Technical Evaluation Reference Group: Thematic Review on HIV Primary prevention

TERG Position Paper, Management Response and Final Report

May 2021

Technical Evaluation Reference Group: Position paper on the Thematic Review on HIV Primary Prevention

MAY 2021

The Global Fund

Executive Summary

Context

The thematic review on HIV primary prevention was commissioned by the Technical Evaluation Reference Group (TERG), as part of its 2020 workplan as approved by the Strategy Committee (SC) of the Board. The overarching aim was to focus on **what the Global Fund can do differently in order to improve and strengthen its support to HIV primary prevention programs** and support countries in taking HIV prevention programs to scale. The TERG considered a thematic review on HIV primary prevention would be timely to inform the development of the Global Fund's new strategy and improvements in its business model as well as to provide inputs into the global discussion on HIV prevention as of the end of 2020.

Questions this paper addresses

The paper provides the TERG's position on the key findings and recommendations from the HIV prevention review report. The paper is intended to help prioritize recommendations and advance the design, implementation and impact of HIV prevention investments.

Review conclusions and recommendations

The review highlights that new HIV infections in countries supported by the Global Fund have fallen by 44%. Increasingly, the Global Fund has been playing a critical stewardship role for HIV primary prevention at the global level. There have also been a number of substantial achievements and improvements over the new funding model 2 (NFM2) cycle.

Building on the review's findings, conclusions and discussions with the Global Fund Secretariat and the TERG, the thematic review lists **nine recommendations** in three areas: **(i) Global Fund funding, capacity and systems; (ii) facilitating country programming and implementation; and (iii) M&E and partnerships**. All conclusions from the HIV primary prevention report are listed below in part 2 of this document within Table 1. The Review high level recommendations are listed in annex 5 (**see more detailed recommendations in the report; pages 72-80).**

TERG Position

The TERG broadly endorses the review's key findings and high-level conclusions and commends the progress demonstrated. The TERG also agrees that, moving forward, the Global Fund should aggressively prioritize some recommendations in order to accelerate the reduction of HIV incidence (in part 3).

While acknowledging the progress and improvements achieved, the TERG has identified several key issues repeated across the report for priority attention, including some long-standing challenges not unique to HIV prevention programming. The TERG notes a lack of a conceptual framework, which would need to set out the impact that the Global Fund wants to achieve with its investment, in line with global goals and objectives and guidance by technical partners. This should be done with an overarching Global Fund monitoring and evaluation framework to address current gaps in the system. The need for a conceptual framework should be applicable for all areas of Global Fund work, not just HIV prevention, to clarify how investments will be prioritized to implement the new Strategy.

The TERG has identified five main recommendations[1], out of the nine made in the report, to be given priority attention by the Global Fund in order to accelerate the reduction of HIV incidence (see more on table 2 and annex 4). For clarity, the TERG has further qualified and categorised these recommendations into six areas based on strategic/policy; operational/tactical and technical/programmatic domains. These identified priority recommendations call for the Global Fund's prioritization of a) funding for HIV prevention; b) developing a conceptual framework for better coordination and clarity of direction on HIV prevention; c) consideration of the balance of prescriptiveness of Global Fund technical guidance; d) developing well-defined approaches to support funding request and grant making for HIV primary prevention; e) ensuring greater prioritization of HIV prevention funding decisions in national strategic plans (NSPs); and f) enhancing TA for HIV prevention implementation.

Input Received

The scope of work and the evaluation questions were developed by the TERG after extensive consultations with the Global Fund Secretariat, the SC, and technical partners such as WHO, UNAIDS and GPC Secretariat. This review was conducted with substantial contributions from the Global Fund Secretariat. Further, during key phases of the review, relevant external partners and stakeholders fed into the review.

The review was challenged due to the COVID-19 pandemic. Despite this, the review contains a wealth of very detailed and rich evidence obtained through a mixed method and theory based analytic approach.

[1] The TERG identified five recommendations from the nine proposed by the consulting team, but this was expanded to six in this position paper (recommendations a-f) due to the categorization of the recommendations into strategic, operational and technical priorities. The recommendations identified include; 1, 2, 4, 7 and 8.

Report

Part 1: Background

1. The Technical Evaluation Reference Group (TERG) commissioned the thematic review on HIV primary prevention. The scope of work and evaluation questions were developed in consultation with the Strategy Committee (SC), the Secretariat, as well as relevant technical partners, such as WHO, UNAIDS, and the Global Prevention Coalition (GPC) Secretariat. The review had four main objectives:
    - better inform Global Fund policies, guidance and suggestions regarding the funding of HIV prevention for country dialogue and funding request processes and grant management practices;
    - clarify needs for TA for design of prevention strategies as the basis of funding requests and make recommendations for how these should be addressed;
    - provide an in-depth understanding of the funding landscape for primary HIV prevention and the relative prioritization of prevention at the country levels, and the Global Fund's role in supporting these efforts alongside partners (domestic and international donors), and make recommendations for future; and
    - provide inputs to the development of the next Global Fund strategy as well as to share lessons learned to inform key Global Fund partners (*e.g.*, UNAIDS, United States government (USG) / PEPFAR, etc.).

2. The overarching aim of the review was to focus on **what the Global Fund can do differently in order to improve and strengthen its support to HIV primary prevention programs** and support countries in taking HIV prevention programs to scale.

3. This review applied a mixed method approach with eight country case studies (Botswana, Côte d'Ivoire, Ethiopia, Indonesia, Jamaica, Philippines, South Africa and Ukraine) and a portfolio analysis of the 25 GPC countries with Global Fund grants. As the COVID-19 pandemic has evolved, the review needed to be adjusted, including remote country case studies leading to a reduced level of insight. The impact of COVID-19 on prevention programs is currently unknown, therefore affecting the assessment of likelihood of scale up, among others. The review has encountered limitations in the quality and comprehensiveness of available data, including: lack of domestic and limited international donor funding data on HIV primary prevention; potential misclassification of interventions against the modular framework in Global Fund budget and expenditure data; budget data availability (only until end-2019) for absorption rate analysis; and differences in classifications, grant length, modular frameworks, as well as incompleteness of data making comparison across time periods challenging.

Part 2: Conclusions and Recommendations from the HIV primary prevention Review Report

4. The review's key findings span three domains: "Global Fund funding, capacity and systems; facilitating country programming; and implementation and M&E and partnerships". In conclusion, the review highlights that new HIV infections in countries supported by the Global Fund have fallen by 44%. The Global Fund has increasingly been playing a critical stewardship role for HIV primary prevention at the global level, due in part to being the second largest donor for HIV

prevention. There have been a number of substantial achievements and improvements during new funding model (NFM) 2:

- "Increased prioritization, with the proportion of Global Fund funding allocated to HIV primary prevention of total HIV funding increasing from 10.8% in 2015-2017 to 13.3% in 2018-2020. The Global Fund has introduced some key initiatives emphasizing HIV primary prevention, with several types of catalytic investments (strategic initiatives, multi-country funding and matching funding)".
- "There has been a noted trend in Global Fund leadership and technical staff being more committed to supporting primary prevention, positioning the organization as an active supporter of this area of work within the donor landscape. Further, the Global Fund has played an improving and more active role in the GPC (Global Prevention Coalition) and other HIV prevention fora over time, which supports its prominence in the HIV primary prevention agenda".

5. Furthermore, progress has been made in terms of country grants and HIV prevention interventions supported by the Global Fund as follows: (i) better targeting of interventions and higher impact interventions being included in grants; and (ii) HIV prevention interventions included in funding requests have been well aligned with national strategic plans (NSPs), highlighting the importance of quality NSPs and other relevant strategies in influencing Global Fund supported-prevention programs given the Global Fund's country-led approach.

6. Despite long-term reductions in new infections overall, progress has not been uniform, and the global target for a 75% reduction in new infections by 2020 has been missed. In addition, countries are failing to meet global coverage targets for comprehensive HIV prevention services, including for key populations (KPs). These trends indicate that greater prioritization and improved implementation are needed to ensure efforts are effective in achieving results, including addressing societal and legal barriers that create environments where people are at risk of HIV infection may not feel safe to utilize health services.

7. The review has drawn high level conclusions in relation to the findings across the four main objectives and identified nine recommendations that span across strategy/policy, operational/tactical and technical/programmatic aspects, as detailed in Table 1 below.

Table 1: HIV primary prevention High-level Conclusions

Key Areas	High level conclusions
Impact	The review highlights that new HIV infections in countries supported by the Global Fund have fallen by 44%. Yet despite these long-term reductions in new infections overall, progress has not been extensive and uniform, and the global target for a 75% reduction in new infections by 2020 has been missed. In addition, countries are failing to meet global coverage targets for comprehensive HIV prevention services, including for KPs. These trends underline the fact that despite a global recognition of the importance of HIV primary prevention for eliminating HIV/AIDS, greater prioritization and improved implementation are needed to ensure efforts are effective in achieving results**.**

Business model	• With the drive from Global Fund leadership to prioritize HIV primary prevention, there has not been concomitant adequate operationalization across Secretariat teams and in Global Fund processes; • Given the complexity of the prevention interventions, there are deep concerns in grant making stage whether there are adequately standardized and transparent approaches to ensure prioritization of HIV prevention and quality programming; • Implementation issues: There are a number of challenges resulting in less than effective implementation of HIV prevention interventions within Global Fund country grants, including the relatively slower use/ absorption of funds.
Investment/Funding for HIV primary prevention	• The Global Fund has increasingly been playing a critical stewardship role for HIV primary prevention at the global level, due in part to being the second largest donor for HIV prevention. This has led to a number of significant achievements and improvements over the previous allocation period (NFM2); • The introduction of some key initiatives by the Global Fund emphasizing HIV primary prevention, *i.e* several types of catalytic investments (strategic initiatives, multi-country funding and matching funding), have been key for HIV primary prevention investments being included in grants, although the quality of the focus of the interventions could be improved.

8. The recommendations suggest approaches for strengthening implementation during the remaining period of the current strategy (quick wins) and for consideration in the development of the next strategy. **The review highlights the following as mission critical to the Global Fund to accelerate its impact on HIV incidence (see Review high summary recommendations and responsibility in annex 5):**
   - **Priority recommendations** (and/or sub-points within recommendations) that the Global Fund should action immediately include:
     Recommendation 1: Further accelerate the momentum achieved for HIV primary prevention within the Global Fund, in terms of funding as well as capacity, specifically on "development of a conceptual framework and its socialization across the Global Fund Secretariat and Board" as "an obvious starting point to enhance effectiveness of funding";
     Recommendation 2: Critically consider select enhancements and deviations from the standardized Global Fund application, approval and reprogramming processes to support strategic investments and programming for HIV primary prevention, in particular on "needed enhancements to the Global Fund application cycle", which is "pure systems/ process issue, which is within the Global Fund's direct purview"; and
     Recommendation 5: Introduce relevant measures to support more effective implementation of HIV primary prevention interventions at the country level, specifically "measures to support more effective implementation of HIV prevention interventions within grants".
   - **Recommendations for impact** relate to
     Recommendation 4: Work with partners and country stakeholders to support more effective and quality programming for HIV primary prevention; and

Recommendation 5: Introduce relevant measures to support more effective implementation of HIV primary prevention interventions at the country level, particularly on "enhancing the quality of programming for HIV primary prevention and the effective implementation of grants respectively. A first step would be for the Secretariat to consider a detailed implementation plan for actioning these aspects".

- **Recommendations relevant to take forward with its core partners** include *Recommendation 7: Continue efforts towards bringing about greater coordination and visibility of TA for HIV prevention, and enhance TA for several unmet needs*; and *Recommendation 8: Introduce improvements in M&E for HIV primary prevention, aligning with partner work in this area*, where "Global Fund's partners would need to take a lead role, with support and/or facilitation (as appropriate) from the Global Fund".

Part 3: TERG POSITION

9. The TERG broadly endorses the review's key findings and the high-level conclusions and commends the Global Fund's progress and improvement in HIV primary prevention identified and demonstrated by the review.

10. The TERG also **agrees that moving forward cannot be business as usual** and the Global Fund should aggressively prioritize some recommendations in order to accelerate the reduction of HIV incidence. It is clear that in recent years progress in the reduction of HIV incidence has been slow and uneven. The TERG is of the clear view that Global Fund's strategy, key processes, policies and investments should be strengthened in order to accelerate the reduction of HIV incidence.

11. The TERG has identified several key issues repeated across the report for priority attention, including some long-standing challenges that are not unique to HIV prevention programming. These include:
    - "During grant implementation, the Global Fund has relatively limited mechanisms for quality assurance/ quality improvement of Global Fund-supported HIV prevention interventions".
    - "Although there has been a greater focus on the provision and coordination of TA by the Global Fund (*e.g.* through the Strategic Initiatives) to address issues related to HIV prevention, there has been limited TA[2] to support grant implementation and lack of multi-sectoral and up-to-date TA".

12. At the country level, there are a number of challenges including:
    - "Grant design and scale-up including (i) limited resources, particularly domestic funding; (ii) structural barriers (e.g. human rights and legal or policy barriers) as well as political barriers (e.g. a lack of political will and commitment, especially to the needs of key and vulnerable populations (KVPs); (iii) inadequate guidance and technical assistance (TA); (iv) insufficient prioritization of HIV prevention in national strategic plans (NSPs)[3] and related strategies as well as limited availability of data and analyses; and (v) whilst improvements have been made with regards to prioritization of KVPs, there continue to be challenges with most appropriate targeting of resources to populations most in need as well as programming of effective interventions".

[2] See TERG thematic review on partnerships, 2019.
[3] See SR 2020 report.

- "Measuring progress of HIV prevention interventions such as difficulty estimating population sizes of KVPs, limited availability of disaggregated data (e.g. by KVP group), issues with double counting of beneficiaries given confidentiality concerns and there is a focus on outputs/ coverage indicators, rather than measuring prevention-related outcomes and achievements".

13. The TERG also notes a lack of a conceptual framework that sets out the strategic and technical vision and plan for Global Fund investments in HIV primary prevention to implement the overall Global Fund Strategy.

14. The TERG in large part endorses the recommendations, which stem from the conclusions and key findings, with some explanations and clarifications discussed below.

15. Of the 9 main recommendations with 36 sub recommendations proposed by the Review, **the TERG has identified five main recommendations[4] with fourteen sub-recommendations to be given priority attention by Global Fund in order to accelerate the reduction of HIV incidence** (table 2 below)**.** The TERG has further qualified and merged some recommendations. For clarity**,** these recommendations are merged and categorized by the TERG into **strategic/policy; operational/tactical and technical/programmatic domains**.

Table 2. Mapping of TERG and Consultant's recommendations

Recommendation Domains	TERG recommendations	Review recommendations	Time frame
Strategic/Policy	a. Prioritize and increase HIV prevention funding.	Recommendation 1 (i)	Mainly for the new strategy
	b. Develop conceptual framework on HIV primary prevention.	Recommendation 1 (ii) and Recommendations 8 (i,ii)	For the new strategy
Tactical/Operational	c. Consider the balance of prescriptiveness of technical guidance.	Recommendation 2 (i) and recommendation 4 (i)	Mainly for the new strategy
	d. Develop well-defined approaches to support funding request and grant making for HIV primary prevention.	Recommendation 2 (ii-1v)	Mainly for the new strategy
Technical/ Programmatic	e. Ensure greater prioritization of HIV prevention funding decisions in NSPs.	Recommendation 4 (ii,iii,iv)	Mainly for the new strategy, and immediately where applicable
	f. Enhance TA Coordination and visibility for implementation of HIV primary prevention programs.	Recommendation 7 (i, ii)	Start as soon as possible

[4] The TERG identified five recommendations from the nine proposed by the consulting team, but this was expanded to six in this position paper (recommendations a-f) due to the categorization of the recommendations into strategic, operational and technical priorities. The recommendations identified include; 1,2,4,7 and 8.

Strategic/policy priorities

16. The TERG recommends **the Global Fund Board and Secretariat enhance the strategic and policy priorities** in the following ways:

a. **Prioritize and increase HIV prevention funding.**

Recommendation 1 (i): "Further accelerate the momentum achieved for HIV primary prevention within the Global Fund, in terms of funding and organizational framework".

Continue to prioritize and increase HIV prevention funding, including the use of targets, recognizing that collective targets will never be achieved if the allocation within the Global Fund is far below the target unless other financiers support significant high investment in HIV primary prevention. Given low absorption in HIV prevention funding in many contexts, the TERG strongly suggests, in addition to country allocations and increasing use of strategic and catalytic mechanisms, setting a target and incentivizing better use of prevention funding, e.g., encourage countries to include more prevention in their prioritized above allocation request (PAARs), noting their success to date in increasing funding for prevention, and continue to use portfolio optimization (PO) to increase investment in this area.

Timeline for implementation: The component on funding is a long-term concerted effort, including for the next strategy period, and the area on PAAR and PO can be immediately implemented as "quick wins".

b. **Develop conceptual framework on HIV primary prevention.**

Recommendation 1(ii): "Further accelerate the momentum achieved for HIV primary prevention within the Global Fund, in terms of funding and organizational framework" and recommendation 8 (i,ii): "Introduce improvements in M&E for HIV primary prevention"

To further underpin the **recommendation d** and facilitate grant making and implementation for technically sound HIV primary prevention**, an overarching conceptual framework should be developed and used in the Global Fund,** and technical capacity should be further developed accordingly. Such a conceptual framework could set out the strategic and technical vision and plan for prioritization of Global Fund investments in HIV primary prevention and situate these investments in the context of the whole investment portfolio. This would in turn inform the implementation of the new Global Fund Strategy and align with global goals and objectives[5] and guidance by technical partners. This should be done in tandem with the establishment of an overarching Global Fund monitoring and evaluation framework to address current gaps in the system. The Global Fund's position and guidance on HIV primary prevention should be understood and uniformly communicated across the Secretariat and stakeholder.

The TERG highlights the needs for a conceptual framework may be applicable for all areas of Global Fund work to clarify how investments will be prioritized to implement the new Strategy.

Timeline for implementation: Developing a conceptual framework for better coordination and clarity of direction for HIV prevention by the Global Fund should be tied to the next strategic period.

c. **Consider the balance of prescriptiveness of technical guidance.**

[5] See World AIDS Day report/UNAIDS

Recommendation 2(i): "Critically consider feasible enhancements and deviations from the standardized Global Fund application, approval and reprogramming processes to support strategic investments and programming for HIV primary prevention and recommendation 4(i) on improving existing guidance"

Recognizing that country ownership is at the heart of the Global Fund business model, the Board should consider **the balance of prescriptiveness of guidance for countries**, including in the new Strategy. While implementers are allowed to use grants for high impact interventions, the scope and definitions of high impact interventions should be further specified to include HIV primary prevention in various contexts, with more *directive/prescriptive guidance and stronger language*, building on available partner guidance but being clearer on what would be funded through Global Fund monies.

Timeline for implementation: For better deliberation on this recommendation by the Board, implementation can commence in the next strategic period. If positively considered by the Board this recommendation could commence implementation in this strategic period.

Tactical/ operational priorities

d. **Develop well-defined approaches to support funding request and grant making for HIV primary prevention.**

Recommendation 2(ii-iv): "Critically consider feasible enhancements and deviations from the standardized Global Fund application, approval and reprogramming processes to support strategic investments and programming for HIV primary prevention."

Recognizing the importance of keeping HIV prevention components and their budgets distinct during grant making, the TERG strongly suggests to the Global Fund Secretariat to **include in funding requests for TRP review further details, or even a checklist, on intervention design and implementation planning** for HIV prevention, alongside ensuring alignment of TRP review with partner guidance. Similarly, **well-defined approaches to support country teams during the grant making stage will ensure the organization-wide priority is reflected across country grants**. Options could range from developing detailed operational guidance to support grant making, by introducing additional checks during this stage by Secretariat staff with strong expertise in HIV prevention or the TRP. The Global Fund can also develop well-defined approaches to support reprogramming of prevention grants in order to ensure that the priority for prevention is retained.

Timelines: There are a mix of recommendations here including some that would need to be implemented for the next strategy and funding cycle (e.g on guidelines) and others that may be considered already (e.g with regards to outstanding country applications for the current funding cycle as well as those that have been approved already.

Technical/programming priorities

e. **Ensure greater prioritization of HIV prevention funding decisions in NSPs.**

Recommendation 4 (ii,iii,iv): "Work with partners and country stakeholders to support more effective and quality programming for HIV primary prevention".

The TERG agrees with the review's conclusion that one of the critical barriers to achieving better impact on HIV incidence relates to country level issues in terms of effective and quality

design and implementation of programs. The TERG strongly suggests that the **Global Fund amplify its support and facilitation for countries to develop evidence-informed NSPs and related multi-sectoral plans with the help of partners (both in-country and global, *e.g.*, through the provision of TA).** These NSPs should ensure that they properly and adequately reflect HIV prevention issues, including addressing availability of quality data on where new infections are arising, as there is still very little disaggregated incidence data reflected in NSPs. Building on past TERG recommendations[6],[7] this can be operationalized by the Global Fund financing and supporting data collection on specific populations and triangulating to determine "who is at highest risk" *i.e.*, who will benefit the most from prevention interventions. In some countries this is due to structural barriers (e.g., denials that specific KVPs exist), therefore having much better-quality incidence and trend data is key to recommendation 4 on prioritization, particularly models of subnational incidence for adolescent girls and young women (AGYW), adolescent boys and young men (ABYM), adults >25, and behavioural survey data for key populations Further, while across NSPs there is a welcomed emphasis on meeting the needs of AGYW in contexts where they are at heightened risk (due to behavioral risk and local incidence) there are almost no interventions focusing on men and boys. This point should also be reflected in NSPs.

The TERG recognizes that this will be a country-led initiative with partner TA support, and the Global Fund has more of a facilitating and leveraging role. Also, the GF should continue to support enhanced KVP engagement through supporting capacity building of these organizations and pushing for the inclusion of Community Based Organizations (CBOs) and KVPs in the implementation, monitoring and review of HIV prevention programs. This should be based on the particular stage of the epidemic in the country.

Timeline of implementation: To be implemented immediately as additional countries apply for funding, in the context of existing grants, as well as for future funding cycles and strategy periods.

f. **Enhance TA Coordination and visibility for implementation of HIV primary prevention programs.**

Recommendation 7(i,ii): "Continue efforts towards bringing about greater coordination and visibility of TA for HIV prevention and enhance TA for several unmet needs."

The TERG appreciates that there are several ongoing initiatives and efforts to bring about improved TA coordination across grants for multiple diseases, and these efforts should continue and include HIV primary prevention as well. In addition, specifically in relation to unmet TA needs for HIV primary prevention, the Global Fund should encourage the availability of TA[8] for grant implementation and monitoring (i.e., beyond the current focus of TA, which is largely on grant design). This can be done by identifying the main implementation challenges across grants and highlighting these at the country level so that countries are encouraged to request the relevant TA support.

The TERG also agrees that the Global Fund should continue to strengthen multisectoral partnership with global and regional NGOs and other organizations (i.e.,

[6] See Strategic investment in monitoring and Evaluation GF/B28/EDP/02
[7] See Board Decision GF/B31/DP06
[8] This TA could be from non-traditional organization i.e., from global and regional NGOs and other organizations (i.e., stakeholders/ networks outside of the UN community.

stakeholders/networks outside of the UN community), and those working in the area of Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) in order to strengthen integration approaches between HIV prevention responses, Sexual and Reproductive health (SRH) services and with community health approaches, in line with the 2025 AIDS targets.

The TERG further acknowledges that developing management capacity for HIV prevention has been challenging and this has been recognized by the GPC for several years on who coordinates and runs the prevention programs at national level; as Ministries of Health tend to prioritize ART programs. However, there are no clear guidelines for who should be responsible for prevention programs of which many components are multisectoral and outside the health systems. The TERG strongly recommends that the Global Fund play an important role in supporting countries to strengthen national capacity for HIV prevention programs, coordination and delivery platforms and documenting successes with community-led networks.

Timeline of implementation: To be implemented immediately, although it would also require a concerted long-term effort.

17. While the TERG clearly understands these recommendations are multilayered requiring responsibility from the Global Fund Secretariat, multi-partners and countries, it suggests as a first step to clear actioning and implementation of these recommendations for the Secretariat to seriously consider developing an overarching conceptual framework for better coordination and clarity of direction on HIV prevention. This framework should link grant inputs, outputs and outcomes to the global targets and the change that the Global Fund wants to achieve through its investments in HIV primary prevention. For further details on the responsibility for these recommendations see below in annex 3.

Annexes

Annex 1: Relevant Past Decisions

The following summary of relevant past Board decision points is submitted to contextualize the decision point proposed above.

Relevant past Decision Point	Summary and Impact
GF/B19/DP34: Enhancing the Global Fund's Response to HIV/AIDS (May 2009)	Among other requests to the Secretariat, the Board urged it to urgently work with partners to adopt measures to identify gaps and to further improve the quality of Global Fund supported prevention, treatment, care and support including operational research to identify effective scaling up strategies to improve outcome
GF/B28/EDP/02: Strategic investment in data monitoring and evaluation. (October 2012)	The Board notes: 1. the importance of strengthened national data systems to ensure effective program implementation; demonstrate impact; and guide the optimal use of limited resources; 2. the High-Level Independent Review Panel's recommendation to focus on outcomes rather than inputs

	and to improve in-country data quality; and 3. the concerns cited in the Five-Year Evaluation and by the Technical Review Panel regarding the need to strengthen in-country data systems and capacity.
GF/B31/DP06: Special initiatives (March 2014)	1. The Board notes that a portion of sources of funds may be excluded from the allocation to Country Bands for future utilization towards initiatives that are not adequately accommodated through the allocation of resources to Country Bands (Annex 1 to GF/B27/DP7) (the "Special Initiatives"). 2. Based on the recommendation of the Strategy, Investment and Impact Committee (the "SIIC"), the Board decided that up to USD 100 million will be available over the 2014 – 2016 allocation period for the following Special Initiatives, as described in GF/B31/08A – Revision 1, in the amounts listed below: a. USD 30 million for the Humanitarian Emergency Fund; b. **USD 17 million for Country Data Systems**; c. USD 29 million for Technical Assistance for Strong Concept Notes and PR Grant-making Capacity Building; d. USD 15 million for Technical Assistance on Community, Rights and Gender; and e. USD 9 million for Enhancing Value for Money and Financial Sustainability of Global Fund Supported Programs.

Annex 2: TERG Thematic Review on HIV Primary Prevention.

The Report is attached separately.

Annex 3: Relevant Past Documents & Reference Materials

- Strategic Review 2020 (December 2020)
- TERG thematic review on partnerships, 2019

Annex 4: TERG recommendations on HIV primary prevention and responsibility

Recommendations	Responsibility
Strategic/policy priorities	
a. Prioritize and increase HIV prevention funding. Continue to prioritize and increase HIV prevention funding, including the use of targets, recognizing that collective targets will never be achieved if the allocation within the GF is far below the target unless other financiers support significant high investment in HIV primary prevention. Given low absorption in HIV prevention funding in many contexts, the TERG strongly suggests, in addition to country allocations and increasing use of strategic and catalytic mechanisms, setting a target and incentivizing better use of prevention funding , e.g., through portfolio optimization and PAAR, noting their success to date in increasing funding for prevention.	Secretariat, working with donors/ funders in particular
b. Develop a conceptual framework for HIV prevention. To further underpin the above	Secretariat

Recommendations	Responsibility
recommendation 3 and facilitate grant making and implementation for technically sound HIV primary prevention**, a conceptual framework on HIV primary prevention may be developed and used in the GF Secretariat,** and technical capacity should be further developed accordingly. Such a conceptual framework sets out the strategic and technical vision and plan for Global Fund investments in HIV primary prevention, to implement the overall Global Fund Strategy. The Global Fund's position and guidance on HIV primary prevention should be understood and uniformly communicated across the Secretariat and stakeholders.	
c. Prescriptiveness of technical guidance. Recognizing that country ownership is at the heart of the GF business model, the GF Board should consider **the balance of prescriptiveness of guidance for countries**, including in the new Strategy. While implementers are allowed to use GF grants for high impact interventions, the scope and definitions of high impact interventions should be further specified to include HIV primary prevention in various contexts, with more *directive/prescriptive guidance and stronger language*, building on available partner guidance but being clearer on what would be funded through Global Fund monies.	Secretariat with support from technical partners on guidance and TRP; if appropriate, changes to standard processes to seek approvals from the Strategy Committee/ Board.
Tactical/ operational priorities	
d. Develop well-defined approaches to support funding request and grant making for HIV primary prevention. Recognizing the importance of keeping HIV prevention components and their budgets during grant making, the TERG strongly suggests to GF Secretariat to **specify in funding requests for TRP review further details, more than a checklist, on intervention design and implementation planning** for HIV prevention, alongside ensuring alignment of TRP review with partner guidance. Similarly, **well-defined approaches to support country teams during the grant making stage will ensure the organization-wide priority is reflected across country grants**. Options could range from developing detailed operational guidance to support grant making, by introducing additional checks during this stage by Secretariat staff with strong expertise in HIV prevention or the TRP. The GF can also develop well-defined approaches to support reprogramming of prevention grants in order to ensure that the priority for prevention is retained.	Secretariat with support from TRP
Technical/programming priorities	
e. **Enhance greater prioritization of HIV prevention funding decisions in NSPs.** The TERG agrees with the review's conclusion that one of the critical barriers to achieving better impact on HIV incidence relates to country level issues in terms of effective and quality design and implementation of programmes. The TERG strongly suggests **GF to amplify its support and facilitation for countries to develop evidence-informed NSPs and related multi-sectoral plans with the help of partners (both in-country and global, e.g., through provision of TA).** These NSPs should ensure that they properly and adequately reflect HIV prevention issues, including addressing availability of quality data on where new infections are arising, as there is still very little disaggregated incidence data reflected in NSPs. Building on the past TERG recommendations**,** this can be operationalized by GF financing and supporting data collection on specific populations and triangulating to determine "who is at highest risk" i.e., who will benefit the most from prevention interventions. In some countries this is due to structural barriers (e.g., denials that specific KVPs exist), but also it seems to be due to lack of attention given to data issue over the course of a strategic plan cycle. Having much better-quality incidence and	Partner responsibility with facilitation/ support of Secretariat.

Recommendations	Responsibility
trend data is key to recommendation 4 on prioritization. Further, while across NSPs there is a welcomed emphasis on meeting the needs of adolescent girls and young women (AGYW), it appears to be missing in most NSPs the role (and responsibilities) of men and boys in driving AGYW incidence rates, with almost no interventions focusing on men and boys. This point should also be reflected in NSPs. The TERG recognizes that this will be a country-led initiative with partner TA support, and the GF has more of a facilitating and leveraging role. Also, the GF should continue to support enhanced KVP engagement through supporting capacity building of these organizations and pushing for the inclusion of CBOs and KVPs in the implementation, monitoring and review of HIV prevention programs. This should be based on the particular stage of the epidemic in the country.	
f. **Enhance TA Coordination and visibility for implementation of HIV primary prevention programs.** The TERG appreciates that there are several ongoing initiatives and efforts to bring about improved TA coordination across Global Fund grants for multiple diseases, and these efforts should continue and include HIV primary prevention as well. In addition, specifically in relation to unmet TA needs for HIV primary prevention, GF should encourage the availability of TA[9] for grant implementation and monitoring (i.e. beyond the current focus of TA, which is largely on grant design). This can be done by identifying the main implementation challenges across grants and highlighting these at the country level so that countries are encouraged to request the relevant TA support. The TERG also agrees that GF should continue to strengthen multisectoral partnership with global and regional NGOs and other organizations (i.e. stakeholders/networks outside of the UN community), and those working in the area of Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) in order to strengthen integration approaches between HIV prevention responses, SRH services and with community health approaches, in line with the 2025 AIDS targets. The TERG further acknowledges that developing management capacity for HIV prevention has been challenging and this has been recognized by the GPC for several years on who coordinates and runs the prevention programs at national level; as Ministries of Health are responsible for ART programs. However, there is no clear guidelines for who should be responsible for prevention programs of which many components are multisectoral and outside the health systems. The TERG strongly recommends GF should play an important role in supporting countries in strengthening national capacity for HIV prevention programs and delivery platforms and documenting successes with community-led networks.	Partner responsibility with facilitation/ support of Secretariat.

Annex 5

High level summary of HIV primary prevention Recommendations from the report

Recommendations	Responsibility
Global Fund funding, capacity and systems	
Recommendation 1: Further accelerate the momentum achieved for HIV primary prevention within the Global Fund, in terms of funding as well as capacity.	Secretariat, working with donors/ funders for (i) in particular

[9] This TA could be from non-traditional organization i.e., from global and regional NGOs and other organizations (i.e stakeholders/ networks outside of the UN community.

