HIV Prevention Evaluation

Final Report

GF/ ELO/2026/02/01
7 October 2026
Geneva, Switzerland

Final Evaluation Report

Evaluation of HIV Prevention

Authors: Sam McPherson; Farai Matsika; Marc Tully; Maria Cecilia Millado; Jacklyne Ashubwe; Anila Shafa

Date: 10 October 2026

Legal Disclaimer for IEP Commentary and Final Report

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

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

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

The user is allowed to copy and redistribute this publication in any medium or format, as well as adapt and transform this work, without explicit permission, provided that the content is accompanied by an acknowledgement that The Global Fund to Fight AIDS, Tuberculosis and Malaria is the source and that it is clearly indicated if changes were made to the original content. You may, however, not use the work for commercial purposes. To view a copy of this license, please visit: https://creativecommons.org/licenses/by-nc/4.0/ .

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

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

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

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

Acknowledgments

The evaluation team is grateful to all stakeholders who generously gave their time to support the evaluation.

Disclaimer

The views expressed in this report are those of the evaluators. They do not necessarily represent those of the funder (the Global Fund), or any individuals and organizations referred to in the report.

Table of Contents

List of figures ..... **vii**

List of tables ..... **vii**

Acronyms and abbreviations ..... **viii**

Executive summary ..... **x**

A: Background x

B: Methods xi

C: Findings xi

The emerging narrative xiv

D: Recommendations xv

Critical recommendations for the Global Fund Secretariat xv

Important recommendations for the Global Fund Secretariat xvi

Recommendation to partners xvi

1 Introduction and background **1**

1.1 Introduction 1

1.2 Background 2

2 Evaluation objectives and evaluation questions **4**

3 Methodology **4**

3.1 Methods and tools 4

3.2 Data collection and stakeholders engagement 8

3.3 Limitations, challenges, and mitigation strategies 10

3.4 Strength of evidence 12

4 Findings **13**

Objective 1 13

Objective 2 40

Objective 3 67

5 Conclusions **75**

5.1 Conclusions by objective 75

5.2 The emerging narrative 77

6 Recommendations **79**

Critical recommendations for the Global Fund Secretariat 79

Important recommendations for the Global Fund Secretariat 79

Recommendation to partners 80

Annexes **81**

1. Evaluation framework 81
2. Dimensions scoring matrix 81
3. EQs response matrix 81
4. Specific/detailed evidence 81
5. List of stakeholders consulted (titles not names) 81
6. List of documents reviewed 81
7. POMT toolkit 81

Endnotes 2

List of figures

Figure 1: Three evaluation objectives and associated EQs xi
Figure 2: Summary of overall narrative from evaluation xv
Figure 3: Three evaluation objectives and associated EQs 4
Figure 4: Overall OGA approach 8
Figure 5: Kenya: Percentage of FSW reached with HIV prevention programs 51
Figure 6: Kenya: Percentage of MSM reached with HIV prevention programs 52
Figure 7: Nigeria: Percentage of FSW reached with HIV prevention programs 52
Figure 8: Nigeria: Percentage of PWIDs reached with HIV prevention programs 52
Figure 9: Philippines: Percentage of transgender people reached with HIV prevention programs 53
Figure 10: Philippines: Percentage of MSM reached with HIV prevention programs 53
Figure 11: Percentage change in total HIV allocations and HIV prevention budgets between GC6 and GC7 55
Figure 12: HIV prevention budgets (absolute numbers) under GC6 and GC7 55
Figure 13: Mixed progress of POMT implementation in sampled countries 70
Figure 14: Summary of overall narrative from evaluation 78

List of tables

Table 1: Summary of headline findings across objectives and 9 EQs xi
Table 2: Summary of methods and tools for Objective 1 5
Table 3: Summary of methods and tools for Objective 2 6
Table 4: Summary of methods and tools for Objective 3 7
Table 5: KIIs and FGDs 10
Table 6: Strength of evidence framework for evaluation findings 12
Table 7: Key challenges identified across the portfolio 29
Table 8: Defined scale target (national) 35

Acronyms and abbreviations

AGYW	Adolescent girls and young women
AI	Artificial intelligence
BBS-lite	Bio-behavioral survey—lite version
CAB-LA	Long-acting injectable Cabotegravir
CCM	Country coordinating mechanism
CLM	Community-led monitoring
CSE	Comprehensive sexuality education
CSO/CBO	Civil society organization/Community based organization
DHIS2	District Health Information Software 2
DIC	Drop-in center
ELO	Evaluation and Learning Office
EQ	Evaluation question
FGD	Focus group discussion
FSW	Female sex worker
GBV	Gender-based violence
GPC	Global Prevention Coalition
HMIS	Health Management Information System
HRG	Human rights and gender
IBBS / BBS	Integrated Bio-Behavioral Surveillance (Survey)/ Bio-Behavioral Survey
IEP	Independent Evaluation Panel
KII	Key informant interview
KP	Key population
M&E	Monitoring and evaluation
MEL	Monitoring, evaluation, and learning
MENA	Middle East and North Africa
MoH	Ministry of Health
MSM	Men who have sex with men
NGO	Non-governmental organization
NSP	National Strategic Plan (HIV)
OGA	Optimal grants agent
OST	Opioid substitution therapy
PAAR	Prioritized above allocation request
PBS	Polling booth survey
PEP	Post-exposure prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief

POMT	Prevention-Outcome Monitoring Toolkit
PR	Principal recipient
PrEP	Pre-exposure prophylaxis
PU/DR	Progress update/disbursement request
PWID	People who inject drugs
RCS	Rapid Coverage Survey
SDG	Sustainable Development Goal
SR	Sub-recipient
SRH	Sexual and reproductive health
SSA	Sub-Saharan Africa
STI	Sexually transmitted infection
TGW	Transgender women
ToR	Terms of Reference
TRP	Technical Review Panel
UK	United Kingdom
UNAIDS	Joint United Nations Programme on HIV/AIDS
US	United States of America
USAID	US Agency for International Development
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization

Executive summary

A: Background

The Global Fund's Evaluation and Learning Office (ELO), under the oversight of the Independent Evaluation Panel (IEP), commissioned Itad to evaluate the extent to which, and the ways in which, increased HIV prevention efforts have contributed to more optimal and coherent Grant Cycle 7 (GC7) grant design for maximizing prevention outcomes and impact, and to examine whether these grants are being implemented as intended.

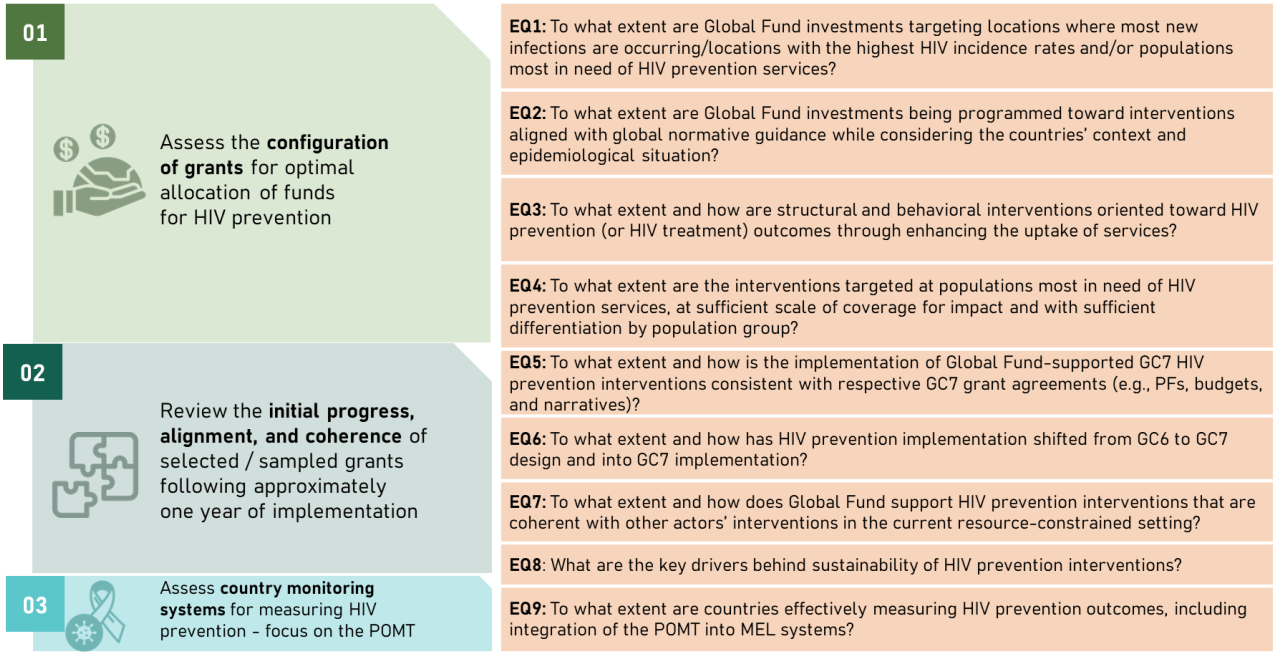
Despite a 38% decline in new HIV infections since 2010, over 1.3 million cases occur annually, far above the 2025 UNAIDS target of 370,000. For the first time, most new infections are outside sub-Saharan Africa (SSA), and key populations (KPs)[1] in all epidemic settings, and adolescent girls and young women (AGYW) in high-incidence settings remain disproportionately affected. Prevention gaps persist: In 2022, KPs and partners accounted for 25% of infections in SSA and 80% elsewhere. Proven interventions such as pre-exposure prophylaxis (PrEP), voluntary medical male circumcision (VMMC) and other bio-medical interventions are underutilized globally.

In 2020, the Technical Evaluation Reference Group found that while the Global Fund had increased prioritization and funding for HIV primary prevention, it lacked a clear overarching results framework and needed stronger, outcome-focused programming and monitoring. Since then, the Global Fund has introduced a dedicated theory of change and M&E framework and further increased prevention investments.[2] In addition, the Global Fund's 2023–28 Strategy seeks to accelerate access to tailored, combination prevention for high-risk populations. The evaluation examines whether GC7 grants are optimally designed and implemented to maximize HIV prevention outcomes, and assesses country outcome monitoring systems for measuring results. Findings will inform ongoing GC7 implementation, the design of GC8 (2026–28), and broader HIV prevention programming. Recommendations aim to help countries and partners strategically allocate limited resources for greatest impact, improve program alignment, and strengthen evidence-based decision-making.

Evaluation objectives and questions

The evaluation is divided into three evaluation objectives with nine evaluation questions (EQs) to be addressed. These are summarized in Figure 1 below:

Figure 1: Three evaluation objectives and associated EQs



B: Methods

The evaluation used a structured mixed-methods design, integrating qualitative and quantitative evidence across the Global Fund's HIV prevention portfolio. It aimed to (1) systematically assess prevention components of HIV grants; (2) provide timely insights for GC7 implementation; and (3) ensure analytical rigor through validation and triangulation. A detailed account of the analytical tools, data sources, and their relevance to the evaluation objectives is provided in the methodology section 3.

C: Findings

The headline findings of the evaluation are presented below across the three evaluation objectives for each of the nine EQs in Table 1. More detailed findings under these EQs are provided in the main report. The strength of evidence underpinning these findings is detailed in the findings section. An assessment has been provided for each specific finding under the relevant EQ, with ratings ranging from strong to limited depending on the breadth and depth of available data sources. Overall, the headline findings are assessed as being supported by strong evidence in most cases.

Table 1: Summary of headline findings across objectives and 9 EQs

EQs	Headline findings
Objective 1: To what extent are Global Fund's grants optimally configured for effective prevention programming?	
Global Fund investments in GC7 are widely aligned with global normative guidance, including targeting appropriate geographies and populations with appropriate biological, behavioral, and structural HIV prevention interventions, indicating optimal allocation.	
EQ1: To what extent are Global Fund investments targeting locations where most new infections are occurring/locations with the highest HIV	Global Fund investments under GC7 grants are highly focused and are both epidemiologically informed and data-driven with respect to both high-burden geographies as well as populations most at risk of HIV infection.

incidence rates and/or populations most in need of HIV prevention services?	
EQ2: To what extent are Global Fund investments being programmed toward global normative guidance while considering the countries' context and epidemiological situation?	Throughout the portfolio, Global Fund HIV prevention investments in GC7 are strongly aligned with Global Prevention Coalition guidance reflecting inputs from a broad coalition of technical partners including UNAIDS, WHO, UNFPA and others and are broadly appropriate to country epidemiology. However, full, at-scale provision of all recommended biomedical and critical enablers to prevention services within structural components is not yet achieved.
EQ3: To what extent and how are structural and behavioral interventions oriented toward HIV prevention outcomes through enhancing the uptake of services?	Structural and behavioral interventions included in GC7 grants are deliberately oriented toward HIV prevention outcomes by enhancing the uptake of biomedical services and addressing barriers to access, but their impact is moderated by resource constraints and restrictive environments, and some gaps remain in the programmatic design, financial commitment, operational scale, and structural implementation necessary to achieve optimal impact.
EQ4: To what extent are the interventions targeted at populations most in need of HIV prevention services, at sufficient scale of coverage for impact and with sufficient differentiation by population group?	Our analysis of the GC7 HIV prevention grants confirms that interventions are overwhelmingly and strategically targeted at the populations most in need, with significant efforts made toward defining appropriate scale and differentiation. However, the attainment of a sufficient scale of coverage for epidemiological impact is the most challenging area across the portfolio, constrained primarily by resource limitations and data deficiencies.
Objective 2: To what extent are Global Fund's grants being implemented amid resource constraints and current contextual challenges?	
After approximately one year of implementation, initial progress, alignment, and coherence of HIV prevention programming supported by GC7 grants appear largely consistent with intent, aligned with in-country partner strategies, leveraging the strength of the Global Fund model to drive sustainability. At the same time, significant risks to programmatic impact persist. These include shifts in the donor landscape, the Global Fund's recent reprioritization exercise[3] (mid-cycle adjustments made by countries to review and reprioritize funding in response to resource constraints and changing country contexts), gaps in coverage of HIV prevention programs in certain contexts, and unresolved structural barriers that hinder access to services.	
EQ5: To what extent and how is the implementation of Global Fund-supported GC7 HIV prevention interventions consistent with respective GC7 grant agreements (e.g., PFs, budgets, and narratives)?	Global Fund-supported HIV prevention interventions are aligned with respective country GC7 grant agreements across all countries. All countries report a strong focus on KPs, although some countries would benefit from increased support for AGYW in high-incidence settings. Many countries also report that changes in implementation compared to grant agreements are primarily driven by the GC7 reprioritization, which has prevented the implementation of, or reduced the focus on, certain HIV prevention interventions. Finally, many countries have also reportedly achieved or exceeded coverage targets (also due to issues with target setting), but this is not consistent across countries, and achievement is impeded by operational, contextual, and political factors.

EQ6: To what extent and how has HIV prevention implementation shifted from GC6 to GC7 design and into GC7 implementation?	Across all countries, HIV prevention implementation under GC7 represents a deliberate and substantive shift from activity/output-oriented programming under GC6 to more targeted outcome-oriented programming involving data-driven and person-centered prevention models aimed at maximizing HIV prevention impact, and choice. At the same time, early GC7 performance varies, and in settings where progress has been weaker, structural barriers and the reduced prioritization of interventions intended to address them appear to be contributing factors.
EQ7: To what extent and how does Global Fund support HIV prevention interventions that are coherent with other actors' interventions in the current resource-constrained setting?	The Global Fund's flexible country-led approach and close coordination with country governments, development partners, non-governmental organization (NGOs)/civil society organizations (CSOs), and communities supports effective collaboration and coherence to HIV prevention service delivery across the majority of countries.
EQ8: What are the key drivers behind sustainability of HIV prevention interventions?	The key drivers behind sustainability of HIV prevention interventions include national ownership and stewardship, integration with health and education systems, robust domestic financing, supportive legal and policy environments, and institutionalized community engagement.
Objective 3: To what extent are countries effectively measuring HIV prevention outcomes?	
Countries are using diverse methods to measure HIV outcomes and have improved integration of prevention data into national health management information systems (HMIS). Only a few have applied prevention-outcome monitoring toolkit (POMT) approaches, with limited uptake into national monitoring, evaluation, and learning (MEL) systems. Where POMT has been used, countries report challenges related to guidance, the novelty of the methods, dependence on external support, and constrained financing.	
EQ9: To what extent are countries effectively measuring HIV prevention outcomes, including integration of the POMT into MEL systems?	Countries are measuring HIV outcomes through a variety of methods that have made progress in integrated reporting of HIV programmatic data into their national HMIS, including the reporting of HIV prevention outcomes. With respect to the POMT, a minority of countries have implemented methods recommended by POMT in their contexts with limited evidence of integration into national MEL systems. Countries that have implemented POMT report a range of technical and operational hurdles during implementation. These include challenges with the Global Fund's guidelines on the toolkit, the newness of methods deployed, the reliance on external technical assistance (in the first iteration of implementation) and finally the rapidly constrained financing environment.

The emerging narrative

Below, the emerging narrative from this evaluation is provided in the form of high-level conclusions.

High-level Conclusion 1: Despite the Global Fund's strong partnership model, emphasis on country ownership, and large-scale financing capacity, and in the context of its resource constraints, there are still opportunities to improve the prioritization of HIV prevention interventions. Key areas include scaling up the most impactful HIV prevention interventions[4] (as guided by global technical guidance), maintaining a strong focus on addressing structural barriers, and ensuring the delivery of critical interventions such as long-acting injectable PrEP and prevention services for people who inject drugs (PWID). Addressing these gaps will be essential to increasing coverage of HIV prevention programs.

High-level Conclusion 2: After approximately one year of implementation, initial progress suggests that HIV prevention programming supported by GC7 grants is largely consistent with its intended design. Programs appear well aligned with in-country partner strategies and leverage the strengths of the Global Fund model to promote sustainability. This coherence underscores the value of GC7's approach compared to previous funding cycles.

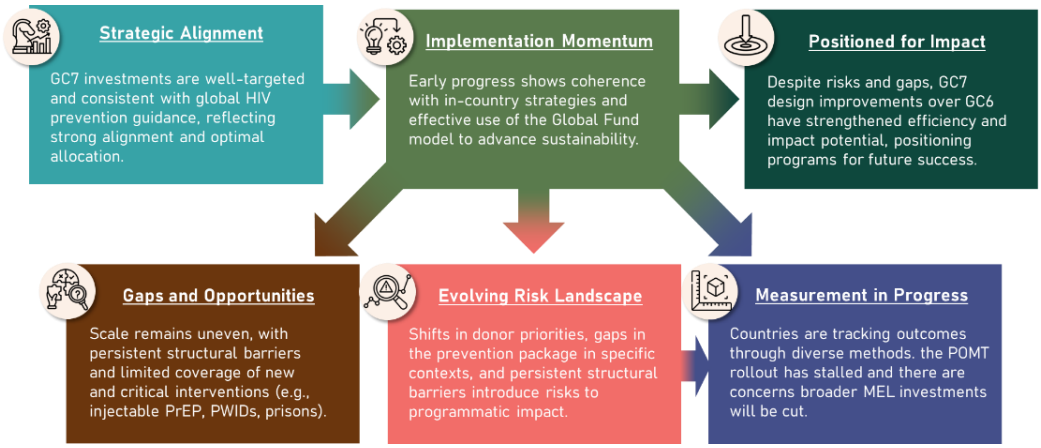
High-level Conclusion 3: Countries are monitoring HIV prevention outcomes through a range of methods, though adoption of POMT approaches into MEL systems varies by context. Progress on POMT has not been as successful as hoped so it is too early to generate conclusive insights on its utility. As a result of the funding cuts, POMT rollout has now stalled, and evidence suggests broader cuts to country-level MEL systems may follow.

High-level Conclusion 4: Significant risks to programmatic impact persist. These include dramatic shifts in the donor landscape, reduction in Global Fund's funding, gaps in coverage of HIV prevention programs in many contexts, and unresolved structural barriers that hinder access to services. These challenges could undermine progress.

High-level Conclusion 5: Nevertheless, the initial design of Global Fund investments under GC7 emphasized maximizing impact and efficiency, building on lessons learned from GC6. As a result, HIV prevention programs may now be better positioned to achieve results despite the risks. While outcomes remain to be seen, the strategic improvements introduced in GC7 provide a strong foundation for success.

These high-level conclusions can be presented in visual form as in Figure 2 below:

Figure 2: Summary of overall narrative from evaluation



D: Recommendations

This section presents the proposed recommendations, drawing on Global Fund guidance and feedback provided during the recommendations workshop held on 9 December 2025. Inputs from Global Fund Secretariat stakeholders and the ELO were consolidated and used to refine and revise the draft recommendations developed previously.

Critical recommendations for the Global Fund Secretariat

Recommendation 1: Global Fund Secretariat should maintain HIV prevention for KPs and high-risk AGYW as a core strategic priority and extend the precision prevention approach into GC8. The focus on KPs and AGYW in high-incidence settings remains the Global Fund's comparative advantage and should be protected despite tightening fiscal conditions and competing demands. Within this changing funding landscape, countries should be encouraged to continually and actively prioritize the most impactful interventions and delivery models, while focusing on geographies and populations most in need.

Recommendation 2: Global Fund Secretariat should ensure that Country Coordinating Mechanisms (CCMs) and PRs sustain alignment with Global Prevention Coalition (GPC) guidance and continue to emphasize differentiated service delivery. Increasing investments in robust data systems and tailored prevention services (including biomedical, structural, and behavioral interventions) will equip local stakeholders to make evidence-based decisions that balance cost and impact. This in turn will support context-specific delivery strategies aimed at preserving user preferences, including options for long-acting injectables.

Recommendation 3: Global Fund Secretariat, with support from technical partners should consolidate and share lessons learned from implementing differentiated vs. integrated service delivery models that demonstrate impact in driving access, uptake, and use of biomedical HIV prevention interventions. Clear communication of the benefits and trade-offs between efficiency and access considerations can support countries to design strategies that sustain essential HIV prevention services in an increasingly fiscally constrained environment.

Recommendation 4: Global Fund Secretariat should continue supporting countries to prioritize KPs according to country specific context. Its support should continue encouraging countries to focus resources on KPs with the highest potential epidemiological impact ensuring that limited resources are directed to optimize outcomes within current fiscal constraints.

Important recommendations for the Global Fund Secretariat

Recommendation 5: Global Fund Secretariat should increase context-specific efforts to promote policies that enable KPs access to services, while CCMs should encourage, and PRs should continue, implementation of innovative KP services (such as PrEP vending machine disbursements and teleconsultation services) to reduce KP stigma and improve access to services. This is fundamental to the future success of Global Fund-supported prevention investments and should be prioritized within both national and sub-national governments and health systems, including primary health care centers. Although, it should be acknowledged that this may be challenging in restrictive policy and legal environment.

Recommendation 6: Global Fund Secretariat should proactively support the monitoring of HIV prevention-related outcomes (e.g., through the POMT approaches). In countries where significant progress has been made in the rollout of the POMT, CCMs and PRs should continue support, and assess its performance and value. In the face of wider pressure of reducing MEL spending, the Global Fund should encourage adoption of lower cost outcome monitoring approaches like those included in the POMT to help generate real-time evidence to inform prevention programming.

Recommendation 7: Global Fund Secretariat should work with technical partners to support CCMs and PRs to proactively plan for and prioritize structural interventions that reduce HIV risk and improve access, uptake, and use of HIV prevention options within a country's specific epidemiological or cultural context. These prioritized interventions should be integrated into future program design to safeguard the continuity of the most critical and effective structural interventions for driving HIV prevention outcomes, while also considering the current environment of limited Global Fund resources. This approach will support continuous flexibility in order to respond to politically challenging contexts that require investments to reduce barriers to accessing services.

Recommendation to partners

Recommendation 8: Global Fund partners should support countries to increase (1) national ownership and domestic financing; (2) integration of HIV prevention services into existing national platforms while ensuring sufficient service delivery differentiation to promote access; (3) community engagement; and (4) effective coordination of in-country stakeholders in order to support the sustainability of future HIV prevention programming, including GC8.

1 Introduction and background

1.1 Introduction

The Global Fund's Evaluation and Learning Office (ELO), with oversight from the Independent Evaluation Panel (IEP), commissioned Itad to conduct an evaluation to examine the extent to which, and the ways in which, the increased Global Fund efforts in human immunodeficiency virus (HIV) prevention have (a) led to Grant Cycle 7 (GC7[5]) grants that are optimally configured and coherent, to enable the maximizing of HIV prevention outcomes and impact, and (b) are being implemented in line with the grant design.[6] The evaluation comprises three interlocking objectives:

- to assess the configuration of grants for optimal allocation of funds for HIV prevention
- to review the initial progress, alignment, and coherence of selected/sampled grants following approximately one year of implementation
- to assess country monitoring systems of the sampled countries for measuring HIV prevention outcomes and subsequent use of information, with specific attention paid to the HIV POMT.

Anchored in a strategy-based evaluation approach, the exercise addresses key EQs framed around three OECD-DAC[7] criteria, including effectiveness, coherence, and sustainability, with the primary emphasis on effectiveness (detailed in Annex 1). The evaluation focuses on the current Global Fund Strategy period and covers GC7. The evaluation combines summative elements that assess the degree of shift toward prevention-focused interventions in GC7 design and early implementation with formative elements intended to inform ongoing implementation of GC7 grants, the design of GC8 grants, and broader HIV prevention programming.

The Global Fund Secretariat is the primary audience of the evaluation results and will utilize its findings and recommendations in providing support to countries in grant-related HIV prevention programming. Additional audiences include the Global Fund Board, national HIV programs, grant implementers, principal recipients (PRs) and sub-recipients (SRs), and technical partners involved in global and country-level HIV responses, for example, the Joint United Nations Programme on HIV/AIDS (UNAIDS), and the World Health Organization (WHO). The Global Fund Strategy spans five years, while the Grant Cycle covers three years.

Most Global Fund-supported countries are currently in the implementation phase of their GC7 grants. Preparations for GC8 have already begun, so findings from this evaluation will serve to inform improvements and adaptations of Global Fund processes and guidance documents in advance of the 2026–28 Global Fund Grant Cycle (GC8). The evaluation proposes actionable recommendations to help countries and partners to strategically direct limited HIV prevention resources toward the greatest epidemiological impact. Its focus on program coherence, alignment, and the use of evidence for decision-making adds value to national program reviews and forthcoming national strategic plan (NSP) development processes. By synthesizing insights on allocation choices, implementation quality, and monitoring systems, the evaluation aims to provide timely inputs that countries can draw upon during these ongoing planning cycles, particularly in an era marked by tightening donor budgets and increasing emphasis on efficiency.

The report is structured as follows:

- The remainder of Section 1 presents the background
- Section 2 presents evaluation objectives and the corresponding questions

- Section 3 presents the evaluation methodology, including approach, methods and tools, statistics on interviews conducted and documents reviewed, triangulation of evidence, strength of evidence, limitations, and ethical considerations
- Section 4 presents findings across all nine EQs
- Section 5 presents the main evaluation conclusions
- Section 6 presents proposed recommendations (revised based on the recommendation workshop on December 9, 2025).

This is supported by a series of annexes, provided separately:

- Annex 1: Evaluation framework
- Annex 2: Dimensions scoring matrix
- Annex 3: EQs response matrix
- Annex 4: Specific/detailed evidence
- Annex 5: List of stakeholders consulted (titles not names)
- Annex 6: List of documents reviewed
- Annex 7: POMT toolkit.

1.2 Background

Although new HIV infections have declined by 38% since 2010, there are still more than 1.3 million new cases every year, well in excess of the 2025 UNAIDS target of just 370,000.[8] According to the 2023 UNAIDS global update, 2023 was the first time in the history of the HIV pandemic that more new infections were occurring outside SSA than inside SSA.[9] Currently, the world is off track to meet both the global goal of ending AIDS by 2030, and UNAIDS' 2025 access to and use of HIV prevention service targets. Drastic reductions in new HIV infections are needed to reach the Sustainable Development Goal (SDG) target. For this evaluation, the focus is on populations with the highest HIV burden in each context;[10] KPs in all epidemic settings, AGYW in high-incidence settings, and AGYW male partners in high-incidence settings. In this evaluation, KPs encompass men who have sex with men (MSM), transgender people (TG), female sex workers (FSW), PWID, and people in prisons or other closed settings. AGYW in high-incidence settings are treated as a distinct population group as they are consistently presented as a separate group throughout the analysis.

The time between the drafting of the original Terms of Reference (ToR) for this assignment and the conclusion of this evaluation has been marked by significant and ongoing shifts in the landscape of global health funding and programming. Major bilateral overseas development donors have either paused or announced large-scale cuts to their funding, with other key bilateral donors likely to follow suit. Impacts resulting from these changes are already being seen at country level, including program cancelations, pauses in interventions, the layoff of field staff, closure of implementing partner agencies, and more. The evaluation team, in close coordination with the Global Fund ELO, has taken this evolving context into account to make appropriate adaptations in the evaluation design and implementation. One example of how the new shifts affected the evaluation design is our phased evaluation approach, focused initially on secondary and then on primary data collection. This approach allowed country teams to focus efforts on responding to emerging changes and provided greater opportunity for the evaluation team to capture the impact of such changes as part of its in-country primary data collection. In addition, we acknowledge that the full impact of recent changes may not yet be evident;

therefore, the analysis considers the processes that the Global Fund and stakeholders have in place to track and respond to changes, alongside the changes observed to date.

Prevention gaps are of particular concern for KPs and AGYW in high-incidence settings. In 2022, KPs and their sexual partners comprised 25% of all infections in SSA and 80% outside of SSA. Women continue to face a greater risk of HIV infection—particularly in SSA, where AGYW aged 15–24 years and women aged 25–49 years are respectively up to three times and 1.4 times more likely to acquire HIV than their male counterparts.[11]

According to the 2025 UNAIDS global update, HIV prevention efforts are still missing millions of people globally.[12] HIV prevention programs must greatly improve the combination and focus of proven interventions where HIV infection rates are especially high. The potential of interventions with proven efficiency, such as PrEP, condom programs, and VMMC, is not fully realized globally. The Global Fund Strategy for 2023–28 aims to address this by accelerating access to and effective use of precision combination prevention, with behavioral, biomedical, and structural components tailored to the needs of populations at high risk of HIV infection.

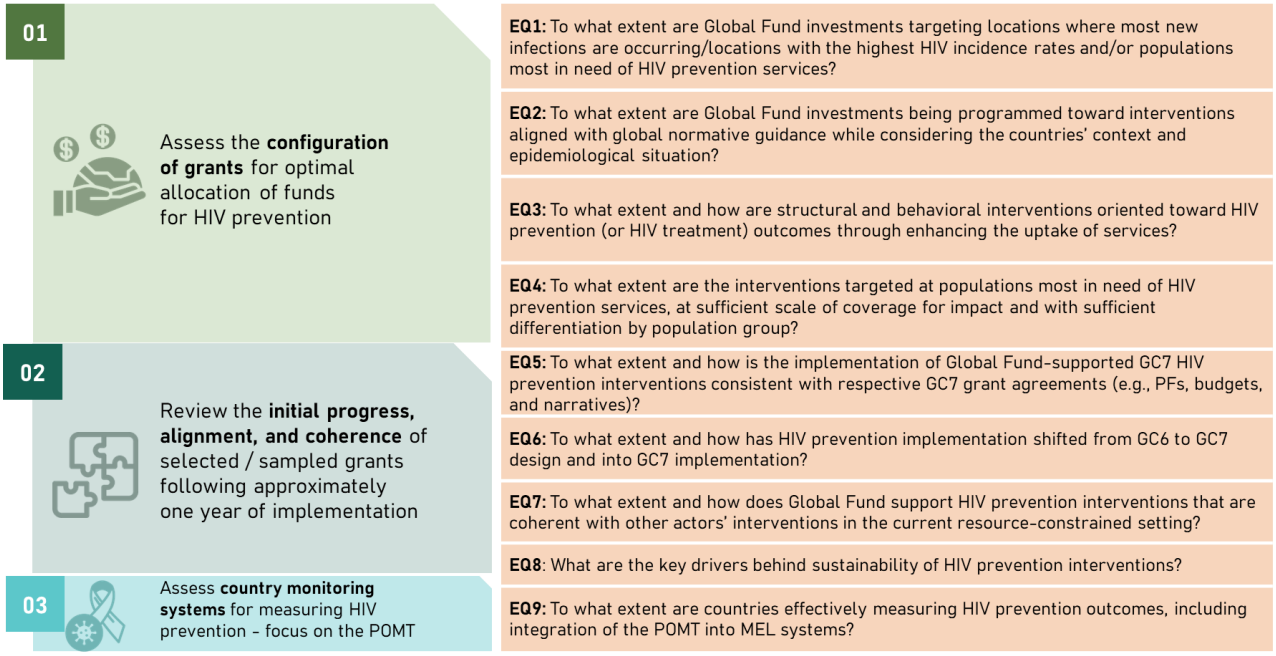
In 2020, the Technical Evaluation Reference Group found that while the Global Fund had increased prioritization and funding for HIV primary prevention, it lacked a clear overarching results framework and needed stronger, outcome-focused programming and monitoring. Since then, the Global Fund has introduced a dedicated theory of change and M&E framework and further increased prevention investments.[13] Against this backdrop, the Global Fund has commissioned this evaluation to assess how effectively it is supporting the impact of HIV prevention efforts through its grant architecture and delivery model, recognizing that the scale and intensity of programming may vary across contexts. The intervention at the heart of this evaluation is not a single program or technical tool, but rather the Global Fund's broader strategic effort to strengthen HIV prevention through GC7 grants. This includes a deliberate push to better align prevention investments where the needs are greatest, focusing on high-burden geographies and populations, including KPs and AGYW in high-incidence settings.[14] This shift toward precision prevention places more attention on how grants are configured and delivered, how prevention is prioritized, who delivers it, and how progress is tracked compared to solely what is funded.[15]

Through GC7, the Global Fund has introduced new technical resources, clearer expectations around prevention priorities, and tools like the POMT to support more effective tracking of results.[16] The evaluation looks at this multifaceted prevention effort as a system-level intervention, one that spans grant design, implementation, and monitoring. Therefore, the evaluation has synthesized findings and recommendations that can be used to inform the systems and processes used by the Global Fund to ensure that its grants are optimally configured to maximize HIV prevention outcomes and impact in the future.

2 Evaluation objectives and evaluation questions

The evaluation is divided into three evaluation objectives with nine EQs to be addressed. These are summarized in Figure 3 below.

Figure 3: Three evaluation objectives and associated EQs



3 Methodology

In this section, we describe the main methodology utilized in the evaluation, including the approach, methods and tools, statistics on interviews conducted and documents reviewed, triangulation of evidence, strength of evidence, limitations, and ethical considerations.

3.1 Methods and tools

This evaluation employed a structured, mixed-methods design, integrating qualitative and quantitative evidence across the Global Fund's HIV prevention portfolio. The methodological approach was anchored in three drivers:

a) ensuring a systematic and comparable assessment of HIV prevention grants across objectives;
b) enabling timely, data-driven insights to inform ongoing GC7 implementation; and
c) upholding analytical integrity through multiple layers of validation and triangulation.

