Secretariat stakeholder described how in one country, SI resources helped fund training for Ministry of Health staff on post-rape care when this was cut during the grant reprioritization exercise, albeit on a smaller scale. Secretariat stakeholders have noted that in general, the absolute scale of SI and GEF funding remains modest relative to overall country allocations, but this is by design and reflects their intended purpose.

Community Engagement SI

Across the portfolio review, Secretariat interviews, and selected country studies, CE-SI–supported community assessments and community-led monitoring were described as helping surface barriers related to stigma, discrimination, GBV, mobility, permission, gender norms, and exclusion of gender-diverse populations. These forms of evidence were cited as particularly important in contexts where routine health information systems

do not capture how gender and power relations affect service access, experience of care, and uptake across HIV, TB, and malaria programs. Stakeholders described these data as informing Funding Request narratives, TWG discussions, and, in some settings, implementation adjustments, particularly in HIV and increasingly in TB and malaria contexts. CE-SI has also played a role in the development and piloting of practical tools that enable communities to systematically document gender- and rights-related barriers and engage more effectively in Global Fund processes including community assessment frameworks, scorecards, and the Malaria Matchbox Assessment Tool.

CE-SI also strengthens the preparedness and influence of women's organizations, AGYW networks, and gender-diverse groups through pre-dialogue preparation, translation of technical content, and facilitation of engagement in CCM and TWG processes. In Tanzania, CE-SI helped establish a malaria gender task force involving the national malaria program and civil society actors, which met repeatedly to identify and address gender-related barriers in malaria programming.

A further contribution of CE-SI is its support for community-led monitoring (CLM) systems that capture gendered experiences of service delivery and rights violations. Stakeholders described these CLM platforms as generating real-time information on issues such as provider disrespect, unsafe service environments, stigma, discrimination, and barriers faced by women and gender-diverse clients. In several countries, these systems have driven concrete responses, including improvements in facility practices, strengthened referral pathways, and adjustments to outreach strategies.

In addition, CE-SI's regional learning hubs were described as supporting the dissemination and uptake of community engagement approaches by translating Global Fund policies, technical guidance, and assessment findings into accessible formats for civil society and community actors. Secretariat stakeholders emphasized that these hubs primarily function as knowledge translation and coordination platforms, through webinars, briefings, and regional exchanges. Learning hub activities were cited as helping communities better understand eligibility, CRG-related guidance, and gender considerations across disease areas, and offering a means of sharing tools and lessons emerging from country-level assessments and TA. However, evidence on the influence of CE-SI regional learning hubs at country level was more limited. Learning hubs were not spontaneously referenced by stakeholders in the country studies, suggesting that their visibility at country level may be limited.

Breaking Down Barriers (Human Rights and Gender Strategic Initiative)

BDB was reported to provide sustained, long-term support to address human rights- and gender-related barriers that limit access to HIV, TB, and malaria services in 24 countries. BDB is designed as a multicycle investment model that combines catalytic matching funds, long-term technical accompaniment, and repeated assessments to strengthen the scale, quality, and durability of rights-based and gender-responsive programming.[57] This structure was highlighted by stakeholders as enabling more context-specific and adaptive responses to GBV, stigma, discrimination, gender norms, and legal barriers than would be possible through the grants alone.

Secretariat stakeholders emphasized that BDB has raised both the level and quality of investments addressing gender discrimination and human rights barriers. As reported by the Secretariat to the Strategy Committee in March 2025, BDB countries have more than three times the level of Board-approved GC7 human rights investments for HIV/AIDS (5.01% vs 1.57%) and more than two times the level of human rights investment for TB (3.52% vs 1.36%) compared to non-BDB countries.[58] Stakeholders noted that BDB countries consistently submit Funding Requests with more explicit articulation of gender-related barriers, and stronger alignment between assessments and funded interventions than comparable non-BDB settings.

Across the evidence reviewed, BDB was associated with support for GBV response, stigma reduction, legal literacy, and rights-based service delivery, particularly in HIV programs. BDB supports survivor-centered GBV care, strengthened referral systems, paralegal accompaniment, rights literacy, and anti-stigma training

[57] BDB operates through three mutually reinforcing mechanisms. First, countries eligible for BDB receive catalytic matching funds, contingent on meeting access conditions that require investment in human rights and gender-related interventions and inclusion of specific programmatic components in Funding Requests. Second, BDB deploys long-term national and international TA providers, who accompany grants across the full grant cycle, from design through implementation. Third, BDB employs a sequenced evidence model, beginning with baseline assessments of human rights and gender-related barriers (initially conducted in 2017), followed by mid-term and progress assessments (most recently in 2023), and now transitioning to annual, country-led self-assessments that feed directly into programmatic adjustments.

[58] Internal Global Fund Secretariat memoranda.

for health providers, law enforcement, and judicial actors. Its multiple-round assessments and emerging country-led scorecards generate longitudinal evidence on GBV, discrimination, and legal and structural barriers, enabling countries to track change over time rather than relying on one-off analyses. In the country studies, there were examples of where BDB strengthened GBV case management, improved linkages between HIV services and legal and psychosocial support, and supported anti-stigma campaigns and community health worker screening for GBV. Country stakeholders described BDB as providing critical continuity in contexts marked by increasingly restrictive legal environments. BDB-supported programs maintained GBV response services, legal literacy, and stigma reduction activities that enabled continued access to services for key populations. Stakeholders emphasized that progress in these settings has been uneven and nonlinear, but BDB has helped preserve this work in highly volatile environments.

BDB countries have incorporated some human rights indicators and workplan tracking measures into performance frameworks, capturing milestones such as development of legal literacy programs, coverage of key populations, and follow-up actions after training. While outcome-level indicators remain limited, particularly in TB and malaria, stakeholders emphasized that BDB has normalized routine monitoring of rights- and gender-related programming in ways not observed in non-BDB countries. Several secretariat stakeholders also stated that countries that received BDB matching funds were less likely to experience disproportionate cuts to gender and human rights programming during GC7 reprioritization compared to non-BDB countries, owing to matching fund conditions, and greater shared understanding of program value among country teams and implementers. These stakeholders described non-BDB contexts as having fewer tools to argue against cuts to GBV response, stigma reduction, and legal literacy programming.

Gender Equality Fund

The GEF, launched after the start of GC7, was found to play a distinct but complementary role by providing direct resources to community-led and feminist organizations to design, deliver, and advocate for gender-transformative and gender-responsive approaches across HIV, TB, and malaria programming. GEF funding has supported interventions addressing gender norms, women's economic autonomy, leadership development, and community-driven advocacy, frequently targeting gaps identified through CE-SI or BDB assessments. Secretariat stakeholders and GEF implementing partners emphasized that GEF funding enables smaller, grassroots organizations, often not eligible for core grant financing, to implement highly targeted interventions addressing norms, stigma, GBV, and access barriers. Many GEF interventions were still at early stages of implementation at the time of data collection, and in some cases activities had not yet been implemented.

Across disease areas, GEF-supported activities were reported to strengthen gender-responsive programming through community-based platforms that link social and structural interventions to disease outcomes. Examples cited in interviews included GEF-supported activities in Nigeria, where female teachers were trained in TB case identification and contributed to the identification of presumptive and confirmed TB cases, demonstrating the potential of gender-responsive community platforms to contribute to disease outcomes. In malaria contexts, interviewees described GEF-supported work through ALMA as strengthening gender-sensitive scorecard tools, community consultations, and advocacy with decision-makers to surface gender-related barriers that are often absent from routine malaria monitoring systems, and to strengthen the capacity of young women leaders to advocate for gender-transformative malaria policies and programming. Interviews also highlighted work supported through Speak Up Africa in several countries where women-led and youth-led organizations were being supported to engage in malaria policy dialogue, accountability, and advocacy, including around women's representation, caregiving burdens, and access barriers linked to malaria prevention and care.

In addition, GEF-supported activities were also reported to explicitly address GBV and social norms, particularly where malaria intersects with maternal health and reproductive decision-making. Implementing partners described activities aimed at engaging male partners, mothers-in-law, and religious and traditional leaders to shift norms affecting women's access to malaria prevention and care, including use of ITNs and timely uptake of antenatal services.

Stakeholders noted that the GEF enables experimentation and learning in areas where gender-transformative approaches are often perceived as high-risk, politically sensitive, or are not prioritized. Several interviewees emphasized that, because the GEF operates with relatively flexible funding and lighter administrative requirements, it allows organizations to pilot approaches that can later inform or influence Funding Requests and grant design. In this sense, the

GEF was described as catalytic not only in financial terms, but also in its ability to shift narratives about what is feasible and legitimate within Global Fund–supported responses. Because the GEF was launched after GC7 Funding Requests were finalized, there was limited influence on GC7 grant design.

Her Voice Fund

The Her Voice Fund plays a distinct and critical role in strengthening the leadership, participation, and influence of AGYW in Global Fund–supported HIV responses and broader health decision-making processes. Across interviews and reviewed materials, Her Voice Fund was consistently described as strengthening both AGYW-led organizations and individual young women leaders to participate meaningfully in policy, financing, and accountability spaces within Global Fund processes. Quantitative reporting reviewed as part of the evaluation also points to substantial reach in supporting AGYW participation, leadership, and advocacy, including on issues related to GBV, stigma, and gender norms.[59]

Qualitative evidence from interviews illustrates how Her Voice Fund support is translated into concrete influence during key decision-making moments. For example, stakeholders described Her Voice Fund–supported coordination of AGYW grantees during the 2025 reprioritization process in Eswatini as helping present a unified advocacy position and reinforcing the case for maintaining AGYW programming, despite broader funding pressures. In Kenya, stakeholders reported that sustained advocacy supported through the Her Voice Fund contributed to the formal appointment of at least one youth-led organization as an SR, reflecting greater institutional recognition of youth- and AGYW-led organizations as implementation partners. In Lesotho, stakeholders described Her Voice Fund–supported AGYW leaders as contributing to grant priorities related to HIV prevention, testing, socioeconomic support, and PrEP uptake, with several of these priorities reflected in the final Funding Request.

Across these examples, stakeholders emphasized that the Her Voice Fund's added value lies in supporting collective advocacy, sustained presence, and technical confidence, and the ability of AGYW to shape priorities and accountability discussions over time. At the same time, stakeholders noted that recognition of Her Voice Fund–supported work within country teams is inconsistent. They recommended that Her Voice Fund be more systematically given space to present progress and learning within country team engagements, noting that competition for visibility among PRs and SRs can limit awareness of SI contributions despite their relevance to grant effectiveness and equity.

Among the SIs examined, the strongest footprint is in HIV programs, but SI reach is expanding across TB and malaria programs, with growing influence in settings where demand, technical openness, and political space allow. Examples cited by stakeholders include malaria-focused gender task forces, stigma and discrimination work in TB settings, and efforts to integrate gender considerations into malaria social and behavior change programming.

Annex 6 presents country insights related to the SIs.

[59] For example, between 2024 and early 2025, Her Voice Fund directly supported 14,673 AGYW to participate in formal decision-making spaces, including 117 AGYW in CCM meetings, 294 in NSP consultations, 612 in Technical Working Groups, 1,771 in civil society coordination platforms, and 11,679 in national and sub-national policy and advocacy spaces. (Her Voice Fund Narrative Report, March 31, 2024). Over the same period, HVF-supported partners trained 46,311 AGYW, reached 57,847 people directly, and supported 374 initiatives strengthening community leadership and 382 initiatives advancing rights-based advocacy and policy change, including work related to GBV, stigma, and gender norms. (Her Voice Fund Annual Report, 2024–2025)

Evaluation Question 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?

Overarching Finding 5: Stakeholders interpret gender and gender equality integration through very different lenses, shaping the depth and type of programming across disease areas.

Across the Global Fund portfolio, stakeholder understandings of gender range from narrow "equal access" interpretations to more nuanced structural perspectives that encompass gender norms, power relations, GBV, and intersectionality. These interpretations strongly influence how gender considerations are operationalized during grant implementation, affecting decisions about service delivery models, outreach strategies, and prioritization of interventions across disease programs. The evidence supporting this finding is **strong**, drawing on consistent patterns across Secretariat and country-level interviews, in-depth country studies, and implementation observations across HIV, TB, malaria, and RSSH country-components.

Stakeholders' conceptualization of gender varies widely by disease area, with HIV actors more likely to articulate gender as a structural determinant of risk, access, and outcomes, while TB and malaria stakeholders more commonly equate gender with biological vulnerability or equal service coverage. In two of the country studies, stakeholders linked gender directly to program effectiveness, describing gender equality as a determinant of HIV risk, retention, and treatment outcomes. This understanding is reflected in implementation choices that prioritize community-based GBV services, peer-led outreach, legal and psychosocial support, and gender-sensitive adherence strategies. Even in these settings, some frontline implementers still equate gender mainly with women and girls, with less attention to men's gender-specific barriers or gender-diverse populations.

Country-level stakeholders involved in TB and malaria programs more often frame gender primarily through lenses of equity, biological vulnerability, or universal access, which influences the extent to which gender insights shape implementation decisions. TB programs frequently conceptualize gender equality as providing the same services to all, reinforced by strong biomedical and diagnostics-driven paradigms, as reflected in interviews with TB stakeholders at the country level. While some PR and facility-level TB stakeholders acknowledge gendered barriers such as women's restricted mobility, men's delayed care-seeking, stigma toward women with chronic cough, or household decision-making constraints, these insights are rarely translated into differentiated implementation strategies. SRs and CSOs engaged in TB outreach often demonstrated stronger practical understanding of these barriers and described adapting activities informally in response, but reported limited influence over program design, indicators, or budgeting. Similarly, national malaria program staff, PR, and CCM members commonly equate gender integration in malaria programming with prioritizing pregnant women and young children, reflecting epidemiological risk rather than systematic engagement with gender norms, intra-household power, or caregiving dynamics. Although some national- and PR-level actors recognize that men's control over resources and decision-making affects prevention and treatment uptake, this understanding only sporadically informs implementation, most often through limited SBC adjustments rather than sustained norm-change efforts.