Recommendations	Responsibility
Recommendation 2: Critically consider select enhancements and deviations from the standardized Global Fund application, approval and reprogramming processes to support strategic investments and programming for HIV primary prevention. In particular:	Secretariat with support from technical partners on guidance and TRP; if appropriate, changes to standard processes to seek approvals from the Strategy Committee/ Board
Facilitating country programming and implementation	
Recommendation 3: Encourage greater prioritization and focus on HIV primary prevention at the country level, based on the evidence available.	Secretariat in conjunction with partners
Recommendation 4: Work with partners and country stakeholders to support more effective and quality programming for HIV primary prevention	Country and multi-partner responsibility with support of Secretariat
Recommendation 5: Introduce relevant measures to support more effective implementation of HIV primary prevention interventions at the country level.	Country and multi-partner responsibility with support of Secretariat
Recommendation 6: The Global Fund should consider relevant measures to encourage greater scale-up and transition of investments in HIV prevention	Country and multi-partner responsibility with support of Secretariat
Recommendation 7: Continue efforts towards bringing about greater coordination and visibility of TA for HIV prevention, and enhance TA for several unmet needs	Partner responsibility with facilitation/ support of Secretariat
M&E and partnerships	
Recommendation 8: Introduce improvements in M&E for HIV primary prevention, aligning with partner work in this area.	Secretariat in coordination with partner guidance on M&E
Recommendation 9: Continue further work on "non-traditional" and multi-sectoral partnerships.	Secretariat

Annex 6– List of Abbreviations

AGYW	Adolescent, Girls and Young Women
ART	Anti-retroviral therapy
CBO	Community based organization
COVID-19	Corona virus Disease 2019
CRG	Community, Rights and Gender
CSOs	Civil Society Organizations
FR	Funding Request
GM	Grant Making

GPC	Global Prevention Coalition
HIV	Human immunodeficiency virus
HRG	Human Rights and Gender
KPI	Key Performance Indicator
KVP	Key and Vulnerable Population
M&E	Monitoring and Evaluation
NSP	National Strategic Plan
PEPFAR	President Emergency Funds for AIDS Relief
PR	Principle Recipient
QA	Quality Assurance/quality-assured
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
RSSH	Resilient Sustainable Systems for Health
SR	Sub - Recipient
SR2020	Strategic Review 2020
SRH	Sexual and Reproductive Health
TA	Technical Assistance
TRP	Technical Review Panel
TERG	Technical Evaluation Reference Group
UNAIDS	The Joint United Nations Program on HIV/AIDS
VfM	Value for Money
WHO	World Health Organization

Secretariat Management Response -TERG Thematic Review on HIV primary prevention

Introduction

The Technical Evaluation Reference Group (TERG) is a critical component of the Global Partnership, providing independent evaluations of the Global Fund's business model, investments, and impact to the Global Fund Board through its Strategy Committee. The Global Fund values transparency and publishes TERG reports according to the TERG Documents Procedure approved by the Strategy Committee.

The Global Fund Secretariat appreciates the HIV prevention thematic review by the TERG and broadly endorses the reviews key findings, high-level conclusions, and recommendations and the TERG's Position, including the consolidation and prioritization of the recommendations. As part of the 2020-2022 allocation cycle, the Secretariat has embarked on a series of activities to accelerate momentum on HIV prevention in line with the TERG recommendations. Continued prioritization and increased investment in HIV prevention are needed to achieve more impact. However, the Secretariat also recognizes its limited span of control with respect to several recommendations (e.g. strengthen National Strategic Plans, or introduce novel incentives and conditionalities for guiding and shaping investment design and country decision making) and, given the timing of this review, many of the recommendations are more relevant for the next strategy period.

Areas of agreement

The Secretariat appreciates the TERG's acknowledgement of the progress made around the improvement in support of HIV primary prevention and the efforts that have been made to maximize impact of Global Fund investments and scale up our response in HIV primary prevention. We acknowledge that gaps and challenges remain, and that in some areas, countries are failing to meet global coverage targets for comprehensive HIV prevention services, including for key populations (KPs). These trends indicate that greater prioritization, and improved implementation and execution capability at country-level, are needed to ensure efforts are effective in achieving results. The Secretariat also acknowledges that the COVID-19 pandemic has, and will continue to, affect progress and that there will be a need to adapt and include more innovative approaches to fight HIV and strengthen HIV primary prevention, noting that prevention and testing services appear most susceptible to COVID-19 related disruptions, particularly during lockdowns.

The Secretariat broadly agrees with the TERG's prioritization of the recommendations[1] and agrees that these are mainly for consideration in the next strategy period, noting that the majority of the funding for HIV for the 2020-2022 allocation cycle has been reviewed and signed into grants which have already begun implementation. There are, however, some factors which are outside the Secretariat's direct span of control and require support and engagement from countries and/or partners. The mandate of the Global Fund is to support comprehensive effective national HIV, TB and malaria programs that include HIV prevention, care, and treatment. Treatment is powerful prevention and must also be supported. Real program data and models show that curbing HIV incidence–requires a combination of primary prevention interventions and preventative effects of high treatment coverage. The Global Fund model is country-driven and many of the issues identified in the report are best resolved at the country-level rather than Headquarters/Geneva level. In order to accelerate the results in prevention & reduction of HIV incidence, it is critical to continue to strengthen key country, CCM, grant application and implementation processes to deliver the most progress against HIV, as well as continue close coordination with partners and utilize focused catalytic funding to further incentivize investments in critical areas.

The Secretariat agrees that increased funding for HIV prevention is needed (Recommendation A[2]), however we note that this may not translate to increased Global Fund financing for HIV prevention in every country, as country context, including domestic and other donor funding, will need to be considered. While we recognize the need for primary prevention funding to increase, we would not support ring-fencing funding one element of the HIV response that is funded by the Global Fund. A combination prevention approach that includes a scale-up of both treatment and prevention (of infection) is still needed. The Secretariat believes a focus on better use of transmission dynamics data, improved program design and superior implementation – directed towards achieving effective coverage of the highest impact interventions for populations most at risk, and incentivizing sound legal and policy choices – would deliver better results for prevention. To accelerate the reduction of HIV incidence and address challenges with prevention in the next cycle, the Secretariat believes that incentive mechanisms, such as catalytic funding, strategic initiatives and targeted allocation letters provide a good approach given the limited resources. For example, in this cycle the Secretariat is using catalytic funding for two prevention-oriented Strategic Initiatives (SIs) to increase condom use and improve national condom program management and prevention support for Adolescent Girls and Young Women (AGYW). For the next strategy period maintaining these priorities and exploring additional incentives and leverage points will be emphasized.

The Secretariat agrees that the balance of prescriptiveness of technical guidance (Recommendation C[3]) is critical, but as the partnership model focuses on country decision

[1] The TERG identified five, of the nine review recommendations, for priority attention by the Global Fund to accelerate HIV incidence reductions and further categorized these recommendations into six areas based on strategic/policy, operational/tactical and technical/programmatic areas. References made in this document refer to the TERG Position Paper's classification. A table of these recommendations is provided at the end of this response.
[2] Prioritize and increase HIV prevention funding.
[3] Consider the balance of prescriptiveness of technical guidance.

making, which reflects country context and epidemiology, we do not feel that it is the role of the Secretariat to issue prescriptive guidance. Partners and technical agencies play a critical role in this area, with the Secretariat best placed to provide additional support to facilitate better program design and measurement that will help drive prioritized prevention choices at country-level. While Global Fund technical guidance is useful, National Strategic Plans (NSPs), program reviews, quality programming with targets and improved measurement, are fundamental to further improving HIV prevention at the country-level. The Secretariat notes that any recommendation to provide more directive guidance to countries requires a careful consideration of the country ownership principle.

The Secretariat concurs with the TERG that well-defined approaches to support HIV primary prevention as part of funding request and grant making (Recommendation D) is useful and action has already been taken in this area. For the 2020-2022 allocation cycle, a modular framework for HIV prevention has been developed that includes evidence-based prevention interventions, and some country allocation letters included specific direction for HIV prevention. Efforts to ensure community systems and improve community-based delivery, including building the capacity of community based and community led implementers was sought within grants, and this has been further prioritized as part of COVID-19 adaptations. HIV prevention guidance will be further updated for the next allocation cycle which will also reflect the direction of the next strategy. While the Secretariat can be more directive on priority activities for primary HIV prevention (precision prevention[4]) based on country context and epidemic transmission dynamics, country decision making must consider the whole of the program and should not create a false sense of dichotomy between the prevention treatment continuum. The Secretariat notes that the quality in the design of prevention programming has been inconsistent and available instruments have not been widely used to study determinants of demand and uptake, most notably where Governments refuse to acknowledge risk groups. However, the Secretariat does not believe that developing specific deviations to application and grant making processes for one component of the HIV response is practical or useful to address these program design issues.

In order to respond to Recommendations E & F[5], the Secretariat will continue to work with partners to support countries in prioritizing and targeting evidence-based HIV prevention interventions as part of NSPs and enhance technical assistance (TA) coordination and visibility for implementation of HIV primary prevention programs. The Secretariat will seek to develop a stronger and wider pool of service providers to support country implementation and portfolio optimization opportunities. Support will focus on better use of data for program implementation and will rely upon multiple partners alongside support from the Secretariat. Several SI's (i.e. Data and RSSH) already offer opportunities to strengthen HIV prevention in NSPs, as well as community system strengthening and

[4] The term 'precision prevention' means more effective delivery HIV prevention that is evidence-based , uses close to real time public health surveillance, insights from behavioral economics, telemedicine, laboratory investigation, geospatial mapping and modelling to allow more precise targeted population and person-centered interventions, moving beyond a simple approach to just target 'key populations'.

[5] Recommendation E: Ensure greater prioritization of HIV prevention funding decisions in NSPs' Recommendation F: Enhance TA Coordination and visibility for implementation of HIV primary prevention programs.

management systems for prevention (e.g. data, microplanning). Opportunities such as country investment cases will also be used to highlight evidence-based prevention components. The Breaking Down Barriers SI is also being aligned to ensure high impact interventions are delivered, while concomitantly addressing critical structural barriers and creating a conducive policy environment.

Supporting effective implementation remains a key priority for the Secretariat. We have been working with partners to ensure that countries are implementing 'precision prevention' through intensified grant support. This includes geographical approaches to intensify efforts in higher-prevalence areas, while maintaining a minimum package of cost-effective interventions everywhere for those most at risk, to improve impact. The Secretariat is working to increase internal technical expertise and ensure cross Secretariat capacity building and alignment, to build an organization wide understanding and recognition for 'precision prevention'. These internal efforts are complimented by a joint Secretariat and partner wide effort to coordinate on-going TA for precision prevention.

The Secretariat believes that a priority for this current cycle and the next strategy is working with partners on an improved measurement framework to support clearly defined, implementable programmatic targets that are clearly linked to interventions and outcomes, and not just restricted to estimated coverage. This will contribute to a system for accountability on prevention of adolescent and adult infections from subnational to national and global levels The Secretariat is also working to improve other components mentioned in the review, e.g. ensuring scale-up to levels required for effective coverage and transition to national financing for HIV prevention and is working actively on social contracting and Private Sector Engagement and on activating partnerships to ensure integration with sexual and reproductive health programming. A credentialled professional development program for staff – which will assist to consolidate and develop better organizational understanding and alignment about HIV primary prevention – is also being developed, and if successful could be further developed for CCMs, PRs and SRs.

Observations on other recommendations

With respect to recommendation to 'develop a conceptual framework for HIV prevention' (Recommendation B), the Secretariat does not agree that developing a specific conceptual framework or theory of change (TOC) for HIV primary prevention would be helpful. Rather, an overarching TOC undergirding the next Strategy, as well as improved metrics for design and results on HIV prevention, would be more impactful, noting that any future TOC will need to recognize i) the Global Fund model; and ii) our intent to have the greatest impact on the HIV epidemic, not only on prevention but also, improving health of people living with HIV and saving lives. The Secretariat is working to enhance and update measurement approaches for HIV primary prevention, to facilitate the use of more proximal indicators to inform program calibration. We are also pursuing alignment with

partners, such as UNAIDS, as new 2025 and 2030 prevention targets are built in, linking also to better investment in prevention management/systems at country level.

Conclusions

The Secretariat will continue to prioritize and accelerate results on HIV prevention, considering the TERG recommendations. A cohort of ambitious precision prevention countries have been identified where the Secretariat has specifically aligned to ensure technical support from Secretariat staff, within grant TA and UNAIDS focused on key bottlenecks or capacity gaps identified as part of implementation support planning. The Secretariat is aligning internally on what and how we offer HIV prevention products to try to accelerate adoption of new prevention tools and to encourage greater attention to them (notably PreP[6], vaginal ring and HIV self-testing). The Secretariat will also explore greater engagement of communities, key populations, and civil society organizations as they are central to the creation of a prevention movement around choice. We believe a focus on greater precision in our prevention programming will go a long way to accelerating impact.

COVID adaptations to address prevention services and delivery platforms are another urgent priority, as all data (Global Fund, WHO, UNAIDS and program data) shows that these have been most disrupted by national responses to COVID. The Secretariat and partners will encourage countries to examine prevention services and continuity as part of their C19RM applications and/ or through portfolio optimization.

We thank the TERG for our continued partnership to strengthen the impact of the Global Fund partnership. A framing of a right to prevention and choice as core principles are fundamental to greater progress and could contribute to overcome the fragmentation of prevention.

[6] pre-exposure prophylaxis

Summary of Recommendations

Area	TERG Recommendations	Review Recommendations	Timeframe	Level of Agreement	Level of Control
Strategy/Policy	A. Prioritize and increase HIV prevention funding	Recommendation 1(i)	Mainly new strategy		
	B. Develop conceptual framework for HIV primary prevention	Recommendation 1 (ii); recommendation 8 (i, ii)	New strategy		
Tactical/Operational	C. Consider the balance of prescriptiveness of technical guidance	Recommendation 2 (i); Recommendation 4 (i)	Mainly new strategy		
	D. Develop well-defined approaches to support funding request and grant making for HIV primary prevention	Recommendation 2 (ii1v)	Mainly new strategy		
Technical/Programmatic	E. . Ensure greater prioritization of HIV prevention funding decisions in NSPs.	Recommendation 4 (ii,iii,iv)	Mainly new strategy, & immediately where applicable		
	F. Enhance TA Coordination and visibility for implementation of HIV primary prevention programs.	Recommendation 7 (i, ii)	Start as soon as possible		

TERG Thematic Review on HIV Primary Prevention

THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA

21 December 2020

FINAL REPORT

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Acronyms

Acronym	Full description
AGYW	Adolescent girls and young women
BBS	Bio-Behavioural Surveys
BMGF	Bill and Melinda Gates Foundation
CBOs	Community-Based Organisation
CCM	Country Coordinating Mechanism
CEPA	Cambridge Economic Policy Associates
CRG	Community, rights and gender
CSO	Civil Society Organisations
CSS	Community Systems Strengthening
DAH	Development Assistance for Health
DRC	Democratic Republic of Congo
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored and Safe Partnership, US Government funded programme for adolescent girls and young women
FPM	Global Fund Fund Portfolio Manager
FSW	Female Sex Workers
GPC	Global HIV Prevention Coalition
GMD	Global Fund Secretariat Grant Management Division
IHME	The Institute for Health Metrics and Evaluation
KII	Key Informant Interview
KP	Key Population
KPI	Key Performance Indicator
KVP	Key and Vulnerable Population
LFA	Local Fund Agent
MoU	Memoranda of Understanding
MSM	Gay men and other men who have sex with men
NAC	National AIDS Commissions / Councils
NCDs	Non-communicable diseases
NSP	National Strategic Plans
NSPA	National Strategic Plan of Action
PAAR	Prioritised above-allocation request
PCE	Prospective Country Evaluations
PEPFAR	United States President's Emergency Plan For AIDS Relief
PIP	People in Prison
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PR	Principal Recipient
PrEP	Pre-Exposure Prophylaxis
PSE	Population Size Estimates

Acronym	Full description
PWID	People who inject drugs
PWUD	People who use drugs
RfP	Request for Proposal
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
RQ	Review Question
RSSH	Resilient & Sustainable Systems for Health
SIID	Strategy, Investment and Impact Division
SR	Sub-Recipient
SRH	Sexual and Reproductive Health
SSR	Sub-Sub-Recipient
STC	Sustainability and Co-financing
STI	Sexually-Transmitted Infections
SW	Sex workers
TA	Technical Assistance
TAP	Global Fund Secretariat Technical Advice and Partnerships Department
TERG	Technical Evaluation Reference Group
TOC	Theory of Change
TRP	Technical Review Panel
TSM	UNAIDS Technical Support Mechanism
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNFPA	United Nations Population Fund
USG	United States Government
UQD	Unfunded Quality Demand
VFM	Value for Money
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization

EXECUTIVE SUMMARY

Review objectives and methodology

The Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund) Technical Evaluation Reference Group (TERG) appointed Cambridge Economic Policy Associates (CEPA) to conduct a thematic review on HIV primary prevention, with the aim to identify what the Global Fund can do differently to improve and strengthen its support for HIV primary prevention programmes and support countries in taking this to scale.

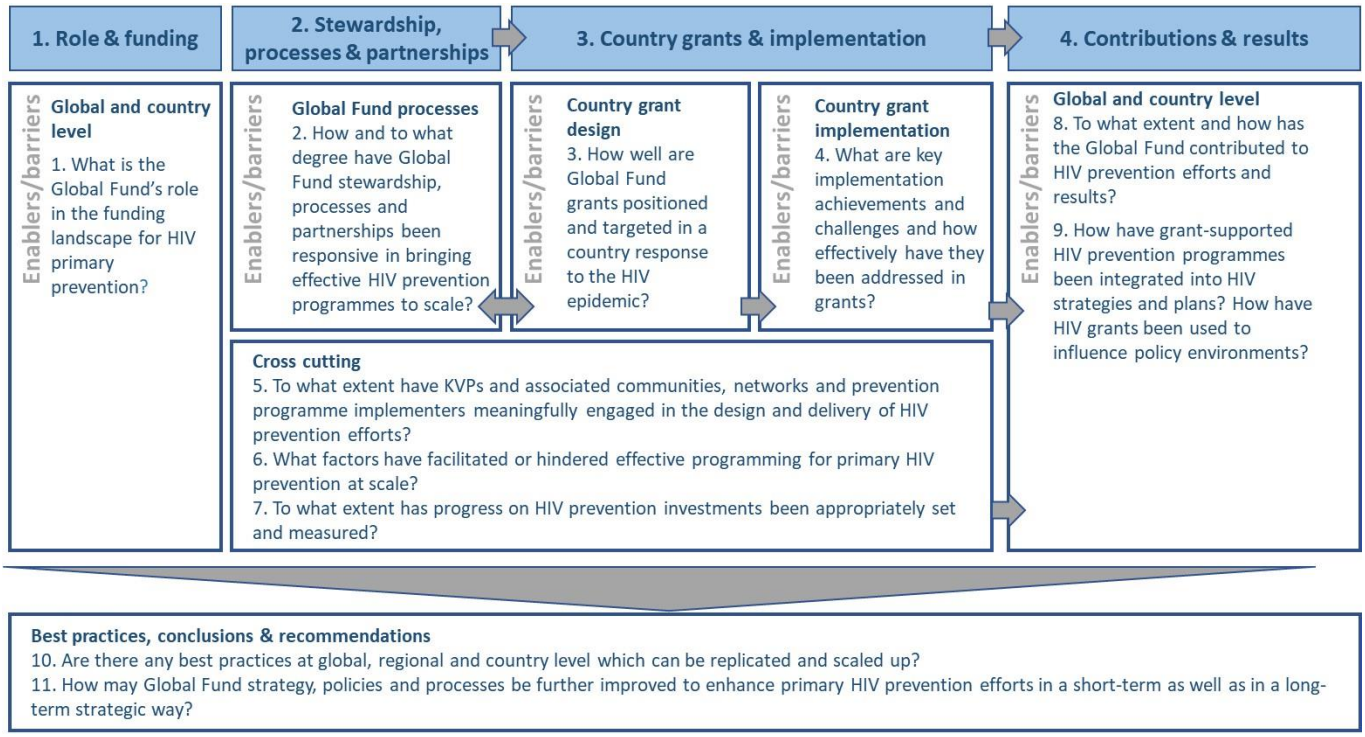
The review focused on four areas:

1. Role and funding;
2. Stewardship, processes and partnerships;
3. Country grants and implementation; and
4. Contributions and results.

In addition, review questions regarding key and vulnerable populations (KVP) engagement, factors facilitating or hindering scale up of effective HIV-prevention programming as well as measurement of HIV prevention interventions were included as cross-cutting questions.

Figure E.1. presents the review framework, indicating the review questions (RQs).

Figure E.1: Review framework



This review applied a mixed methods approach including (i) review and analysis of documentation; (ii) quantitative funding and programmatic data analysis; (iii) eight country case studies (Botswana, Côte d'Ivoire, Ethiopia, Indonesia, Jamaica, Philippines, South Africa and Ukraine); (iv) semi-structured interviews with key stakeholders and focus-group interviews; and (v) portfolio analysis of the 25 Global Prevention Coalition (GPC) countries. The key limitation of the review has been that majority of the country case studies were conducted remotely due to travel restrictions on account of COVID-19.

Key findings

Table E.1. over page includes the key findings of this review, presented by review question.

Table E.1: Key findings from the review

Review question	Sub-area of review[2]	Key findings
RQ 1: Role and funding	Global Fund funding for HIV primary prevention	• There has been a modest increase in HIV primary prevention funding by the Global Fund from 10.8% in 2015-2017 to 13.3% in 2018-2020, reflecting an increase in prioritisation. • Global Fund investments contribute to the aspirational target of 25% funding for HIV primary prevention of total national HIV response funding envisioned by the GPC, but more is needed by donors and governments themselves to enable countries to reach the 25% target, which only six out of 25 GPC countries reviewed manage to achieve.
	Global Fund prevention funding by GPC prevention pillar	• Compared to previous periods, in New Funding Model 2 (NFM2) there has been greater prioritisation within HIV primary prevention funding for adolescent girls and young women (AGYW) and continued prioritisation for key populations (KPs), whilst general population funding has declined. Funding for voluntary medical male circumcisions (VMMCs) declined as well (an intervention for which PEPFAR is a key donor).
	Comparative Advantage	• Compared to other donor organisations, the Global Fund has a strong advantage as a funder for HIV prevention given its quantum and focus of funding (as above), alongside its country-led approach and partnership model, which have several advantages although also present key issues for effective prevention funding.
	Advocacy	• Global Fund's external advocacy role on HIV prevention and participation in the GPC has improved over the years and Secretariat leadership has also been perceived as more committed to HIV primary prevention; however, areas of improvements and the need for continued advocacy remain.
RQ 2: Global Fund stewardship, processes and partnership	Stewardship	• The Global Fund is increasingly playing an important stewardship role for HIV primary prevention at the global level over time. • There has been a drive from Global Fund leadership to prioritise HIV primary prevention, but this has not been adequately operationalised across Secretariat teams and in Global Fund processes. • The Global Fund's stewardship role for HIV primary prevention at the country level is more challenging, by virtue of its country-led and CCM model, which while offering several advantages across the board, has proven to have particular limitations in the context of HIV primary prevention. Specifically, the country-led model relies on country-owned and country-proposed approaches to managing the HIV epidemic, which may not always prioritise high impact interventions for HIV primary prevention.
	Grant application, approval and management processes	• The Global Fund technical guidance is well aligned with partner guidance but is complex and more theoretical than operable. • Balancing a country-led approach with an optimal investment approach for HIV prevention within the standard Global Fund processes requires further attention and consideration. This particularly relates to the guidance which is more suggestive than directive (in line with Global Fund's country-led model, but has proven to be challenging to steer countries for effective programming), the limited detail available for Technical Review Panel (TRP) review and the lack of visibility during grant making. • Portfolio optimisation has proven to be a useful mechanism to increase HIV prevention investment by the Global Fund.

[2] Only included in applicable.

Review question	Sub-area of review[2]	Key findings
		• Global Fund prerequisites for minimum programmatic, financial, and management capacities and systems may preclude some relevant organisations working in HIV prevention from being Principal Recipients (PRs) or Sub-Recipients (SRs), implying the need for more capacity building of these organisations. • The Global Fund is considered to be relatively slow at offering support for new interventions/ innovations.
	Technical Assistance (TA)	• TA in relation to Global Fund grants, both generally for HIV and specifically for HIV prevention, is provided through a number of channels which are not well-coordinated resulting in limited visibility, oversight and potential impact of TA investments. • There are key weaknesses in TA for HIV prevention in terms of the following: (i) TA for the design of grants has been more forthcoming than TA for implementation and monitoring of grants; (ii) there are challenges in sourcing multi-sectoral and up-to-date technical expertise on HIV prevention, and an overreliance on United Nations (UN) agencies; and (iii) there are challenges with TA for capacity building of implementers. • Recently, there has been a greater focus on the provision of TA by the Global Fund to address key issues related to KPs and AGYW, including through community, rights and gender (CRG) and AGYW Strategic Initiatives.
	Partnerships	• Global level coordination and harmonisation with partners for HIV primary prevention represents a mixed picture with room for improvement, whereas country level coordination is generally considered to work well.
RQ 3: Country grants	Inclusion of HIV prevention interventions in NFM2 grants	• In essence, effective inclusion of HIV prevention in country grants is determined by (i) quality national strategic plans (NSPs) and other relevant strategies; (ii) quality TA for NSP development and funding requests; (iii) use of guidance; (iv) timely/ early conducting of situational analyses alongside availability of disaggregated data as well as other studies; (v) structural and political barriers; (vi) KVP engagement and (vii) total resource envelope for the HIV response. There are several challenges with each of these that in turn effect quality programming, although where these aspects are working well they support quality grant design. • There has been some progress in NFM2 with regards to: (i) the extent to which HIV prevention interventions are being prioritised for the relevant populations and geographical areas; and (ii) the inclusion of more evidence-based high impact interventions in grants. However further improvements are needed. For example, a number of countries are trying to cover too many different population groups and there is insufficient attention to groups most at risk. • Catalytic funding approaches in NFM2 have been key for HIV primary prevention investments being included in grants, although the quality of the focus of the interventions could be further improved in some instances.
	Retention of HIV prevention interventions following funding requests	• When comparing the budgets for HIV prevention between funding requests and current grant budgets, there has been a decrease of 10% across GPC countries in NFM2, despite an increase in funding for HIV overall (4%). Evidence from case study countries (and select other countries) suggest key reasons for this decline include a re-categorisation of interventions in the Modular Framework and grant consolidation to avoid duplication with other funders. Wider discussions with both global and country stakeholders have also suggested a potential deprioritisation of HIV primary prevention funding, but this review has not been able to gather robust evidence to support this claim. Overall the need for greater transparency in budget developments over time has been highlighted.
	Value for Money (VFM)	• Lack of consolidated guidance and information on “best buys” as well as challenges with data availability have prevented effective VFM assessments in grant design. There is a mixed picture as to whether VFM considerations have been incorporated by countries – although TRP and Secretariat reviews have been helpful in this regard. There is evidence of cost effective and

Review question	Sub-area of review[2]	Key findings
		VFM investments being included in grants but there is a focus on social and behaviour change communication (SBCC) interventions which are not deemed to represent VFM in all contexts.
RQ 4: Grant implementation	Grant absorption and implementation challenges	• Data for the current allocation cycle (NFM2) from 2018 to the end of 2019 shows that HIV prevention interventions have an absorption rate of 66% which is below that for all HIV interventions (71%) and all Global Fund interventions (73%). Absorption has been particularly low for interventions aimed at reducing human rights-related barriers, followed by AGYW and PrEP, and then condoms and VMMC. Only KP interventions have an absorption rate similar to the average of all Global Fund interventions. • There are a number of factors contributing to low fund absorption and implementation challenges, which we categorise as: (i) systemic issues; (ii) the particular nature of HIV prevention programming; (ii) grant level issues; (iv) country issues; (v) weak data systems; and (vi) Global Fund processes and systems issues.
RQ 5: KVP engagement		• Overall, the Global Fund model and systems aim to be supportive of KVP engagement, and Secretariat engagement with these groups at the global level is active, although fragmented, with several community systems strengthening interventions implemented by different Global Fund Secretariat teams. • At the country level, stakeholders report large variations in levels of engagement of KP networks/ organisations and communities by CCMs, PRs and SRs. Key reasons underpinning the variable levels of engagement include absence of or low capacity of KVP groups and community organisations to input during CCM and funding request design meetings and less importance accorded to KVPs by decision makers and key partners during the grant design and implementation processes. • Engagement of KVPs and communities is strong during the design of the funding requests (at times also leading to some challenges), but generally tends to be more limited during the implementation of HIV prevention interventions.
RQ 6: Factors facilitating or hindering effective scale up		• The main aspect that hinders scale up of HIV primary prevention programming is the limited resource envelope. Other key challenges include structural barriers, inadequate participation of prevention groups in national coordination mechanisms, transition challenges and inadequate guidance/ TA.
RQ 7: Measurement of HIV primary prevention	Approach to M&E	• The Global Fund lacks an overarching framework/ approach to the results it aims to achieve through its investments in HIV prevention, making it challenging to measure, report and interpret its achievements.
	Strategy KPI framework	• At a strategy level, the Global Fund monitors progress on HIV prevention through the reporting of a number of KPIs which have helped to focus attention on HIV prevention, although these are not comprehensive, indicating a need to maintain close monitoring through programmatic indicators. The indicators and targets for the KPIs have also presented challenges for measurement.
	Grant M&E	• The limited availability and quality of data, especially population size estimates for KVPs, is one of the major issues with reporting, monitoring and target-setting for HIV prevention interventions. • At the country level, there is a focus on outputs/ coverage indicators, rather than measuring prevention-related outcomes and achievements. In addition, despite the improvements made to the Modular Framework, a number of limitations remain with regards to monitoring results.

Review question	Sub-area of review[2]	Key findings
RQ 8 &9: Contributions and results		• Since the Global Fund was established in 2002, new HIV infections in countries supported by the Global Fund have fallen by 44%. Trends in more recent years have continued to follow previous long-term trends. Despite these long-term reductions, progress has not been extensive and uniform, and global targets for a 75% reduction in new infections by 2020 will not be met.
		• There is some evidence of Global Fund-supported HIV prevention interventions being integrated into national policies and plans, as well as evidence that Global Fund grants have been used to influence policy dialogue on HIV prevention at the country level.

Conclusions

HIV primary prevention is of significant importance if global targets of reducing HIV incidence are to be met. Since the Global Fund was established in 2002, new HIV infections in countries supported by the Global Fund have fallen by 44%. Yet despite these long-term reductions in new infections overall, progress has not been extensive and uniform, and the global target for a 75% reduction by 2020 will not be met. These trends highlight that despite a global recognition of the importance of HIV primary prevention for eliminating HIV/AIDS, greater prioritisation and improved implementation are needed to ensure efforts are effective in achieving results.