The evaluation included a total of 12 countries, reflecting a mix of epidemiological contexts, geographic regions, and HIV prevention programming models, as outlined in the ToR. The original ToR listed Cuba and Kyrgyzstan among the sample countries. For operational and strategic reasons, these were replaced with Kosovo and Paraguay, retaining the diversity of contexts while reflecting practical considerations such as feasibility of engagement. Of the 12 countries, four were selected for in-depth, "deep-dive" analysis including Pakistan, Nigeria, the Philippines, and Kenya while the remaining eight were assessed through a lighter-touch review (Eswatini, Madagascar, Mozambique, Tanzania, Uganda, Zimbabwe, Kosovo, and Paraguay). However, primary data was collected across all 12 countries with varying degrees of inquiry.

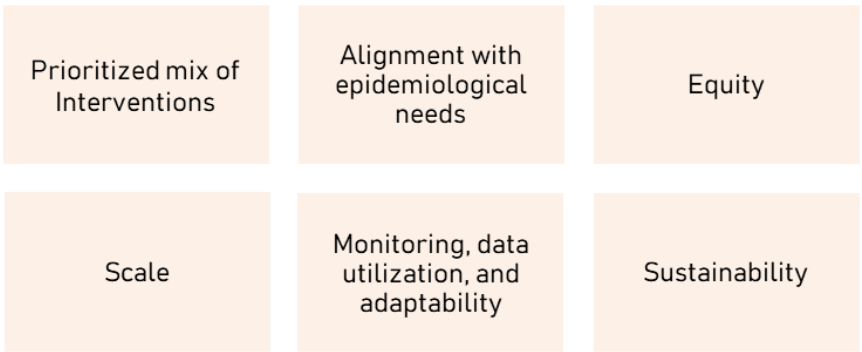
The section below outlines the methods implemented for each evaluation objective, the data sources and analytic tools used, and the processes followed to ensure quality, ethical rigor, and reliability of evidence.

Objective 1 assessed grant design against the four EQs shown in Figure 1, drawing on three analytical tools to enable triangulation.

Table 2: Summary of methods and tools for Objective 1

Analytical tool	Description	Main data sources
A cross-portfolio analysis of 101 grants and 116 countries[17] (listed in Annex 6)	This analysis was conducted through an AI driven process that processed the wide variety of documentation on the GC7 design (and allowed information to be generated against the four EQs under the Objective 1.)	Funding Request Packages; Budget and Financial Tables; National Strategy and Planning Documents; Human Rights and Related Assessments; Allocation Requests and Prioritized Above Allocation Request (PAAR) Documents; Performance Frameworks data; Technical Review Panel (TRP) Review and Recommendation Documents.
12 in-depth case studies	Consultant-led case studies (4 in depth, 8 lighter touch) conducted by country expert consultants.	Country documents (funding request packages, performance frameworks, National M&E plans, Grant agreements etc.); key informant interview (KIIs) with in-country and global stakeholders.
Optimal grants agent (OGA)[18] ran on 12 case studies	AI driven review of the prevention components of HIV Grants in case studies countries against six dimensions as presented in Box 1.	Funding request packages; Budget and financial tables; National Strategy and Planning documents; Human rights and related assessments; PAAR; Performance and frameworks data; TRP review and recommendation documents.

Box 1: Six dimensions



A cross-portfolio analysis of 101 grants and 116 countries: The evaluation assessed the extent to which Global Fund HIV prevention grants are optimally configured to maximize HIV prevention outcomes and impact. The grants were assessed to answer the four EQs in Objective 1 using a series of documentation including funding requests, TRP recommendations, and other relevant grant design documents (1,559 in total, a select list is added in Annex 6).

12 in-depth case studies: KIIs were conducted in all 12 countries to triangulate information from the grant design assessment based on secondary documents. These were triangulated with primary data collected through remote KIIs and focus group discussions (FGDs) with in-country stakeholders, supported by CCMs. Selective KIIs were also conducted with stakeholders at the Global Fund Secretariat as well as global technical partners (UNAIDS, Global Prevention Coalition (GPC), WHO) to help answer EQs under Objective 1.

OGA ran on 12 case studies: OGA assessed grants in the 12 case study countries against the six dimensions agreed during inception (detailed in Annex 2). The tool uses machine learning and AI to support high-quality, efficient grant evaluation. It analyzed grant documentation, budgets, performance frameworks, epidemiological data, and interview transcripts stored in a secure vector datastore. OGA retrieved evidence snippets and generated consistent rubric-based scores across the six dimensions using the Grants Assessment Compass. Outputs were produced under an evaluator-in-the-loop approach for calibration, expert feedback, and validation. OGA generated visualizations and reports showing the extent to which grants meet the six dimensions of an optimal HIV prevention grant. These key elements of the OGA and how it worked are illustrated in Figure 4.

For **Objective 2**, the evaluation reviewed the implementation of 21 grants across 12 sampled countries over the last year of implementation in order to understand results, the targeting of prevention interventions, and the extent to which the Global Fund Secretariat is adapting to actual and potential changes in available funding.

The sources to inform this objective include:

Table 3: Summary of methods and tools for Objective 2

Analytical tool	Description	Main data sources
12 in-depth case studies	Consultant-led case studies (4 in depth, 8 lighter touch) conducted by country expert consultants.	Country documents (funding request packages, performance frameworks, National M&E plans, Grant agreements etc.) KIIs with in-country and global stakeholders.
OGA ran on 4 case studies	AI driven review of the prevention components of HIV Grants in case studies countries against six dimensions (see Box 1.)	Analysis generated by the OGA which reviewed grants against six dimensions and leveraged data from the GC7 design analysis conducted under Objective 1 with implementation data (derived from the county case studies and KIIs).

12 in-depth case studies: Objective 2 examined implementation based on five assessment dimensions:

a) early grant results;
b) changes in implementation compared to plans;
c) coherence and relevance to context;
d) adherence to best practices in HIV prevention grant-making;
e) comparison between GC6 and GC7 program design and shifts in program focus.

This comparison enabled analysis of changes in Global Fund Strategy focus, global normative guidance, country fiscal landscapes, and other funding sources across the 12 countries. Mixed methods were used. Country leads conducted desk reviews drawing on Global Fund documentation and gray literature, producing 12 country reports subsequently refined by the

core team. These were triangulated with primary data collected through remote KIIs and FGDs with in-country stakeholders, supported by CCMs. Selective KIIs were also conducted with stakeholders at the Global Fund Secretariat as well as global technical partners (UNAIDS, GPC, WHO) to help answer Objective 2.

OGA ran on 4 case studies: As examples, OGA was used for four deep-dive countries to assess grants using implementation evidence from KIIs, FGDs, and performance documentation. The assessment compared dimension scores and showed differences driven by implementation data.

For **Objective 3** there was only one EQ and the evaluation focused on the same country cases. The focus was on integration of the POMT approaches into national data collection systems. A mixed-methods approach combined:

Table 4: Summary of methods and tools for Objective 3

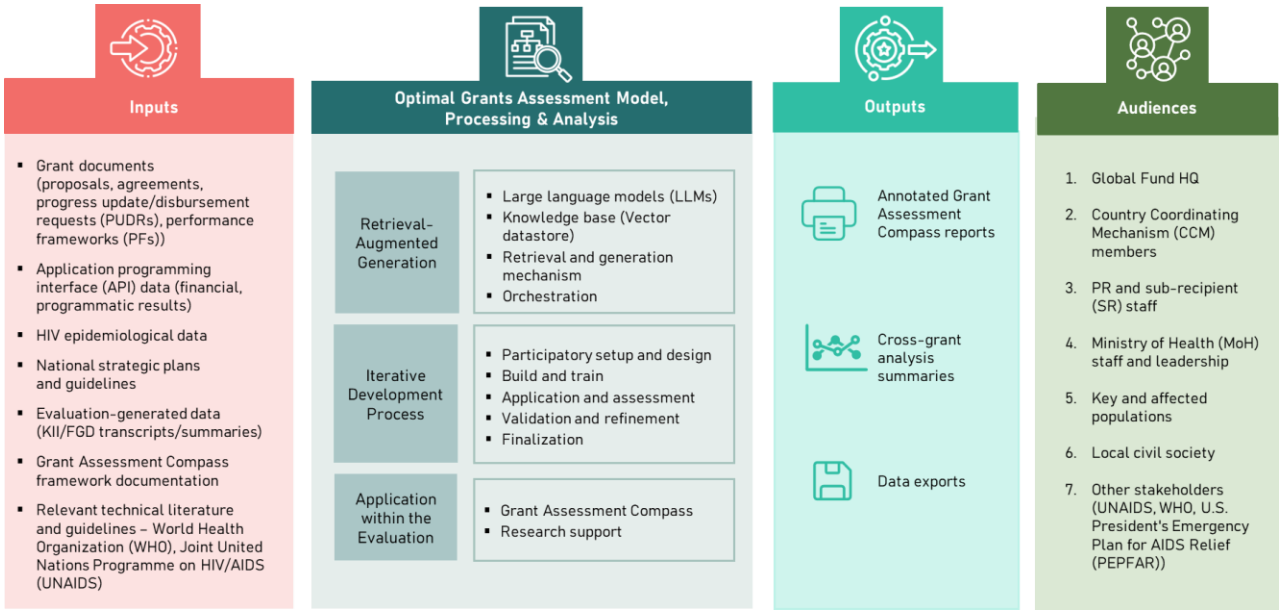
Analytical tool	Description	Main data sources
12 in-depth case studies	Consultant-led case studies (4 in depth, 8 lighter touch) conducted by country expert consultants.	Country documents (funding request packages, performance frameworks, National M&E plans, Grant agreements etc.); KIIs with in-country and global stakeholders.
POMT evaluation toolkit (checklist and online survey)	The survey was disseminated to stakeholders in eight countries with advanced POMT implementation.	A checklist was developed and used to guide the desk review of POMT-related documentation, including presentations, protocols, reports, and feedback provided. Also, the POMT survey drew a response rate of 32% (24/74). All the eight POMT-priority countries were represented in the responses. There was a mix of respondents, including state, non-state, PRs, SR, and development partners.

12 in-depth case studies: The evaluation assessed systems in the 12 countries for measuring HIV prevention outcomes and the use of information, with a specific focus on the HIV POMT. The analysis followed the OECD-DAC effectiveness criterion and examined the extent to which countries are utilizing and integrating POMT approaches into their MEL systems. Country leads conducted desk reviews drawing on national MEL frameworks, PR/SR reporting (including progress update/disbursement requests (PU/DRs)), national studies and evaluations, and POMT-related documentation. These were triangulated with primary data collected through remote KIIs and FGDs with in-country stakeholders, supported by CCMs. Selective KIIs were also conducted with stakeholders at the Global Fund Secretariat as well as global technical partners (UNAIDS, GPC, WHO) to help answer Objective 3.

POMT evaluation toolkit (checklist and online survey): To support systematic analysis, the team developed a POMT evaluation toolkit: a checklist and an online survey (Annex 7), created in collaboration with the Global Fund technical team responsible for POMT. The checklist guided the review of POMT-related documents, while a digitized SurveyMonkey questionnaire was disseminated to stakeholders across the eight countries where POMT implementation was most advanced. Respondents were invited to complete the survey and share their experiences with adopting and using POMT approaches. Data from the checklist and the survey were then triangulated with KII findings to generate a consolidated picture of prevention-outcome monitoring across the sampled countries.

These key elements of the OGA and how it worked are illustrated in Figure 4:

Figure 4: Overall OGA approach



3.2 Data collection and stakeholders engagement

Data collection for this evaluation occurred in two overlapping stages:

- **Stage I (Aug–Oct 2025):** Document review and KIIs with global stakeholders.
- **Stage II (Sep–Nov 2025):** KIIs and FGDs with country-level actors across 12 countries.

Discussion topics during both stages explored shifts in HIV programming, changes in KP focus and reach, and stakeholder responses to actual or anticipated funding changes. Topic guides were tailored for each stakeholder group, and local languages were used when relevant.

During Stage I, the evaluation team documented significant contextual developments, including recent shifts in fiscal and programmatic environments. Detailed country context profiles were developed for each of the 12 countries through a comprehensive document review led by country leads. This included a review of GC7 program results and relevant GC6 documentation.

The phased approach to data collection supported targeted follow-up on emerging findings and lines of inquiry and enabled the evaluation team to address identified data gaps and improve strength of evidence. Primary data collection began in September 2025 and concluded in November 2025. While some programmatic changes were still unfolding during the evaluation period and certain adaptations may remain temporary, the evaluation captured both what was in place at the time of data collection, and the processes through which countries were managing and responding to changes. KIIs and FGDs were essential in gathering insights into contextual developments, the drivers of observed results, shifts in program design and focus, and how teams are responding to real-time challenges in HIV prevention.

The evaluation also examined the extent to which country responses aligned with best practice in HIV prevention. This was achieved through a combination of document review, qualitative interviews, and structured analysis using the OGA. The OGA supported the review of extensive datasets linked to GC6 (across the 12 countries) and GC7 grants. All outputs were reviewed and contextualized by country leads and the core evaluation team and discussed with key Global Fund stakeholders and in-country stakeholders.

Primary and secondary data sources

- **Primary data:** KIIs and FGDs with stakeholders from the Global Fund Secretariat, Ministries of Health (MoH), PRs and SRs, and participants from KPs and affected populations, including people living with HIV. These engagements provided insights into contextual developments, contributed to understanding how results were achieved, and helped identify gaps, weaknesses, and adaptive practices in HIV prevention programming.
- **Secondary data:** Reports and datasets provided by the Global Fund Secretariat, national ministries and agencies, IPs (PRs/SRs), national HIV/AIDS programs, and technical partners such as UNAIDS, WHO, and PEPFAR.

To ensure quality, rigor, and consistency across all data collection activities, the evaluation team provided targeted training to the in-country leads. A half-day virtual training session was held to introduce the data collection tools and the scoring framework underpinning the Grant Assessment Compass. This was followed by a series of weekly check-ins and workshop-style sessions during which country leads presented preliminary desk review findings. These sessions allowed for iterative feedback and real-time clarification, after which the country desk reviews were revised and finalized.

For the primary data collection phase, additional training was conducted on the use of topic guides and the facilitation of FGDs, with emphasis on ethical protocols, confidentiality, and participant safety. FGDs were conducted in pairs to ensure consistency of approach across evaluators and to strengthen the reliability of the evidence gathered.

Stakeholders were engaged in the evaluation primarily through KIIs and FGDs. Purposive sampling was used to ensure that diverse, informed, and critical perspectives were included. To identify KII respondents and FGD participants, a stakeholder mapping exercise was conducted in close collaboration with the Global Fund's ELO and country teams. The mapping exercise was conducted immediately after the inception period, starting with Secretariat-level contacts to identify relevant stakeholders. Within each country, stakeholders were selected to capture perspectives across multiple levels of HIV prevention implementation. This included representatives from national health authorities, PRs and SRs of Global Fund grants, CSOs, KP networks, and implementing partners. Selection aimed to ensure breadth of insight across policy, program delivery, and community engagement, while considering practical constraints such as stakeholder availability and accessibility. FGDs with KPs were used to sense-check and build on emerging country findings around grant implementation, to ensure that the voices of KPs were heard and that they were meaningfully included in the evaluation.

Stakeholders included the Global Fund Secretariat, global and regional technical partners, grant implementers, and stakeholders from the 12 evaluation countries. They were consulted through KIIs, as outlined below:

- *Global Fund Secretariat*: KIIs were conducted with key stakeholders at the Global Fund Secretariat level, including Global Fund country teams. Stakeholders included HIV and Community, Rights & Gender advisors, Monitoring, Evaluation & Country Analysis and Resilient and Sustainable Systems for Health specialists, a POMT expert, TRP members, as well as Senior Fund Portfolio managers, Program officers, Public Health and Monitoring & Evaluation (M&E) specialists, and AGYW technical advisors.
- *Global and regional* technical partners: KIIs were conducted with stakeholders from key global and regional technical partners (e.g., UNAIDS, WHO). Stakeholders from the GPC were also included.

- *Country-level partners*: KIIs were conducted with stakeholders within the 12 evaluation countries, for example, MoH Permanent Secretaries, MoH Directors General and other staff from relevant ministries, agencies and departments, Country Coordinating Mechanism (CCM) members, staff from PRs/SRs, and MEL/SI leads.
- *In-country KPs and representatives of KPs*: KPs (including PWID, SWs, and MSM), AGYW and their male partners, as well as affected populations such as people living with HIV, were engaged through FGDs.

Table 5 presents the planned number of KIIs and FGDs by stakeholder group alongside the actual numbers completed.

Table 5: KIIs and FGDs

Stage	Geography	Planned	Completed (KII)	Completed (FGD)
Stage 1	Global Fund Secretariat	35 KIIs	31	
	Global Technical Partners	4 KIIs	3	
Stage 2	Kenya	6 KIIs + 1 FGD	7	1
	Pakistan	7 KIIs + 1 FGD	10	1
	Philippines	7 KIIs + 1 FGD	4	1
	Nigeria	6 KIIs + 1 FGD	7	1
	Eswatini	4 KIIs + 1 FGD	7	2
	Kosovo	4 KIIs + 1 FGD	4	1
	Madagascar	4 KIIs + 1 FGD	3	0
	Paraguay	4 KIIs + 1 FGD	2	1
	Mozambique	4 KIIs + 1 FGD	5	0
	Tanzania	4 KIIs + 1 FGD	6	1
	Zimbabwe	4 KIIs + 1 FGD	4	1
	Uganda	4 KIIs + 1 FGD	0	0
	Total	**97 KIIs + 12 FGDs**	**93**	**10**

3.3 Limitations, challenges, and mitigation strategies

The evaluation encountered several practical challenges related to stakeholder engagement, data collection logistics, and the use of AI-enabled analytical tools. Mitigation strategies were applied throughout to maintain methodological rigor and ensure that evidence remained robust, ethical, and credible.

Operational and logistical limitations: Primary data collection was conducted entirely virtually. No in-person in-country KIIs or FGDs took place. This shift reflected a combination of contextual constraints, varying country readiness, and delays in local coordination processes.

To mitigate these limitations, the evaluation team implemented a phased and flexible virtual engagement approach, which included:

- detailed secondary data review prior to interviews;
- early scheduling of virtual KIIs and FGDs;
- repeated follow-up reminders to secure participation;
- dedicated country teams responsible for liaison and scheduling.

Despite these efforts, coordination challenges persisted in several settings. The most significant challenge occurred in Uganda, where coordination with the CCM started late in the evaluation timeline. As a result, KIIs and FGDs could not be conducted for Uganda. For the remaining 11 countries, interviews and FGDs were completed largely as planned, although often following prolonged engagement efforts.

Stakeholder engagement challenges: Engaging stakeholders across multiple levels required sustained effort. Scheduling KIIs frequently involved delays, repeated rescheduling, and gaps in stakeholder availability. Coordinating interviews with CCMs, national programs, and PRs/SRs required consistent and persistent follow-up by the country teams.

For KP and community groups, participation was facilitated through:

- provision of data bundles or internet support;
- flexibility in scheduling;
- small-group virtual facilitation to ensure comfort, privacy, and accessibility.

CCMs were supportive overall, but the coordination burden remained high which prolonged timelines in several countries.

Ethical and safeguarding considerations: No major ethical or safeguarding risks materialized during data collection. All KIIs and FGDs followed Itad's ethical protocols, including:

- informed consent (recorded verbally);
- clear explanation of voluntary participation and confidentiality;
- anonymization of all interview content;
- careful handling of sensitive discussions with KPs;
- secure management of transcripts and recordings.

It was ensured that virtual engagement was conducted in private, secure settings to maximize participants' safety and comfort.

AI-related limitations: The OGA added efficiency but also introduced methodological considerations. The team encountered:

1. variability in document interpretation by the model;
2. occasional retrieval biases;
3. the need for more extensive human validation than originally planned.

Mitigation strategies included:

- systematic human verification of all AI-generated outputs;
- manual triangulation of AI-extracted evidence with original documents and interview transcripts;
- iterative model prompting and refinement;
- use of fallback manual analysis where AI outputs lacked clarity.

These measures ensured that AI served as a support tool rather than a determinant of findings, preserving methodological integrity.

3.4 Strength of evidence

The evaluation relied heavily on triangulation of evidence and findings. Quantitative and qualitative data and information was collated and coded in line with the evaluation matrix to support the triangulation process and minimize the risk of bias. Doing this enabled the evaluation team to understand the extent to which varied evidence supported similar findings. For all key findings and recommendations, the evaluation addressed the quality of evidence. When assessing quality of evidence, considerations were made regarding the reliability of the source, the credibility of quantitative and/or qualitative data, and any obvious bias (e.g., when people from implementing agencies may tend toward a positive assessment of their own interventions).

In line with good evaluation practice, the evaluation team has assessed the strength of the evidence, using the framework shown in Table 6.[19]

Table 6: Strength of evidence framework for evaluation findings

Rating	Strength of evidence assessment criteria for conclusions
Strong (1)	Evidence comprises multiple data sources, both internal (e.g., across portfolio analysis and across case study countries) and external (good triangulation from at least two different sources, e.g., portfolio analysis, country case studies, document review and KIIs, or multiple KIIs of different stakeholder categories), which are generally of good quality.
Moderate (2)	Evidence comprises multiple data sources (good triangulation across case studies) of lesser quality, or the finding is supported by fewer data sources (limited triangulation, e.g., only documents of KIIs from one stakeholder category) of decent quality.
Limited (3)	Evidence comprises few data sources across limited stakeholder groups (limited triangulation) and is perception-based or is generally based on data sources that are viewed as being of lesser quality.
Poor (4)	Evidence comprises very limited evidence (single source) or incomplete or unreliable evidence. Additional evidence should be sought.

By examining evidence from various sources, the evaluation team has scored the strength of evidence supporting each evaluation finding (at the beginning of each findings paragraph(s)).

4 Findings

Objective 1

EQ1

EQ1: To what extent are Global Fund investments targeting locations where most new infections are occurring/locations with the highest HIV incidence rates and/or populations most in need of HIV prevention services?

Global Fund investments under GC7 grants are highly focused and are both epidemiologically informed and data-driven with respect to high-burden geographies as well as populations most at risk of HIV infection. The cross-portfolio analysis[20] shows a high degree of focus toward both the geographic locations where new infections are occurring and the specific populations most in need of HIV prevention services. This strategic allocation is a foundational element of the GC7 grant configurations across the portfolio, with a focused approach that is comprehensive and utilizes up-to-date epidemiological data to focus limited resources for maximal impact in concentrated and generalized epidemic settings. Program partners in the vast majority of portfolio-wide countries have identified and prioritized specific geographic locations with the highest burden of HIV, using both prevalence and incidence data as proxies for areas seeing the largest number of new infections. The focus on populations most in need of HIV prevention services is virtually universal and highly robust across the portfolio. The grant interventions are generally designed to cover the specific high-burden locations and populations identified, demonstrating an integrated, targeted approach. This finding is supported by the in-depth case studies, which show that in these countries, grants consistently reference burden, surveillance, and modeling data (e.g., Spectrum, Naomi, integrated biological and behavioral surveillance surveys (IBBS)) to prioritize high-incidence geographies and populations at greatest risk, notably KPs and AGYW in high-incidence settings. In several contexts, it was noted that while the strategic direction toward data-driven targeting is clear, operationalization remains constrained by implementation challenges.

The Global Fund is now focusing on where the infections actually happen. The investment is not spread thinly anymore; it is concentrated where data shows the highest risk." [Global stakeholder]

"We are now mapping and focusing more on urban centers where incidence is higher. The data clearly shows that's where infections are clustering." [Mozambique]

"In the Global Fund GC7 proposal, there was a shift to prioritizing high-burden districts, and we used Spectrum and Naomi data to identify those areas." [Kenya]

Finding 1.1: Across the portfolio, countries utilize various data sources, including national surveillance, prevalence studies, and mathematical modeling to pinpoint geographic areas of concentrated transmission and prioritize geographic locations that are experiencing, or predicted to experience, the largest number of new HIV infections. Within the sampled 12 countries, grants consistently reference burden data, bio-behavioral surveillance, and modeling (e.g., Spectrum, Naomi, IBBS) to prioritize high-incidence geographies and populations at greatest risk, notably KPs and AGYW in high-incidence settings.

Strength of evidence:

			Strong

In Kenya, Uganda, Mozambique, and Tanzania, prevention planning is guided by national modeling tools such as Spectrum/Naomi and by vulnerability mapping to identify high-burden sub-national areas.[21] Kenya, Uganda, and Mozambique are reported to use epidemiological and programmatic data to inform resource allocation decisions, geographic prioritization, and annual adaptation of prevention coverage.[22] In Tanzania, stakeholders highlighted that Naomi modeling and periodic incidence mapping are now central to sub-national planning, enabling the identification of high-burden counties where community-led delivery is prioritized.[23] Uganda's approach is reported to combine Naomi and Spectrum data with national M&E reviews to determine where resources can generate the greatest impact, with mid-cycle reprogramming used to adjust activities accordingly.[24] Mozambique applies routine program data and partner performance reports, ensuring that districts with higher prevalence or underserved KPs receive greater emphasis.[25] Similarly, cross-portfolio analysis indicates that countries rely heavily on prevalence data, and incidence estimates. Zambia's geographic targeting focuses on 48 priority districts that collectively account for 80% of new HIV infections, based on 2022 HIV Spectrum estimates.[26] Ecuador concentrated investments in six provinces where 73% of new HIV cases were diagnosed in 2023.[27] In addition, program partners often use systematic stratification methodologies to allocate resources. For example, Tajikistan used the OPTIMA mathematical modeling exercise, which estimated that 29% of new infections in 2021 occurred among FSWs and their clients, guiding resource allocation to related services and locations.[28] In the same way, Indonesia prioritizes 178 districts, using Spectrum modeling and focusing on regions like Tanah Papua, which has a high HIV positivity rate.[29] Eswatini applies IBBS 2021 data to prioritize four cities for MSM/FSW, supplemented by hotspot outreach to locations such as Matsapha, Waluza, and Enguleni.[30] Nigeria uses IBBS, KP size estimates, and NSP analyses to identify states with the largest burden of new infections, including Gombe and Anambra, which show "high yield" in detecting new infections.[31] Pakistan identifies priority locations using mapping, surveillance, and early warning systems that detect emerging clusters of new infections in sites such Nawabshah.[32] Madagascar identifies high-burden regions through stratified prevalence results,[33] Kosovo applies IBBS 2022 and program analysis to identify KP-dense locations.[34] Uganda uses Spectrum and Naomi modeling to identify high-burden administrative units,[35] and Zimbabwe expands MSM and FSW sites based on district-level burden and size estimates.[36] The Philippines concentrates on 123 high-burden cities and municipalities, moving away from inclusion of moderate/low-burden sites; partners pair this with KP-led delivery and mobile CombiVans to reach mapped hotspots.[37] For Madagascar, in-country stakeholders and the Global Fund Secretariat report that geographic targeting has shifted from a broad geographic footprint (46 districts) to a concentrated model in just 10 high-burden cities for MSM/FSW and five for PWID—a change recognized by the Global Fund Secretariat as enhancing value for money.[38] The country also identifies high-burden northern, southern, and eastern regions through stratified KP prevalence.[39] Kenya demonstrates strong geographic precision in identifying locations with the

highest new infections. For example, five high-incidence counties were prioritized for AGYW programming (Busia, Kisii, Kajiado, Machakos, Turkana), while MSM and FSW coverage is extended nationally with hotspot-based targeting, and PWID services focused on coastal and urban zones.[40] The country also selects AGYW from "hotspot areas" and clubs and deploys mobile teams to far-flung locations such as Kitengela and Hisinha.[41] More examples are given in Box 1A below:

Box 1A:

- **Mozambique** categorized its 82 districts by HIV incidence, classifying 38 (46%) as high-incidence districts, which are the focus of the grant.
- **Tanzania** categorized the country's councils into incidence bands (low, moderate, high, and very high) based on AGYW HIV incidence data from UNAIDS, using this framework to shift investments toward moderate-incidence areas.
- **Kenya** prioritizes "precision prevention efforts" in the 18 counties that account for most new infections.
- In **Afghanistan**, seven high-priority provinces, including Kabul and Herat, were identified based on a matrix analysis of data on HIV prevalence and concentration of KPs.
- In **Myanmar**, five high-burden regions (Yangon, Mandalay, Kachin, Shan North, and Sagaing) were identified, and sub-national modeling further showed that new infections among PWID contribute over 60% of all new cases in Kachin, Shan North, and Sagaing.
- In **Madagascar**, 10 high-priority cities were selected based on programmatic mapping, HIV positivity rate, and high HIV prevalence among MSM (e.g., 31.6% in Antananarivo).

Mozambique's KP programming (supported by the Global Fund) is anchored in the southern region, where organizations such as LAMBDA lead implementation in Maputo City and Province, aligning with the country's highest HIV incidence among KPs.[42] Pakistan identifies priority districts where KP networks are largest and applies early warning systems to detect location-specific clusters of new infections.[43] Eswatini's analyses identify priority KPs.[44] This is also evidenced across the portfolio whereby several countries explicitly cite in the funding requests and the associated grants documents, sub-national statistics on the proportion of new HIV infections to define priority locations as presented in Box 1B.

Box 1B: Illustrative examples of HIV infection statistics drawn from portfolio analysis of grant documentation

- In **Guyana**, Region 4, which includes the capital Georgetown, was identified as the primary epicenter, accounting for 72.8% of all new HIV infections diagnosed in 2023.
- In **Chad**, seven of the country's 23 provinces accounted for two-thirds (66%) of all new infections in 2022. The leading provinces included N'Djamena (27%), Lac (8%), and Moyen Chari (8%).
- In **Ecuador**, grant documentation states that 73% of new HIV cases diagnosed in 2023 are concentrated in six provinces: Guayas, El Oro, Manabí, Esmeraldas, Los Ríos, and Pichincha.
- In **Nicaragua**, eight Local Systems for Comprehensive Health Care (SILAIS) concentrate 82% of new HIV cases, with Managua alone accounting for 39.6% of these cases.
- In **Armenia**, the capital city of Yerevan reported more than a quarter (26.4%) of all new HIV infections in 2023.
- In **Peru**, the department of Lima and the constitutional province of Callao receive the largest number of HIV notifications, contributing, along with a few Amazonian regions, to 71% of accumulated cases from 2019 to 2023.

- In **Zambia**, the program targets 71 districts, of which 48 are designated as priority districts that collectively account for 80% of new HIV infections in the country.

However, in locations where explicit incidence data is limited (such as Cape Verde, Eritrea, and Sudan), program partners rely on high-prevalence rates among KPs or the physical concentration of KPs in major urban centers (e.g., Djibouti Ville in Djibouti, Montserrado County in Liberia, and Nouakchott in Mauritania) as proxies for identifying locations with the highest number of new infections.[45] Overall, evidence from multiple data sources confirms that KPs and AGYW in high-incidence settings remain the focus of Global Fund prevention investments. Global stakeholders emphasized that GC7 puts much greater emphasis on KPs and AGYW in high-incidence settings than previous cycles.[46] Country-level data corroborate this: stakeholders in Nigeria, Mozambique, and Kenya cite increased attention to KPs and expansion of community-led approaches.[47]

Finding 1.2: The focus on populations most in need of HIV prevention services is virtually universal and highly robust across the portfolio. Global-level stakeholders emphasize that KPs and other populations at high-risk of HIV form the central focus of precision HIV-prevention approaches across the 12 sampled countries. Furthermore in 8 of these countries that are generalized epidemics they also identify AGYW as a population most in need of HIV prevention services.

Strength of evidence:

			Strong

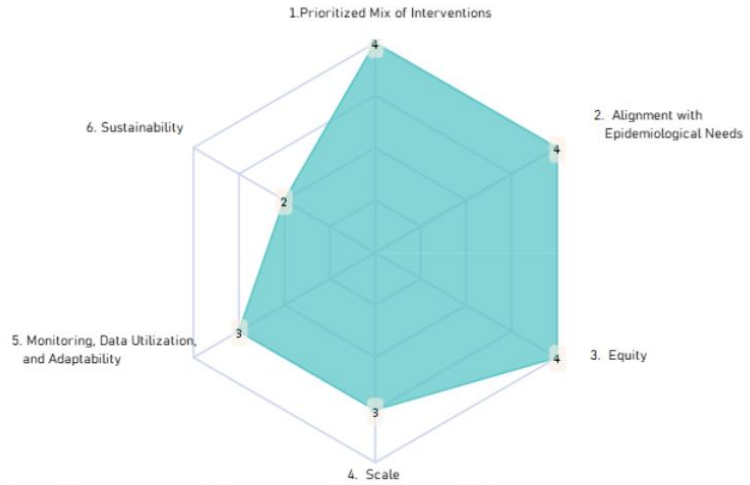
Country-level data reinforce this: Kosovo identifies MSM as the "main KP" where most transmission occurs, with resources allocated proportionally for MSM and PWID.[48] Madagascar defines its epidemic as "concentrated among KP", prioritizing KPs in hotspot regions.[49] Kenya identifies KPs, fisherfolk and orphans as priority groups and applies age-differentiated strategies such as greater primary prevention emphasis for younger MSM.[50] Zimbabwe highlights the need to sustain prevention among KPs, noting that these populations lag behind the general population in progress toward 95-95-95.[51] Pakistan similarly identifies MSM, FSW and PWID as the highest-risk groups.[52] These are mirrored in national strategies across Mozambique, Nigeria, Paraguay, Philippines, Tanzania, Uganda, and Zimbabwe, where strategic plans explicitly prioritize KPs.[53]

Evidence from primary data collection shows that AGYW HIV prevention interventions focus on those at some of the highest epidemiological risk.[54] Eswatini, a high-burden setting, prioritizes AGYW as core prevention groups under the Global Fund grant.[55] Nigeria similarly prioritizes AGYW because of the "percentage they contribute to new infections."[56] In Kenya, about "41% of new adult infections" occur among 15 to 24-year-olds, driving AGYW prioritization.[57] Global stakeholders describe efforts to refine AGYW denominators through the use of risk profiling, reducing previously inflated, age-based population estimates and enabling more precise targeting.[58] The outcome-focused prevention, with new global targets, including prevention-outcome indicators, supports this precise focus.[59] Country strategic plans across Mozambique, Tanzania, and Uganda similarly prioritizes AGYW alongside KPs in line with national burden

patterns.[60] This is also illustrated in Box 1C, which shows high scores for epidemiological alignment and equity in Mozambique's Grant Assessment Compass design.

Box 1C: Mozambique Grant Assessment Compass

The compass diagram for the Mozambique GC7 grant highlights how the grant design demonstrated an impressive score in terms of alignment with epidemiological needs, mix of appropriate interventions and equity. It also scores relatively well in terms of M&E due to the strong proposed M&E framework—see EQ9.



Grant Assessment Compass for Mozambique

Design of Global Fund GC7 HIV Prevention Grant(s) in Mozambique

Countries from the cross-portfolio analysis also consistently identify and prioritize specific KPs where the epidemic is concentrated, justifying this focus with prevalence data as evidenced in the Box 1D:

Box 1D:

- In **Angola**, **FSW, MSM, and Transgender people** are prioritized based on the 2017 IBBS.[61]
- **The Congo** focused on **MSM** due to their extremely high HIV prevalence (30.8%).[62]
- **South Africa** targeted **AGYW** due to their significantly higher incidence (1,100 new infections per week) compared to their male counterparts.[63]
- **Nigeria** prioritized **KPs** due to high-prevalence rates.[64]

While identification is generally comprehensive, a few grants were noted for omitting or underscoring certain KPs, representing a limited gap in the overall focus on KPs and AGYW in high-incidence settings. Due to the criminalization of some KPs such as MSM within Ethiopia, MSM are labeled differently or subsumed in other categories.[65]

Finding 1.3: Global structures play a significant role in ensuring that countries correctly identify locations of highest transmission.