Across disease areas, GBV is most consistently recognized as a core gendered driver of outcomes within HIV programs, where stakeholders explicitly link violence to risk, adherence, and service uptake. HIV implementers in multiple contexts described GBV response, legal aid, and survivor-centered care as integral components of effective HIV programming. In contrast, TB and malaria stakeholders seldom frame GBV as relevant to their programs, despite evidence from community interviews that violence, fear of disclosure, and economic dependence significantly constrain women's and girls' ability to seek care. This disconnect reflects both the limited gender knowledge often observed in non-HIV programs and limited operational guidance on how to integrate GBV considerations into TB and malaria implementation as reported by some country-level stakeholders. On review of Global Fund GC7 applicant guidance, HIV and TB technical guidance for countries includes GBV, as does the Modular Framework within its

HIV and TB modules.[60] In malaria, neither the technical guidance nor the Modular Framework include GBV.[61] However, a specific guide on gender and malaria developed in 2024 does discuss GBV in relation to CHWs.[62] However, interestingly, several malaria Funding Requests reviewed did include GBV-related activities such as training for health workers and sensitization campaigns.

Country-level stakeholders interviewed in the country studies report signs of gradual improvement in gender awareness, particularly under GC7. They described increased recognition of gender as an important programming consideration rather than simply a reporting requirement, and some implementation decisions, such as outreach timing, beneficiary selection, and service location, reflect more gender-responsive thinking, especially among community implementers and CHWs. However, these shifts remain uneven and are more conceptual than operational in TB, malaria, and RSSH programs as country-level interviews described that increased gender awareness was not being consistently reflected in Funding Request and grant design choices, implementation practices, or routine monitoring and supervision systems. Country-level stakeholders reported that limited training, lack of practical tools, and weak integration of gender considerations into grant-level supervision, monitoring, and review processes continue to impact the translation of understanding into sustained action.

Differences in gender understanding are also evident across stakeholder roles. Across multiple contexts, PRs and national-level actors tended to demonstrate stronger familiarity with gender terminology and Global Fund requirements, particularly at proposal and reporting stages, while SRs, CSOs, and community-based implementers demonstrated deeper practical understanding of gendered barriers grounded in lived experience. CCM members often recognized gender as a strategic or inclusion priority, but less consistently articulated how gender considerations should translate into indicators, budgets, or routine monitoring. Facility-level and district implementers, particularly visible in malaria contexts in Tanzania, most commonly associated gender with maternal and child health or sex-disaggregated reporting, unless reinforced through targeted training or supervision.

Training and exposure to gender-focused technical support were associated with more nuanced understandings across stakeholder groups. In two of the country studies, stakeholders who had participated in proposal-writing sessions, SI-supported activities, or CHW capacity building were more likely to describe gender-responsive practices, including adapted outreach timing, confidentiality safeguards, and male engagement strategies.

These findings underscore that integration of gender equality in Global Fund–supported programs is not solely a function of formal guidance or technical inputs, but is shaped by how key stakeholders understand gender and gender integration itself. Where gender is understood as a structural determinant of health and equity, it is more likely to inform substantive implementation decisions; where it is framed narrowly as equal access or biological vulnerability, integration remains limited. Annex 6 highlights country insights from three countries related to stakeholder understanding of gender and gender integration.

[60] Technical Brief Removing Human Rights-related Barriers to TB Services, Technical Brief on Removing Rights-Related Barriers to HIV Services, Global Fund Modular Framework Handbook, Allocation Period 2023-2025.

[61] Technical Brief Equity, Human Rights, Gender Equality and Malaria.

[62] https://www.theglobalfund.org/media/15055/crg_strengthen-gender-approaches-malaria-response_report_en.pdf

Evaluation Question 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?

Overarching Finding 6: **Gender equality approaches to address barriers to access to HIV, TB, and malaria services that were integrated into GC7 grants show partial alignment between grant design and implementation, and gender commitments are sometimes adapted, reduced in scale, or delayed during grant implementation. In some settings, implementation has also advanced beyond design intent, reflecting adaptive, community-led responses to identified gendered barriers. Implementation is further shaped by financing dynamics, institutional capacity, and the national enabling environment.**

Evidence indicates that alignment between gender commitments articulated in Funding Requests and grant budgets[63] and their implementation as reported in PUDR data and stakeholder interviews is uneven, with differences observed in both directions. While many GC7 Funding Requests include explicit references to gender equality, women and girls, and, in some cases, gender-transformative approaches, the translation of these commitments into practice varies by disease area, country context, and implementation modality. Across the country-components reviewed, implementation of gender equality approaches reflects a clear pattern: activities that are embedded within established service delivery platforms, including RMNCAH and ANC services, AGYW and KP programs, Lady Health Worker (LHW)/CHW outreach systems, drop-in centers, and other national or partner-supported delivery mechanisms, are more likely to be delivered as intended, while stand-alone, resource-intensive, or gender-transformative activities are described as more vulnerable to delays, reductions in scale, or redesign during implementation. The extent to which gender activities are being delivered as planned also varies by disease area and national context, reflecting differences in program design, availability of gender-specialized implementing partners, and the broader enabling environment. The evidence supporting this finding is **strong**, drawing on triangulated data from in-depth country studies, portfolio review, and Secretariat stakeholder interviews.

Variations across disease areas reflect differences in how gender was conceptualized at the Funding Request stage, the availability of gender-experienced implementing partners, and the degree to which gender equality and gender barriers are understood as integral to disease outcomes. HIV programs demonstrate the most consistent implementation of gender-related activities, particularly those focused on AGYW, key populations, and GBV response. In two of the country studies, peer-led outreach, youth-friendly services, differentiated care models, post-violence care, paralegal services, and psychosocial and referral support for survivors are being delivered broadly in line with grant commitments. These interventions benefit from long-standing civil society engagement, clearer operational linkages between gender inequality and HIV risk, and a stronger ecosystem of NGOs with experience implementing gender and rights-based programming. These interventions are seen by stakeholders as central to advancing gender equality within the HIV response, particularly by improving safety, trust, and access for women, AGYW, and survivors of violence.

TB implementation remains variable. In the country studies, it was observed that some gender-informed outreach exists through female screeners, LHWs, privacy measures, and community camps, but these efforts are often limited in scale, and were not typically articulated as explicit gender-responsive activities.

Malaria programs examined in the country studies show strong and consistent implementation of gender-responsive activities linked to maternal and caregiving roles. Intermittent Preventive Treatment in Pregnancy (IPTp) is delivered through ANC, ITNs are distributed to pregnant women and young children, and CHWs conduct home visits focused on mothers and caregivers. These

[63] For the purposes of this analysis, "grant design" refers to the activities articulated in the Funding Request and budgets that were finalized during grant-making, because these documents constitute the most detailed information on planned implementation available to the evaluators.

interventions rely on long-established delivery platforms and based on implementation experience are widely perceived as effective in improving coverage and uptake. In one country, a subset of SBC interventions goes further by promoting joint household decision-making around net use, depicting fathers as active caregivers, and supporting women's participation in environmental vector control. These elements, while not uniformly implemented, reflect more deliberate engagement with gender norms as part of the malaria response.

A comparison of malaria programming in two countries illustrates how alignment between design and implementation can differ. In one, the Funding Request articulates relatively ambitious gender-transformative intent, but implementation has narrowed to gender-targeted and gender-responsive service delivery following grant-making decisions. In the other, in contrast, the Funding Request frames gender approaches in broad terms without great specificity, while reported implementation in some areas demonstrates deeper engagement with household power dynamics and norms. For example, stakeholders described case-management and SBC activities that explicitly addressed women's autonomy in care-seeking, men's norms around delayed treatment, and shared household decision-making for ANC attendance and IPTp uptake. Annex 6 presents a side-by-side comparison of gender commitments at the grant design stage and reported implementation in both countries, highlighting how feasibility, funding decisions, and real-time adaptation shape what aspects of gender ambition are ultimately realized.

Across the country studies, implementation of gender-related activities to reduce disease burden was also shaped by broader donor and partner ecosystems. In HIV programs, stakeholders described AGYW, GBV, legal literacy, and community-based programming as sustained through combined financing from the Global Fund and complementary partners, while TB programming was described as more heavily dependent on Global Fund resources. Malaria programming operates alongside complementary financing from partners, and stakeholders noted that broader donor funding shifts in 2025 affected coordination, supervision, and SBCC activities that underpin gender-responsive community engagement. Respondents indicated that withdrawal or reduction of other donor support reduced complementary financing in TB, weakening the broader delivery ecosystem.

A complementary care pathway analysis conducted in selected country studies further illustrates how gender-related barriers within HIV, TB, and malaria programs are addressed across the continuum of care. The analysis shows that gender-responsive interventions are most consistently implemented at earlier stages of service delivery, particularly prevention, outreach, and diagnosis, while gender-related barriers affecting treatment continuation, adherence, and longer-term social and economic barriers are less systematically addressed. These include, for example, limited control over resources, and caregiving burdens that can affect continuity of care, as well as longer-term barriers such as food insecurity or income loss during treatment. The detailed care pathway analysis is presented in Annex 7.

Implementation Progress and Expenditure Data

PUDR and budget expenditure data provide an additional lens for assessing the extent to which gender-related activities are being implemented across the broader set of 38 country-components included in the portfolio review, beyond the five in-depth country studies (see Tables 20 and 21). While these data are more limited in their level of detail and do not capture implementation quality or contextual nuance, they allow for identification of some broader patterns. Across the country-components reviewed, these data generally mirror the uneven implementation observed in qualitative reporting.

Component	% of Country-components with Gender Activities that are On Track†	% of Country-components with Gender Activities that are Partially On Track†	% of Country-components with Gender Activities that are Off Track†	Gender Integration Score (Implementation) (max score=3)†
HIV (10 country-components)	30%	20%	50%	1.92
TB (4 country-components)	37.5%	62.5%	0	2.22
Malaria (8 country-components)	50%	37.5%	12.5%	2.42
RSSH (1 country-component)	0	0	100%	2.0

Table 20. Implementation Patterns Across the Reviewed PUDR Data from 23 Country-components

†Data were available for the reporting period ending Dec 31, 2024.

Analysis of the PUDR data shows that among the 23 country-components with available information on implementation of gender-related modules, approximately one-third are on track, while one-third are off track and one-third report being partially on track (see Table 20). PUDR data were obtained for all sampled country-components, but the level of information on gender-related modules and implementation varied considerably, ranging from very limited to none. Thus, the GIS for implementation should be interpreted with caution. Delays are largely attributable to structural and administrative factors. Concrete examples include procurement delays linked to pending guideline revisions, late reprogramming of funds and contracting bottlenecks, ARV and condom procurement delays, and legal and operating environment constraints. In one country, changes in the legal and institutional environment affecting a key NGO SR working with a marginalized population disrupted national-level implementation. Subsequent efforts to identify alternative implementers were unsuccessful, and attempts to transition services to public sector facilities encountered limitations related to low acceptability among the population concerned. In several other cases, activities involving development of curricula, standard operating procedures, tools, and training materials were delayed due to consultant contracting processes or regulatory requirements. PUDR data reviewed for this evaluation did not explicitly mention delays related to broader shifts in the funding landscape in 2025 because the reports were submitted in December 2024, before these developments and related reprogramming took place. Overall, reported implementation challenges in PUDR data appear primarily driven by financial execution, procurement systems, institutional coordination, and restrictive operating environments.

In Table 21, examination of grant expenditure data shows that in the HIV country-components reviewed, gender-related activities to address barriers to service account for about 13% of the overall GC7 budgets for HIV per country-component; however, on average, only about half (50.1%) of the gender-allocated funds earmarked for Year 1 of the country-components had been spent by the time of reporting.[64] Malaria shows a similar pattern. While a smaller share of the total budget for malaria country-components is allocated to gender activities (on average 3.8%), approximately 45% of the gender funds planned for the first reporting period had been spent, reinforcing that there were some delays in implementation of planned gender-responsive activities as described in the PUDR data. In contrast, TB and RSSH report no dedicated budget allocations for gender activities and therefore no corresponding expenditures. As discussed earlier, this does not necessarily indicate absence of gender-responsive activities in these grants as these might be included in other modules. However, when gender activities are not identified in budgets, they are harder to track during implementation.

Component	Total % of Country-component Budget Allocated for Gender Activities†	% of Gender Activities Budget for the Respective Component spent in Reporting Period 1††	Gender Integration Score (Use of Gender Funds) (max score=3)
HIV (10 country components)*	13.33	50.06	1.40
TB (11 country components)	0	N/A	N/A
Malaria (10 country components)**	3.81	45.04	1.80
RSSH (3 country components)	0	N/A	N/A

Table 21. Use of Gender Funds by Component

†Calculated by totaling budgeted amounts for modules and interventions related to (1) gender-targeted activities (e.g., intermittent preventive treatment (IPT) – in pregnancy or condom and lubricant programming for AGYW in high HIV incidence settings), and (2) gender-responsive and -transformative activities (e.g., removing human rights and gender-related barriers to vector control programs) within each country-component. This amount was then divided by the total budgeted amount for the relevant disease component in that country to determine the percentage of the budget allocated to gender-related programming. The percentages were then averaged across all country-components for each disease. See Annex 1 for the full list of modules and interventions in each category.

††Calculated by comparing the funds budgeted to gender-related activities for the first year with the actuals for that period as reported by August 12, 2025; this does not represent execution of the full GC7 gender allocation.

*All 12 HIV country-components reviewed had available budget data, but expenditure data were available for only 10 of these.

**All 12 malaria country-components reviewed had available budget data, but expenditure data were available for only 10 of these.

[64] Expenditure data were downloaded on August 12, 2025, and reflect Year 1 expenditures reported up until that date.