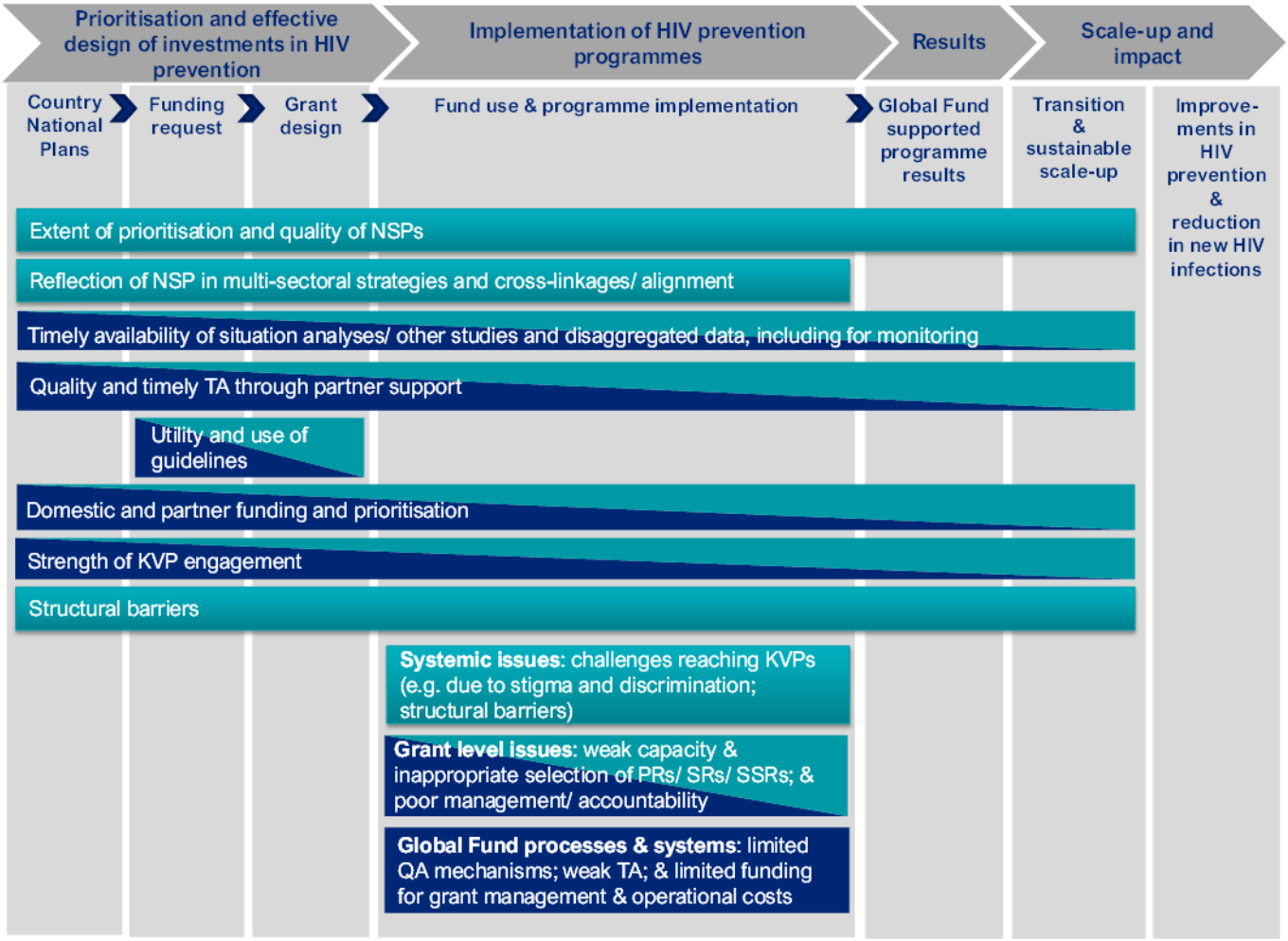
Within this context, our review has highlighted the following:

The Global Fund has increasingly been playing a critical stewardship role for HIV primary prevention at the global level, due in part to being the second largest donor for HIV prevention. There have been a **number of substantial achievements and improvements** during NFM2:

- Increased prioritisation, with the proportion of Global Fund funding allocated to HIV primary prevention of total HIV funding increasing from 10.8% in 2015-2017 to 13.3% in 2018-2020. In addition, the Global Fund has introduced some key initiatives emphasising HIV primary prevention, with several types of catalytic investments (strategic initiatives, multi-country funding and matching funding).
- There has been a noted trend in Global Fund leadership and technical staff being more committed to supporting primary prevention, positioning the organisation as an active supporter of this area of work within the donor landscape. Further, the Global Fund has played an improving and more active role in the GPC and other HIV prevention fora over time, which supports its prominence in the HIV primary prevention agenda.
- Progress has been made in terms of country grants and HIV prevention interventions supported by the Global Fund as follows: (i) better targeting of interventions and higher impact interventions being included in grants; and (ii) HIV prevention interventions included in funding requests have been well aligned with NSPs, highlighting the importance of quality NSPs and other relevant strategies in influencing Global Fund supported-prevention programmes given the Global Fund's country-led approach.
- The Global Fund's partnership approach is considered to be a comparative advantage for HIV prevention, encouraging wide partnership of country government, civil society, communities and technical partners.
- KVP engagement is particularly strong in some areas (e.g. at the global level and during the grant design stage), supported by the Global Fund model and systems which are generally well designed, especially in terms of engagement of KVPs at the global level.

However, there are a number of challenges that remain, many of which are at the country level and thus beyond, or only somewhat within the realms of influence of the Global Fund. This review has highlighted a number of these key issues as well as aspects with regards to Global Fund support and processes for HIV primary prevention which the Global Fund can influence. Figure E.2. below summarises these issues, which is followed by more details.

Figure E.2: Key findings



**Blue refers to issues that can be impacted by Global Fund processes and systems and green refers to country level issues. To note: this is a summary figure, which aims to capture and illustrate all the factors affecting the findings of the report. It is not meant to be fully representative of the pathways of the findings (in particular we note that results do not lead to scale up).*

With regards to **Global Fund processes and systems**, key issues include:

- Although there has been a drive from leadership to prioritise HIV primary prevention, this has not been adequately operationalised across Secretariat teams and in Global Fund processes.
- The Global Fund's stewardship role for HIV primary prevention at the country level is more challenging, by virtue of its country-led and CCM model. Notably, this model relies on country-owned and country-proposed approaches to managing the HIV epidemic, which may not always prioritise high impact investments for HIV primary prevention.
- With regards to grant design, balancing a country-led approach with an optimal investment approach for HIV prevention within the standard Global Fund processes requires further attention and consideration, especially in relation to whether the guidance provides sufficient direction to countries as well as the limited information in funding requests to aid an effective review by the TRP. In addition, the retention of HIV prevention interventions in grants after funding requests are submitted warrants further exploration. Furthermore there are concerns as to whether there are adequately standardised and transparent approaches during the grant making stage to ensure prioritisation of HIV prevention and quality programming.
- During grant implementation, the Global Fund has relatively limited mechanisms for quality assurance/ quality improvement of Global Fund-supported HIV prevention interventions.

- Although there has been a greater focus on the provision and coordination of TA by the Global Fund (e.g. through the Strategic Initiatives) to address issues related to HIV prevention, there has been limited TA to support grant implementation and lack of multi-sectoral and up-to-date TA.
- Despite a number of KPIs to track its investments in HIV prevention, the Global Fund faces a number of challenges in the measurement of HIV prevention progress and results.

At the **country level**, there are a number of **challenges including**:

- Grant design and scale-up including (i) limited resources, particularly domestic funding; (ii) structural barriers (e.g. human rights and legal or policy barriers) as well as political barriers (e.g. a lack of political will and commitment, especially to the needs of KVPs); (iii) inadequate guidance and TA; (iv) insufficient prioritisation of HIV prevention in NSPs and related strategies as well as limited availability of data and analyses; and (v) whilst improvements have been made with regards to prioritisation of KVPs, there continue to be challenges with most appropriate targeting of resources to populations most in need as well as programming of effective interventions.
- Implementation issues which are reflected in a low absorption rate including (i) systemic issues (e.g. challenge for implementers to reach KVPs especially due to stigma and discrimination and structural issues); (ii) nature of HIV prevention programmes with HIV prevention planning and implementation being particularly complex and therefore requiring greater oversight, coordination and engagement; the need for multi-sectoral engagement; (iii) grant level issues, especially weak capacity of PRs, SRs and Sub-Sub-Recipients (SSRs) as well as potential inappropriate selection of SRs and SSRs; and (iv) country issues such as low coordination capacity amongst governments, challenges with devolved structures and conflicts.
- Measuring progress of HIV prevention interventions such as difficulty estimating population sizes of KVPs, limited availability of disaggregated data (e.g. by KVP group), issues with double counting if beneficiaries given confidentiality concerns and there is a focus on outputs/ coverage indicators, rather than measuring prevention-related outcomes and achievements.
- Sustainability and transition challenges. In particular for HIV prevention programmes this relates to the financial sustainability of KVP programmes as well as challenges around social contracting with regards to having mechanisms to allow national takeover of support for civil society organisations (CSOs) when countries transition from Global Fund support.
- Given the plethora of issues that impact HIV primary prevention interventions, it is clear that the Global Fund needs to consider a renewed approach that is better clarified, more engaged and represents somewhat of a departure from its standard processes and systems, as per the set of recommendations below.

Recommendations

Based on the main findings and conclusions from the review, we present recommendations in the following three areas: (i) Global Fund funding, capacity and systems; (ii) facilitating country programming and implementation and (iii) M&E and partnerships. We highlight implementation responsibility as well as prioritisation within this, however emphasise that we do not believe that a handful of measures would make the needed change for the effectiveness of Global Fund HIV primary prevention funding – rather, concerted effort is needed towards the full package of recommendations described below.

Recommendation	Responsibility	Prioritisation and implementation
Global Fund funding, capacity and systems		
Recommendation 1: Further accelerate the momentum achieved for HIV primary prevention within the Global Fund, in terms of funding as well as capacity. Specifically: (i) **Continue to prioritise and increase HIV prevention funding**, by making a strong case for investing in prevention to its donors, and especially to feed into the HIV resource needs analysis that determines overall funding allocations by disease and country (recognising the large needs for treatment funding). Catalytic funding streams such as matching funding and strategic initiatives should also be enhanced for HIV primary prevention, although with the need to ensure more strategic and catalytic use of the funds. (ii) **Build and continue to develop an organisation-wide understanding and recognition for HIV primary prevention**, supported through the development of a conceptual framework that sets out the strategic and technical vision and plan for Global Fund investments in HIV primary prevention, in line with the overall Global Fund Strategy. The framework would need to set out the impact that the Global Fund wants achieve with its monies, in line with global goals and objectives, also considering a longer-term view of intended impact. The Global Fund's position and guidance on HIV primary prevention should be uniformly communicated and understood across the Secretariat and stakeholders. (iii) **Additional technical expertise** on HIV primary prevention should be incorporated in the Secretariat to improve technical and management capacity, whether through additional FTE or secondments from partner organisations, subject to budget constraints.	Secretariat, working with donors/ funders for (i) in particular	(ii) would be an essential first step (and a quick win) to help frame Global Fund investments in the area
Recommendation 2: Critically consider select enhancements and deviations from the standardised Global Fund application, approval and reprogramming processes to support strategic investments and programming for HIV primary prevention. In particular: (i) Recognising the challenge with effective programming for HIV primary prevention, we recommend **replacing the current suggestive guidance with more directive guidance**, building on available partner guidance but being more clear on what would be funded through Global Fund monies. This could be done through further focusing of the key guidance/ HIV Information Note and/ or broad instructions within the country allocation letters and/ or developing operational guidance by relevant country groupings, with the aim of encouraging more effective tailoring of programmes to country context and yet retaining some flexibility for countries. This recommendation requires a careful consideration of the country ownership principle, with Board-level discussion, as deemed appropriate. (ii) **Inclusion of additional details on HIV prevention intervention design and implementation planning in funding requests** for TRP review, alongside ensuring alignment of TRP review with partner guidance. (iii) **Development of standardised/ well-defined approaches to support grant making for HIV primary prevention** in order to support country teams during the grant-making stage, so as to ensure the organisation-wide priority is reflected across country grants. Options could be to develop detailed operational guidance to support grant making, and/or to provide additional	Secretariat with support from technical partners on guidance and TRP; if appropriate, changes to standard processes to seek approvals from the Strategy Committee/ Board	This is a priority recommendation, fully within the remit of the Global Fund to action.

Recommendation	Responsibility	Prioritisation and implementation
temporary surge support to Global Fund Secretariat teams during this stage, and/ or introducing additional checks during this stage by Secretariat staff with strong expertise in HIV prevention or the TRP. (iv) **Development of standardised/ well-defined approaches to support reprogramming of prevention grants** in order to ensure that the priority for prevention is retained.		
Facilitating country programming and implementation		
Recommendation 3: Encourage greater prioritisation and focus on HIV primary prevention at the country level, based on the evidence available. While not feasible for the Global Fund to impact on its own, discrete recommendations on actionable areas within the Global Fund purview include: (i) including "soft" conditionalities for governments/ partners to increase and/ or take over HIV primary prevention funding (e.g. through the Global Fund allocation letters or by requiring matching funding from implementers); (ii) encourage the use of the prioritised above-allocation request (PAAR) mechanism provided by the Global Fund to programme additional HIV primary prevention interventions; and (iii) continued efforts towards greater advocacy for HIV primary prevention with partners.	Secretariat in conjunction with partners	
Recommendation 4: Work with partners and country stakeholders to support more effective and quality programming for HIV primary prevention. Given the country-led and partnership-based model of the Global Fund, this is not an area that the Global Fund can affect on its own. Rather, countries will need to take a lead and the range of partners (advocacy-based, technical, multi-sectoral) would need to drive change. However, as Global Fund monies are being invested in HIV primary prevention, it also bears the responsibility to steer and/ or facilitate progress. Key recommendations include: (i) **Improving existing guidance** to make more navigable and operable – building on existing guidances developed by partners, and reflecting in the Global Fund HIV Information Note (and approach to *directive* guidance as per recommendation 2 above). (ii) **Supporting the development of quality HIV NSPs and related multi-sectoral plans**, with appropriate reflection of HIV prevention through provision of TA through partners as appropriate. It is recognised that this will be a country-led initiative with partner TA support, and the Global Fund has more of a facilitating and leveraging role. (iii) **Encouraging and supporting timely availability of situation analysis and other studies and importantly, the collection and use of key data**, again with the Global Fund in a facilitating and leveraging role. (iv) **Supporting KVP engagement** – whilst largely driven by country and partner-led initiatives, the Global Fund should continue to support enhanced KVP engagement through supporting capacity building of these organisations and pushing for the inclusion of CBOs and KVPs in the implementation, monitoring and review of HIV prevention programmes.[3]	Country and multi-partner responsibility with support of Secretariat	Priority recommendation for impact, albeit complex to implement given multi-partner and country responsibility. A first step would be for the Secretariat to consider a detailed implementation plan for actioning these aspects.

[3] We note that there are strict requirements to be eligible as a PR or SR, and we would not recommend reducing these requirements in keeping with the Global Fund's approach to managing financial and fiduciary risks; rather, work at improving capacity of relevant organisations themselves.

Recommendation	Responsibility	Prioritisation and implementation
(v) **Funding innovations**, especially where potentially "game-changing", whilst conforming with Global Fund's WHO PQ and other related requirements. Flexibilities should be introduced in grants so as to accommodate "game-changing" innovations within the funding cycle. (vi) **Affecting structural barriers** – The Global Fund should use its position in the global landscape to affect structural barriers to access of HIV prevention services in country, noting that these are complex, slow to change and involve country-level issues that require country-led movements and updating of legislations as well as are supported through certain global partners. This could be through advocating at the global level (in partnership with the GPC and other relevant organisations) or at the country level (through the CCM, Secretariat engagements with governments and partners, etc). Further, the Global Fund should also facilitate greater understanding within the Secretariat on these barriers, and provide relevant TA for countries as appropriate.		
Recommendation 5: Introduce relevant measures to support more effective implementation of HIV primary prevention interventions at the country level. Specifically: (i) As a priority, **ensure that appropriate mechanisms are in place to oversee, review and quality assure implementation of HIV primary prevention interventions** through the CCM oversight body (where well-functioning) and/ or LFA (where requisite skills are available), and/ or where these options don't make sense working through a partner organisation, or even the Global Fund Secretariat, or at an extreme, a specifically contracted organisation for implementation guidance and monitoring. We propose these more extreme options given the specific nature of HIV primary prevention interventions and the dire need to better support implementation as a means to improve the efficacy and results of these interventions. (ii) Continue to support existing initiatives to **improve the quality of KVP engagement in grant implementation** processes ensuring active participation by KVP associations and networks, not only during the design of funding requests but also during grant making and grant implementation. An example approach could be inviting KVP representatives to grant implementation review meetings. (iii) **Ensure adequate investment and close monitoring of PR/ SR management arrangements and capacity**. It would be important to ensure that management arrangements set out in the grant design are indeed implemented in practice alongside a close monitoring of these arrangements as to whether these are well functioning and if any changes are needed. Again, given this is a pertinent issue for HIV primary prevention, greater focus should be accorded by the Global Fund in ensuring the processes/ systems around its grants effectively pick up this aspect.	Country and multi-partner responsibility with support of Secretariat	Priority recommendation for impact, especially given the stage in the funding cycle with several NFM3 grants recently approved. A first step would be for the Secretariat to consider a detailed implementation plan for actioning these aspects.
Recommendation 6: The Global Fund should consider relevant measures to encourage greater scale-up and transition of investments in HIV prevention. Options include: (i) Advocate for, build knowledge on and share best practices for approaches to scaling-up and transition of HIV prevention interventions across countries, whether in terms of social contracting or public-private mix (PPM) models. (ii) Linking with recommendation 4 above, the Global Fund should continue to ensure adequate and quality investments in addressing community strengthening, human rights, gender and other structural barriers to services for KVP, and ensure that the outcomes from these investments are monitored and contributing to prevention outcomes. The Global Fund should also	Country and multi-partner responsibility with support of Secretariat	

Recommendation	Responsibility	Prioritisation and implementation
use its position and participation in the GPC to encourage greater country government accountability for HIV primary prevention outcomes. (iii) Ensure that Global Fund guidance clearly states the requirement that countries address scaling up coverage of HIV prevention programmes for relevant KPs, and for AGYW and male partners as appropriate given the country context, especially for transition countries.		
Recommendation 7: Continue efforts towards bringing about greater coordination and visibility of TA for HIV prevention, and enhance TA for several unmet needs. We appreciate that there are several ongoing initiatives and efforts to bring about improved TA coordination, quality and accountability across the board (i.e. across Global Fund grants for multiple diseases), and these efforts should continue in relation to TA for HIV primary prevention as well. In addition, specifically in relation to unmet TA needs for HIV primary prevention: (i) **Encourage the availability of TA for grant implementation and monitoring** (i.e. beyond the current focus of TA, which is largely on grant design). Several things can be done here such as (i) identifying the main implementation challenges across grants and highlighting these at the country level so that countries are encouraged to request TA support in relation to these; (ii) developing a roster of TA providers with diversified suppliers beyond traditional UN organisations and to include CSOs with relevant implementation capacity and (iii) encouraging greater in-country partner involvement (e.g. UNAIDS, WHO, national CSOs/ CBOs, etc. through CCM oversight) during implementation and monitoring so they are encouraged to identify TA needs during these stages, etc and (iv) where relevant, such TA should be made more 'visible' by linking to programmatic delivery rather than be viewed as programme management. (ii) **Encourage the provision of TA that has a multi-sectoral perspective** (as is the need for HIV primary prevention interventions). Identification of relevant partner organisations/ consultant rosters in this regard would be useful, including diversifying beyond the traditional UN partners for TA and where appropriate, using regionally based CSOs with relevant implementation experience. (iii) **Encourage TA to assist countries to achieve greater sustainability and prepare for transition**, including supporting long term TA for capacity building.[4] (iv) **Encourage the provision of TA for programme and financial management for CSO/ NGO/ CBO PRs/ SRs/ SSRs**. Partnerships with relevant organisations (e.g. in the private sector) would facilitate effective availability of this type of TA. (v) **Work with partners to ensure regular updating of trainers' capacity** on programmatic and technical subjects so as to facilitate the provision of relevant and up-to-date TA.	Partner responsibility with facilitation/ support of Secretariat	Key recommendation for action with partners

[4] This is in line with a recommendation from the recent review of the GPC. Barbara O. de Zalduondo, L. Gelmon and H. Jackson (2020) External Review of the Global HIV Prevention Coalition and 2020 Road Map; Final Report. October 5, 2020

Recommendation	Responsibility	Prioritisation and implementation
M&E and partnerships		
Recommendation 8: Introduce improvements in M&E for HIV primary prevention, aligning with partner work in this area. The following are proposed: (i) Develop an overarching conceptual framework, linking grant inputs, outputs and outcomes to the global targets and the change that the Global Fund wants to achieve through its investments in HIV primary prevention. (ii) The framework would also elaborate how outputs and outcomes are to be effectively measured, ensuring that the focus is not only on coverage/ reach, but also on the quality of services delivered, and on actual results achieved (i.e. qualitative aspects such as behaviour change). The framework should inform the revised KPI framework. (iii) During the development of the performance framework for the next Strategy/ strategic period, the Global Fund could revise some of the HIV prevention related KPIs to better enable monitoring of prevention progress and results. (iv) Continue to invest in the collection and use of population level data and surveys, especially for KVPs, including sub-national data. (v) Strengthen the linkage between results monitoring and key investments by ensuring that results data from grants is effectively fed back to improve investment.	Secretariat in coordination with partner guidance on M&E	Key recommendation for action with partners
Recommendation 9: Continue further work on "non-traditional" and multi-sectoral partnerships. (i) Strengthen partnership with global and regional NGOs and other organisations working in the area of Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) in order to strengthen integration approaches between HIV prevention responses and SRH services and with community health approaches, in line with the 2025 AIDS targets. (ii) Make information on Global Fund investments and areas of funding more accessible for partners who are not fully appraised of Global Fund processes and systems (i.e. stakeholders outside of the UN community, large donors, large NGOs/ CSOs).	Secretariat	

1. INTRODUCTION

Cambridge Economic Policy Associates (CEPA) has been appointed by the Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund) Technical Evaluation Reference Group (TERG) to conduct a thematic review on HIV primary prevention.

This introduction section presents the review context and objectives (Section 1.1) and structure of the remainder of the document (Section 1.2).

1.1. REVIEW CONTEXT AND OBJECTIVES

Within the commitment to "Ending the AIDS epidemic by 2030",[5] global progress has been made in the reduction of HIV incidence, including in countries where the Global Fund invests, where new infections have reduced by 13% between 2010 and 2018.[6] However, progress has not been uniform across countries and many countries will not achieve the 2020 target to reduce new infections by 75% from the 2010 baseline.[7] The Global Fund is committed to increasing the reach and quality of HIV prevention, treatment and care services in countries. The HIV primary prevention support that countries can receive from the Global Fund includes funding through HIV and HIV-TB grants based on country allocations, matching funds, recent strategic initiatives including an adolescent girls and young women (AGYW) focus, and the Breaking Down Barriers initiative[8] and, in some instances, funding through multi-country grants. Additionally, the Global Fund is directly supporting some technical partners to provide countries with technical assistance (TA) in the area of HIV prevention and community, rights and gender (CRG) as well as providing TA through other means such as set-aside funding for the 5% initiatives.

As per the Request for Proposal (RfP), this thematic review aims to:

1. better inform Global Fund policies, guidance and suggestions regarding the funding of HIV prevention for country dialogue and funding request processes and grant management practices;
2. clarify needs for TA for design of prevention strategies as the basis of funding requests and make recommendations for how these should be addressed;
3. provide an in-depth understanding of the funding landscape for primary HIV prevention and the relative prioritisation of prevention at the country levels, and the Global Fund's role in supporting these efforts alongside partners (domestic and international donors), and make recommendations for future; and
4. provide inputs to the development of the next Global Fund strategy as well as to share lessons learned to inform key Global Fund partners (e.g., UNAIDS, United States government (USG) / PEPFAR, etc.).

The overarching aim of the review is to focus on **what the Global Fund can do differently in order to improve and strengthen its support to HIV primary prevention programmes** and support countries in taking it to scale.

In line with HIV prevention interventions set out in the Global Fund HIV Information Note[9] and understanding within the Global Fund HIV team, for the purposes of this review, **HIV primary prevention is considered to include:** (i) HIV prevention programmes addressing key populations (KPs)[10] in all epidemic settings; (ii) HIV prevention programmes

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[5] UNAIDS (2014), Ending the AIDS Epidemic by 2030

[6] The Global Fund (2019) Results Report 2019

[7] Global Prevention Coalition (2017) HIV Prevention 2020 Road Map

[8] The Breaking Down Barriers initiative aims to scale up of programmes to remove human rights-related barriers to health services in 20 Countries. (https://www.theglobalfund.org/media/1213/crg_breakingdownbarriers_qa_en.pdf)

[9] The Global Fund (2019) HIV Information Note

[10] KPs include: sex workers (SWs); gay men and other men who have sex with men (MSM); transgender people (TG); people who use drugs (PWUD) / people who inject drugs (PWIDs); and people in prison (PIPs).

addressing AGYW and their male partners in high burden settings; (iii) voluntary medical male circumcision (VMMC) for adolescent boys and men in high burden settings; (iv) comprehensive condom programming; (v) pre-exposure prophylaxis (PrEP) programmes for populations with substantial HIV risk and (vi) integration of family planning and sexual and reproductive health (SRH) services into HIV care for all women in high prevalence areas. It is noted that human rights interventions are programmed by some countries as part of prevention interventions. However, for the purposes of this review we are using the HIV prevention interventions as identified in the five Global Prevention Coalition (GPC) pillars and are considering human rights and other structural interventions as cross-cutting. Further, HIV primary prevention is not considered to include HIV testing, except where there are combination prevention interventions which also include testing such as self-testing and community testing. Whilst some stakeholders do consider HIV testing to be part of HIV prevention, the exclusion of HIV testing in this review has helped to bring further visibility of key issues with regards to primary prevention. Prevention of mother-to-child transmission of HIV (PMTCT) is also not included, nor is HIV 'treatment as prevention'. HIV testing has not been included as it is not classified as HIV primary prevention in the 2019 Global Fund HIV Information Note.

1.2. STRUCTURE OF THE DOCUMENT

The rest of the document is structured as follows: Section 2 provides the review framework as well as the methods and approach to synthesis of the evidence, Section 3 presents the findings by review question (RQ), Section 4 presents conclusions and Section 5 includes draft recommendations. Best practice examples are included throughout Section 3. Additional information is provided in the supplementary appendices as well as country case study reports.

2. REVIEW FRAMEWORK, APPROACH AND METHODS

2.1. REVIEW FRAMEWORK

Figure 2.1 presents our review framework, based on the questions included in the RfP. It is structured as four closely related review pillars on as follows:

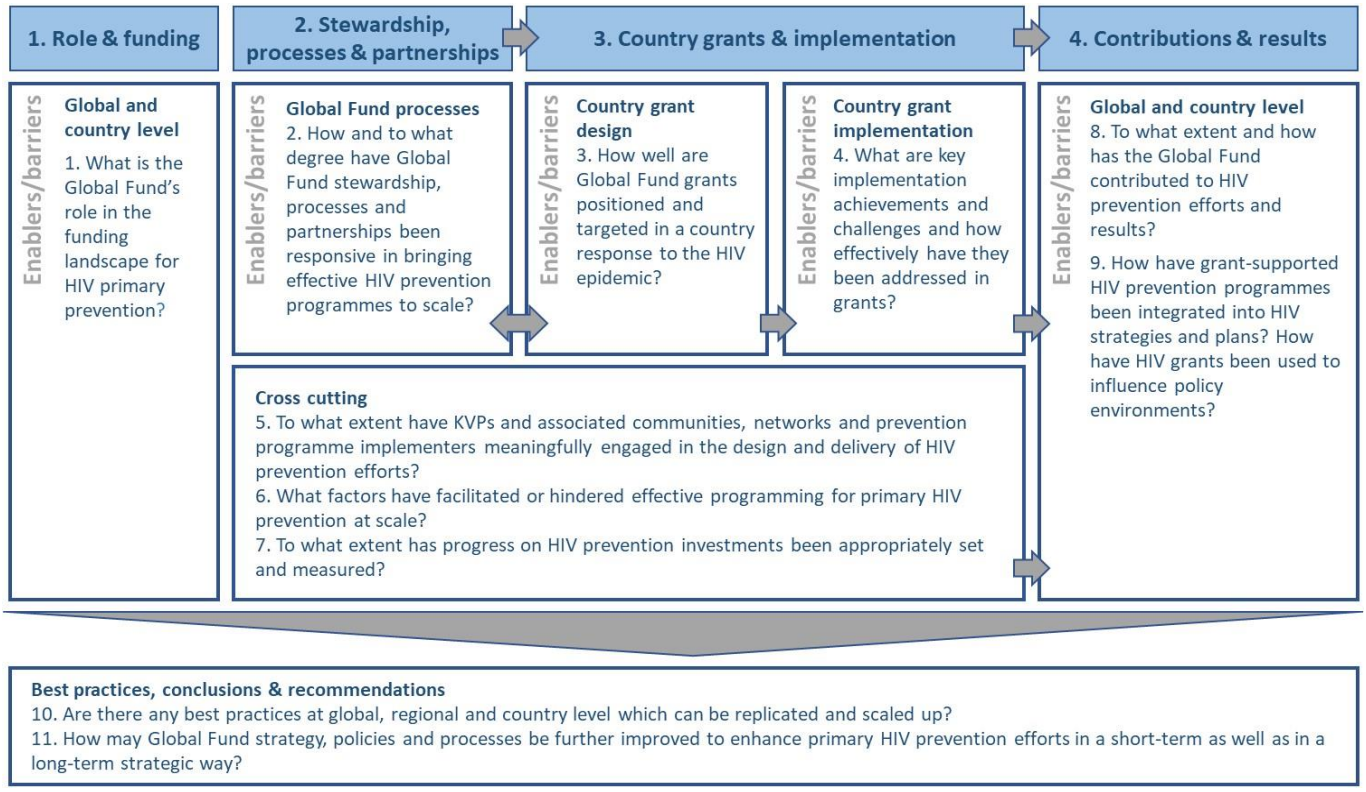
- **Pillar 1: Role and funding** which examines what the Global Fund is funding with regards to HIV primary prevention as well as the comparative advantage of Global Fund funding alongside its advocacy role.
- **Pillar 2: Stewardship, processes and partnerships** including effectiveness of Global Fund (i) stewardship; (ii) grant application, approval and management processes; (iii) TA and partnerships in relation to HIV primary prevention.
- **Pillar 3: Country grants and implementation** which considers key aspects of country grant design such as the inclusion of HIV prevention investments in grants, country ownership, alignment and harmonisation, value for money (VFM) and sustainability as well as with regard to country implementation achievements and challenges.
- **Pillar 4: Contributions and results** considering the contribution of Global Fund-supported programmes to HIV prevention efforts and results as well as influence on national strategies and policies.

Review questions regarding key and vulnerable populations (KVP)[11] engagement, factors facilitating or hindering scale up of effective HIV-prevention programming as well as measurement of HIV prevention interventions are cross-cutting across pillars 2 and 3.

[11] Key and vulnerable populations (KVPs) include: KPs, as well as other vulnerable populations, such as AGYW, migrants, and other groups, depending on the country context.

Together with identified best practices, these four pillars inform the overall conclusions and recommendations for review.

Figure 2.1 Review framework



2.2. REVIEW METHODS

2.2.1. Summary of review methods

Table 2.1 below summarises the mixed-methods that have been applied in the review.

Table 2.1: Review methods

Method	Detail
Review and analysis of relevant documentation	This included key Global Fund documents (e.g. HIV information notes, previous reviews, Technical Review Panel (TRP) reports, implementation reports on the 2017-2019 cycle) and relevant partner documents, broader literature (e.g. Global HIV Prevention Coalition (GPC) Prevention Roadmap); as well as country specific documents for country case studies and the portfolio analysis. Appendix A includes a bibliography.
Quantitative data analysis	Quantitative data analysis has focused on two main aspects: (i) funding for HIV primary prevention and (ii) outputs, outcomes and impacts of primary prevention interventions. The key component of the funding analysis is a detailed breakdown of the Global Fund budgets across budget periods for 2015-2017 and 2018-2020. This includes analysing the funding across prevention pillars, funding modules, GPC countries and cost components. The budget analysis has been be complemented with an analysis on the absorption rate of HIV interventions for the 2018-2019 period. Both analyses build on the analyses conducted by the Global Fund HIV team and data from the Global Fund (data extracted from the Global Fund grant operating system in June 2020). A second component of this analysis is a high level funding landscape analysis to assess Global Fund funding in relation to other HIV prevention donors and, as far as possible, other domestic financing. The analysis on donor landscape is based on available data from PEPFAR and the Institute for Health Metrics and Evaluation (IHME). The available data on domestic funding data for HIV prevention is more challenging. The review uses Global Fund

Method	Detail
	data for "high impact countries" to aggregate across countries and, where available, uses funding data from UNAIDS for the country case studies. Appendices H, I and J includes the funding methodology and analysis. The results analysis has primarily drawn on programmatic data collected as part of Global Fund grants, which includes an analysis of outputs in terms of coverage indicators and performance against targets at the global level. For impact, we have drawn on external sources, particularly UNAIDS data, to analyse global trends in HIV incidence, including a specific analysis of incidence among AGYW. Results have been analysed at the global level, country level as part of the case study analysis and specifically for the 25 GPC countries. Outcome data (e.g. extent to which behaviour change has been realised) has not been analysed due to the limited amount of results data collected for prevention-based indicators, limiting the ability to monitor trends over time.
Key stakeholder and focus-group interviews	Semi-structured interviews have been conducted with key informants. Appendix B lists the global level stakeholders consulted which include: Global Fund Secretariat teams, key global partners such as UNAIDS, WHO, GPC, donors, global community organisations etc. County level interviewees are listed in the country case studies. Interview guides for both global and country level stakeholders are included in Appendix C. All consultations were conducted remotely except some country level interviews.
Country case studies	We have undertaken eight country case studies which included (i) documentation review (e.g. funding requests, grant reporting); (ii) data analysis (e.g. relating to HIV prevention funding from the Global Fund; domestic and other international HIV prevention funding, Global Fund performance target results etc.); (iii) stakeholder consultations (e.g. with Ministries of Health, National AIDS Councils, Principal and Sub-Recipients (PRs, SRs), civil society, etc). The county case studies include Botswana, Côte d'Ivoire, Ethiopia, Indonesia, Jamaica, Philippines, South Africa and Ukraine. Botswana and Ethiopia have included some in-person interviews but the rest were conducted remotely. Further details regarding the country selection and methodology are provided in Appendix E.
Portfolio analysis	A portfolio analysis of Global Fund grants to the 25 GPC countries which received funding for HIV prevention interventions was undertaken. The analysis covers successive phases from funding request, budget agreement and development to grant performance and absorption of HIV prevention interventions. The predominantly quantitative analysis is complemented with a review of select documents and key informant interviews (KIIs) with stakeholders in four countries to put any positive or negative deviations from the general trend into context. Further details can be found in Appendix D.