Strength of evidence:

	Limited		

UNAIDS and WHO support data validation and correction so that geographic patterns of new infections are accurately captured, noting that programmatic data often requires external validation to ensure reliability.[66] The GPC provides prevention scorecards, roadmaps, technical guidance and global epidemiological standards, helping countries identify priority geographic areas.[67] There is an emphasis on the need for objective, non-country-driven validation to ensure accurate understanding is gained of where new infections occur.[68] TRP explicitly question how planned interventions relate to changes in prevention outcomes, driving countries to justify why certain locations are prioritized.[69] TRP reviews confirm that funding requests in countries such as Eswatini, Madagascar, Kosovo, and Zimbabwe rely on the most recent HIV incidence and prevalence data to identify high-burden locations.[70] These global mechanisms contribute to strengthening the identification of locations with the highest new infections.

Finding 1.4: Opportunities exist to improve focus on populations and locations that remain insufficiently captured.

Strength of evidence:

			Strong

There are also pockets where the identification of priority locations has not fully translated into inclusive focus. Zimbabwe's PWID communities are calling attention to the need for enhanced harm-reduction support in settings with clear epidemiological risk.[71Error! Bookmark not defined.] Pakistan's methamphetamine-using communities highlight that their high-risk sites are identified through program data, yet funding restrictions prevent provision of essential safe-use equipment.[72] Zimbabwean stakeholders highlight that insufficient disaggregation of "men at high-risk" may obscure MSM/TGW hotspots.[73Error! Bookmark not defined.] Structural gaps also affect identification accuracy: Pakistan indicates that lack of childcare support prevents FSWs from remaining engaged long enough for precise hotspot mapping,[74Error! Bookmark not defined.] and Nigeria reports that reductions in behavioral and peer-led interventions weaken the identification of KP-dense locations[Error! Bookmark not defined.].[75] While partners do identify major high-incidence locations, gaps persist among transgender, PWID, and women and children, which are not consistently reflected in available data and monitoring systems.

EQ2

EQ2: To what extent are Global Fund investments being programmed toward HIV prevention interventions aligned with global normative guidance while considering the countries' context and epidemiological situation?

Throughout the portfolio, Global Fund HIV prevention investments in GC7 are strongly aligned with global normative guidance[76] and are broadly appropriate to country epidemiology. In the cross-portfolio analysis as well in the 12 case study countries, funding requests and grants are anchored in national HIV strategies and global normative guidance; they are increasingly focused on combination prevention approaches that integrate biomedical, behavioral, and structural components for KPs and AGYW in high-incidence settings.[77] Program partners systematically prioritize PrEP, condoms and lubricants, harm reduction for PWID, VMMC in appropriate settings, and integrated sexual and reproductive health (SRH)/gender-based violence (GBV) services, alongside human rights and community-led interventions.[78] This alignment is reflected in country documentation across a majority of grants in the portfolio and in the sampled countries (for example, Eswatini, Tanzania, Uganda, Zimbabwe, Pakistan and Paraguay). Among the sampled countries, both country and global stakeholders describe GC7 as a shift toward "precision prevention" and high-impact interventions focused on the populations and geographies at greatest risk—including AGYW at highest risk.[79] Despite the generally strong alignment, the portfolio analysis of programmed biomedical interventions highlights both high adoption of key tools and critical gaps, particularly concerning harm reduction and, in some cases, the assured funding of PrEP.[80]

Finding 2.1: The portfolio analysis confirms that program partners in the vast majority of countries have either identified or are in the systematic process of identifying the UNAIDS/WHO HIV prevention interventions most appropriate to their specific epidemiological context and are moving from broad coverage to more targeted, risk-stratified "precision prevention" for KPs and AGYW in high-incidence settings .

Strength of evidence:

			Strong

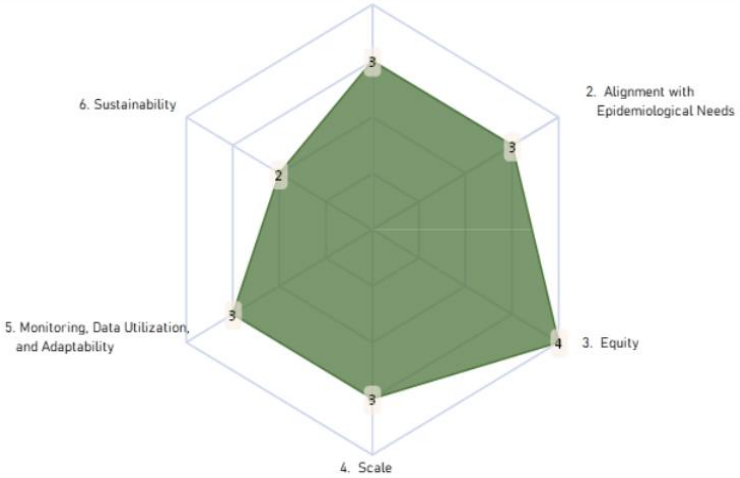
Across the 12 countries, GC7 grants mirror national strategies that were developed using WHO/UNAIDS guidance and GPC roadmaps, with deliberate focus on KPs and AGYW in high-incidence settings. Country documents show inclusion of global guidance into national prevention roadmaps and NSPs (e.g., Tanzania's HIV Prevention Road Map; Uganda's precision combination prevention for KPs and AGYW in high-incidence settings; Pakistan's tailoring of UNODC/WHO harm-reduction guidelines to 19 priority districts; Paraguay's sub-national KP combination prevention), and their translation into GC7 modules and delivery platforms (drop-in centers (DICs), peer-led outreach, community–facility linkages, digital platforms.)[81] Global KIIs describe a deliberate shift between GC6 and GC7 away from "all AGYW" targets in the tens of millions toward AGYW at highest risk in high-incidence districts and KPs in concentrated epidemics, driven by collaboration with UNAIDS/WHO to re-define denominators and focus on high-risk segments.[82]

"For every prevention intervention that is being implemented in Nigeria, it follows the national guideline. And this national guideline is usually adapted from the guidelines that have been implemented, the WHO guidelines, the UNODC guidelines, the UNAIDS direction that give the technical assistance to the country."[Nigeria]

Nigeria's alignment with the normative guidance is also evident in the Grant Assessment Compass scores shown in Box 2A:

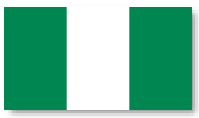
Box 2A: Nigeria Grant Assessment Compass

The compass diagram for the Nigeria GC7 grant highlights how its design demonstrates strong alignment with epidemiological needs and good mix of appropriate interventions. It scores extremely highly on the equity access directly investing in solutions to human rights, gender, and stigma-related barriers, with affected communities at the center of the response.



Grant Assessment Compass for Nigeria

Design of Global Fund GC7 HIV Prevention Grant(s) in Nigeria



"Global Fund was able to fund different guidelines e.g., CLM guideline and minimum package of services for AGYW that was supported by Global Fund and PEPFAR jointly." [Tanzania]

Many countries in the portfolio explicitly stated that their selection of interventions was mandated by or aligned with overarching normative documents, ensuring that global best practices were adopted. The selection process is consistent with UNAIDS/WHO guidelines in an overwhelming majority of prioritized interventions. Some examples from the portfolio are given in Box 2B.[83]

Box 2B: Examples of alignment with normative guidance.

- Jamaica's Prevention Package of Care was designed "in accordance with the WHO Consolidated Guidelines 2021."
- In Serbia, program partners supported the scale-up of PrEP and aligned with existing national policy and guidelines.
- Peru built its entire HIV prevention component around the recently approved "Technical Health Standard on HIV Combination Prevention."

Finding 2.2: Biomedical tools recommended by WHO/UNAIDS (especially PrEP and condoms/lubricants) are widely programmed with delivery models tailored to country context and, in several countries, sit alongside rapid adoption of newer technologies.

Strength of evidence:

			Strong

Across the portfolio, including in countries such as Eswatini, Kenya, Mozambique, Nigeria, Pakistan, Paraguay, the Philippines, Tanzania, Uganda, and Zimbabwe, PrEP (oral and increasingly long-acting) is embedded within GC7 prevention modules for KPs and AGYW in high-incidence settings.[84] PrEP is explicitly programmed in many grants as a core, WHO-recommended intervention, with several countries planning to introduce or scale newer modalities such as Long-Acting Injectable Cabotegravir (CAB-LA), Lenacapavir (LEN) and the vaginal ring.[85] Country KIIs describe Eswatini as "quite advanced" with oral PrEP, the vaginal ring and CAB-LA (introduced in 2024), and LEN was formally launched on World AIDs Day with reported strong uptake in December 2025 and January 2026.[86] LEN has also been introduced in Zambia and the Eswatini, while Zimbabwe, Nigeria, Kenya, Mozambique, Uganda, South Africa, and Lesotho are planning for the rollout of LEN for KPs and AGYW in high-incidence districts.[87] Nigerian stakeholders also specifically referenced multiple PrEP options (oral, CAB-LA) available through Global Fund-supported channels.[88] Consistent with PrEP, condoms and lubricants are programmed as a core component of the minimum package across nearly all country contexts, with structured demand generation and distribution through DICs, peer outreach, and primary care networks (Tanzania, Nigeria, Mozambique, Pakistan, Paraguay).[89]

FGDs further confirm that PrEP and Post-Exposure Prophylaxis (PEP) are visible and valued at community level. For instance, AGYW in Eswatini confirmed the availability of commodities, stating, "We also have PEP for preventing HIV."[90] In the Philippines, CSOs reported that alongside PrEP, the uptake of PEP is "much improved" with organizations providing "emergency PEP" through community help desks.[91] Similarly, peer educators in Kenya emphasized their role in ensuring FSW and MSMs have access to "PrEP and PEP."[92] This aligns with health authorities in Paraguay, who articulated a specific vision to strengthen "all prevention strategies, PrEP and PEP" from the first level of care,[93] and in Mozambique, where stakeholders noted that PEP remains a sustainable intervention because it utilizes the same antiretrovirals used for treatment.[94]

Overall, biomedical intervention delivery models reflect strong contextual tailoring with most countries diversifying beyond facility-based care toward differentiated, community- and peer-led models such as DICs (Pakistan, Madagascar, Uganda), mobile and community outreach (Mozambique, Philippines), and integration with private sector and pharmacy channels (Kenya).[95] Several countries (Nigeria, Pakistan, Tanzania) also emphasize digital and virtual outreach, alongside harm reduction and human rights programming.[96]

"We are trying to focus more on how we move forward with supporting this cascade… and make sure that AGYW that are at the biggest risk have access to PrEP."[Eswatini]

"[drop-in centers provide a] safe space where we can sit together and talk openly about community dynamics." [Kenya]

"We provide differentiated service delivery models including community-based distribution, pharmacy access, and integrated SRH/HIV services." [Tanzania]

Finding 2.3: Long-acting PrEP is not planned or financed everywhere, with variation in readiness and prioritization across countries in the portfolio.

Strength of evidence:

			Strong

Due to resource and other constraints, first introduction of PrEP new generation technologies to address adherence challenges was prioritized in 9 countries, with an additional 13 to follow. These include early adoption of LEN in Zambia and Eswatini and planned introduction of LEN in Eswatini, Kenya, Lesotho, Mozambique, Uganda, Zimbabwe, Nigeria and South Africa. In addition, planned introduction or scale-up of long-acting injectable PrEP (CAB-LA) in countries facing generalized epidemics such as Eswatini,[97] Lesotho,[98] Kenya,[99] Rwanda,[100] Uganda,[101] and Zimbabwe[102] is another example. Similarly, Cambodia addressed high-incidence among specific populations by including a pilot for CAB-LA.[103] In countries with severe generalized or concentrated epidemics, PrEP already formed a core component and often included new modalities. For example, Lesotho incorporated oral PrEP, the dapivirine vaginal ring, and CAB-LA,[104] and Botswana also planned to introduce CAB-LA.[105] Within the sampled countries, document reviews indicate eight countries will be introducing long-acting PrEP (CAB-LA and/or LEN). At the time of writing this report (December 2025), Eswatini and Zambia had introduced LEN.[106] In Kosovo, stakeholders report that long-acting PrEP is not planned for introduction in GC7 due to fiscal and programmatic trade-offs.[107] Philippine stakeholders in particular identify low PrEP uptake, competing testing and treatment priorities, and broader system challenges as limiting the feasibility of adding long-acting options in the near term.[108]

Finding 2.4: According to the cross-portfolio analysis, harm-reduction interventions for PWID are uneven across countries, with inclusion in several settings but major gaps in others due to policy and resource constraints.

Strength of evidence:

			Strong

Close to a third of grants across the portfolio explicitly include or prominently discuss harm-reduction services, including needle and syringe programs and opioid substitution therapy (OST). Among the sampled countries there is a divergence in the extent to which harm-reduction interventions are reported.[109]. One group of countries (Nigeria, Pakistan, Kenya, Zimbabwe, Kosovo, Uganda, Mozambique) report the inclusion of harm-reduction interventions such as needle and syringe programmes and opioid agonist therapy/medication-assisted treatment (OAT/MAT), whereas this is less evident or not reported at meaningful scale in others (Eswatini, Madagascar, Tanzania, Paraguay, Philippines), including contexts where PWID remain a key driver of HIV transmission, such as Tanzania and the Philippines.[110] Selective examples of countries with harm-reduction interventions are presented in Box 2C.

Box 2C: Country examples demonstrating the presence of harm-reduction interventions

- Kazakhstan prioritized harm reduction needle and syringe programs, scale-up for PWID using "Optima" modeling.[111]
- Afghanistan prioritized a comprehensive harm-reduction package, appropriate for an epidemic concentrated among PWID.[112]
- Nigeria demonstrates the most mature model, with MAT expansion to 13 states described as a "first in the country," reflecting growing national ownership with Global Fund support.[113]
- Pakistan and Kenya implement needle exchange through community-based platforms.[114]
- Mozambique has recently expanded services, establishing four harm-reduction centers nationally.[115]

Elsewhere, harm-reduction scale and scope remain limited: Zimbabwe's programming is at pilot stage, and Kosovo faces resource-driven trade-offs that restrict comprehensive service delivery.[116] Global partners note that, despite WHO/UNAIDS recommendations, political resistance in concentrated epidemic contexts continues to constrain implementation.[117]

"Needle and syringe programs are unlikely to continue… Government thinks prevention is health promotion and education."[Kosovo]

"We cannot do needle exchanges or OST due to local regulations."[Philippines]

Finding 2.5: The cross-portfolio analysis indicates strong evidence that countries and the Global Fund are actively planning to address priority unmet needs and are embedding innovation (both in biomedical tools and in delivery and data systems), but these efforts are still maturing and unevenly resourced.

Strength of evidence:

			Strong

HIV prevention grants reveal a highly strategic approach to addressing programmatic weaknesses and gaps, with evidence of plans to address priority unmet needs (within GC7 grants) or innovation across an overwhelming majority of countries/multi-country programs. These plans extend beyond simply restoring basic services, often involving the introduction of cutting-edge biomedical technologies, innovative service delivery modalities, and sophisticated monitoring tools.[118] Selective examples of plans to address priority unmet needs and proactive adoption of innovative strategies and technologies to address known weaknesses in service delivery are presented in Box 2D.

Box 2D: Selective examples of plans to address unmet needs in recommended interventions.

- Plans for stepwise inclusion of a full harm-reduction package, including OST and overdose management, in **Ethiopia**.[119]
- **Cameroon** with the introduction of a harm-reduction strategy (needle and syringe programs and OST) addressed a critical service gap.[120]
- **Somalia** included a "brand-new module" for harm reduction following epidemiological evidence.[121]
- In **Tanzania**, a formal action plan was mandated to address the high rate of **PrEP discontinuation**.[122]
- The grant in **Togo** proposed solutions, such as providing badges to peer educators and subsidizing client check-ups, to overcome **weak PrEP uptake**.[123]

- **Community-led monitoring (CLM)** was planned or mandated in **Burkina Faso, Guatemala, Senegal, Zanzibar**.[124]
- In **Angola**, a **new IBBS** for KPs was planned to provide updated data, ensuring interventions are better targeted.[125]
- **Afghanistan** planned annual **mini-IBBS** studies to update epidemiological data and track trends among PWID and prisoners.[126]
- **Serbia** planned to pilot both HIV self-testing and s**ocial network-based testing** through operational research.[127]
- For PWID, **Ukraine** prioritized **digitally facilitated prevention services** and the use of **mobile clinics** to reach displaced populations.[128]

A similar pattern is also evidenced in the sampled countries whereby many grants in GC7 include explicit "prevention stewardship" or similar modules that finance planning and governance for new modalities, total market approaches, and adaptive scale-up (e.g., Kenya, Mozambique, Nigeria, Tanzania, Pakistan, Zimbabwe).[129] Country KIIs detail concrete plans for the introduction or expansion of CAB-LA, the dapivirine ring, and especially Lenacapavir, alongside capacity building for providers and PrEP eligibility tools to ensure equitable targeting.[130] Service delivery innovations (e.g., mobile clinics, differentiated KP services, digital and social network-based testing, expansion of prevention staff in primary care, and deliberate adaptations to restrictive legal environments such as re-classifying MSM/trans reporting as "other vulnerable populations" in Uganda) are used to maintain reach in difficult contexts.[131] Some countries are placing a particular emphasis on digitization of service delivery, outreach, and monitoring systems to strengthen access, demand generation, and data use in programming. Examples of digital innovations include Madagascar's E-Zaho platform for reporting rights violations,[132] Tanzania's Unified Community System for community-level reporting,[133] and Paraguay's teleconsultation and digital access pilots.[134] Kenya is pioneering a polling booth survey (PBS) to generate near real-time behavioral data for adaptive management,[135] while Eswatini and Uganda are advancing digital demand creation and community-led reporting systems that engage KPs and AGYW online, enabling rapid feedback on service quality and access barriers.[136]

"The polling booth survey represents an innovation in prevention outcome monitoring that is now being replicated in other countries. We pioneered this approach to get faster, more actionable data for program adaptation." [Kenya]

"We are now working on a unified community system (UCS) that has come up to digitize the various registers and the paper-based system. All the modules for all interventions have been digitized but not yet rolled out at scale." [Tanzania]

EQ3

EQ3: To what extent and how are structural and behavioral interventions oriented toward HIV prevention (or HIV treatment) outcomes through enhancing the uptake of services?

Structural and behavioral interventions included in GC7 grants are deliberately oriented toward HIV prevention outcomes by enhancing the uptake of HIV prevention options and addressing barriers to access, but their impact is moderated by resource constraints and restrictive environments, and some gaps remain in the programmatic design, financial commitment, operational scale, and structural implementation necessary to achieve optimal impact.

Across countries, GC7 funding requests and national strategies consistently apply a combination prevention approach, linking targeted HIV prevention communication and demand creation and other critical enablers with HIV prevention options such as PrEP, condoms or sterile syringes tailored to KPs and AGYW in high-incidence settings.[137] Global and national stakeholders describe a clear shift from GC6 to GC7 toward more targeted and outcome-driven investments for populations and locations at highest risk.[138] Evidence suggests countries prioritize structural interventions addressing human rights to a greater extent than social protection as tools to maximize biomedical intervention impact.[139] Community perspectives from Kenya, Eswatini, Pakistan, Nigeria, the Philippines and Paraguay further underscore that peer networks, safe spaces and human rights programs in particular function as the essential "bridge" that transforms biomedical the availability of HIV prevention options into access "without stigma and discrimination."[140]

Cross-portfolio analysis of G7 grants identified a number of challenges relating to the programmatic design, financial commitment, operational scale, and organizational structures and systems necessary to achieve optimal impact in some countries. For example, across several sampled country contexts (Mozambique, Nigeria, Kosovo, Tanzania, Kenya, Pakistan, Paraguay), stakeholders describe how restrictive policy and legal environments (e.g., criminalization, discriminatory policing, health system stigma) continue to limit access to and uptake of biomedical prevention options.[141] Country and Global Fund KIIs highlight growing pressure on available resources which have led to reduction in interventions focusing on fighting social, human rights and gender (HRG) related barriers to HIV, TB, and malaria services. These pressures, combined with persistent legal and social barriers, weaken the capacity of structural and behavioral approaches to consistently drive uptake at scale. This shift is justified by some stakeholders on the grounds that while social protection (e.g., economic empowerment, schooling support) addresses root causes of vulnerability for KPs and AGYW, it has a lower or less direct evidence base for reducing HIV transmission compared to biomedical tools like PrEP and Antiretroviral Therapy (ART), particularly when resources are scarce. For instance, in Tanzania, income-generating activities for AGYW were reduced based on global guidance, suggesting these activities have "relatively low impact on HIV-related outcomes" compared to direct clinical interventions.[142] Similarly, in Eswatini, structural interventions such as vocational training and GBV case management were deprioritized because they were "no longer identified as lifesaving" in the context of funding cuts, with the expectation that national governments should absorb these social safety net responsibilities.[143] However, this rationale creates a tension in the portfolio: while biologically justified, deprioritizing these "enablers" risks undermining the uptake of the very biomedical services being protected. Implementers in Kenya argued that cutting HRG activities ignores the reality that stigma remains the primary barrier to access; without these structural bridges, the target populations cannot reach the clinic to utilize biomedical commodities.[144] Consequently, while the deprioritization of social protection is financially rationalized to preserve immediate survival mechanisms (treatment and diagnostics), stakeholders warn that removing these critical enablers may weaken the program's capacity to drive uptake at scale among the most vulnerable.[145]

Finding 3.1: Structural and behavioral interventions are systematically embedded in GC7 design and are increasingly concentrated on the most critical and high-impact prevention levers for populations at greatest risk.

Strength of evidence:

			Strong

Global Fund-supported countries have adopted a combination prevention approach that explicitly organizes investments across biomedical, behavioral, and structural interventions with people-centered approaches aimed at optimizing choice, with GC7 grants mapping these components clearly for KPs and AGYW in high-incidence settings in line with NSPs and global normative guidance.[146] Biomedical packages prioritize PrEP expansion (including CAB-LA and Lenacapavir), harm reduction for PWID, targeted VMMC in relevant settings, sexually transmitted infection (STI) services, while behavioral and structural interventions include social and behavior change communication, peer navigation, legal literacy, stigma and GBV reduction, human rights mechanisms and community-led monitoring (CLM).[147] KIIs with country stakeholders confirm that partners are using epidemiological data and risk profiling to refine and focus these intervention packages (e.g., precision targeting of AGYW and KPs in high-incidence districts in Eswatini, Uganda, Madagascar and Philippines; IBBS-informed targeting of MSM in Kosovo).[148] Global stakeholders report a clear pivot in focus from GC6 to GC7 away from diffuse, lower yield investments (e.g., very broad AGYW coverage and large-scale but low-impact comprehensive sexual education) toward more targeted investments in interventions and populations with the strongest evidence of effect on primary prevention outcomes.[149]

"For AGYW, we combine biomedical interventions like PrEP with social protection programs, economic empowerment, and education. This comprehensive approach is more likely to have an impact than biomedical interventions alone." [Tanzania]

"They prioritized PrEP. Obviously, they have CAB-LA and the vaginal ring introduced... They also have covered areas for gender-based violence prevention, human rights and stigma reduction and they have a good and robust harm reduction program." [Uganda]

Finding 3.2: Structural interventions (especially human rights programming, safe spaces, and social protection) are widely perceived as essential to enabling uptake of biomedical prevention, yet they are increasingly vulnerable to deprioritization and resource cuts.

Strength of evidence:

			Strong

Approximately 90% of the grants in the portfolio included reference to structural interventions (e.g., removing human rights barriers, anti-stigma campaigns, legal reform, community empowerment) in their programming, recognizing these as critical enablers for HIV prevention access and use.[150] At the same time, virtually all grants included behavioral elements, such as peer outreach, communication campaigns, and comprehensive sexuality education (CSE).[151] Also, more specifically within the sampled countries, documents and KIIs highlight HRG interventions including legal literacy, law enforcement sensitization, GBV prevention and response as well as

CLM, as integral to the recommended combination prevention package, with Global Fund matching funds and prevention stewardship modules supporting these in multiple regions.[152]

Country stakeholders describe extensive structural work: Legal framework development and police training for MAT in Nigeria; "know your rights" interventions in Kosovo; social protection and vocational training for AGYW in Tanzania; integration of prevention information and PrEP in primary care in Paraguay; and mobile clinics in Eswatini to overcome stigma.[153] FGDs reinforce the centrality of behavioral models—peer educators, small-group sessions ("stepping stones"), and "lessons" with AGYW over six months, and community mobilization—to support uptake of PrEP and condoms.[154]

Yet Eswatini civil society stakeholders report that across donors (including the Global Fund) there has been a marked reduction in structural components such as financial literacy, livelihoods, and GBV case management, and Kenyan implementers report HRG activities being dropped from GC7 in some districts despite persistent socio-economic drivers of risk.[155] Stakeholders across several other contexts (Mozambique, Nigeria, Kosovo, Tanzania, Kenya, Pakistan, Paraguay) describe how restrictive policy and legal environments (e.g., criminalization, discriminatory policing, health system stigma) continue to limit access to and uptake of HIV prevention options.[156]

Country FGDs and KIIs with the Global Fund Secretariat and country stakeholders indicate that countries prioritize structural interventions addressing human rights to a greater extent than social protection[157]in line with the technical guidance.[158] FGDs highlight that HRG investments, including legal literacy, stigma reduction, GBV response and engagement with law enforcement, directly address "the core issue of inaccessibility" by reducing fear, discrimination and violence that deter KPs and AGYW from accessing services in public health facilities.[159] In Mozambique, Kosovo, and Nigeria, KIIs identify stigma and discrimination (both social and institutional) as the "biggest obstacle" to clinical service uptake and describe Global Fund-supported community centers, KP-friendly services, mobile brigades and collaborations with human rights institutions and police as critical mechanisms to mitigate these barriers.[160]

Social protection and economic-empowerment measures (e.g., vocational training and livelihoods support for AGYW, school retention, and support packages for affected households) are used in Tanzania, Eswatini, and Pakistan to reduce socio-economic vulnerability and associated risk behaviors.[161] At the same time, there is evidence that these interventions do not necessarily improve HIV incidence or prevalence and, as a result, the Global Fund has made a deliberate effort to focus resources on the most effective HIV prevention interventions.[162]

However, KIIs from Eswatini, Tanzania, Kenya and Global Fund Secretariat stakeholders consistently report that some structural interventions such as socio-economic strengthening interventions have recently reduced as higher impact HIV prevention interventions have been prioritized. Concerns were raised about ensuring enabling environments for HIV prevention, noting that structural investments, particularly socio-economic and longer-term components sometimes perceived as non-life saving, appear to have faced reductions in recent grant allocations as funding priorities shift toward commodities and treatment.[163]

On the other hand, there is limited evidence across the portfolio on the inclusion of innovations to address weaknesses in service delivery, including within structural and behavioral interventions (see examples in Box 3).

Box 3: Country examples of targeted innovations for addressing structural and behavioral intervention gaps:

- implementation of a "**Digital Prevention Hub**" in **Papua New Guinea**[164]
- the use of **online ordering and courier delivery** of commodities in **Georgia**[165]
- introduction of a national "**cyber education strategy**" in **Nicaragua**[166]
- the use of "**Combi Vans**" (mobile clinics) and a **virtual HIV clinic** via the "AwraSafely" app to improve discreet access in **Philippines**[167]

"Due to budget reductions, we've had to focus more sharply on the highest-impact structural interventions while maintaining core biomedical services." [Kenya]

Finding 3.3: Community-led HIV prevention interventions (especially peer-led outreach, community mobilization and demand creation) are widely regarded as the backbone of prevention programming and a key driver of product uptake and continuation but are not consistently resourced or optimally linked to services.

Strength of evidence:

			Strong

Across FGDs, peers are described as trusted actors who shift risk perception, reduce fear and directly connect community members to PrEP, condoms, HIV testing, harm-reduction services and STI services in Kenya, Eswatini, Zimbabwe, Pakistan, Nigeria, and the Philippines.[168] Country KIIs in Eswatini, Tanzania, Madagascar, and Paraguay indicate that peer-led approaches are the "main strategy" for reaching and sustaining KPs and AGYW, with substantial peer network training supported under AGYW and KP modules to provide behavioral counseling, risk screening, referral and accompaniment to services, as well as direct HIV prevention commodities such as condoms and lubricants, and clean syringes.[169] HIV prevention and demand creation also targets social norms and visibility (e.g., open placement of condoms and HIV information in work places and public venues in the Philippines, community-level messaging in Nigeria and Pakistan) to normalize HIV prevention and reduce stigma around service use.[170] At the same time, several countries report reduced investments in HIV prevention communication including mass media and community demand creation (e.g., Eswatini, Mozambique, Pakistan, Nigeria), alongside gaps in PrEP awareness and suboptimal PrEP uptake among MSM, transgender people and AGYW, suggesting that behavioral components are not consistently financed at the level required to fully unlock HIV impact.[171] Global Fund Secretariat KIIs further note that some large, context-specific, behavioral investments that were referred to by some informants as low-impact (e.g., broad CSE curriculum-based comprehensive sexual and reproductive health education, enabling children and young people to develop knowledge, attitudes and skills) are being scaled down but in a constrained envelope there is a perceived risk that demand creation and linkage functions may be under-prioritized relative to commodities unless outcome data is systematically used to guide investment decisions.[172]

Finding 3.4 Cross-portfolio analysis of GC7 documentation reveals that while program partners demonstrate a comprehensive commitment to identifying and planning appropriate HIV prevention interventions, significant challenges remain relating to the programmatic design, availability of resources, operational scale, and level of implementation necessary to achieve optimal impact.

Strength of evidence:

		Moderate	

Analysis indicates a range of policy and implementation gaps which affect HIV prevention interventions, specifically gaps related to funding of PrEP and harm-reduction interventions, and the fundamental challenge of overcoming legal barriers to access services. These challenges of HIV prevention have been further compounded by Global Fund's limited resources which according to some Global Fund Secretariat stakeholders, only accounts for 5–10% of the global resources needed for HIV prevention.

A quantification of the key challenges identified across the portfolio is provided in Table 7 below, followed by a detailed description of the nature of those gaps:

Table 7: Key challenges identified across the portfolio

Category of gap	Number of grants reporting gap	Percentage of portfolio (N = 101)
I. Intervention gaps		
Insufficient scale/funding of PrEP or new modalities	22	22%
Absence/limited provision/scale of harm reduction (OST/needle and syringe programs)	16	16%
Absence/unfunded status of PEP	11	11%
Restrictive legal environment/unaddressed policy barriers (e.g., criminalization)	16	16%
Unaddressed stigma/discrimination in healthcare/community (insufficient scale/plan)	13	13%
Lack of social protection/economic empowerment	8	8%
Lack of safety/security frameworks for KPs/CSOs	3	3%
II. Financing/implementation gaps		
Interventions critical to gap-filling are in PAAR (unfunded)	16	16%
Insufficient overall coverage/scale of interventions (suboptimal targets)	12	12%
Lack of operational detail/sustainability plan (e.g., CSO contracting, PrEP rollout standard operation procedures)	12	12%
Commodity stockouts/supply chain issues (affecting condoms, etc.)	3	3%

III. Data/targeting		
Exclusion/insufficient focus on specific KPs	10	10%
Need for better data/MEL systems (e.g., Stigma Index in PAAR, outdated estimates)	8	8%

Biomedical interventions

The most frequently cited specific challenge involves the provision and ambitious scale of key biomedical interventions:

- **PrEP and new modalities (22 Grants, 22%):** While PrEP is identified, its provision is often limited or lacks ambition (low coverage relative to estimated populations and constrained budgets).[173] PrEP scale-up has been identified as an area with scope for greater ambition in Mozambique,[174] Eswatini (where budget allocations remain limited),[175] and Belarus.[176] PrEP accessibility is limited in Timor-Leste, where its provision is restricted to MSM and male sex workers (MSW), excluding transgender people despite high HIV prevalence among them.[177]
- **Harm-reduction services (OST/needle and syringe programs) (16 Grants, 16%):** The absence or severely limited scale of comprehensive harm-reduction services for PWID is a major gap. OST is not provided or explicitly planned in several grants[178] and is not included in the current allocation for Egypt (though limited pilots predate GC7), despite civil society identifying it as a high community priority.[179] In Mongolia, OST and needle and syringe programs are not described or budgeted despite PWID being a KP.[180] In the Republic of the Congo, the TRP explicitly noted the absence of harm reduction.[181] In Nepal, low retention in the slow-to-scale OST program remains a critical gap.[182]
- **PEP and VMMC (11 Grants, 11%):** PEP is often missing or not explicitly detailed in the prevention package, as noted in Timor-Leste,[183] Uzbekistan,[184] Egypt,[185] and Mauritania.[186] VMMC is not a prominent strategic priority nor is it mentioned in grants like Burkina Faso[187] and Mali.[188]

Structural interventions

In some grants, structural interventions, while widely included, suffer from issues of insufficient scale, lack of operational detail, or significant challenges posed by external barriers.

- **Legal/policy barriers (16 Grants, 16%):** The core challenge often lies in the legal environment that criminalizes KPs, undermining service uptake. Tanzania and the Gambia both lack a comprehensive plan to address elements of its restrictive legal and policy framework (e.g., laws that decriminalize same-sex sexual activity, sex work; and allow adolescents and KPs to access HIV prevention and treatment services without fear of arrest or discrimination).[189] In Uganda, the challenging environment stemming from the new anti-homosexuality legislation poses the most significant threat to structural interventions for MSM and transgender populations,[190] and Uzbekistan lacks a comprehensive plan to address elements of its restrictive legal and policy framework.[191]
- **Insufficient scale/planning for stigma reduction (13 grants, 13%):** Stigma persists in healthcare settings, and the programmatic response is often noted as insufficient. In Armenia, interventions addressing GBV and stigma in healthcare settings would benefit from greater scale and funding, including the development of funded plans to operationalize recommendations from recent structural assessments.[192] In Madagascar, there remain opportunities to strengthen the response through the inclusion of a gender assessment and the development of targeted interventions.[193]

- **Safety and security (3 grants, 3.0%):** In some regions, the environment is so restrictive that even the basic safety of service providers is a concern. The Middle East and North African (MENA) multi-country grant highlights a gap in planning as well as in the budgeting and follow-through needed to implement safety and security measures for advocacy work in these challenging contexts.[194]

Implementation and funding

Challenges related to the execution and funding architecture frequently undermine otherwise well-designed plans:

- **Interventions in the unfunded PAAR (16 grants, 16%):** A primary gap is the relegation of critical prevention activities to the PAAR, making their funding uncertain. This includes PrEP scale-up in Guinea (for FSW)[195] and both needle and syringe programs and demand creation in South Sudan.[196]
- **Insufficient overall coverage/scale predominantly driven by financial gaps (12 grants, 12%):** Many grants acknowledge that the scale of coverage achieved or planned is insufficient for epidemiological impact. Suriname explicitly noted that the 65% coverage target for MSM falls significantly short of what is needed for population-level impact.[197] Togo noted that financial shortfall is the primary gap, limiting the scale and potential impact of interventions.[198]
- **Lack of operational detail/sustainability (12 grants, 12%):** Several grants require more detailed planning to ensure effectiveness and long-term sustainability. In Serbia and Moldova, strengthening plans for the sustainability of CSO services, particularly through adequate social contracting has been identified as an important next step.[199]

Data and targeting gaps

Finally, insufficient data or data utilization creates challenges in the ability to design and monitor effective interventions:

- **Exclusion of KPs from data/programming (10 grants, 10%):** Several grants have significant blind spots. In Egypt, the exclusion of transgender people from the IBBS highlights an opportunity to strengthen data collection in order to better inform targeted interventions[200]. Women who use drugs have similarly been under-represented in available data in Egypt[201] and Pakistan, and in Pakistan this presents an opportunity to further develop tailored activities for this population.[202]
- **Weak monitoring/evaluation systems (8 grants, 8%):** The ability to track whether gaps are being filled is hindered by weak M&E. In Cape Verde, the TRP highlighted the value of strengthening baseline data on human rights and gender-related barriers.[203] In Congo, improving population size estimates, potentially through a new IBBS would support more accurate coverage target-setting.[204]

EQ4

EQ4: To what extent are the interventions targeted at populations most in need of HIV prevention services, at sufficient scale of coverage for impact and with sufficient differentiation by population group?

