HIV Prevention Evaluation

Annexes

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Annexes – Final Evaluation Report

Evaluation of HIV Prevention

Date: 10 April 2026

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Annexes

1. Evaluation framework

Evaluation objectives	EQs	Illustrative sub-EQ	Secondary data sources	Methods of data analysis	Primary data sources	Methods of analysis
Grant configuration for optimal allocation of resources (Effectiveness; Coherence)	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?	▪ Is there evidence that program partners have identified which locations are seeing the largest number of new HIV infections? ▪ For the country in question, have program partners identified the populations most in need of HIV prevention services? ▪ Are interventions covering specific locations and/or populations?	**Global Fund investment data sources:** grant proposals, grant budgets, financial reports. **HIV-related data sources:** UNAIDS HIV epidemic data, country HIV data, gray literature. **Grant targeting/coverage sources:** grant proposal documents. **Assessment methodology data sources:** Grant Assessment Compass.	Human analyst and optimal grants agent (Optimal Grants Agent)[i] will use a combination of the following analysis methods: - Semantic search - Topic modeling - Entity recognition - Quantitative analysis methods - Natural language text processing Optimal Grants Agent will use methods to establish nature of HIV investments and where they are intended, and finally will use assessment methodology from Grant Assessment Compass for scoring.	Key informant interviews (KIIs) with Global Fund country teams and HIV fund portfolio managers for the 12 countries	Although the analysis of the grants will be portfolio-wide, we will also use the same KIIs and focus group discussions (FGDs) for Objective 2 to validate the results of the 12 countries. We will then use these as a sample to validate the rest of the analysis and to calibrate Optimal Grants Agent's analysis.

	EQ2. To what extent are Global Fund investments being programmed toward UNAIDS/WHO-recommended HIV prevention interventions while considering the countries' context and epidemiological situation?	1. For the country in question, have program partners identified or in the process of identifying the UNAIDS/WHO HIV prevention interventions most appropriate, considering the country's context and epidemiology *(consider service delivery models, geography, target populations, countries context and epidemiological situation and programme objectives)?* 2. Are all recommended interventions provided? 3. If not, is there evidence of a plan to fill those gaps? To what extent does HIV prevention programming include or plan to include innovations to address gaps/ weaknesses not sufficiently addressed through evidence-based programming?	**Global Fund investment data sources:** grant proposals, grant budgets, financial reports, International Aid Transparency Initiative documents (IATI). **HIV-related data sources:** national HIV strategic plans, UNAIDS HIV epidemic data, country HIV data, gray literature. **Grant targeting/coverage sources:** grant proposal documents. **Assessment methodology data sources:** UNAIDS and WHO HIV prevention guidelines, GPC materials including country profiles, gray literature, Grant Assessment Compass.	Human analyst and Optimal Grants Agent will use a combination of the following analysis methods: - Semantic search - Topic modeling - Entity recognition - Quantitative analysis methods - Natural language text processing Optimal Grants Agent will use methods to establish the nature of HIV investments and where they are intended and finally will use WHO and UNAIDS normative guidance to establish the extent to which programming is following this guidance. Optimal Grants Agent will then refer to Grant Assessment Compass criteria for scoring.	KIIs with Global Fund country teams and HIV fund portfolio managers for the 12 countries	Although the analysis of the grants will be portfolio-wide, we will also use the same KIIs and FGDs for Objective 2 to validate the results of the 12 countries. We will then use these as a sample to validate the rest of the analysis and to calibrate Optimal Grants Agent's analysis.
	EQ3. To what extent and how are structural and behavioral interventions oriented towards HIV prevention outcomes through enhancing the uptake of services?	4. Is there evidence that program partners have or plan to identify the biomedical, behavioral, and structural interventions most appropriate for the country? 5. To what extent does the GC7 grant focus on the most critical interventions or are	**Global Fund programmatic data sources:** grant proposals, grant budgets, Progress Update and Disbursement Request (PU/DR), financial reports. **HIV-related data sources:** UNAIDS HIV epidemic data, UNAIDS human rights reports, country HIV data, gray literature.	Human analyst and Optimal Grants Agent will use a combination of the following analysis methods: - Semantic search - Topic modeling - Entity recognition - Quantitative analysis - Qualitative analysis - Natural language	KIIs with Global Fund country teams and HIV fund portfolio managers for the 12 countries	Although the analysis of the grants will be portfolio-wide, we will also use the same KIIs and FGDs for Objective 2 to validate the results of the 12 countries. We will then use these as a sample to validate the rest of the analysis and to calibrate Optimal Grants Agent's analysis.

		there plans to address the most critical interventions? 6. If not, or if in the process of planning what are the gaps?	**Grant targeting/coverage sources:** grant proposal documents. **Assessment methodology:** WHO HIV prevention guidelines, GPC materials including country profiles, Grant Assessment Compass.	text processing Optimal Grants Agent will use methods to establish how structural interventions are integrated into HIV prevention programs. Optimal Grants Agent will then refer to Grant Assessment Compass criteria for scoring.		
	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?	7. For the country in question, have program partners identified the populations most in need of HIV prevention services? 8. For each population, is the desired scale of coverage to achieve impact defined? 9. To what extent does grant design address monitoring of HIV prevention outcomes and impact (beyond input and output monitoring)? 10. To what extent does the HIV prevention program design address cost-effectiveness? Have cost-effectiveness measures been defined in the design? 11. Are monitoring, evaluation, and learning (MEL) systems included in the HIV prevention program designed to enable tracking of	**Global Fund programmatic data sources:** grant proposals, grant budgets, Portfolio Management Quality Tool (PMQT), M&E systems analysis, PU/DR, financial reports. **HIV-related data sources:** national HIV strategic plans, UNAIDS HIV epidemic data, UNAIDS human rights reports, country HIV data, gray literature. **Grant targeting/coverage sources:** grant proposal documents, project site location. **Assessment methodology:** WHO HIV prevention guidelines, GPC materials including country profiles, Grant Assessment Compass.	Human analyst and Optimal Grants Agent will use a combination of the following analysis methods: - Semantic search - Topic modeling - Entity recognition - Quantitative analysis - Qualitative analysis - Natural language text processing Optimal Grants Agent will use methods to establish the scale and coverage of prevention interventions as well as the disaggregation of data by population group.	KIIs with Global Fund country teams and portfolio HIV fund managers for the 12 countries	Although the analysis of the grants will be portfolio-wide, we will also use the same KIIs and FGDs for Objective 2 to validate the results of the 12 countries. We will then use these as a sample to validate the rest of the analysis and to calibrate Optimal Grants Agent's analysis.

		progress and data utilization to inform adaptations? 12. 13. To what extent has available funding been allocated to the interventions, populations, and areas with highest potential to achieve impact or not, even when it is not possible to achieve NSP desired coverage rates for impact and when other targets have not been met? 14. What are your main recommendations for prioritizing diminishing resources for HIV prevention in different contexts to maximize their impact on the epidemic?				
Initial progress, alignment, coherence (Effectiveness; Coherence; Sustainability)	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., performance frameworks, budgets, and narratives)?	15. What interventions have been undertaken since the start of GC7? 16. What results have been achieved in the sampled countries under GC7 against expected targets? 17. If intervention targets were not achieved, what was the reason for this? For example, have any planned GC7 interventions not been completed? If yes, what was the reason for this?	Funding requests (FRs). Grant agreements, performance frameworks, budgets, and narratives. PR and SR performance frameworks, M&E plans, pulse checks, progress updates/disbursement requests, funding gap analyses.	Analysis will be conducted using the developed artificial intelligence (AI) tool and thematic analysis of a document review using qualitative software such as Dedoose	KIIs with PRs/SRs KIIs with Global Fund Secretariat, including Global Fund country teams, HIV fund portfolio managers, and HIV technical advisors	Thematic analysis using qualitative software such as Dedoose