2.2.2. Robustness framework to assess strength of evidence for our findings

We have assessed the strength of evidence for the findings using a robustness framework based on both the *quality* of relevant quantitative or qualitative evidence, consistency after triangulation, and/or *quantity*, of the evidence. Bringing together these aspects we use a four-point scale to assess the strength of the evidence (strong, good, limited and poor) as shown in Table 2.2 below.[12] Findings are presented in bold text throughout the report, against which the strength of the evidence is noted in **blue** font using the scale below.

Table 2.2: Robustness rating for findings

Rating	Assessment of the findings by strength of evidence
Strong (A)	• The finding is supported by data and/or documentation which is categorised as being of good quality by the evaluators; **and** • The finding is supported by majority of consultations, with relevant consultee base for specific issues at hand; **and/or** • The finding is supported by all/ the majority of our country case studies.

[12] All robustness rankings are relative robustness rankings, based on careful consideration and are ultimately judgement-based.

Rating	Assessment of the findings by strength of evidence
Good (B)	• The finding is supported by majority of the data and /or documentation with a mix of good and poor quality; **and/ or** • The finding is supported by majority of the consultation responses; **and/or** • The finding is supported by a good proportion of our country case studies.
Limited (C)	• The finding is supported by some data and/or documentation which is categorised as being of poor quality; **or** • The finding is supported by some consultations as well as a few sources being used for comparison (i.e. documentation): **or** • The finding is supported by some country case studies, with no contradictions across country case studies.
Poor (D)	• The finding is supported by various data and/or documents of poor quality; **or** • The finding is supported by some/ few reports only and not by any of the data and/or documents being used for comparison; **or** • The finding is supported only by a few consultations or contradictory consultations: **or** • The finding is supported by few country case studies with some contradictions between country case studies.

2.3. LIMITATIONS AND MITIGATING MEASURES

We present key limitations for the review and mitigation measures in Table 2.3.

Table 2.3: Limitations experienced within the review and mitigation measures

Limitation	Mitigation measures
(i) As the COVID-19 pandemic has evolved, the review methodology has needed to be adjusted. In particular, this has meant that the majority of country case studies have been conducted remotely and this has been the most significant limitation for the review. Remote country case studies offer a reduced level of insight, given the more limited scope of remote key respondent enquiries as compared with country visits. (ii) COVID-19 has also affected the availability of country level stakeholders. (iii) The impact of COVID-19 on prevention programmes is also currently unknown, therefore affecting assessment of likelihood of scale up etc.	(i) We have tried to address the limitation of remote country case studies as much as possible by careful selection of informants and detailed tailored interview guides, alongside targeted efforts to collate relevant data. (ii) We have included the portfolio analysis of GPC countries as a method to mitigate this through providing further breadth of findings. (iii) Our review team includes country-based associates in two case study countries who have knowledge of the local HIV response context and have undertaken in-person interviews where possible for these countries.
Consultation limitations including: (i) possible respondent bias, especially as a number of the consultees are implementers and/ or recipients of funding; (ii) challenges securing most appropriate interviewee, (iii) some political sensitivities.	(i) We have triangulated our findings against other evidence; (ii) If a key informant was unavailable, we sought to identify a replacement interviewee with comparable insight or experience. However in a number of instances this has not been possible. (iii) We have anonymised comments and informed respondents as such.
Measuring attribution of impact, recognising the role of multiple factors that contribute to prevention outcomes.	This has been mitigated through understanding the pathways to impact and the results the Global Fund has been responsible for as much as possible. This has been achieved through conducting quantitative analysis of results based mainly on Global Fund programme results data, as well as modelled data from UNAIDS, while complementing this with qualitative findings drawn from global and country stakeholders.

Limitation	Mitigation measures
Limitations in the quality and comprehensiveness of quantitative data, including: (i) lack of domestic and (to some extent) international donor HIV primary prevention funding data allowing for a robust trend analysis across countries; (ii) the Global Fund budget and expenditure data has some limitations with regard to countries misclassifying interventions against the Global Fund modular framework; (iii) absorption rate analysis only includes budget data up until the end of 2019 and, thus, has no data on the last year of the current allocation cycle; and (iv) comparison across time periods is challenging due to differences in classifications, grant length, modular frameworks, incompleteness of data and included countries.	A range of mitigation measures has been taken to address these limitations as far as possible, including: (i) triangulation of different database to overcome data gaps (e.g. for the wider funding analyses); (ii) analysis is conducted on multiple levels to test robustness of findings (e.g. across total Global Fund portfolio, across GPC countries, across country case studies); (iii) examination of outliers and testing robustness of findings by excluding outliers (e.g. for South Africa in the absorption rate analysis); and (iv) adjustments to the way data is compared to reduce biases in the data as far as possible (e.g. use of budget periods to compare trends in HIV budgets).

3. FINDINGS

In this section we present our findings by review pillar and specifically for each review question (RQ).

3.1. ROLE AND FUNDING

The first review pillar considers the Global Fund's role in the funding landscape for HIV primary prevention.

RQ 1: What is the Global Fund's role in the funding landscape for HIV primary prevention?

Within this review question we consider the Global Fund's role in the funding landscape for HIV primary prevention in terms of: (i) the level of Global Fund investment in HIV prevention, including types of prevention interventions as well as addressing structural drivers (e.g. human rights barriers), contextualised for the wider funding landscape for HIV prevention; (ii) Global Fund's comparative advantage in relation to other donors for HIV prevention; and (iii) Global Fund's participation in and support for advocacy for HIV prevention. A summary of the main findings for each of these areas is presented in the table below, followed by more details on the evidence base and analysis.

Area of review	Key findings
Global Fund funding for HIV primary prevention	• There has been a modest increase in HIV primary prevention funding by the Global Fund from 10.8% in 2015-2017 to 13.3% in 2018-2020, reflecting an increase in prioritisation. • Global Fund investments contribute to the aspirational target of 25% funding for HIV primary prevention of total national HIV response funding envisioned by the GPC, but more is needed by donors and governments themselves to enable countries to reach the 25% target, which only 6 out of 25 GPC countries reviewed manage to achieve. • Analysis of the funding request data for the upcoming allocation cycle (NFM3) suggests that the trend of moderate increases in primary prevention funding will likely continue going forward but also currently suggests that no substantial shift in funding towards HIV primary prevention will take place.
Global Fund prevention funding by GPC prevention pillar	• Compared to previous periods, in NFM2 there has been greater prioritisation within HIV primary prevention funding for AGYW and continued prioritisation for KPs, whilst general population funding has declined. Funding for VMMCs declined as well (an intervention for which PEPFAR is a key donor).
Wider landscape analysis	• There is a lack of robust data on funding for HIV primary prevention, especially in terms of domestic funding.

Area of review	Key findings
	• HIV prevention funding represents a relatively small percentage of total HIV funding (~13%) in terms of Development Assistance for Health (DAH) and PEPFAR funding (~12%). This impacts on countries' ability to meet the GPC target to spend 25% of HIV funding on HIV primary prevention. • Countries have not reached the GPC target of spending 25% of total national HIV response investment on HIV primary prevention. • The Global Fund is the second largest organisation to disburse HIV prevention funding behind PEPFAR and the third largest distribution channel after USA bilateral funding and direct NGO and foundation funding. • PEPFAR has a stronger focus on biomedical interventions (especially VMMC) and has larger focus on general population investment largely due to investment in VMMC programmes.
Comparative Advantage	• Compared to other donor organisations, the Global Fund has a strong advantage as a funder for HIV prevention given its quantum and focus of funding, alongside its country-led approach and partnership model, which have several advantages although also present key issues for effective prevention funding.
Advocacy	• Global Fund's external advocacy on HIV prevention and participation in the GPC has improved over the years and Secretariat leadership has also been perceived as more committed to HIV primary prevention; however, areas of improvements and the need for continued advocacy remain.

3.1.1. Level and types of investment in prevention

Global Fund funding for HIV primary prevention

(A/B) **There has been a modest increase in HIV primary prevention funding by the Global Fund over time reflecting an increase in prioritisation.**

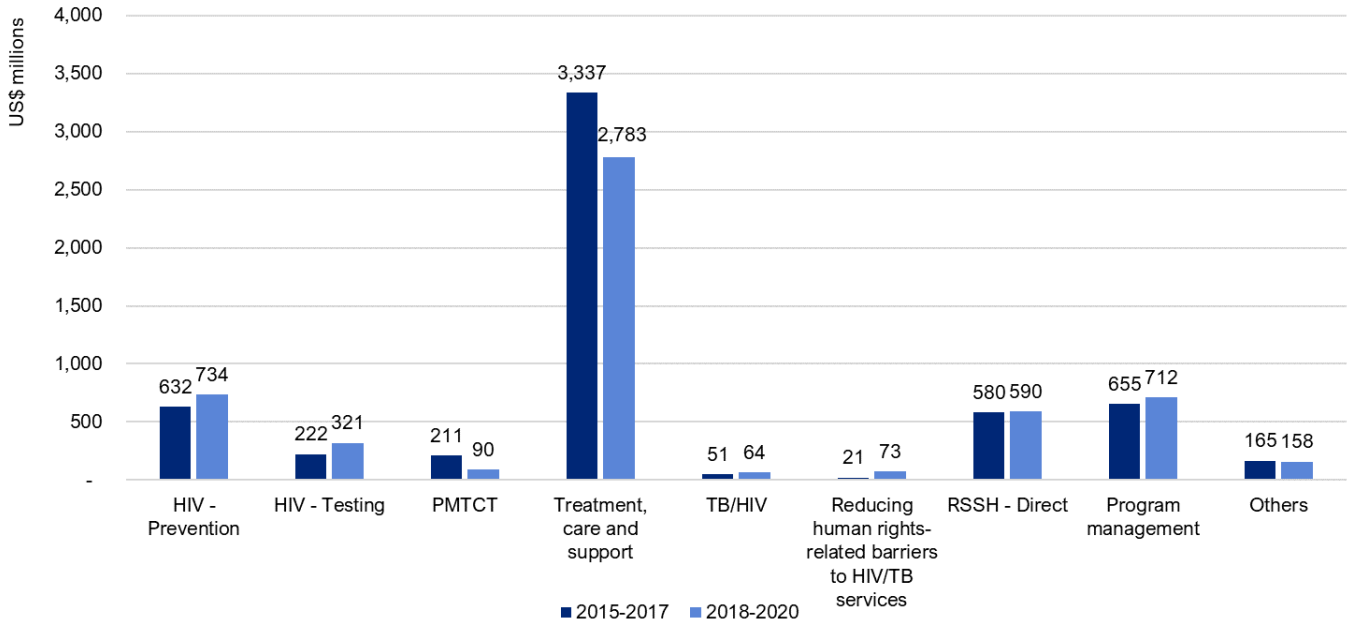
Global Fund funding for HIV primary prevention has increased by ~US$ 102.2 million (16%) from US$ 631.9 million in 2015-2017 to US$ 734.1 million in 2018-2020.[13] Using Global Fund budget data from the grant operating system in June 2020, the budget for HIV primary prevention was compared across two budget periods (2015 to 2017 and 2018 to 2020).[14] A detailed description of the data categories, methodology and limitations of the analysis is presented in Appendix H.[15] The trend across key HIV modules is shown in Figure 3.1.

[13] Primary prevention funding has been defined as funding coded as HIV prevention programme modules under the Global Fund Modular Framework. All HIV testing interventions in these modules has been excluded when analysing HIV prevention trends. For more detail see Appendix H.

[14] Using three year budget periods that corresponds to the Global Fund implementation cycles was seen as more accurate than using the allocation periods themselves. This is due to the fact that some countries have different grant lengths (e.g. such as Nigeria that received an extension of their HIV grant under the NFM1 allocation cycle) which means that a comparison across allocation cycles may not be accurate.

[15] The budget includes funding requested from countries through HIV and HIV-TB grants based on country allocations, matching funds and multi-country grants during the grant application stage as well as any changes made after grant making through reprogramming and additional funding as part of the Prioritised Above Allocation Request (PAAR) process. The use of catalytic funding through matching funds and strategic initiatives is discussed in more detail under RQ3.

Figure 3.1 Global Fund funding (budgets) for HIV primary prevention and other HIV interventions by budget period

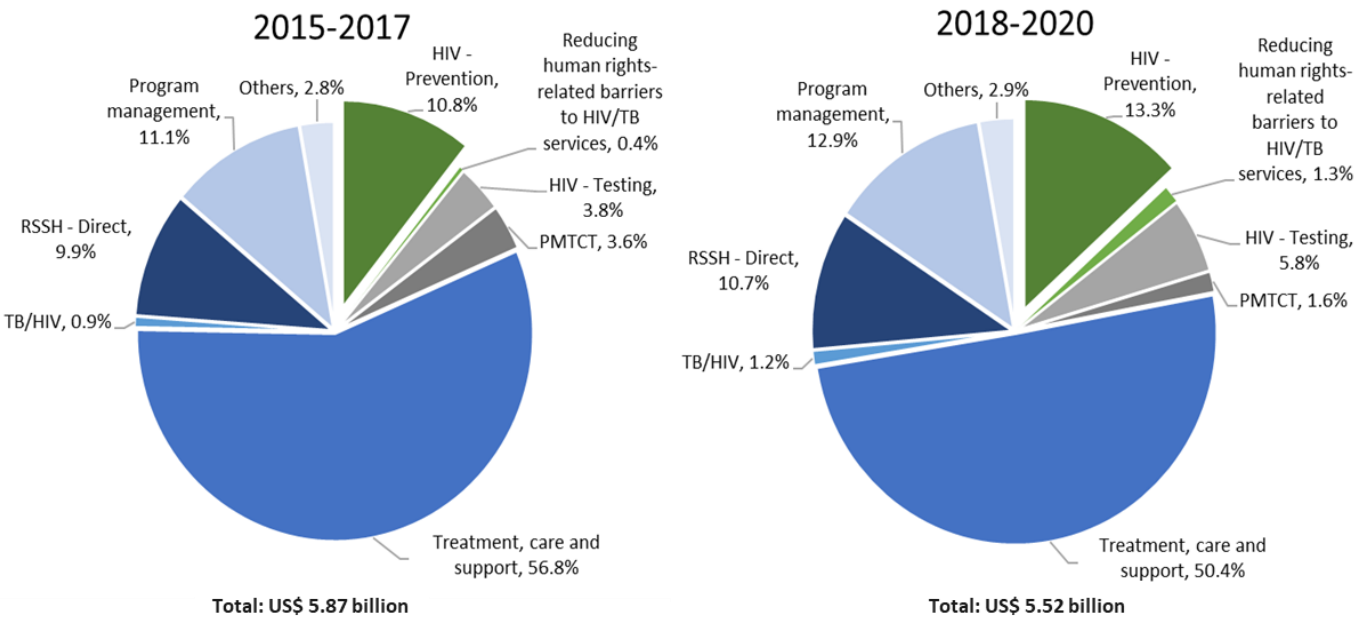


Source: CEPA analysis based on Global Fund data and analysis

There has been an increase in the proportion of Global Fund HIV primary prevention funding of the total HIV funding from 10.8% in 2015-2017 to 13.3% in 2018-2020, reflecting increasing prioritisation. However, funding for treatment, care and support remains the dominant budget area receiving more than 50% of funding. With an increase by 2.5 percentage points, HIV primary prevention had the largest increase in the proportion of funding of any HIV area as illustrated in Figure 3.2 below. In contrast, the total HIV budget from the Global Fund has declined slightly by 6% from US$ 5.87 billion to US$ 5.52 billion, further highlighting the increased prioritisation accorded to HIV primary prevention. Most HIV modules increased over the two budget periods with the exception of prevention of mother-to-child transmission of HIV (PMTCT) and treatment, care and support, with the latter dropping by around 17% but still constituting the largest budget item and representing around half of all funding for the 2018-20 budget period. The funding for reducing human-rights related barriers experienced the biggest increase in relative terms of around 250%.[16]

[16] The proportion of funding for treatment, care and support dropped from 56.8% to 50.4% but remains by far the most dominant funding area with a ratio of nearly 4 to 1 to prevention. The proportion of interventions related to reducing human rights-related barriers to HIV/TB services also increased from 0.4% to 1.3%.

Figure 3.2: Global Fund budget proportion by HIV modules and budget periods



Source: CEPA analysis based on Global Fund data and analysis

The increase in HIV primary prevention by the Global Fund in 2018-2020 in both absolute and relative terms, contributes to countries national HIV response funding and supports them making progress towards reaching the aspirational target envisioned by the GPC of 25% funding for HIV primary prevention of total national HIV response funding. This finding needs to be seen in conjunction with developments for other domestic and donor funding which support countries in implementing their National Strategic Plans for the HIV/AIDS response (NSPs), given that countries may be using support from these sources for HIV prevention interventions (see section on wider landscape analysis below). The Global Fund support is only one source of HIV prevention funding for countries. This is similar to other donors funding for HIV prevention as shown the wider funding landscape below.

This trend is also evident when analysing funding for individual GPC countries. The portfolio analysis in Appendix D for GPC countries showed that for the current allocation cycle the proportion of Global Fund support for HIV primary prevention is 13% with only 6 out of 25 countries achieving proportions above 25% (including Botswana, South Africa, Namibia, Pakistan, Indonesia and Ukraine).

The increase in HIV prevention funding from 2015-2017 to 2018-2020 is mostly driven by increases in the High Impact African 2 region with substantial increases in the following countries (in order of magnitude):[17] Tanzania, South Africa, Kenya, Zambia, Mozambique, Uganda and Zimbabwe. Funding for HIV prevention increased also in the Southern and Eastern Africa region driven predominately by increases in Malawi, Lesotho and Botswana.[18] However, HIV primary prevention funding remained stable or decreased in all other Global Fund regions. A detailed breakdown by region can be seen in Appendix H.

(C/D) Analysis of the funding request data for the upcoming allocation cycle (NFM3) suggests that the trend of moderate increases in primary prevention funding will likely continue going forward but also currently suggests that no substantial shift in funding towards HIV primary prevention will take place. The preliminary

[17] The order of magnitude is based on the increase in US$ between budget periods and as such is also driven by the overall HIV funding allocation to countries.

[18] These counties are not classified as High Impact Africa 2 but instead are classified under the Southern and Eastern Africa region.

data from funding requests submitted for NFM3[19] indicated that countries requested HIV primary prevention funding of around US$ 782 million which corresponds to around 13.7% of all funding requested for HIV interventions (~ US$ 5.7 billion). Treatment, care and support remains the HIV intervention area with the most funding requested (54.7% of all HIV funding in funding requests). Funding to reduce human-rights related barriers to HIV/ TB services represented around 1.5% of all HIV funding. The funding request data cannot be directly compared to the budget period analysis above and only provides very tentative evidence given that the data remains incomplete and may change substantially during grant making and once outstanding countries are added.[20]

Global Fund prevention funding by GPC prevention pillar

(A/B) Compared to previous periods, in NFM2 there has been greater prioritisation within HIV primary prevention funding for AGYW and continued prioritisation for KPs, whilst general population funding has declined. Funding for VMMCs declined as well (an intervention for which PEPFAR is a key donor).

Figure 3.3 below outlines the trend in the Global Fund budget for HIV prevention analysed across GPC prevention pillars and budget periods. More detailed analysis on each prevention pillar can be found in Appendix H. The prevention periods are non-exclusive, i.e. the same intervention can be counted twice – once with regard to the target population (e.g. AGYW or KP) and with regard to the intervention type (e.g. condom, VMMC or PrEP).[21,22]

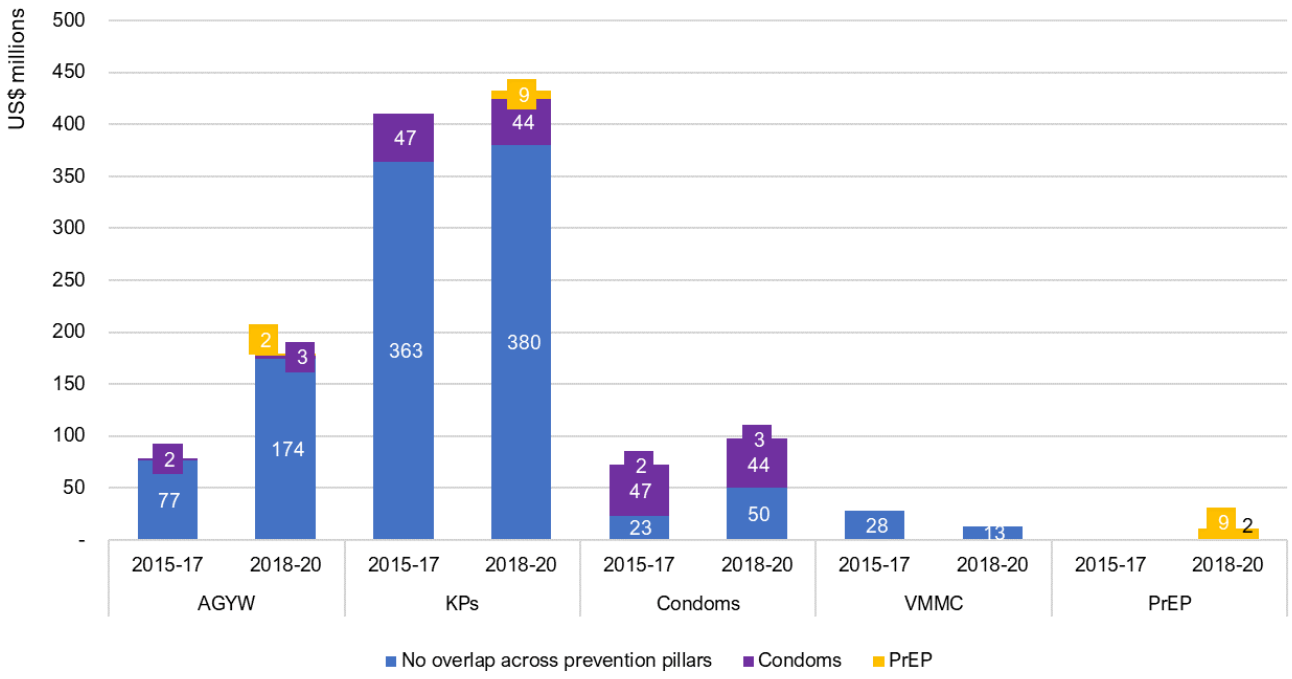
[19] The dataset includes all funding requests submitted up to the Window 3 submission deadline of August 31st2020. Therefore, some countries with a later submission window, such as South Africa, are not included in the data. The analysis was conducted using the Global Fund Modular Framework for NFM3 which includes a module for HIV primary prevention. The calculation for the total HIV spending follows the approach used for the NFM2 analysis which is described in Annex H. The current funding request data does not include data on the target population of interventions so therefore analysis for the GPC pillars cannot be conducted. Analysis of intervention data suggests there has been a moderate increase in the proportion of HIV prevention funding requested for condoms (17%), VMMC (2.8%) and PrEP (2.5%).

[20] The addition of South Africa that submits is Funding request in 2021 might increase the share of prevention funding as South Africa has been the country with the highest level of HIV primary prevention funding in NFM3.

[21] HIV prevention funding targeting the general population and that is not used for either condoms, VMMC or PrEP is not included. For further details on the methodology please see Appendix H.

[22] The duplicated interventions are depicted with the overlap in condom and target population marked in purple and an overlap in PrEP marked in yellow. For example, condoms can then be counted as those given to (i) general population, (ii) KPs and (iii) AGYW.

Figure 3.3: HIV prevention budget by GPC prevention pillar and budget periods



Source: CEPA analysis based on Global Fund data and analysis

The budget for AGYW interventions more than doubled from US$ 79 million in 2015-2017 to US$ 179 million in 2018-2020.[23] In contrast, funding for KP only increased by around 5% from US$ 410 million in 2015-17 to US$ 433 million. Table 3.1 below shows the proportion of funding by target populations between the budget periods with AGYW showing the biggest increase in received funding while there is a decrease in the proportion of funding going to most KPs and the general population.

Table 3.1: Proportion of target population as a percentage of total HIV prevention funding by budget period

	AGYW	KPs							General Population
		MSM	*SW*	*TG*	*PWID*	*PIP*	*Other*	Total KP	
2015-17	**12%**	17%	18%	-	20%	0%	10%	**65%**	**23%**
2018-20	**24%**	15%	18%	1%	17%	1%	8%	**59%**	**17%**

The analysis also shows that for KP, gay men and other men who have sex with men (MSM), people who inject drugs (PWID) and sex workers (SW) are the predominant categories that receive the majority of funding. Funding for programme for people in prisons (PIPs) and transgendered (TG) people started to emerge in 2018-20 but is still very low at ~1%.[24]

With regard to the intervention types included in the GPC prevention pillars, the following can be observed:

- **Condom funding has increased across the budget periods from US$ 72 million to US$ 97 million** with the increase coming entirely from condoms used for the general population (increase by US$ 27million).
- **Funding for VMMC decreased between the budget periods from US$ 28 million to US$ 13 million and the number of countries requesting funding dropped from nine to six countries**. The available evidence

[23] For example, in 2015-17 US$ 79 million was allocated to AGYW which includes US$ 77 million for AGYW unrelated to condoms/ PrEP and US$ 2 million in funding for condom programmes targeted at AGYW.

[24] TG funding cannot be compared across budget periods as it was previously included in MSM interventions.

also suggests that this is driven by the fact that PEPFAR has focused on this area (see wider landscape analysis below) so that there have been fewer requests from countries to the Global Fund.

- **PrEP has started to receive funding for the 2018-20 period with around US$ 11 million.**[25] This remains a very low proportion (~1.5%) of the overall HIV primary prevention funding. Reportedly one of the challenges for countries was in terms of understanding of the incidence rates that justify programming for PrEP intervention. Recently there have been improvements in grant design, including with countries starting off with PrEP pilots and then moving to larger scale up from there.

Wider landscape analysis

(A) There is a lack of robust data on funding from all sources for HIV primary prevention, especially in terms of domestic funding. There remains a lack of robust funding data with regard to HIV primary prevention that is consistently applied across countries. There has been some progress at the international level, but the data remains scarce at the domestic level. The work conducted by UNAIDS under the Global AIDS Monitoring is useful progress, however, at this stage, there remain too many gaps in the data to allow for trends to be aggregated across countries and time. The recent GPC external review also observes the challenges related to the complexity of compiling data on HIV prevention funding, including the changes over time in categorisation of funding into prevention.[26]

(A/B) HIV prevention funding represents a relatively small percentage of total HIV funding (~13%) in terms of Development Assistance for Health (DAH) and PEPFAR funding (~12%). (B/C) This impacts on countries' ability to meet the GPC target to spend 25% of HIV funding on HIV primary prevention.

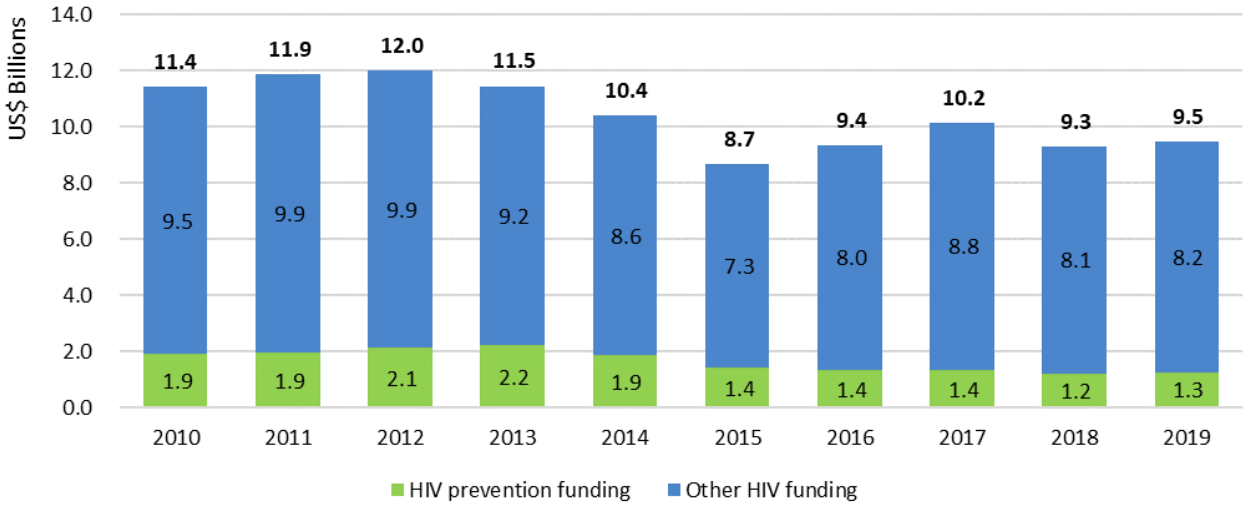
DAH for wider HIV prevention has decreased compared to 2010-levels and the proportion of HIV prevention also decreased from 16.6% in 2010 to 13.4% in 2019. In the absence of better data, we have used data from the IHME, which applies a different definition for HIV prevention than the Global Fund,[27] and find that there has been a decrease in DAH for HIV prevention interventions since 2010, as shown in Figure 3.4.

[25] There has been some funding for PrEP under NFM1 but this was budgeted for 2018 and, as such, is reflected in the 2018-20 period.

[26] Barbara O. de Zalduondo, L. Gelmon and H. Jackson (2020) External Review of the Global HIV Prevention Coalition and 2020 Road Map; Final Report. October 5, 2020

[27] The IHME data does determine the type of funding based on the application of a keyword search (e.g. "condoms", "prevent", "HIV Education" etc.) rather than using the classifications under the Global Fund Modular Framework. As such, the magnitude and recent trend in HIV prevention funding is different to those of the Global Fund and PEFPAR.

Figure 3.4: Trends in DAH for HIV overall and HIV prevention between 2010-19



Source: CEPA analysis based on data from IHME[28]

While there has been a reduction in both DAH for HIV as well as specifically for HIV prevention, there was a relatively higher reduction in HIV prevention funding reflected in a drop in the proportion of HIV prevention as part of all DAH for HIV from 16.6% in 2010 to 13.4% in 2019.

PEPFAR funding for HIV prevention is at around 12% of all HIV funding (US$ 476million out of US$ 4.03billion) in 2019 while treatment and care is at 46% (see Appendix J for further details and methodology). Similar to the Global Fund, PEPFAR has also increased the proportion of its HIV prevention spending moderately from previously 10% of all HIV spending in 2015 to ~12% in 2019 (an increase from US$ 326million to US$ 476million).[29]

(C) Countries have not reached the GPC target of spending 25% of total national HIV response investment on HIV primary prevention. The Global Fund data on the planned investments for the 2018-2020 period for 22 "High Impact countries" suggests that on average approximately 13.4% of total HIV funding was for HIV prevention or related activities such as reducing human rights barriers (for more detailed findings and methodology see Appendix J). Of the 22 countries, six countries had HIV prevention funding proportions above 25%.[30] Moreover, the self-reported data of these countries suggests that there is a lower share of domestic funding for prevention activities (~32%) compared to non-prevention activities (~55%). This suggests the crucial role that funding from donors plays in HIV primary prevention and in reaching the GPC target of 25% of in-country HIV funding for HIV primary prevention.