Our analysis of the GC7 HIV prevention grants confirms that interventions are overwhelmingly and strategically focused on the populations most in need, with significant efforts made toward defining appropriate scale and differentiation. However, the attainment of a sufficient scale of coverage for epidemiological impact is the most challenging area across the portfolio, constrained primarily by resource limitations and data deficiencies.

The focusing of interventions on populations most in need of HIV prevention services is a foundational strength across the entire GC7 portfolio. All countries/multi-country programs in the portfolio-wide analysis demonstrate clear, evidence-based identification and prioritization of KPs. This identification is consistently based on updated epidemiological data, such as IBBS or comparable studies, which demonstrate disproportionately high HIV prevalence among KPs compared to the general population. Across the 12 country case studies, interventions are similarly consistently focused on populations most in need.

The cross-portfolio analysis found that the vast majority of grants demonstrate sufficient differentiation by population group, tailoring comprehensive prevention packages to the specific needs, risks, and contexts of each prioritized group. Differentiation is generally achieved through modular grant structures that allocate specific biomedical, behavioral, and structural interventions to each population. This finding was also evidenced in all of the case study countries with a range of differentiated approaches, such as stigma-free service models, behavior-based eligibility, and tailored outreach packages designed for specific sub-groups, although the case studies did highlight some specific challenges to implementing differentiated programs.

While targeting and differentiation are strong, the attainment of a sufficient scale of coverage for impact is the most challenging area across the portfolio. The cross-portfolio analysis of the GC7 HIV grants found that about two-thirds of country programs explicitly define or articulate the desired scale of coverage for key prevention populations or interventions intended to achieve epidemiological impact. However, a significant portion (nearly half) of all the grants explicitly acknowledged that the defined scale was insufficient to achieve measurable epidemiological impact with the current allocation. This finding was reflected in the case study countries where challenges to achieving scale such as funding restrictions and the resulting lack of decentralized service delivery were highlighted.

Finding 4.1: Evidence from multiple data sources, including the overall portfolio analysis and the country case studies indicates that, for GC7, program partners have systematically identified the populations most in need of HIV prevention services. Also, programming is generally responsive to epidemiological and contextual realities (distinguishing generalized vs. concentrated epidemics and population targets), but it is constrained by limited resources, political barriers and investment in poorly designed interventions.

Strength of evidence:

			Strong

The portfolio analysis of the GC7 HIV grants reveals a near-unanimous finding that program partners have clearly and systematically identified the populations most in need of HIV prevention services, basing their prioritization on robust epidemiological data and **national strategic priorities and** consistently justified by quantitative evidence—typically derived from specialized surveillance—and references to epidemic dynamics and community consultations (see Box 4A).

Box 4A: Examples of data sources used in GC7 Grants from portfolio analysis

1. Bio-behavioral surveillance data: The use of recent epidemiological data, such as IBBS surveys, was cited across multiple countries, including The Gambia (IBBS 2022/2023),[205] Honduras (IBBS 2023-2024),[206] Egypt (IBBS 2023-2024),[207] and Madagascar (BBSS 2022).[208]

2. Epidemic dynamics: The documents consistently cite the disproportionate contribution of epidemiologically identified key and priority population groups to new HIV infections; for example, in Nepal, two out of three new cases (67%) occurred among KPs,[209] and in the Caribbean region, KPs and their partners account for 84% of new infections.[210]

3. Community consultations: The identification process often included dialogue with civil society organizations (CSOs) and community-based and KP-led organizations, ensuring community perspectives informed the final prioritization.[211]

Case study country program partners were also found to have consistently identified and prioritized specific populations deemed most in need of HIV prevention services. This reflects a global shift toward "precision prevention" aimed at maximizing outcomes among those "at highest risk".[212] As with the portfolio analysis, this prioritization relied heavily on utilizing epidemiological data such as national surveys and estimates to inform strategies and target investments effectively.[213] The prioritized populations fall generally into two high-burden categories: KPs in all epidemic settings, and AGYW and their sexual partners especially in high-incidence settings.[214] See selective examples in Box 4B.

Box 4B: Examples of systematic identification the populations most in need of HIV prevention services

- Eswatini's funding request (FR) aligns with the NSP and focuses on KPs to maximize impact.[215]
- Kenya's FR anchors interventions in the NSP, prioritizing KPs and AGYW in high-incidence settings.[216]
- In Kosovo and Madagascar, the FRs also align with their respective NSPs and focus on KPs.[217]
- Mozambique's PEN V prioritizes KPs and AGYW in high-incidence settings.[218]
- Nigeria's NSP sets explicit prevention priorities for KPs and AGYW in high-incidence settings.[219]
- Pakistan's FR targets KPs in priority districts,[220] and Paraguay's FR focuses on KPs.[221]
- The Philippines' 7th AIDS Medium Term Plan identifies KPs) as the priority.[222]
- Tanzania's GC7 modules mirror national priorities for KPs and AGYW in high-incidence settings.[223]
- Uganda's NSP prioritizes combination prevention for KPs and AGYW in high-incidence settings.[224]
- Zimbabwe's FR emphasizes a combination prevention package for KPs and AGYW in high-incidence settings.[225]

This strong alignment demonstrates a robust, evidence-based approach to targeting those most at risk across diverse epidemic settings.

KPs and various mobile or bridge populations and AGYW—are recurrently prioritized across diverse settings including Eswatini, Pakistan, Tanzania, Uganda, Kenya, Nigeria, and others. For instance, in Kosovo, the epidemic is highly concentrated among MSM, leading to focused programming and PrEP provision.[226] In Mozambique and Nigeria, prevention interventions explicitly target KPs.[227] [228] Similarly, portfolio analysis indicates that programming decisions were actively informed by local context and epidemiological data such as (see Box 4C).

Box 4C: Examples of contextualization and responsiveness

- High-prevalence countries such as **Tanzania** adapted WHO guidelines to address high discontinuation rates for PrEP.[229]
- **Cambodia** addressed the high incidence among specific populations by including a **pilot for long-acting injectable PrEP (CAB-LA).**[230]
- **Iran** prioritized the introduction and scale-up of newer evidence-based interventions like **PrEP and HIV self-testing (HIVST)** due to the nature of their concentrated epidemic.[231]
- In **Bhutan, Guinea-Bissau, Mongolia, Philippines,** the use of **digital platforms and social networks** for outreach to reach hidden KPs.[232]
- The introduction or expansion of **HIV self-testing** to improve access in **Bolivia, Dominican Republic, Guinea-Bissau, Iran, Nicaragua, Senegal, Somalia.**[233]
- The implementation of **differentiated service delivery models** based on risk assessment or geography, as planned in Mozambique and Paraguay, which proposed offering PrEP in hotspots through mobile clinics and recruiting "PrEP champions" from the MSM community.[234]

Equally, KIIs across sampled countries show tailored focus: AGYW targeting refined to those at highest risk in high-burden districts (e.g., Eswatini, Kenya), KP-only packages in concentrated epidemics (e.g., Kosovo MSM), and harm reduction targeted to states or cities where PWID prevalence is highest (e.g., Nigeria).[235] FGDs provide concrete examples of context-sensitive delivery: shifting PrEP delivery from treatment centers to CBOs in Sindh, Pakistan, to reduce stigma for MSM; using DICs and mobile clinics in Pakistan and Eswatini; and using epidemiological surveys (IBBS,) to guide targeting in Tanzania and Nigeria.[236] At the same time, stakeholders acknowledge that not every intervention that is in line with global normative guidance is feasible or relevant in every context and that politics can block KP programming even where epidemiology demands it.[237] In addition, few grants in the portfolio placed essential

interventions in line with global normative guidance, including PrEP scale-up, harm-reduction services and other new innovations, in the PAAR, indicating that their implementation depends on future funding and is not assured under the core allocation.[238] KIIs with global stakeholders also point to cases where large investments went into low-impact or mis-specified activities (e.g., a sexuality education curriculum in Zambia in which condom use is not covered, early AGYW programs with large but poorly targeted reach targets), requiring technical partners to reclassify such work as non-prevention.[239] Delayed adoption of UNAIDS normative guidance on PrEP and harm-reduction scale-up (e.g., in Kosovo) and sub-scale pilots (e.g., PrEP implementation in Pakistan at a limited scale) further illustrate that while intervention types are broadly appropriate, their scale and pace are not always commensurate with epidemic need.[240]

Finding 4.2: The interventions are well-targeted and highly differentiated by design, with a clear strategic focus on the populations and areas where they can have the greatest impact, and where ambition to achieve scale is evident

Strength of evidence:

			Strong

The cross-portfolio analysis of GC7 HIV grants identified that a significant majority of grants (over 70%) define the desired scale of coverage using specific, global HIV prevention targets, often expressed as a percentage of the estimated KP size. In these cases, the existence of specific numerical targets, often tied to NSP goals or epidemiological thresholds (like the 95% reach goal), provides a clear measure of the desired scale of coverage (national targets) to achieve impact (see Table 8).

Table 8: Defined scale target (national)

Example country / program	Population/intervention	Defined scale target	Source citation
Madagascar	MSM prevention package	Reach 95% of MSM in need annually (9,964 by 2026)	[Madagascar_Objective1_Report, 270, 277]
Eswatini	AGYW, FSW, MSM coverage	95% coverage for primary KPs by 2027	[Eswatini_Objective1_Report, 140]
Zanzibar	FSW, MSM, PUD coverage	FSW 96%, MSM 95%, PUD 95% coverage by 2026	[Zanzibar_Objective1_Report, 469]
Cambodia	MSM/TG prevention package	Reach 95% of MSM and 95% of TG in 17 provinces	[35ambodia_Objective1_Report, 489]
South Africa	MSM coverage	Increase percentage of MSM reached with prevention package from 83% to 95%	[South_Africa_Objective1_Report, 385, 388]
Angola	FSW coverage (in priority provinces)	Increase from 53% to 75% in Benguela, and 75% in Cuanza Sul	[Angola_Objective1_Report, 9]
Bangladesh	MSM coverage (in 26 districts)	Cover approximately 80% of the total population size estimate (PSE)	[Bangladesh_Objective1_Report, 25, 30]
Paraguay	MSM prevention coverage	Reach 66.46% of MSM in priority regions (138% increase from baseline)	[Paraguay_Objective1_Report, 347]
Ethiopia	Harm reduction (PWID)	60% receiving 2+ interventions by 2027	[Ethiopia_Objective1_Report, 142]
Kosovo	MSM coverage	Reach 76% of estimated MSM population by 2027	[Kosovo_Objective1_Report, 222]

Tanzania	AGYW/KP saturation	Achieve 95% saturation for KPs in targeted councils	[Tanzania_Objective1_Report, 432]
Honduras	MSM coverage	Increase from 29.86% baseline to 43.86%	[Honduras_Objective1_Report, 180]
Ecuador	PrEP (MSM)	Reach 17% of estimated population at substantial risk in 2026, rising to 21% in 2028	[Ecuador_Objective1_Report, 105]

This finding was also reflected in the 12 sampled countries, with all countries covered providing explicit, quantitative targets for key interventions like PrEP initiation and overall prevention service coverage. These targets are often derived from NSPs and epidemiological models, and while the level of detail varies, the use of precise annual reach numbers or percentage-based targets reflects a strong commitment to measurable, results-based programming (see Box 4D).

Box 4D: Examples of coverage targets from case study countries

- Eswatini's grant sets out objectives such as training approximately 200 MSM peers to reach 24,000 MSM annually.[241]
- Kenya, Kosovo, Madagascar, and Mozambique all define explicit coverage goals for KPs and AGYW in high-incidence settings.[242]
- Nigeria's grant documents articulate coverage goals for KPs and AGYW in high-incidence settings.[243]
- Pakistan's Grant set coverage goals for KPs in 19 priority districts.[244]
- In Paraguay, the grant aims to scale up PrEP for MSM from 6 to 16 facilities combined with the telemedicine services.[245]
- The Philippines targets KPs in 100 high-burden cities.[246]
- Tanzania's grant includes clear coverage goals and sub-national phasing for KPs, such as training 200 MSM peers to reach 24,000 MSM annually in 40 councils.[247]
- Uganda grant set ambitious PrEP coverage targets for MSM (30%/40%/50% of need).[248]

Across the portfolio, interventions are also highly differentiated, with tailored packages of services designed for different populations and delivered through a variety of platforms (DICs, mobile outreach, facility-based services, digital channels) to meet diverse needs and preferences. Differentiation is generally achieved through modular grant structures that allocate specific biomedical, behavioral, and structural interventions to each population (see Box 4E).

Box 4E: Differentiation mechanisms highlighted from portfolio analysis

1. Tailored packages: Grants are structured with dedicated modules, such as the Prevention Package for MSM and their sexual partners in **Pakistan**.[249] This ensures that the mix of commodities and services (e.g., harm reduction for PWID versus PrEP and targeted outreach for MSM) is appropriate.[250]

2. Addressing sub-groups: Differentiation extends beyond core KPs to address internal variations. For example, the **Tajikistan** grant specifically targets **younger MSM** who reported lower condom use,[251] while the **Mongolia** program targets urban MSM, married MSM, and young MSM.[252] The **South Africa** grant, while generalized, differentiates services based on the severe burden among FSW, MSM, transgender people, and AGYW.[253]

3. Differentiated delivery models: The programming incorporates differentiated service delivery models, such as using CSO hubs for MSM and TGW in **Belize,**[254] or virtual outreach and mobile services in **Suriname** and **Philippines** to reach hidden KPs facing high stigma.[255]

Similarly, across the 12 sampled countries, there is a broad strategic intent to allocate HIV prevention funding to interventions, populations, and geographies with the highest potential for impact. Epidemiological and burden-of-disease data are guiding principles in many countries' funding decisions, particularly in nations such as Paraguay, Philippines, Tanzania, and Kenya. For example, Tanzania has concentrated investments in HIV prevention among MSM, achieving approximately 92% testing coverage through differentiated service delivery models guided by epidemiological data and modeling tools.[256] Kenya's approach also demonstrates evidence-based resource allocation, prioritizing adolescents and young people in high-incidence areas and integrating tailored interventions to address their unique barriers to access [Funding Request Form, pp.17–18].[257] Similarly, Mozambique uses community-based, decentralized strategies and modeling tools to inform geographic targeting and budgetary shifts, such as prioritizing PrEP delivery for vulnerable populations.[258] These examples reflect a precision prevention strategy aligned with the goal of maximizing epidemiological impact.

Finding 4.3: While targeting and differentiation are strong, the attainment of a "sufficient scale of coverage for impact" is the most challenging area across the portfolio, constrained primarily by resource limitations which also negatively affect data collection and quality, and amplify existing data deficiencies.

Strength of evidence:

			Strong

Across the overall portfolio, a significant portion of the grants explicitly acknowledge that the defined scale was insufficient to achieve measurable epidemiological impact with the current allocation. Approximately 45 grants (45%) noted that critical interventions were under-scaled or that full coverage targets were unattainable due to resource constraints, outdated, or insufficient data, and/or lack of clarity around the articulation of the targets (see Box 4F).

Box 4F: Reasons for disconnect between target scale and reality (from cross-portfolio analysis)

Targets based on unachievable NSP goals or limited resources

In several grants, while the NSP defines an impact-level scale (e.g., 80% coverage), the planned scale is limited by budget availability:

- Afghanistan: The NSP defines the desired scale for injecting drug users as "substantial coverage (reaching 80%)," but the grant documents acknowledge that the funding available only covers 12% of the NSP need, making the desired scale unattainable.[259]
- Suriname: The grant explicitly defines coverage targets, aiming for 44% of MSM by 2027. However, it also acknowledges that the desired scale for impact is 95%, demonstrating a gap of 30 percentage points due to "severe resource constraints."[260]
- Togo: The grant defines specific coverage targets for MSM (up to 69.04% by 2026) but explicitly notes that the available funding is insufficient to achieve the NSP's desired coverage rates for impact.[261]
- Venezuela: Targets are defined (e.g., 15.8% of MSM by Year 3), but this low figure is acknowledged as being budget-driven rather than based ON THE SCALE REQUIRED FOR EPIDEMIOLOGICAL IMPACT.[262]

Targets based on outdated or insufficient data

In other cases, the credibility of the defined scale is hampered by unreliable underlying data:

- Kyrgyzstan: Targets are defined (e.g., 85% coverage for MSM), though they rely on population size estimates that are now considered outdated and subject to revision, with a new study planned.[263]

- Djibouti: The grant includes numerical targets for the number of people to be reached; however, these are informed by population size estimates from 2011, which may limit the ability to define more meaningful targets.[264]

Scale not defined or articulated in quantitative terms

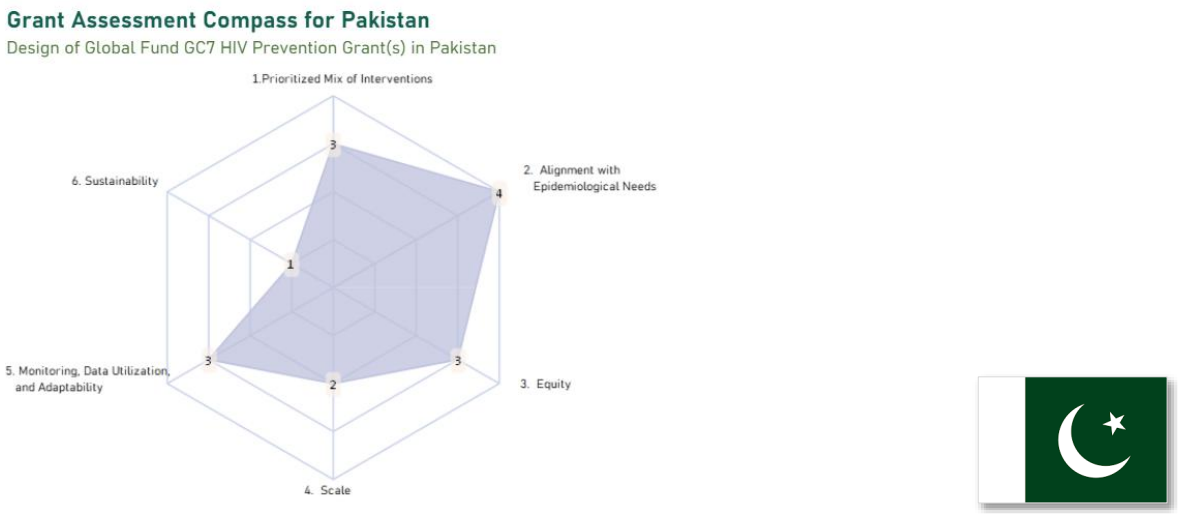
A small portion of the grants failed to define scale quantitatively for prevention interventions in the narrative reviewed:

- Equatorial Guinea: At present, the scale of primary prevention interventions for key populations is not clearly articulated, with programmatic gap tables for Prevention, PrEP, and condoms yet to be completed.[265]
- Cameroon, Nigeria, Zambia, and Sudan: These grants express a clear intention to "scale-up," "intensify," or prioritize based on the high-burden districts, but specific, quantified targets (percentages or absolute numbers) for the desired coverage required to achieve impact are not consistently provided in the narrative.[266]
- MENA multi-country grant: The grant documents provide limited explicit information about the desired scale of coverage needed to achieve impact for each KP group.[267]

Similarly, within the 12 sampled countries, the evaluation found persistent partial misalignment between strategic intent and the likelihood of impact. For example, in Pakistan, while there is a focus on high-burden geographies and innovative models, the gap between available funding and the NSP's overall financial requirements limits the extent to which all high-impact opportunities can be addressed.[268] Recommendations to rebalance allocations toward neglected areas and to integrate interventions focused on reducing barriers to service delivery including gender and rights underscore the need for a more comprehensive approach.[269] This is also reflected in the Grant Assessment Compass for Pakistan in Box 4G, where the sustainability score remains the lowest.

Box 4G: Pakistan Grant Assessment Compass

The compass diagram for the Pakistan GC7 grant highlights how the grant design demonstrates extremely strong alignment with epidemiological needs, and a good mix of appropriate interventions. However, the analysis identified issues with achieving required scale for impact (mainly related to the level of funding available) and associated concerns around sustainability.



In Zimbabwe, while the funding is aligned with the highest impact interventions, implementation barriers (including stigma, limited access, and weak delivery systems) are highlighted as potentially limiting the translation of allocations into measurable outcomes.[270] Uganda is noted

to be an exemplar country with a clearly documented, fully funded mechanism for prevention impact measurement, operationalizing cost-effectiveness via the Total Market Approach for condoms and low-cost last-mile distribution, supported by concrete administrative cost data.[271] However, sustainability concerns persist, alongside a challenging environment for some key populations.

A critical limitation identified across multiple countries is the lack of explicit documentation linking funding decisions to impact metrics. In Madagascar and Mozambique for example, the evaluation identified gaps in how financial allocations are linked to expected outcomes, which limit transparency, accountability, and the ability to compare or learn across contexts.[272] This absence of formal analytical frameworks hinders meaningful assessment of whether funding truly aligns with high-impact potential.

Objective 2

EQ5

EQ5: To what extent and how is the implementation of Global Fund-supported GC7 HIV prevention interventions consistent with respective GC7 grant agreements (e.g., PFs, budgets, and narratives)?

Global Fund-supported implementation of HIV prevention interventions has not changed in comparison with the original GC7 grant agreements across all countries. All countries reported a continued strong focus on KPs, although some countries state they would benefit from increased Global Fund support for adolescents in high-incidence settings. Many countries reported that any changes in grant implementation as compared to the original grant agreements were related to disruptions due to withdrawal of external funding that impacted planned program activities and Global Fund's reprioritization exercise , which has prevented the implementation of, or reduced the focus on, certain HIV prevention interventions. Finally, many countries claim they have achieved or exceeded coverage targets, but this is not consistent across countries, and achievement is impeded by operational, contextual, and political factors

Secondary data analysis and Global Fund Secretariat stakeholders, including many country teams such as Mozambique, Tanzania, and Nigeria, indicate that Global Fund investments are very strongly aligned to what has been articulated in the grant documentation, supporting the fact that grants are not only developed collaboratively with country stakeholders, but they are also based on national HIV strategies. In some cases, such as Mozambique and Nigeria, alignment was supported through high-quality and intense country support provided by the Global Fund country team. Stakeholders across many countries report that the Global Fund's reprioritization exercise negatively affected planned interventions, including those related to mobile clinics, community centers, and commodity procurement. However, expected outcomes, and both programmatic and strategic focus, remain consistent.

Finding 5.1: HIV prevention interventions under GC7 have a strong emphasis on key populations, expanding PrEP access, and integrating comprehensive harm reduction and community-led services, but the consistency of implementation varies across countries.

Strength of evidence:

			Strong

Stakeholders report that PrEP has been expanded to 18 health regions within Paraguay,[273] and PrEP services for AGYW have also increased within Eswatini.[274] Pakistan has increased its focus on loss to follow-up services, social support and delivery of PrEP, condoms and lubricants,[275] and both Pakistan and Kenya have introduced community DICs and safe spaces to improve outreach in HIV hotspots.[276] Kenya has also supported harm-reduction packages and comprehensive HIV prevention packages for KPs and AGYW in high-incidence settings.[277] Similarly, Uganda has supported the use of CAB-LA and vaginal ring interventions and prioritized the use of PrEP.[278] This progress in GC7 implementation was corroborated through secondary data analysis for countries including Eswatini, Nigeria, Pakistan, the Philippines, Mozambique, and Tanzania. Country teams within the Global Fund, as evidenced by secondary

data analysis, also report that the Global Fund has supported interventions focused on a range of KPs. For example, Nigeria reports an expanded programmatic focus on PWID, while Madagascar reports increased recognition of PWID needs without corresponding inclusion of harm-reduction services, and in-country stakeholders within Kosovo state that, through close collaboration with local NGOs and CSOs, they have increased their focus on PWID, MSM, and FSW.[279] Within the Philippines, 31% of its GC7 grant budget is allocated to prevention, focusing on MSM, TGW, and PWID via peer-led outreach and digital tools.[280]

Although GC7 grant agreements primarily focus on KPs of interest which is relevant for the majority of countries, in-country stakeholders from both Pakistan and Kosovo also expressed the need to focus on the general population and adolescents, which are not catered for within the current grant.[281]

"In the year 2022, we ended the year with 248 users on PrEP. In one year, this year with teleconsultations, in a period of seven months, we reached approximately 700 users" [Paraguay]

Finding 5.2: The flexibility of grant agreements and implementation approaches was viewed as necessary to make adjustments and maintain alignment to country needs.

Strength of evidence:

			Strong

Grants were viewed by some country stakeholders, including Tanzania, Kosovo, and Pakistan, as being dynamic in order to adapt to country needs to ensure that Global Fund inputs remain relevant and support overall grant goals and objectives.[282] This was reportedly achieved through national technical working groups, which were central to this process, providing structured platforms for consensus-building and rapid adaptation, particularly regarding the introduction of new HIV prevention options such as Lenacapavir in Kenya, Nigeria, Uganda, and Zimbabwe.[283] For example, countries were able to make savings in one area, and repurpose this funding elsewhere while ensuring consistent alignment to the grant agreement.[284] Within Mozambique and Pakistan, partial programmatic savings were achieved through the reduction of overhead costs such as in-person training and supervision visits.[285] The sources used by country teams to evidence necessary implementation adaptations include formal program reviews, Office of the Inspector General audits, TRP recommendations, routine monitoring data, and CLM. However, some Global Fund country teams (e.g. Eswatini, Nigeria, Tanzania, and Mozambique) observed that reflection on the drivers of these deviations was limited, with strategic allocation decisions often articulated after changes occurred and not consistently captured in the Global Fund's "reasons for variance" frameworks.

Some countries reported that intervention implementation has been affected by KP stigma. To mitigate this, countries such as Pakistan, Kosovo, and Madagascar have introduced some of the following approaches: (a) increased support for peer educators through more practical training sessions, mentorship and refresher training; (2) shifts from facility-based, to more community-based services; and (3) changes in outreach schedules to include evening and weekend hours and the introduction of teleconsulting options.[286] Paraguay introduced a "pay-for-results"

approach with in-country implementers to shift focus from input tracking to outcome achievement which promoted efficiency and accountability. However, it was acknowledged by a Paraguay in-country stakeholder that this approach required, with technical assistance, organizations to change from activity-focused to outcome-focused programming, and added additional pressure to reach KP targets.[287] In addition, Paraguay is piloting PrEP vending machines (viewed to have otherwise likely stalled under rigid public procurement systems) which are accessible after a teleconsultation in order to reduce clinic-based stigma and time barriers.

"We follow the grant agreement narrative closely, but budget execution has been flexible. We've been able to reallocate funds between activities based on what works best in practice. The performance framework is generally realistic, though some indicators required adjustment during the first year of implementation."
[Kosovo]

"Organizations had to completely change their approaches from activity-focused to outcome-focused programming. We provided extensive technical assistance, developed new monitoring tools, and created peer support networks for organizations to learn from each other."
[Paraguay]

Finding 5.3: Many countries report that progress is being made towards Global Fund targets despite changes in funding, but this is not consistent across either key populations or countries.

Strength of evidence:

			Strong

Paraguay and the Philippines report positive results for HIV prevention scale-up. For example, Paraguay appears to be on track to scale its PrEP services for MSM from 6 to 16 facilities, and this progress is said to be driven by significant CSO contributions with KPs.[288] Many in-country stakeholders within Pakistan also report good achievements of coverage targets across a range of KPs.[289] However, for countries such as Tanzania, Nigeria, and Zimbabwe, targets for some KPs were not fully achieved:[290] For example, in Nigeria, one in-country stakeholder noted that prevention (incl. PrEP) reach fell below the expected 90% targets for MSM and transgender people,[291] while in Zimbabwe the planned scale-up of MSM programming has progressed more slowly than anticipated.[292] Similarly, Kenya and Mozambique did not fully meet their AGYW coverage targets.[293]

"For over 70% of the key population prevention (and testing indicators), the results are over 120% of the target, noting that the Global Fund scorecard caps achievement at 120% although actual performance in some cases exceeds this."
[Nigeria]

"In some areas, targets were not met, while in others they were exceeded by three to five times."
[Mozambique]

Finding 5.4: The Global Fund's requirements for GC7 funding requests and high key population coverage targets within some countries posed challenges to initial target achievement.

Strength of evidence:

		Moderate	

For Madagascar, Pakistan, and Nigeria, stakeholders report that delays were experienced at the application stage of the GC7 Grant Cycle due to a range of factors, including misalignment of objectives, timeliness of expected intervention start dates, and slow mobilization of CSOs which each affected target achievement.[294] There were also said to be complications in contracting partners for both Madagascar and Uganda country teams, which impeded early target achievement, although targets were achieved or exceeded by Year 2 of implementation.[295] Furthermore, Kosovo and Kenya in-country stakeholders report the need to adjust KP targets to account for factors such as population size and accessibility, as initial targets were perceived to be too optimistic.[296]

"We had only six weeks between grant signing and expected service delivery startup. This didn't allow adequate time for staff recruitment, training, and system setup. Many of our early targets were missed simply due to insufficient preparation time built into the grant schedule."
[Pakistan]

"Was just that the grant was really slow in picking up, but then as at the end of 2024, I think that they had reached about 110% of their service targets which boosted up their performance a bit."
[Uganda]

Finding 5.5: The withdrawal of major international donors and the Global Fund's reprioritization exercise is negatively affecting the ability of many countries to implement all planned HIV-prevention interventions and to achieve coverage targets.

Strength of evidence:

			Strong

Many countries reported being affected by shifts in support from major international donors, alongside the Global Fund's reprioritization exercise. In Nigeria, changes in donor support led to the gradual phase-out of some implementing partners. While Global Fund-procured commodities and medicines were, in some cases available, the absence of previously donor-supported implementers constrained HIV prevention service delivery and commodity distribution, resulting in some resources not being fully utilized.[297] In Eswatini, recent stop-work orders issued by a major bilateral donor disrupted mobile clinics and community-based service points, leading some key population clients to rely more heavily on centralized public health facilities. These changes also affected certain Global Fund-supported interventions that had previously relied on shared in-country infrastructure supported by external donors.[298]

"We don't have [enough] finance [to cover] the National Strategic Plan targets for AGYW. We are covering about 40% of what we should be covering as HIV prevention."
[Kenya]

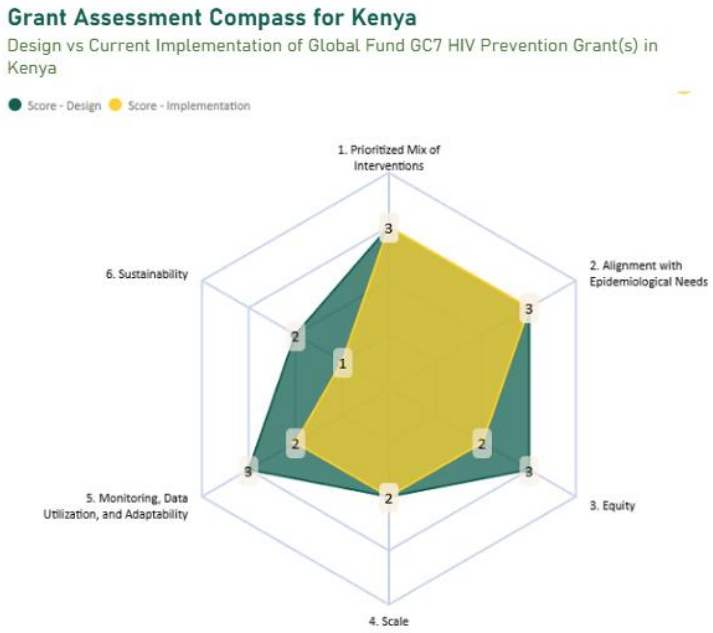
As a direct result of the reprioritization exercise, the Global Fund informed country implementers, such as those within Kenya[299], to pause some activities, which slowed down the progress of HIV prevention services. For example, Kenya experienced a lack of condom and lubricant availability, in addition to reduced travel allowances, which was seen to have an effect on HIV transmission rates and the ability to focus on hard-to-reach areas within the country.[300] Similarly, focus group participants within Kenya reported a deprioritization of human rights and gender-focused interventions which are reportedly necessary to support vulnerable population groups' access to HIV prevention services and reduce KP stigma.[301] This is also reflected in Box 5A, which illustrates the gap between Kenya's design and implementation through the evaluation's Grant Assessment Compass analysis. Similarly, structural and community-based interventions were disrupted in Eswatini, Zimbabwe, Mozambique, and Pakistan.[302] In Pakistan, this reprioritization led to a reduction of approximately 40% in the peer educator network, along with the closure of two drop-in centres (DICs), which affected coverage levels and service availability.[303] Similarly, Kosovo experienced an approximate 14% reduction in funding, and within Mozambique and Zimbabwe, the reprioritization exercise resulted in the reduction of approximately US$42 million, and US$48 million in HIV funding respectively: although in the case of Zimbabwe, this shortfall was partially recovered through efficiency savings of antiretrovirals procured in bulk by the United Nations Development Programme (UNDP).[304] Finally within Nigeria, the CAB-LA pilot rollout was delayed and focus group participants noted reduced focus on capacity building and community mobilization efforts, which were reportedly more prominent in Grant Cycle 6.[305]

"The grant, due to funding restrictions, was unable to cover necessary harm reduction measures like providing safe use equipment [such as] foils or safe smoking equipment."
[Pakistan]

"Despite this [reduction in Global Fund funding], the redirection aimed to respond to the macro areas of the grant and retain core intervention focus."
[Mozambique]

Box 5A: Design versus implementation GAC Kenya

The compass diagram for the Kenya GC7 grant with scores for implementation (yellow) against the original design illustrates the finding that despite strong alignment and mix of interventions being maintained, funding cuts have eroded scores across equity, M&E and sustainability.