Facilitators and Barriers to Implementation

Drawing on the country studies, Table 22 presents a set of facilitators that support stronger and more sustained implementation of gender equality approaches, and barriers that hinder implementation across disease areas. Across the country studies, implementation is most effective where gender-related activities are embedded within existing delivery platforms, such as AGYW services, ANC/IPTp, CHW outreach, and KP programming. In Lesotho, several gender-responsive interventions were operational early in implementation because they were integrated into delivery systems that were already functioning and had experienced implementing partners. Examples include GBV screening integrated into service delivery, active paralegal accompaniment and referral systems, and peer-led outreach and drop-in center platforms for key populations. In Côte d'Ivoire, interviews describe a mature delivery ecosystem where community-led approaches and adapted service delivery models (e.g., drop-in centers and rights-based accompaniment) are embedded across cycles and can be activated quickly during implementation. In Tanzania and Guinea, malaria interventions such as IPTp via ANC, ITN distribution through maternal and child health platforms, and CHW outreach demonstrated strong implementation because they relied on long-established delivery systems.

The catalytic investments assessed in this evaluation (notably CE-SI, BDB, and the GEF) support implementation by helping implementers translate design into practice, adapt interventions as challenges emerge, and address implementation bottlenecks. Strong national partners, women-led and community-based organizations with gender expertise and trusted community access, alongside committed program staff and frontline implementers, also play a critical role. Côte d'Ivoire's thematic networks and civil society actors, Lesotho's women-led and peer-based organizations, Tanzania's functional CHW systems, and Pakistan's community intermediaries illustrate how frontline implementers adapt delivery to gendered realities, particularly around confidentiality, stigma, and mobility constraints. Finally, the availability of gender analyses, assessments, and community-generated evidence supports more informed implementation choices, particularly where delivery models allow flexibility and community-led adaptation. For example, in Pakistan, implementers referenced gender and stigma studies and described integrating recommendations through targeted adjustments (e.g., camps for stigmatized groups or increased engagement of female providers), although implementation of broader recommendations was described as limited by operational and funding realities. In Lesotho, vulnerability assessments and risk screening tools supported identification of beneficiaries and alignment of services that address gender barriers.

Barriers in the first year of grant implementation included structural, programmatic, and contextual factors. Funding volatility in 2025, including GC7 reprioritization in mid-2025 and the broader donor shifts, affected implementation, reducing or delaying coordination, training, SBCC, and community-based interventions in some contexts. In some settings, funding shocks affected partners and CSOs relying on multiple donors, creating staffing instability and financial precarity and weakening delivery capacity for community- and gender-focused interventions even when Global Fund financing remained intact. Biomedical grant structures, which appropriately prioritized diagnostics, commodities, and clinical targets, can also limit fiscal and operational space for relational and norm-focused work. This dynamic was visible in a malaria program in one of the country studies, where country stakeholders reported that decisions were made to focus on commodity distribution rather than on gender-transformative activities to address disease burden.

Capacity gaps, particularly limited gender-technical expertise within national TB and malaria programs and limited use of sex- and gender-disaggregated data to track, or adapt implementation, were reported in some contexts. Some implementers were also noted to lack the skills or institutional support required to deliver more complex interventions, such as economic empowerment, norm change, or GBV legal services.

Several constraints are rooted in the national enabling environment. In Pakistan, stakeholders described gendered stigma associated with TB (including fear of divorce and concealment within households), restrictions on women's mobility, and discrimination affecting stigmatized populations in health settings. These realities influence delivery decisions around confidentiality, outreach modality, and the feasibility of scaled rights-based programming. In one country, episodes of anti-LGBTQI+ backlash altered implementation modalities, requiring more discreet outreach and reliance on protective referral networks.

Weak institutionalization of gender accountability was also noted as a barrier to implementation of gender activities within the context of HIV, TB, and malaria programs. As mentioned earlier in this report, the country insights observed two cases where specialized

gender positions in the national programs were not filled due to cuts in donor funding.

Across all disease areas, implementation decisions are strongly shaped by national enabling environments. In contexts with relatively supportive policy environments, active women's rights movements, and established partnerships between government and feminist or community-based organizations, such as Lesotho and Côte d'Ivoire, implementation of GBV services, community-led initiatives, and rights-based programming is viable, sustained, and is mostly implemented as planned. In some contexts, legal and sociopolitical sensitivities influenced the scope and visibility of gender-responsive programming and required adaptation of delivery modalities. Stakeholder interviews, including TRP members, described cases where criminalization, stigma, or cultural resistance shaped what could be explicitly articulated in Funding Requests, planned activities, and how these activities were delivered in practice.

	Facilitators to Implementation	Barriers to Implementation
Structural/ Financing Factors	• Strategic Initiatives (CE-SI, BDB, GEF) that support operationalization, adaptation, and problem-solving during implementation and provide TA • Clearly articulated and budgeted gender-responsive components embedded within core service modules (e.g., AGYW packages, MDR-TB adherence incentives, structured community platforms)	• Insufficient and inflexible funding and limited fiscal space for gender and community-based interventions • Biomedical grant structures which may appropriately prioritize diagnostics, commodities, and clinical targets; there may be limited attention and space to include social and gender-responsive interventions • External shifts in funding landscape affecting partners and CSOs weakening staffing continuity, financial stability, and delivery capacity
Programmatic/ Implementation Factors	• Embedding within existing delivery platforms, such as AGYW services, ANC/IPTp, CHW/ LHW outreach, Drop-in Centers, and KP programming, which enables smoother roll-out of gender-responsive activities • Presence of strong national partners, women-led and community organizations with gender expertise, trust, and access to affected populations • Commitment among program staff and frontline implementers, including individual champions who adapt delivery to gendered realities • Availability of gender studies, assessments, and community-generated evidence, which inform implementation choices and adaptations • Flexible, community-led delivery models, allowing frontline actors to adapt outreach, timing, and engagement strategies	• Limited gender-technical expertise, particularly within national TB and malaria programs, constraining the translation of gender analysis into implementation decisions • Weak systematic use of sex- and gender-disaggregated data, especially in TB and malaria, limiting the ability to track, or adjust gender-responsive implementation • Limited technical and operational capacity to implement complex interventions, such as economic empowerment, norm change, or GBV legal services, particularly among health-sector implementers • Early-cycle implementation delays (e.g., contracting, hiring, procurement, guideline revisions) affecting rollout of structural and coordination-intensive components

	Facilitators to Implementation	Barriers to Implementation
Contextual/ Sociopolitical Factors	• Supportive national policy environments and functioning gender or GBV frameworks • Active women's rights movements and established partnerships between government and community/feminist organizations that facilitate trust and coordination	• Deeply rooted patriarchal norms affecting women's autonomy, mobility, treatment initiation, and disclosure (e.g., marriage-related stigma in TB, male-dominated household decision-making) • Persistent stigma at community, household, and sometimes provider levels, affecting care-seeking and adherence • Political sensitivities and periodic social backlash (e.g., anti-LGBTQI+ narratives) reshaping delivery modalities and increasing operational risk • Restrictive legal and political contexts, including criminalization and stigma affecting MSM, female sex workers (FSW), and gender-diverse groups • Weak or disrupted institutionalization of gender accountability, including unfilled gender focal positions and loss of externally funded gender focal roles following donor cuts, limiting sustained oversight and influence over implementation decisions

Table 22. Facilitators and Barriers to Implementation of Gender Equality Approaches within HIV, TB, and Malaria Programs

Evaluation Question 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?

Overarching Finding 7: Partnerships are a major delivery channel for gender equality approaches within Global Fund–supported HIV, TB, and malaria programs. The composition of partnership ecosystems, particularly the inclusion of gender- and rights-specialized partners and actors beyond the health sector, varies by disease area and context, influencing the extent of gender integration in HIV, TB, and malaria program design and implementation by national- and community-level actors.

Across the country-components reviewed, partnerships play a central role in advancing the integration of gender equality approaches within national disease programs supported by the Global Fund, particularly by enabling access to trusted community-based actors who can reach marginalized populations, specialized expertise, and delivery platforms that government systems alone cannot provide. However, the depth, structure, and strategic orientation of these partnerships vary markedly by disease area and national context, shaping both the reach and ambition of gender-related programming. HIV programs demonstrate the most mature partnership ecosystems, while TB and malaria programs engage gender-specialized partners more modestly. The evidence supporting this finding is **strong**, drawing on portfolio review, country studies, stakeholder interviews at Secretariat and country levels, and analysis of implementation arrangements across multiple disease contexts.

HIV programs consistently leverage partnerships with women-led organizations, feminist groups, KP networks, and PLHIV associations as core delivery mechanisms for gender equality work. Across countries, these partnerships underpin activities such as GBV case management, legal accompaniment, stigma reduction, peer-led outreach, AGYW programming, and community-led monitoring. In Côte d'Ivoire, HIV partnership ecosystems extend beyond the health sector to include ministries responsible for women, justice, social affairs, police and magistrates, as well as UN agencies, enabling multisectoral responses to violence, discrimination, and gender norms. These structured and sustained partnerships provide the institutional backbone for more transformative approaches, including norm-change initiatives, survivor-centered services, and empowerment-focused programming, and are widely perceived by stakeholders as essential to achieving both gender and disease outcomes.

In contrast, TB and malaria programs engage a range of partners but rarely place gender expertise at the center of partnership strategies, limiting the depth and consistency of gender integration in HIV, TB, and malaria programs. TB programs commonly collaborate with community intermediaries such as LHWs, teachers, religious leaders, private providers, and local NGOs to improve access and coverage, enabling some gender-sensitive practices such as women screeners, and women-only spaces. However, partnerships with feminist organizations, women-led groups, and KP networks remain minimal or informal in many settings. TB stakeholders, including PRs and National TB programs in the country studies, frequently described gender as an access or equity issue and it was rarely cited as influencing partnership selection or strategy. Malaria programs similarly rely on partnerships with CHWs, ANC platforms, and local leaders, which support strong maternal and child health delivery but seldom extend to organizations with specialized gender or rights expertise.

Country studies illustrate both the strengths and limitations of these partnership models. Across contexts, partnerships supported by Global Fund investments are often operationally strong and well embedded at community level, enabling the identification of gender-related barriers such as mobility constraints, permission norms, stigma, and delayed care-seeking that are not visible through facility-based information systems alone. However, the country data also reveal that gender equality is most often advanced indirectly through access-oriented and community-delivery partnerships rather than through partnerships explicitly designed to address gender norms, power relations, or rights. Formal collaboration with women's rights organizations, feminist groups, and gender-specialist actors is inconsistent, and mechanisms to translate gender insights generated through partnerships into higher-level planning and decision-making are often weak or absent. Annex 6 includes country insights to

illustrate how these dynamics play out across different disease areas and national contexts.

Global Fund–supported TA delivered through SIs plays an important role in strengthening partnership ecosystems for gender equality. TA most commonly strengthens partnerships by facilitating relationships between implementers and gender actors, supporting stakeholder mapping and inclusive partner selection, and helping partners translate gender evidence into feasible program choices, budgets, and performance commitments. In several contexts, stakeholders described TA as enabling implementers and CCM/TWGs to work more effectively with women-led organizations, KP networks, and human-rights actors by clarifying roles, improving technical preparedness, and sustaining engagement beyond one-off consultations, particularly where local systems lack embedded gender expertise.

BDB most explicitly structures partnerships around gender and human rights. It establishes multistakeholder human-rights working groups or steering committees that bring together ministries of health and justice, national human-rights institutions, law enforcement, and civil society. These platforms create formal spaces for collaboration across sectors that rarely interact in routine disease programming, enabling coordinated responses to GBV, stigma, discrimination, and legal barriers. Evidence from HIV-focused settings shows that these arrangements strengthen trust, clarify roles, and institutionalize collaboration between health and justice actors.

CE-SI strengthens partnerships by increasing the influence and preparedness of community-led organizations within existing governance structures. Through pre-dialogue preparation, translation of technical content, accompaniment to CCMs and TWGs, and support for community-led assessments, CE-SI enables women-led organizations, AGYW networks, and KP groups to engage more effectively with government and technical partners. Community actors are thus better able to articulate evidence-based priorities, engage in technical discussions, and sustain their involvement across multiple stages of planning and oversight. These contributions were most notable in the Tanzania country study, where CE-SI presence was associated with improved preparedness and quality of engagement of community-led organizations in dialogue and technical spaces. In other country studies where CE-SI was present, evidence of sustained influence on partnership dynamics was more limited.

Initiatives such as the Her Voice Fund and the Gender Equality Fund expand opportunities for AGYW groups and women-led organizations to engage in decision-making and implementation, often enabling actors who would otherwise lack access to Global Fund resources. Secretariat stakeholders and technical partners stated that these mechanisms strengthen the quality of partnerships and expand the pool of gender-competent actors informing grants. At the same time, the actual funding reaching grassroots organizations through these channels is often small, limiting their ability to scale interventions or sustain leadership roles within national partnership ecosystems.

Across disease areas, the analysis suggests that partnerships are most effective in advancing gender equality when they are formalized, resourced, and embedded within core program structures. Where partnerships with gender-specialized organizations are sustained and linked to decision-making, as is more common in HIV, gender-responsive and gender-transformative work are more likely to be included. Where gender-focused partnerships are narrower, informal, or weakly resourced, as is more typical in TB and malaria, the contribution of partners to gender equality work remains limited, despite their recognized potential.

Evaluation Question 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)?

Overarching Finding 8: Sex-disaggregated data are now widely collected by country stakeholders but use is variable; few HIV, TB, and malaria programs systematically collect or analyze data on norms, decision-making, GBV, or gender-specific access barriers.