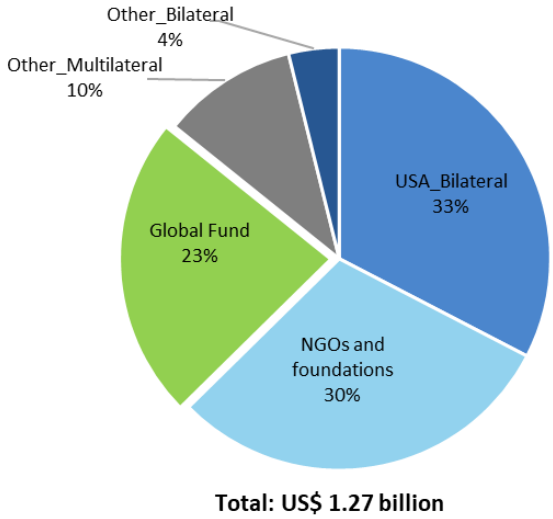
(A) The Global Fund is the second largest external funding organisation to disburse HIV prevention funding behind PEPFAR and the third largest distribution channel after USA bilateral funding and direct NGO and foundation funding. Similar to its position with regard to overall HIV funding disbursement, the Global Fund also is a key channel with regard to HIV prevention. As shown in Figure 3.5 below, in 2019, the key disbursement channel for HIV prevention was USG bilateral funding, predominately through PEPFAR, followed by funding disbursed directly through a wide range of different NGOs and foundations at 30% and then the Global Fund at 23%.

[28] Institute for Health Metrics and Evaluation (IHME). Development Assistance for Health Database 1990-2019. Seattle, United States of America: Institute for Health Metrics and Evaluation (IHME), 2020.

[29] Additionally, there also has been an increase in "Socio-economic" interventions which are also relevant for prevention efforts.

[30] Bangladesh, Indonesia, Kenya, Mali, Pakistan and Tanzania.

Figure 3.5: Proportion of disbursement channel of HIV prevention funding



Source: CEPA analysis based on data from IHME[31]

(A) PEPFAR has a stronger focus on biomedical interventions (especially VMMC) and has larger focus on general population investment largely due to investment in VMMC programmes. The focus of PEPFAR's prevention funding is different to the Global Fund's prevention focus. As outlined in the analysis in Appendix J PEPFAR's HIV prevention funding is focused heavily on VMMC with over 50% of HIV prevention funding going to VMMC programmes over the last five years. In 2019, PrEP made up 6% of total PEPFAR HIV prevention spending. In contrast to the Global Fund, communication, mobilisation, behaviour and norm change interventions only make up 20% of all PEPFAR funding in 2019. This is also reflected in the target populations of PEPFAR-supported interventions with a higher proportion of male and general population interventions and with only 14% of funding going to interventions marked for key or priority populations.

3.1.2. Comparative advantage[32]

(A) Compared to other donor organisations, the Global Fund has a strong advantage as a funder for HIV prevention given its quantum and focus of funding, alongside its country-led approach and partnership model, which have several advantages although also present key issues for effective prevention funding.

The Global Fund has a strong comparative advantage as a funder for HIV primary prevention, first of all on account of its quantum of funding in relation to the large needs as well as its focus of funding. HIV primary prevention features prominently in the current Global Fund Strategy 2017-2022 and the Secretariat has increased its focus and better defined its priorities on HIV prevention. As presented in the preceding section, the Global Fund is the second largest external donor for HIV prevention and its funding in this area is also increasing over time. Further, as also presented above, the focus of Global Fund HIV primary prevention funding has been on KPs, which is a much needed area of funding, also because it is not usually the focus of country governments.

In comparison to other funders, the Global Fund's country-led and partnership-based model offer unique advantages for countries. Specifically, country ownership is one of the four principles of the Global Fund model and the Global Fund allows the country to apply for funding which is aligned with, and in support of, its national priorities as detailed in its National Strategic Plans (NSPs). As a result, the Global Fund's approach focuses on investing in and strengthening national programmes, thereby avoiding the establishment of parallel and vertical systems and the implementation of stand-alone HIV prevention projects. This is particularly important for HIV prevention given its multi-

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[31] Institute for Health Metrics and Evaluation (IHME). Development Assistance for Health Database 1990-2019. Seattle, United States of America: Institute for Health Metrics and Evaluation (IHME), 2020.

[32] Comparative advantage considers the relative advantage in relation to other organisations, as the term is used in evaluation practice.

sectoral nature that goes beyond health and covers issues related to education, human rights and gender amongst other areas. As mentioned by one stakeholder, the strength of the Global Fund country-led model is that it "*devolves a lot of the responsibility of programme implementation to the country and also that countries know better about the intricacies of their own responses".* However, there are also limitations to the country-led model, especially in relation to the degree to which the Global Fund can emphasise the prioritisation of HIV prevention interventions in grants. This is discussed in more detail in Section 3.2.1. Further, the Global Fund partnership model is also considered an important comparative advantage, as it encourages wide partnership of country government, civil society, communities and technical partners; and a key strength of the partnership model is the engagement of civil society and communities, including those less represented such as KVP communities. However coordination and engagement between partners as well as KP engagement is not always effective – aspects that are discussed in Sections 3.2.4 and 3.4.1 respectively.

3.1.3. Advocacy

(B) Global Fund's external advocacy role on HIV prevention and participation in the GPC has improved over the years and Secretariat leadership has also been perceived as more committed to HIV primary prevention; however, areas of improvements and the need for continued advocacy remain.

During the initial years of the GPC, the Global Fund engagement in the GPC was not perceived to be strong: at first the Global Fund had not analysed its investments in HIV prevention and had not been able to provide detailed and up-to-date data of its prevention investments. But this has since changed and the Global Fund is now viewed as an active partner in the coalition and one which plays an important role in terms of sharing an investment perspective, as well as insights from the HIV prevention programmes it supports in countries. Furthermore, the Global Fund has also aligned its grant design and technical guidance with the GPC's five pillars approach: the 2019 HIV Information Note highlights that Global Fund applicants should "*focus their national HIV prevention responses on the five prevention pillars endorsed by the Global Prevention Coalition*".[33] Thus, the five prevention pillars are now presented as a viable investment focus for countries. In recent years, the Global Fund Secretariat leadership has also been perceived as more committed to supporting HIV primary prevention (discussed in more detail in Section 3.2.1 on stewardship).

In general however more work is needed to encourage countries to further prioritise HIV primary prevention aspects within their NSPs and cross-sectoral plans, Global Fund grants and other activities. As a major funder of HIV prevention, the Global Fund has also been advocating for the reduction of gender inequality and removal of human rights barriers through its investments. Through Strategic Objective 3, the Global Fund 2017-2022 Strategy has positioned the promotion and protection of human rights and gender equality as a core element of its investment approach. In practice however, the Global Fund Strategy Review in 2020 (SR2020)[34] and stakeholders interviewed for this review have noted that despite improved advocacy, human rights, gender and other structural interventions continue to be seen as insufficient or not well designed. This may be partly due to the country-led model whereby countries may prefer to omit politically sensitive or contested HIV prevention elements from their grants. As such, further work remains in this regard.

3.2. STEWARDSHIP, PROCESSES AND PARTNERSHIPS

The second review pillar of the evaluation focusses on Global Fund stewardship, processes and partnerships (including for TA) for HIV prevention and areas for improvement.

RQ 2: How and to what degree have Global Fund stewardship, processes and partnerships been responsive in bringing effective HIV prevention programmes to scale?

[33] Global Fund (2019) HIV Information Note

[34] Euro Health Group, Itad, UCSF (forthcoming), The Global Fund Strategic Review 2020, Final Report (SR2020)

Under this question we have assessed how, and to what degree, Global Fund stewardship, grant application, management and TA processes, as well as partnerships, have been responsive in bringing effective HIV prevention programmes to scale. Aspects relating to Global Fund monitoring and reporting systems are covered under RQ7.

A review of these aspects is contextualised for two key aspects, namely: (i) inherent challenges for HIV prevention programming at the country level (e.g. prevention delivery platforms are much more complex and multi-sectoral than biomedical platforms, human rights and legal barriers are experienced by providers who are trying to reach KP and other vulnerable groups,[35] there has been a global emphasis on testing and treatment, including treatment as prevention rather than primary prevention, there is difficulty quantifying and demonstrating results of prevention investments which have long lead times, etc.); and (ii) the overall Global Fund model (e.g. country-led approach, partner centric, etc.). The assessment is cognisant of these aspects and seeks to highlight issues and make suggestions within this context.

A summary of the main findings for each of these areas is presented in the table below, followed by more details on the evidence base and analysis.

Area of review	Key findings
Stewardship	• The Global Fund is increasingly playing an important stewardship role for HIV primary prevention at the global level over time. • Governance systems are generally inclusive and supportive, and there has been a drive from leadership to prioritise HIV primary prevention, but this has not been adequately operationalised across Secretariat teams and in Global Fund processes. • The Global Fund's stewardship role for HIV primary prevention at the country level is more challenging, by virtue of its country-led and CCM model, which while offering several advantages across the board, has proven to have particular limitations in the context of HIV primary prevention. • Global Fund policies and guidelines for funding applications and grant management assist countries in designing programmes that are inclusive of all population groupings and tailored to each country or applicant's needs. However, some aspects could be better leveraged.
Grant application, approval and management processes	• The Global Fund technical guidance is generally well aligned with partner guidance but it is overly complex and more theoretical than operable. • Balancing a country-led approach with an optimal investment approach for HIV prevention within the standard Global Fund processes requires further attention and consideration. • Portfolio optimisation has proven to be a useful mechanism to increase HIV prevention investment by the Global Fund. • Global Fund prerequisites for minimum programmatic, financial, and management capacities and systems may preclude some relevant organisations working in HIV prevention from being PRs or SRs, implying the need for more capacity building. • The Global Fund is considered to be relatively slow at offering support for new interventions/ innovations.
Technical Assistance	• TA in relation to Global Fund grants, both generally for HIV and specifically for HIV prevention, is provided through a number of channels which are not well-coordinated resulting in limited visibility, oversight and potential impact of TA investments. • The level of TA available for HIV prevention is generally considered adequate by countries, but there are weaknesses in sourcing and delivery of TA and in using it for technical and organisational capacity strengthening. • Recently, there has been a greater focus on the provision of TA by the Global Fund to address key issues related to HIV prevention for KPs and AGYW, including through CRG and AGYW Strategic Initiatives.

[35] This challenge exists for treatment programmes as well but as many prevention programmes focus on KVP groups, it is particularly relevant for prevention.

Area of review	Key findings
Partnerships	• In general, the Global Fund's model is considered to be participatory, inclusive and open to close collaboration with partners, including for HIV prevention investments. • Global level coordination and harmonisation with partners for HIV primary prevention represents a mixed picture with room for improvement, whereas country level coordination is generally considered to work well.

Key findings in terms of Global Fund stewardship (Section 3.2.1), grant application, approval and management processes (Section 3.2.2), technical assistance (Section 3.2.3) and partnerships (Section 3.2.4) are presented in turn below.

3.2.1. Stewardship

(A) The Global Fund is increasingly playing an important stewardship role for HIV primary prevention at the global level over time. The Global Fund is the second largest donor for HIV with an increasing proportion of its total HIV funding going towards HIV primary prevention (as discussed under RQ1). In addition, the Global Fund has introduced some key initiatives emphasising HIV primary prevention, with several types of catalytic investments (strategic initiatives, multi-country funding and matching funding).[36] The Global Fund has also played an improving and more active role in the GPC and other HIV prevention fora over time, which supports its prominence in the HIV primary prevention agenda (as discussed in RQ1). Moreover, there has been a noted trend in Global Fund leadership and technical staff being more committed to supporting primary prevention, positioning the organisation as an active supporter of this area of work within the donor landscape.

(B) Governance systems are generally inclusive and supportive, and there has been a drive from leadership to prioritise HIV primary prevention, but this has not been adequately operationalised across Secretariat teams and in Global Fund processes. KPs and communities are represented on the Board and Country Coordinating Mechanism (CCMs), and in some countries are implementers of Global Fund programmes. Furthermore, as noted in global level consultations and documentation, there is recognition that across the Global Fund leadership there is an impetus to prioritise HIV prevention, and over the past few years, the Secretariat has made a concerted effort to analyse their investments in prevention which has aided accountability and understanding. However, stakeholders noted that this high-level steering and prioritisation has not permeated across Secretariat processes, with the operationalisation of this prioritisation being relatively weak, with one stakeholder noting "*we need a full organisational effort around prevention which we don't yet have*".

Although this review has not explored Secretariat teams' capacity and structural issues in depth, a number of key aspects have been noted:[37]

- HIV prevention is a particularly complex technical area and the technical knowledge is not widespread across the Secretariat. There have been some initiatives to increase capacity across the Secretariat such as support from the Bill and Melinda Gates Foundation (BMGF) for HIV prevention but in general more capacity is needed.
- A conceptual framework for HIV prevention is not adequately understood within the organisation.
- Decision-making and advice on HIV prevention investment is distributed amongst a number of teams in the Secretariat. This has created a lack of clarity across the organisation in terms of guidance as well as lines of accountability. For example, both the HIV and CRG teams are technical teams for HIV primary prevention within the Secretariat and also provide advice to countries (with this latter aspect being led by the Grant Management Division (GMD)), and there is a need for greater coordination and integration (although this has

[36] Matching funds for HIV prevention include AGYW in high prevalence settings, scaling up community-led KP programmes and condom programming as well as cross cutting human rights programmes. Strategic Initiatives include technical support for aspects such as CRG and human rights.

[37] These points are supported by global level stakeholder feedback as well as reviewers' own assessment.

reportedly improved over time). M&E and finance aspects are managed outside of the technical teams on HIV and CRG, while appropriate in terms of overall Secretariat structural efficiency, poses challenges for more complex investment areas such as HIV prevention (and also resilient & sustainable systems for health (RSSH)) where there is a need for better linkage and analysis of funding trends, implementation progress and programmatic results, especially given that quantitative monitoring provides more limited insights on grant progress (as discussed under RQ7).

- Secretariat stakeholders noted that to date there has been more of a focus on KVPs (for prevention and treatment), rather than on primary prevention per se (e.g. for KVPs as well as VMMC, condom programming for all populations with significant HIV prevention needs), in the Global Fund discourse and processes. This was recognised as one of the barriers to obtaining more of a strategic and cross cutting shift to prevention.

(B) The Global Fund's stewardship role for HIV primary prevention at the country level is more challenging, by virtue of its country-led and CCM model, which while offering several advantages across the board, has proven to have particular limitations in the context of HIV primary prevention. Key issues in this regard are:

- **The country-led model relies on country-owned and country-proposed approaches to managing the HIV epidemic, which may not always prioritise high impact interventions for HIV primary prevention**, given the challenging political economy for many of these activities across countries (i.e. political opposition, legal issues, lack of budget lines, etc.). This is notwithstanding the fact that the Global Fund has become more 'directive' over allocation periods whilst maintaining country ownership, as well as more focused (e.g. reducing investment in broad-based interventions such as mass media campaigns). This has raised questions as to whether the Global Fund should be providing more support for TA (discussed below) and whether there should be a larger emphasis on country reviews to help to bring out the evidence-base on key interventions.

- **The principle of country ownership limits to some extent the degree to which cost-effective and VFM interventions in HIV prevention are adopted and scaled-up by countries through their Global Fund grants.** This is because in line with the country-led model, the NSPs are the foundations of funding requests and they may not be prioritising cost-effective interventions for HIV prevention and/ or may not be targeting KVPs (also given the sensitivities around these groups in certain countries). Although the Global Fund provides guidance on the programmatic priorities in HIV primary prevention, in practice the Global Fund country-led model cannot require countries to select HIV prevention interventions with highest cost-effectiveness and/ or to prioritise prevention investments to populations most at risk. The Strategic Review of the Global Fund Strategy conducted in 2020 (SR2020) also found that the Global Fund model leads to prioritisation of biomedical/ facility-based services, mostly focused on scaling up testing and treatment and a weaker prioritisation of activities to scale-up prevention programming and address human rights and gender related barriers.[38] In order to ensure appropriate, prioritised, cost-effective HIV prevention programmes, strong technical support in-country is required in some countries to guide grant design and implementation, whilst ensuring interventions are linked to NSPs and evidence-based programming. To counteract the lack of leverage the country-owned model engenders, the Global Fund has established a system of catalytic investments through which it supports priority interventions, some of which focus on, or include, primary prevention priorities.

- Whilst CCM composition was not explored in detail in this review, based on global level consultations and the Global Fund report on the CCM evolution process,[39] **CCMs in several countries do not include effective champions and core implementers or beneficiaries of HIV primary prevention:** either the right groups are not included (e.g. one representative across KPs is included instead of representatives from multiple KP groups, or no KP organisation is included). See Section 3.4.1 for further details on KP engagement including good examples of KP engagement in CCM processes and challenges.

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[38] Euro Health Group, Itad, UCSF (forthcoming), The Global Fund Strategic Review 2020, Final Report

[39] The Global Fund (2019): Evolving CCMs to Deliver on the Global Fund Strategy. 42nd Board Meeting, November 2019

(B) Global Fund policies and guidelines for funding applications and grant management assist countries in designing programmes that are inclusive of all population groupings and tailored to each country or applicant's needs. However, some aspects could be better leveraged including:[40]

- With regards to the Sustainability and Co-financing (STC) Policy, it has been argued by some that the policy could be more directive in encouraging countries to increase domestic funding for HIV prevention, given it is a less funded area by governments (particularly interventions targeting certain groups, e.g. KPs, when they are criminalised or stigmatised). Whilst Global Fund guidance encourages countries to focus on KVPs (although not specifically prevention), there is a need to ensure that countries focus on a broad range of HIV prevention KVP programme costs within the overall country-led model.[41] Our own assessment, without a detailed review of the STC policy per se, is that the STC policy cannot be the solution to all aspects of Global Fund investments regarding increasing domestic financing of Global Fund investments and that solutions to promote domestic funding for HIV prevention need to consider other avenues as well.
- The Modular Framework (2019)[42] and the 2020 funding request template have been updated to reflect developments in HIV primary prevention and to improve the classification of HIV prevention interventions, although some challenges were observed in the implementation of the new Modular Framework (e.g. the removal of the target population specification in modules to a separate category[43] aimed to lead to better tracking on KP investments has not been filled out comprehensively by all countries during the funding request stage).

3.2.2. Grant application, approval and management processes

(B) The Global Fund technical guidance is generally well aligned with partner guidance but it is overly complex and more theoretical than operable. In particular we note the following issues:

- The **main Global Fund technical guidance (i.e. the HIV Information Note)** is directly in line with, and refers to, guidance set out by UNAIDS, WHO, GPC and other technical partners. It has also improved over time with regards to the emphasis on HIV prevention. However in the 2019 note, there is an imbalance between the guidance on prevention and treatment, e.g. the treatment section is elaborate, comprehensive and applies to most contexts while the prevention section remains relatively unspecific and relies on readers referring to WHO and other guidance, as well as assumes prior knowledge of prevention interventions for different epidemic settings and KPs and relies on the modular framework guidance. Appendix F includes more detail regarding our review of the Global Fund HIV Information Notes and an assessment of changes over time.
- There are multiple **supporting technical guidances from the Global Fund**[44] (alongside a considerable number of partner guidance documents) which is a lot for country stakeholders to navigate. In addition, the Global Fund guidance is largely theoretical rather than operable in the sense that they do not aid the identification of cost-effective priority interventions within a certain resource envelope and achievable impact. Whilst we recognise that intervention prioritisation depends on local epidemic and unit costs, and this

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[40] Guidance reviewed includes Global Fund Guidelines for Grant Budgeting (2019), Modular Framework Handbook (2019), Operational Policy Manual (2019), Value for Money Technical Brief (2019), Guidelines on Principal Recipient Progress Update and Disbursement Request (2017), Guidance Document – Prioritization Framework for Financing Items on the Register of Unfunded Quality Demand (2017), Guidelines on Implementers of Global Fund Grants (2015).

[41] Technical Evaluation Reference Group (2020): Thematic Review on Sustainability, Transition and Co-financing (STC) Policy Position Paper, Management Response and Report January 2020

[42] https://www.theglobalfund.org/media/4755/fundingmodel_applicanthandbook_guide_en.pdf

[43] The Modular Framework in NFM3 (refer below) has separated the target population from the prevention modules. For that reason, the budget template now has an additional tab/worksheet for analysing modules and interventions by target populations. The "Population" tab of the budget template allows for a more focussed analysis of prevention investments by population groupings.

[44] Including on AGYW in High Burden Settings (2020), Harm Reduction for PWID (2017), Technical brief on HIV and key populations (2019), HIV, Human Rights and Gender (2019)

guidance primarily should be provided by partners, some of the guides provide a long list of interventions, which reads more as a menu of options to choose from rather than being prioritised or specified per target population or intervention area (discussed further under RQ3 with regards to VFM).

- When considering **guidance from technical partners**,[45] the quality, robustness and scope of technical guidance for HIV prevention has generally improved. However, guidance documents have also multiplied in number with different levels and approaches, even for the same target KVP, which may make it less clear to countries to decide on which guidance to use. Therefore, a challenge for the Global Fund is with regards to choice of guidance to prioritise, and a challenge for country stakeholders is to navigate the multitude of available resources when designing HIV prevention strategies and grant submissions. Stakeholders in countries such as Indonesia and Côte d'Ivoire observed that generally only technical experts/ consultants hired to assist countries in the funding application process read all the detailed guidance documents in relation to funding requests. Appendix G provides details regarding strategic and technical guidance as well as implementation tools available from partners.

(B) Balancing a country-led approach with an optimal investment approach for HIV prevention within the standard Global Fund processes requires further attention and consideration. In particular, we note the following aspects:

- **Guidance**: In terms of facilitating effective grant design, most global partners interviewed consider the Global Fund technical guidance as mainly suggestive, which reflects the country-led programming approach (with support from technical partners) and consider that the guidance could become more directive and binding. This would further ensure that when a country applies for HIV prevention funding, the interventions proposed are evidence-based in order to be approved (e.g. implying that interventions have to focus on populations most at risk and the interventions themselves have been proven to be effective) and contribute to reaching minimum coverage of KVP interventions (i.e. to aim to achieve the goal of minimum KP intervention coverage of 90% suggested in Global Fund Technical Brief on HIV and KPs (2019)).[46] This is also a particularly significant issue with regards to human rights interventions, especially when there are political sensitivities in countries. One way that the Global Fund incentivises countries is through the use of matching funds, but stakeholders consider that a lot of countries are still not prioritising the most appropriate interventions adequately enough within these to obtain impact with regards to HIV prevention. However, we recognise that one of the challenges of having standard directive guidance is that it can be challenging given different country contexts.

- **TRP review**: Given the relatively light touch approach adopted for reviewing funding requests (i.e. implementation details are not reviewed by the TRP), the TRP is not able to effectively weigh in their expertise for reviewing HIV prevention aspects, which is particularly challenging given the complexity of these interventions. Global and country level stakeholders noted that the detail that is included in the funding request, and thereby reviewed by the TRP, is fairly limited (in line with standard Global Fund processes), which poses a challenge for an effective review by the TRP and also implies that the implementation plans - determined during the grant making stage - can be different from what was covered in the TRP review. This was noted to be an issue which is more challenging for HIV prevention than for HIV treatment programmes as there is a lot more variability in terms of how HIV prevention programmes may be implemented and what is meant in the use of high-level terms. While the benefits of a light touch funding request cannot be undermined, some stakeholders (e.g. in South Africa) suggested that there was a need for more detail to be included upfront in the funding requests. In addition, while some TRP members have very strong expertise in HIV prevention and the contributions are considered to be incredibly useful, given the complexity of HIV prevention, a number of TRP members' expertise is considered either too general (e.g. for community, rights

[45] Guidance including from the GPC, UNAIDS, WHO, UNFPA, Mann Global Health, etc.

[46] Whilst the 90% may be overambitious for a number of countries, there could be a requirement to address scaling up coverage of KP/ AGYW interventions in the funding request (in reference to NSPs).

or gender more broadly) or too specific (e.g. on PrEP or AGYW). Furthermore stakeholder feedback indicates that on some limited occasions, the TRP review has not been in line with recommendations from technical partners and developments in evidence, especially with regards to HIV prevention programs for AGYW. These aspects pose a challenge to obtain strategic insights for HIV prevention investments.

- **Grant making stage:** The grant making stage is the key stage when decisions are made with regards to implementation planning and quality of programming which is a key concern for the Global Fund and partners. There are a number of issues, as follows:
    - At the Secretariat level, we understand that this is a very challenging process given the tight timelines in relation to the extensive and intensive detail that need to be covered. While this is a general issue, for HIV prevention this is particularly challenging given variable expertise as well as prioritisation across Country Teams on this complex area. Further, as there isn't a standardised set of criteria/ checks, as well as limited tracking of how the funding request has been progressed at this stage, there is reduced transparency on the finalisation of planned interventions.
    - At the country level, a few challenges which have been noted, including that unit costs for HIV prevention interventions can be particularly difficult to estimate given they are not standardised (e.g. for KP prevention packages which vary in degrees of comprehensiveness, human rights interventions, community empowerment, etc.), as was an issue flagged during our consultations for the South Africa case study. This can subsequently pose challenges for implementers and as such warrants attention at this stage. In addition, several global and country consultees have reported that KVPs are not as involved in this stage as much as they are in the stage leading up to the funding request submission which poses a barrier to effective grant making (discussed further under RQ5). Finally, there are challenges experienced with target setting which are discussed in RQ7.
- **Funding cycle duration:** Given particular capacity challenges amongst some HIV prevention implementers, and the fact that quite a few HIV prevention programmes are newly introduced within grant funding cycles, stakeholders noted that the three year funding cycle was often too short. Whilst we understand that the funding cycle duration will not be extended, this was noted to be a bigger issue for HIV prevention than other areas and as such warrants consideration with regards to ways in which stronger long term planning can be introduced.

(A) Portfolio optimisation has proven to be a useful mechanism to increase HIV prevention investment by the Global Fund. On the positive side, during grant implementation, portfolio optimisation has been used as mechanism to increase HIV prevention investment. Grant optimisation generally increases budget for prevention interventions, provided they are applied for as part of the prioritised above-allocation request (PAAR) approved by the TRP as such and confirmed as unfunded quality demand (UQD) by the Global Fund Secretariat. Informants noted that the PAAR and UQD have been useful for countries who have applied for prevention investments, especially given that often large proportions of funding request budgets are allocated to supporting HIV treatment. Around US$ 108 million of HIV prevention funding came through the PAAR process during 2017-19.[47] This was the case in Eswatini and Malawi where additional funds for VMMC scale up were received.

(B) Global Fund prerequisites for minimum programmatic, financial, and management capacities and systems may preclude some relevant organisations working in HIV prevention from being PRs or SRs, implying the need for more capacity building.[48]

- **With regards to PRs**, these are often government organisations or national NGOs – which may work well in a number of instances – but in other situations this has caused challenges (discussed further in RQ4). PRs are selected by CCMs in line with the country-led approach but some have questioned whether the right framework is in place for their selection (e.g. in some countries the choice of PR is reportedly made (or is

[47] Global Fund (2020). HIV Prevention Budget Analysis

[48] See: The Global Fund (2015): Guidelines on implementers of Global Fund grants

perceived to be made) by key stakeholders for political reasons). In addition, whilst it may be beneficial to have a larger number of PRs as a way of addressing this issue, in some countries this has created implementation arrangement challenges and therefore in subsequent allocation periods, implementation arrangements have needed to be streamlined with a reduction in PRs (e.g. South Africa).

- **With regards to SRs**, Global Fund-supported programmes are often implemented by a number of high capacity national NGOs who are involved in the implementation of large scale prevention programming, as well as at the community level. However, a challenge is that reportedly Global Fund pre-requisites can sometimes preclude KVP-led organisations from being able to qualify for becoming an implementing organisation (SR or Sub-Sub-Recipient (SSR)), as KVP organisations may lack the required capacity (e.g. to deliver services, manage funds and monitor results). As a result, in a number of countries such as Botswana and Ethiopia, KVP-led organisations are only indirectly involved in programme implementation. Whilst the Global Fund requirements are important to manage risks, some stakeholders have queried whether the required SR/ SSR standard is too high and may create instances where some community-based organisations (CBOs) who have been working in communities for an extended period of time are not selected to implement, which may mean that the SR who is selected is not best placed to adequately reach the KPs targeted, and existing CBOs miss out on opportunities for further capacity building and strengthening. This is the case in Botswana where KP associations and networks do not have the legal status or capacity to be formally included as implementers.

(C) **The Global Fund is considered to be relatively slow at offering support for new interventions/ innovations**. Global and country stakeholders consider that the Global Fund is slower at introducing innovative products than other partners such as PEPFAR. Stakeholders noted that there is demand from countries (e.g. Indonesia, South Africa, Philippines) to adopt more innovative approaches as it is recognised that sufficient gains have not been made with interventions applied so far. A number of stakeholders consider the slow uptake of innovations to be due to the fact that there is no clear mechanism within the Global Fund to provide a concerted and timely response to technical innovations. However other stakeholder feedback indicates that the Global Fund process to introduce new innovations includes: (i) technical partners recommending the introduction as well as country policies adopting the innovation and (ii) depending on the timing of the introduction of the new intervention, this may lead to grant revisions and if particularly significant, these may require TRP review. The latter aspect is considered to be one of the barriers to adoption of new innovations. However, one stakeholder noted that in some instances while countries wanted to try innovative approaches (e.g. PrEP, online outreach), there was hesitancy to adopt this, considered to be due to a general hesitancy to introduce new innovations. Alongside the Global Fund's approach to introducing new innovations, some countries have reportedly been slow in taking up new interventions such as PrEP due to political barriers given that PrEP is prioritised for KPs, despite a number of country stakeholders recognising the demand for it.

In addition, there were a number of key points regarding Global Fund processes that were mentioned with regards to measurement which is discussed under RQ7, TA which is discussed below and specific management aspects which are picked up in Section 3.3.1.

3.2.3. Technical assistance

A number of the issues discussed below apply to TA in relation to Global Fund grants more generally, however they are particularly acute for HIV prevention programmes given their complexity, multi-sectoral nature, as well as the type of organisations involved in implementation (i.e. smaller-scale CBOs, NGOs and KP groups).

(A) **TA in relation to Global Fund grants, both generally for HIV and specifically for HIV prevention, is provided through a number of channels which are not well-coordinated resulting in limited visibility, oversight and potential impact of TA investments.** As a financing institution, the Global Fund primarily depends on technical partners to provide TA. However, evidence from Global Fund documents and stakeholders suggest that there are a range of mechanisms to provide TA, which are not always clear to stakeholders, nor well-coordinated, resulting in limited visibility, oversight and impact of investments in TA. Recent reviews of the Global Fund's TA have identified

three main mechanisms for TA: (i) TA investments of bilateral set-asides[49] and of multilateral partners financed through other resources; (ii) TA investments embedded in Global Fund grants; and (iii) TA investments by the Global Fund's Strategic Initiatives.[50] In addition to the TA provided by partners, the Global Fund Secretariat itself also provides technical support to countries and grant recipients, including support provided by the following Secretariat teams: (i) Country Teams; (ii) the HIV Team; and (iii) the Community, Right and Gender unit.[51] A number of structural weaknesses hamper the Global Fund Secretariat's ability to track, monitor and assess the potential impact of these TA flows:

- **The Global Fund has limited visibility and influence over TA** provided by bilateral and multilateral partners through their set-asides.[52] This not only constrains the ability of the Global Fund to plan and coordinate TA, but also enhances the risk of duplication and reduces potential for long-term impact.[53] The recent external review of the GPC also observed weaknesses in the coordination and transparency of HIV prevention TA provided by partners.[54]
- **The Global Fund lacks a well-defined structure to oversee and monitor TA investments:**[55] there is no consolidated TA planning and no specific monitoring of TA by Country Teams;
- **The Global Fund's management of TA is fragmented** and spread across a number of Secretariat divisions and departments[56] with no clear roles and responsibilities limiting the potential for synergies.

Despite these systemic weaknesses, at the global level there is some evidence that coordination is improving to better align the supply and demand of TA, specifically for HIV. The SR2020 review and stakeholders interviewed identified the HIV Situation Room[57] as a useful platform in bringing bilateral and multilateral partners together with Global Fund Secretariat, although there was mixed evidence of its effectiveness in resolving grant implementation issues linked to TA. SR2020 also found some level of coordination amongst technical support mechanisms of bilateral set-asides for HIV: for example, UNAIDS Technical Support Mechanism (TSM), GIZ and Expertise France shared country draft

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[49] The bilateral set-asides model refers to "the funding channelled directly by bilateral partners (donors) to country partners using a proportion of their total contribution to the Global Fund set aside for use alongside Global Fund-managed programmes" (Global Fund, Partnership Model Review, 2018, p.vi).