In case of one of the twelve focus countries, FGD participants (in-country) reported a lack of consultation in the decision-making processes of the Global Fund's re-prioritization exercise, which was felt to "*significantly deviate from the spirit of community involvement often emphasized in Global Fund grant commitments.*" (Kenya focus group)

Finding 5.6: Procurement processes, safety concerns, and associated stigma with key populations prevented some countries from achieving their coverage targets.

Strength of evidence:

			Strong

Secondary data analysis, and multiple stakeholders, particularly within both Madagascar and Pakistan, including a technical partner, cite that commodity stockouts due to delays in the procurement process caused implementation delays.[306] To address this, one stakeholder established a buffer of commodity stock, diversified supplier networks, and implemented early warning systems to monitor stock.[307] Pakistan in-country stakeholders also report structural challenges around access to services for some KPs: for example, barriers to reaching PWID in Punjab related to ID verification requirements, alongside delivery models that are not fully aligned with the specific needs of this population.[308] In addition, due to safety and security concerns within three districts of Pakistan, one in-country stakeholder reported that many services, particularly those focused on PWID, were stopped, resulting in more frequent reallocations of budgets from planned interventions.[309] Similarly, Uganda's Anti-Homosexuality Act creates barriers in accessing HIV prevention services, specifically for MSM.[310] Finally, secondary data analysis, in addition to many country stakeholders, including those from Pakistan, Kosovo, and Zimbabwe, report continued stigma and discrimination against KPs. For example, local leaders in Pakistan reportedly prevented or delayed intervention implementation,

and Zimbabwe faces challenges in scaling up MSM programming due to stigma, criminalization, lack of provider sensitization, and underfunded community outreach systems.[311]

"The centralized procurement system created bottlenecks that weren't anticipated during target setting."
[Pakistan]

EQ6: To what extent and how has HIV prevention implementation shifted from GC6 to GC7 design and into GC7 implementation?

Across all countries, HIV prevention implementation under GC7 represents a deliberate and substantive shift from activity/output-oriented programming under GC6 to more targeted outcome-oriented programming involving data-driven and person-centered prevention models aimed at maximizing choice. At the same time, early GC7 performance varies, and in settings where progress has been weaker, structural barriers and the reduced prioritization of interventions intended to address them appear to be contributing factors.

GC7 grants prioritize sub-national tailoring, stronger focus on KPs and AGYW in high-incidence settings, diversification of PrEP options, and the expansion of community-led and differentiated delivery platforms. These shifts are reflected in funding requests, which consistently reference epidemiological evidence, delivery platform selection, and equity-focused targeting. There is a strong indication that Global Fund investments have moved from broad coverage under GC6 toward more targeted, adaptive, and community-led programming under GC7. Grant Cycle 7 investments are clearly pushing coverage in a more precise and, in some contexts, measurably expanded direction, particularly for PrEP and selected AGYW and KP packages such as screening for STIs and provision of condoms. However, early results also highlight that deprioritization of certain interventions, legal constraints, and service gaps for the most stigmatized groups continue to limit the full realization of precision combination prevention. Systemic and programmatic facilitators have supported these shifts. Flexible grant mechanisms, active technical working groups, strengthened national planning processes, and global technical partnerships have enabled countries to adjust targets, plan for new biomedical tools, and deepen outcome-oriented programming. These enablers have contributed to improved adaptability across multiple settings.

Despite this progress, cross-country evidence points to variable operational maturity. While early translation into practice is visible in contexts such as Kenya, Uganda, Mozambique, Nigeria, and the Philippines, others remain in foundational stages due to regulatory constraints, institutional readiness challenges, and supply chain or financing bottlenecks. Recent developments, including fiscal pressures and evolving policy such as Lenacapavir approval, have prompted real-time adjustments as countries seek to prioritize geographies and populations with the highest incidence while sequencing innovations and maintaining continuity of essential services.

Finding 6.1: GC7 grants prioritize high-impact targeting through sub-national tailoring and a greater emphasis on KPs and AGYW in high-incidence settings .

Strength of evidence:

			Strong

Across all countries, GC7 represents a clear strategic shift toward precision prevention**,** with program partners using more granular epidemiological and surveillance data to target populations and geographies at highest risk**.** Countries such as Eswatini, Kosovo, and Madagascar shifted to more focused KP targeting in priority geographies (e.g., urban centers) using updated surveillance data, marking a more precise approach compared to GC6.[312] Mozambique leveraged 2022 incidence estimates to refine AGYW targeting, transitioning from broader, less targeted strategies deployed in GC6.[313] Pakistan underwent one of the clearest targeting shifts, narrowing to 19 priority districts and intensifying community-led delivery based on its 2023 program review.[314] A major global shift concerned AGYW whereby GC6's ambition to reach all AGYWs was replaced in GC7 by explicit prioritization of those at the highest risk (districts with the highest incidence and sub-populations with the highest incidence based on behavior). AGYW coverage target denominators were drastically reduced to reflect this targeting.[315] For KPs, the Global Fund Secretariat highlighted that the maturity of programming in many settings enabled "more nuanced" differentiation, including distinct strategies for younger versus older MSM.[316] Some countries expanded KP scope in GC7, such as Zimbabwe's move from focusing largely on FSW in GC6 to prioritizing the "diversity" of KPs (particularly PWID).[317] Pakistan reintroduced services for FSWs in Punjab after 10 years of exclusion, demonstrating a deliberate prioritization of previously neglected populations.[318] Local and sub-national tailoring is similarly embedded in GC7 design, with grants structured around granular incidence data and geographic prioritization at district, council, province, or city level. Countries such as Eswatini, Kenya, Pakistan, Uganda, Tanzania, Madagascar, Mozambique, and Philippines demonstrate explicit tailoring through prioritized cities, districts, councils, and regions based on epidemiological burden.[319] Reprioritization processes in Mozambique, Kenya, Kosovo, and Pakistan have required implementers to refine targeting models and concentrate resources on those at highest risk rather than broad, heterogeneous groups. This includes risk-based targeting of AGYW and significant reductions in target denominators for prevention programming specifically in Mozambique and Kenya.[320] These align to strengthen precision prevention, ensuring resources flow to geographies and sub-populations with the highest incidence and risk profiles.[321] As a result, overall breadth of targeting is expected to narrow, but the depth and relevance of services for priority populations are likely to increase.

"Instead of putting a lot of money in a lot of cities without a good program quality, what was decided is to focus on fewer cities and to improve the quality of the program. So, for example, in GC6, we were implementing the program in 46 cities. In GC7, it's 10 cities for MSM and sex workers, and 5 cities for people who inject drugs." [Madagascar]

Finding 6.2: GC7 grants aim to enhance choice and preferences for the users of prevention through biomedical intervention diversification and community-led and differentiated service delivery platforms.

Strength of evidence:

			Strong

Expanding access to PrEP is a priority for Global Fund investments in GC7. This includes accelerated introduction and scale-up of PrEP modalities and expanding delivery through community-led and differentiated platforms. Nigeria expanded to multiple PrEP options including oral PrEP, CAB-LA, and preparations for Lenacapavir rollout.[322] Zimbabwe similarly positioned GC7 grants to integrate Lenacapavir, stating it as a major advancement.[323] Kenya adjusted procurement plans to accommodate Lenacapavir and emphasized PrEP choice and diversification.[324] The Philippines used GC7 to shift from small pilots to a full national PrEP rollout across more than 100 cities and began piloting CAB-LA.[325] HIV prevention programs in Eswatini also incorporated LEN, and innovations such as the PrEP ring for AGYW.[326]

Grant arrangements mandate local adaptation of delivery through recruitment of local community actors, use of local languages, and alignment with provincial or district governance arrangements, as seen in Mozambique, Nigeria, Paraguay, and Eswatini.[327] Tailoring is further reflected in differentiated programming by KP typology and AGYW risk profiles, such as Kenya's separate modalities for PWID and MSM, Tanzania's refined AGYW vulnerability assessments, and the Philippines' differentiated access points for KPs.[328] At grant level, Global Fund guidance emphasizes selecting delivery platforms and resource allocation based on geography, risk, and incidence, reinforced through mechanisms like the approach to reach AGYW most at risk (using Sexual Health Investment Prioritization and Planning (SHIPP) tool estimates) and sub-national targeting informed by Naomi modeling and IBBS data.[329]

Delivery platforms in particular continued to rely heavily on peer and community-led outreach to reach hidden and vulnerable groups, with countries such as Kenya and Eswatini using mobile services and hotspot outreach to improve access among people facing work-related, geographic or stigma-related barriers.[330] Alongside peer-led outreach, many countries rely on DICs, mobile units and extended-hour services to bring interventions closer to KPs and AGYW in high-incidence settings, including late-night PrEP services in the Philippines, peer-accompanied screening in Madagascar and mobile outreach for FSW in Zimbabwe.[331] A more intentional GC7 focus on ensuring HIV prevention reaches those at greatest risk through context-appropriate delivery channels is evident across several countries in the sample. GC7 grants consistently embed differentiated delivery platforms as a core design feature, reflecting that high-impact HIV prevention depends on reaching KPs and AGYW in high-incidence settings through modalities tailored to their mobility, stigma environments, and service-seeking patterns. Across countries, GC7 maintains community-led and peer-led delivery as the primary platform for engaging KPs, with consistent evidence from Eswatini, Kenya, Nigeria, Pakistan, Madagascar, the Philippines, and Uganda showing that peer educators, community navigators, and CBO-implemented models remain central to service delivery.[332] Several grants further incorporate mobile and outreach modalities to extend reach into hotspots, hard-to-access locations, and nighttime economies, including in Zimbabwe, Kosovo, Mozambique, and Nigeria.[333] Digital and virtual platforms also emerge as new delivery modalities in GC7, with Paraguay implementing teleconsultations for PrEP, the Philippines using TelePrEP and courier refills, and Mozambique expanding digital outreach for awareness and testing promotion.[334] Across countries, diversification of prevention delivery platforms to increase reach and accessibility remains a key development. For example, in Nigeria, services have shifted away from hospitals toward peer-led mobile clinics as they are

more trusted by KPs and can reach previously unreachable hotspots.[335] Similarly, in Paraguay, stakeholders noted that teleconsultations and home delivery models made it possible to reach KPs who avoided facilities.[336] In Kosovo, mobile outreach was adopted to compensate for the lack of regional centers, though coverage remains limited to a single mobile clinic.[337] At grant level, these platforms are reported to be selected to match population characteristics, legal constraints, and geographic barriers.

> *"For small countries like ours, precision means maintaining a minimum package for all while improving focus on the most vulnerable, not excluding anyone."*
> *[Kosovo]*

Several countries are shifting away from fragmented, vertical programming toward more integrated, people-centered delivery models, partly due to the need for efficiency under resource constraints.[338] This includes integrating HIV prevention communication and demand creation with case management such as in Eswatini, Madagascar, and Kosovo, which is expected to enhance uptake and continuity of services,[339] and adopting council clustering models in Tanzania to improve geographic targeting and delivery efficiency.[340] Community-led delivery platforms are becoming more central in Pakistan for example, strengthening trust and continuity where they remain functional.[341]

Finding 6.3: Across countries, readiness to change under GC7 was supported by several systemic and programmatic facilitators.

Strength of evidence:

		Moderate	

Readiness was enhanced by the Global Fund's increasing emphasis on outcome-oriented programming, reflected in the theory of change and results framework,[342] as well as funding requests and planning for rollout of the POMT, which encourages countries to improve the link between interventions and measurable prevention outcomes.[343] Global partnerships also played a role; UNAIDS supported data validation to strengthen programmatic accuracy, while the GPC provided technical tools and accountability mechanisms that reinforced adaptation efforts.[344] At country level, processes such as National Strategic Plans in Kenya, Mozambique, and Nigeria, program reviews in Pakistan, and strong CBO monitoring in the Philippines similarly acted as facilitators of change.[345]

Finding 6.4: While early GC7 achievements are visible in several countries, broader PU/DR data suggests that this is not uniform across countries particularly when coverage is assessed against KP size estimates.

Strength of evidence:

			Strong

At the point of data collection (August—November 2025), stakeholders in Tanzania reported that the Christian Social Services Commission grant (via Ministry of Finance of the United Republic of Tanzania) was performing strongly against its targets for AGYW, FSW, and MSM service packages.[346] Similarly, KIIs in Zimbabwe described prevention programming that was meeting or exceeding targets for FSW and reaching substantial numbers of AGYW and young women with comprehensive prevention services, alongside expanded access to PrEP for high-risk adolescent girls and young women.[347] In Nigeria, one implementer reported surpassing key population prevention and testing targets in at least one state and achieving high coverage of AGYW minimum package indicators, with community-based platforms engaging large numbers of AGYW through salons and schools.[348] Biomedical scale-up was also widely noted. The Philippines reported a marked increase in PrEP initiations among young MSM and TGW during the first year of GC7 implementation.[349]Zimbabwe and Eswatini expanded PrEP funding and access, Kosovo introduced PrEP for the first time, and Paraguay and other countries are increasing the number of PrEP service delivery points.[350] Combination prevention investments also support harm-reduction expansion in Nigeria (OST scale-up and needle–syringe programs), structural interventions in Pakistan, and integrated structural–behavioral biomedical packages for AGYW in Tanzania. This indicates that GC7 resources are being used to build more complete prevention packages for KPs where fiscal and political space allows.[351]

> *"Different countries are at different stages; some have fully adopted precision prevention; others are only starting to discuss what that means." [Uganda].*

While based on the KIIs alone, in the countries reviewed, early implementation under GC7 suggests performance and measurable scale-up of priority prevention interventions. Stakeholders reported that service delivery for KPs and AGYW is meeting or exceeding targets in several contexts. However, to better understand the extent of coverage in relation to country realities, PU/DR data for selected countries and indicators were compared with population size estimates of KP groups. Findings from this additional analysis are presented in Box 6.

Box 6: Analysis of selected coverage indicators based on progress update/disbursement request data and population size estimates of KP groups

The following analysis examines Global Fund coverage across selected HIV prevention indicators, with a particular focus on coverage relative to estimated population sizes of specific KP groups. Population size estimates were drawn from the UNAIDS Atlas. However, available population estimates did not fully align with the reporting periods reflected in the PU/DR data. In several instances across GC6 and GC7, population size datasets were missing for specific years. Where an estimate was available for only one year within a given cycle, that same estimate was applied to calculate coverage for other relevant PU/DR reporting years within the cycle. Also, for each year, the maximum reported value was selected for analysis, given the presence of multiple figures within the same year across different reporting cycles. This approach was adopted to enable comparability across years and between funding cycles, while acknowledging the underlying data limitations.

Due to gaps and inconsistencies in population size estimates within the UNAIDS Atlas, the analysis was limited to the selected deep-dive countries. Pakistan was excluded, as no population size estimates were available for the relevant KPs. In addition, data availability and consistency varied across indicators. As a result, the set of indicators analyzed is not uniform across all deep-dive countries and has instead been determined based on the availability of comparable data across reporting years.

Across the countries and KP groups analyzed, coverage trends reflect a mixed picture of progress between GC6 and early GC7 implementation. In Kenya, coverage among MSM increased gradually across GC6 (from about 13% to nearly 17%), with achieved results rising while population size estimates remained broadly stable. A slight moderation is observed in early GC7, largely reflecting changes in results rather than shifts in estimated population size. Among FSW in Kenya, coverage improved steadily through GC6 (from about 15% to nearly 45%), supported by relatively constant population estimates and increasing program reach, before stabilizing in GC7. In Nigeria, coverage among FSW fluctuated across GC6, with a dip in the middle of the cycle followed by recovery in GC7. Given that population size, estimates remained broadly consistent; these variations are primarily driven by changes in reported reach rather than denominator effects. For PWID in Nigeria, coverage shows a clear upward trajectory across the period, with substantial increases in program reach against stable population estimates (from approximately 20% to 80%), indicating expanded service delivery into GC7. Compared to 2021, nearly three times as many PWIDs were reached (from 127,849 to 357,716) in 2024 in Nigeria.

In the Philippines, trends differ by population group. Among MSM, coverage increased during GC6 but declined sharply in early GC7 (from 122,774 to 86,327), despite relatively stable or increasing population size estimates, suggesting a reduction in reported reach. However, between 2021 and 2024, the population of MSM more than doubled, and coverage did not expand at a commensurate rate. A similar pattern is observed for transgender people, where moderate gains during GC6 were followed by a marked decline in early GC7 coverage. Population estimates for transgender people increased over time, which may also contribute to the observed decline in coverage ratios. Overall, the analysis highlights that in most settings, population size estimates remained relatively stable across years, and changes in coverage are therefore largely attributable to variations in program results.

Snapshots of coverages based on population size estimates for a few countries are shown in the Figures 5-10 below.

Figure 5: Kenya: Percentage of FSW reached with HIV prevention programs

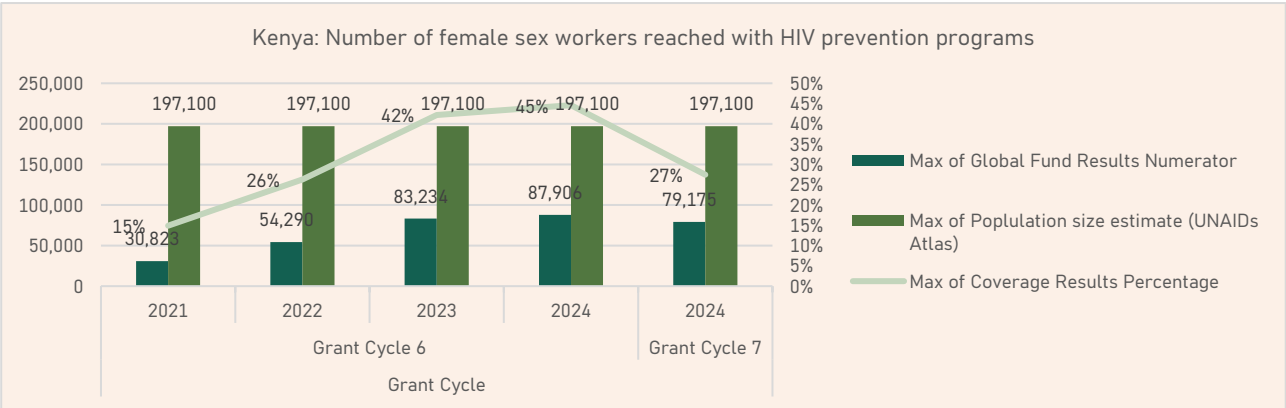


Figure 6: Kenya: Percentage of MSM reached with HIV prevention programs

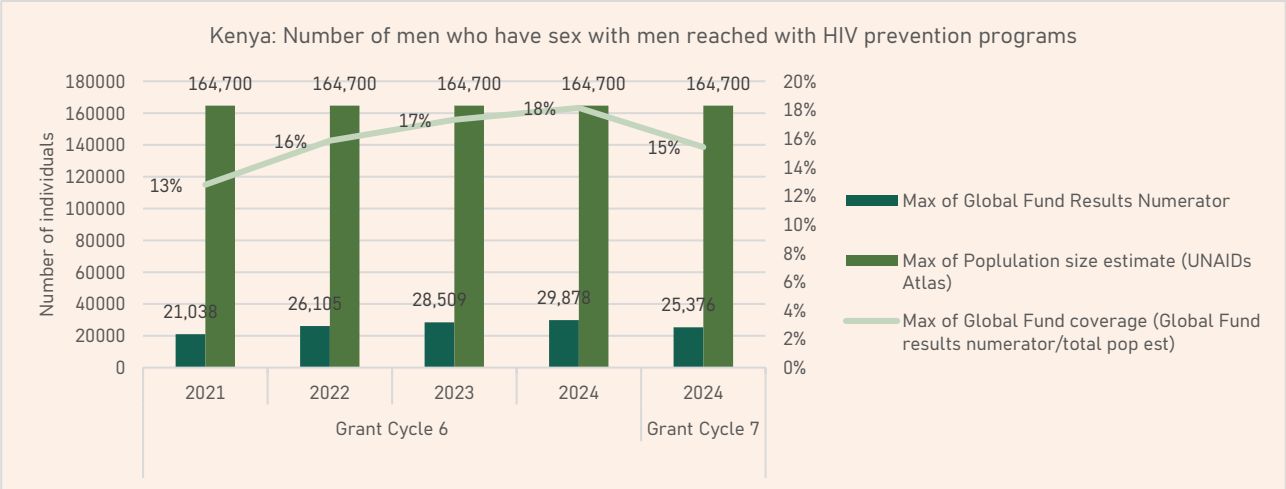


Figure 7: Nigeria: Percentage of FSW reached with HIV prevention programs

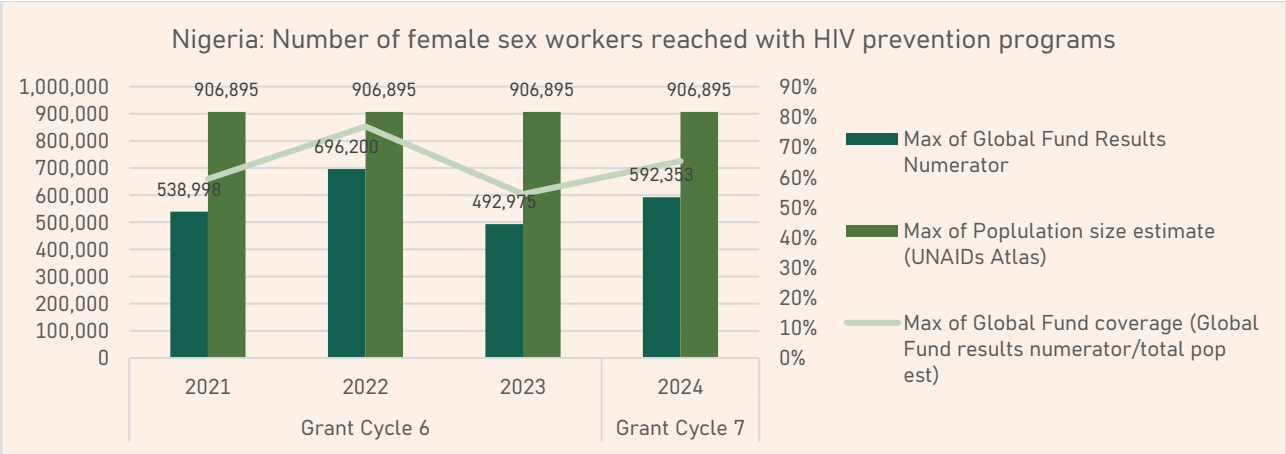


Figure 8: Nigeria: Percentage of PWIDs reached with HIV prevention programs

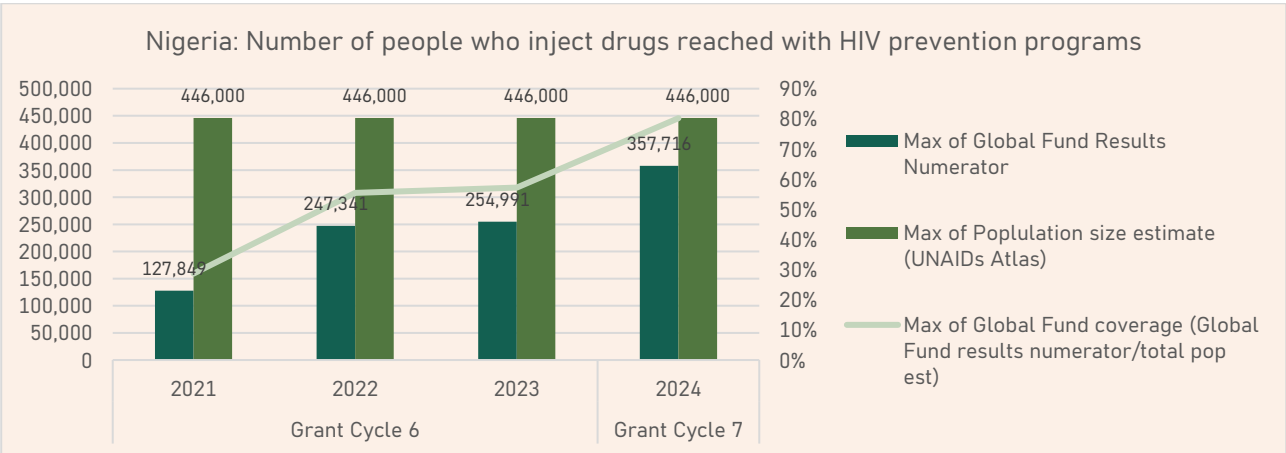


Figure 9: Philippines: Percentage of transgender people reached with HIV prevention programs

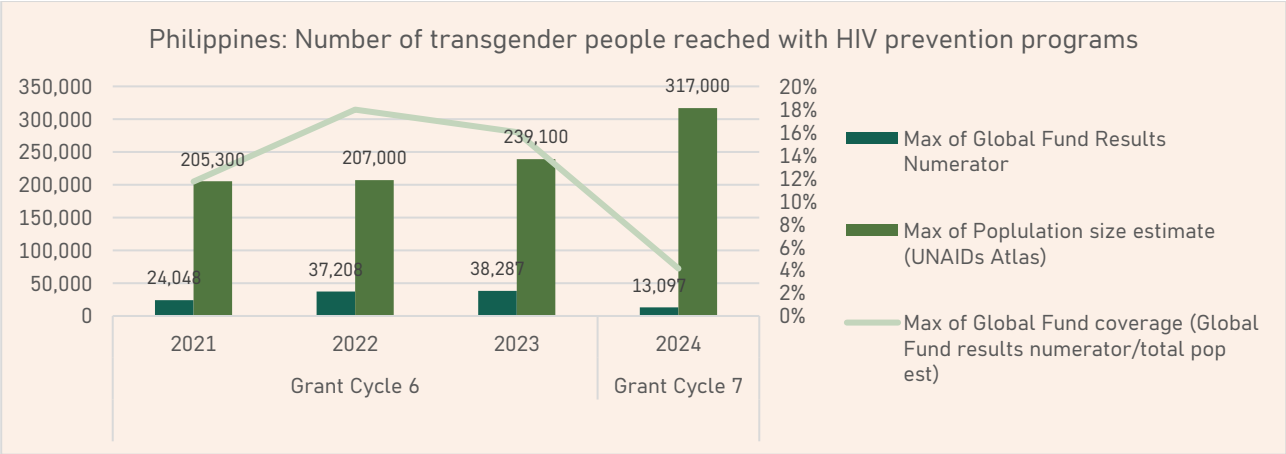
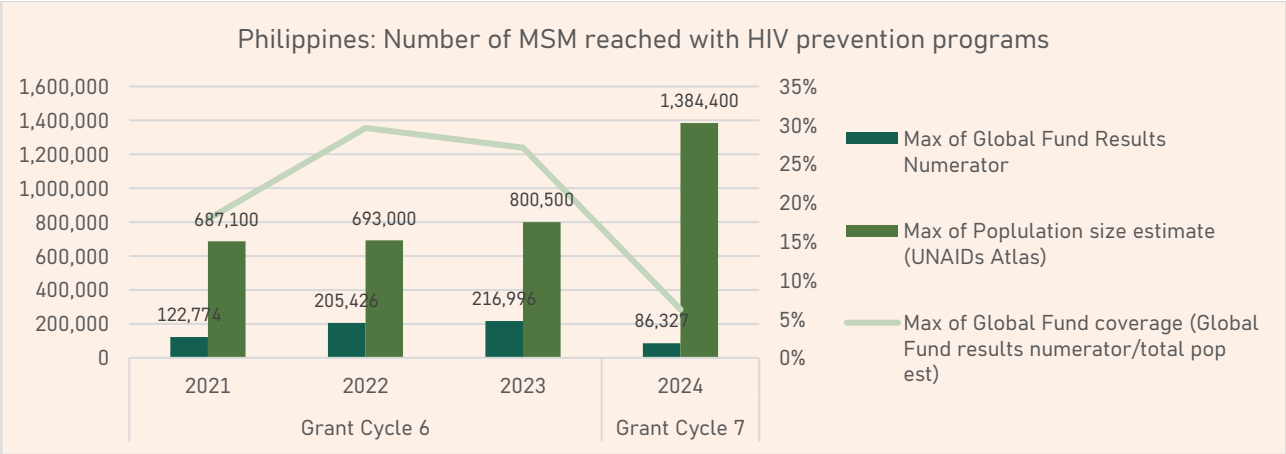


Figure 10: Philippines: Percentage of MSM reached with HIV prevention programs



Finding 6.5: In contexts where performance to date has not been as expected, evidence points to structural barriers and the deprioritization of interventions aimed at addressing these barriers as contributing factors.

Strength of evidence:

			Strong

Performance letters and early grant reports indicate that AGYW coverage in Kenya, Mozambique and Nigeria remains below target, despite the adoption of more targeted approaches. For example, in Kenya, coverage has reached approximately 18% of AGYW identified as being at higher risk.[352] However, in some of these cases, administrative delays in engagement of SRs contributed to the low numbers. In Zimbabwe progress for AGYW contrasts with ongoing gaps for MSM and the absence of harm-reduction services for PWID.[353] In several countries, precision investments have coincided with cuts to structural and behavioral components and the reduction of community platforms that are critical for effective combination prevention: Community, rights and gender interventions were deprioritized in Kenya; condoms and lubricants are less available in Nigeria; mobile clinics and community centers serving KPs and AGYW in Eswatini have closed;

harm-reduction services for PWID are not currently in place in Zimbabwe and constrained in Pakistan; and transgender communities in Nigeria and Tanzania remain largely dependent on FSW/MSM platforms rather than dedicated services.[354] In Uganda and similar challenging legal environments, PrEP and KP coverage targets are at risk by criminalization and rights restrictions that drive communities underground and constrain use of delivery platforms.[355]

The anticipated changes in implementation may shift the coverage and mix of interventions toward more intensive biomedical scale-up, potentially at the expense of structural and behavioral components. Several countries expect to expand coverage of PrEP, including long-acting products such as CAB-LA and future Lenacapavir, as well as HIV self-testing, given their measurable impact and efficiency.[356] In contrast, reductions in funding have already resulted in the contraction of structural and behavioral interventions, including HRG programming in Kenya, community outreach and mobile clinics in Eswatini and Nigeria, and socio-economic support for AGYW in Zimbabwe and Pakistan.[357] GC7 is expected to deliver greater depth in biomedical prevention within priority populations and geographies, while the breadth of comprehensive combination prevention packages may decline. These shifts indicate that GC7 grants will deliver more efficient, targeted coverage but face challenges in maintaining the holistic mix of interventions required for long-term HIV prevention impact. Implementation changes are also expected to influence program efficiency strategy efforts and the quality of supported interventions. However, these adaptations also risk deepening inequities where political conditions or stigma limit the feasibility of integrated delivery.[358]

"We had planned to refresh community actors on HIV, tuberculosis, and human rights issues. This activity was paused. We will not be doing it anymore."
[Mozambique]

"GC7 brought many ideas, but we are still adjusting systems and structures. It will take another cycle before we see the full effect."
[Kenya]

"Punjab is a nightmare, and they also don't allow registration without ID cards. So our clients, majority of them don't have ID cards.... It's quite painful to see that people are dying just because they don't have ID cards or they're not getting access to services."
[Pakistan]

Finding 6.6: HIV prevention budget patterns from GC6 to GC7 show significant cross-country divergence, shaped by both strategic reallocation and contextual constraints.

Strength of evidence:

			Strong

The details are presented in Box 6A and Figures 11 and Figure 12.

Box 6A: Analysis of HIV prevention budgets across GC6 and GC7

The shift from GC6 to GC7 allocations across the 12 sampled countries shows considerable variation in both absolute HIV prevention budgets and its share of total HIV allocations. In absolute terms, HIV prevention budgets increased in nine countries, most notably in Madagascar, where funding rose by approximately 178%, followed by Nigeria with an increase of around 111%, Mozambique with an increase of about 60%, and Eswatini where prevention funding grew by roughly 58%. Tanzania also recorded a sizable increase of approximately 47%, while Zimbabwe and Uganda saw increases of about 35% and 26% respectively. More modest increases were observed in Paraguay, where prevention funding increased by around 18%, and in Kenya, where the increase was approximately 3%. By contrast, HIV prevention budget declined in three countries, falling by roughly 42% in Kosovo, 60% in Pakistan, and 21% in the Philippines. Over the same period, changes in total HIV allocations were comparatively smaller and more mixed, ranging from a reduction of about 16% in Eswatini and 9% in Pakistan to an increase of approximately 39 % in Madagascar and 23% in the Philippines, with several countries experiencing changes of 2% or less. Overall, the budget analysis highlights that changes in HIV prevention budgets between GC6 and GC7 are generally larger in magnitude than changes in total HIV allocations across the sampled countries. In most cases, prevention budgets present sharper increases or declines than overall HIV envelopes particularly in contexts where total HIV funding remained relatively stable. Figure 11 shows these percentage changes of HIV allocation versus HIV prevention budgets across GC6 and GC7.

In addition to percentage changes, Figure 12 presents absolute HIV prevention budgets under GC6 and GC7 for the sampled countries. In most countries, prevention allocations are higher under GC7 than under GC6, while a small number of countries show lower allocations under GC7. The differences in the scale of prevention funding across countries also provides the basis for the percentage changes shown in Figure 11 of the analysis. The absolute figures as well as the percentage changes for HIV allocations and prevention budgets across both GC6 and GC7 are included in the Annex 4.2 for reference.

Figure 11: Percentage change in total HIV allocations and HIV prevention budgets between GC6 and GC7

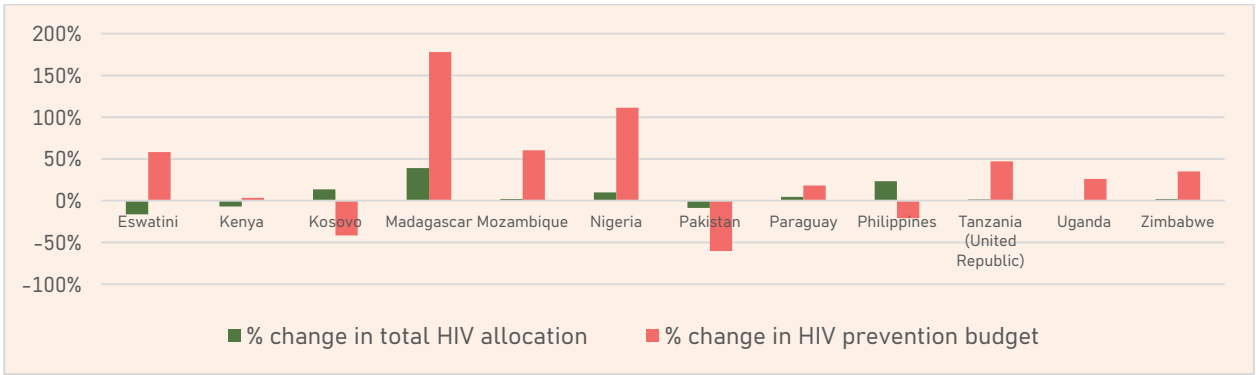
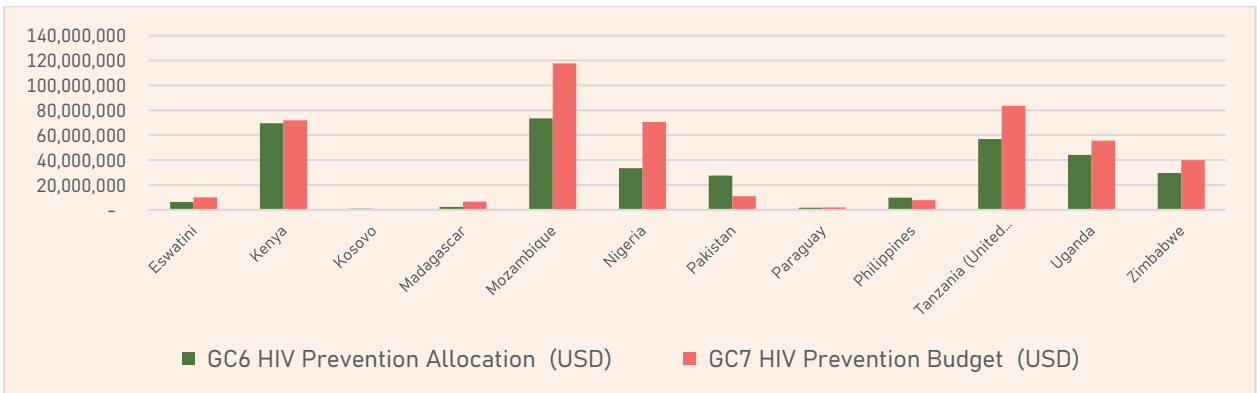


Figure 12: HIV prevention budgets (absolute numbers) under GC6 and GC7



EQ7

EQ7: To what extent and how does Global Fund support HIV prevention interventions that are coherent with other actors' interventions in the current resource-constrained setting?