	EQ6. To what extent and how has HIV prevention implementation shifted from GC6 to GC7 design and into GC7 implementation: : (i) considering implementation changes/ adaptations or potential changes to implementation of GC7. (ii) in terms of shifts in targeting of programs <u>Areas to consider:</u> 6a. Are HIV prevention services targeted and accessible to those most in need of HIV prevention? 6b. Is there any indication of sufficient utilization of HIV prevention delivery platforms? 6c. Is there any indication of subnational tailoring of HIV prevention interventions? 6d. To what extent are Global Fund GC7 investments contributing to increased coverage of KVPs with precision combination prevention interventions (early results)? 6e. How are the current/ potential changes in	<u>Grant level</u> 18. What shifts have occurred (if any) to GC7 grants compared to previous GC6 grants in terms of targeting those in most need of HIV prevention and ensuring accessibility? 19. How (if at all) are delivery platforms and local tailoring considered/incorporated at grant level? 20. Considering implementation changes/ adaptations or potential changes made to implementation of GC7 (if any), how do revised GC7 grants align with the Global Fund's HIV prevention framework? 21. Thinking about readiness to change and emerging responses, what are the facilitators and barriers to this? (Probe: is there a process in place? How has this worked or not? <u>Intervention level</u> 22. To what extent are interventions accessible to, reaching, and used by KVPs? 23. To what extent are Global Fund GC7 investments contributing	FRs. Grant agreements amended grant agreements. PR and SR performance frameworks, M&E plans, pulse checks, progress updates/disbursement requests. Global Fund Key Performance Indicator data by country for HIV modules. Country context information collected through literature review analyzed by the developed AI tools[1]. Correspondence between technical/ grant implementers and the Global Fund. For example, communications about changes permitted as part of implementation activities and operational updates including shifts in targeting. Relevant articles published by the Global Fund, technical partners, and grant implementers in response to the changes in funding context. Risk assessments, assurance activities; spot checks and program/data quality reviews for	Thematic analysis using qualitative software such as Dedoose	KIIs with Global Fund Secretariat, including Global Fund country teams, HIV technical advisors, and Global Fund Portfolio Managers KIIs with HIV country leads within global and regional technical partners such as WHO or UNAIDS, and Country Coordinating Mechanism (CCM) members KIIs with national Ministry of Health (MoH) representatives, including Directors General for Health, and Senior Health Advisors KIIs with PRs and SRs FGDs with key populations	Thematic analysis using qualitative software such as Dedoose

[1] For example: factors such as change in GF Strategy focus, changes in normative guidance and other global strategies, changes in countries' fiscal landscape, changes in how other sources of funds (domestic, other external) have been programmed relative to the country needs

	implementation expected to affect coverage and mix of supported interventions?	to increased coverage of KVPs with precision combination prevention interventions (early results)? Consider, for example, subnational tailoring of HIV prevention interventions and use of HIV prevention delivery platforms. 24. How are the current/ potential changes in implementation expected to affect: targeting and integration, coverage and mix of supported interventions; breadth vs depth? 25. How likely is it that direct changes to GC7 implementation (if any) will affect coverage and mix of supported interventions? 26. Thinking about readiness to change interventions and emerging responses, what are the facilitators and barriers to this process? (Probe: is there a process in place? How has this worked or not?	implementing partners of selected grants.			
	EQ7. To what extent and how does Global Fund support HIV prevention interventions that are coherent (including complementarity, harmonization, and coordination) with other actors' interventions in the	27. What added value does Global Fund support provide to HIV prevention interventions compared to that of other funders? 28. What processes do country stakeholders follow to identify gaps	Annual and progress reports from similar funders in the region Country context information collected through literature review analyzed by the specially developed AI tool.	Thematic analysis using qualitative software such as Dedoose	KIIs with Global Fund Secretariat, including Global Fund country teams, HIV technical advisors, HIV fund portfolio managers, and MEL system/data collection focal points KIIs with HIV country leads within global and	Thematic analysis using qualitative software such as Dedoose

	current resource-constrained setting? *Note: Complementarity will be considered in serval ways when considering what constitutes "optimal" funding allocation. For example, using incidence data, alignment with existing partner support, alignment with Global Fund best practice guides and other innovative approaches to harmonization and complementarity and of course – complementarity with other national and subnational policy and strategy.*	where support is most needed? 29. How effectively have country stakeholders coordinated and collaborated with sector partners such as governments, other funders, and non-governmental organizations (NGOs)/ civil society organizations (CSOs) to deliver HIV interventions? Please give examples. 30. To what extent are HIV prevention interventions integrated into broader health service delivery platforms (e.g., maternal, newborn, and child health, family planning, STI services) and/or local systems such as schools, health clinics, and hospitals? 31. To what extent have HIV prevention monitoring and evaluation (M&E) systems and data collection systems been designed to be aligned, harmonized, and complimentary? 32. To what extent is the data from country-level HIV prevention MEL systems utilized to guide country-level and Global Fund Secretariat decision making?	Country-level HIV MEL and data collection systems		regional technical partners such as WHO or UNAIDS KIIs with national MoH representatives, including the MoH Permanent Secretary, Directors General for Health, and Senior Health Advisors	

	EQ8. What are the key drivers behind sustainability of HIV prevention interventions? Which areas of HIV prevention/interventions/ platforms are more resilient and sustainable, given diminishing or potentially diminishing resources?	33. What are the key drivers behind sustainability of HIV prevention interventions? What are the barriers and facilitators? 34. Which areas of HIV prevention/interventions/ platforms are more resilient and sustainable, given diminishing or potentially diminishing resources? 35. What are your top three recommendations for prioritizing diminishing resources for HIV prevention in different contexts to maximize their impact on the epidemic?	Literature from similar HIV-focused programs Research papers focused on HIV program sustainability	Thematic analysis using qualitative software such as Dedoose	KIIs with Global Fund Secretariat, including Global Fund country teams and HIV technical advisors KIIs with PRs and SRs KIIs with HIV country leads within global and regional technical partners such as WHO or UNAIDS KIIs with key MoH representatives, including Directors General for Health, and Senior Health advisors	Thematic analysis using qualitative software such as Dedoose

Outcome monitoring systems (Effectiveness)	EQ9. To what extent are countries effectively measuring HIV prevention outcomes, including integration of the POMT into MEL systems? (Areas to be considered are measurement approaches, scale and reach, coherence/integration and capabilities, and subsequent use of information.)	▪ What data collection systems have countries adopted to measure prevention outcomes, including the POMT, factoring in ease of administration and cost-effectiveness? ▪ How has their experience been so far (positive and negative)? ▪ To what extent have countries addressed adequate allocation of resources (both human and financial) to sustain prevention outcome monitoring within the broader MEL systems? ▪ To what extent is the data on prevention interventions' coverage and outcomes that is collected being utilized for learning and adapting to optimize HIV prevention programming?	National MEL frameworks, Progress Update / Disbursement Requests, existing studies, and evaluation reports, POMT documentation (where available)	Thematic analysis using appropriate qualitative data analysis software	MEL and Strategic Information (SI) personnel—Global Fund Secretariat and; in-country stakeholders—MEL and SI at MoHs, PR and SR offices, and technical partners such as UNAIDS, and WHO	Thematic analysis using appropriate qualitative data analysis software, e.g., Dedoose

2. Dimensions scoring matrix

Dimension	Questions	Scoring
1: Prioritized mix of Interventions	1.1: Have the country's top **programmatic needs** for HIV prevention been identified (e.g., condom programming, needle and syringe programs (NSP), VMMC, PMTCT, PrEP, other)? List the top programmatic needs as specifically as possible.	1: The grant has a **limited mix of interventions**, with key gaps/weaknesses in addressing the known programmatic priorities and priority geographic areas.
	1.2: To what extent do the grant interventions align with the country-level **programmatic needs** documented in country HIV strategies and plans?	

	Provide examples.	2: The grant has a **fair mix of interventions, with notable gaps/weaknesses** in addressing the known programmatic priorities and priority geographic areas. 3: The grant has a **good mix of interventions,** addressing the key programmatic priorities and priority geographic areas. 4: The grant has an **excellent mix of interventions**, with no notable gaps or weaknesses in addressing the key programmatic priorities and priority geographic areas.
	1.3: To what extent does the grant include **evidence-based, high-impact interventions**[2] likely to lead to changes in prevention outcomes. Provide examples.	
	1.4: Do grant information sources identify any **gaps in evidence-based, high-impact interventions** that are <u>not</u> included in the grant? Provide examples.	
	1.5: To what extent are grant interventions aligned with the programmatic **recommendations from past evaluations and/or audits**? Provide examples.	
	1.6: To what extent is the grant evolving to **deliver more with fewer resources**? Provide examples.	
	1.7: To what extent are GC7 HIV prevention interventions **consistent with GC7 grant agreements** (e.g., performance frameworks, budgets, and narratives)?	
	1.8: To what extent are HIV prevention interventions **complementary and coordinated** with other actors' interventions? Provide examples, both showing complementarity and gaps in complementarity.	
	1.9: To what extent does the grant include **initiatives/ programs that have potential to improve the overall impact** of HIV prevention efforts in the country? Provide examples.	
	1.10: To what extent is the grant making plans to integrate **Lenacapavir** delivery into HIV prevention service delivery or into the wider health system? Provide examples.	
	1.11: To what extent does the grant include service delivery models that will ensure prevention interventions and services are **accessible where and when needed?** Provide examples.	
	1.12: Is the grant leveraging innovations such as **online service delivery** to maintain or expand reach and coverage?	
	1.13: Is there any evidence to indicate that funding for HIV prevention is **shifting towards the highest priority HIV prevention interventions** that key stakeholders (WHO, UNAIDS, Global Fund, , etc.) agree are effective and likely to deliver	

[2] High-impact HIV primary prevention interventions include structural, behavioral, and biomedical interventions [e.g., condoms and lubricants, PEP and PrEP, STI interventions, opioid substitution treatment (OST), needle and syringe programs (NSP), and VMMC].