Across disease areas and contexts, routine collection of sex- and age-disaggregated data is reported to have improved substantially under GC7, reflecting clearer Global Fund requirements and stronger performance framework expectations. However, the extent to which these data are analyzed and used to inform programmatic decisions remains limited. Most programs continue to rely on basic sex-disaggregation without examining underlying gendered patterns of access, risk, or outcomes, and very few routinely capture data on structural (e.g., legal barriers, economic vulnerability, or weak protection systems) or normative (e.g., gender norms, stigma, or unequal power relations) dimensions of gender inequality. The evidence supporting this finding is **strong**, drawing on portfolio-level performance framework analysis, in-depth country studies, and consistent testimony from Secretariat, implementer, and community stakeholders across HIV, TB, malaria, and RSSH portfolios.

Routine collection and reporting of sex-disaggregated data, particularly for core service indicators, is widely occurring across most country-components. Secretariat stakeholders emphasized that this represents a significant shift from earlier cycles, when disaggregation by sex was inconsistently applied. In the HIV country-components reviewed, disaggregation by sex, age, and in some cases KP category is relatively well established, particularly for AGYW-focused interventions and selected KP services. In malaria, sex- and pregnancy-disaggregated data are routinely collected for ANC, IPTp, and long-lasting insecticidal net (LLIN) distribution, and in TB, most countries now report sex disaggregation for notifications and treatment outcomes. Despite these improvements, stakeholder interviews and data from the country studies consistently indicate that such disaggregated data are rarely interrogated to identify gendered trends or inform adaptation. For example, in one country, TB data showing higher notification rates among women did not trigger further analysis or programmatic response. In another, based on in-country interviews and review of available program data, the TB program collects sex-disaggregated data, but these data are not routinely analyzed or used in planning or review processes. This limited use is often attributed to lack of political will, or limited capacity.

Beyond basic sex disaggregation, routine monitoring systems are primarily designed to track service delivery outputs and are not structured to systematically collect more complex social and power-related dimensions of gender inequality that shape service access and outcomes. Health management information system (HMIS) platforms, performance frameworks, and PUDR reporting remain primarily oriented toward service delivery outputs and outcomes. Indicators related to mobility constraints, intra-household decision-making, stigma, safety, or GBV, which are often qualitative, are not easily integrated into standardized routine facility data and are often more appropriately measured through surveys, qualitative research, community-based monitoring, or targeted assessments. For example, in one country study, stakeholders noted that indicators related to intra-household decision-making, exposure to gender-based violence in TB care, or sexual orientation and gender identity are not included in routine TB reporting due to sensitivities of these topics, social and religious norms, stigma, and the perception that such variables fall outside the scope of routine clinical reporting for TB programs. In two other countries, respondents similarly emphasized that constructs such as permission-seeking behavior, mobility constraints, economic dependence, or fear of partner violence are difficult to integrate into routine facility–based systems due to confidentiality risks, reporting burden on frontline staff, and the absence of standardized tools. Implementers cautioned that incorporating sensitive indicators into routine reporting could compromise privacy, discourage disclosure, and create safety risks.

Component	% of Country Components for which at least 1 Grant Performance Framework includes Gender-Sensitive Indicators†	% of Country-components for which at least 1 Grant Performance Framework Tracks Gender Equality Outcomes††	% of Country-components Reporting Sex-Disaggregated Data*	% of Country-components Reporting Gender-Relevant Indicator Data Beyond Basic Sex-Disaggregation**
All (38 country-components)	86.8%	21.1%	2.7%	62.2%
HIV (12 country-components)	100%	66.7%	0	100%
TB (11 country-components)	100%	0%	9.1%	9.1%
Malaria (12 country-components)	83.3%	0%	0	91.7%
RSSH (3 country-components)	0%	0%	0	0

Table 23. Comparison of Gender Indicators in Performance Frameworks and Reporting of Gender Data

†Specifically defined as indicators that are sex-disaggregated

††Includes indicators focused on gender-specific key populations and/or indicators related to GBV, gender equality, power, and decision-making

*This was assessed using available PUDR data (37 of the 38 country-components had available indicator data)

**This includes indicators focused on gender-specific key populations and/or indicators related to GBV, gender equality, power and decision-making, and was assessed using available PUDR data (37 of the 38 country-components had available indicator data)

Beyond the stakeholder interviews and country studies, there was limited Secretariat-level information about data being collected across the 38 country-components reviewed, reflecting the intentional design of these systems to minimize reporting burden on countries. PUDR data represented the only source of information available for analysis at the portfolio review level, and this tool was not designed to report sex-disaggregated data. In general, the performance frameworks and PUDR reporting of the grants reviewed are primarily oriented toward service delivery outputs and outcomes. Only 1 of the 37 country-components for which PUDR data were available presented any sex-disaggregated data (Table 23). On the other hand, other gender-related data, typically key populations data, were commonly available in HIV and malaria country-components, but not TB country-components. Some gender data are being collected in countries through complementary means. For example, in one HIV program, GBV referrals were tracked and vulnerability scoring tools were used in prevention of mother-to-child transmission of HIV (PMTCT) and community programming. Multiple contexts reported community-led monitoring processes generating data on gender barriers. However, these complementary data sources are not systematically incorporated into grant performance frameworks or consistently reflected in PUDR reporting or grant review meetings. Stakeholders described discussion on gender during grant review meetings as ad hoc and dependent on the presence of individuals with gender expertise or interest, rather than embedded within standard review processes.

Capacity and systems gaps further constrain the generation and use of gender-relevant data. Across countries, stakeholders reported limited training, tools, and methodological guidance on how to analyze gendered access barriers or interpret sex-disaggregated trends. This gap is particularly pronounced in TB and malaria programs, where implementers often equate gender analysis with reporting disaggregated numbers rather than examining underlying drivers. Frontline actors, especially CHWs and community organizations, routinely observe gendered constraints such as women requiring permission to seek care, fear of partner backlash, financial dependence, stigma, or safety concerns related to travel. However, these insights remain informal, captured in notebooks, conversations, or anecdotal reporting rather than in structured monitoring tools. This disconnect represents a lost opportunity for adaptive management, as rich qualitative gender information generated at community level is not systematically documented, analyzed, or fed back into planning and decision-making.

Secretariat interviews also highlighted structural risks to the sustainability of systems used to collect, manage and report on gender-relevant data. In several

contexts, routine data collection for gender-tagged indicators, particularly those elevated to Strategy-level KPIs, relies in part on externally funded data systems, often supported by bilateral partners. Stakeholders noted that if such external funding were significantly reduced, core service delivery might continue, but the availability and quality of gender-relevant data could be affected, potentially limiting the ability to monitor gender-tagged indicators with the same consistency as core coverage indicators.

Annex 6 presents country insights regarding gender data collection, use, and challenges in several countries. These cross-country insights demonstrate that while routine sex-disaggregated data collection has become standard, the depth, scope, and use of gender-relevant data varies substantially. Across all contexts, rich gender insights are often generated through SIs, CLM, and CSOs, underscoring the value of these mechanisms. The findings also highlight the limited use of these data in decision-making, program monitoring, and adaptation.

RSSH investments provide an important entry point for strengthening national data systems to better integrate gender. The GC7 modular framework explicitly includes gender and GBV considerations within RSSH modules for HRH and Quality of Care, Community Systems Strengthening, and Monitoring and Evaluation Systems. Secretariat-level interviews highlight that GC7 marked a shift toward more explicit consideration of gender within RSSH country-components, particularly through HRH and CHW programming, where gender is increasingly understood as both a service-access issue and a workforce equity issue. According to these stakeholders, these RSSH-supported activities have begun to generate gender-relevant information in areas such as CHW remuneration, supervision, workforce distribution, and access in fragile or humanitarian settings, and in some countries have supported gender analyses linked to HRH planning and community health strategies. However, these data remain largely fragmented in terms of their integration into grant monitoring systems. For example, while some countries report CHW sex composition under RSSH-supported HRH activities, Secretariat stakeholders noted that there is currently no consistent portfolio-level visibility on the number and types of CHWs supported disaggregated by gender across grants. Comprehensive master lists of CHWs are rare, and where they exist, gender data are not always systematically consolidated or linked to broader HRH information systems. Although some country-components include indicators related to CHW remuneration or timely payment, there is no consistent inclusion of indicators tracking gendered pay equity, retention, or career progression within performance frameworks, despite the relevance of these factors for sustaining the predominantly female community health workforce that supports HIV, TB, and malaria service delivery in many contexts. Similarly, tools such as CHW systems maturity assessments, used by countries and technical partners to assess the strength and functionality of community health systems, have only recently begun to integrate gender considerations related to workforce composition, roles, remuneration, safety, and career progression. The portfolio review examined Funding Request narratives and Funding Request-stage performance frameworks for three RSSH country-components, and none of them had incorporated gender-sensitive or gender equality indicators. In the grant documentation for these three RSSH country-components, and based on data from the country studies, there is no evidence of consistent collection or analysis of gendered workforce patterns (e.g., gender composition of CHWs, pay equity, career progression), facility-level safety, or disclosure of GBV to CHWs, nor are community-level gender insights routinely captured or fed back into planning. In one of the country studies, for example, CHW sex composition and service outputs are reported through DHIS2, but these are not systematically analyzed as workforce equity indicators, nor linked to structured RSSH gender targets. In Lesotho, GBV referral tracking and paralegal case management systems generate important gender-relevant data connected to HIV and TB programming, yet these data are not incorporated into RSSH performance indicators or PUDR reporting. Similarly, disclosures of GBV to CHWs or safety concerns identified during supervision are addressed operationally but are not captured as structured monitoring indicators.

Strategic Initiatives play a critical role in filling these data gaps in the contexts where they operate. CE-SI and the BDB have generated actionable gender- and rights-related data, including community-led gender barrier assessments, human-rights scorecards, and targeted population studies. In one notable example, an SI-supported assessment of HIV among transgender populations informed the inclusion of peer-led drop-in centers in the GC7 design; a subsequent follow-up study was being implemented in late 2025, reflecting increasing institutionalization of this evidence base. CE-SI–supported CLM systems capture GBV referrals, rights violations, and access barriers that are not captured in

routine reporting. The SIs also include learning hubs[65] that serve as collaborative knowledge platforms, connecting implementers, country teams, and civil society to share evidence, practical tools, and lessons on addressing gender, human rights, and community engagement challenges across disease programs. The learning hubs were described by Secretariat stakeholders but were not discussed by stakeholders at the country level, which could be a reflection of limited awareness.

Across national HIV, TB, and malaria programs, while sex-disaggregated data collection has become routine, the analytical and institutional use of gender-relevant data remains limited. HIV programs demonstrate the strongest data ecosystems, supported by AGYW tracking, CLM, and periodic gender or GBV studies, yet even here gender norms, autonomy, and safety are rarely measured systematically or used to drive adaptation. TB and malaria programs continue to treat gender primarily as a reporting category rather than an analytical lens, and RSSH grants rarely incorporate indicators related to gendered workforce dynamics, facility safety, or quality-of-care differences. Without stronger systems, capacity, and incentives to move beyond disaggregation toward analysis and use, the potential of gender-relevant data to inform more responsive and effective programming remains largely unrealized.

[65] For example: https://learning-hub.me/about/

Evaluation Question 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?

Overarching Finding 9: An emerging set of gender-targeted, gender-responsive, and gender-transformative approaches in HIV, TB, and malaria programs demonstrates indications of success in contributing to improved disease outcomes. Gender-targeted and -responsive approaches are most effective when embedded within established service platforms and delivered through trusted community actors, whereas transformative approaches require sustained financing, specialized expertise, supportive enabling environments, and longer timeframes, often beyond a single Global Fund grant cycle, to achieve deeper shifts in norms and power relations that influence care-seeking, treatment adherence, exposure to risk, and control over health-related decisions. The most successful approaches are multilayered, community-led, rights-based, and explicitly tailored to gendered realities.

In line with the scope and design of this evaluation, indications of success are assessed based on stakeholder perceptions, reported changes in service delivery and uptake, and observed implementation effects, rather than on causal attribution or measured impact. This evaluation draws on qualitative evidence from implementers, community actors, and Secretariat stakeholders to understand which gender equality approaches are perceived to be working in practice, why they are valued, and under what conditions they appear to contribute to improved HIV, TB, and malaria outcomes.

Based on these data, an emerging set of gender-targeted, gender-responsive, and gender-transformative approaches across the Global Fund grants reviewed shows indications of success in contributing to improved disease outcomes. The depth and scale of these successes vary by disease area, context, and enabling conditions. Across countries and disease programs, the approaches most consistently described as successful share several common characteristics: they are embedded within existing service delivery platforms; delivered through trusted community, peer, or frontline actors; and explicitly tailored to gendered barriers relevant for HIV, TB, and malaria programs such as mobility constraints, time poverty, stigma, violence, and household decision-making. Where these conditions align, Secretariat and in-country stakeholders report improved access, uptake, retention, trust, and service quality for women, AGYW, and key populations. The evidence supporting this finding is **strong**, drawing on findings from the country studies, and reinforced by consistent testimony from implementers, community actors, and Secretariat stakeholders. At the same time, stakeholders frequently noted that the continuation and scale of such approaches remain sensitive to shifts in funding availability and donor priorities.

Across disease areas, stakeholders typically define success of gender-related approaches in relation to disease and service-delivery outcomes rather than in relation to gender equality outcomes (see Table 24). This reflects the primary objective of HIV, TB, and malaria programs, where gender approaches are implemented as strategies to improve disease prevention, care-seeking, and treatment outcomes, rather than as stand-alone gender equality interventions. Interventions are most likely to be described as successful when they can plausibly demonstrate improvements in testing, treatment uptake, adherence, case detection, or prevention coverage. Gender-targeted approaches, as well as gender-responsive interventions that reduce visible barriers to access to health services, are therefore more easily recognized as successful than gender-transformative approaches whose effects unfold over longer time horizons and are less directly linked to these routinely tracked indicators. While many stakeholders at global and country level, particularly those engaged in HIV and community-led programming, acknowledge that norm change, economic empowerment, and shifts in power relations are critical to sustained impact and eradication of disease, they also express caution given their higher costs, their reliance on specialized expertise and challenges in implementing these approaches with high quality.