The Global Fund's flexible country-led approach and close coordination with country governments, development partners, NGOs/CSOs, and communities supports effective collaboration and coherence to HIV prevention service delivery across the majority of countries.

Many countries, including Eswatini, Nigeria, and Tanzania report that the Global Fund's main aim is to compliment government programmes and strategies, often facilitated through CCMs. Global Fund's unique approach and clear delineation of roles among key partners (including PEPFAR) within countries allows the Global Fund to not only provide HIV prevention services not offered by other donors, but also limits the duplication of program efforts implemented within a given country. Although, collaboration challenges exist with some countries reporting capacity limitations in managing all the support offered by partners. Multiple countries also report continued coordination challenges, both among in-country partners, and with national governments. While countries like Tanzania, Mozambique, and Kenya demonstrate progress in system integration and evidence-based planning, persistent challenges—including fragmented M&E systems and technical incompatibilities with donor reporting—highlight the need for continued harmonization. Finally, progress in integrating HIV-prevention services within broader health service delivery platforms has been reported, but this is not uniform across countries.

"Kenya has multiple partners in HIV prevention - Global Fund, PEPFAR, bilateral donors UN agencies. The coordination challenge is enormous. Each donor has different reporting requirements, different timelines, different priorities. We spend a lot of time in coordination meetings but sometimes feel like we're not making progress on actual coordination"
[Kenya]

Finding 7.1: The Global Fund is one of the largest HIV prevention donors globally, has a comparative advantage of scale, and uses its reputation to convene relevant in-country stakeholders to promote coherence across national HIV programs through institutionalized coordination mechanisms.

Strength of evidence:

		Moderate	

In-country stakeholders in both Kosovo and Madagascar noted that the Global Fund's approach to provide 3-year funding cycles allows stakeholders to build sustainable programs and relationships with KP networks over time compared to other donors.[359] Furthermore, it was viewed by one Pakistan in-country stakeholder that compared to other donors in the sector, the Global Fund offers comprehensive funding to cover not only HIV prevention, but also testing and treatment services.[360] Many country teams, including Eswatini, Nigeria, and Tanzania report that Global Fund's main goal is to compliment government programs, and avoid setting up parallel systems and implementation of projects without in-country stakeholder input.[361]

"Without Global Fund, there would be no HIV prevention service for key populations in Pakistan" [Pakistan]

"The Global Fund supports the establishment of uniform minimum intervention standards across the country that transcend individual implementers and align with national guidelines" [Nigeria]

Finding 7.2 The Global Fund promotes community engagement and for many countries, there is a strong reliance on national NGOs and CSOs to support HIV prevention interventions, but some challenges remain.

Strength of evidence:

		Moderate	

FGD participants within Tanzania and Kenya stress the importance of community engagement, and that within Tanzania specifically, this engagement and consultation ensures that donor priorities are aligned to community needs which supports long-term sustainability. Similarly, countries such as Paraguay, Kenya, and the Philippines cite strong dependance on local NGOs and CSOs to reach KPs and ensure accessibility and community ownership.[362]

"80% of the national response falls on civil society" [Paraguay]

"We are working very closely with Center for Social Group Development (CSGD), which is an NGO working with MSM or with LGBTIQ. The main objective of these activities is increasing HIV prevention among key populations, through health education and health promotion for them, but also increasing the advocacy and lobbying for other groups, with the key stakeholders on HIV in Kosovo." [Kosovo]

Finding 7.3: The Global Fund works closely with many local and national governments whose roles in HIV prevention vary, yet collaboration challenges with some national governments remain.

Strength of evidence:

			Strong

In-country stakeholders report that the donor funding landscape is limited within Pakistan meaning there is high reliance on Global Fund support.[363] The Global Fund also plays a more supportive and catalytic role (supporting community-led delivery and innovation where governments face constraints) in countries such as Eswatini, Paraguay, the Philippines and Pakistan, where specifically within Eswatini, the government is the key funder of the HIV response.[364] For example, FGD participants in both Paraguay and Tanzania observed strong collaboration between the Global Fund and national governments.[365] In contrast, in one case, a development partner acting as the PR reported challenges in engaging with a specific country government as suggested feedback was not fully incorporated which was felt to have contributed to the Global Fund's TRP's rejection of the initial funding request.[366] Within Kenya,

sub-national coordination challenges remain as counties not only have different capacities for coordination, engagement approaches with NGOs also differ by county.[367] Furthermore, one Global Fund Kenya country team member noted that, as the Kenyan government receives support from multiple donors, including the Global Fund, coordinating and managing this assistance can present challenges.[368] Some stakeholders reported challenges related to government coordination and engagement in Pakistan and Kosovo. In Pakistan, stakeholders noted the absence of a formal coordination mechanism to support collaboration, perceived differences in implementation flexibility between government entities and national NGOs, and a CCM composition characterized by relatively strong government representation compared to civil society and private sector participation.[369] In Kosovo, stakeholders reported limited political and government engagement among some in-country implementers.[370] This challenge was also noted in relation to data utilization by one in-country stakeholder.

"We usually have quarterly review oversight meeting every quarter. All the peers are supposed to prepare quarterly reports. And after they prepare the quarterly report, then there's an oversight committee meeting. That report goes through the Interagency Coordinating Committee. Then, from the Interagency Coordinating Committee, it comes to the Oversight Committee. Then the Oversight Committee now, presents recommendation to the Kenya Coordinating Committee. So all these committees meet, every, every quarter."
[Kenya]

Finding 7.4 The Global Fund compliments existing development networks and avoids duplication of its activities across many countries through stakeholder collaboration and consultation. However, some challenges between international donor and development partner coordination persist.

Strength of evidence:

			Strong

Within countries such as Tanzania, the Philippines, Nigeria, Pakistan, and Zimbabwe, the roles of the Global Fund and PEPFAR are clearly delineated.[371] In Tanzania and the Philippines, the two organizations decide on clear geographical locations of operation.[372] In Nigeria, coordination is formalized through two avenues: (1) through a signed letter of agreement—the Global Fund is only focused on four states (which are not the primary focus of other major donors) compared to PEPFAR which focused on 36 states in GC7,[373] and (2) through the "Alignment 2.0" approach, which is not only informed by local communities, but also formalizes the division of labor between the Global Fund and other donors.[374] This collaborative approach is reportedly facilitated through technical working groups and CCMs that bring together a range of stakeholders, including key development partners, civil society, KP, youth constituencies, and private sector stakeholders, which ensures approaches are country driven, relevant data can be shared, and stakeholders have the opportunity to raise concerns.[375]

"Target districts and regions were shared between PEPFAR, The Africa Center for Disease Control and Prevention, and the Global Fund" [Tanzania]

"There's good complementarity in technical areas - WHO provides policy guidance, Global Fund funds implementation, PEPFAR supports capacity building. However, gaps exist in monitoring and evaluation support, with no single donor taking comprehensive responsibility for national M&E system strengthening" [Pakistan]

Multiple countries, including Kosovo, Pakistan, Kenya and Paraguay observe coordination challenges between in-country partners. For example, in-country stakeholders within Pakistan and Kenya both stressed that differing development partner requirements, timelines and priorities impede coordination efforts.[376] However, to overcome this challenge within Kenya, one government in-country stakeholder reported that, coordination meetings, shared monitoring systems, and joint planning processes were established.[377] Even in countries with few development partners such as Paraguay and Kosovo, development partner coordination reportedly needs constant attention to ensure coherence.[378] In one country, the PR noted advice from the government's technical teams did not align to advice provided by the Global Fund, with the latter based on policy guidance published by Pan American Health Organization (PAHO). Similarly, in another country, an element of duplicity remains; in-country stakeholder reports observing overlap in capacity building activities of the Global Fund, PEPFAR and WHO, each of whom provide training for health care workers.[379]

"The CCM is supposed to coordinate all HIV partners, but it's dominated by government representatives who don't always understand key population needs. Civil society has limited voice, and private sector is barely represented. This affects the quality of coordination and decision-making." [KII, country case study]

"We need more structured, regular coordination mechanisms that include all major HIV stakeholders at both national and provincial levels." [Pakistan]

Finding 7.5: The Global Fund promotes a flexible country-led approach, enabling reach of KPs with innovative and community-led approaches which are often not prioritized by other donors.

Strength of evidence:

			Strong

Many Global Fund Secretariat stakeholders observe that the Global Fund not only places a strong emphasis on KPs and promotes a country-led approach, but for many countries, it is the only donor focused on certain KPs and HIV prevention services, often due political sensitivities and policy restrictions.[380] Many in-country stakeholders within Pakistan, and another in Kenya note the Global Fund's adaptability to local contexts and its focus on service delivery funding compared to other donors who focus solely on capacity building, or have a pre-defined and rigid programmatic approach which limits flexibility.[381] This tailored approach is further supported by community involvement in initial grant development.[382] Within Paraguay, the country has supported the implementation of a unique pay-for results approach (among donors) which incentivizes in-country implementers to demonstrate impact rather than solely activity completion.[383] Similarly, the Global Fund reportedly funded a novel teleconsultation service

within Paraguay which increased the number of people taking PrEP within the country.[384] Within Tanzania, Pakistan, Nigeria, and Eswatini for example, many in-country stakeholders report that the Global Fund is able to provide support for interventions focused on providing needles for safe administration of drugs which other donors are unable to support.[385] Within Pakistan, Tanzania, and the Philippines, the Global Fund provides much needed support for community-led delivery models and KP outreach efforts to effectively reach KPs.[386] Finally, within Nigeria, the Global Fund also focuses efforts on previously under-resourced harm-reduction services.[387]

"Bilateral donors provide good infrastructure support but limited direct service funding. Global Fund fills the gap by funding actual service delivery with flexibility to adapt based on what works." [Kenya]

In addition, the Zimbabwe country team shared observations related to aspects of country ownership, including the interpretation and use of program results and data, as well as the progression of HIV prevention activities.[388] In Kosovo, stakeholders indicated that while a working relationship has been established with a relevant Ministry of Health counterpart, competing responsibilities associated with that role may affect the extent of ongoing engagement.[389]

Finding 7.6: The Global Fund has made some progress in integrating HIV services into broader health service delivery platforms across many countries, although this is limited by continued key population stigma and political buy-in.

Strength of evidence:

			Strong

For example, within Mozambique, data collection at the health unit level is fully integrated, with no distinction made based on funding source, and the country is delivering some AGYW services through the Servicios Amigos dos Adolescentes platform.[390] Despite the Global Fund's efforts to prioritize integration, another Mozambique in-country stakeholder observes continued challenges of integration within family planning and STI services as funders often want to monitor the impact of their own funding.[391] Within Tanzania, the country has developed the Unified Community System (UCS) which is a digital platform that integrates various HIV prevention services and synchronies with the national District Health Information Software 2 (DHIS2) database, ensuring real-time data flow from community to central systems. Institutional mechanisms, such as Tanzania's coordination with the President's Office—Regional Administration and Local Government, and Nigeria's use of SWAP (sector-wide approach), further embed HIV programs into existing health governance. Other countries continue to work toward integration; for example, Nigeria and Uganda aim to increase interoperability between Electronic Medical Records and DHIS2, and Zimbabwe is delivering its DREAMS program focused on AGYW through a combination of community and facility platforms.[392]

In Kosovo, stakeholders noted that levels of political engagement may influence the extent of service integration. While HIV prevention interventions are reflected in guidelines and legal frameworks in both Kosovo and Mozambique, stakeholders indicated that implementation may vary in practice.[393] For example within Kosovo, PrEP services are difficult to access because the main center is located in an infectious disease clinic which leads to visitor complaints about

privacy and confidentiality, despite efforts to integrate them into primary health care.[394] Many stakeholders across the Global Fund Secretariat (including country teams) and in-country stakeholders also note continued stigma associated with accessing, or being seen to access HIV prevention services among the general population.[395] This stigma is reportedly most prevalent when accessing these services through traditional approaches such as hospitals and Antiretroviral Therapy (ART) centers.[396] Within Pakistan, it was reported that KP programs also face challenges due to community resistance, often led by local leaders.[397] In addition, across many countries, including Paraguay and Pakistan, the Global Fund is encouraging and supporting the decentralization of some services, in addition to promoting a community and peer-led approaches to HIV prevention services to create safer and more discreet environments for KPs to access and use HIV prevention services.[398] For example, within the Philippines, the country has implemented 10 mobile clinic vans and 18 support vehicles serving 123 sites across 18 regions in addition to funding peer KP group case managers. [399] Similarly, within Kenya, clients are encouraged to access HIV prevention commodities such as PrEP through community pharmacies, and Eswatini offers general consultations services in the same office instead of stand-alone visitor sites or specific rooms.[400] However, it must also be noted that due to recent changes in the funding landscape, there is movement within the Global Fund to promote a more centralized approach.

"So, for people who do go in for services [like] diabetes medication or to check their hearts or because they broke their leg, you know, I think it's great to have PrEP. I don't know why PrEP isn't available in all places." [Global Fund stakeholder]

"The Global Fund is the only donor that explicitly supports human rights interventions and dedicates a solid percentage of its grant to advocacy for human rights to foster HIV prevention programs." [Kosovo]

Within Pakistan, in-country stakeholders report weaker integration of HIV services within broader health systems as efficient integration is needed at multiple levels, including policy integration for enabling environments, service integration for efficiency, and data integration for monitoring. This lack of integration is also observed by Kenya and Paraguay in-country stakeholders, in addition to Eswatini focus group participants, who report this lack of integration was because KPs not only require confidentiality of service providers, but also that health personnel providing services focused on KPs require specialized training; neither of which are viewed to integrate well within general health services.[401] To mitigate these issues within Eswatini, the Global Fund Secretariat confirmed that it will support the country to provide specific training to some public health facilities to become more KP and youth friendly. Similarly, within Kosovo, digital health services and health information system are reportedly not well-established, and only one mobile clinic is available which is partly integrated into the broader health system.[402] Finally, within Madagascar, funds are reportedly primarily allocated to the procurement of commodities such as rapid tests, medicines, and syringes, with minimal investment in institutional capacity which is not perceived to support long-term integration.[403] To mitigate some of these challenges, the Pakistan government has started to integrate HIV-related services into specific health services such as STI clinics, reproductive services, and harm-reduction centers.[404] This approach has been effective within Paraguay where it was reported that HIV prevention services have been well integrated within sexual and reproductive services as these services serve similar populations and share common approaches.[405] Furthermore, countries including Mozambique, Nigeria, Tanzania, and Kosovo also utilize school-based programs to share relevant HIV prevention messaging and education.[406]

"It's just about ticking a checkbox…doctors at tertiary care hospitals (intended integration points) often deny prevention services like PrEP to clients suspected of drug use, rendering the planned complementarity [of services] ineffective" [Pakistan]

"Where facility managers understand key population needs and support integration, it works well. Where managers are unsupportive or staff are untrained, integration attempts fail and can actually harm key populations by exposing them to discrimination" [Kosovo]

Finding 7.7: For the majority of countries, country needs that are not addressed by current HIV-prevention interventions are identified through national document reviews and data analysis before being discussed during multi-stakeholder engagements. Although this approach is not consistent across countries.

Strength of evidence:

		Moderate	

Many countries describe the reliance on national documentation such as NSPs, National Strategic Frameworks, and HIV Prevention Roadmaps to identify relevant gaps.[407] Most countries also reportedly use structured mechanisms that bring together government entities, technical working groups, partners, and community representatives to collaboratively assess needs and identify gaps. Similarly, Kenya and the Philippines underscore inclusive processes involving all partners and regular portfolio reviews to ensure transparency in funding landscapes and timely identification of risks or emerging needs.[408] In particular, Kenya uses data from Spectrum[409] and national surveys.[410] According to many country stakeholders, this participatory approach is complemented by a strong reliance on epidemiological and program data where national estimates, IBBS and size estimations inform gap analyses and resource allocation decisions.[411]

Countries like Kosovo and Paraguay also emphasize adaptive financial mechanisms—budget revisions and mid-term national evaluations that allow reprogramming of resources based on changing circumstances or evaluation findings.[412] In contrast, Pakistan illustrates challenges in stakeholder engagement and external support, relying more heavily on internal management information systems and informal networks to address implementation issues.[413]

"I think the main challenge that we see is that the there's so much deprioritization of HIV prevention programs and there's a lot of shifts towards treatment. So whatever the donors are still putting towards prevention is hugely effective because we now have a gap of about over $200 million."
[Kenya]

EQ8: What are the key drivers behind sustainability of HIV prevention interventions?

The key drivers behind sustainability of HIV prevention interventions include national ownership and stewardship, integration with health and education systems, robust domestic financing, supportive legal and policy environments, and institutionalized community engagement.

Global Fund can play a role in facilitating key drivers of sustainability by continuing to provide flexible funding that delivers adaptive programming, advocating for community-centered systems, and pursuing strategic partnerships.

Finding 8.1: Transitioning stewardship to national institutions is essential for embedding HIV prevention within national systems and strengthening long-term resilience.

Strength of evidence:

			Strong

The Tanzania Commission for AIDS) coordinates national HIV efforts, embedding prevention within the broader public health strategy.[414] In Zimbabwe, national ownership by the National AIDS Council and the MoH is recognized as a major factor for success.[415] In Mozambique, achieving sustainability requires moving beyond exclusive reliance on the National Health Service and its partners, and instead fostering multisectoral involvement from sectors such as education and labor.[416] The dual reporting system in Eswatini and ongoing development of the HIV prevention module within its national HMIS illustrate efforts to strengthen national data stewardship for more accountable and responsive programming.[417] Stakeholders report the process of transitioning donor-dependent programs to national ownership (e.g., Kosovo's focus on government takeover milestones) should emphasize accountability, timelines, and sustainability as an evolving process rather than a fixed state.[418]

Finding 8.2: Systematic integration of HIV prevention into existing health and education platforms reduces reliance on parallel donor-funded programs and fosters sustainable service delivery.

Strength of evidence:

			Strong

Kenya has successfully integrated HIV prevention within primary health care and community health systems, ensuring service continuity and leveraging established delivery structures that rely on domestic planning cycles.[419] Similarly, in Mozambique, youth-friendly services integrated into public health facilities (such as Serviços Amigos dos Adolescentes e Jovens (SAAJ)) were found to be more sustainable than stand-alone projects.[420] Paraguay in particular is working to decentralize PrEP access by incorporating it into primary healthcare facilities and family health units.[421] In Nigeria, prioritizing interventions built upon the "existing structure" supported by the Government of Nigeria, such as healthcare facilities, healthcare workers, commodities, and data

systems, is seen as the pathway for interventions to "flourish" even without donor funding.[422] In Kenya, decentralization has placed primary healthcare delivery under county governments, necessitating that HIV work be integrated into these "standard health facility" structures for sustainability.[423]

Stakeholders in Kosovo and Madagascar identified health system–related constraints as factors influencing integration, alongside ongoing policy alignment efforts.[424] In Nigeria, stakeholders noted that fragmentation across data systems may affect monitoring and adaptive decision-making and in Tanzania and Pakistan, stakeholders described structural features of government systems that may influence the scalability of integration efforts.[425] In Tanzania, stakeholders also highlighted that the presence of parallel donor structures, together with existing system characteristics, may affect integration and adaptation efforts.[426]

Finding 8.3: Predictable, government-led financial investment is critical for sustainability. Domestic financing of HIV interventions is essential to achieving program sustainability and protecting services from the volatility of donor funding.

Strength of evidence:

			Strong

Government-led financial mechanisms, such as Zimbabwe's AIDS levy and Tanzania's AIDS Trust Fund signal a strategic move toward nationally owned programming and reduced dependence on external donors, though allocations may sometimes fall short of commitments.[427] Donor reliance remains a risk in contexts like Mozambique and Pakistan where the vast majority of HIV responses are donor funded.[428] Respondents of this study also highlight the fragility of programs when domestic co-financing is insufficient and donor priorities shift. In Uganda and Eswatini, funding cuts resulted in halted staff salaries and the closure of specialized clinics.[429] Likewise, country stakeholders in Zimbabwe reported that the recent rapid donor withdrawal led to significant service disruptions.[430] To improve sustainability, expanding national healthcare financing mechanisms (e.g., PhilHealth) to cover HIV prevention and establishing social contracting for CBOs to access local government budgets are being advocated for by stakeholders in the Philippines.[431] Prioritizing interventions that leverage government institutions across sectors is essential for reducing long-term donor dependency and ensuring continued delivery of vital HIV services.[432]

Finding 8.4: The legal and policy environment profoundly influences the effectiveness and continuity of intervention delivery.

Strength of evidence:

			Strong

Across several countries, criminalization and the lack of enabling legal frameworks serve as persistent barriers, fostering stigma and discrimination that deter KPs from accessing essential services. In Kosovo, for example, the criminalization of sex work and harm-reduction services for PWID creates conditions that significantly undermine HIV prevention efforts, as NGOs providing 100% of HIV prevention services are heavily reliant on donor funding and face

heightened risk when external support wanes.[433] Nigeria similarly confronts legal constraints that perpetuate stigma and restrict service access for marginalized groups, with program implementation for KPs hindered by both national law and societal attitudes.[434] In Madagascar, the lack of government investment in HIV response is compounded by legal and policy challenges that limit progress toward equitable prevention outcomes.[435]

Additionally, social and institutional stigma remains a pervasive barrier in Zimbabwe, where MSM programming is particularly challenged by legal and policy obstacles.[436] Uganda and Mozambique report similar difficulties, with stigma and discrimination in health system settings impeding sustained service uptake and undermining the gains achieved through technical and financial investments.[437] In Pakistan, stigma among health workers and broader societal discrimination further hinder access to prevention services for KPs, including PrEP.[438]

Collectively, these findings underscore that without enabling legal and policy reforms and concerted efforts to address stigma and discrimination, the sustainability of HIV prevention interventions will remain at risk, even where technical and financial investments are present.[439]

Finding 8.5: Community engagement, particularly when formalized through CLM, governance structures, and participatory service delivery platforms, stands out as a foundational driver of long-term sustainability.

Strength of evidence:

			Strong

Pakistan's institutionalization of community-led service delivery platforms and participatory monitoring systems exemplifies pioneering practice, embedding accountability in national programming.[440] Kosovo's multi-year social contracting arrangement further illustrates an innovative approach; by securing government funding for CSOs over several years, Kosovo not only strengthens equity and programmatic reach but also fosters continuity and local ownership.[441] Peer-led models in Kenya and Philippines highlight the resilience of interventions deeply rooted in community networks. These models leverage trusted relationships, cultural insight, and low operational costs to sustain HIV prevention activities even in resource-constrained environments.[442] Uganda's experience further emphasizes the importance of a proactive, adaptive civil society in sustaining HIV prevention gains. Nevertheless, the persistence of a restrictive legal and policy environment poses severe challenges to sustainability, particularly for programs serving KPs. Without enabling legal frameworks and government commitment, even the most resilient community-led initiatives may struggle to survive.[443]

Finding 8.6: Global Fund can play a role in facilitating key drivers of sustainability by continuing to provide flexible funding that delivers adaptive programming, advocating for community-centered systems, and pursuing strategic partnerships.

Strength of evidence:

			Strong

In Mozambique and Nigeria, flexible financing and adaptive programming are allowing prioritization of impactful interventions within limited budgets, directly enabling responsiveness to shifting epidemiological trends and resource constraints.[444] Pakistan has demonstrated how embedding CLM and governance into national strategies builds accountability and local ownership, while Philippines has proposed social contracting mechanisms that leverage domestic funds for CBO-led outreach.[445] Effective, well-coordinated collaboration among government, civil society, and international partners is foundational for maximizing coverage and leveraging complementary strengths. Paraguay exemplifies this through strong community engagement and sustained national dialogue, though ongoing challenges with fragmented human rights mechanisms persist.[446] Collectively, these country experiences illustrate that Global Fund-supported flexible, community-driven, and partnership-based programming is crucial to maintaining and scaling HIV prevention interventions amid fluctuating external resources. Strategic investments in accountability, local ownership, and collaborative frameworks are essential for a resilient, impactful HIV response.[447]

Objective 3

EQ9

EQ9: To what extent are countries effectively measuring HIV prevention outcomes, including integration of the POMT into MEL systems?

Countries are measuring HIV outcomes through a variety of methods that have made progress in integrated reporting of HIV programmatic data into their national HMIS, including the reporting of HIV prevention outcomes. With respect to the POMT, a minority of countries have implemented methods recommended by POMT in their contexts with limited evidence of integration into national MEL systems. Countries that have implemented POMT report a range of technical and operational hurdles during implementation. These include challenges with the guidelines, the newness of method deployed, the reliance on external technical assistance and finally the rapidly constrained financing environment.

All the countries in the sample show evidence of measuring HIV prevention outcomes, primarily using population-based surveillances—and have made progress in integrating the reporting of HIV programmatic data into their national HMIS. Moreover, they have been making positive strides toward alignment and harmonization of the data reporting systems between partners. However, operational and technological challenges encumber the MEL systems harmonization process and these successes which are being exacerbated with the current funding crisis.

In terms of the POMT, eight countries have engaged with the POMT to date, catalyzed by a workshop held in Botswana in 2024.[448] Pace of adoption and MEL system integration has varied across contexts, as has preferred POMT method. Methods chosen include rapid coverage surveys (RCS) and PBS targeting KP and AGYW while bio-behavioral survey lite (BBS-lite) targeting KP.

Of the three countries that have deployed prevention outcomes monitoring approaches in line with the POMT to date (Uganda, Eswatini, Mozambique), there is limited documented evidence of systematic deployment of these surveys to support routine monitoring of prevention outcomes. Further, deployment was dependent on donor funds, and findings from the surveys had not yet been disseminated (at the time of the review), indicating limited effectiveness and sustainability of these approaches.

Of the countries who had implemented POMT methods, both positive and negative experiences were reported. Stakeholders reported in-country receptiveness and perceived value of POMT, including a sense of higher cost-effectiveness for monitoring prevention outcomes. Conversely, stakeholders reported a steep learning curve to adoption, which required external technical assistance. Further, divergent interpretations were reported on necessary scale of implementation, frequency, and level of scientific rigor.

Undoubtably, the dramatic reduction in external donor funds resulting from the withdrawal of other major international players and the Global Fund reprioritization processes has negatively impacted on the implementation progress. The focus and priorities of countries shifted to preserving lifesaving interventions; and countries were hesitant to initiate something new due to the uncertainties. Nearly all countries in our sample reported the POMT process being put on hold, while even more concerning, anecdotal evidence of potential upcoming broader cuts to MEL systems were identified.

Finding 9.1: All the countries in the sample show evidence of measuring HIV prevention outcomes—primarily using population-based surveillances—and have made progress in integrating the reporting of HIV programmatic data into their national HMIS. Moreover, they have been making positive strides toward alignment and harmonization of the data reporting systems between partners. However, operational and technological challenges encumber these successes, which are being exacerbated with the current funding crisis.

Strength of evidence

		Moderate	

Across the 12 countries there have been measuring HIV prevention outcomes primarily using population-based surveillances such as IBBS, demographic and health surveys (DHS), and population-based HIV impact assessment (PHIAs). Selective examples of these are presented in Box 9A.

Box 9A:

- In Tanzania, priorities and geographical focus are informed by epidemiological data, including the Tanzania AIDS Indicator Survey and the IBBS.[449]
- Kenya uses data from demographic health surveys, the Kenya AIDS Indicator Survey (KAIES), and HIV impact assessments (KENPHIA) to inform gaps and advocate for policy formulation.[450]
- Kosovo utilized past IBBS from 2016, along with later mapping and population estimates, to align prevention services with scientific data.[451] This data pointed to MSM as the key group for prevention focus.[452]
- Nigeria's GC7 grant design utilized KP size estimates, even when still in draft form, to estimate the target number of individuals to reach with prevention and PrEP services.[453]
- In Zimbabwe, outcome monitoring is achieved through studies, specifically mentioning contributions to the Zimbabwe Demographic and Health Survey and conducting behavioral surveys.[454]

However, a pervasive issue across multiple countries is that the necessary financial allocations for comprehensive prevention-outcome monitoring remain heavily dependent on external donor funding, making them highly vulnerable to resource cuts.[455] In Eswatini, the monitoring of prevention outcomes has relied heavily on large-scale surveys funded by partners such as USAID, CDC, and PEPFAR.[456] The planned IBBS for KPs was canceled in January, just as data collection was expected to begin.[457] Subsequently, the HIV prevention-outcome monitoring work stream was paused due to funding constraints.[458] Similarly, Nigeria's national data systems remain heavily dependent on donor financing.[459] Nigeria has previously relied on expensive surveys such as the IBBS, which can cost up to US$2 million, and is now seeking to transition to more sustainable, routine data-based monitoring. This shift is driven by the need to reduce reliance on large-scale surveys and to enable quicker deployment of the POMT approach.[460]

The evaluation found good examples of integration of HIV programmatic data into countries' national HMIS including the reporting of HIV prevention program data. In Kenya, for example, prevention-outcomes data that has been integrated includes uptake of VMMC and PrEP cascade data (uptake, continuation and HIV status);[461] in Nigeria qualitative data on behavioral outcomes such as condom use and safe injection practices is collected through partner reporting systems;[462] in Eswatini a PrEP module has been built into the patient-level data management (known as Client Management Information System) to ensure that PrEP data is captured in the

national data reporting system going forward especially with the launch of LEN PrEP;[463] and in Tanzania data on community-level HIV prevention monitoring data on PrEP uptake, and effect of social and behavior change communication is collected through the Unified Community System.[464]

The study also highlighted varying levels of advancement regarding digitization and harmonization between national and sub-national data collection. Pakistan and Paraguay demonstrated a high level of technological advancement of the MEL systems which they have deployed for collecting HIV prevention program data;[465] other countries use hybrid data reporting systems comprising both electronic and paper-based records. Both Eswatini and Nigeria use the national HMIS as the primary data reporting system, which is electronic, and a partner-led community-level data collecting system for KP and AGYW, which is paper-based.[466] Tanzania also relies heavily on the paper-based data reporting system that is present in most of its facilities.[467]

Some countries are also making headway toward harmonization of data reporting between government and partners, for example Tanzania is working toward rolling out a web-based system for capturing community-level data from the different partners—the Unified Community System.[468]

Across the case studies harmonization efforts have, however, encountered challenges. These include multiplicity of donor reporting requirements, data quality, technological, political, and financial hurdles (see Box 9B).

Box 9B: Examples of challenges with MEL harmonization at country level

Eswatini has been encountering challenges with interoperability and data sharing between the national and partner systems;[469]

- In Kosovo, the MEL system shows limited national ownership, as current leadership within the Ministry of Health tends to view HIV programme data as primarily partner-owned;[470]
- Madagascar is making progress toward consolidating data on people living with HIV; however, data spot checks identified some gaps in the quality of reported data;[471]
- Stakeholders in Nigeria highlighted challenges related to the siloing of data reporting channels;[472]
- In both the Philippines and Pakistan, challenges linked to fragmentation of data systems were reported. In the Philippines, data from CLM platforms remain separate from the national Oasis data system, while in Pakistan fragmentation between national and provincial data systems limits comprehensive monitoring of prevention outcomes.[473]

"We have a data management system commissioned in 2021 used by partners, but it faces challenges in interoperability with national systems. We are developing an electronic system owned by the Ministry of Health to be used by all partners for community service reporting to standardize data collection and reporting." [Eswatini]

Finding 9.2: The POMT methodologies were conceptually easy and quick to administer and expected to facilitate more cost-effective approaches for prevention outcomes monitoring. There was initial enthusiasm for the rollout of the POMT among the eight pilot counties. However, pace of implementation has varied significantly across these countries.

Strength of evidence

			Strong

The POMT toolkit had been envisioned as a prevention-outcome monitoring approach that would (1) be easier and quicker to administer, and (2) make prevention-outcome data more readily available at a cheaper cost.[474] The initial expectation was that the PR would lead the outcome monitoring which would reduce the need for complicated scientific sampling procedures.[475] The motivation for this approach was to make data available to support adaptive program management at the local level.

Stakeholders demonstrated initial receptiveness and appreciation for the POMT toolkit. The countries that had implemented some of the methodologies included in the POMT toolkit shared their experiences at the meeting held in Botswana, which also served as a South-to-South learning opportunity. This enhanced buy-in among the country representatives in attendance; in Nigeria for example, respondents cited that due to the high cost of implementing the population-based surveys, it was imperative to shift to a more cost-effective outcome monitoring approach.

> *"... future outcome monitoring must leverage routine programmatic data and be more decentralized so that implementers can regularly run small surveys and use the information for decision-making." [Nigeria]*
>
> *"The prevention outcome monitoring is well accepted, and I think the countries are seeing that this is actually a good tool for them to get data..." [Nigeria]*

Eight countries from our sample have engaged with the POMT toolkit to date, catalyzed by a peer-to-peer learning workshop held in Botswana in 2023. Pace of adoption and MEL system integration has varied significantly across contexts, as summarized in Figure 13 below. There was also variation in the POMT approaches used. Approaches chosen include RCS and PBS targeting KP and AGYW, and BBS-lite targeting KP.

Figure 13: Mixed progress of POMT implementation in sampled countries



Eswatini was one of the pilot countries and deployed the RCS in 2023 under the GC6 funding period, executed by FHI 360's EpiC project, a USAID-funded program that also included Global Fund AGYW sites. Similarly, Mozambique also made substantive progress by implementing a pilot of the RCS among KPs in Maputo, and the country is now planning to expand this to include

a broader geographical scope.[476] Uganda is the third country that implemented POMT approaches; the country conducted both RCS among AGYW, FSW, and PWIDs, and also piloted BBS-lite among FSW and PWIDs through a separate UNAIDS pilot initiative.[477]

Kenya and Tanzania also made some progress in implementing POMT approaches. Both countries have approved survey protocols that are ready for implementation. Tanzania will use RCS, while Kenya will implement PBS (building on its prior experience conducting multiple PBS rounds).[478]

Finding 9.3: Countries that have implemented POMT report a range of technical and operational hurdles during implementation, These include challenges with the guidelines, the newness of method deployed, the reliance on external technical assistance and finally the rapidly constrained financing environment.