	value for money in terms of achieving HIV prevention outcomes (e.g., condoms and lubricants, PEP and PrEP, STI interventions, OST, NSP, and VMMC)? For example, are there any **grant-related reports, evaluations, or audits** that address the extent to which the grant's interventions are providing value for money in terms of attaining HIV prevention outcomes? Provide examples.	
	1.14: To what extent are HIV prevention interventions – including structural (human rights and social protection) and behavioral interventions – oriented towards **increasing adoption of key HIV prevention practices** and **uptake of priority services** (e.g., condoms and lubricants, PEP and PrEP, STI interventions, OST, NSP, and VMMC)? Provide examples.	
	1.15: To what extent has the **design of HIV prevention grants shifted from GC6 to GC7?** For example, are the high priority HIV prevention **interventions** (e.g., condoms and lubricants, PEP and PrEP, STI interventions, OST, NSP, and VMMC) more prominent in the GC7 grant than they were in the GC6 grant? For example, is there a greater focus in the GC7 grants on the priority populations most at risk of HIV compared to GC6? Note: For this question, we are interested specifically in the grant design, meaning the planned strategies, approaches, interventions, and target populations in the grant documents.	
	1.16: Have the **programmatic** priorities for HIV prevention been **further prioritized**, especially to account for recent funding constraints? [For example, by focusing on interventions known to be high impact for HIV prevention (e.g., condoms and lubricants, PEP and PrEP, STI interventions, opioid substitution treatment (OST), needle and syringe programs (NSP), and VMMC?] Provide specific examples to show where such further prioritization has taken place.	
2: Alignment with epidemiological needs	2.1: To what extent does the grant's HIV prevention interventions address the country's **main epidemiological needs** (e.g., addressing gaps in key populations covered; expanding to target regions where most new infections are taking place; etc.)? Provide examples. To what extent do available grant documents (programmatic reports, evaluations, media, grey literature) refer to the **grant's alignment with epidemiological needs?** Do these sources identify instances where the grant is not aligned with epidemiological needs? Provide examples.	1: Interventions **do not align** with epidemiological needs. 2: Interventions have **fair alignment**, with significant gaps and weaknesses in addressing epidemiological needs. 3: Interventions have **good alignment**, with some notable gaps and weaknesses in addressing epidemiological needs. 4: Interventions have **excellent alignment**, with no notable gaps or weaknesses in addressing epidemiological needs.
	2.2: Have **geographical priorities been identified and documented** in the country-level HIV strategies and plans? To what extent do grant interventions **align with the geographical priorities** documented in country-level HIV strategies and plans? To what extent does the grant target locations where most new infections are occurring and locations with the highest HIV incidence rates? Have **geographical priorities** been further **prioritized**, especially to account for recent funding constraints? (For example, prioritizing coverage of regions with high HIV incidence over those with lower HIV incidence?) Provide examples of strong alignment where priority regions are well covered. Provide examples of gaps, where priority regions are not covered.	

	2.3: Have the **populations** most in need of HIV prevention been **further segmented**, especially to account for recent funding constraints? (For example, prioritizing AGYW who have multiple sex partners or prioritizing FSWs living with HIV?) Provide specific examples to show where such further prioritization has taken place.	
3: Equity	3.1: To what extent does the grant's HIV prevention interventions address the needs of the **key and vulnerable populations** identified by country stakeholders? Provide examples. Be specific about the key population groups you are referring to (e.g., MSM, transgender people, FSW, PWID, and their sexual partners and/or clients). Be specific about the vulnerable populations you are referring to (e.g., racial minorities, people with disabilities, people experiencing extreme poverty, AGYW, etc.).	1: The grant has **limited focus on** equity, with the needs of key and vulnerable populations not addressed. 2: The grant has **fair focus** on equity, with significant gaps and weaknesses in addressing the needs of key and vulnerable populations. 3: The grant has **good focus** on equity, with some notable gaps and weaknesses in addressing the needs of key and vulnerable populations. 4: The grant has **excellent focus** on equity, with no notable gaps and weaknesses in addressing the needs of key and vulnerable populations.
	3.2: Are other active, **non-GF HIV prevention programs** reaching the populations not reached by the GF HIV prevention grant? Provide examples.	
	3.3: To what extent is the GF grant making **adaptations** that would enable better coverage of populations not yet sufficiently covered? Provide examples.	
	3.4: To what extent are the proposed interventions in the grant aligned with **recommendations** for equity considerations from past evaluations/ audits? Provide examples.	
	3.5: To what extent are key and vulnerable populations **involved in the design, implementation, and evaluation** of the grant? Provide examples. If there are no examples, please note that.	
	3.6: To what extent are HIV prevention programs being delivered in a way that **protects the safety** of both implementers and beneficiaries? Provide examples, both positive and negative.	
4: Scale	4.1: Does the grant include **coverage targets**[3] for specific HIV prevention interventions or for specific populations? Are these targets set at a scale sufficient to achieve impact? For example, regarding priority HIV prevention **interventions,** are there coverage targets for: condom programming? PrEP? OST? NSP? VMMC? For example, regarding specific key and priority **populations,** are there coverage targets for: FSW, MSM, Transgender people, PWID, or other groups?	1: Coverage achieved is **low** (0%–24%). 2: Coverage achieved is **fair** (25%–49%).

[3] Note that grants may refer to **reach targets** (e.g., aiming to "reach" 800 MSM with PrEP education) or **coverage** targets (e.g., aiming to "cover" 80% of the 1,000 MSM eligible for PrEP education). The difference is that coverage also takes note of the total number of people eligible for the intervention, and the proportion to be covered.

	Have the sizes of key and vulnerable population groups been estimated at the national and/or subnational levels? Provide specific examples.	3: Coverage achieved is **good** (50%–74%). 4: Coverage achieved is **excellent** (75%–100%).
	4.2: To what extent is the grant **achieving** the coverage targets? Provide data of reach achieved.	
	4.3: To what extent are intervention coverage at s**ufficient scale of coverage to achieve HIV prevention impact?** Provide examples, both positive and negative.	
	4.4: If sufficient coverage is not being attained, what are the **main limitations** (i.e. Insufficient funding? Hesitancy to uptake services? Other?) Provide specific examples and data, if available.	
	4.5: To what extent do the grant interventions **address critical gaps in coverage for key and vulnerable populations** that are most in need of HIV prevention but are not sufficiently covered by other programs? Which populations (if any) are **well addressed**. Which populations (if any) are **not sufficiently addressed**	
5: Monitoring, data utilization, and adaptability	5.1: To what extent does the grant have clear **systems, approaches, or tools** that are being used for monitoring HIV prevention outcomes? Provide examples.	1: The grant has **no mechanisms** for prevention outcome monitoring and **no evidence** of data utilization informing programmatic shifts. 2: The grant has **limited mechanisms** for prevention outcome monitoring and **minimal evidence** of data utilization informing programmatic shifts. 3: The grant has **good mechanisms** for prevention outcome monitoring and **some evidence** of routine data utilization informing programmatic shifts. 4: The grant has **excellent mechanisms** for prevention outcome monitoring and **strong evidence** of consistent data utilization informing programmatic shifts.
	5.2: To what extent are **prevention outcome monitoring tools being utilized**? For example, have BBS Lite, Rapid Coverage Surveys, or Poll Booth Surveys been integrated into the grant's monitoring systems?	
	5.3: To what extent is the grant supporting the country to **reach its HIV prevention outcome targets**? Provide examples to demonstrate **how the grant is supporting the country** in this way. Provide examples of **missed opportunities** to support the country in this way.	
	5.4: Are there any evidence (quantitative data, qualitative evidence, or even anecdotal evidence) from HIV prevention outcome monitoring demonstrating that **HIV prevention interventions are** contributing to behavior change or uptake of prevention services?? Provide examples.	
	5.5: Are there any data from prevention outcome monitoring that demonstrates **negative HIV prevention results**? Provide examples.	
	5.6: To what extent are implementers of HIV prevention interventions funded by the Global Fund grant **using data to inform programmatic improvements and refinements** to maximize HIV prevention outcomes? Provide examples.	