Disease Component	Gender-Targeted	Gender-Responsive	Gender-Transformative
HIV	Improved reach to women, AGYW, and key populations; increased HIV testing and linkage among AGYW, FSW, MSM, and transgender populations; ensuring that services are visibly available and accessible to intended groups	Increased trust, privacy, and acceptability of services; improved uptake and retention in HIV and SRH services; clients feeling safe to disclose violence or key-population status; reduced stigma in facilities; better continuity of care through community and peer-led models	Shifts in gender norms and power relations (e.g., men repositioned as partners in care); increased agency and leadership of AGYW and women in accountability and decision-making spaces; strengthened rights awareness and use of legal pathways; normalization of survivor-centered and rights-based responses which can support earlier care-seeking, greater uptake and continuity of treatment, and reduced exposure to HIV-related risks
TB	Increased case identification among women and men reached through targeted outreach (e.g., prisons, factories); improved access for groups previously underreached due to stigma or mobility constraints	Reduced stigma in TB services; earlier care-seeking (especially among men prone to delayed presentation); improved household cooperation during contact tracing; greater comfort and privacy in screening and treatment; services adapted to gendered access barriers (timing, location, staffing)	Changes in norms around masculinity, care-seeking, and disclosure; recognition of TB as shaped by gendered stigma and power relations; women and community actors being accepted as legitimate contributors to TB response
Malaria	Improved access to ITNs, IRS, and IPTp for pregnant women and children; higher coverage among biologically vulnerable groups; improved attendance at ANC-linked malaria services	Behavior change supporting prevention and timely care-seeking; increased women's participation in community sessions; reduced male gatekeeping; improved household support for prevention practices; stronger trust in CHWs and community delivery	Household and community norms shifting toward shared responsibility for malaria prevention; women participating beyond caregiving roles (e.g., leadership, mobilization); malaria programming recognizing and addressing intra-household decision-making dynamics

Disease Component	Gender-Targeted	Gender-Responsive	Gender-Transformative
RSSH	Equitable distribution of services and human resources across populations; visible inclusion of women in the health workforce (e.g., female CHWs in communities where women prefer female providers); sex- and age-disaggregated reporting in HMIS	A gender-balanced health workforce that improves access, trust, and acceptability (e.g., women able to speak openly with female CHWs; safer outreach for women and girls); supervision and deployment that account for gendered safety, mobility, and workload constraints; data used to identify who is being left behind	Health systems that deliberately address gendered power relations (decision-making authority, safety, pay, recognition) within the workforce critical for HIV, TB, and malaria service delivery; institutional norms that value community and care work; accountability for discrimination, harassment, and GBV affecting both clients and health workers; redistribution of authority toward frontline workers, women, and communities

Table 24. Stakeholder Definitions of Success of Gender-Targeted, Gender-Responsive and Gender-Transformative Approaches by Disease Component

Gender-targeted approaches remain among the most widely implemented gender approaches in GC7 and are generally viewed as practical mechanisms to expand reach among priority populations. These approaches strengthen who is reached, but do not necessarily adapt how services are delivered or address the gendered factors that shape uptake, retention, or disclosure. This includes interventions such as ANC-based malaria prevention (IPTp and ITN distribution), prioritization of pregnant women and children under five in malaria campaigns, and AGYW-specific HIV prevention and treatment targets. In several countries, prioritizing pregnant women and young children through free malaria services, LLIN distribution, IPTp, and Seasonal Malaria Chemoprevention (SMC) was widely viewed as effective, socially acceptable, and straightforward to operationalize. In two country studies, AGYW-focused HIV interventions, such as the prioritization of AGYW within HIV programs, targeted outreach to AGYW, and focused follow-up and linkage support within existing service platforms were described as successful in improving service uptake, and continuity of care, and in legitimizing adolescent girls as a priority population within health and community systems. Stakeholders emphasized that these approaches work because they align closely with existing service mandates, and performance frameworks, allowing them to be implemented at scale with minimal resistance. Respondents noted that gender-targeted approaches help improve access and are not intended to address the underlying gender norms or power relations that shape risk, decision-making, and vulnerability.

Gender-responsive approaches, defined as adaptations to service delivery that account for gendered realities and remove practical, social, or safety-related barriers, also demonstrate strong indications of success, particularly when they are locally designed and community-led. Across countries, stakeholders highlighted the effectiveness of AGYW safe spaces and mentorship programs, PMTCT mentorship models, female-only or privacy-adapted TB screening and service delivery, recruitment and support of female CHWs and peer educators, alignment of outreach with ANC days, mobile and community-based service delivery, and tailored approaches for stigmatized or hard-to-reach populations. In one country study, CSOs showed that shifting the timing of community dialogues and malaria sensitization sessions to evenings or weekends rapidly increased women's participation by reducing conflicts with domestic and livelihood responsibilities. Female CHW recruitment strengthened trust and communication with pregnant women and young mothers, contributing to earlier ANC attendance and improved IPTp uptake. Household-level negotiation by CHWs and village committees directly addressed male gatekeeping, reducing refusals and delays in care-seeking. In some countries, relatively modest but intentional design adaptations, such as female screeners, privacy curtains, separate service spaces, LHW home visits, peer-led outreach for key populations, bundled multi-disease health camps, and co-located TB–HIV services in safe spaces, were cited as having positive effects on women's participation and disclosure. In Lesotho, community-based outreach, peer navigation, and gender-sensitive supervision

were described as improving confidentiality, respect, and retention in care. Stakeholders emphasized that these approaches are successful because they respond directly to lived gender barriers, are perceived as practical, and can be integrated into routine service platforms without requiring fundamental redesign of programs.

A critical feature of these successes is that they are primarily driven by CSOs, CHWs, peers, and community actors who are embedded in daily social realities and able to identify gender barriers in real time. These actors observe how permission norms, time poverty, safety concerns, stigma, and household decision-making shape access and adherence, and they adapt service delivery accordingly. As several stakeholders emphasized, these adaptations are often low-cost, pragmatic, and highly effective. However, because they are rarely specified in Funding Requests, grant design or performance frameworks, they often remain localized, driven by individual champions and unevenly implemented across districts. Their success highlights both the potential of gender-responsive programming and the limits of current systems to recognize, document, and scale what works.

Gender-transformative approaches, those approaches that explicitly seek to shift gender norms, power relations, and structural barriers that shape vulnerability to HIV and access to HIV, TB, and malaria services, show promising but uneven indications of success, primarily concentrated in HIV programs and in contexts with supportive enabling environments and dedicated resources. Strong examples come from Lesotho and Côte d'Ivoire, where HIV programs integrate GBV response, legal empowerment, psychosocial support, and community norm-change initiatives. Stakeholders consistently described paralegal services, legal literacy, survivor-centered GBV case management, and integrated referral pathways as critical in improving women's safety, disclosure, trust, and retention in care. Male-engagement and couples' approaches were cited as particularly powerful, shifting gender norms, repositioning men as partners in care, reducing conflict and disclosure risk, and improving women's access to HIV, ANC, PMTCT, and TB services. In northern Côte d'Ivoire, FGM norm-change interventions involving religious and traditional leaders, community watch committees, and intersectoral collaboration were described as reducing these practices and reshaping community norms; these approaches were expressed to be important for reducing gender-based vulnerability to HIV and barriers to access for HIV prevention and services. Country stakeholders also noted that support from other donors helped finance gender-transformative work in some contexts.

Despite these promising indications, stakeholders emphasized that gender-transformative approaches remain limited in scale and vulnerable to disruption. In TB and malaria, explicitly gender-transformative interventions, such as sustained work with men on masculinities, economic empowerment, or systematic norm-change programming, are less common, despite their potential to reduce barriers to timely diagnosis, treatment adherence, and continuity of care and thereby contribute to lowering disease burden. This limits the evaluation's ability to assess examples of successful transformative programming in these areas but does not indicate that such approaches are unnecessary. In fact, care pathway analysis across HIV, TB, and malaria identified gender-related barriers in all three diseases that could potentially be addressed through gender-transformative approaches, even where such interventions were not widely documented in the portfolio (see Annex 7). In this evaluation, where gender-transformative approaches do exist, typically in HIV programs, they are often pilot-level, dependent on external catalytic funding, or driven by individual champions rather than institutionalized systems (see Tables 25–27). Several Secretariat and country-level stakeholders cautioned that while these approaches address root causes, they require long-term investment, specialized skills, and strong intersectoral partnerships that are difficult to sustain within short funding cycles and commodity-focused grant architectures.

Tables 25, 26, and 27 present a comparative synthesis of gender-targeted, gender-responsive, and gender-transformative approaches across malaria, HIV, and TB, respectively, drawing on country data. For each disease area, the tables summarize the types of approaches implemented across countries, and the results or changes stakeholders perceive to be associated with the approaches. Together, the tables illustrate how patterns of implementation of gender equality approaches and observable effects differ by disease area and by the depth of gender integration.

	Gender-Targeted	Gender-Responsive	Gender-Transformative
Core Country in Western and Central Africa	• Intermittent preventive treatment in pregnancy (IPTp) delivered through ANC services • SMC and community case management for children under five • LLIN distribution through ANC and expanded program on immunization (EPI) platforms for pregnant women and infants	• Daytime and night household visits adjusted to men's mining schedules and women's caregiving responsibilities • Deployment of male community relays to mining sites and for night travel, and female relays for child-focused services • Prioritization of women and young children during facility-based malaria treatment • Engagement of religious leaders to encourage male household heads to permit women and children to seek care	• No explicit gender-transformative malaria activities were identified
High Impact Africa 2 Country	• IPTp and malaria prevention delivered through ANC platforms • Malaria case management and SBC activities directed at caregivers of young children • School-based malaria prevention for school-age children (IPT)	• CHW outreach scheduled around women's unpaid care workload and mobility constraints • Mixed-gender delivery teams, with gendered task allocation reflecting safety and logistics • Community-led monitoring identifying gendered barriers such as permission, safety, transport, and time poverty • Male engagement strategies linked to ANC attendance and malaria prevention	• Case-management SBC explicitly addressing women's autonomy, men's care-seeking norms, and shared household decision-making • Vector-control SBC challenging the framing of malaria prevention as women's responsibility • Community dialogues using male champions to model alternative norms • Expanded roles for women and youth in community-led monitoring, research, and advocacy • Measures to increase women's participation in technical, surveillance, and coordination structures
Early Results*	• Improved coverage and uptake among biologically vulnerable groups, particularly pregnant women and children under five, across both countries • More predictable access points for women and caregivers through ANC, EPI, and child-focused service delivery platforms • Earlier diagnosis and treatment observed where child and pregnancy-specific services were consistently available	• Stronger service reach and acceptability where implementation adapted to gendered realities (mobility, safety, caregiving roles, community trust) • Improved care-seeking, referral, and follow-up linked to adjusted outreach timing, mixed-gender teams • Community actors and CHWs identified and responded to gender barriers in real time	• In one of the countries, norm-focused SBC, CLM, and leadership initiatives contributed to increased male engagement, shared decision-making, and stronger voice for women and youth • Greater community ownership of malaria prevention and care when gender norms were explicitly challenged • Shifts in participation, dialogue, and responsibility in households and community structures

Table 25. Comparison of Gender-Targeted, Gender-Responsive, and Gender-Transformative Approaches Implemented in Global Fund–Supported Malaria Activities in Two Countries and their Perceived Results, as Identified through Document Review, Interviews, and Site Observations

*This table reflects approaches identified in Global Fund–supported malaria activities through this evaluation and does not exclude the possibility that similar or additional gender-related activities were supported by other partners.

	Gender-Targeted	Gender-Responsive	Gender-Transformative
Core Country in Southern and Eastern Africa	• PMTCT for pregnant and breastfeeding women • PrEP for AGYW; PrEP for men/male partners • KP-targeted services for MSM, FSW, and transgender people • Condoms and lubricants targeted to women and MSM/transgender populations • Audience-segmented SBC for pregnant women, AGYW, male partners • Recruitment of women and KP peers as providers/peer workers	• Differentiated HIV services adapted to women's time/ caregiving constraints • KP-friendly testing and counseling emphasizing confidentiality and safety, peer delivery • PrEP delivery adapted to schooling, mobility, stigma, and follow-up barriers • Integrated mobile and community outreach for MSM and transgender people (bundled HIV, SRH, psychosocial support) • Psychosocial support for MSM/ transgender people and survivors of violence • Community-led monitoring identifying gendered barriers (stigma, safety, provider behavior) and prompting service adaptations • Gender-sensitive supervision, mentorship, and team composition (e.g., gender-balanced outreach teams)	• Rights-based GBV response linked to HIV (paralegals; referral and accompaniment) • Community dialogue and norm change addressing HIV-related stigma and blame • Institutional norm change with law enforcement/ corrections/ public services • Peer leadership shaping service design and accountability (MSM/transgender people and other KPs) • Male norm-change programming addressing gender norms and control • Strengthening women's, AGYW, and gender-diverse leadership in coordination/decision-making
High Impact Africa 1 Country	• PMTCT for pregnant and breastfeeding women • PrEP for AGYW; PrEP for male partners of AGYW • KP-targeted services via peer drop-in centers and outreach (MSM and transgender people) • Condoms and lubricants (including gel lubricants) targeted to women and MSM/transgender people • Audience-segmented SBC (AGYW, pregnant women, male partners) • Recruitment of women and transgender peers within KP platforms	• KP-friendly services through peer drop-in centers (safe-space function; counseling; referral; commodities) • HIV testing integrated into ANC platforms as a reliable entry point for women • Couple testing promoted via ANC, implemented as a service adaptation with disclosure considerations • Differentiated service delivery and home-based antiretroviral therapy (ART) for women facing mobility or stigma constraints • Community-led monitoring documenting stigma, discrimination, and access barriers and feeding into program adjustments. • Routine sex-disaggregated data collection to monitor uptake gaps.	• Rights-based GBV response linked to HIV through community paralegals (case identification; referral and accompaniment) • Model couples/male engagement promoting shared decision-making, nonviolence, and partner support for HIV, PMTCT, and ART • AGYW empowerment work (life skills/agency components as documented, although uneven in depth/scale) • FGM norm-change initiatives (community watch committees; engagement of religious/ traditional leaders) • Strengthening women's and AGYW leadership and voice through platforms such as Voix Essentielles and peer networks
Early Results*	• Expanded reach to priority groups (pregnant/ breastfeeding women, AGYW, male partners, MSM/transgender people) • Increased access for highly stigmatized populations through targeted platforms	• Higher acceptability, trust, and continuity of engagement where services adapt to gendered barriers (safety, stigma, time constraints) • Peer-led models show sustained engagement among MSM and transgender people	• Improved linkage of survivors to HIV and protection services. • Attitudinal shifts and norms change • Increased male testing and engagement in prevention activities • Increased engagement of AGYW in prevention and care

Table 26. Comparison of Gender-Targeted, Gender-Responsive, and Gender-Transformative Approaches Implemented in Global Fund–Supported HIV Activities in Two Countries and their Perceived Results, as Identified through Document Review, Interviews, and Site Observations

*This table reflects approaches identified in Global Fund–supported HIV activities through this evaluation and does not exclude the possibility that similar or additional gender-related activities were supported by other partners.