Strength of evidence

			Strong

"So, as you already know, this was a new tool. So, they're kind of learning how to do this….unfortunately, it took quite a bit of time. The survey started late… It was done by the consultant…; even though they participated, they were kind of either on-lookers or maybe answering questions. They were not the full implementer. So, there is that gap between… like… can they take it on…"
[Global Fund stakeholder]

"…despite the guidance we shared we're kind of somewhere in between… the rigor wasn't as great as in the big surveys, but it wasn't as simple as we wanted it and most of the time was also too big in size… most of the questionnaires still focus a lot on other things like on more general risk factors, on actual reach and even treatment questions… still they struggled to really focus on the outcomes with all of the proposals that we had to say: keep it simple, keep it short, but focus on the outcomes."
[Global Fund stakeholder]

Some stakeholders in pilot countries reported difficulties with adopting the Global Fund guidelines to simplify the procedures and strike a balance in their protocols between scaling down the approach while maintaining scientific rigor.

Countries reported a range of technical and operational hurdles during implementation. For the countries encountering POMT methods for the first time, the newness of the concept presented them with a steep learning curve. Eswatini, for example, relied entirely on externally funded technical assistance from USAID during the initial implementation of the RCS. The Global Fund played a limited advisory role by providing input into the report, but no structured technical capacity transfer took place. As a result, the country team was left with limited proficiency in using the RCS tool.[479] Tanzania similarly faced administrative hurdles with procurement of external technical support for implementation were the major setback to the process.[480] From the POMT survey, respondents from countries that had made significant implementation progress indicated that despite the useful insights emerging from the POMT methodologies, there were challenges with sampling approach and sample sizes which made meaningful analysis difficult.[481]

In other countries technical issues were cited as a barrier to POMT rollout. In Kenya, for example the process of deployment was deferred due to the delayed release of the 2023/24 IBBS results while in Nigeria, respondents cited local contextual factors, including cultural sensitivities surrounding prevention-outcomes monitoring among AGYW, that would make the process more costly and complicated to implement than projected in the guidelines provided.[482]

Undoubtably, the reduction in other donor funds and the Global Fund reprioritization processes has negatively impacted on the implementation progress. The focus and priorities of countries shifted to preserving lifesaving interventions; and countries were hesitant to initiate something new due to the uncertainties.

In Kenya, Zimbabwe, and Nigeria for example, the POMT adoption process was put on hold, as country stakeholders focused on the reprioritization process.[483] In the Philippines, the POMT was also deprioritized along with other surveys and studies, subject to availability of savings.[484]

"...because of all the things happening in countries and people just not having like space in their minds to think about the outcome monitoring work because they're just struggling to get programs up and running. So, Nigeria has been involved, was planning to do something, but that is on hold." [Global Fund stakeholder]

"... Kenya was supposed to adopt the POMT, but the process has faced delays due to the restructuring in terms of the funding landscape..." [Kenya]

"We envisaged this work we're doing now is a bit of an intermediate step to make it even simpler...these methods might still be too costly and human resource intensive. So, we might want to work towards something even simpler... to a lower level, implement surveys that are not having a sample size calculation, not even having a random sample because it's really about your clients..." [Global Fund stakeholder]

"...the IBBS because it's at a national level... for individual implementers also often not used... because they don't know what the case in the area is they are operating in... IBBS data more for high level programming and planning, but for actual implementers I don't see that used a lot because they don't know what is related to their service provision... [Global Fund stakeholder]

"We're supposed to do one here. We could not do it when they cut resources, but they've asked us to revive it..." [Zimbabwe]

From the onset, it is clear that the funding for the POMT deployment was heavily dependent on external donor funds.[485] This aligns with the fact that the majority of traditional large-scale outcomes-monitoring surveillance processes, evaluations and studies implemented prior to the introduction of POMT were also heavily reliant on external donor funds. This, of course, raises significant concerns around sustainability.

This concern is exacerbated by the fact that a number of stakeholders highlighted that MEL is afforded a low prioritization for budgetary allocation by country health ministry leadership. In Nigeria and Pakistan, for example, respondents indicated that MEL systems were the first to suffer budget cuts during funding crises. Furthermore, in Nigeria, stakeholders noted limited investment in human capacity development within MEL systems and high costs associated with digitization of health data reporting systems, whereas in Pakistan, treatment monitoring was given preference over prevention monitoring.[486]

The 30% budget cuts have particularly affected M&E activities, and prevention outcome monitoring has been deprioritized in favor of maintaining basic service delivery." [Pakistan]

"Sustainability is actually threatened because over time we have realized that M&E gets cut first, when we want to prioritize or reprioritize. The basic challenge we have for M&E is sub optimal capacity in terms of numbers and in terms of quality of staff down there and the also over dependence on donors for funding M&E activities." [Nigeria]

Finding 9.4: As a result of POMT implementation being in its early phases, limited evidence is available on the utilization of data collected through the POMT methodologies for adaptive programming. However, the stakeholder survey carried out as part of this evaluation highlighted continued enthusiasm for the POMT among users and receptiveness towards sustainable integration of POMT methodologies with country MEL systems.

Strength of evidence

			Strong

Among the three countries that had made substantive progress in implementing POMT methodologies, there was no documentary evidence of how the outcomes data collected through these RCS and BBS-lite methods was used to inform program improvements. POMT survey respondents validated this finding, with the respondents from Uganda, for example, indicating that internal dissemination activities were still in the planning stages.[487]

The shifts in the funding landscape that occurred in the early part of 2025 has dramatically slowed progress of POMT integration into country MEL systems, exacerbating the scenario of paucity of evidence on utilization of data from POMT implementation. The limited experience with POMT methods implementation has contributed to the unavailability of evidence on POMT data use for adaptive programming.[488]

The survey conducted among users of the POMT (see Annex 7) highlighted continued enthusiasm for the approach and acknowledgment that it was both efficient (due to the reduced resources requirements for implementation) and effective, because it provided insights on performance of prevention interventions (see Box 9C).

Box 9C: Findings from POMT survey

Description of respondents

The POMT survey drew a response rate of 32% (24/74). All the eight POMT-priority countries were represented in the responses. There was a good mix of respondents, including State, non-State, PRs, SR, and development partners.

Stakeholder engagement in POMT implementation

Responses were indicative of broad stakeholder engagement at the different stages of POMT adoption that the countries had attained. These included national and sub-national government officers, PRs, academia, development partners and CSOs.

Experience with Global Fund guidance and support

The respondents documented responsive technical support from the Global Fund across the different stages; moreover, there was broad consensus regarding the usefulness of the technical guidance for implementing the POMT methodologies. However, a few respondents highlighted limited guidance on sampling and implementation.

Perceptions of the POMT

There was resonance across all respondents on the relevance of the POMT methodologies within their programmatic contexts; feasibility was cited as contingent on further methodological refinement, continued technical guidance and adequate resource allocation. Respondents who had implemented the POMT described it as efficient and effective: Efficient due to the reduced resources requirements for implementation; and effective because it provided insights on performance of prevention interventions. Sustainability was described as uncertain because of the shifts in the funding landscape and lack of domestic investment. These responses reflected receptiveness towards sustainable integration of POMT methodologies with country MEL systems; actualization of this depended on overcoming the cited barriers.

Conclusions from survey respondents

Greater emphasis on national ownership and leadership of the POMT implementation process is needed, despite provision of external technical assistance, to facilitate integration. Hence, technical capacity transfer needs to be integral to the process.

Redesign and further adaptation of the POMT methodologies is required to accommodate respective country contextual circumstances. Therefore, considerations for flexible design and implementation need to be factored in.

5 Conclusions

The headline conclusions drawn from the findings of the evaluation are outlined below. The first section provides a summary of the conclusions separated into three groups based on the three evaluation objectives. The second section provides an overarching narrative based on these conclusions.

5.1 Conclusions by objective

Below we provide 16 **conclusions from the evaluation** grouped under **each of the three evaluation objectives.**

Objective 1: *To what extent are Global Fund's grants optimally configured for effective prevention programming?*

Conclusion 1.1: Global Fund HIV prevention investments in GC7 are strongly aligned with global normative guidance. This alignment is evident in the way resources are structured ensuring that high-impact HIV prevention interventions and critical enablers promote equitable access. Such an approach reflects an optimal allocation of resources, designed to maximize impact and efficiency in combating HIV.

Conclusion 1.2: Global Fund investments in GC7 are epidemiologically informed and data-driven. By leveraging robust data, the Global Fund targets high-burden geographies and populations most at risk of HIV infection. This evidence-based strategy ensures that prevention efforts are concentrated where they can achieve the greatest reduction in new infections.

Conclusion 1.3: Most countries in the sample of 12 participating in GC7 utilize advanced data systems and benefit from enabling policy environments to guide resource allocation. These frameworks support the adoption of combination prevention strategies that integrate biomedical, behavioral, and structural interventions. Importantly, these strategies are tailored to the country context, with a particular focus on KPs who face heightened vulnerability to HIV.

Conclusion 1.4: Across nearly all countries, grant portfolios include the full range of core biomedical prevention interventions such as HIV testing, condom programming, and oral PrEP. The support for and delivery of structural and behavioral interventions varies across settings. These interventions are adapted to local contexts with the goal of increasing uptake of biomedical services and addressing barriers to access. This flexibility ensures that prevention programs remain responsive to the unique challenges faced by different communities.

Objective 2: *To what extent are Global Fund's grants being implemented amid resource constraints and current contextual challenges?*

Conclusion 2.1: The Global Fund has made significant efforts across all 12 case study countries to support HIV prevention interventions for KPs in all epidemic settings and AGYW in high-incidence settings. These efforts are closely aligned with global guidance and national strategies, ensuring that prevention programs are both evidence-based and responsive to local priorities.

Conclusion 2.2: Prior to the withdrawal of other international funding and the Global Fund's reprioritization exercise, grant implementation was highly consistent with the original GC7 agreements. Compared to GC6, GC7 grants are more outcome-oriented, data-driven, and person-centered, reflecting a stronger focus on measurable impact and tailored service delivery.

Conclusion 2.3: Although Global Fund's reduction of country funding envelopes has had an effect on in-country resources available for prevention, the programmatic focus and strategic alignment of HIV prevention efforts remain largely consistent. Countries have responded to

financial disruptions by prioritizing precise and integrated approaches for KPs. However, some interventions have been amended or removed entirely, reflecting the need to adapt to resource constraints while maintaining core prevention objectives.

Conclusion 2.4: The Global Fund continues to provide added value through its flexible, country-led approach, which enables programs to reach KPs that may not be adequately supported by other donors or governments. Despite this, persistent challenges—such as resource constraints, stigma within national governments and health systems, regulatory constraints, and supply chain bottlenecks—limit the effectiveness of HIV prevention interventions funded by the Global Fund in some contexts.

Conclusion 2.5: The Global Fund has supported countries in beginning the process of integrating HIV prevention services within broader health service delivery platforms. However, stigma against KPs and a lack of political buy-in remain significant barriers to achieving full integration and sustainability.

Conclusion 2.6: The key drivers of sustainability for HIV prevention interventions include strong national ownership and stewardship, integration with health and education systems, robust domestic financing, supportive legal and policy environments, and institutionalized community engagement. These elements are essential to ensuring that prevention programs remain effective and resilient in the long term.

Conclusion 2.7: Despite the strengths, coverage gaps for HIV prevention remain. Gaps persist in delivering the required HIV prevention services in certain contexts, including limited availability of long-acting injectable PrEP and insufficient harm-reduction services for PWID. In some cases, structural barriers that hinder access to prevention services remain unaddressed, posing challenges to achieving the full potential of HIV prevention efforts.

Objective 3: *To what extent are countries effectively measuring HIV prevention outcomes?*

Conclusion 3.1: All countries in the sample demonstrate efforts to measure HIV prevention outcomes, primarily through population-based surveillance, and have made progress integrating HIV programmatic data into national HMIS. While countries have relied on surveys such as IBBS, DHS, and PHIA, heavy dependence on donor funding can make monitoring vulnerable and difficult to sustain. Positive strides toward alignment and harmonization of reporting systems between partners are evident, but operational and technological challenges—now compounded by a funding crisis—continue to impede full MEL system harmonization.

Conclusion 3.2: Eight countries have engaged with the POMT, though adoption pace and integration into MEL systems vary widely. Countries have selected different methods based on context, including RCS for KPs and AGYW, BBS-lite for FSWs, and PBS for general population data.

Conclusion 3.3: Uganda, Eswatini, and Mozambique have deployed POMT-aligned approaches, but due to the first year of GC7 implementation, with the exception of Eswatini, the others have not been able to establish repeated, systematic use to support routine monitoring. Implementation remains donor-dependent, and survey findings have yet to be disseminated.

Conclusion 3.4: Experiences with POMT have been mixed. Stakeholders noted strong in-country receptiveness and perceived cost-effectiveness for monitoring prevention outcomes. However, adoption required significant external technical assistance, and interpretations differed in scale, frequency, and scientific rigor, highlighting a steep learning curve.

Conclusion 3.5: The sharp reduction in external donor funding, driven by the withdrawal of other international funding and Global Fund reprioritization, has stalled the shift toward outcome monitoring for HIV prevention. Countries have shifted focus to preserving lifesaving interventions, putting POMT on hold amid uncertainty. Worryingly, anecdotal evidence suggests broader cuts to MEL systems may follow.

5.2 The emerging narrative

Below the emerging narrative from this evaluation is provided in the form of high-level conclusions.

High-level Conclusion 1: Despite the Global Fund's strong partnership model, emphasis on country ownership, and large-scale financing capacity, and in the context of its resource constraints, there are still opportunities to improve the prioritization of HIV prevention interventions. Key areas include scaling up the most impactful HIV prevention interventions[489] (as guided by global technical guidance), maintaining a strong focus on addressing structural barriers, and ensuring the delivery of critical interventions such as long-acting injectable PrEP and prevention services for PWID. Addressing these gaps will be essential to increasing coverage of HIV prevention programs.

High-level Conclusion 2: After approximately one year of implementation, initial progress suggests that HIV prevention programming supported by GC7 grants is largely consistent with its intended design. Programs appear well aligned with in-country partner strategies and leverage the strengths of the Global Fund model to promote sustainability. This coherence underscores the value of GC7's approach compared to previous funding cycles.

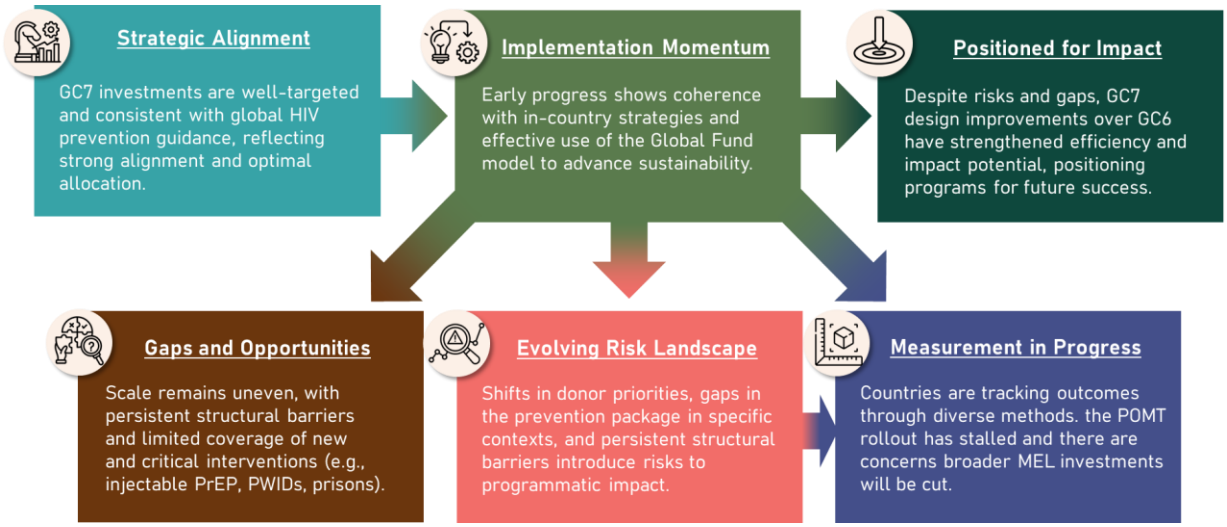
High-level Conclusion 3: Countries are monitoring HIV prevention outcomes through a range of methods, though adoption of POMT approaches into MEL systems varies by context. Progress on POMT has not been as successful as hoped so it is too early to generate conclusive insights on its utility. As a result of the funding cuts, POMT rollout has now stalled, and evidence suggests broader cuts to country-level MEL systems may follow.

High-level Conclusion 4: Significant risks to programmatic impact persist. These include dramatic shifts in the donor landscape, reduction in Global Fund's funding, gaps in coverage of HIV prevention programs in many contexts, and unresolved structural barriers that hinder access to services. These challenges could undermine progress.

High-level Conclusion 5: Nevertheless, the initial design of Global Fund investments under GC7 emphasized maximizing impact and efficiency, building on lessons learned from GC6. As a result, HIV prevention programs may now be better positioned to achieve results despite the risks. While outcomes remain to be seen, the strategic improvements introduced in GC7 provide a strong foundation for success.

These high-level conclusions can be presented in visual form as in Figure 14 below.

Figure 14: Summary of overall narrative from evaluation



6 Recommendations

This section presents the proposed recommendations, drawing on Global Fund guidance on recommendations as well as feedback provided during the recommendations workshop held on December 9, 2025. Inputs from Global Fund Secretariat stakeholders and the ELO were consolidated and used to refine and revise the draft recommendations developed previously.

Critical recommendations for the Global Fund Secretariat

Recommendation 1: Global Fund Secretariat should maintain HIV prevention for KPs and high-risk AGYW as a core strategic priority and extend the precision prevention approach into GC8. The focus on KPs and AGYW in high-incidence settings remains the Global Fund's comparative advantage and should be protected despite tightening fiscal conditions and competing demands. Within this changing funding landscape, countries should be encouraged to continually and actively prioritize the most impactful interventions and delivery models, while focusing on geographies and populations most in need.

Recommendation 2: Global Fund Secretariat should ensure that CCMs and PRs sustain alignment with GPC guidance and continue to emphasize differentiated service delivery. Increasing investments in robust data systems and tailored prevention services (including biomedical, structural, and behavioral interventions), while considering the current environment of limited Global Fund resources, will equip local stakeholders to make evidence-based decisions that balance cost and impact. This in turn will support context-specific delivery strategies aimed at preserving user preferences, including options for long-acting injectables.

Recommendation 3: Global Fund Secretariat, with support from technical partners, should consolidate and share lessons learned from implementing differentiated vs. integrated service delivery models that demonstrate impact in driving access, uptake, and use of biomedical HIV prevention interventions. Clear communication of the benefits and trade-offs between efficiency and access considerations can support countries to design strategies that sustain essential HIV prevention services in an increasingly fiscally constrained environment.

Recommendation 4: Global Fund Secretariat should continue supporting countries to prioritize KPs according to country specific context. Its support should continue encouraging countries to focus resources on KPs with the highest potential epidemiological impact ensuring that limited resources are directed to optimize outcomes within current fiscal constraints.

Important recommendations for the Global Fund Secretariat

Recommendation 5: Global Fund Secretariat should increase context-specific efforts to promote and advocate for policies that enable KPs access to services, while CCMs should encourage, and PRs should continue implementation of innovative KP services (such as PrEP vending machine disbursements and teleconsultation services) to reduce KP stigma and improve access to services. This is fundamental to the future success of Global Fund-supported prevention investments and should be prioritized within both national and sub-national governments and health systems, including primary health care centers. Although, it should be acknowledged that this may be challenging in restrictive policy and legal environment.

Recommendation 6: Global Fund Secretariat should proactively support the monitoring of HIV prevention-related outcomes (e.g., through the POMT approaches). In countries where significant progress has been made in the rollout of the POMT, CCMs and PRs should continue support, and assess its performance and value. In the face of wider pressure of reducing MEL spending, the Global Fund should encourage adoption of lower cost outcome monitoring approaches like those included in the POMT to help generate real-time evidence to inform prevention programming.

Recommendation 7: Global Fund Secretariat should work with technical partners to support CCMs and PRs to proactively plan for and prioritize structural interventions that reduce HIV risk and improve access, uptake, and use of HIV prevention options within a country's specific epidemiological or cultural context. These prioritized interventions should be integrated into future program design to safeguard the continuity of the most critical and effective structural interventions for driving HIV prevention outcomes, while also considering the current environment of limited Global Fund resources. This approach will support continuous flexibility in order to respond to politically challenging contexts that require investments to reduce barriers to accessing services.

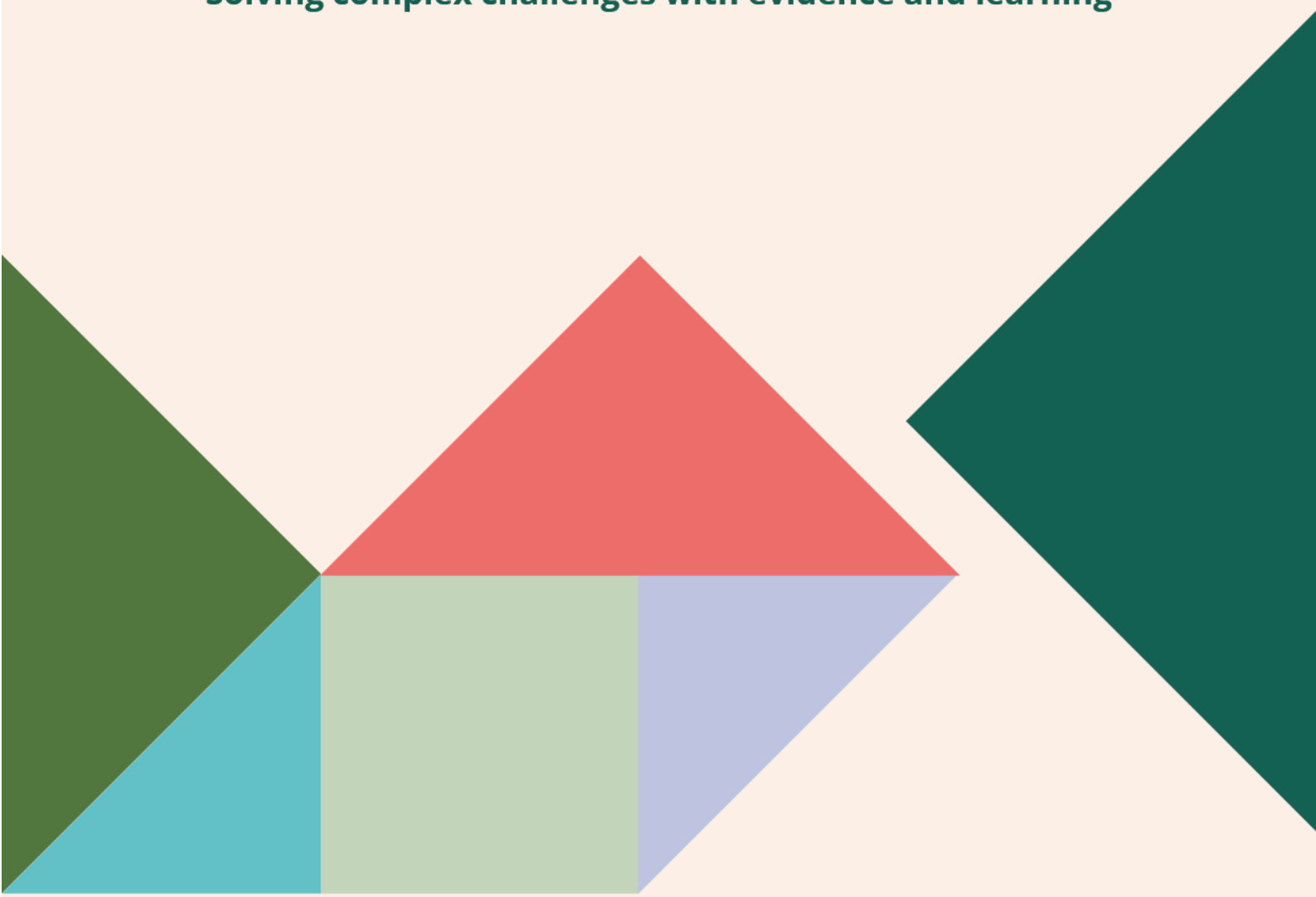
Recommendation to partners

Recommendation 8: Global Fund partners should support countries to increase (1) national ownership and domestic financing; (2) integration of HIV prevention services into existing national platforms while ensuring sufficient service delivery differentiation to promote access; (3) community engagement; and (4) effective coordination of in-country stakeholders in order to support the sustainability of future HIV prevention programming, including GC8.

Annexes

1. Evaluation framework
2. Dimensions scoring matrix
3. EQs response matrix
4. Specific/detailed evidence
5. List of stakeholders consulted (titles not names)
6. List of documents reviewed
7. POMT toolkit

Solving complex challenges with evidence and learning



itad.com @ItadLtd Itad mail@itad.com

Itad UK
International House
Queens Road
Brighton, BN1 3XE
United Kingdom

Tel: +44 (0)1273 765250

Itad US
c/o Open Gov Hub
1100 13th St NW, Suite 800
Washington, DC, 20005
United States

Itad Kenya
1870/610 The Westwood Building
Vale Close
Westlands, Nairobi
Kenya

Endnotes

1 In the context of HIV, key populations include: men who have sex with men, transgender , female sex workers, people who use and/or inject drugs, people living with HIV, people in prison and other closed settings

2 Global Fund to Fight AIDS, Tuberculosis and Malaria (2025). Terms of Reference: HIV Prevention Evaluation (IEP_GF-ELO-2025-08) https://www.theglobalfund.org/media/ihiaqtca/iep_gf-elo-2025-08_tor_en.pdf

3 The GC7 reprioritization exercise refers to mid-cycle adjustments made by countries during Grant Cycle 7 (GC7) to review and reprioritize funding in response to resource constraints and changing country contexts

4 This is effectively a zero-sum situation, and scaling up these interventions would require countries to identify areas where funding could be reduced

5 GC: Grant Cycle; hence e.g., Grant Cycle 7 = GC7.

6 Terms of Reference for Evaluation of HIV Prevention. https://www.theglobalfund.org/media/ihiaqtca/iep_gf-elo-2025-08_tor_en.pdf

7 OECD-DAC: Organization for Economic Co-operation and Development's Development Assistance Committee.

8 Global AIDS Strategy 2021-2026: End Inequalities. End AIDS. UNAIDS (2021). https://www.unaids.org/sites/default/files/media_asset/global-AIDS-strategy-2021-2026_en.pdf

9 The Path that Ends AIDS: 2023 UNAIDS Global AIDS Update. UNAIDS (2023). https://www.unaids.org/sites/default/files/media_asset/2023-unaids-global-aids-update_en.pdf

10 12 sampled countries

11 New HIV infections data among key populations: proportions in 2010 and 2022, Joint United Nations Programme on HIV/AIDS. https://www.unaids.org/en/resources/documents/2024/new-hiv-infections-data-among-key-populations-proportions ; Fighting Pandemics and Building a Healthier and More Equitable World Global Fund Strategy (2023-2028). The Global Fund (n.d.). https://www.theglobalfund.org/media/11612/strategy_globalfund2023-2028_narrative_en.pdf

12 UNAIDS. Global AIDS Update 2025. Geneva: Joint United Nations Programme on HIV/AIDS, (2025) https://www.unaids.org/sites/default/files/2025-07/2025-global-aids-update-JC3153_en.pdf

13 Global Fund to Fight AIDS, Tuberculosis and Malaria. (2025). Terms of Reference: HIV Prevention Evaluation (IEP_GF-ELO-2025-08). https://www.theglobalfund.org/media/ihiaqtca/iep_gf-elo-2025-08_tor_en.pdf

14 The Global Fund (2022). Fighting Pandemics and Building a Healthier and More Equitable World: The Global Fund Strategy 2023–2028. Geneva. https://www.theglobalfund.org/media/11612/strategy_globalfund2023-2028_narrative_en.pdf

15 The Global Fund (2022). HIV Information Note for Applicants to the 2023–2025 Funding Cycle (GC7). Geneva. https://resources.theglobalfund.org/media/14327/cr_hiv_infonote_en.pdf (Webpage Archived).

16 The Path that Ends AIDS: 2023 UNAIDS Global AIDS Update. UNAIDS (2023). https://www.unaids.org/sites/default/files/media_asset/2023-unaids-global-aids-update_en.pdf

17 Including countries listed in the 4 Multi-Country grants and excluding Zanzibar which is part of Tanzania

18 The Optimal Grant's Agent (OGA) is a custom-designed, virtual research assistant used within a human-led evaluation process to analyze large volumes of grant documents and interview transcripts that would not be feasible to review manually

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

20 Data sources listed in Table 2: Summary of methods and tools for objective 1

21 Funding Request form for Kenya section 1 summary information; Funding Request form for Uganda pp.25-26; Funding request form for Mozambique summary information; Funding Request form for Tanzania section 1 summary information, pp.66-71

22 KII_Global_Uga002;KII_Global001; Mozambique TRP Review and Recommendation Form(2023), Section TRP Assessment of strategic focus and prioritization

23 KII_Global_Tan002

24 KII_Global_Uga002

25 KII_Global_Moz002

26 Objective Report for Zambia, p.366

27 Objective Report for Ecuador, p.76

28 Funding Request Form for Tajikistan (2023), Module 2 (HIV.2)

29 Funding Request Form for Indonesia (2023) Section 1.3 Context & Section 2 Maximizing Impact

30 Funding Request From for Eswatini (2023) pp.4–11, 18–22, 63–65; Eswatini TRP Review and Recommendation Form p.2; FGD_National_Eswatini01

31 FGD_National_Nigeria; National HIV & AIDS Strategic Plan for Nigeria, p.3

32 Funding Request Form for Pakistan (2023) Modules 1-5; KII_In-country_Pak007

33 KII_In-country_Mad007

34 Funding Request for Kosovo (2023) pp.4–11, 18–22, 63–65

35 Funding Request for Uganda (2023), p.38

36 Funding Request for Zimbabwe(2023), Modules 2–3

37 KII_In-country_Phi010

38 KII_In-country_Mad006

39 KII_In-country_Mad007

40 KII_In-country_Ken009

41 FGD_National_Kenya

42 KII_In_Country_Moz008; Funding Request for Mozambique (2023), p.265

43 KII_In-country_Pak004; KII_In-country_Pak007

44 KII_Global_Esw001

45 Funding Request Form Cape Verde (2023), Section 1.1; Funding Request Form for Eritrea (2023), Module 3; Funding Request Form for Sudan (2023), Section 1; Secretariat Briefing Note for Djibouti Section 1.2; Funding Request Form for Liberia (2023), Section 3; Funding Request Form for Mauritania (2023), Section 2

46 KII_Global005

47 KII_In-country_Nig008; KII_In-country_Ken009; KII_Global_Moz002

48 KII_Global_Kos001; KII_Global_Kos002; KII_In-country_Kos003

49 KII_Mad001; KII_Mad006; KII_In-country_Mad007

50 KII_Global 002

51 KII_In-country_Zim016; KII_In-country_Zim006

52 KII_In-country_Pak014

53 HIV National Strategic Plan for Nigeria p.16; AIDS Medium Term Plan (AMTP) Philippines p.19; Tanzania Road Map pp.21–38; HIV National Strategic Plan for Uganda pp.28–36; Zimbabwe National Health Strategy 1.4, 3.4, 5

54 KII_Global005; KII_Global001

55 KII_In-country_Esw012; KII_In-country_Esw011; KII_Global_Esw002

56 KII_In-country_Nig029; FGD_National_Nigeria

57 KII_In-county_Ken009

58 KII_Global001

59 KII_Global004

60 Tanzania HIV Prevention Road Map pp.21–27; Uganda HIV National Strategic Plan Executive Summary xiii–xvi; Mozambique HIV National Strategic Plan

61 Objective Report for Angola, p.10

62 Objective Report for Congo, p.61

63 Objective Report for South Africa, p.304

64 Objective Report for Nigeria, p.264

65 Objective Report for Ethiopia

66 KII_Global011

67 KII_Global012

68 KII_Global011

69 KII_Global004

70 TRP Review for Eswatini, Section 4.1; TRP Review for Madagascar, Section 4.1; TRP Review for Kosovo, TRP Review for Section 4.1; Zimbabwe, Section 4.1

71 FGD_National_Zimbabwe

72 FGD_National_Pakistan

73 FGD_National_Zimbabwe

74 FGD_National_Pakistan

75 FGD_National_Nigeria

76 World Health Organization, Consolidated Guidelines on HIV Prevention, Testing, Treatment, Service Delivery and Monitoring: Recommendations for a Public Health Approach (2021); World Health Organization, Consolidated Guidelines on HIV, Viral Hepatitis and STI Prevention, Diagnosis, Treatment and Care for Key Populations (2022); World Health Organization, Consolidated Guidelines on Differentiated HIV Testing Services (2024); World Health Organization, Guidelines on Long-Acting Injectable Cabotegravir for HIV Prevention (2022); Global HIV Prevention Coalition, HIV Prevention Roadmap (2022); UNAIDS, Global AIDS Strategy 2021–2026—End Inequalities. End AIDS (2021)

77 TRP Review for South Africa, Section 4.1; Funding Request for Tanzania (2023), AGYW Program Narrative; TRP Review for Uganda, Section 4.1; TRP Review for Mozambique, Section 4.1; Funding Request for India (2023), Summary Information; Funding Request for Philippines (2023), Module 1; Eswatini, Module 6; Ukraine, Section 1.3; TRP Review for Kosovo, Section 4.1; TRP Review for Haiti, Section 4.1; Secretariat Briefing Note for Zimbabwe, Section 1.1; Tanzania, National HIV Prevention Road Map 2023/24–2026/27 (2023); KII_National_Ken007; KII_In-country_Moz003; KII_In-country_Zim006

78 KII_Global_Esw001; KII_Global_Esw002; KII_In-country_Tan016; KII_In-country_017; KII_In-country_Tan018; KII_In-country_Tan019; KII_In-country_Nig026; KII_In-country_Mad005; KII_In-country_Ken006 FGD_National_Eswatini01;KII_In-country_Kosovo Kos006; FGD_National_Pakistan

79 [GC7 Funding Request, Eswatini; GC7 Funding Request, Tanzania; GC7 Funding Request, Uganda; GC7 Funding Request, Zimbabwe; GC7 Funding Request, Pakistan; GC7 Funding Request, Paraguay; KII_Eswatini05; KII_Global07; KII_Global12; KII_Nigeria18

80 Objective 1 Report Global, pp.12-16; Cambodia Objective Report, para 582; Lesotho Objective Report, para 268; Botswana Objective Report, para 625; Pakistan Objective Report, para 434; Bhutan Objective Report, para 36; Tanzania Objective Report, para 513; India Objective Report, para 192

81 National HIV Prevention Road Map 2023/24–2026/27, Tanzania (2023); GC7 Funding Request, Uganda (2023); GC7 Funding Request, Pakistan (2023); GC7 Funding Request, Paraguay (2023)