6: Sustainability	6.1: To what extent is the grant and its main HIV prevention interventions **reliant on Global Fund financing**? Provide details.	1: Interventions are **not sustainable.** Financing of HIV prevention interventions relies completely on GF. Services are not integrated into locally sustainable structures. 2: Interventions have only a **fair likelihood** of being sustained. There is limited financing of HIV prevention interventions from non-GF sources. Services are only minimally integrated into locally sustainable structures. 3: Interventions have a **good likelihood** of being sustained. Some HIV prevention interventions will be sustained from non-GF sources. Some HIV prevention services are integrated into locally sustainable structures. 4: Interventions have an **excellent likelihood** of being sustained. Many HIV prevention interventions will be sustained from non-GF sources. Many HIV prevention services are already integrated into locally sustainable structures.
	6.2: To what extent has funding been identified **to sustain the priority HIV prevention interventions after the GF grant has ended**? This could mean funding from a different donor or funding from the national health budget. Provide examples.	
	6.3: To what extent are HIV prevention interventions/services on the Global Fund grant already **integrated into or delivered through locally-sustainable health or other structures** (e.g., hospitals, clinics, sexual and reproductive health (SRH) or family planning (FP) services, schools, churches, social service providers, NGOs with funding from social contracting or other funding mechanisms, etc.)? Provide examples.	
	6.4: Is there any evidence that HIV prevention services on the grant will be **integrated into locally-sustainable health and other structures** in the future? Provide examples.	
	6.5: To what extent does the grant include strategies to build capacity at individual and organizational levels to support **integration of HIV prevention interventions into the locally-sustainable service delivery structures**?	
	6.6: Is there any evidence to indicate that national funding for HIV prevention (beyond Global Fund) is **shifting towards the highest priority HIV prevention interventions** that key stakeholders (WHO, UNAIDS, Global Fund, PEPFAR, etc.) generally agree to be effective and likely to deliver value for money (e.g., condoms and lubricants, PEP and PrEP, STI interventions, OST, NSP, and VMMC) in terms of achieving HIV prevention outcomes? For example, are there any national budget documents, government reports, grant-related **reports (beyond Global Fund), evaluations, or audits** that address the extent to which the grant's interventions are providing **value for money** in terms of attaining HIV prevention outcomes? Provide examples.	

3. Evaluation question response matrix

Evaluation Question	Summary response
EQ 1.1 Is there evidence that program partners have identified which locations are seeing the largest number of new HIV infections?	There is extensive evidence that program partners systematically identify high-incidence locations using surveillance systems, modeling, and sub-national data. Across all countries, partners use multiple epidemiological tools to determine where new HIV infections are concentrated, demonstrating clear identification of high-burden locations. Evidence also shows that partners identify high-burden locations by analyzing which specific populations within those locations drive new infections However, data also points to the existence of pockets where location identification does not fully translate into inclusive targeting.
EQ 1.2 For the country in question, have program partners identified the populations most in need of HIV prevention services?	Across a majority of the sampled countries, program partners have identified key populations as the groups most in need of HIV prevention services. Global-level stakeholders emphasize that key populations and other sub-populations form the central focus of precision-prevention approach, and the country level data reinforce this. Program partners also consistently identify Adolescent Girls and Young Women (AGYW) as a population most in need of HIV prevention services in high-incidence countries. While identification of priority populations is strong, evidence also highlights important gaps where needs of certain subgroups remain insufficiently addressed
EQ 1.3 Are interventions covering specific locations and/or populations?	HIV prevention interventions are delivered in the specific locations and among the specific populations identified as priorities, using tailored platforms designed to reach individuals where they live, work and congregate. While the extent varies, evidence shows that interventions are being implemented in the specific sites and among the specific groups prioritized through epidemiological analysis, supported by diverse community-based and mobile delivery modalities.
EQ5.1 What interventions have been undertaken since the start of GC7?	HIV prevention interventions under GC7 have a strong emphasis on expanding PrEP access and integrating comprehensive harm reduction and community-led services, specifically focused on key populations, but the consistency of implementation varies across countries. Some changes in grant implementation as compared to the original grant agreements related primarily to disruptions due to withdrawal of external funding that impacted planned program activities and Global Fund's reprioritization exercise. The flexibility of grants is appreciated by stakeholders to ensure consistent alignment to country needs.
EQ5.2 What results have been achieved in the sampled countries under GC7 against expected targets?	Many countries report achieving or exceeding key population coverage targets stipulated in their Global Fund grants, although this does not always translate into reduced HIV prevalence within countries. Although key population focus is a priority for many countries, additional HIV-prevention support amongst the general population is needed for the minority of countries.
EQ 5.3 If intervention targets were not achieved, what was the reason for this?	The withdrawal of other major donors and the Global Fund's reprioritization exercise negatively impacted many countries' ability to implement all planned HIV-prevention interventions. Other challenges related to high key population coverage targets, bureaucratic grant processes, key population stigma, and limited political buy-in each contributed to partial achievement of intervention targets.
Grant level: 6.1: What shifts have occurred (if any) to GC7 grants compared to previous GC6 grants in	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. Alongside sharper targeting, GC7 adopted enhanced biomedical accessibility

terms of targeting those in most need of HIV prevention and ensuring accessibility?	strategies, particularly through the accelerated introduction and scale-up of PrEP modalities. However, despite clear advances in precision and biomedical accessibility, in a number of settings, it was reported that reduced funding envelopes affected the continuity of specific structural and behavioral components.
6.2: How (if at all) are delivery platforms and local tailoring considered/incorporated at grant level?	GC7 grants consistently embed differentiated delivery platforms as a core design feature, reflecting that high-impact HIV prevention depends on reaching KVPs and AGYW through modalities tailored to their mobility, stigma environments, and service-seeking patterns. 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. However, some constraints influence how delivery platforms and tailoring are operationalized: reductions in funding have weakened structural components, reduced HRG activities, and in some contexts led to the loss of community-based platforms such as mobile clinics and drop-in centers.
6.3: Considering implementation changes/ adaptations or potential changes made to implementation of GC7 (if any), how do revised GC7 grants align with the Global Fund's HIV prevention framework?	Revised GC7 grants show alignment with the Global Fund's HIV prevention framework. Many countries have strengthened precision prevention and expanded combination prevention in line with the framework, using better data to target high-risk populations and scaling PrEP and community-led approaches. However, alignment varies across contexts, with budget reductions leading some countries to scale back behavioral, structural and human rights interventions. As a result, while the overall direction reflects the framework's intent, implementation remains inconsistent and shaped by differing resource and contextual constraints.
6.4: Thinking about readiness to change and emerging responses, what are the facilitators and barriers to this? (Probe: is there a process in place? How has this worked or not?	Readiness to change under GC7 reflects a strong programmatic and institutional commitment to adaptation but is moderated by external political constraints, resource limitations, and systemic barriers. Countries demonstrated agility in adopting high-impact biomedical innovations, refining targeting practices, and strengthening outcome measurement, supported by TWGs, TRP guidance, national strategies, and community-led monitoring. Yet this readiness often could not be fully realized due to challenging legal environments (Uganda, Kosovo, Zimbabwe), fragmentation in health and data systems (Eswatini, Madagascar, Paraguay), sustainability concerns (Philippines), and reductions in funding that undermined previously effective delivery platforms and structural interventions. While GC7's strategic orientation encourages responsiveness and innovation, the ability to operationalize these shifts depends heavily on the broader political, financial, and systems context in which grants are implemented.
Intervention level: 6.5: To what extent are interventions accessible to, reaching, and used by KVPs?	Across GC7, the accessibility of HIV prevention interventions for KVPs is shaped by a deliberate shift toward differentiated, community-based platforms, although gains remain uneven. Countries rely on peer-led outreach, DICs, mobile units and extended-hour services to bring interventions closer to KVPs and AGYW, including late-night PrEP services, peer-accompanied screening and mobile outreach for FSW. However, reach remains inconsistent and utilization continues to be undermined by structural, political and social barriers, limiting the full effectiveness of interventions for KVPs across settings.
6.6: To what extent are Global Fund GC7 investments contributing to increased coverage of KVPs with precision combination prevention interventions (early results)? Consider, for example, subnational tailoring of HIV prevention interventions and use of HIV prevention delivery platforms.	Early implementation results show that GC7 investments are translating into coverage gains in some settings, particularly for AGYW and selected key populations. At the same time, these gains are partial and uneven.