[50] Source: OIG (2020) Audit Report on capacity building and TA. However, SR2020 identifies an additional mechanism of "private sector in-kind donations", but these make up a very small proportion of overall TA flows. Overall, SR2020 analysis of TA investments estimated funding flows at US$ 725million 2017-2019, including the "private sector in-kind donations". (Source: Euro Health Group, Itad, UCSF (forthcoming), The Global Fund Strategic Review 2020, Final Report).

[51] (i) Country Teams (within the GMD): they support countries and organisations applying for country grants and strategic initiatives by providing the country Allocation Letters; dialoguing about the potential focus on applications and suggesting which technical guidance produced by the Global Fund and by partners would be useful for the country / applicant to follow. (ii) HIV Team (within the Technical Advice and Partnerships (TAP) of the Strategy, Investment and Impact Division (SIID)): they provide technical support to Secretariat Country Teams. They also review funding applications and provide advice to Country Teams on applications. (iii) Community, Right and Gender unit (within the Global Fund Strategic Investment Department): provides TA to countries and organisations applying for country grants and for strategic initiative as well as during grant implementation.

[52] OIG (2020) Audit Report on capacity building and TA, p.11 and Euro Health Group, Itad, UCSF (forthcoming), The Global Fund Strategic Review 2020, Final Report

[53] The issue of duplication was also noted in the TERG Thematic Review of Partnerships (2019): "*Insufficient communication about investments and activities amongst technical partners, and with the Global Fund Secretariat, leads to duplication*". Global Fund (2019) TERG Thematic Review of Partnerships (2019)

[54] Barbara O. de Zalduondo, L. Gelmon and H. Jackson (2020) External Review of the Global HIV Prevention Coalition and 2020 Road Map; Final Report. October 5, 2020

[55] OIG (2020) Audit Report on capacity building and TA, p.12 and Euro Health Group, Itad, UCSF (forthcoming), The Global Fund Strategic Review 2020, Final Report

[56] OIG (2020) Audit Report on capacity building and TA, p.12 and Euro Health Group, Itad, UCSF (forthcoming), The Global Fund Strategic Review 2020, Final Report

[57] The HIV Situation Room is hosted by the Global Fund and co-chaired by PEPFAR, UNAIDS and WHO; this aims to coordinate the provision of operational and technical support to countries, including for HIV primary prevention interventions in countries.

TA plans, whilst GIZ's Backup Health initiative has adopted a transparent approach with the Global Fund.[58,59] The TERG Thematic Review of Partnerships (2019) noted that "*Set Asides support works best when there is a planning and implementation link between the bilateral funder, the technical assistance provider, the country partner, and the Global Fund/ CCM*".[60]

(A/B) The level of TA available for HIV prevention is generally considered adequate by countries, but there are weaknesses in sourcing and delivery of TA and in using it for technical and organisational capacity strengthening. As noted above, the Global Fund provides TA to countries through its partners via a number of channels. Despite the limited visibility of the amounts of funding being provided specifically for TA for HIV prevention, available evidence from the country case studies indicates that the levels of TA have generally been appropriate. However, the Global Fund's TA approach is not viewed as being adequate for HIV prevention due to: (i) TA for the design of grants has been more forthcoming than TA for implementation and monitoring of grants; (ii) challenges related to sourcing partners with the appropriate expertise to support implementers; and (iii) challenges with TA for capacity building of implementers:

- **TA for the design of grants has been more forthcoming than TA for implementation and monitoring of grants:** The Global Fund's country ownership model means that countries are largely responsible for the sourcing of the TA providers through grants. Combined with the Global Fund's decentralised approach to providing TA (as described above), the model does not enable the Global Fund to have clear view of TA needs of HIV prevention programming throughout the whole grant cycle (from design to implementation to monitoring) and to match those with the technical partners who have the best capacity to provide support. Findings from the country case studies highlight that whilst funding TA for HIV prevention is generally available, there are still a number of gaps in terms of TA needs, in particular during the implementation and monitoring of HIV prevention programmes. This is important given the country-led approach and the need for adequate technical support to be provided to countries, particularly in the area of HIV prevention programming which generally is more complex to design than other areas of the HIV response. For example, in the Philippines, stakeholders noted that although there was sufficient TA for HIV prevention programmes, additional areas for implementation support were identified. Similarly, in Botswana stakeholders noted that although Global Fund and partners have provided TA during funding request and implementation, more technical support would be appreciated during grant implementation to better monitor the quality of implementation and the burn rate. The recent annual GPC progress report observed that there are technical assistance gaps, for example, "*for tackling structural barriers, promoting social contracting, condom market development, programme management and integration with sexual and reproductive health services*".[61] In addition, TA may be budgeted under programme management rather than being linked to programmatic delivery and therefore this poses a challenge to the 'visibility' and retention of budgets for TA.

- **There are challenges in sourcing multi-sectoral and up-to-date technical expertise on HIV prevention, and an overreliance on United Nations (UN) agencies**: Stakeholders have identified the sourcing of expertise for TA for all aspects of HIV prevention as a key challenge. Overall, stakeholders noted an overreliance on TA being provided by UN agencies, even when they are not necessarily the best placed providers for specific HIV prevention technical needs, especially in relation to implementation. This is mainly because of the broad needs for HIV prevention - which go beyond biomedical interventions to also cover behavioural and structural interventions – and as such, there is also a challenge in determining who the most appropriate TA providers are, even within the family of UN agencies. Stakeholders mentioned that the quality and consistency of TA provided reportedly varies between countries depending on expertise, availability and commitment of UN staff in countries and on resources available to fund the TA. Therefore, there is a need to

[58] Euro Health Group, Itad, UCSF (forthcoming), The Global Fund Strategic Review 2020

[59] OIG (2020) Audit Report on Capacity building and Technical Assistance

[60] Global Fund (2019) TERG Thematic Review of Partnerships

[61] GPC (2020): Implementation of the HIV Prevention 2020 Road Map; Fourth Progress Report, November 2020

expand the types of providers both multi-sectorally and also beyond UN agencies, to also include country-level and community agencies. Global Fund Secretariat suggested that they found it useful to involve regional UN offices which often have greater technical expertise than their country-based colleagues and can encourage their country offices to support grant design and implementation through TA and other resources. It has also been observed that TA for prevention platforms/networks benefit from a range of types of providers, including (regional) civil society organisations, where prevention programme delivery at scale is one of the key competencies. An additional issue that has been highlighted, especially with regards to AGYW and human rights programming, is the need to ensure that sourcing of the TA is technically "up-to-date" and provided by experts/specialist in the respective fields. The availability of high-quality TA for AGYW interventions was seen as critical challenge. This is particularly an issue due to the fact that there is limited consensus globally on what constitutes quality programming for AGYW, thereby making it challenging for TA providers and consultants to deliver high-quality support. For example, in Cameroon, TA was seen as a barrier for AGYW as the intervention was new and the TA required to develop protocols did not deliver expected outputs. In addition, in South Africa, there were challenges in sourcing appropriate TA to support the wide spectrum of interventions provided by the AGYW programme, in line with continually updated technical guidance which was seen as a barrier to implementation. This is especially relevant given the wide-ranging spectrum of interventions and the fact that technical guidance is continually being updated to reflect the best available evidence. In this respect, one example of best practice that was noted as potentially replicable for HIV prevention, is the existence of a multi-country learning network of professionals on HIV Differentiated Service Delivery – the CQUIN Network – as a reference point to provide quality and up-to-date technical TA in countries.[62]

- **Challenges in capacity building of implementers, especially community organisations, for HIV prevention:** Particularly, stakeholders noted that programme management can often be weak within the HIV prevention sphere and that there is a need to strengthen the organisational and managerial capacity of implementors, particularly civil society and community-led organisations who are (sub-)sub-recipients of Global Fund grants (this was also noted in our country case studies such as Côte d'Ivoire, Ethiopia and the Philippines). This is especially important for HIV prevention given that the effectiveness of TA provided to implementing community organisations is dependent on these organisations' capacity to access and absorb the right-type of TA for HIV prevention (i.e. targeted capacity strengthening rather than "fly-in/ fly-out consultants"). To improve this, stakeholders have suggested the inclusion of: (i) "dynamic portfolio support" in Global Fund grants to support capacity strengthening of civil society SR and SSRs, especially the provision of country-level TA by national civil society organisations (CSO) to community organisations during development of funding requests; and (ii) the provision of support by regional organisations to countries and the facilitation of cross-country TA (e.g. South-South collaboration) to promote horizontal learning, particularly in "sensitive" areas such as HIV prevention programmes for KVPs and lowering of human rights barriers. Country level evidence suggests that these approaches are successful in strengthening the capacity of implementers through the provision of TA for HIV prevention. For example, in 2017 the Kenya civil society PR, the Kenya Red Cross, provided support to CBOs during the development of funding requests. As a result, a number of Kenyan community groups are now well-established implementers and some even managed to obtain PEPFAR funding during following years for additional programme implementation. Similarly, reportedly CSOs have provided useful and cost-effective South-South collaboration, such as Frontline AIDS bringing together Ukrainian civil society HIV prevention specialists working with Kenyan HIV prevention CBOs to build capacity for harm reduction programming in Kenya.

Thus, it is important to recognise that **TA for prevention programming has to be tailored to the specific needs of the technical area and scale of interventions targeted by the TA.** For example, TA for KPs will address different needs to the TA for AGYW or the TA for large-scale prevention programme delivery and that the TA will be most effective when it is delivered by providers whose key competencies are able to address those needs.

[62] https://cquin.icap.columbia.edu/

(A/B) Recently, there has been a greater focus on the provision of TA by the Global Fund to address key issues related to HIV prevention for KPs and AGYW, including through CRG and AGYW Strategic Initiatives. Strategic Initiatives are one of the Global Fund's mechanisms supporting the provision of TA. The CRG Strategic Initiative is a US$ 15million investment over the 2017-2019 period (and renewed during the 2020-2022 cycle) aimed at strengthening the meaningful engagement of civil society and communities in Global Fund related processes[63] through supporting the provision of short-term and long-term TA to communities.[64] Both the recent evaluation of the CRG Strategic Initiative[65] and consultees for this review have noted that TA for communities is being used to strengthen the engagement of KVPs in HIV-related country dialogue. One stakeholder noted that the TA provided through the CRG Strategic Initiative enabled KPs such as TG to be part of the dialogue with the CCM and giving them voice to identify their needs and discuss them with the PR, not just during the Country Dialogue phase but throughout the grant process. The evaluation of the CRG Strategic Initiative also found evidence that: "*Key populations communities received assistance to assure integration of their HIV-related needs into funding requests in five countries and one multi-country grant".* In South Africa "*the TA provided allowed the country to identify, prioritize and define activities for KPs*". Similarly, there were a number of lessons learnt which informed the AGYW Strategic Initiative for 2020-2022 to streamline the focus of the TA being provided and to strengthen links to programmatic outcomes for HIV incidence reduction.[66] In this respect, during the 2020-2022 cycle the AGYW Strategic Initiative aims to support HIV incidence reduction in line with Key Performance Indicator (KPI) 8 by focussing on country driven TA with the aim of strengthening and improving implementation quality.[67]

3.2.4. Partnerships

The Global Fund's participation in global level HIV prevention coordination and advocacy mechanisms such as the GPC are discussed in Section 3.1 while this section looks at the Global Fund's partnership model and how it coordinates and harmonises support with partners.

(B) In general, the Global Fund's model is considered to be participatory, inclusive and open to close collaboration with partners, including for HIV prevention investments.

Global partners welcome that they are represented on the Global Fund's Board and other global level coordination and advisory mechanisms which enables them to contribute to policy-making and decision-making on HIV prevention. They also appreciate that their country-level colleagues and partner organisations are represented to the CCM in countries, which offers opportunities for participating in decision making on HIV prevention interventions supported by the Global Fund. The 2019 TERG partnership review states that where possible, Global Fund partnerships should

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[63] Global Fund (2020) The Community, Rights and Gender Strategic Initiative: Engaged Communities, Effective Grants, Update, June 2020

[64] Component 1: short-term TA providing peer-led TA to ensure that communities are meaningfully engaged in Global Fund - related processes; Component 2: long-term capacity building to ensure that communities are (i) engaging safely and effectively; (ii) advocating for increase investment and more rights-based and gender responsive programmes, and (iii) adapting and using evidence-based implementation tools and guidance; and Component 3 support to regional platforms strengthening communication and coordination systems to ensure that communities are (i) utilizing quality information and communication; (ii) participating in decision-making processes; and (iii) accessing coordinated and harmonised TA and support.

[65] APMG Health (2020) Community, Rights and Gender Strategic Initiative 2017-2019 Independent evaluation, June 2020.

[66] Lessons learnt include the need to shift TA requests on AGYW topics to specific areas that: (i) implementers are likely to struggle with; (ii) are not addressed within the grants; (iii) require external expertise; and (iv) require support to operationalize new evidence. GFATM, "Adolescent Girls and Young Women Strategic Initiative (AGYW SI)" presentation to SI Office and Business Partners Review, 7 May 2020

[67] The two objectives of the AGYW SI are: (i) To improve AGYW implementation quality through TA that prioritises innovative implementation arrangements and growing/ strengthening local expertise; and (ii) To increase domestic financing through TA for critical processes and enablers. Source: Adolescent Girls and Young Women Strategic Initiative (AGYW SI), For SI Office and Business Partners Review, 7 May 2020.

incorporate demand and meaningful participation by KVPs as well as broader communities.[68] See Section 3.3.3 for further details on KVP engagement.

(B) Global level coordination and harmonisation with partners for HIV primary prevention represents a mixed picture with room for improvement, whereas country level coordination is generally considered to work well.

- The Global Fund Secretariat is perceived as committed to coordination and harmonisation with major donors through regular meetings at the global level. For example, the Global Fund signed various co-financing agreements with the World Bank to support priority issues in certain countries,[69] and has regular meetings with USAID-PEPFAR to align priorities of HIV response support and ensure geographic coordination of support. However, some stakeholders interviewed consider the current global level engagement by the Global Fund Secretariat with donors as less active compared to previous periods and the challenges of coordinating with technical partners on TA has been described above. In general, the level of engagement with partners reportedly depends on the interest of the partner, and varies when Global Fund Secretariat and partner staff change. Engagement of the Global Fund with regional offices of technical partners, particularly UN agencies, was found useful but also reportedly varied following rotation in regional staff.

- Stakeholders interviewed consider that the Global Fund could play a more active role in facilitating exchange of information between partners and donors at global level on programmes supported. For example, global community and advocacy partners in general complained of lack of transparency on investment and results data, e.g. not easy to access such data on the Global Fund website, etc. Stakeholders suggested that the Global Fund strengthen partnership with global and regional NGOs working in the area of Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) in order to strengthen integration approaches between HIV (prevention) responses and SRH services and with community health approaches.

- Global Fund technical partnerships at global level are perceived as more organised whereas partnership with other entities are perceived as more ad-hoc. Global stakeholders described the Global Fund's specific technical partnerships - such as the HIV situation room, the CRG department with global and regional advocacy and community groups,[70] and the joint working group with WHO – as seeming more organised in themselves, whereas the Global Fund's partnerships with other UN agencies, other donors, other global health mechanisms and global funding mechanisms and civil society service providers - are perceived to function more on an ad-hoc basis.

The 2019 TERG partnership review states that it is important to ensure a clear identification of roles and responsibilities between the Global Fund and its partners and that these can be defined in Memoranda of Understanding (MoUs) to ensure better alignment and coordination.[71] In the past years, the Global Fund has signed and renewed MoUs with a wide range of technical, advocacy and funding partners, such as UNAIDS[72] (on behalf of the UNAIDS Secretariat and co-sponsor UN organisations), WHO,[73] the World Bank, and the Inter-Parliamentary Union.[74] These MoUs aim to strengthen the partnership between the Global Fund and its partners and agree on joint positions and roles for provision of funding, technical support and advocacy efforts, including regarding HIV primary

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[68] Itad (2019), Thematic review of the Global Fund country level technical support partnership model, final report

[69] https://www.theglobalfund.org/en/news/2019-10-22-world-bank-and-global-fund-deepen-partnership-with-co-financing-agreement/

[70] The CRG department's partnership with global and regional advocacy and community groups focuses on issues related to KP and AGYW programming, including for HIV primary prevention interventions.

[71] Itad (2019): Thematic review of the Global Fund country level technical support partnership model, final report

[72] https://www.theglobalfund.org/en/news/2014-12-09-unaids-and-global-fund-sign-cooperation-agreement/

[73] https://www.theglobalfund.org/en/news/2017-12-01-who-and-global-fund-sign-cooperation-agreements/

[74] https://www.theglobalfund.org/en/news/2017-03-23-global-fund-and-inter-parliamentary-union-sign-mou/

prevention priorities.[75] However, stakeholders interviewed mentioned that MoUs do not guarantee that partnerships between the Global Fund and its partners are strong.

At country level, the Global Fund model facilitates harmonisation of Global Fund support with support provided by the country government and other partners. The funding request requires mapping of current and planned HIV response support and a gap analysis to inform the programmatic and geographic areas to which Global Fund investments should be targeted. Informants consider that at country level the Global Fund is committed to strengthening partnerships and facilitating coordination of its support with support provided by national governments and other partners. This was confirmed in Côte d'Ivoire, Jamaica and Indonesia where there is harmonisation of support provided by various partners in order to avoid duplication. However, whereas national health sector and multisectoral coordination mechanisms are usually led by country governments, global and regional stakeholders interviewed consider that the Global Fund could play a more active role in facilitating exchange of information between country-level partners and donors on programmes supported.

3.3. COUNTRY INVESTMENTS AND IMPLEMENTATION

The third review pillar focuses on aspects that are working well and less well at the country level. We first consider country grant design, including an assessment as to how well Global Fund grants are positioned within country responses to the HIV epidemic (Section 3.3.1), followed by achievements and challenges in grant implementation (Section 3.3.2). Cross cutting issues are also discussed with regards to KVP engagement (Section 3.3.3), issues impacting scale-up (Section 3.3.4) and measurement of HIV primary prevention investments (Section 3.3.5).

3.3.1. Country grant design

RQ 3: How well are Global Fund grants positioned and targeted in a country response to the HIV epidemic?

We consider several aspects of grant design including: (i) extent of effective inclusion of HIV prevention interventions in the current allocation cycle (NFM2) grants and contributing factors; (ii) retention of HIV prevention interventions in grants following funding requests – the extent to which this has been the case and reasons for attrition; (iii) value for money (VFM); and (iv) sustainability. A summary of the main findings for each of these areas is presented in the table below, followed by more details on the evidence base and analysis.

Area of review	Key findings
Inclusion of HIV prevention interventions in NFM2 grants	• In essence, effective inclusion of HIV prevention in country grants is determined by (i) quality NSPs and other relevant strategies; (ii) quality TA for NSP development and funding requests; (iii) use of guidance; (iv) timely/ early conducting of situational analyses alongside availability of disaggregated data as well as other studies; (v) structural and political barriers; (vi) KVP engagement and (vii) total resource envelope for the HIV response. • There has been some progress made in NFM2 with regards to (i) the extent to which HIV prevention interventions are being prioritised for the relevant populations and geographical areas; and (ii) the inclusion of more evidence-based high impact interventions in grants. However further improvements are needed. • Catalytic funding approaches in NFM2 have been key for HIV primary prevention investments being included in grants, although the quality of the focus of the interventions could be further improved in some instances.
Retention of HIV prevention interventions in grants following funding requests	• When comparing the budgets for HIV prevention between funding requests and current grant budgets, there has been a decrease of 10% across GPC countries in NFM2, despite an increase in funding for HIV overall (4%). Evidence from case study countries (and select other countries) suggest key reasons for this decline include a re-categorisation of interventions in the Modular Framework and grant consolidation to avoid duplication with other funders. Wider discussions with both global and country stakeholders have also

[75] For example, the AGYW TA provided by WHO and UNICEF in the last funding cycle was through an MOU.

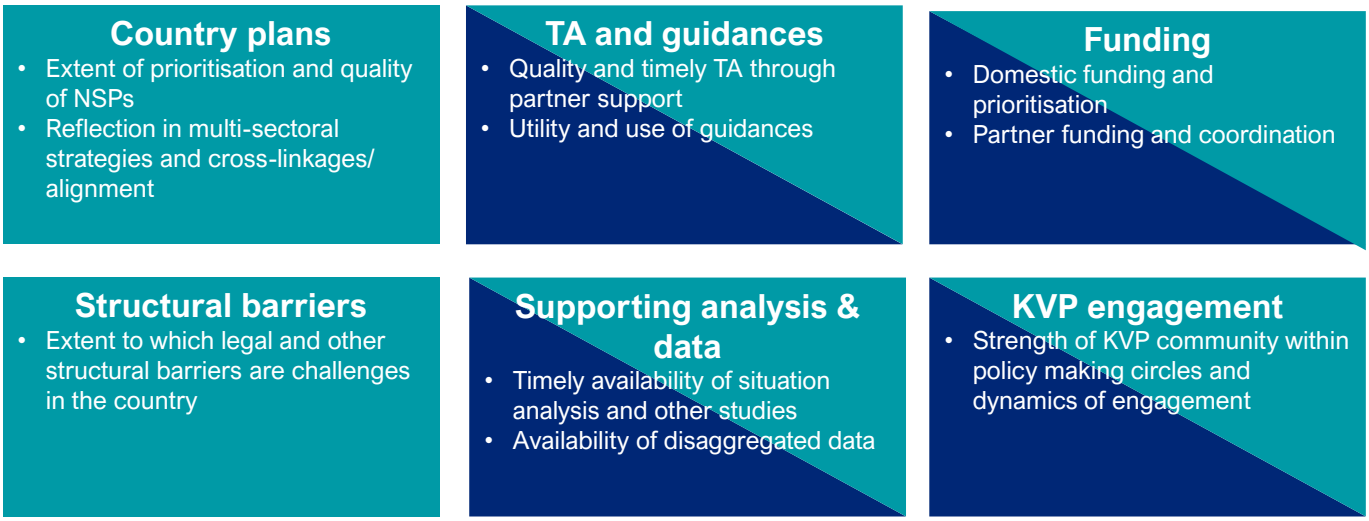
Area of review	Key findings
	suggested a potential deprioritisation of HIV primary prevention funding, but this review has not been able to gather robust evidence to support this claim. Overall the need for greater transparency in budget developments over time has been highlighted.
Value for Money (VFM)	• Lack of consolidated guidance and information on "best buys" as well as challenges with data availability have prevented effective VFM assessments in grant design. There is a mixed picture as to whether VFM considerations have been incorporated by countries – although TRP and Secretariat reviews have been helpful in this regard. There is evidence of cost effective and VFM investments being included in grants but there is a high focus on SBCC interventions which are not deemed to represent VFM in all contexts. There is limited evidence to ascertain the VFM of certain interventions, posing challenges for assessing the inclusion of these interventions in HIV prevention programming.
Sustainability	• Through the STC Policy, countries are increasingly cognisant of the sustainability of HIV prevention programmes in their grants but key issues remain with regards to (i) financial support to HIV prevention programmes for KPs/ KVPs and (ii) social contracting.

Inclusion of HIV prevention interventions in NFM2 grants

(B/C) **In essence, effective inclusion of HIV prevention in country grants is determined by (i) quality NSPs and other relevant strategies; (ii) quality TA for NSP development and funding requests; (iii) use of guidance; (iv) timely/ early conducting of situational analyses alongside availability of disaggregated data as well as other studies; (v) structural and political barriers; (vi) KVP engagement and (vii) total resource envelope for the HIV response.**

These are summarised in Figure 3.6 and then discussed in turn below.

Figure 3.6: Key aspects impacting effective inclusion of HIV prevention in funding requests



**Blue refers to issues that can be impacted by Global Fund processes and systems and green refers to country level issues.*

NSPs and other relevant strategies: Given the Global Fund's country-led approach, the extent to which HIV prevention is incorporated, and aligned across national strategies and primary health care approaches in countries, has a significant effect on Global Fund HIV prevention grant design.

There have been a number of positive examples within our case study countries, with strong national strategies which are based on epidemiological data, reviews and include prioritisation on investment areas (including examples where the funding requests themselves have contributed to stronger NSPs), as presented in the box below.

South Africa has a strong multi-sectoral NSP which was designed based on extensive situational analysis including programme reviews and bio-behavioural surveys (BBS).[76] In addition to their NSP, South Africa has plans such as the National Sex Worker HIV plan, and a national human rights plan to respond to human rights-related barriers to HIV and TB services and gender inequality.[77] These strategies, including prevention priorities, supported the development of a funding request which appropriately prioritised HIV prevention (alongside the fact that treatment is covered with domestic funds).

In the **Philippines**, there was a step-wise approach to the funding request for NFM3, which started with a consultative joint programme review of the existing HIV efforts, and then lessons learned from the review were used to develop the next NSP (the Health Sector HIV Strategic plan 2020-22). The funding request under NFM3 drew lessons from the joint programme review and is closely aligned to the national strategy.

In **Côte d'Ivoire** a similar process to the Philippines was used with a step-wise approach starting with conducting a joint review of the current NSP implementation, followed by the development of the new HIV NSP, and then development of the NFM3 funding request. The situation analyses and modelling of most effective HIV prevention investments, conducted under the leadership of the government and with support from various partners, were seen as crucial for providing orientation and prioritisation of both the NSP and the Global Fund funding request.

In **Indonesia**, there is evidence of synergistic effects between the Global Fund grant and the National Strategic Plan of Action (NSPA) for HIV and AIDS as the development of Global Fund funding requests have contributed to better and more fully integrating HIV prevention into NSPs. HIV prevention programmes for KVPs are fully integrated into the national strategy and plans for HIV prevention, care and treatment (2020-2024 NSPA).

However there have also been some issues in this regard, particularly in terms of *inadequate reflection of prevention in multi-sectoral strategies*. HIV primary prevention is relevant for a number of country-level strategies including HIV NSPs, national health, primary health care, community health, human rights and gender strategies. Global level stakeholders reported that there is insufficient attention on how prevention aligns across these strategies. This is especially the case for community strategies, where HIV primary prevention components are often not reflected, and also these strategies are not operationalised which can create barriers to funding and implementation. However, there have been some gains made recently in communities, for example with regards to community health strategies in West and Central African countries.

TA for NSP development and funding requests: In some countries, the level and quality of TA for both the development of the NSP as well as funding request has been a key determinant of the quality of design and programming for HIV prevention within Global Fund grants (see examples in the box below).

In **South Africa** considerable resources were dedicated to support NSP development which aided the development of a strong NSP.

In the **Philippines** and **Côte d'Ivoire,** the process for the joint programme review, update of the NSP and the funding request was well supported through multiple external consultants funded through UNAIDS.

In **Indonesia**, the design and development of the Global Fund funding request, NSPA and HIV/ sexually transmitted infection (STI) programme review all benefited from strong TA mobilised and coordinated across different partners – in all of these cases, the TA was considered as key to developing a strong funding request aligned with the NSP.

Quality TA was credited with increasing the inclusion of HIV prevention interventions in **Côte d'Ivoire** where a KP expert was part of the technical support team assisting the country in developing the funding request. The expert was able to ensure that the evidence for HIV prevention programmes for KVPs was better compiled and presented in the funding request, and could effectively explain the required focus on HIV prevention programmes supporting KVPs during meetings with decision-makers.

Use of guidance from the Global Fund and partners: Notwithstanding the challenges with the guidelines as discussed in Section 3.2.2, overall, they have supported development of HIV prevention interventions within funding requests. As an example, global level stakeholders noted that the quality of AGYW interventions submitted have improved in recent years based on using Global Fund and partner guidance, although the VFM guidance was used

[76] South Africa's National Strategic Plan for HIV, TB and STIs 2017-2022

[77] South Africa's National Human Rights Plan. A comprehensive response to human rights-related barriers to HIV and TB services and gender inequality in South Africa

less (discussed below). However, some countries have reportedly not followed the guidance in instances where they are not aware of its existence, or because they have found it challenging to navigate through the multiple guidances.

Timely/ early conducting of situational analyses alongside availability of disaggregated data as well as other studies: In Botswana and Côte d'Ivoire, stakeholders interviewed credited the timely/ early conducting of situation analysis as having facilitated the advocacy work by country partners with government to accord priority to HIV programmes for KVPs, and thus having contributed to increasing the inclusion of HIV prevention interventions in the funding request. In addition, where disaggregated data, and/ or other studies such as allocation efficiency studies, were available, HIV prevention investments were more appropriately included (including the prioritisation of investments geographically, and by populations). However, this has been challenging for many countries, with KVP data disaggregation not being available in many instances (as discussed in RQ7). Further, in some contexts, findings from Prospective Country Evaluations (PCEs) have resulted in increased investments for HIV prevention, with Sudan and Mozambique being highlighted as particular examples where funding requests were changed following PCE reports suggesting additional prevention activities be included in funding requests.[78]

Structural and political barriers, specifically:

- Political barriers: Political will and commitment to HIV is critical in the HIV response, particularly to support the needs of KPs.[79] However, the lack of political will to respond to HIV and particularly to the needs of KP is an extensive issue in many countries, resulting in the de-prioritisation of certain populations and services from receiving funding, including in funding requests.[80]
- Structural barriers: The lack of political commitment is deeply intertwined in the existence of structural barriers, including the criminalisation of sex workers, of same sex relations and of the possession and use of drugs, as well as unequal gender norms resulting in stigma and discrimination, violence and abuse, and increasing HIV risk and vulnerability for KP. Amongst other barriers, the TRP noted undue criminalisation and regressive policing to be an issue in the 2017-2019 funding requests. As a result of these barriers there is insufficient focus on the needs of groups who are most at risk (see also Section 3.3.4).

KVP engagement: The strength of engagement of the KVP community within policy making circles and the dynamics of engagement is another key issue affecting inclusion of HIV prevention interventions, especially for KVP in policies as well as funding requests. This is discussed in Section 3.3.3.

Total resource envelope for the HIV response including from domestic resources as well as funding from other partners: A key issue determining the extent to which HIV prevention is included in funding requests is the total resource envelope available for the HIV response from domestic financing and support from other donors. In many countries, HIV prevention is de-prioritised due to the need to allocate funds to other HIV response interventions, especially treatment (e.g. as evidenced in Botswana, Côte d'Ivoire and Ethiopia in our country case studies). However there are some exceptions including: (i) countries which can domestically fund treatment (e.g. South Africa where domestic resources are used to fund treatment and therefore a very large component of the HIV grant is allocated to prevention); and (ii) countries where it is more politically favourable to use partner resources to fund KVP prevention components rather than domestic resources.

In addition, a key aspect influencing HIV prevention requests is with regard to investments from other donors, with PEPFAR investments being the most relevant. Reportedly there has been improvements in the collaboration between the Global Fund and PEPFAR at the global level which has aided further harmonisation of investments in countries, especially following a mapping process of investments where the organisations have subsequently focused their

[78] Global Fund TERG (2020), Position Paper on findings from Prospective Country Evaluations (PCEs)

[79] One positive development is that in some instances participation in the GPC by countries has contributed to high-level officials in countries being more aware of and committed to addressing HIV prevention as part of their national strategies and including it in funding requests to the Global Fund (e.g. Côte d'Ivoire).

[80] A Quarter for Prevention? Global Fund Investments in HIV Prevention Interventions in Generalized African Epidemics

investments in countries. This also helped these organisations to ascertain which hot-spot areas were not being funded by either organisation (some specific examples are included in the box).

In **Jamaica**, Global Fund and PEPFAR funding (as well as funding from government) is provided to the same organisations supporting prevention, though specific activities supported by these funds differs. Consultees noted that both organisations work closely together to ensure that their funding is well-coordinated, enabling organisations to plan their preventions programmes effectively.

In **South Africa**, at the start of the NFM2 implementation period, it was established that there was overlap in sub-district being supported by both the Global Fund and PEPFAR and subsequently the HIV prevention programme supported by Global Fund was moved to another location to avoid overlap. This caused implementation delays for that programme but was considered positive with regards to avoiding duplication. In general there have been coordination discussions, especially with regards to PEPFAR expanding their DREAMS programme, which stakeholder consider to be ensuring improvements with regards to alignment and ensuring complementarity or programmes.

However, there have been challenges reported in harmonisation between interventions supported by the Global Fund and PEPFAR in countries. The fact that the PEPFAR investments have annual planning cycles whereas Global Fund supports 3-year cycles is sometimes a further challenge here. Global stakeholders reported that during a Global Fund grant cycle, US Government authorities sometimes shifted the geographic targeting of PEPFAR interventions, which in some cases resulted in PEPFAR investments including districts or areas previously allocated to the Global Fund, which then resulted in the duplication of efforts (e.g. Botswana).