82 KII Global_005; KII Global_001; KII_Global_Esw001; KII_Global_Moz002; KII_Global_Uga002

83 Objective 1 Portfolio Analysis Global, pp.14-16; Funding Request for Jamaica (2023), Section 2.1; Funding Request for Serbia, (2023), Section 1.3; Funding Request Form for Peru, HIV Component

84 Objective 1 Report, Global, para 33 & 245; Funding Request Forms, multiple countries (2023); National HIV & AIDS Strategic Plan 2023–2027, Nigeria (2023)

85 Funding Request for South Africa (2023), Section 2.2; Funding Request for Eswatini (2023), Module 1 & 10; Funding Request for Zimbabwe (2023), Module 1; Funding Request for Kenya (2023), Module 3 & 7; Funding Request for Botswana (2023), Module 1; Funding Request for Lesotho (2023), Module 1; Funding Request for Cambodia (2023), Module 1a/1; Funding Request for Zambia (2023), Section 2.2; Funding Request for Peru (2023), Section 1.1

86 KII_In-country_Esw002; KII_In-country_ Esw003

87 KII_in-country_Nig018; KII_In-country_Zim010; KII_In-country_Ken008; KII_In-country_Moz005

88 FGD_National_Nigeria

89 Funding Request for Tanzania (2023), Package Components Table; Funding Request for Nigeria (2023), Funding Request for Module 11.1; Funding Request for Mozambique (2023), Module 2 & 4; Funding Request for Pakistan (2023), Module 1 & 6; Funding Request for Paraguay (2023), Module 1 National HIV Prevention Road Map 2023/24–2026/27, Tanzania (2023)

90 FGD_National_Eswatini01

91 FGD_National_Philippines

92 FGD_National_Kenya

93 KII_In-country_Par007

94 KII_In-country_Moz006

95 KII_Global_Uga001; Funding Request for Uganda (2023), Section 2.2 & Module 10; Funding request for Pakistan (2023), para 682; FGD_National_Pakistan; KII_In-country_Mad005; KII_In-country_Moz005; KII_In-country_Phi010; KII_In-country_Ken007; Funding Request Form for Philippines, Section 1.6.1

96 KII_In-country_Nig026; FGD_National_Tanzania; FGD_National_Pakistan; Nigeria, Module 11, Module 4, Module 14; Funding request for Pakistan (2023), para 682

97 Objective Report for Eswatini, p.167

98 Objective Report for Lesotho, p.259

99 Objective Report for Kenya, p.231

100 Objective Report for Rwanda, p.446

101 Objective Report for Uganda, p.644

102 Objective Report for Zimbabwe, p.562

103 Objective Report for Cambodia, p.582

104 Objective Report for Lesotho, p.268

105 Objective Report for Botswana, p.625

106 KII_Global_Esw002; KII_Global_Esw001_KII_Global_Esw003

107 KII_In-country_Kos006

108 KII_In-country_Phi010

109 Objective 1 Report Global, para 451; Bolivia Objective Report, para 37; Egypt Objective Report, para 108, 122; Mongolia Objective Report, para 346; Congo Objective Report, 70; Pakistan Objective Report, para 434; Nepal Objective Report, para 369

110 Prevalence and risk factors associated with HIV-1 infection among people who inject drugs in Dar es Salaam, Tanzania: a sign of successful intervention? | Harm Reduction Journal | Springer Nature Link ; IJISRT24NOV1665.pdf

111 Secretariat Briefing Note for Kazakhstan, Section 2.1;· TRP Review for Kazakhstan, Section 4.1

112 Funding Request for Afghanistan, Module 3 & Section 1.3; Secretariat Briefing Note for Afghanistan, Section 1.1

113 KII_Global_Nig002; KII_In-country_Nig026

114 KII_In-country_Pak011; FGD_National_Kenya; FGD_National_Pakistan

115 KII_In-country_Moz005; KII Global_Moz001

116 Funding Request for Zimbabwe (2023), para 1332; KII _In-country_Kos006

117 KII_Global010

118 Objective 1 Report, Global, para 534,570,575; UGA_C_NSP_FundingRequestForm_20230424_En_1.docx, Uganda, 850; ZAF_C_FULL_FundingRequestForm_20241014_En_1.docx, South Africa, 892,900, 905; PHL_H_FULL_FundingRequestForm_20230424_En_1.docx, Philippines, 671 - 676; ZWE_C_PC_FundingRequestForm_20230703_En_1.docx, Zimbabwe,

931; IND_H_NSP_FundingRequestForm_20230925_En_1.docx, India, 317; IND_H_NSP_FundingRequestForm_20230925_En_1.docx, India, 314, 316; MDA_C_FOC_FundingRequestForm_20230703_En_1.docx, Moldova, 431; EGY_C_FOC_FundingRequestForm_20241014_En_1.docx, Egypt, 161

119 Objective Report for Ethiopia, p.172

120 Objective Report for Cameroon, p.70

121 Objective Report for Somalia, p.463

122 Objective Report for Tanzania, p.513

123 Objective Report for Togo, p.521

124 Objective Report for Burkina Faso, p.57; Objective Report for Guatemala, p.188; Objective Report for Senegal, p.462; Objective Report for Zanzibar, p.557

125 Objective Report for Angola, p.12

126 Objective Report for Afghanistan, p.4

127 Objective Report for Serbia, p.636

128 Objective Report for Ukraine, p.524

129 Global Fund, GC7 Funding Request Forms – Prevention Stewardship and CLM modules, multiple countries (2023); TRP Review and Recommendation Forms, multiple countries (2023).

130 KII_In-country_Nig018; KII_In-country_Zim011; KII_In-country_Ken008; KII_In-country_Moz005; KII_In-country_Zim006

131 KII_In-country_Esw006; KII_In-country_Kos006; KII_in-country _Ken013; KII_Uganda_Uga001; KII_In-country_Par007

132 MDG_H_FULL_FundingRequestForm_20230601_En_1.docx, Madagascar

133 KII_In-country_Tan016; KII_In-country_Tan017; KII_In-country_Tan018; KII_In-country_Tan019

134 KII_In-country_Par006

135 KII_In-country_Ken003; KII_Global004

136 SWZ_C_PC_FundingRequestForm_20230925_En_1.docx, Eswatini 801; UGA_C_NSP_FundingRequestForm_20230424_En_3.docx, Uganda 1055-1056

137 Funding Request Form, Uganda, GC7; Funding Request Form, Zimbabwe GC7, Modules #1–3; National HIV Prevention Road Map 2023/24–2026/2027, Tanzania, pp.21–27 (2023)

138 KII_Global005; KII_Global001; KII_Global_Uga001; KII_Global_ Uga002;

139 KII_Global005; FGD_National_Tanzania; KII_In-country_Esw011; KII_In-country_Moz008; FGD_National_Kenya; FGD_National_Eswatini01

140 FGD_National_Eswatini01; FGD_National_Kenya; FGD_National_Eswatini, FGD_National_Pakistan ; FGD_National_Nigeria ; FGD_National_Philippines; FGD_National_Paraguay

141 KII_In-country_Moz008; KII_In-country_Nig017; KII_In-country_Kos006; FGD_National_Tanzania; FGD_National_Kenya; FGD_National_Pakistan; FGD_National_Paraguay

142 KII_Global_Tan001; KII_Global_Tan002

143 KII_In-country_Esw011; KII_In-country_Moz004

144 FGD_National_Kenya

145 KII_In-country_Esw011

146 Funding Request for Eswatini (2023); Funding Request for Paraguay (2023); Funding Request for Philippines (2023); Funding Request for Uganda (2023), p4-7

147 Funding Request Form, Zimbabwe GC7, Modules #1–3 (2023); Funding Request Form (Full Review), Pakistan GC7, Module 6, p.22 (2023); Funding Request Form, Nigeria GC7, pp.39–42, 91 (2023)

148 KII_In-country_Par007; KII_Global_Esw001; KII_Global_Esw002; KII_In-country_Kos006; KII_In-country_Tan017

149 KII_Global_005; KII_Global_001

150 Objective 1 Report, Global, para 445, 576, 583-585

151 Objective 1 Report, Global para 649

152 KEN_C_FULL_FundingRequestForm_20230925_En_1.docx, Kenya, 248, 255, 246; UGA_C_NSP_FundingRequestForm_20230424_En_3.docx,Uganda, 927,930; PHL_H_FULL_FundingRequestForm_20230424_En_1.docx,Philippines, 602; MOZ_C_FULL_SecretariatBriefingNote_20230703_En_1.docx,Mozambique, 402; NGA-HT_FundingRequestForm_en_1.docx,Nigeria 445,445; SWZ_C_PC_FundingRequestForm_20230925_En_1.docx,Eswatini 717, 722;

153 [KII Nigeria, Kosovo, Tanzania, Paraguay, <, Eswatini,

154 FGD_National_Kenya; FGD_National_Eswatini01; FGD_National_Eswatini02

155 FGD_National_Kenya; KII_In-country_Esw0011; KII_In-country_Ken006

156 KII_In-country_Kos006; FGD_National_Tanzania; FGD_National_Kenya; FGD_National_Pakistan; FGD_National_Paraguay

157 FGD_National_Tanzania; KII_In-country_Esw011; KII_In-country_Moz008; FGD_National_Kenya; FGD_National_Eswatini01

158 UNAIDS and the Global Fund launch guidance on HIV human rights programmes. UNAIDS (2017) https://www.unaids.org/en/resources/presscentre/featurestories/2017/may/20170529_Fast-Track_humanrights

159 FGD_National_Kenya; FGD_National_Paraguay

160 KII_In-country_Kos006; KII_In-country_Nig017; KII_In-country_Moz008

161 KII_In-country_Tan027; KII_In-country_Tan028; KII_In-country_Tan029; KII_In-country_Tan033; FGD_National_Pakistan; FGD_National_Eswatini01

162 HIV prevention: A systematic review. PLoS Med. (2021) doi:10.1371/journal.pmed.1003866. PMID:34843468

163 KII_In-country_Esw0011; KII_In-country_Ken006; KII_In-country_Tan027; KII_In-country_Tan028; KII_In-country_Tan029; KII_In-country_Tan033; KII_Global005

164 Objective Report for Papa New Guinea, p.418

165 Objective Report for Georgia, p.183

166 Objective Report for Nicaragua, p.409

167 Objective Report for Philippines, p.431

168 FGD_National_Kenya; FGD_National_Eswatini01; FGD_National_Zimbabwe; FGD_National_Pakistan; FGD_National_Nigeria; FGD_National_Philippines

169 KII_In-country_Esw003; KII_In-country_Tan027; KII_In-country_Tan028; KII_In-country_Tan029; KII_In-country_Tan033; KII_In-country_Mad006; KII_In-country_Par007

170 FGD_National_Philippines; KII_In-country_Nig026; KII_In-country_Pak015

171 KII_In-country_Esw003; KII_Global_Moz001; KII_In-country_Nig024; KII_In-country_Pak007

172 KII_Global_004; KII_Global_005

173 Objective Report for Kosovo, p.230; Objective Report for Belarus, p.516

174 Objective Report for Mozambique, p.357

175 Objective Report for Eswatini, p.166

176 Objective Report for Belarus, p.516

177 Objective Report for Timor-Leste, p.476

178 Objective Report for Bolivia, p.37

179 Objective Report for Egypt, pp.108-122

180 Objective Report for Mongolia, p.346

181 Objective Report for Congo, p.70

182 Objective Report for Nepal, p.369

183 Objective Report for Timor-Leste, p.476

184 Objective Report for Uzbekistan, p.484

185 Objective Report for Egypt, p.108

186 Objective Report for Mauritania, pp.317-318

187 Objective Report for Burkina Faso, pp.44-48

188 Objective Report for Mali, pp.311-315

189 Objective Report for Tanzania, p.468; Objective Report for Gambia, p.177

190 Objective Report for Uganda, p.585

191 Objective Report for Uzbekistan, p.486

192 Objective Report for Armenia, pp.12-13

193 Objective Report for Madagascar, p.308

194 Objective Report for MENA, pp.286-287

195 Objective Report for Guinea, p.538

196 Objective Report for South Sudan, p.415

197 Objective Report for Suriname, p.441

198 Objective Report for Togo, p.478

199 Objective Report for Serbia, p.576; Objective Report for Moldova, p.340

200 Objective Report for Egypt, p.106, 111, 125

201 Objective Report for Egypt, p.125

202 Objective Report for Pakistan, p.378

203 Objective Report for Cape Verde, p.58, 59

204 Objective Report for Congo, p.77

205 Objective Report for Gambia, p.138

206 Objective Report for Honduras, p.165

207 Objective Report for Egypt, p.103

208 Objective Report for Madagascar, p.24

209 Objective Report for Nepal, p.314

210 Objective Report for MENA, p.231

211 Objective Report for Azerbaijan, p.24; Objective Report for Haiti, p.164; Objective Report for Myanmar, p.307; Objective Report for Malaysia, p.493

212 KII_Global_Esw001; KII_Global005

213 KII_Global_Moz002; KII_In-country_Ken009; KII_In-country_Pak014

214 Objective 1 Report, Global, para 261, 267, 286, 323, 324

215 TRP Review for Eswatini, pp.2-3

216 Kenya Funding Request Form (2023), p.59-60

217 Funding Request for Kosovo (2023), Section 1; Funding Request for Madagascar (2023)

218 Mozambique HIV NSP (PEN V 2021–2025, Executive Summary), pp.10 - 13

219 Nigeria National HIV & AIDS Strategic Plan 2023–2027, p.16

220 Pakistan TRP Review and Recommendation Form, Sec. 4.1, pp.3–4

221 Paraguay Funding Request Form (2023), Section 1—Modules 1–3

222 Philippines HIV NSP (AMTP 2023–2028), p.19

223 Tanzania National HIV Prevention Road Map 2023/24–2026/27, pp.21–27

224 Uganda HIV NSP, Executive Summary xiii–xvi

225 Zimbabwe National Health Strategy 2021–2025, Sections 1.4, 3.4 and 5

226 KII_Global_Kos001

227 KII_Global_Moz002

228 FGD_National_Nigeria; KII_In-country_Nig015

229 Objective Report for Tanzania, p.513

230 Objective Report for Cambodia, p.582

231 Objective Report for Iran, p.213; Objective Report for MENA, p.274

232 Objective Report for Bhutan, p.37; Objective Report for Guinea-Bissau, p.186; Objective Report for Mongolia, p.334; Objective Report for Philippines, p.421

233 Objective Report for Bolivia, p,43; Objective Report for Cape Verde, p.68; Objective Report for Dominican Republic, p.108; Objective Report for Guinea-Bissau, p.186; Objective Report for Iran, p.213; Objective Report for Nicaragua, p.380; Objective Report for Senegal, p.444; Objective Report for Somalia, p.458

234 Objective Report for Mozambique, p.353; Objective Report for Paraguay, p.408

235 KII_In-country_Ken008; KII_In-country_Pak011; KII_Global_Esw001; KII_Global_Esw002; KII_Global_Kos001; KII_In-country_Nig018

236 FGD_National_Pakistan; FGD_National_Eswatini01; FGD_National_Eswatini02; FGD_National_Tanzania; FGD_National_Nigeria

237 KII_Global010

238 Objective 1 Report, Global Portfolio, para 390; PHL_H_FULL_FundingRequestForm_20230424_En_1.docx, Philippines, Table 3: PAAR Summary Budget; PHL_H_NSP_TRPReviewandRecommendationFormApplicant_20230424_En_1.pdf; Philippines, Section 4.2; PAK_H_FULL_SecretariatBriefingNote_20230424_En_1.docx, Pakistan, PAAR; NPL_H_PC_TRPReviewandRecommendationFormApplicant_20240603_En_1.pdf, Nepal, Section 4.2; ARM_C_TR_FundingRequestForm_20240603_En_1.docx, Armenia, Module 2 Intervention 1.2;
SSD_C_FULL_FundingRequestForm_20230424_En_1.docx, South Sudan, Program Essentials Table; BDI_Z_PC_TRPReviewandRecommendationFormApplicant_20230703_En_1.pdf, Burundi, Section 6A Issue 1
GNQ_Z_FOC_TRPReviewandRecommendationFormApplicant_20230925_En_1.pdf, Equatorial Guinea, Section 5A Issue 2;
MRT_Z_FOC_TRPReviewandRecommendationFormApplicant_20240603_En_1.pdf, Mauritania, Section 6A Issue 8

239 KII_Global_005

240 KII_In-country_Kos006; KII_In-country_Pak011; KII_In-country_Phi010

241 Funding Request Form for Eswatini (2023), MSM module

242 Funding Request Form for Mozambique (2023), pp.5–6, 17–18]

243 Funding Request Form for Nigeria(2023), pp.17–18

244 Pakistan TRP Review and Recommendation Form (2023), Sec. 4.1, pp.3–4

245 Paraguay TRP Review and Recommendation Form (2023), Sec. 4.1

246 Philippines Funding Request to the Global Fund GC7. 2023. PCCM

247 Tanzania Funding Request Form (2023)—MSM module

248 Uganda Funding Request Form (2023), p.10

249 Objective Report for Pakistan, p.367

250 Objective Report for Sierra Leone, p.395

251 Objective Report for Tajikistan, p.458

252 Objective Report for Mongolia, p.302

253 Objective Report for South Africa, p.417

254 Objective Report for Belize, p.38

255 Objective Report for Suriname, p.436; Objective Report for Philippines, p.381

256 Tanzania Funding Request Form (2023)—MSM module

257 Kenya Funding Request Form, pp.17–18

258 Mozambique Funding Request Form, pp.5–6, 17–18

259 Objective Report for Afghanistan, p.4, 6

260 Objective Report for Suriname, p.405, 406, 409

261 Objective Report for Togo, p.444, 445

262 Objective Report for Venezuela, p.456

263 Objective Report for Kyrgyzstan, p.227, 228

264 Objective Report for Djibouti, p.96

265 Objective Report for Equatorial Guinea, p.121

266 Objective Report for Cameroon, p.63; Objective Report for Nigeria, p.333; Objective Report for Zambia, p.463; Objective Report for Sudan, p.393

267 Objective Report for MENA, p.258

268 Pakistan TRP Review and Recommendation Form (2023), Sec. 4.1, pp.3–4

269 KII_In-country_Pak004

270 KII_In-country_Zim011; KII_In-country_Zim003

271 Funding Request Form for Uganda (2023), p.10

272 Funding Request Form for Madagascar (2023), para 365; Secretariat Briefing Note for Mozambique, para 485; KII_In-country_Moz004

273 KII_In-country_Par007

274 FGD_National_Eswatini01

275 KII_In-country_Pak010; KII_In-country_Pak014

276 FGD_National_Pakistan; FGD_National_Kenya

277 FGD_National_Kenya

278 KII_In-country_Uga001; UGA_C_NSP_FundingRequestForm_20230424_En_3.docx,Uganda, 722

279 KII_Global_Nig002; KII_In-country_Mad006; KII_In-country_Kos005

280 KII_In-country_Phi008

281 KII_In-country_Pak014; KII_In-country_Kos005

282 KII_In-country_Pak011

283 KII_National_Ken006; KII_Global_Nig001; KII_Global_Uga001; KII_In-country_Zim010

284 KII_Global_Tan001; KII_In-country_Kos006

285 KII_Global_Moz002;KII_In-country_Pak010

286 KII_In-country_Pak013; KII_In-country_Kos006;KII_In-country_Pak015; KII_In-country_Mad006

287 KII_Global_Par001

288 Paraguay TRP Review and Recommendation Form (2023), Section 4.1

289 KII_In-country_Pak011; KII_In-country_Pak016; KII_In-country_Pak017

290 KII_In-country_Nig008; KII_In-country_Tan011; KII_In-country_Tan012; KII_In-country_Tan025; KII_In-country_Tan014; KII_In-country_Tan013; KII_In-country_Tan026

291 KII_In-country_Nig008

292 Zimbabwe TRP Review and Recommendation Form (2023), Section 4.1

293 KII_In-country_Ken017; KII_In-country_Moz006

294 KII_Global_Mad001; KII_In-country_Nig008; KII_In-country_Pak014

295 KII_Global_Mad001; KII_Global_Uga001

296 KII_In-country_Kos005; KII_National_Ken007

297 KII_Global_Nig001

298 FGD_National_Eswatini01; FGD_National_Eswatini02

299 KII_Global_Ken001

300 FGD_National_Kenya

301 FGD_National_Kenya

302 KII_In-country_Esw011; FGD_National_Kenya; KII_In-country_Moz004; FGD_National_Pakistan; FGD_National_Zimbabwe

303 KII_In-country_Pak013; KII_In-country_Pak010

304 KII_Global_Kos001; KII_In-country_Zim006; KII_Global_Moz001

KII_In-country_Kos006; KII_In-country_Moz006; KII_In-country_Zim006

305 FGD_National_Nigeria; KII_Global_Nig002

306 KII_Global_Mad001; KII_In-country_Pak011

307 KII_In-country_Pak011

308 KII_In-country_Pak016

309 KII_In-country_Pak015

310 Uganda TRP Review Form (2023), p.6–7

311 Annual Report 2024: Performance of HIV, TB, and Malaria Grants in Zimbabwe. UNDP, 2024

312 Funding Request Form for Madagascar (2023), pp.4–11

313 Funding Request Form for Mozambique (2023), p.5–6

314 TRP Review and Recommendation Form for Pakistan (2023), Sec. 4.1

315 KII_Global001

316 KII_Global002

317 FGD_National_Zimbabwe

318 FGD_National_Pakistan

319 KII_Global_Phi002; KII_Global_Mad001; KII_Global_Tan002; KII_Global_Uga002; Funding Request Forms; TRP Review Pakistan

320 KII_Global001; KII_In-country_Moz004; KII_Global_Ken001

321 KII_Global005; KII_Global_Esw001

322 FGD_National_Nigeria

323KII_In-country_Zim006

324 KII_National_Ken006

325 KII_In-country_Phi008

326 FGD_National_Eswatini01

327 KII_In-country_Moz003; KII_In-country_Nig008; KII_In-country_Par006; KII_In-country_Esw011

328 KII_National_Ken006; FGD_National_Tanzania; KII_In-country_Phi008

329 Global_001; KII_Global_Tan002; KII_Global_Kos001

330 KII_In-country_Ken017; KII_In-country_Esw011

331 FGD_National_Philippines; KII_In-country_Mad006; KII_In-country_Zim011

332 KII_Global002; KII_In-country_Esw010; KII_In-country_Esw007; KII_In-country_Ken017; KII_In-country_Ken013; KII_In-country_Nig026; KII_In-country_Mad006; KII_In-country_Phil008

333 KII_In-country_Zim006; KII_In-country_Kos005; KII_In-country_Kos003; KII_In-country_Moz003

334 KII_In-country_Moz003; KII_In-country_Moz008; KII_In-country_Par006; KII_In-country_Par007; KII_In-country_Phi009

335 Nigeria FGD

336 KII_In-country_Par006; KII_In-country_Par007

337 KII_In-country_Kos005; KII_In-country_Kos003

338 KII_Global003

339 SWZ_C_PC_FundingRequestForm_20230925_En_1.docx, Eswatini pp.734; MDG_H_FULL_FundingRequestForm_20230601_En_1.docx, Madagascar, 299; QNA_C_TR_FundingRequestForm_20240603_En_1.docx, Kosovo 666-668

340 Tanzania National HIV Prevention Roadmap

341 TRP Review for Pakistan(2023)

342 Global Fund to Fight AIDS, Tuberculosis and Malaria. (2025). Terms of Reference: HIV Prevention Evaluation (IEP_GF-ELO-2025-08). https://www.theglobalfund.org/media/ihiaqtca/iep_gf-elo-2025-08_tor_en.pdf

343 KII_Global004; KII_Global001

344 KII_Global011; KII_Global012

345 TRP Review Pakistan (2023), Sec.4.1; TRP Review, Kenya (2023), para 460; Funding Request Form doe Philippines (2023), Paragraphs 878, 88; MOZ_C_FULL_TRPReviewandRecommendationFormApplicant_20230703_En_1.pdf, Mozambique, Para 619, 621

346 KII_In-country_Tan011; KII_In-country_Tan012; KII_In-country_Tan025; KII_In-country_Tan014; KII_In-country_Tan013; KII_In-country_Tan026

347 KII_In-country_Zim006; KII_In-country_Zim011

348 KII_In-country_Nig026; FGD_National_Nigeria

349 KII_Global_Phi002

350 KII_Global_Esw001; KII_Global_Esw002; KII_In-country_Kos006; ZWE_C_PC_FundingRequestForm_20230703_En_1.docx, Zimbabwe (2023), 717, 722, 727

351 KII_Global_Nig002; FGD_National_Nigeria; KII_In-country_Pak014; KII_In-country_Pak006; KII_In-country_Tan027; KII_In-country_Tan028; KII_In-country_Tan029; KII_In-country_Tan033

352 NGA-C-IHVN Performance Letter, Nigeria, 2024

353 FGD_National_Nigeria; FGD National Zimbabwe; Annual Report 2024: Performance of HIV, TB, and Malaria Grants in Zimbabwe. UNDP, (2024)

354 FGD_National_Nigeria; FGD_National_Kenya; FGD_National_Eswatini01; FGD _National_Tanzania; FGD_National_Pakistan

355 KII_Global_Uga001; Funding Request Form for Uganda (2023)

356 KII_Global_Uga001; KII_National_Ken006; Funding Request for Philippines (2023)

357 FGD_National_Kenya; FGD_National_Eswatini01; FGD National Zimbabwe; FGD_National_Pakistan

358 FGD_National_Nigeria; FGD_National_Uganda

359 KII_In-country_Kos006

360 KII_In-country_Pak007

361 KII_Global_Esw001

362 KII_In-country_Par007; KII_In-country_Par006; KII_In-country_Ken013; KII_In-country_Ken017; FGD_National_Paraguay; FGD_National_Philippines

363 KII_In-country_Pak006

364 KII_Global_Esw001; KII_Global_Par002

365 FGD_National_Paraguay; FGD_National_Tanzania

366 KII_In-country_Pak006

367 KII_Global_Ken001

368 KII_National_Ken007

369 KII_In-country_Pak015; KII_In-country_Pak013

370 KII_In-country_Kos008

371 Funding Request Form, Module #2 & #3

372 KII_Global_Tan001; KII_Global_Phi001

373 Funding Request Form for Nigeria (2023), pp.77, 92

374 FGD_National_Nigeria; Funding Request Form for Nigeria (2023), pp.77, 92

375 KII_Global_Ken001; KII_Global_Esw003; KII_In-country_Nig010

376 KII_In-country_Pak013; KII_National_Ken007; KII_In-country_Pak015; KII_In-country_Pak014

377 KII_National_Ken007

378 KII_In-country_Kos005; KII_In-country_Par006

379 KII_National_Ken007

380 KII_Global005; KII_Global001; KII_Global008; KII_Global006; FGD_National_Kosovo

381 KII_In-country_Pak013; KII_In-country_Pak004; KII_In-country_Ken006; KII_In-country_Ken007; KII_In-country_Ken017; KII _Global005

382 FGD_National_Nigeria

383 KII_In-country_Par007

384 KII_In-country_Par007

385 KII_Global_Tan001; KII_In-country_Pak014; KII_In-country_Pak011; KII_In-country_Pak015; KII_In-country_Nig026; KII_In-country_Esw007

386 PAK_H_FULL_FundingRequestForm_20230424_En_1.docx, Pakistan 603,622,630; PHL_H_FULL_FundingRequestForm_20230424_En_1.docx, Philippines 652, 676;
TZA_C_NSP_FundingRequestForm_20230703_En_2.docx, Tanzania 861-865; TACAIDS Strategic Plan 2021/22–2025/26)

387 KII_In-country_Nig026

388 KII_In-country_Zim011

389 KII_Global_Kos002

390 KII_In-country_Moz007; Funding Request Form for Mozambique (2023), p.5–6

391 KII_In-country_Moz008

392 TZA_C_NSP_FundingRequestForm_20230703_En_2.docx, Tanzania, 305; NGA-HT_FundingRequestForm_en_1.pdf, Nigeria (2023), 182-185, 190;
UGA_C_NSP_FundingRequestForm_20230424_En_1.docx, Uganda (2023), 321; ZWE_C_PC_SecretariatBriefingNote_20230703_En_1.docx, Zimbabwe (2023), 360;

393 KII_In-country_Kos006; KII_In-country_Moz004

394 KII_In-country_Kos006

395 KII_Global005

396 KII_In-country_Pak015

397 KII_In-country_Pak015

398 KII_Global_Par001; KII_In-country_Pak013

399 KII_In-country_Phi008

400 KII_Global_Esw003; KII_In-country_Ken016

401 KII_National_Ken007; KII_In-country_Par006; FGD_National_Eswatini02

402 KII_In-country_Kos005

403 KII_In-country_Mad005

404 KII_In-country_Pak013; KII_In-country_Pak011

405 KII_In-country_Par006

406 KII_In-country_Moz005; KII_Global_Moz002; KII_In-country_Nig026; KII_In-country_Tan027; KII_In-country_Tan028; KII_In-country_Tan029; KII_In-country_Tan033; KII_In-country_Kos003

407 KII_National_Ken007; KII_In-country_Zim006; KII_In-country_Esw003; KII_In-country_Moz004

408 KII_National_Ken007; KII_Global_Phi001

409 https://naomi-spectrum.unaids.org

410 Kenya Funding Request (2023), p.60

411 KII_Global_Moz002; KII_In-country_Zim003; KII_In-country_Esw003; KII_Global_Uga002; KII_In-country_Ken017; KII_In-country_Kos005; FGD_National_Nigeria; NGA-HT_FundingRequestForm_en_1.pdf, Nigeria (2023), para 678; ZWE_C_PC_FundingRequestForm_20230703_En_1.docx, Zimbabwe(2023), para 1065

412 KII_Global_Kos001; KII_Global_Par001

413 KII_In-country_Pak016

414 KII_In-country_Tan027; KII_In-country_Tan028; KII_In-country_Tan029; KII_In-country_Tan033

415 KII_In-country_Zim006

416 KII_In-country_Moz003

417 KII_In-country_Esw004

418 KII_In-country_Kos006

419 Kenya Funding Request Form, p.86

420 Mozambique Funding Request Form, p.5–6

421 TRP Review for Paraguay (2023), Section 5A; KII_Global_Par001; KII_In-country_Par007

422 KII_In-country_Nig008

423 KII_Global_Ken001

424 QNA_C_TR_FundingRequestForm_20240603_En_1.docx, Kosovo (2023), Paragraphs 695, 698, 699; MDG_H_FULL_FundingRequestForm_20230601_En_1.docx, Madagascar (2023), Paragraphs 454, 458

425 Tanzania National HIV Prevention Road Map 2023/24–2026/27; Pakistan TRP Review and Recommendation Form, Sec. 5A; Nigeria National HIV & AIDS Strategic Plan 2023–2027; NGA-HT_FundingRequestForm_en_1.pdf, Nigeria (2023), Paragraph 590, 1015

426 Tanzania National HIV Prevention Road Map 2023/24–2026/27

427 KII_In-country_Zim006; KII_In-country_Tan027; KII_In-country_Tan028; KII_In-country_Tan029; KII_In-country_Tan033

428 KII_In-country_Moz004; KII_In-country_Pak006

429 KII_Global_Uga001 KII_Global_Esw002

430 KII_In-country_Zim003

431 KII_Global_Phi001; KII_In-country_Phi009

432 KII_In-country_Nig026; KII_In-country_Moz008

433 KII_In-country_Kos006; FGD_National_Kosovo

434 KII_In-country_Nig008

435 KII_Global_Mad001

436 KII_In-country_Zim003

437 KII_Global_Uga001; KII_In-country_Moz006

438 KII_In-country_Pak015; KII_In-country_Kos006

439 KII_In-country_Zim003; KII_In-country_Moz006; KII_In-country_Pak015; KII_Global_Mad001; KII_In-country_Nig008; KII_Global_Uga001; KII_In-country_Kos006; FGD_National_Kosovo; KII_In-country_Moz008

440 KII_In-country_Pak006; KII_In-country_Pak015

441 KII_In-country_Kos006

442 KII_National_Ken007; KII_In-country_Phi004

443 Funding Request for Uganda (2023), p.6–7

444 Mozambique PEN V 2021–2025; National HIV & AIDS Strategic Plan 2023–2027

445 TRP Review and Recommendation Form for Philippines (2023), Sec. 5A; Philippines Objective 2&3 Report

446 TRP Review-Paraguay, Sec. 5A, paras. 7–10

447 Mozambique HIV NSP (PEN V 2021–2025-Mozambique), Strategic Objective 2, pp.25–27; National HIV & AIDS Strategic Plan (2023–2027), Nigeria (2023) p.41–45; TRP Review and Recommendation Form, Pakistan, paras. 3–5; TRP Review-Paraguay, Sec. 5A, paras. 7–10

448 The evaluation was conducted in 2025, approximately one year after the workshop

449 FGD_National_Tanzania

450 KII_In-country_Ken017

451 KII_In-country_Kos005; KII_In-country_Kos008

452 KII_Global_Kos001

453 KII_In-country_Nig026

454 KII_In-country_Zim003

455 KII_Global012; KII_Global001

456 KII_In-country_Esw004; KII_In-country_Esw008

457 KII_In-country_Esw004; KII_In-country_Esw008

458 KII_Global004

459 KII_In-country_Nig033

460 KII_Global_Nig003; KII_In-country_Nig033; FGD_National_Nigeria

461 KII_In-country_Ken017

462 KII_In-country_Nig015

463 KII_In-country_Esw012

464 KII_In-country_Tan016; KII_In-country_Tan017; KII_In-country_Tan018; KII_In-country_Tan019

465 KII_Global_Par002; KII_In-country_Pak010

466 KII_In-country_Esw004; KII_In-country_Nig023

467 KII_In-country_Tan017; KII_In-country_Tan019

468 KII_In-country_Tan016; KII_In-country_Tan017; KII_In-country_Tan018; KII_In-country_Tan019

469 KII_In-country_Esw012

470 KII_In-country_Kos008

471 KII_Global_Mad001

472 FGD_National_Nigeria

473 KII_Global_Phi003; KII_Global_Pak003

474 KII_Global001; KII_Global_Ken003; KII_Global004

475 KII_Global_Ken003

476 Based on information from Global Fund Secretariat internal documents on the Prevention Outcomes Monitoring Tool (POMT),[2025]

477 KII_Global_Uga002

478 KII_In-country_Tan013; KII_In-country_Ken017

479 KII_Global_Esw001

480 KII_In-country_Tan016; KII_In-country_Tan017; KII_In-country_Tan018; KII_In-country_Tan019

481 POMT survey conducted by the evaluation team, [Oct/2025], internal dataset

482 KII_Global_Nig003; FGD_National_Nigeria

483 KII_In-country_Zim003; KII_In-country_Nig015; KII_In-country_Ken017

484 KII_In-country_Phi010

485 Based on information from Global Fund Secretariat internal documents on the Prevention Outcomes Monitoring Tool (POMT),[2025]

486 KII_In-country_Pak010; KII_In-country_Pak006; KII_In-country_Pak013; KII_In-country_Nig033

487 POMT survey conducted by the evaluation team, [Oct/2025], internal dataset

488 KII_Global004

489 This is effectively a zero-sum situation, and scaling up these interventions would require countries to identify areas where funding could be reduced