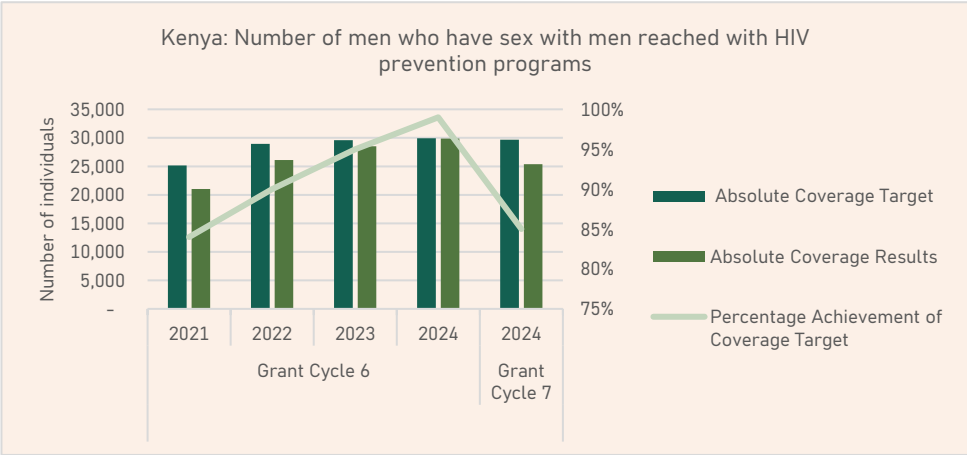
6.7: How are the current/ potential changes in implementation expected to affect: targeting and integration, coverage and mix of supported interventions; breadth vs depth? 6.8: How likely is it that direct changes to GC7 implementation (if any) will affect coverage and mix of supported interventions?	Across GC7 implementation, countries are increasingly moving toward more precise and integrated prevention approaches, driven both by financial constraints and deliberate strategic shifts. Implementation changes are also expected to influence integration efforts and the quality of supported interventions. 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. 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.
6.8: How likely is it that direct changes to GC7 implementation (if any) will affect coverage and mix of supported interventions?	Direct changes to GC7 implementation are highly likely to affect both coverage and the mix of supported interventions. Budget reductions and reprioritization exercises have already driven programs toward narrower geographic reach and sharper sub-population targeting. The mix of interventions is also likely to shift further towards biomedical interventions as countries rapidly integrate new technologies such as Lenacapavir, which was introduced or planned for scale-up in a few countries.
6.9: Thinking about readiness to change interventions and emerging responses, what are the facilitators and barriers to this process? (Probe: is there a process in place? How has this worked or not?	Several facilitators support readiness to change and the adoption of emerging responses within GC7. Adaptive grant mechanisms, including budget revisions and reprogramming, were used in some countries. At the global level, outcome monitoring frameworks and the shift toward targeted, high-impact interventions serve as additional facilitators guiding resource allocation. Significant barriers remain. Resource constraints are the most consistent challenge, driving forced reprioritization and reducing the scope for structural or community-led programming. Political and legal environments also constrain readiness, particularly where criminalization or restrictive laws limit key populations' access.
EQ7.1 What added value does Global Fund support provide to HIV prevention interventions compared to that of other funders?	The Global Fund uses its reputation and comparative advantage of scale to support HIV-prevention services focused on key populations. This allows the Global Fund to promote a country-led approach and implement interventions not prioritized by other donors or some country governments.
EQ7.2 What processes do country stakeholders follow to identify gaps where support is most needed?	HIV-prevention intervention gaps are identified through a range of measures, specifically through the review and assessment of national documentation, in addition to country dialogues and survey analysis amongst CCM and country specific technical working groups
EQ7.3 How effectively have country stakeholders coordinated and collaborated with sector partners such as governments, other funders, and non-governmental organizations (NGOs)/ civil society organizations (CSOs) to deliver HIV prevention interventions?	The Global Fund's role varies within countries but it is often closely integrated with national governments, international donors and development partners, in addition to both national NGOs and CSOs. Across these stakeholders, duplication is limited through CCMs and country specific Technical Working Groups, but challenges continue to remain, primarily driven by government buy-in and international donor ways of working and reporting requirement.
EQ7.4 To what extent are HIV prevention interventions integrated into broader health service delivery platforms (e.g., maternal, newborn, and child health, family planning, STI services) and/or local systems such as schools, health clinics, and hospitals?	Many countries have made progress in integrating HIV-prevention services within broader health systems, specifically around the integration of health data systems and the de-centralization of health care activities to the community level via peer-led services. Although, key population stigma remains a major challenge, but many countries are currently or are planning implementation activities to mitigate this.
EQ7.5 To what extent have HIV prevention monitoring and evaluation (M&E) systems and data collection systems been designed to be aligned, harmonized, and complimentary?	The countries have also made some strides towards alignment and harmonization of the HIV prevention MEL systems across the different implementing partner (Ips) and the national systems including the establishment of electronic reporting platforms for partners to report their data. However, they have encountered challenges such as lack of interoperability between the systems; unstandardized tools used for

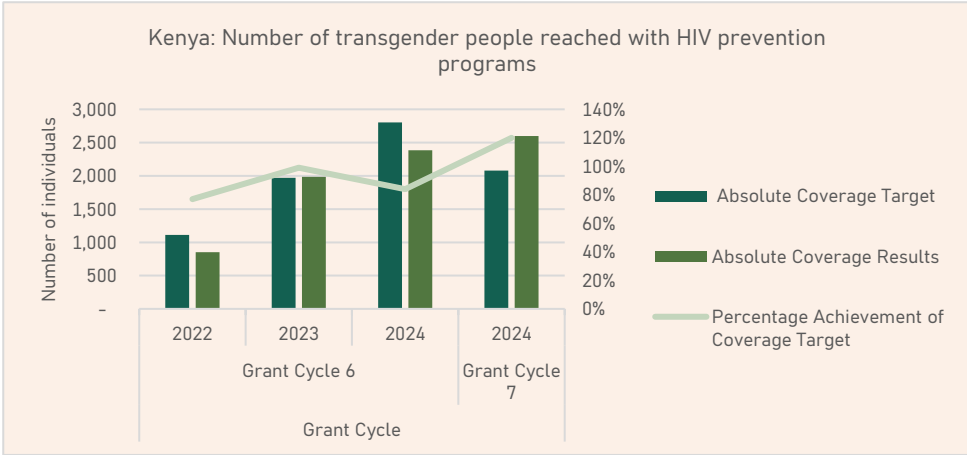
	community-level among the IPs; extensive use of paper-based health records in health facilities which are prone to errors.
EQ7.6 To what extent is the data from country-level HIV prevention MEL systems utilized to guide country-level and Global Fund Secretariat decision making?	The country-level HIV MEL systems are actively utilized to guide country-level and Global Fund decisions; indicators for the grant performance frameworks are aligned to the indicators within the country HIV MEL systems; additionally, target setting during grant writing process is aligned to the countries' strategic plans and targets.
EQ 9.1 What data collection systems have countries adopted to measure prevention outcomes, including the POMT, factoring in ease of administration and cost-effectiveness?	The sampled countries have been measuring prevention outcomes using population-based surveys and studies for monitoring prevention outcomes such as the IBBS; additionally, there are a limited number of HIV prevention outcome indicators that have been integrated into the routine national HMIS, primarily the PrEP cascade indicators and uptake of VMMC. Adoption of POMT has demonstrated varying degrees of success across the prioritized countries. Three countries have made most implementation progress; Eswatini has used lessons on the feasibility and cost-effectiveness of the RCS to inform the choice to use the same method for regular prevention outcomes monitoring. On the opposite end of the spectrum, POMT integration stalled in the Philippines, Zimbabwe and Nigeria due to funding reduction. Kenya and Tanzania have protocols that are ready for deployment.
EQ 9.2 How has their experience been so far (positive and negative)?	The experiences of the countries who had engaged with the POMT methods comprised a blend of positive and negative experiences. The positive experiences included in-country stakeholder buy-in for adoption of POMT methodologies as well as successful completion of data collection, analysis and write-up by three countries. Conversely, challenges in POMT implementation entailed technical complexity of the methodologies warranting external technical assistance; operational challenges such as application of the Global Fund guidelines for simplified methodologies with smaller sample sizes and simpler data collection tools; and financial constraints, with interruptions to POMT implementation following funding reductions.
EQ 9.3 To what extent have countries addressed adequate allocation of resources (both human and financial) to sustain prevention outcome monitoring within the broader MEL systems?	The sampled countries are yet to adequately allocate both financial and human resources to ensure sustainability of prevention outcome monitoring within their broader MEL systems. All the prevention outcomes monitoring methods before and after the introduction of the POMT have fully relied on external donor funds. Additionally, in the face of funding reduction, budgetary allocations for MEL systems appear to be among the first to be cut. Monitoring of treatment outcomes had also been prioritized relative to prevention monitoring. These factors pose significant sustainability risks for prevention outcomes monitoring and the broader MEL systems.
EQ 9.4 To what extent is the data on prevention interventions' coverage and outcomes that is collected being utilized for learning and adapting to optimize HIV prevention programming?	The countries have demonstrated positive strides towards use of prevention outcomes data both from the larger surveys and limited routinely collected prevention outcomes data to inform programmatic decisions. PrEP cascade data has been used to monitor trends and outcomes to inform targeted interventions when poor performance is detected; additionally, IBBS prevention outcomes data has been used to define service delivery packages, geographical prioritization and quantification of commodities. However, challenges related to data quality and fragmentation of reporting systems hamper progress towards comprehensive and sustainable prevention outcomes monitoring.