(B/C) There has been some progress made in NFM2 with regards to (i) the extent to which HIV prevention interventions are being prioritised for the relevant populations and geographical areas; and (ii) the inclusion of more evidence-based high impact interventions in grants. However further improvements are needed.

There have been some examples of improvements with regards to countries adequately prioritising populations and geographical areas with Global Fund HIV prevention investments, with the TRP noting that there has been (i) better quality descriptions of epidemiology in terms of geographic and sub-populations identified; and (ii) a general increase in willingness of countries to invest in KP programmes.[81] Our analysis of GPC countries comparing country epidemiology type with the intervention pillars supported showed good correlation of appropriate interventions for the epidemic type. Positive and negative examples from our country case studies are summarised in the box below.

More **positive** examples from country case studies include the Philippines, Ukraine and South Africa where there have been examples of good prioritisation on KPs as well as geographic locations with the highest need. In South Africa, further prioritisation of districts to receive support was decided upon post TRP review and whilst that was a difficult process for stakeholders, many stakeholders consider it to be a strength of the grant. In Ukraine, there is strong data on the population group driving the epidemic (particularly PWID) and the interventions for this population group are appropriately reflected in the grant. In Ethiopia, the TRP grant review and approval process informed the shift of prioritisation of prevention investment from general population to some KP groups, especially SW (although there is need for ongoing efforts in this regard, discussed below).

Findings from our review regarding **insufficient attention on groups** most at risk include: (i) in the Philippines this was particularly relevant for PWID interventions, where PWID programmes could not be adequately defined and certain interventions such as OST/ needle syringe programmes were not possible to be included; (ii) in Indonesia, young people who use drugs (PWUD), especially amphetamine-type substances are often left out of HIV prevention programmes and yet are vulnerable to and at risk of HIV infection and (iii) in Ethiopia the new NSP and NFM3 funding request reflect the widened KP focus by including PWID, but other KPs such as MSM and TG are still not included.

As a generalisation, these challenges are particularly acute in generalised epidemics where there are limited resources for the existing need. In contrast, prevention interventions have been more appropriately focused in concentrated epidemics.

[81] TRP 2017-2019 Windows 1-2 review

Overall, as noted by UNAIDS and the TRP, countries have not adequately prioritised populations and geographical areas with Global Fund HIV prevention investments.[82,83] The following keys issues have been identified:

- *Countries are trying to cover too many different population groups* which results in insufficient interventions being given to each group.[84] Stakeholders reported this is particularly due to insufficient data and analysis to help inform the investment decisions. For example, in Jamaica, many stakeholders noted that disaggregated data on KVPs has been a continuous challenge, and while there have been improvements in recent years in data collection, analysis of this data to inform prevention programming is currently lacking.

- *There is insufficient attention on groups who are most at risk.*[85] This is reportedly due to a lack of data to inform decision making as well as importantly due to political and structural barriers for support to HIV prevention programmes (as discussed above). An example related to political will impacting prioritisation of prevention investments to support KPs relates to harm reduction in West Africa and the Philippines where this has only been implemented at a very small scale. A lack of political will, coupled with gaps in funding, has been found to limit the provision of harm reduction services in many countries.[86] Similarly, in many countries in Africa, the Middle East and Asia, MSM programmes cannot be taken to scale because of the lack of political acceptability.

- In addition, this may also be due to situations where *stakeholders are not confident with regards to population-specific prevention programming* – e.g. PWID interventions are generally less well articulated than MSM and female sex workers (FSW) programmes in funding requests and for populations where the health department is not the main implementer.

In NFM2, more evidence-based high impact prevention interventions were included in grants, and the box below provides lessons learnt and examples of interventions that were viewed as effective and well performing in our country case studies.[87] We do not view these examples as comprehensive or generalisable per se, noting that high-impact interventions would be determined based on the country context and epidemiology, and this strategic review has not conducted a systematic assessment in this regard (which would be more appropriate for partner guidance documents rather than a review of this nature).

Lessons learnt and examples of high impact interventions from the case study countries

There have been a number of learnings and examples from this review with regards to good practice interventions:

- Where relevant, investments in generic general population programmes should be reduced, as often there is scope for domestic funding (given structural barriers do not come to the fore here), and has more limited potential for impact when supported through limited Global Fund monies. That said, there are examples of where general population interventions would help identify "hidden populations".
- Continue to emphasise vulnerable populations where KP programmes have not been as forthcoming so far, e.g. AGYW, recently released prisoners, PWID and young male SW, as well as with regards to improving human rights. This would however need to be balanced by overall portfolio cost effectiveness and VFM considerations.
- Comprehensive packages for HIV prevention (including comprehensive condom and lubricant programming, pre-exposure prophylaxis and post-exposure prophylaxis, violence prevention and response, harm reduction for PWID, behavioural interventions, sexual and reproductive health services, and prevention and

[82] TRP (2019), The Technical Review Panel's Observations on the 2017-2019 Allocation Cycle

[83] UNAIDS (n.d.), Prioritizing high-impact HIV prevention investments

[84] UNAIDS (n.d.), Prioritizing high-impact HIV prevention investments

[85] TRP 2017-2019 Windows 1-2 review

[86] UNAIDS (2020) Seizing the moment, tackling entrenched inequalities to end epidemics; Global AIDS Report 2020

[87] See Figure 3.3 in Section 3.1.1 for the trends in prevention funding by GPC prevention pillar based on a funding analysis.

management of co-infections and other co-morbidities)[88] have shown good promise in certain countries and should be supported where appropriate, keeping in mind cost effectiveness and VFM considerations.

- In the **Philippines**, the Global Fund-supported KP programmes were considered to be high-impact, especially with regard to interventions including prevention components targeting communities and KPs, such as through CBO-run clinics and community health outreach workers. The interventions have been credited with managing to reach epidemiologically important sub-groups within the KP population that were previously not reached effectively (such as white-collar MSM, and adolescent and young MSM and TG).
- In **Ethiopia**, drop-in centres are considered as best practice for reaching sex workers for HIV primary prevention, testing and treatment. The centres have been identified in the new NSP as priority interventions to be supported and scaled up.
  In **Côte d'Ivoire**, the following have been noted to work well: (i) night clinics and community-based drop-in centres are considered effective for reaching SW and MSM, (ii) outreach to local drug use hotspots has enabled PWUD and PWID to be reached.
- In **Malawi**, VMMC programming was scaled up through the use of VMMC kits as an innovative alternative to surgical procedures. This enabled nurses to conduct circumcisions instead of surgeons which reduced waiting time. In addition, the kits are less expensive to procure and quicker to administer the procedure. To this end, Malawi received US$ 2 million in additional funding through portfolio optimisation.
- A number of measures have been noted to be effective and make gains with regards to reaching to reach KVPs, especially "hidden" KVPs. This has included the involvement of civil society in implementation resulting in the creation of safe spaces for KPs in a number of countries, such as **Jamaica** and the **Philippines**.
- **In response to the COVID-19 pandemic** there have been innovations in service delivery which have kept services running despite restrictions, including for PWID, and may be leveraged by the Global Fund to improve service delivery in the future. Although the restrictions severely disrupted harm reduction service delivery initially, networks and services were also quick to respond and adapt, and these successful responses could potentially be leveraged across countries and regions in the future. For example, PWID peers contributed to filling the gap in service provision with peer-to-peer syringe distribution and opioid agonist therapy regulations were eased in many countries.[89] Another example has been the increased use of online outreach activities in the **Philippines** which have been strengthened as response to the challenges to conduct face-to-face outreach activities A similar development was observed in **Botswana** where use of social media was increased to conduct community activities instead of face-to-face outreach.

Despite these select positive examples, further improvement is needed. In particular the following key points are noted:

- There has been a **positive shift away from 'generic' general population prevention programmes** such as behaviour change communication and information education communication programmes. This is shown by the decrease in funding for supporting HIV prevention programmes for the general population dropping from US$ 143.1 million in 2015-17 to US$ 121.7 million in 2018-20. While funding for general population prevention programmes decreased across budget periods, it increased when comparing the initial funding request stage with the current budget in NFM2 (see Appendix D).

- There has been an **increasing and improving focus on KP programmes, but key gaps remain.** Investments in KP programmes have varied between countries, with countries with concentrated epidemics generally having better targeted programmes, as noted above. A positive example has been in Ethiopia, where Global Fund investments have contributed to the establishment of targeted programmes for FSW in about 80 public health facilities located in various regions as well as 30 one-stop drop-in centres, an approach used to reach FSW outside the formal service delivery model and with flexible hours. In addition, in terms of the packages that are included in grants, Global Fund support provides an opportunity for more comprehensive packages to be included such as in South Africa where this was noted to be a strength. However in several countries, there is a concern that there is a shift away from comprehensive prevention interventions aimed to reach KVPs, including aspects such as social and behaviour change communication (SBCC) and condom programming. In addition, whilst progress has been made with regards to investments

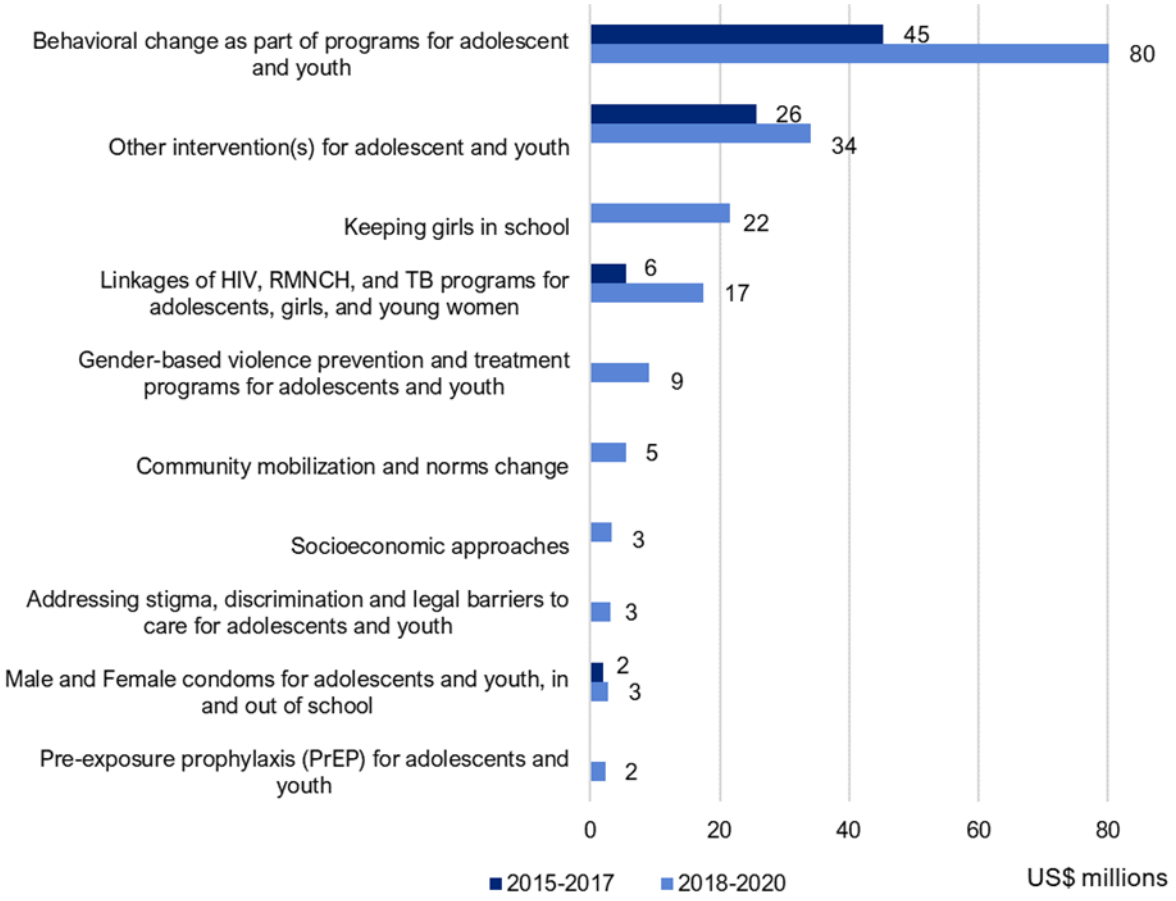
[88] The Global Fund (2019): Technical brief on HIV and key populations; programming at scale with sex workers, men who have sex with men, transgender people, people who inject drugs, and people in prison and other closed settings.

[89] Harm Reduction International (2020) Global State of Harm Reduction 2020, 7th Edition

to address human rights challenges faced by KPs over the 2017-2019 period, this remains an area which requires further attention.[90]

- **AGYW has seen a mixed picture in terms of programming of relevant and cost-effective interventions**: In country grants, there have been large increases in AGYW investments, including through the use of matching funds (discussed below). AGYW grants have included a mix of interventions (see Figure 3.7 below for the types of funded interventions such as behaviour change, keeping girls in school, linkages to other health programmes and gender-based violence prevention and response) and have aimed at supporting AGYW at different age brackets between 10-24 years. While investments for AGYW have been welcomed, there is an ongoing debate on investment choices given (i) effectiveness considerations are contested and (ii) some interventions may be effective in terms of aspects which are more distally related to HIV (e.g. keeping girls in school) while others are more closely linked to reducing HIV transmission. This ongoing debate raises concerns regarding VFM for AGYW interventions in particular with regards to the prioritisation of AGYW investments (e.g. need to prioritise given limited resources and dependent on the specific epidemiological context). The TRP commentaries on the relevance of the proposed AGYW interventions reflects this global debate, and some countries (e.g. Kenya) were encouraged to increase focus on AGYW, whereas others (e.g. Eswatini) were encouraged to review the cost-effectiveness, scalability and sustainability of the proposed interventions. In some countries, there has been a shift away from certain AGYW interventions such in South Africa due to learnings during implementation, as well as other changes regarding the design of AGYW investments (e.g. Malawi). In addition, an overarching assessment of AGYW programmes is that there is a need to ensure better linkages with sexual and reproductive health/ family planning interventions. Further details are included in Appendix H regarding VFM of AGYW investments.

Figure 3.7: *Funding for AGYW intervention categories by budget periods*



[90] Ibid

Source: CEPA analysis based on Global Fund data

For NFM3, the TRP noted that: (i) progress has been made in planning, with priority HIV prevention investments being more appropriately included and interventions being better articulated, focused and tailored to KVPs; and (ii) there has been an increase in focus on VFM of investments. This has been noted in our country case studies as well – for example in Côte d'Ivoire, where the development of a new NSP based on situation analyses and benefitting from consistent mid-term (embedded) TA - supported by the Global Fund and partners - resulted in the NFM3 funding request according greater focus on HIV prevention programmes for KVPs. In Ethiopia, the NMF3 prevention funding request includes a shift to a wider range of KVP populations including PWID, PiP, SW, AGYW and other vulnerable populations and men in high prevalence settings (although MSM and TG are still not mentioned). However, the TRP noted there are weaknesses across country funding requests as well, in particular that few countries attained the targets proposed by the GPC. In addition, the TRP noted that (i) AGYW interventions especially were not well prioritised or based on evidence and (ii) human rights and gender interventions remain too simplified and broad.[91,92]

(B) Catalytic funding approaches in NFM2 have been key for HIV primary prevention investments being included in grants, although the quality of the focus of the interventions could be further improved in some instances. In NFM2, the Global Fund had three matching funds for HIV (KP, AGYW and Breaking Down Barriers) which aimed to scale up services for KPs towards impact (e.g. condom programming), reduce human rights related barriers and to reduce HIV risk and incidence amongst AGYW.[93] HIV matching funds had a total of US$ 145 million but not all funding was directly used for HIV primary prevention services. In addition, grants could benefit from strategic initiatives, the most relevant for HIV prevention being the CRG Strategic Initiative for a total of US$ 15 million. Another important source of funding for countries to invest in HIV prevention interventions is the multi-country support for HIV (US$ 50 million) with a focus on "*Strategic support for development, innovative delivery of services and sustainability of community-led service delivery and monitoring, and support for regional advocacy, address legal barriers, also laying the groundwork for continuity of these services as part of a transition process*".[94]

Catalytic funding has been an important means to encourage countries to prioritise HIV primary prevention. Based on some stakeholder opinion, catalytic funding has strengthened community capacity for implementing HIV prevention programmes and facilitated KP programming. In addition, in the Philippines matching funding to reduce human rights related barriers were seen as important to strengthen CSOs capacity with regard to providing education to KPs on their legal rights. However, TRP feedback on funding requests noted that some matching fund applications lacked strategic aims, noting, "*many matching funds requests did not present a coherent approach likely to catalyse better program performance. A few matching fund applications included long, non-prioritized lists of programs and interventions, which as a result were not likely to have impact*." [95] In addition, the TERG summary of the PCE of eight countries over NFM2 noted that the evaluations found it difficult to quantify and measure impact of matching funds, largely because little guidance was given on how matching funds are expected to be catalytic. These reviews also found limited evidence of funds resulting in the type of ambitious and innovative programming intended through this modality.[96]

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[91] TRP Lessons Learned from Review Window 1 of the 2020-2022 Funding Cycle, 9 June 2020

[92] TRP Lessons Learned W2, 25 August 2020

[93] Global Fund 2016. 36th Board Meeting - Catalytic Investments for the 2017-2019 Allocation Period

[94] Global Fund 2016. 36th Board Meeting - Catalytic Investments for the 2017-2019 Allocation Period

[95] TRP (2019), The Technical Review Panel's Observations on the 2017-2019 Allocation Cycle

[96] Global Fund TERG (2020), Position Paper on findings from Prospective Country Evaluations (PCEs)

Under NFM3, the focus of the catalytic funding towards HIV prevention has been strengthened with HIV matching funding now directly targeting prevention activities.[97] This is intended to catalyse HIV prevention investments and programme improvements.

Retention of HIV prevention interventions in grants following funding requests

(C) **When comparing the budgets for HIV prevention between funding requests and current grant budgets, there has been a decrease of 10% across GPC countries in NFM2, despite an increase in funding for HIV overall (4%). Evidence from case study countries (and select other countries) suggest key reasons for this decline include a re-categorisation of interventions in the Modular Framework and grant consolidation to avoid duplication with other funders. Wider discussions with both global and country stakeholders have also suggested a potential deprioritisation of HIV primary prevention funding, but this review has not been able to gather robust evidence to support this claim. Overall the need for greater transparency in budget developments over time has been highlighted.** The available evidence suggests there is some attrition with regard to funding for HIV primary prevention after the funding request stage, with both the overall amount, as well as the focus towards interventions supporting KPs and, to a lesser extent, AGYW being reduced.[98] Table 3.2 presents details of a change in HIV prevention funding from the funding request stage (methodology and limitations can be found in Appendix D).

[97] In addition to the KP and AGYW matching funds, a US$ 10million matching fund for condom programmes has been introduced. A total of around US$ 115million of matching for HIV primary prevention activities will be available under NFM3 (in addition to funding aimed at reducing human rights related barriers). The Global Fund has also introduced Strategic Initiatives targeting HIV primary prevention including two on condom programming (US$ 5million) and AGYW (US$ 8million). Source: HIV Prevention Budget Analysis, July 2020 HIV Team

[98] This is in general across countries, although in a few countries funding for HIV prevention was actually increased after the funding request was submitted. This holds in particular for AGYW funding.

Table 3.2: Overview of HIV prevention funding change by Global Fund funding module by number of countries between the funding request stage and current budget within NFM2 (green represents increase, red a decrease)

Module	Total Change[99]	Number of countries			
		Increase	Decrease	Stable[100]	Total[101]
Prevention programs for general population	20%	8	2	2	12
Prevention programs for adolescents and youth	-5%	8	6	2	16
Comprehensive prevention programs for PWID and their partners	-18%	1	11	1	13
Comprehensive prevention programs for SW and their clients	-18%	2	15	3	20
Prevention programs for other vulnerable populations	-22%	6	7	1	14
Comprehensive prevention programs for MSM	-29%	2	11	5	18
Comprehensive prevention programs for TG	-37%	4	5	0	9
Comprehensive programs for PIPs and closed settings	-37%	2	5	1	8
Prevention Total	**-10%**	**5**	**15**	**3**	**23**
Payment for results	100%	2	0	0	2
Other program activities-HIV	92%	1	0	0	1
HIV Testing Services	21%	11	4	2	17
Program management	19%	13	6	3	22
Treatment, care and support	3%	5	6	11	22
TB/HIV	-3%	6	11	1	18
Programs to reduce human rights-related barriers to HIV services	-8%	3	7	4	14
PMTCT	-31%	5	11	3	19
Total HIV Funding	**4%**	**8**	**0**	**15**	**23**

Source: CEPA analysis based on Global Fund data

In addition to the information presented in Table 3.2, the analysis of changes in funding requests and the current budget indicated that all KP prevention modules experienced a reduction in funding ranging between -18% (PWID, SW) and -37% (TG, PIP). This trend can be observed in the majority of countries with the reduction taking place in between 55% (TG) and 85% (PWID) of all countries that included a module in their funding request. However we note that stakeholder feedback indicated that for some countries, funding for HIV prevention increased between the funding request and the finalised budget. It is not possible with the available data to track when specifically changes have been made to the decrease in funding (e.g. during grant-making or after grant approval through reprogramming). In addition, the Modular Framework structure and data quality within funding requests prevents the undertaking of a quantitative analysis of investments on a more granular level. However, qualitative evidence from the country case studies and portfolio analysis suggests that **shifts in funding after the funding request stage** were due to:

- Shifting of funding from prevention to other interventions. For example, in Côte d'Ivoire and in Indonesia there were shifts towards treatment and in Ethiopia there was a decrease in general population prevention

[99] The total change is based on the percentage change in the US$ funding across all GPC countries.

[100] Funding was judged to be stable if the approved budget remained within 5% of the funding request.

[101] The total describes the number of countries that funding for relevant module in either the funding request or the budget stage.

funding (in line with feedback from the TRP) and a shift towards funding for RSSH and testing. Some of these shifts were during reprogramming, while others were in response to requests from the TRP.

- Shifting of funding from prevention to other interventions due to a consolidation of the grant to avoid duplication with other funders. For example, in Eswatini there was a shift towards treatment, but this was partly driven by increase in PEPFAR funding for KP.
- A different categorisation of prevention funding rather than a shift from prevention investments per se. These changes in funding allocation are likely due to differences in the way in which interventions are categorised in the Modular Framework and in the approved grant budgets. For example, in South Africa, stakeholders considered the decrease to be due to components of the HIV prevention interventions being categorised differently, e.g. to programme management or RSSH modules. In Cameroon, the grant budget for MSM prevention interventions decreased following re-classification from HIV prevention to human rights interventions.

In addition, there have been examples of shifts between different prevention funding categories (e.g. in the case of Cameroon, of prevention interventions managed by the same PR).

Further detail on the funding shifts for HIV prevention after the funding request stage by GPC country and HIV prevention module is presented in Appendix D.

We note that there are a number of benefits from **re-programming,** such as re-programming to more effective interventions or bringing in new stakeholders. However, apart from categorisation related changes, there are challenges if funds from prevention in particular are being re-programmed towards non-prevention modules (given the already limited funding).[102] This raises questions about how the Global Fund could encourage changes in processes to further discourage reprogramming of prevention investments resources towards other intervention areas, whilst leaving enough flexibility to account for national circumstances.

Global level stakeholders have also indicated that funds have been **reprogrammed for COVID-19**, including specifically HIV prevention funds such as community prevention programmes. Our country level interviews had mixed evidence to this effect (for example, in South Africa, funds were re-programmed but this was not disproportionately from HIV prevention funds; however in Botswana, stakeholders mentioned that CCMs and/ or government PRs had reallocated resources away from civil society implementers to COVID-19 response interventions). A larger issue flagged is the lack of transparency on decisions by CCMs on reallocation of resources and other issues since the pandemic.

Value for Money (VFM)

(A/B) **Lack of consolidated guidance and information on "best buys" as well as challenges with data availability have prevented effective VFM assessments in grant design. There is a mixed picture as to whether VFM considerations have been incorporated by countries – although TRP and Secretariat reviews have been helpful in this regard. There is evidence of cost effective and VFM investments being included in grants but there is a high focus on SBCC interventions which are not deemed to represent VFM in all contexts. There is limited evidence to ascertain the VFM of certain interventions posing challenges for assessing the inclusion of these interventions in HIV prevention programming.** Appendix K includes full details regarding VFM and cost effectiveness explored in this review. In this section we highlight the following key points:

- Global Fund has developed guidance on VFM, which although has been seen as useful, more guidance on VFM in specific HIV documentation (including the HIV Information Note) is thought to be beneficial for countries. In addition, countries have been unable to draw on a consolidated source of information provided by the Global Fund or partners to determine what are "best buys" for prevention interventions.

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[102] As outlined above, based on the available data it is not possible to differentiate whether the reduction in HIV prevention funding between funding request stage and current budget is driven by re-programming or changes during the grant making process. Stakeholder feedback suggests that changes are made due to both aspects.

- Assessing and determining whether prevention interventions are achieving VFM remains a challenge, primarily due to the lack of suitable data.
- While it is unclear the extent to which countries are using Global Fund guidance in the development of their grants, the extent to which VFM has been considered as part of country grant assessments has been mixed.
- Based on a review of studies assessing the cost-effectiveness of prevention interventions, those that are suggested to be highly cost-effective include condom promotion and distribution, as well as VMMC. On the other hand, PrEP is considered cost-effective only when provided for KVPs. Evidence on behavioural change interventions is far more limited, yet this has accounted for the largest proportion of Global Fund interventions across populations and as such this warrants further investigation.[103]
- AGYW interventions have also been prioritised in recent years, but qualitative evidence suggests countries are not clear on what constitutes VFM interventions for AGYW, and instead have relied on precedent from other programmes when choosing interventions. That said, evidence reviewed on the effectiveness and cost-effectiveness of some AGYW interventions suggests that interventions can be cost-effective, although more evidence from country settings is needed going forward.

Sustainability[104]

The Global Fund defines sustainability as the ability of a health programme or country to both maintain and scale-up service coverage to a level that will provide continuing control of a public health problem and support efforts for elimination, even after the removal of external funding by the Global Fund and other major external donors (STC policy).[105] Sustainability of Global Fund-supported HIV prevention programmes has been a concern in the past, especially as in some transition countries HIV prevention programmes for KPs have no longer been supported by governments which has resulted in these programmes being stopped.

(A) Through the STC Policy, countries are increasingly cognisant of the sustainability of HIV prevention programmes in their grants but key issues remain with regards to (i) financial support to HIV prevention programmes for KPs/ KVPs and (ii) social contracting.

The SR2020 review highlights that the sustainability of the Global Fund support for CSOs to continue to provide services and HIV prevention programmes for KVPs is precarious, especially given the significant challenges, many of which are outside of the Global Fund's ability to influence.[106] Acknowledging the significant overarching issues, we discuss the two most pertinent aspects highlighted in this review:

- **HIV prevention programmes for KVPs and financial sustainability:** Through the STC Policy, stakeholders noted that a number of countries have made progress in their efforts to contribute to the sustainability of interventions for KVP, for example by integrating HIV prevention programmes for KVPs into their national systems with allocation of domestic funding. However funding for HIV prevention programmes for KVPs remains a challenge with countries not taking responsibility for these but rather placing the responsibility on PRs and SRs continuing to use Global Fund support. Although the Global Fund provides suggestions to address this in their grants such as countries nearing transition to systematically include plans to fund CBOs or NGOs after transition in sustainability plans, the TRP noted that there were not sufficient examples of this being done in practice. One of the causes reported in various case study countries and by regional and global community organisations is high turnover of government officials with newly appointed individuals not understanding HIV prevention and HIV prevention programmes for KVPs. This can result in reducing

[103] Social, behavioural Communication Change (SBCC) component of Global Fund grants includes a large variety of activities (e.g. peer support, outreach workers, social mobilisation, community outreach) and as such these need to be considered on an individual basis to fully determine VFM.

[104] Aspects regarding sustainability to changes in country policies are discussed in RQ9.

[105] Global Fund (n.d.), 35th Board Meeting. The Global Fund Sustainability, Transition and Co-financing Policy

[106] Euro Health Group, Itad, UCSF (forthcoming), The Global Fund Strategic Review 2020, Final Report

government commitment to these programmes and in slowing down approval of interventions aimed at KVPs requiring government resources and/ or government approval. In addition, the TRP also noted that an ongoing weakness in grants is the tendency for siloed community-based and facility-based programmes. This reflects ongoing tensions that in the short term community services may be needed to reach KVPs but in the long term, KVPs need to have access to public services. A positive example of overcoming a siloed approach to programming has been the use of Community Health Outreach Workers (CHOWs) in the Philippines who are recruited from the community but are also stationed at government-run health facilities.

- **Social contracting:** The SR2020 review and the TRP noted that there is a lack of legal frameworks in some countries to contract CSOs and that despite the importance of CSOs in reaching KVPs, very few countries had social contracting mechanisms to allow for national takeover of support for when countries transitioned from Global Fund support.[107, 108] This issue is also highlighted in the Fourth Annual GPC Progress Report which notes that social contracting continued to be a weak performing areas, with only 11 out of 28 reporting Coalition focus countries completing the relevant steps to advance social contracting in 2020.[109] However the SR2020 report also noted that the sustainability of CSOs via social contracting may not always be appropriate for countries and therefore flexible approaches are needed. Within our country case studies we noted the following positive experiences (with additional details provided in Section 3.3.4):
    - In Ukraine, despite several challenges remaining, implementation of the transition strategy and social contracting was implemented largely as planned. An OIG audit in early 2018 and stakeholders consulted during the review expressed concerns about the impact of transition on changes in SRs, consolidation of data systems and governance processes, like mapping technical capacity, regional presence and administrative costs. KP beneficiaries expressed concerns about the access to services and reduction in scope of services to 'essential' packages'. Yet the Public Health Centre of the Ministry of Health (PHC), responsible for social contracting in Ukraine, reports that as of end 2019, the state procurement mechanism covered all three KP groups in all regions of the country.
    - Botswana is in the process of establishing systems for social contracting of CSOs for KP service provision, with support from the Global Fund, PEPFAR and other partners. Stakeholders noted the importance of social contracting being included in the transition agreement which the Global Fund will make with the Government of Botswana, to ensure that this is continued to be prioritised over the coming years even if there is government staff turnover.

3.3.2. Implementation achievements and challenges

RQ 4: What are key implementation achievements and challenges and how effectively have the challenges been addressed in grants?

The assessment of grant implementation starts with a review of financial absorption, followed by programmatic achievements and challenges. A summary of the main findings for each of these areas is presented in the table below, followed by more details on the evidence base and analysis.

Area of review	Key findings
Grant absorption	• The absorption rate of HIV primary prevention interventions is lower than that of other HIV interventions and overall funding.
Factors contributing to low grant absorption and	• There are a number of factors contributing to low fund absorption and implementation challenges, which we categorise as: (i) systemic issues; (ii) the particular nature of HIV

[107] TRP 2017-2019 Windows 1-2 review

[108] Euro Health Group, Itad, UCSF (forthcoming), The Global Fund Strategic Review 2020, Final Report

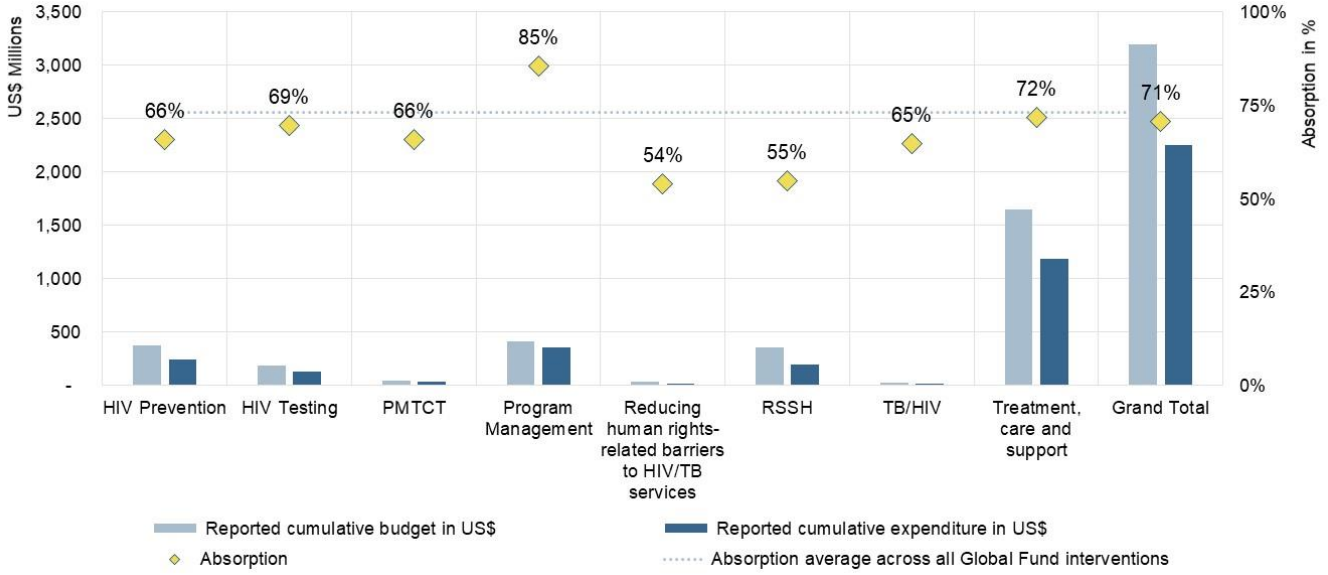
[109] Global HIV Prevention Coalition (2020) Implementation of the HIV Prevention 2020 Road Map, Fourth Progress Report, November 2020

Area of review	Key findings
grant implementation achievements and challenges	prevention programmes; (ii) grant level issues; (iv) country issues; (v) weak data systems; and (vi) Global Fund processes and systems issues.