	Gender-Targeted	Gender-Responsive	Gender-Transformative
Core Country in Southern and Eastern Africa	• TB screening and treatment prioritized for biologically vulnerable groups • Targeted TB case finding among key populations based on risk profiles	• Community-based TB screening adapted to women's caregiving roles and time constraints • Use of female community workers to increase acceptability and trust • Integrated TB–HIV services reducing stigma and improving continuity of care • Support mechanisms (e.g., follow-up, counseling) adapted to reduce loss to follow-up among women	• No explicit gender-transformative TB activities were identified
High Impact Africa 1 Country	• Targeted TB screening among key populations based on exposure and epidemiological risk • Focused outreach to vulnerable groups to improve diagnosis and treatment initiation	• Peer-supported TB outreach through community platforms to address stigma and fear of disclosure • Service delivery adapted to improve confidentiality and reduce access barriers	• No explicit gender-transformative TB activities were identified
High Impact Asia Country	• Targeted TB outreach for high-risk occupational groups (e.g., coal miners) • Mobile TB screening camps specifically for transgender populations to improve access • Outreach to women through LHWs	• Doorstep sputum collection and mobile screening to address women's mobility constraints and stigma • Female screeners and gender-matched providers to increase women's comfort and disclosure • Co-located TB–HIV services and bundled multi-disease camps to reduce stigma • Privacy adaptations (curtains, separate waiting or screening spaces)	• No explicit gender-transformative TB activities were identified
Early Results*	• Improved identification of TB cases among priority groups (men, PLHIV, transgender people) • Expanded reach to populations with elevated biological or occupational risk	• Reported improvements in service uptake and treatment initiation where access barriers were reduced • Greater acceptability of TB services when privacy, safety, and convenience were prioritized	• N/A

Table 27. Comparison of Gender-Targeted, Gender-Responsive, and Gender-Transformative Approaches Implemented in Global Fund–Supported TB Activities in Three Countries and their Perceived Results, as Identified through Document Review, Interviews, and Site Observations

*This table reflects approaches identified in Global Fund–supported TB activities through this evaluation and does not exclude the possibility that similar or additional gender-related activities were supported by other partners.

Integrated HIV/TB/Malaria Service Delivery and Gender Integration

In addition to stand-alone adaptations, integrated HIV/TB and multi-disease service delivery platforms demonstrate indications of success as gender-responsive approaches. Across country studies, stakeholders emphasized that integration of service delivery can function as a practical mechanism for addressing gendered barriers related to time poverty, transport costs, repeated disclosure, and stigma exposure. Evidence from Lesotho and Pakistan shows that integrated HIV/TB and multi-disease delivery platforms can create new entry points for gender-responsive programming when they reduce the cumulative burdens associated with care-seeking and expand access through trusted community and peer interfaces. In Lesotho, HIV/TB integration was well established at both facility and community levels. Routine TB symptom screening was observed within HIV testing, ART clinics, and mobile outreach, alongside systematic HIV testing for individuals diagnosed with TB. Integration reduced time, transport, disclosure, and stigma-related barriers, factors that disproportionately affect women, AGYW, and men with limited health-seeking patterns.

Integrated outreach platforms created safer entry points for men and boys and facilitated linkage of women to SRH rights and psychosocial services, illustrating how integration can support both gender-responsive and people-centered care. Pakistan illustrates a related but distinct form of integration. Community-based multiservice platforms, often delivered through peer networks and trusted intermediaries, bundled TB and HIV screening with counseling and psychosocial supports. Stakeholders described these integrated encounters as lowering transaction costs and minimizing exposure to stigma in facility settings, particularly for gender-diverse populations, women, and adolescents facing intersecting forms of discrimination. Integration was also perceived to reduce stigma through reframing TB/HIV screening as part of general health checks and through the involvement of gender-matched screeners and peer educators.

Taken together, these examples illustrate that integration can contribute to more gender-responsive programming when services reduce the cumulative costs of care-seeking, such as time, transport, disclosure, and stigma, when trusted community and peer interfaces enable safe access for women, men, adolescents, gender-diverse groups, and key populations, when SRH rights, GBV, psychosocial, or adherence supports are linked to integrated platforms, and when gender-specific risks are recognized and addressed across the care-seeking pathway.

Annex 6 presents selected country insights that illustrate how specific gender equality approaches function in practice and why they are perceived as effective by stakeholders. The examples highlight different entry points, community-led monitoring in malaria and AGYW programming in HIV, but underscore common mechanisms through which gender approaches appear to contribute to improved access, acceptability, and adaptation during implementation. The examples demonstrate how locally embedded actors, tailored delivery models, and attention to lived gendered realities shape implementation quality, and provide insight on the conditions required to sustain and deepen these approaches over time.

The evidence suggests that success in gender equality programming under Global Fund–supported HIV, TB, and malaria interventions is not driven by a single model, but by the interaction of design choices, delivery platforms, community ownership, and financing structures. Gender-targeted approaches appear to deliver reliable gains in access and coverage; gender-responsive approaches are capable of effectiveness in addressing lived barriers when communities are empowered to adapt implementation; and gender-transformative approaches show great potential for sustained change in the norms, power relations, and structural conditions that shape vulnerability, access, and continuity of care across the disease pathway.

At the same time, stakeholders emphasized that the depth, scale, and continuity of these approaches vary widely across disease areas and contexts. While many gender-responsive and gender-transformative interventions demonstrate strong indications of effectiveness at local or pilot levels, their broader institutionalization remains uneven. These variations point not to limitations in the approaches themselves, but to differences in enabling environments, implementation capacity, and the extent to which gender integration is embedded within routine program structures. These issues are examined further in Evaluation Question 10, which explores the conditions associated with sustaining gender integration over time.

Evaluation Question 10

What good practices, structure, and resources need to be in place to ensure that gender equality approaches will drive the sustained impact of HIV, TB, and malaria programs?

Overarching Finding 10: Gender equality approaches may be more likely to drive the sustained impact of HIV, TB, and malaria programs when they are supported by dedicated financing, strong partnerships, gender-responsive governance and data systems, and TA.

The recent major shifts in the global funding landscape and intensification of risks to human rights and gender equality work globally have highlighted the fragility of gender equality work, especially when it is not institutionalized. Across the country studies, fiscal pressure and funding reductions have affected community engagement, human rights, and gender-focused activities in different ways (see Evaluation Question 2), underscoring the importance of identifying approaches to support their sustained impact in HIV, TB, and malaria programs. Country studies and global stakeholder interviews indicate that gender equality approaches may be more likely to contribute to sustained HIV, TB, and malaria impact when they include dedicated funding, strong community-rooted partnerships, gender-responsive governance and data systems, and TA. However, across the various aspects of this evaluation, evidence of long-term sustainability is modest, as many elements perceived to be enablers of sustainability are still early in implementation or unevenly institutionalized. The strength of evidence for this finding is therefore **moderate**, because, while the evaluation draws on multiple sources of data, implementation remains recent, and several systems-level conditions identified by stakeholders have not yet been fully realized or implemented at scale.

The broader changes in the global funding landscape that occurred in 2025 have had implications beyond budget reductions. In Lesotho, stakeholders described how interruptions or uncertainty in financing have weakened multisectoral coordination related to GBV response and community engagement. When activities such as community dialogues, safe spaces, or referral coordination were paused, relationships between health services, justice actors, and social support structures may have been weakened, affecting survivor trust, disclosure, and referral completion. Women-led and community-based organizations in Lesotho reported heightened financial precarity, affecting their ability to retain trained paralegals and peer supporters and maintain outreach continuity. These dynamics suggest that sustainability risks extend beyond individual activities to institutional capacity and cross-sector linkages.

Across the country studies, the most consistently supported condition for sustained gender-responsive implementation is the presence of robust partnerships with feminist, women-led, key population, and AGYW organizations, and other gender-focused actors such as government ministries responsible for gender issues. In Côte d'Ivoire, Lesotho, and Tanzania, gender- and GBV-related activities were more fully implemented, better adapted over time, and more embedded in routine delivery when community-rooted CSOs played established roles in outreach, peer support, case management, and, in some cases, community-led monitoring. These organizations contributed contextual knowledge, trust with marginalized groups, and the ability to surface gendered barriers that formal systems are unable to capture. In settings where such actors were weak, marginal, or absent, gender-related activities tended to show limited implementation or scale. While these patterns do not establish causality, they do point to a strong association between the depth of partnership ecosystems and the quality and continuity of gender integration.

A second condition supported by country evidence is the role of dedicated and strategically positioned financing in enabling the implementation and continuity of gender-responsive and community-led components. Across the country studies, stakeholders repeatedly noted that gender and GBV-related activities were more likely to be implemented when they were explicitly included and budgeted within grants, and that gender-transformative and community-led activities were vulnerable to delays, reductions in scope, or deprioritization when resources were constrained. In several contexts, catalytic or matching fund mechanisms, particularly under initiatives such as BDB, provided additional leverage during reprioritization discussions, strengthening the case for retaining human rights and gender-related investments. The evaluation cannot determine whether such protection guarantees long-term sustainability, but the observed pattern suggests that dedicated financing plays an important buffering role during periods of fiscal pressure.

Implementation quality also appears higher where gender technical capacity and assistance are present. Grants supported by SIs or gender-specialized partners were often described as better able to translate gender-responsive designs into operational practice, troubleshoot implementation challenges, and adapt interventions as contexts evolved. In addition, Global Fund Secretariat advisors strengthen programs primarily through specialist technical support including advising on Funding Requests, supporting gender analysis, participating in selected country missions, and developing Secretariat tools and requirements (e.g., GEM, gender KPIs, technical guidance) that shape how gender integration is assessed and operationalized in grants.

Beyond these conditions, stakeholders across various categories articulated a set of system-level requirements that they view as critical for sustaining gender equality approaches but that remain largely aspirational in the current evidence base. These include institutionalized gender governance structures, such as resourced gender focal points with clear mandates within ministries of health, principal recipients, and CCMs; gender-responsive data and CLM systems that capture GBV, norms, decision-making, and service safety; and longer-term, dedicated and stable financing for gender equality approaches, particularly those addressing structural drivers such as GBV, stigma, and gender norms. Country stakeholders noted that gender-transformative interventions are critical for eradicating HIV, TB, and malaria, and that they require sustained engagement over time and are unlikely to produce measurable impact if treated as short-term pilots.

While interviewees emphasized the importance of these elements, the evaluation found few concrete examples where they were fully operational or demonstrably linked to sustainability. Stakeholders frequently identified resourced gender focal persons as important for institutionalizing gender integration. However, in the country studies, gender focal points within Ministries of Health, National Disease Programs, and implementing partners are largely absent (although some PRs were able to maintain gender focal persons with other funds) and the evaluation did not identify concrete examples where the presence of such roles was demonstrably linked to sustained HIV, TB, and malaria outcomes. Country data show limited institutionalization of gender-relevant data systems beyond sex-disaggregation. Furthermore, the evaluation did not identify examples of long-term funding for transformative work within the Global Fund portfolio. These elements should therefore be treated as stakeholder-identified priorities rather than validated determinants.

At the Secretariat level, several institutional processes and levers were identified as potentially important for ensuring that gender equality approaches translate into sustained HIV, TB, and malaria impact. These include internal accountability tools such as the GEM and gender-related KPIs, disease-specific guidance on priority gender investments, and the integration of gender considerations into program reviews and risk assessments, not only Funding Requests. With respect to the gender-related KPIs, while they may not directly influence country-level programming, Secretariat stakeholders emphasized that they ensure that gender is at least considered in the performance assessment of the grant, something that had not been systematically done prior to GC7. It was noted that PRs would need to implement corrective actions in the case of underperformance.

Stakeholders also emphasized the importance of dedicated and stable financing that allows multiyear investment in norm change, capacity building, and community systems, as well as strategic partnerships beyond the health sector, including with ministries that focus on gender. Secretariat stakeholders and technical partners noted that the Global Fund's comparative advantage lies in health system response, but that many structural drivers of gender inequality affecting HIV, TB, and malaria outcomes fall outside of the health sector and require collaboration with justice, education, and social protection actors. Country evidence supports the value of cross-sectoral collaboration. In Côte d'Ivoire, respondents described collaboration with the Ministry of Women, Family and Children in the implementation of GBV response and FGM norm-change initiatives, including coordination around referral pathways and community engagement processes. These collaborations enabled linkages between health services and protection structures and were viewed as important for addressing barriers to disclosure, safety, and service continuity.