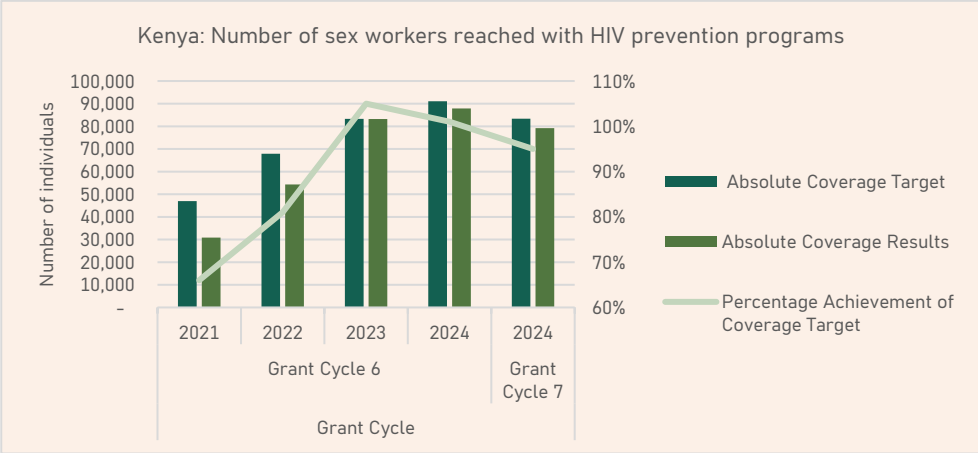
6.

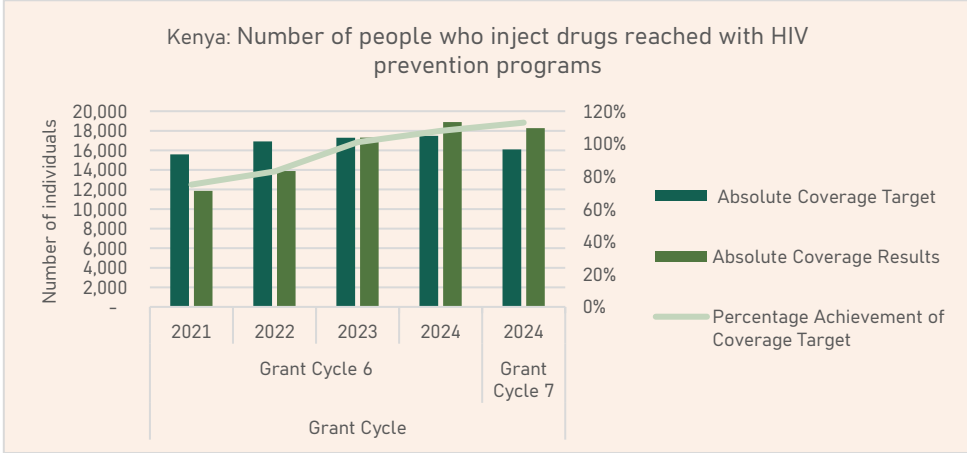
4. Specific/detailed evidence

4.1 Coverage data analysis for Kenya (based on internal Global Fund records)









4.2 HIV budgets across GC6 and GC7

These allocation figures draw on two main data sources. Total HIV allocations for GC6 and GC7 were obtained from the Global Fund's publicly available eligibility and allocation data[ii], accessed through the archived allocations portal. Estimates of HIV prevention budgets were derived from the detailed budget dataset provided by the Global Fund for the evaluation. Prevention budgets were calculated through a structured mapping exercise that applied the Global Fund Budget Team's guidance, the HIV-related modules and interventions defined in the Modular Framework Handbook[iii], and the results framework in the Measurement Framework for HIV Prevention[iv]. While this approach follows established technical guidance, the categorization of activities into "HIV prevention" is not always clear cut across all grants and modules. Some interventions have cross-cutting characteristics that can influence how they are classified, which means that prevention totals may be slightly overstated or understated in specific cases. These figures should therefore be interpreted as the best available estimates derived from consistent, transparent criteria rather than precise financial totals.

Countries	GC6 HIV Prevention Budget (USD)	GC7 HIV Prevention Budget (USD)	GC6 Total HIV Allocation (USD Equivalent)	GC7 Total HIV Allocation (USD Equivalent)	% change in total HIV allocation	% change in HIV prevention budget
Eswatini	6,346,250	10,040,008	39,348,102	32,901,259	-16%	58%
Kenya	69,578,113	71,898,268	271,649,197	252,843,015	-7%	3%
Kosovo	936,854	546,743	1,990,223	2,261,907	14%	-42%
Madagascar	2,356,563	6,550,535	20,407,983	28,371,317	39%	178%
Mozambique	73,397,581	117,664,987	496,359,122	506,987,373	2%	60%
Nigeria	33,433,622	70,646,325	329,107,978	361,689,416	10%	111%
Pakistan	27,574,870	10,973,690	71,687,227	65,446,113	-9%	-60%
Paraguay	1,633,471	1,931,717	6,722,401	7,028,868	5%	18%
Philippines	9,733,939	7,701,106	20,338,651	25,087,000	23%	-21%
Tanzania (United Republic)	56,788,682	83,530,954	364,840,423	370,004,151	1%	47%
Uganda	44,078,529	55,555,913	289,203,023	288,484,740	0%	26%
Zimbabwe	29,557,726	39,921,097	425,034,567	432,970,984	2%	35%
Grand Total	**355,416,200**	**476,961,343**	**2,336,688,897**	**2,374,076,143**		

5. List of stakeholders consulted (titles not names)

Country (if applicable)	Position
Global	Head of Monitoring, Evaluation & Country Analysis (MECA)
Global	Head of CRG (Community, Rights & Gender)
Global	Senior Specialist, Integration
Global	POMT expert
Global	HIV Prevention Lead
Global	AGYW/KP Advisor

Global	Senior Strategy and Policy Advisor
Global	Technical Officer WHO
Global	Deputy Executive Director for the Programme at UNAIDS
Global	Co-chair GPC
Pakistan	M&E
Kenya	Senior Fund Portfolio Manager
Kenya	Public Health and M&E Specialist
Philippines	Senior Fund Portfolio Manager
Philippines	(Senior) Program Officer
Philippines	Public Health and M&E Specialist
Nigeria	Senior Fund Portfolio Manager
Nigeria	(Senior) Program Officer
Nigeria	Public Health and M&E Specialist
Eswatini	Senior Fund Portfolio Manager
Eswatini	Senior TB/HIV advisor
Eswatini	Public Health and M&E Specialist
Eswatini	Regional AGYW Technical Advisor
Kosovo	Fund Portfolio Manager
Kosovo	PHM&E Specialist
Madagascar	PHME Specialist
Mozambique	Fund Portfolio Manager
Mozambique	Senior HIV advisor
Paraguay	Fund Portfolio Manager
Paraguay	PHM&E Specialist
Tanzania	Senior Fund Portfolio Manager
Tanzania	Senior HIV advisor
Uganda	Specialist, HIV and Matching Funds
Uganda	PHM&E Specialist (Uganda and Tanzania)
Kenya	Kenya CCM Oversight Committee member
Kenya	The National Treasury (TNT) Republic of Kenya
Kenya	Kenya CCM Oversight Committee member
Kenya	Grant manager Kenya Red Cross Society (KRCS)
Kenya	NASCOP HIV & STI Prevention Lead
Kenya	KP Focal Point in Prevention docket
Kenya	KRCS MEL
Kenya	FGD
Pakistan	UNAIDS - Strategic Information Adviser
Pakistan	Grant manager UNDP Pakistan, Principal Recipient
Pakistan	Grant manager Pakistan NACP
Pakistan	Chief Surveillance & Information Manager (MEL Focal Person)
Pakistan	National Coordinator

Pakistan	Strategic Information Specialist (National HIV Focal Point)
Pakistan	M&E Coordinator (MEL Focal Person)
Pakistan	Executive Director
Pakistan	CCM Coordinator Pakistan
Pakistan	HIV country lead within WHO
Pakistan	FGD
Philippines	Executive Director/HIV lead within The Philippine National AIDS Council (PNAC)
Philippines	Grant manager within Pilipinas Shell Foundation, Inc. (PSFI)
Philippines	National HIV focal point within the Department of Health
Philippines	M&E Focal person within UNAIDS
Philippines	FGD
Nigeria	Deputy Director, Head Prevention Division, Community Prevention & Care Services, Directorate
Nigeria	Chief Programme Officer, Health Policy | Advocacy | Strategy | Strategic Communication, Dept. of Policy, Planning & Stakeholders' Coordination
Nigeria	Project Director, PMU, Global Fund Projects, NACA
Nigeria	Principal Programme Officer (Monitoring and Evaluation, Strategic Information Division, Department of Research Monitoring and Evaluation
Nigeria	Project Director, PMU, Global Fund Projects, NACA
Nigeria	NASCP GF PMU Lead
Nigeria	M & E Lead
Nigeria	FGD
Kosovo	HIV lead within the National Institute of Public Health (NIPHK)
Kosovo	CCM chair – Deputy Minister of Health
Kosovo	Grant manager within Community Development Fund (CDF)
Kosovo	M&E Officer for HIV/ AIDS
Kosovo	FGD
Madagascar	CCM Chair – Directeur du CICM
Madagascar	Grant manager within Population Services International (PSI HQ)
Madagascar	HIV focal point within the Ministère de Santé Publique (Madagascar)
Paraguay	Grant manager within Centro de Information y Recursos para el Desarrollo (CIRD)
Paraguay	national focal point within the Programa Nacional de Control de VIH/SIDA/ITS which is part of the Ministerio de Salud Publica y Bienestar Social PRONASIDA
Paraguay	FGD
Mozambique	CCM Chair Executive Secretary of National AIDS Council
Mozambique	Grant manager within Fundacao para o Desenvolvimento da Comunidade (FDC)
Mozambique	Grant manager within Ministry of Health (MISAU)
Tanzania	Program Officer PMU, Ministry of Finance
Tanzania	Director Health Services CSSC
Tanzania	M & E Officer

Tanzania	KVP Advisor
Tanzania	Head of HIV AIDS Prevention
Tanzania	Director National Response
Tanzania	FGD
Zimbabwe	M&E Director within the National AIDS Council (NAC)
Zimbabwe	CCM Vice Chair
Zimbabwe	Grant manager within UNDP
Zimbabwe	MOHCC programme Manager
Zimbabwe	FGD
Eswatini	FGD
Eswatini	FGD
Eswatini	Director of Strategic Information, NERCHA (representing HIV Program Director)
Eswatini	M&E manger NERCHA
Eswatini	M&E Manager CANGO
Eswatini	Grant manager within the Coordinating Assembly of Non-Governmental Organization (CANGO)
Eswatini	Eswatini World Vision- GF Sub Recipient - Program Manager
Eswatini	National M&E officer, Ministry of Health
Eswatini	Director of Programs CANGO

6. List of documents reviewed

Summary of grants, countries, and documents reviewed

Number of Grants	Number of Countries (listed below)	Number of Documents
101	116	1,559

Selective list of documents reviewed (list is too long to attach)

Documents
Country Dialogue Narrative
Detailed Budget
Funding Landscape Table TB
Funding Request Form
National Strategic Plan HIV
Programmatic Gap Table HIV
Secretariat Briefing Note
TRP Review and Recommendation Form Applicant
Essential Data Table
Funding Priorities from Civil Society and Communities Annex
Human Rights Assessment
PAAR Review Template with TRP Recommendation
Performance Framework

Prioritized Above Allocation Request PAAR
Sustainability and Transition related Documentation
TRP Review and Recommendation Form Secretariat
Funding Landscape Table HIV
Programmatic Gap Table TB HIV
PAAR Update

116 (including countries listed in the 4 Multi-Country grants and excluding Zanzibar which is part of Tanzania)

Unit of Analysis	Number of Countries
Afghanistan	1
Angola	1
Armenia	1
Azerbaijan	1
Bangladesh	1
Belarus	1
Belize	1
Bhutan	1
Bolivia	1
Botswana	1
Burkina Faso	1
Burundi	1
Cabo Verde	1
Cambodia	1
Cameroon	1
Central African Republic	1
Chad	1
Colombia	1
Congo	1
Congo, Democratic Republic	1
Costa Rica	1
Dominican Republic	1
Ecuador	1
Egypt	1
El Salvador	1
Equatorial Guinea	1
Eritrea	1
Eswatini	1
Ethiopia	1
Gabon	1
Gambia	1
Georgia	1
Ghana	1
Guatemala	1

Guinea	1
Guinea-Bissau	1
Guyana	1
Haiti	1
Honduras	1
India	1
Indonesia	1
Iran	1
Jamaica	1
Kazakhstan	1
Kenya	1
Kosovo	1
Kyrgyzstan	1
Lao	1
Lesotho	1
Liberia	1
Madagascar	1
Malawi	1
Malaysia	1
Mali	1
Mauritania	1
Mauritius	1
Moldova	1
Mongolia	1
Montenegro	1
Morocco	1
Mozambique	1
Multi Caribbean	0
Multi MECA	3
Multi Middle East	5
Multi Western Pacific	12
Myanmar	1
Namibia	1
Nepal	1
Nicaragua	1
Niger	1
Nigeria	1
Pakistan	1
Papua New Guinea	1
Paraguay	1
Peru	1
Philippines	1
Russia	1
Rwanda	1
Sao Tome and Principe	1
Senegal	1

Serbia	1
Sierra Leone	1
Somalia	1
South Africa	1
South Sudan	1
Sri Lanka	1
Sudan	1
Suriname	1
Tajikistan	1
Tanzania	1
Thailand	1
Timor-Leste	1
Togo	1
Uganda	1
Ukraine	1
Uzbekistan	1
Venezuela	1
Viet Nam	1
Zambia	1
Zanzibar	0
Zimbabwe	1
Grand Total	**116**

7. POMT toolkit

The POMT toolkit includes a checklist and a survey to identify the stage of POMT implementation in each country and to explore in more detail the specific implementation progress across the sampled countries.

a. POMT checklist

A. Country details

1. Name of country:
2. Stage of POMT:
    a. I – Preparatory stage (preliminary discussions)
    b. II – Protocol development (early)
    c. III – Protocol development (advanced i.e., feedback on protocol has been received)
    d. IV – Protocol implementation (pre-test)
    e. V – Protocol implementation (actual)
        i. V-a – Data has been collected
        ii. V-b – Data has been analyzed
        iii. V-c – Results have been disseminated

B. Preparation for uptake of POMT

3. There is evidence of in-country discussions (with/ without Global Fund involvement) on the importance/ need of undertaking prevention outcome monitoring and potential implementation of one of the methods included in the toolkit (minutes from meetings, correspondences, meetings' reports): Y/ N

C. Protocol documentation: (applicable for countries that have attained stage III and above)

4. An outline of who was involved in the development of the protocol has been provided: Y/ N
5. Methodology (BBS Lite/ RCS/ PBS) adopted mentioned: Y / N
6. Rationale for methodology adopted explained: Y / N
7. The target population for routine monitoring has been defined: Y / N
    a. Age group(s) of the target population has been described: Y / N
8. The sampling strategy (programme-based / population-based) has been explained: Y / N
9. The sampling approach (probability/ non-probability) has been described: Y / N
10. Rationale for sampling approach has been provided: Y/ N
11. The sample size calculation approach has been explained: Y / N
12. The geographical locations for routine prevention outcome monitoring have been listed: Y / N
13. Rationale for the geographical locations for routine prevention outcome monitoring has been provided: Y / N
14. The staff to conduct routine data collection have been designated: Y / N
15. Methodology (quantitative/ qualitative/ mixed methods) has been described: Y / N
16. Rationale for the methodology has been provided: Y/ N
17. Data collection methods have been described: Y / N
18. Approach to training for data collection has been described: Y / N
19. Questionnaire includes questions collecting data on:
    a. Biomedical outcomes (use of HIV prevention services, including consistency of use): Y / N
    b. Behavioral outcomes (HIV risk behaviors): Y / N
    c. Structural outcomes: Y / N
20. Whether ethical approval is required is indicated: Y / N
21. Rationale for whether ethical approval is required or not has been provided: Y/ N
22. Informed consent process has been described: Y / N
23. Rationale for whether informed consent is required has been provided: Y/ N
24. Measures for data security and confidentiality have been described: Y / N
25. Planned duration of data collection has been defined: Y / N
26. Planned data management and analysis approach has been explained: Y /N
27. Rationale for the selected data analysis approach has been provided: Y/ N
28. Estimated cost of the activity has been documented: Y / N
29. The source of funds for the implemented has been indicated: Y/ N
30. Methodology limitations have been described: Y / N

D. **Implementation process** (applicable for countries that have attained stage IV and above)

31. The findings from the POMT method used have been documented: Y/ N

E. **Data reporting and use (**applicable for countries that have attained stage IV and above)

32. The findings from the POMT method used have been documented in a report: Y/ N
33. Plans for (further) capacity building of PRs, SRs, national programme staff to implement routine HIV prevention outcome monitoring and utilize the information to make evidence-informed decision have been described: Y / N
34. Proposed methods for results dissemination/ review/ sharing and learning have described (e.g., peer-review forums, evidence/ policy briefs,): Y / N
35. Approaches for how the data from the prevention outcome monitoring will used have been described (e.g., for strategic reprogramming; national strategic plan development/ updates, funding requests development): Y/ N

F. **Sustainability** (applicable for countries that have attained stage IV and above)

36. The frequency for routine prevention outcome monitoring data collection has been defined: Y / N
37. A plan for integration of the POMT approach(es) into the country's MEL system has been described: Y / N
38. A plan to ensure resource mobilization to support prevention outcome monitoring activities has been described (e.g., a costed M&E plan, inclusion of resource mobilization for HIV prevention outcome monitoring activities within national strategic plans for HIV programs): Y/ N

b. POMT survey

Survey questions on Prevention Outcomes Monitoring Toolkit (POMT) implementation
Note: Only questions with (*) are compulsory