Findings from Lesotho provide a clearer illustration of how cross-sector collaboration strengthens HIV, TB, and malaria programming. Global Fund–supported HIV and TB implementation was described as operating in coordination with justice actors, education authorities, community governance structures, and, in some cases, social protection mechanisms. Civil society organizations providing paralegal services worked closely with police and magistrates' courts to support survivors of violence engaged in HIV care. Stakeholders noted that without legal protection and follow-up, GBV screening within health services would have limited impact on retention and adherence. Similarly,

collaboration with schools and education authorities enabled comprehensive sexuality education and referral pathways for adolescents, addressing gender norms and risk patterns upstream of clinical service delivery. Engagement with community leaders and councils was described as critical, especially in rural areas, for reducing stigma, improving acceptability of services, and mitigating backlash against women and young people seeking care. Where limited linkages with social protection or community development structures existed, respondents reported improved retention among economically vulnerable women. Respondents also noted that such collaboration is often relationship-based rather than formally institutionalized within grant design, budgeting, or monitoring frameworks. As a result, its sustainability depends heavily on local coordination capacity and complementary funding.

Country stakeholders also identified a supportive national enabling environment as an important enabling factor for sustaining gender equality approaches in HIV, TB, and malaria programs. In Lesotho, for example, the National Strategic Plan (NSP) for HIV, the AGYW strategy, the National GBV Strategy, the Domestic Violence Act, and the Gender and Development Policy collectively provide a legal and policy framework that enables gender-responsive programming supported by the Global Fund and facilitates coordination between health, justice, and social sectors. In Tanzania, the National Malaria Strategic Plan (2021–2025) references gender responsiveness within its strategic objectives, and broader national gender policies provide a general framework for mainstreaming. In Côte d'Ivoire, national HIV strategies and GBV frameworks similarly create policy space for gender and human rights integration. These types of gender-responsive national strategies were viewed as enabling Global Fund investments to scale gender work through national systems, while restrictive legal and political environments tend to constrain gender approaches. While these enabling factors align with the patterns observed in the country data, their contribution to sustained impact remains to be demonstrated.

Conclusions

The following conclusions synthesize findings across the evaluation and highlight the key factors shaping the integration of gender equality approaches in Global Fund–supported HIV, TB, malaria, and RSSH programs. Overall, the findings broadly validate the pathways articulated in the Global Fund's Gender ToC, particularly the importance of building knowledge, capacity, and political will among partners to mainstream gender equality (Outcome 1); strengthening structures and processes that incentivize gender equality in disease responses (Outcome 2); prioritizing catalytic programming on gender equality (Outcome 3); and reinforcing partnerships and coordination across community, national, and international actors (Outcome 4). Partnerships, accountability mechanisms, and SIs emerge as key drivers of integration, aligning with the ToC's assumptions. At the same time, the evaluation identifies several areas where the ToC does not fully articulate linkages between the integration of gender equality approaches in HIV, TB, and malaria programs and sustained disease outcomes including the role of gender-relevant data beyond basic sex-disaggregation in informing Funding Requests, grant design and implementation, how gender commitments in grant design are translated into funded activities, how design-stage review tools such as the GEM are linked to implementation accountability, and the ways that engagement of women-led and community-based organizations in TB, malaria, and RSSH contexts contribute to improved disease outcomes.

Objective 1: To assess the extent to which gender equality approaches are being integrated into HIV, TB, and malaria disease programs supported by the Global Fund.

Conclusion 1. The GC7 country-components demonstrate substantial progress in integrating gender equality approaches in HIV, TB, and malaria programs, where relevant to epidemiological context, at the design stage. For this progress to contribute lasting improvements in disease outcomes, the integration of gender equality approaches must extend consistently into budgeting, implementation, and monitoring processes across disease programs.

Across the GC7 country-components reviewed, gender considerations are more systematically incorporated into Funding Requests than in earlier grant cycles. This is supported by strengthened review tools such as the GEM, gender assessments, Global Fund technical guidance and SI support, and inclusive country dialogue processes (Findings 1, 3, and 5). The depth, methodological rigor, and recency of gender assessments to inform Funding Requests vary, and in many cases do not systematically examine gender barriers across the full disease acquisition and care pathway (Findings 1, 5, and 6). The GEM has elevated the visibility of gender equality approaches in HIV, TB, and malaria programs during Funding Request review by the TRP. However, it was not designed to include structured follow-up mechanisms, and it has limited country-level visibility. This presents an opportunity to enhance its influence on program quality and implementation by positioning it as a lever for accountability across the grant cycle.

There is variation within and across disease areas in the degree to which gender barriers are identified, the types of gender equality approaches included, and implementation fidelity to program design (Findings 1, 2, and 6). Some degree of variation across disease programs is expected and appropriate, given differences in disease patterns, delivery platforms, historical program contexts, and country disease epidemiology. HIV programs are more likely to draw on gender assessments during design and to meaningfully engage women's and gender-diverse organizations. They also are more likely to conceptualize gender as a driver of disease risk and service access.

As a result, HIV country components tend to demonstrate more extensive use of gender-targeted and gender-responsive approaches, as well as gender-transformative components, although these appear in fewer grants and are typically limited in scope where included (Findings 1 and 6). In contrast, TB and malaria country components primarily include gender-targeted approaches, with some examples of gender-responsive approaches but limited inclusion of approaches that address norms, power relations, and structural barriers (Findings 1, 5, and 6). While RSSH provides a critical entry point for institutionalizing gender-responsive care, conclusions related to RSSH are based on a limited sample of country components and relatively modest evidence. Within this sample, the evaluation finds limited attention in Funding Requests to gendered dimensions of health systems in practice, including the composition and safety of the health workforce, gendered access to quality care, facility-level discrimination, and the routine integration of GBV or rights considerations into service delivery and monitoring systems. Overall, the uneven gender integration in GC7 reflects both disease-specific differentiation and missed opportunities to embed gender-responsive approaches and to support potentially transformative approaches where they are programmatically relevant and feasible.

Objective 2: To identify internal and external enabling and hindering factors, and their causes and effects, for integrating gender equality approaches into Global Fund–supported disease programs.

Conclusion 2. The integration of gender equality approaches in HIV, TB, and malaria programs in response to country epidemiology is strongest when design, financing, partnerships, and data systems are mutually reinforcing.

Successful integration of gender equality approaches in HIV, TB, and malaria programs requires alignment across four areas: (1) design informed by recent, high-quality gender analyses; (2) sufficient and traceable financing to carry out the gender approaches required; (3) meaningful and institutionalized partnerships with women-led, gender-diverse, and gender-focused organizations; and (4) gender-relevant data that is actively used to guide adaptation (Findings 1, 2, and 6–10). When these elements align, as in the examples of HIV programs in Côte d'Ivoire or Lesotho, gender-responsive and -transformative interventions are implemented with greater fidelity to program design, and stakeholders report clearer indications of success (Findings 6–9). Where this alignment is weak, gender integration in HIV, TB, and malaria programs is more fragmented. For example, in the TB and malaria programs examined, gender considerations are present in Funding Requests and grant design but limited in implementation due to resource gaps, weak engagement with gender-specialized partners, or limited use of gender-related data (Findings 6–9). Low visibility of gender integration in these programs can also make progress in addressing gender barriers difficult to measure. For example, across disease programs, Funding Requests do not always articulate gender barriers to access and approaches to address these barriers, grant budgets do not include gender tagging or dedicated budget lines and PUDRs and grant review processes do not systematically include attention to gender barriers. External conditions, including funding volatility, shifting donor landscapes, and restrictive legal or sociopolitical environments, also shape the extent to which gender equality approaches can be sustained in HIV, TB, and malaria national programs (Findings 6 and 10).

Objective 3: To identify key lessons and successes that would allow the Global Fund partnership to reinforce, advance, and sustain integration of gender equality approaches in national health programs.

Conclusion 3. Gender-responsive service adaptations embedded in routine HIV, TB, and malaria service delivery platforms, especially when involving community actors, offer the most consistent short- to medium-term returns for achieving disease outcomes, and represent a pragmatic and scalable strategy for strengthening access.

Across contexts, gender-responsive approaches integrated into routine delivery platforms, such as ANC, CHW outreach, peer-led services, and community-based models, and implemented by CSOs, CHWs, peers, and community actors with close proximity to everyday social realities, demonstrate consistent indications of improved access, acceptability, trust, and continuity of care for women, AGYW, and key populations (Findings 6, 7, and 9). These approaches focus on adapting service delivery to address gender barriers to access related to time, mobility, safety, stigma, and household decision-making. Community actors are particularly effective at identifying gender barriers across the care pathway and translating these insights into practical delivery adaptations (Findings 5, 6, and 7). These actors are most effective when they are not only engaged in service delivery, but are also able to influence national and subnational decision-making processes on targeting, outreach strategies, service adaptations, referral pathways, supervision, and resource allocation.

Integrated HIV/TB/malaria service delivery in primary healthcare provides expanded entry points for addressing gender barriers to access. These integrated platforms can reduce cumulative care-seeking burdens, stigma exposure, and disclosure risks, particularly for women, AGYW, and key populations (Finding 9), but may also obscure barriers that are disease-specific (e.g., GBV within HIV). Guidance, tools, and partnerships focused on reducing barriers to access within integrated service delivery platforms have not yet kept pace with the increased emphasis for disease programs to shift toward more integration (Finding 6).

Conclusion 4. Gender-targeted approaches are essential for expanding reach and coverage, but achieving sustained and equitable HIV, TB, and malaria disease outcomes depends on complementing these approaches with interventions that address the context-specific normative, relational, and structural barriers affecting disease risk and vulnerability and access, retention, and continuity of care.

Sustained disease control depends not only on reaching priority populations relevant for a country's epidemiological context, but also on maintaining retention, safety, and continuity of care across the treatment and prevention pathway. Across disease areas, gender-targeted approaches have been widely implemented and have contributed meaningfully to expanding access and improving uptake of services for women, girls, AGYW, gender-diverse populations, and key populations (Findings 1, 6, and 9). However, because gender-targeted approaches in HIV, TB, and malaria programs primarily focus on who is reached, they do not directly address the structural, relational, or normative drivers of gender inequality that shape exposure, access, or continuity of care (Findings 5 and 9). They are not designed to address intra-household decision-making dynamics, mobility and permission constraints, GBV and IPV, stigma, discrimination, or unequal power relations, factors that disproportionately

affect women, AGYW, gender-diverse groups, and key populations across the care pathway (Findings 5, 6, and 8). While gender-targeted approaches are necessary and programmatically valuable, these approaches may be insufficient on their own to ensure durable and equitable outcomes across the care pathway (Findings 9 and 10).

Conclusion 5. Gender-transformative approaches show context-specific potential for longer-term impact on disease outcomes, particularly in HIV programs, but available evidence in TB and malaria (beyond ANC) remains limited. These approaches require sufficient financial resources, dedicated capacity and partnerships, and high-quality implementation over longer timeframes.

Sustained reductions in HIV, TB, and malaria incidence depend, in part, on addressing structural and normative drivers that shape exposure, disclosure, retention, and safety across the care pathway. The evaluation observed promising examples of gender-transformative approaches in contexts where such barriers are central to epidemic dynamics and where interventions are clearly articulated, adequately resourced, and delivered through experienced, rights-based partnerships (Findings 7, 9, and 10). These examples are most evident in HIV programs and to a lesser extent in malaria programs. Evidence in TB remains inconclusive due to limited implementation of gender-transformative approaches in the programs reviewed, despite the presence of gender-related barriers linked to norms and decision-making.

However, gender-transformative interventions in HIV, TB, and malaria programs can be more resource-intensive and institutionally demanding than other gender approaches. Successful interventions are typically multilayered, and combine community dialogue and norms change work with survivor-centered GBV response, legal empowerment, psychosocial support, stigma and nondiscrimination interventions, male engagement, and household- or couples-based approaches, and are implemented by experienced women-led, feminist, AGYW, and key population organizations capable of navigating sensitive social dynamics and safeguarding participants (Findings 7 and 10). These approaches require skilled facilitation, contextual adaptation, and sustained accompaniment to build trust and avoid reinforcing gender norms or triggering backlash. They require specialized technical expertise, cross-sector collaboration, sustained financing, and careful implementation to avoid unintended consequences (Findings 6, 9, and 10). The absence of sufficient funding, technical capacity, or experienced partners may limit effectiveness and undermine intended outcomes, and in the worst case, introduce additional risks or unintended consequences. Across the portfolio, such conditions are unevenly present, and gender-transformative approaches remain vulnerable to fiscal volatility and are impeded by short funding cycles.

Conclusion 6. The selected SIs examined in this evaluation demonstrated strong contribution to driving the integration of gender equality approaches in HIV, TB, and malaria programs, and their contribution is strongest when learning, evidence, and practices generated through these initiatives are actively taken up within disease programs.

The CE-SI and BDB have strengthened the availability of gender- and rights-focused evidence through gender assessments and community-led monitoring (Findings 4 and 8). In select contexts, such evidence has directly informed Funding Requests and grant design

and program adaptation, as illustrated by the transgender population assessment conducted in one of the countries, which shaped GC7 HIV programming and was subsequently incorporated into national analytical processes (Finding 8). SIs have also reinforced partnership ecosystems. CE-SI has strengthened community preparedness and engagement in dialogue and oversight processes, while BDB has supported structured collaboration across health, justice, and civil society actors. The Gender Equality Fund and Her Voice Fund have enabled grassroots women-led and AGYW organizations to participate more substantively in planning, advocacy, and reprioritization processes, in some cases influencing allocation and implementation decisions (Findings 4 and 7). In addition, BDB-supported investments have provided continuity for GBV response and rights-based programming in contexts facing restrictive legal environments or fiscal pressure, suggesting that SIs can reinforce elements of the enabling environment for gender integration (Findings 4 and 10). These examples point to the value of strengthening mechanisms that connect SI learning, evidence, and community leadership (such as the existing Learning Hubs) more consistently to disease program design, implementation, and monitoring.

The evaluation suggests that the contribution of SIs is shaped by ecosystem conditions. In restrictive or politically sensitive contexts, SIs may provide protective space for community engagement and rights-based programming that would otherwise be hindered. In more enabling environments, they may be better positioned to generate scalable models and influence broader programs. Given their focused scale, the relative return on investment appears highest where SIs are deployed either to address clearly identified structural bottlenecks affecting HIV, TB, and malaria outcomes or to support ongoing institutional efforts to strengthen gender integration. In addition, norm-change and gender-transformative pilots can yield benefits in specific contexts, and SIs provide an important platform for developing and testing innovative approaches, particularly in areas where the evidence base is still emerging, such as TB.

Recommendations

The recommendations presented in this section build directly on the evaluation's findings and conclusions and are intended to support the Global Fund partnership in strengthening the quality, consistency, and sustainability of gender equality integration across HIV, TB, malaria, and RSSH programs. They focus on actionable levers within the Global Fund's influence, while recognizing the diversity of national contexts and implementation capacities. Draft recommendations were presented and discussed in a Secretariat stakeholder workshop in Geneva, and subsequently refined based on feedback from participants. In line with ELO guidance, recommendations have been classified as either critical (to be addressed by the Global Fund in the short term), important (to be addressed by the Global Fund in future grant cycles), or for partners (implementing programs supported by Global Fund investments).[66]

Critical Recommendations

Recommendation 1: Continue to support effective gender-targeted programming, in line with country epidemiology, and strengthen implementation of gender-responsive approaches in HIV, TB, and malaria programs by reinforcing routine and integrated delivery platforms. When resources are constrained, prioritize high-impact barrier-removal interventions.

Critical

To maximize implementation quality and epidemic impact in GC8 and beyond:

- To action this recommendation, there needs to be **clear guidance and technical support from the Global Fund and technical partners** at key points in the grant cycle:
  - **During Funding Request and grant-making stages**, to ensure that gender-responsive service adaptations include clear activities, budgets, and performance indicators.
  - **During the early implementation phase of the grant,** when detailed activity design and operational planning often occur.
- **Sustain gender-targeted interventions that expand coverage among women, AGYW, key populations, and other affected groups,** particularly in TB and malaria programs where targeted approaches are a key mechanism for improving access to services and early case detection.
- **Where relevant for the epidemiological context, prioritize gender-responsive service adaptations embedded within routine and integrated/multi-disease delivery platforms**, including primary health care, ANC, CHW systems, peer networks, and community outreach, to reduce access, mobility, stigma, and safety barriers (e.g., integrated visits, flexible hours, decentralized delivery, enhanced privacy, community-led accompaniment).

[66] Formulating Recommendations in Global Fund Independent Evaluations Guidance for Evaluators, ELO, 2025. Critical recommendations address areas that evaluators feel are essential and necessary for the Global Fund Secretariat to address to deliver the Strategy successfully. These recommendations emphasize the urgency and the potential impact on achieving Strategy objectives by not addressing the recommendations. Important recommendations focus on areas where changes made by the Global Fund Strategy will very likely increase the impact of investments. While they may focus on near-term changes, they are more likely to be addressed by actions introduced over a longer time period (1–3 years). Partner recommendations articulate changes required that are beyond the Secretariat's span of control but that are needed to support or enable Global Fund investments to achieve greater impact.

- Under constrained resources, **prioritize high-impact barrier-removal interventions**, including:
  - Service delivery adaptations that reduce access barriers, such as flexible clinic hours, decentralized delivery, integrated visits, and enhanced privacy and confidentiality.
  - Stigma and discrimination reduction initiatives.
  - Interventions addressing mobility and permission constraints, caregiving burdens, and household decision-making dynamics.
  - Strengthened referral and support systems for GBV/IPV survivors, including survivor-centered response services and referral pathways within health systems.
  - Community-led monitoring to identify gender-related barriers and inform adaptive service delivery improvements during implementation.

Recommendation 2: As relevant to the context, continue to support coordinated financing and partnership efforts that implement gender-transformative interventions that address structural drivers of HIV vulnerability and service access. Continue to learn through SIs and with partners on how to contribute to addressing these barriers in malaria and TB programs.

Critical

- Encourage **coordinated financing and partnerships with governments, community actors, and other donors** to support gender-transformative programming that addresses structural drivers of HIV vulnerability and service access.
- **Prioritize high-impact, multilayered gender-transformative interventions relevant to the epidemiological context that can meet minimum quality and duration standards**, including:
  - Community dialogue and norms-change initiatives.
  - Targeted male engagement addressing gender norms and masculinities.
  - Couples-based approaches addressing decision-making and disclosure dynamics.
  - Rights-based GBV response and prevention approaches.
  - AGYW empowerment and leadership initiatives that strengthen agency, economic autonomy, and participation in decision-making spaces.
- Given the limited evidence identified in this evaluation for gender-transformative programming in **malaria and tuberculosis country-components, prioritize strengthening gender-responsive approaches** in these programs while encouraging learning and evidence generation on structural interventions through SIs and with technical partners where relevant.

Recommendation 3: Strengthen and reinforce the gender components of the CE-SI and BDB, the GEF, and Her Voice Fund and enhance relationships and learning exchange with disease programs to enable adoption of effective gender interventions and gradual institutionalization of core functions where feasible.

Critical

To build on their progress thus far and to maximize their strategic value and impact in GC8 and beyond:

- **Under constrained resources, prioritize SI areas where the evidence base remains limited or the catalytic value of investment is high**, particularly in TB, malaria, and RSSH portfolios where gender integration is less mature, including:
  - Gender-barrier data generation and interpretation (e.g., stigma, GBV, mobility, disclosure, decision-making dynamics).
  - Strengthening feminist and rights-based community capacity, community-led monitoring, and structured partnership mechanisms.
  - Piloting and adapting emerging approaches, including in integrated HIV/TB/malaria delivery platforms where gender-responsive implementation models are still evolving.
  - Early-stage TA during design and implementation.
- **Strengthen structured uptake pathways between SI implementers, disease programs** (PRs, SRs, CCMs, TWGs) and broader national and subnational fora to ensure SI-generated assessments, data, and pilots inform grant design, budgeting, implementation, and oversight. This could include:
  - Strengthening existing learning mechanisms (e.g., Learning Hubs).
  - Systematic orientation of country stakeholders to SI objectives and outputs.
  - Providing clearer expectations regarding how SI-supported learning should inform NSPs and Funding Requests.
  - Creating structured opportunities for SI implementers and disease programs to jointly review evidence and identify scalable applications.

Recommendation 4: Require Funding Requests to be informed by high-quality, recent gender assessments (<5 years old) that systematically examine gender barriers along the disease acquisition and care pathway. These assessments could be disease or RSSH component-specific, or integrated as per the Funding Request but must examine gender barriers to services for all diseases covered in the Funding Request and meet minimum quality standards.

Critical

To strengthen disease impact in GC8 and beyond:

- **Require all Funding Requests to be informed by gender assessments conducted within the last 5 years,** with updates required where evidence is outdated or methodologically weak.
- **Ensure assessments examine gender barriers across the full acquisition-to-care pathway** (exposure, diagnosis, initiation, retention, safety), for women, men, boys, girls, and gender-diverse populations.
- **Apply differentiated depth of assessment by portfolio type:**

- High Impact/Core: Comprehensive disease- and/or RSSH-specific assessments.
- Focused: Rapid assessments, targeted pathway analyses, or structured syntheses of existing evidence.
- Barrier analysis should be used to inform transition planning for transitioning disease components.

- **Strengthen and formalize minimum quality standards for assessments in all disease areas and RSSH in collaboration with technical partners, including expectations regarding:**
  - Methodological rigor (e.g., mixed methods, triangulation, community-led evidence).
  - Scope (barriers along the disease acquisition and care pathway).
  - Representativeness (variation across populations, geographies, service platforms).
  - Applicability (clear implications for service delivery, budgeting, partnerships, and monitoring and evaluation).
  - Collaboration with local gender actors.
- **To facilitate the use of gender assessments in informing Funding Requests, provide practical guidance on translating assessment findings into intervention packages, costed budgets, and indicators.**

Recommendation 5: Optimize the systematic use of the GEM to enhance accountability, strengthen portfolio-level learning, and improve the integration of gender equality considerations at key points in the grant life cycle.

Critical

To strengthen the operational influence and ongoing utility of the GEM:

- **Maintain the current GEM methodology for GC8** to enable comparability with GC7 scores.
- **Embed GEM results into structured follow-up between the TRP, the Secretariat, and applicant countries during TRP review and grant-making,** ensuring that low scores trigger clarification, mitigation measures, or targeted technical support.
- **Systematically communicate GEM findings to applicants using standardized feedback templates,** so that countries can address identified gender gaps and strengthen gender integration in subsequent Funding Requests.
- **Institutionalize the use of GEM findings within key internal decision points (e.g., GAC deliberations, portfolio optimization and prioritization discussions)**, so identified gender barriers and gaps inform funding trade-offs.
- **Use aggregated GEM data to guide differentiated TA and disease-specific guidance**, particularly for TB, malaria, and RSSH, where gender integration is weaker.
- **Following the GC8 Funding Request application period, consider a post-cycle methodological review of GEM,** including potential differentiated scoring by disease area or sensitivity to transformative approaches, while maintaining comparability across cycles.

Important Recommendations

Recommendation 6: Ensure that gender interventions considered during design of HIV, TB, and malaria grants to improve disease outcomes are translated into costed and trackable investments in grants by establishing dedicated and clearly labeled budget lines that include gender-responsive and gender-transformative activities.

Important

To strengthen coherence between design commitments and financing decisions in GC8 and beyond:

- **Ensure that stand-alone gender-responsive and -transformative activities identified during design as being critical to achieving disease outcomes are explicitly costed and clearly labeled within grant budgets,** improving visibility during grant-making and implementation.
- **Improve traceability of gender-related investments embedded within broader modules** (e.g., ANC/IPTp, CHW outreach, community systems strengthening) through practical labeling conventions within existing financial systems, without introducing parallel tracking mechanisms.

Recommendation 7: Adapt Global Fund levers, where relevant, to establish a coherent reporting and learning throughline across the grant cycle stages to improve visibility and understanding of efforts and progress on the integration of gender approaches in Global Fund investments.

Important

To address limited continuity of gender priorities across design, financing, and performance review processes in GC8 and beyond:

- **Require explicit documentation in Funding Requests of the gender-related barriers affecting disease prevention, transmission, and care aligned to epidemiological context, and description of corresponding programmatic responses,** to strengthen coherence between gender analyses, design choices, and implementation plans, using existing Funding Request templates rather than introducing new reporting tools.
- **Differentiate approaches by disease area,** including:
  - Strengthen guidance for the use of existing gender- and barrier-related indicators in HIV grants.
  - Together with technical partners, support development or adaptation of feasible gender-relevant indicators in TB, malaria, and RSSH, aligned with the GC8 modular framework along with clear technical guidance.
  - Support countries to align indicator selection with identified gender priorities while managing operational and reporting burden risks, and provide targeted capacity-building for PRs, SRs, and implementers to generate and use gender-related data effectively.
- **Encourage consideration of available gender-related evidence, including qualitative or community-generated information, within existing PUDR and grant review processes.**

Recommendations for Countries and Implementing Partners

Recommendation 8: Strengthen the routine collection and use of sex-disaggregated and gender-relevant data across all disease areas, especially malaria, TB, and RSSH, to inform program design, implementation, and course correction.

Countries and Implementing Partners

To strengthen adaptive management and program responsiveness across disease areas:

- **Institutionalize systematic processes for collecting, reviewing, and applying sex-disaggregated and gender-relevant data** on service uptake, case detection, adherence, and prevention coverage within HIV, TB, malaria, and RSSH programs.
- **Establish simple, structured processes for interpreting gender differences in service outcomes,** including engagement of CHWs, community actors, and local gender-focused organizations who observe mobility, permission, stigma, safety, and caregiving constraints.
- **Integrate qualitative and community-generated data into routine program management and reviews,** including through presentation of community-led monitoring findings in performance meetings, and incorporation of qualitative data into PUDR narrative reporting.
- **Use both quantitative and qualitative evidence** to identify gender-related implementation gaps and inform timely adjustments in service delivery, outreach, and resource allocation.
- **Provide practical guidance and targeted analytic support and capacity-building where needed,** enabling PRs, SRs, and implementers to generate, interpret, and apply gender-relevant data effectively.
- **Use performance discussions and portfolio reviews** as opportunities to present and apply gender-related evidence for adaptive management.

Recommendation 9: Expand and formalize partnerships with women-led, feminist, key population, and community-based organizations, particularly in TB, malaria, and RSSH, to strengthen the delivery of gender-responsive interventions to improve disease outcomes.

Countries and Implementing Partners

To enhance the reach, relevance, and quality of gender-responsive programming:

- **Proactively identify, expand, and formalize partnerships with women-led, AGYW, youth, and key population organizations at national and subnational levels,** particularly in TB, malaria, and RSSH programs where such partnerships remain less institutionalized than in HIV programs.
- **Establish equitable contracting and budgeting arrangements,** enabling smaller and community-based organizations to assume meaningful roles in service delivery, outreach, referral, and monitoring.
- **Formalize partnership functions aligned with epidemiological priorities,** including gender-sensitive outreach, GBV referral pathways, stigma reduction, rights-based accompaniment, and community-led monitoring, where relevant.
- **Embed structured two-way communication mechanisms within partnership agreements,** ensuring that community-generated evidence informs implementation decisions and that partners receive feedback on how their input is used.