A. **Country details**

1. What is the name of your country*?
2. In GC7, the Global Fund has promoted the implementation of the Prevention Outcome Monitoring Toolkit (POMT) for PRs/SRs to get better insights into the results of their prevention activities. The POMT includes the (i) BBS-Lite, (ii) Rapid Coverage Survey (RCS) and (iii) Polling Booth Survey (PBS) methodologies. Have you been involved in any discussions / work around this*? **Y/ N / other; if "other" please provide details**
   (If your response here is a **N**, kindly end the survey; thank you for your time)

3. What is your organizational affiliation? State / non-State; GF PR / SR; other (please provide details)
4. At what stage of POMT implementation has your country progressed*?
   a. I – Preparatory stage (preliminary discussions)
   b. II – Protocol development (early)

c. III – Protocol development (advanced i.e., feedback on protocol has been received)
d. IV – Protocol implementation)
    i. Pre-test
    ii. Early - Data collected
    iii. Intermediate – Data analysis and report development
    iv. Advanced – Report development; feedback on the report has been received
e. V. Report disseminated and/ or results presented to stakeholders
f. VI. Repeating implementation of prevention outcomes monitoring
g. I do not know

B. Experience with POMT implementation

5. How would you describe your experience in undertaking the following steps in the POMT development process (respond to the relevant questions based on the development stage):
    a. Preliminary discussions:
        i. Have there been discussions on the importance of undertaking prevention outcome monitoring? **Y/ N/ Don't know/ Other (if other, please provide details)**
            - Which stakeholders were involved in the discussions?
        ii. Have you attended any presentations by the Global Fund on the Prevention Outcome Monitoring Toolkit (e.g. virtual, Botswana workshop September 2024)? **Y/ N/ Other (if other, please provide details)**
    b. Protocol development (*short text answer questions*):
        i. Who was involved in drafting the protocol?
        ii. Were the Global Fund POMT guidelines and methods-specific guidance documents used for the protocol development?
        iii. How useful were the Global Fund POMT guidelines and methods-specific guidance documents for the protocol development?
        iv. Did the country PR or SR receive technical support for protocol development? **Y/ N/ Don't know/ Other (if other, please provide details)**
            - If yes, who provided the support?
            - If yes, what was the source of funding for the protocol development?
        v. Was feedback received on the protocol? **Y/ N/ Don't know/ Other (if other, please provide details)**
            - If yes, who did this feedback come from?
    c. POMT implementation
        i. Which method has the country adopted (BBS Lite / RCS / PBS /Don't know / Other; if other, please provide details)?
        ii. What was the rationale for the chosen method?
        iii. Who was involved in the data collection?
        iv. Who was involved in the data analysis and reporting?
        v. Who was the source of funding for data collection?
        vi. Who was the source of funding for data analysis and reporting?
        vii. Was there support for data analysis and reporting? **Y/ N/ Don't know/ Other (if other, please provide details)**

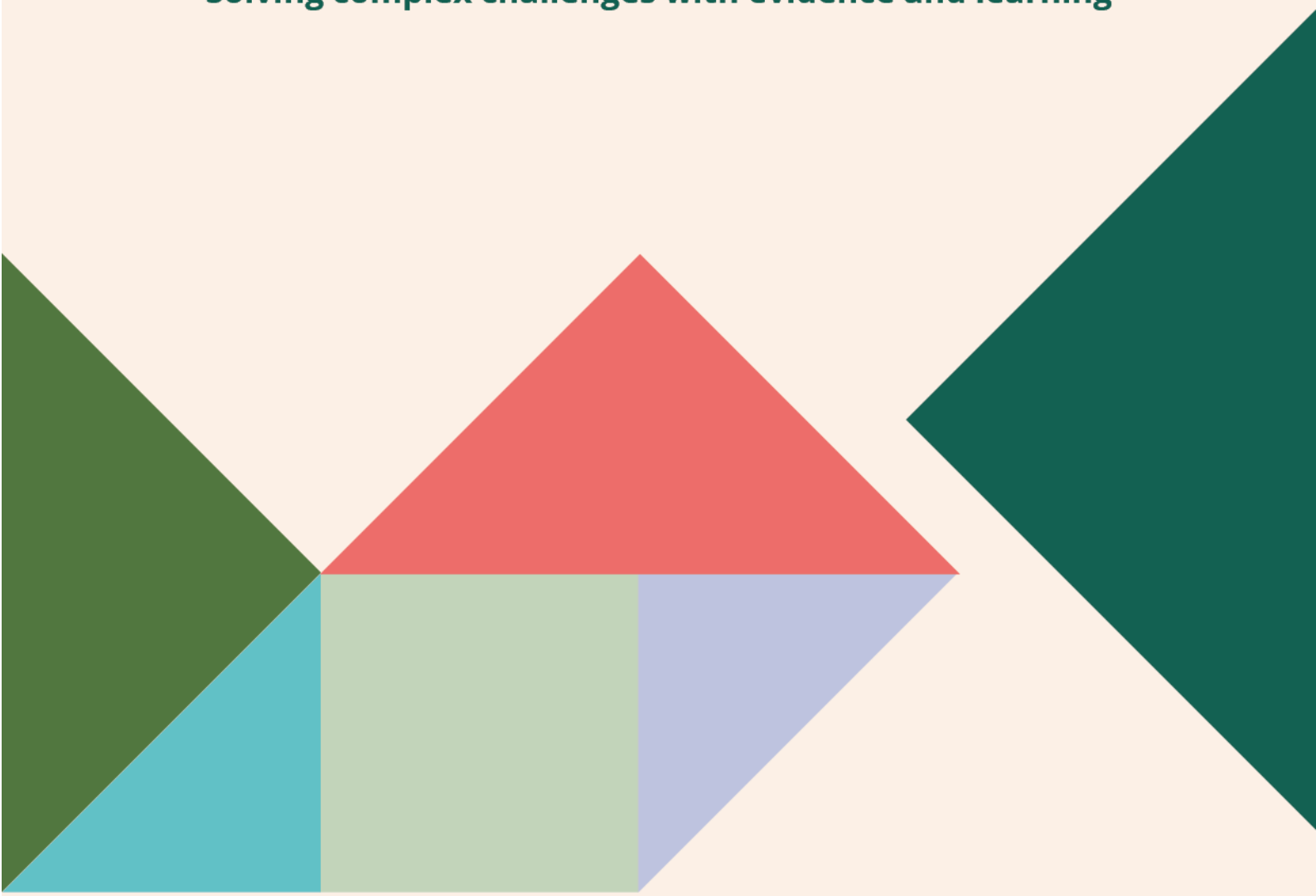
viii. Are there plans to automate the data analysis process? **Y/ N/ Don't know/ Other (if other, please provide details)**
ix. Has a report on the POMT implementation been drafted? **Y/ N/ Don't know/ Other (if other, please provide details)**
x. Has feedback on the report been received? **Y/ N/ Don't know/ Other (if other, please provide details)**
- If yes, who did this feedback come from?

**** If at the stage of disseminating results:**

d. Dissemination and utilization of the prevention outcome results:
   i. Have the results been disseminated e.g. report shared, results presented to stakeholders? **Y/ N/ Don't know/ Other (if other, please provide details)**
   ii. Who were the target audience(s) for the dissemination?
   iii. What will the results be used for?

6. How would you describe the following aspects of the prevention outcome monitoring toolkit implementation process:
   a. Relevance (aligned with the program and national goals)
   b. Feasibility (possible to implement within the program)
   c. Efficiency (does not demand heavy resource investment – money, time, human)
   d. Effectiveness (generates the expected results on status of prevention outcomes)
   e. Sustainability (has the likelihood of continuing to be implemented by the program)
   f. Challenges – e.g., sudden changes in bilateral funding priorities, Global Fund reprioritization process
7. Which areas of implementing the POMT method used:
   a. Worked well?
      i. What were the facilitators of success?
   b. Did not work well?
      i. What were the key barriers?
   c. Are there plans to repeat the POMT implementation?
      i. How frequently?
      ii. Will it be the same method previously used? **Y/ N/ Don't know/ Other (if other, please provide details)**
      iii. If No, what is the reason for changing the methods?
8. What recommendations would you provide moving forward?
   a. How can the POMT approach be adapted further considering funding constraints?

Solving complex challenges with evidence and learning



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Endnotes

i 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

ii The Global Fund to Fight AIDS, Tuberculosis and Malaria, "Eligibility & Allocations," Global Fund Archive, accessed November 25 2025, https://archive.theglobalfund.org/eligibility-allocations/

iii The Global Fund to Fight AIDS, Tuberculosis and Malaria, Modular Framework Handbook: A Tool for Grant Design and Development, https://resources.theglobalfund.org/media/13907/cr_modular-framework_handbook_en.pdf. (Webpage archived)

iv The Global Fund to Fight AIDS, Tuberculosis and Malaria, Measurement Guidance for Global Fund Supported HIV Prevention Programmes, 1 August 2022 (updated 27 March 2024), https://resources.theglobalfund.org/media/13909/cr_me-measurement-hiv-prevention-programs_guidance_en.pdf