Grant absorption

(A) The absorption rate of HIV primary prevention interventions is lower than that of other HIV interventions and overall funding. Global Fund data for the current allocation cycle (NFM2) from 2018 to the end of 2019[110] shows that HIV prevention interventions have an absorption rate of 66% which is below that for all HIV interventions (71%) and all Global Fund interventions (73%), as shown in Figure 3.8 below.

Figure 3.8: Absorption rate of HIV primary prevention compared to other HIV modules



Source: Global Fund analysis

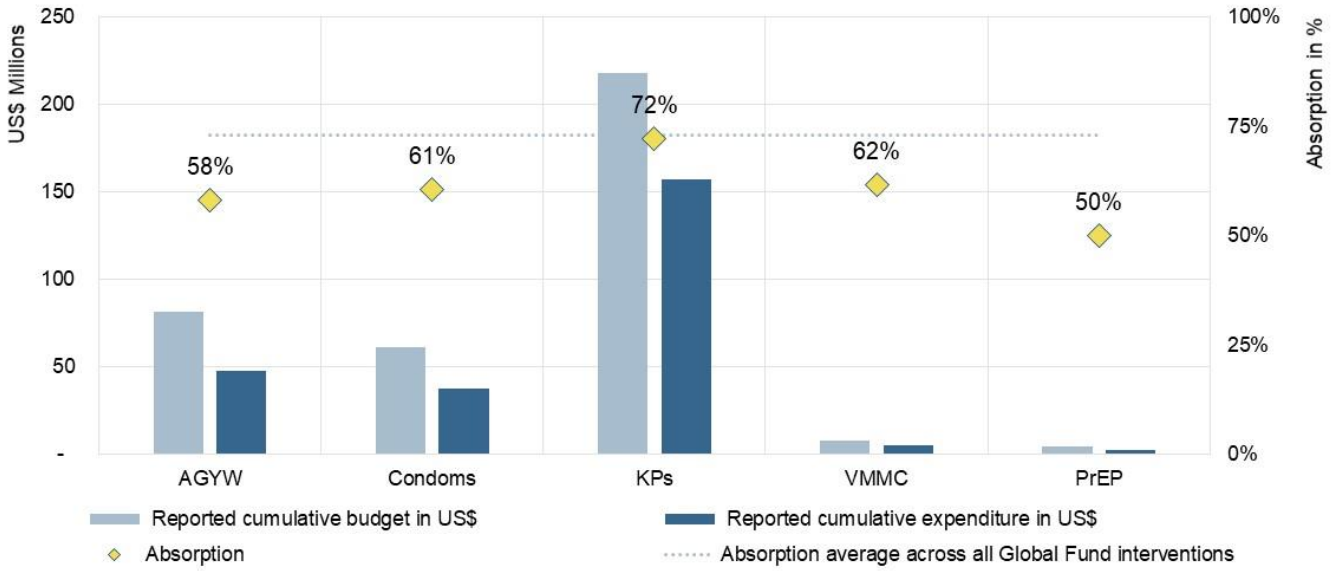
Analysis of the GPC portfolio shows that many countries have lower absorption rates for HIV prevention rather than this lower rate being driven by a few outlier countries. Of the 24 GPC countries with available prevention expenditure data, 15 countries had lower absorption rate for their HIV prevention programmes with five countries (Cameroon, Côte d'Ivoire, Namibia, Nigeria and Uganda) having a lower absorption rate by more than 25 percentage points (see Appendix D). Global and country stakeholders, the portfolio analysis and a number of country cases studies (Côte d'Ivoire, Ethiopia) provide further evidence that HIV primary prevention interventions have relatively low absorption rates. Low absorption rates for prevention has also been reported in the PCE reports.[111] Reasons for lower absorption are discussed as part of the implementation challenges discussed in the findings below.

Absorption has been particularly low for interventions aimed at reducing human rights-related barriers, followed by AGYW and PrEP, and then condoms and VMMC. Only KP interventions have an absorption rate similar to the average of all Global Fund interventions. This is illustrated in Figure 3.9 below.

[110] The absorption rate has been calculated based on the budget for 2018 and 2019 under NFM2 (with the budget for 2020 not being included) and the actual expenditure for these two years. As such, the figures need to be interpreted with caution as absorption rates often increase in year 3 of a grant when countries spend un-utilised funding from the first two years. As such, the HIV primary prevention absorption rates figures presented in this section are best interpreted relative to the absorption rate of other interventions. As the data is only up until 2019, the absorption rate has not been impacted by adjustments due to COVID-19. A detailed description of the methodology and limitations of the analysis can be found in Appendix I.

[111] The Global Fund (2019): 2019 Prospective Country Evaluation synthesis report

Figure 3.9: Absorption rate of HIV primary prevention by prevention pillar



Source: Based on data and analysis from the Global Fund

In particular, we note the following with regards to specific interventions:

- **AGYW:** AGYW specific interventions such as gender-based violence prevention (22% absorption rate), keeping girls in school (39%) and linkages of HIV, RMNCH, and TB programs for adolescents, girls, and young women (41%) have particularly low rates.
- **KP programmes**: The absorption rate in NFM2 with regard to interventions aimed at KP was relatively high (i.e. nearly on par with the average absorption rate for all Global Fund interventions). This varied somewhat across different KP groups with PWID interventions having the highest absorption rates at 78%, specially harm reduction (86%).[112]
- **Condom programming**: Condom programming interventions absorption was 61% which is somewhat surprising given the higher commodity cost component as well as the longstanding experience with regard to condom interventions. The low absorption is driven by the groups receiving the most funding which are SW (44%) and the general population (56%).
- **PrEP**: Interventions for PrEP also had low absorption rates. However this should not be over interpreted given that many countries only recently started to include PrEP interventions and are in the process of rolling out access schemes and/ or pilot studies.
- **VMMC**: The absorption rate for VMMC is also relatively low (62%).
- **General population:** Interventions targeted at the general population have a low absorption rate at 56% (see Figure I.2 in Appendix I). Absorption is low across all key interventions including condoms (56%) and VMMC (62%) as noted above, as well as other prevention interventions (51%).
- **Reducing human rights-related barriers:** As shown in Figure 3.8 above, interventions aimed at reducing human rights-related barriers have an absorption rate of only 54%, nearly 20% below the average of all interventions supported by the Global Fund. Interventions providing legal services had a high absorption rate (87%) while most other interventions were much lower, especially: stigma and discrimination reduction

[112] However, the quantitative evidence on the absorption rate for KP interventions should be interpreted with caution due to the fact that KP interventions are disproportionately more likely to be reprogrammed (as discussed in Section 3.3.1 above). This could potentially mean that funding for KP activities with very low absorption is re-programmed to other areas and, as such, the more positive absorption results for KPs could be biased.

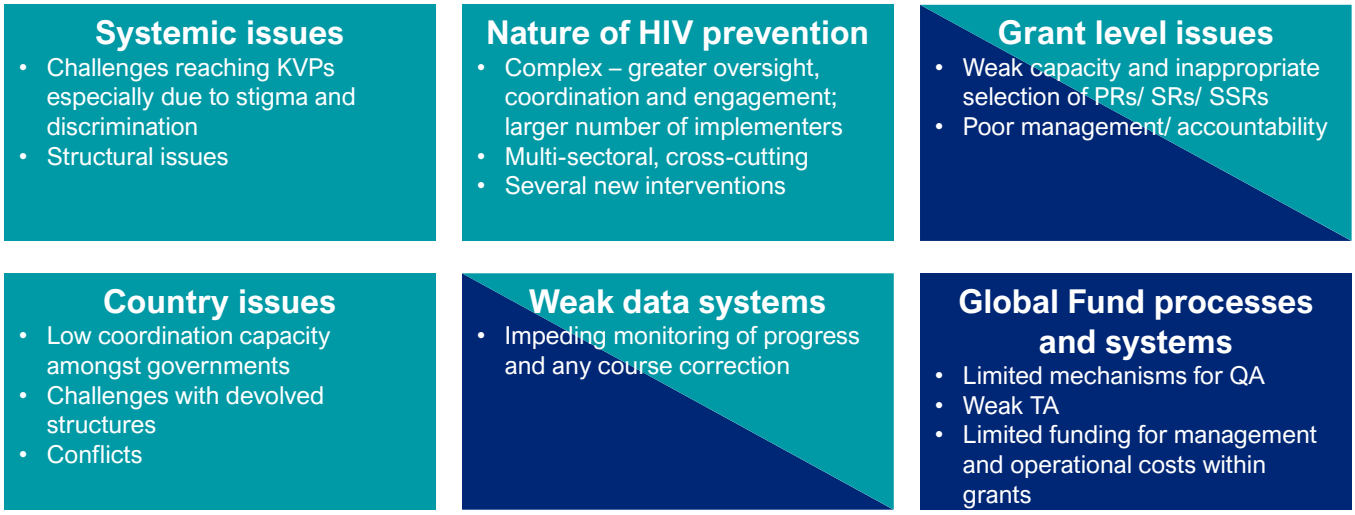
(39%), improving laws, regulation and policies (43%) and sensitisation of law-makers and law-enforcement agents (46%).

Factors contributing to low grant absorption and grant implementation achievements and challenges

(B/C) **There are a number of factors contributing to low fund absorption and implementation challenges, which we categorise as: (i) systemic issues; (ii) the particular nature of HIV prevention programmes; (ii) grant level issues; (iv) country issues; (v) weak data systems; and (vi) Global Fund processes and systems issues.**

These are summarised in Figure 3.10 followed by a detailed discussion of each factor. We also note below where achievements have been made and the contributing factors towards these.

Figure 3.10: Key challenges impacting implementation



**Blue refers to issues that can be impacted by Global Fund processes and systems and green refers to country level issues.*

Systemic issues: A number of systemic issues affect the implementation of HIV prevention interventions, including challenges for implementers to reach KVPs and beneficiaries not accepting HIV prevention interventions due to stigma, lack of knowledge/ awareness and other structural barriers.

- *Challenge for implementers to reach KVPs*: This is particularly in the case where there are human rights and legal barriers which make it hard to reach 'hidden populations', especially when the population size estimates or mappings are inaccurate or absent. In addition, challenges reaching KPs are particularly acute in countries where KPs are criminalised and the political climate prohibits public institutions from providing services for KPs and therefore depending on non-state actors – often CSOs – for KP service provision. The political and structural barriers behind these issues are described in Section 3.3.1 above and expanded in Section 3.3.3 below).

  In **Jamaica** consultees were unanimous in their view that the programme has struggled to reach hidden populations of MSM and TG because of stigma and discrimination associated with these groups in the country, which historically has been reinforced by legal barriers that have inhibited access to prevention services.

  In **Indonesia**, stigma and discrimination continue to hinder primary HIV prevention, especially in public health facilities in areas where staff capacity is low, turnover is high and there is lack of familiarity and training on working with KPs.

  In **Botswana**, KPs have also been subject to discrimination in public health facilities, although this has reportedly recently improved due to the important efforts by programmes supported by the government, Global Fund and other partners.

- *Beneficiaries not accepting interventions*: In some instances, populations have not been willing to accept interventions, potentially due to stigma. For example, PrEP has not been accepted by all KPs as it is

associated with HIV treatment (e.g. Botswana) and as reported by global level stakeholders, some KPs wanted additional evidence on the efficacy before taking PrEP.

Particular nature of HIV prevention programmes: HIV prevention planning and implementation are particularly complex in design, require multisectoral engagement and adequate integration of services. In addition, a number of interventions may be newly introduced in HIV prevention programming.

- *Complexity of HIV prevention programmes*: Implementing HIV prevention programmes – particularly KP and AGYW interventions – is more complex and challenging than other programmes as they tend to require a larger degree of oversight and coordination, higher numbers of implementers (especially SSRs) and more engagement across sectors. In addition, different aspects of national prevention programme (e.g. human rights, Community Systems Strengthening (CSS), RSSH) are likely to be implemented by different implementers, with subcontractors not necessarily complementary, or linked.

  In **Jamaica**, the allocation of responsibility for treatment and prevention lies with the Ministry of Health and Wellness (MOHW) and the National Family Planning Board (NFPB) respectively. However, MOHW is the PR for the overall HIV grant, while NFPB does not receive funding directly from the Global Fund, which many stakeholders have noted as being a challenge for coordinating the prevention and treatment aspects of the HIV response in the country.

  In **Ethiopia**, a lack of clarity on the mandates between the MOH and the Federal HIV/AIDS Prevention and Control Office (FHAPCO) at the federal level, and between various institutions at regional level, has created some confusion regarding roles and responsibilities in the coordination of the components of the HIV response, including prevention.

  In **Botswana**, the MoHW is officially the PR, but because of challenges of the MoHW ensuring multisectoral implementation, the Project Management Unit for the grant was moved to the National AIDS and Health Promotion Agency (NAPHA), the Botswana NAC equivalent. NAHPA sits under a different Ministry (Ministry of Presidential Affairs, Governance and Public Administration) and does not report to MoHW. Also, the MOHW is the main implementer in the grant and is supposed to report to the project management unit at NAHPA, for a grant for which it is a PR. This situation does not facilitate easy coordination and implementation of the grant.

- *Need for multi-sectoral engagement*: The prevention response transcends the health sector and includes other sectors such as education, social affairs, gender and youth. In order to be effective, it is necessary for these sectors to coordinate well with one another. For example, multi-sectoral engagement is required for AGYW interventions, especially with the Ministry of Education and this requires more time for coordination and agreement across a larger number of stakeholders. Stakeholders in South Africa noted the large time required for consultation with different stakeholders which has slowed down implementation. Another pertinent challenge is that in recent years the capacity of National AIDS Commissions/ Councils (NAC)- which were established to ensure multi-sectoral coordination of HIV responses – has been eroded (for example in Côte d'Ivoire) or the NAC has even been dismantled (for example in Indonesia). As a result, in many countries there is no longer an entity with the capacity and mandate to oversee and facilitate the engagement of various sectors and sectoral government authorities in the HIV response.

- *Challenges with introducing new interventions, including reprogramming:* New programmes generally can be particularly challenging to implement, especially if there is limited guidance, such as for AGYW. Country stakeholders confirmed issues with the implementation of new interventions such as in Cameroon and South Africa. Furthermore, lower KVP prevention programmes absorption may be due to the fact that some of the programmes such as PrEP are still new in a number of countries and therefore have faced challenges associated with programme design, target setting and the set-up of a new programme. In Indonesia, there were delays in implementing and operationalising a PrEP component of HIV prevention among MSM in the current grant, following regulatory, policy and procedural obstacles. In a number of countries, the design of AGYW programmes have also needed to be changed based on new evidence and learnings especially given that a number of the interventions have only been introduced in recent years. For example, as highlighted in the portfolio analysis, Malawi stopped their AGYW interventions to re-plan and re-orient the programme as they realised that a number of interventions were not effective. In addition, in Eswatini, the budget for AGYW

was reduced as the programme was re-designed, where some interventions were de-prioritised (e.g. vouchers, comprehensive demand creation). This was a positive approach given that the interventions were not considered to be effective but did result in lower absorption.

Grant level issues: There are two overarching sets of grant level issues affecting the implementation of HIV prevention grants: (i) weak capacity and inappropriate selection of PRs/SRs/SSRs to implement HIV prevention activities; and (ii) issues related to poor management/ accountability.

- **Weak capacity and inappropriate selection of PRs/SRs/SSRs:**
  - *Weak capacity of PRs/SRs/SSRs***:** There can be challenges with inadequate capacity of PRs, SRs or SSR in areas of technical, programmatic and financial planning, management and reporting. In some PCE countries the capacity (managerial and financial) of civil society PRs have at times been a bottleneck for timely disbursement to SRs.[113]

    However there are some examples of strong capacity of PRs and SRs which have aided high quality programming, especially for community based interventions. This is particularly the case when organisations with strong capacity are implementing HIV prevention programmes (e.g. **Ukraine, Kenya, Zimbabwe** and **Jamaica** – where SRs were highlighted as being among the most capable in the Caribbean region).

  - *Inappropriate selection of SRs and SSRs:* SRs and SSRs selected are not always the right type of implementers for HIV prevention programme delivery, which can lead to a number of challenges. Sometimes implementers are selected because they are able to meet Global Fund compliance requirements for aspects such as organisational status, or capacity to manage, monitor and report on implementation, or for political reasons. However, some of these implementers may not represent or understand the communities they are supporting, because they are not present there and have not built up trust amongst those communities. An example is Ukraine where social contracting of KP interventions is introduced as part of transitioning to government funding for HIV prevention, and as a result some small CBOs that used to implement KP interventions are no longer able (or willing) to comply with government contracting rules, whilst new, and unproven private sector contractors have come in. There is a balance between choosing implementers who can deliver programme management compliance and those who have expertise in the interests and needs of KPs.

    More positively, if local CBOs and KVP groups are able to implement HIV prevention programmes, this has significant benefits for sustainability. However, as noted above it is often a challenge for these organisations to be selected as CBOs. Some positive examples are as follows:

    In **Kenya**, the CSO PR (Kenya Red Cross) provided support to CBOs during the development of funding requests. As a result, many community groups are now well-established implementers and as such demonstrates an example where CBOs' capacity can be increased to enable them to be selected as implementers.

    CBO involvement was also highlighted as a success in the delivery in the **Philippines** and the need for capacity building in areas beyond the programmatic areas (e.g. financial and organisational management, strategic planning) was seen as critical for a successful scale-up of CBO involvement.

    In **Ukraine**, community involvement in HIV prevention programming has been highlighted as a major reason for the successful implementation of HIV programme.

    In **Côte d'Ivoire**, KP organisations being accepted as SSRs for the implementation of Global Fund-supported programmes contributed to these organisations gaining legitimacy, whereas previously they were not accepted as such by some institutions in spite of being legally registered. This enabled them to establish management systems in preparation for becoming an SSR.

[113] TERG (2020): PCE synthesis report 2020

Inadequate systems and capacity for implementation management and accountability, in the following two ways:

- **Limited grant oversight during implementation***:* Stakeholders at the global level noted that in general, CCMs have focused much more on grant design and not sufficiently on providing oversight for grants during implementation – an issue particularly relevant for HIV prevention given challenges with implementer capacity. In addition, stakeholders noted that the role of local fund agents (LFAs), and questioned the degree to which they have expertise in HIV programme delivery, alongside financial expertise, could have a significant impact on helping to steer implementation when there are needs to course correct. Whilst some stakeholders highlighted that LFAs programming knowledge had improved over recent years, a few implementers in particular noted this to be an issue and hindered insight into the need to be more flexible in implementing HIV prevention interventions in some instances. Stakeholders noted that the challenges with management of grants were sometimes due to a lack of supervision, such as peer educators overseeing implementation. Whilst inclusion of a more adequate grant supervisory and monitoring role would result in less budget being available for other aspects, it has been noted to aid the quality of implementation of other grants (e.g. funded by PEPFAR) and therefore may warrant further consideration.

- **Lack of accountability at the country level** due to the fact that (i) prevention programmes are implemented by a large number of stakeholders and across sectors; (ii) lack of clarity regarding who PRs and SRs are accountable to (i.e. whether this is the CCM, national authorities, directly to the Secretariat); and (iii) national authorities do not always sufficiently hold implementers to account. Furthermore, there has been a lack of strong HIV prevention focal points/ counterparts in government to ensure coordination and implementation of prevention interventions, as mentioned by global and country stakeholders. This is often compounded by high turnover of government officials.

Country issues, including lack of adequate coordination across the HIV response, issues with administrative structures and issues with ongoing conflicts.

- **Lack of adequate coordination of the HIV response in general and/ or HIV prevention interventions in particular.** Global and country stakeholders observed that in a number of countries, the capacity of government to ensure adequate coordination of HIV prevention programmes is low, sometimes compounded by governments lacking HIV prevention focal points or champions.

- **Administrative structures (e.g. devolution) do not facilitate implementation and coordination of HIV prevention activities**: This is particularly in settings with district-level decision making and implementation of prevention programmes. For example, in the Philippines, local government units (i.e. sub-national units) are responsible for the operation of local social and hygiene clinics as well as prevention outreach. In Ethiopia, there is a lack of uniformity in designing and implementing prevention activities among, and within regions, given the context of decentralisation. However, the extent to which this is conducted is often highly dependent on local support and budgets, thus engaging sub-national decision makers is key to supporting effective HIV primary prevention programme implementation.

- **Ongoing conflicts hamper the implementation of HIV prevention programmes**: for example, in Ukraine, a particular challenge is the conflict in Crimea and Eastern Ukraine, two regions with already high HIV prevalence areas which have become more vulnerable due to decreased access to services, increased sex work and internal displacement. Similarly, in the Philippines, the "war on drugs" remains a key challenge with regard to the implementation of appropriate preventive measures for PWID.[114]

In addition, **weak data systems** have been noted to be an issue hampering prevention implementation, as it is hard to monitor implementation progress and course correct in the absence of good data. This is discussed in RQ7 (data systems).

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[114] The "war on drugs" refers to the stringent anti-drug policy and actions of the Philippines government which started in 2016.

Global Fund processes and systems: Several issues are relevant here, namely:

- **The Global Fund has relatively limited mechanisms for quality assurance/ quality improvement during implementation**: The Global Fund has several mechanisms to encourage grantees to include high impact HIV prevention in grant design (e.g. catalytic funding, technical guidance notes, TA, country team support for country dialogue, TRP recommendations, grant agreement finalisation by country team/ LFA, etc.). In contrast, during grant implementation the Global Fund has relatively limited mechanisms for quality assurance/ quality improvement of Global Fund-supported HIV prevention interventions (e.g. the quality of CCM monitoring of implementation is variable, limitations to monitoring of results data, reliance on external partners for TA and therefore potential reduced feedback loops for need for grant reprogramming) which can present issues during the implementation stage.
- **Slow processes for approval of grant budget reprogramming**: SRs reported that it often took a long time to approve budget reprogramming requests submitted by SRs (e.g. Botswana, South Africa).
- In addition, **weak TA** (supported by the Global Fund and others) has been noted as an issue hampering prevention implementation. Issues related to TA for HIV prevention are discussed in detail in RQ2 (TA).
- **Limited funding for grant management and operational costs:** There has been reduction in programme management related costs within HIV primary prevention programmes which have decreased by 36% between budget periods from US$ 113 million in 2015-2017 to US$ 73 million in 2018-2020 (See Appendix H for a full analysis of Global Fund funding by costing category). Moreover, the proportion of programme management related costs declined from 18% in 2015-2017 to 10% in 2018-2020. Instead the majority of funding has been used for programme activity related activities (64% in 2018-2020, an increase from 52% in 2015-2017) and for health products/ commodities and procurement related costs (30% in 2018-2020, a decrease from 26% in 2015-2017). Whilst this is not a negative trend from a donor perspective (i.e. minimising management costs and maximising programme costs), we note that this could be a factor contributing to challenges related to implementation. Our country case studies have not highlighted low management costs as an issue except in Botswana where low population density and vast geographic areas results in high programme cost per target person reached. The Global Fund's cap on programme management costs allowed in budgets therefore presents a considerable challenge for implementing organisations and may result in it no longer being financially possible to reach remoter populations. In other countries, such as Côte d'Ivoire, stakeholders raised the recent decision by the Global Fund not to allow national implementing organisations to budget for organisational overhead costs as affecting the capacity by the civil society PR, SRs and SSRs to implement quality programmes.

3.3.3. Engagement of KVPs and associated communities, networks and prevention programme implementers

RQ 5: To what extent have KVPs and associated communities, networks and prevention programme implementers meaningfully engaged in the design and delivery of prevention efforts?

A summary of the main findings for each of these areas is presented in the table below, followed by more details on the evidence base and analysis.

Key findings
• Overall, the Global Fund model and systems aim to be supportive of KVP engagement, and Secretariat engagement with these groups at the global level is active, although fragmented. • At the country level, stakeholders report large variations in levels of engagement of KP networks/ organisations and communities by CCMs, PRs and SRs. • Engagement of KVPs and communities is strong during the design of the funding requests (at times also leading to some challenges), but generally tends to be more limited during the implementation of HIV prevention interventions.

(B) Overall, the Global Fund model and systems aim to be supportive of KVP engagement, and Secretariat engagement with these groups at the global level is active, although fragmented.

Global and regional KVP organisations and networks are represented on the Global Fund Board and participate in other global level policy making and coordination mechanisms. HIV prevention programme implementers and advocacy organisations are also engaged in these mechanisms. Further, the most recent guidance of the Global Fund highlights the central role and leadership of communities affected in the HIV response and the importance of ensuring engagement with communities during the grant lifecycle.[115]

At the global level, the engagement by the Global Fund Secretariat with community groups and networks is seen as active, albeit somewhat fragmented. Particularly, the Secretariat CRG department's partnership with global and regional community and advocacy organisations is perceived as actively seeking partnership and promoting HIV primary prevention interventions. The TERG Partnership review describes the CRG Strategic Initiative as an example of a partnership that aims to expand engagement and capacity by reaching smaller networks through larger networks from regional and country to sub-national levels.[116] However, according to global level stakeholders, while the Global Fund has tried to increase community engagement, its efforts have been fragmented, with several community systems strengthening interventions implemented by different Global Fund Secretariat teams.

(B) At the country level, stakeholders report large variations in levels of engagement of KP networks/ organisations and communities by CCMs, PRs and SRs. Across countries, there has been a variation in the level of engagement of KP and others, including some particular KVP groups that are less represented.

More positively, in **Jamaica,** organisations that represent different KVPs form part of the CCM, while a number of CSOs that participate in CCM meetings have often advocated for the needs of KVPs in the HIV programme design. In **Ukraine**, the involvement of HIV-affected communities was seen as instrumental in the design and allocation of Global Fund and domestic resources within the HIV programme. In **Indonesia**, CSO representatives interviewed also welcomed the openness and willingness of the Global Fund to hear from CSOs. In **South Africa**, stakeholders highlighted that the latest funding request was an example of very inclusive and transparent processes especially with strong engagement of civil society and representatives from KP groups.

Less positively, in **Indonesia** the lack of representation of young people, and especially young KPs in Global Fund design processes means that challenges and issues specific to young vulnerable groups may not be adequately reflected in funding requests; whilst in the **Philippines** although HIV infections are higher among certain KVPs (e.g. MSM and TG) than other KVPs, some stakeholders considered that there was insufficient involvement of FSW and PIPs, as well as KVPs from rural and remote settings. However we note that the value for money of the inclusion of KP groups with lower levels of HIV infections needs to be considered within resource constrained environments.

Evidence from the case study countries indicates there are a number of reasons underpinning the variable levels of engagement:

- **Absence of or low capacity of KVP groups and community organisations to input during CCM and funding request design meetings:** Stakeholders at the country level reported the low capacity of KVP groups and CSOs as a factor limiting engagement. For example, in Botswana, stakeholders noted that there is need to continually build the capacity of the CSOs and KVPs on what is expected from them when participating in the country and Global Fund processes. In Ethiopia, the capacity of CSOs in engagement and implementation has remained weak due to the legal constraints in the past, although there have been recent investments in strengthening the capacity of CSOs.
- **Less importance accorded to KVPs by decision makers and key partners during the grant design and implementation processes:** A challenge observed in a few countries is that even when KVPs are included, their participation may not be meaningful as the dynamics of CCM discussions and decision making do not always afford an active voice for these groups (e.g. in Ethiopia where there is a concern that CSOs are not fully involved in the decision making processes, even though they represent the majority in the CCM). Civil society informants noted that more could be done by the CCMs, PRs/SRs and programme design/

[115] The Global Fund (2019): HIV Information Note. The Global Fund (2016): HIV Information Note and The Global Fund (2019): Operational Policy Manual. Issue 2.24

[116] Itad (2019), Thematic review of the Global Fund country level technical support partnership model, final report

implementation technical working groups to ensure genuine meaningful engagement and participation of KVP organisations and networks during the design and the implementation of grants.

(B) Engagement of KVPs and communities is strong during the design of the funding requests (at times also leading to some challenges), but generally tends to be more limited during the implementation of HIV prevention interventions. Many global and country stakeholders (including stakeholders in Indonesia, Jamaica, Côte d'Ivoire, South Africa, Philippines, Botswana) reported that engagement of KVP organisations and networks was strong during the design of Global Fund supported programmes, with KVP organisations and networks invited to participate in or at least attend meetings focusing on the development of funding requests. However an issue has also been that in some countries where civil society and KVP representation is strong, there have been challenges with the prioritisation of interventions in funding requests. For example, in South Africa, stakeholders highlighted the delay in decision making due to the process of extensive consultations and the time taken to reach consensus on issues. Similarly in Ukraine, civil society demands increased the scope of proposed community-led activities which caused concern for some stakeholders in relation to the sustainability and prioritisation of these activities.

However, overall, this engagement tails off in the implementation stages – mainly because there is are no mechanisms in place to oversee and review the implementation of Global Fund grants together with a broader set of stakeholders, including KVPs (as also highlighted in Section 3.3.2). PRs and SRs generally have grant implementation and grant management meetings amongst themselves, and PRs report directly to the CCM, but there is no mechanism in place to also engage with or communicate to KVP networks/ organisations on grant implementation. KVP organisations are reportedly often not part of grant review meetings. The new Global Fund initiative of supporting the establishment of community-based monitoring is seen by stakeholders as a useful way to strengthen community engagement during grant implementation.[117]

There have been some positive examples regarding involving KVP organisations in the implementation of Global Fund-supported programmes especially as they are well placed to reach their KVP populations. For example, in **Jamaica** consultees noted that a number of interventions have involved KVPs themselves supporting the delivering of prevention services and outreach activities, which has been regarded as a more effective approach to engaging with these populations. Similarly in the **Philippines**, the involvement of CBOs and/ or KPs with regards to running clinics and providing safe spaces for prevention, testing and treatment was viewed as having a strong contribution to reaching KVPs. In **Ukraine**, community involvement in HIV prevention programming is a major reason for successful implementation of HIV programmes, as two PRs are community based organisations with a long history in HIV prevention design, implementation and capacity building.

3.3.4. Factors hindering or facilitating effective HIV primary prevention programming at scale

RQ 6: What factors have facilitated or hindered effective programming for HIV primary prevention at scale?

In this question we consider what factors have hindered or facilitated scaling up of HIV primary prevention, including both factors at the country level and in terms of Global Fund processes and systems. A key question within this is how the Global Fund, as a key funder and GPC member, can help countries move beyond a grant performance lens to achieve the prevention targets of the UNAIDS prevention 2020 output and coverage targets. This question builds off the other review questions on Global Fund processes and partnerships as well as country grant design and implementation issues. A summary of the main findings for each of these areas is presented in the table below, followed by more details on the evidence base and analysis.

[117] Community-based monitoring as defined by the Global Fund are mechanisms that service users or local communities use to gather, analyse and use information on an ongoing basis to improve access, quality and the impact of services, and to hold service providers and decision makers to account.

https://www.theglobalfund.org/media/9622/core_css_overview_en.pdf?u=637319006203930000

Key findings
• The main aspect that hinders scale up of HIV primary prevention programming is the limited resource envelope. Other key challenges include structural barriers, inadequate participation of prevention groups in national coordination mechanisms, transition challenges and inadequate guidance/ TA.

(B/C) **The main aspect that hinders scale up of HIV primary prevention programming is the limited resource envelope. Other key challenges include structural barriers, inadequate participation of prevention groups in national coordination mechanisms, transition challenges and inadequate guidance/ TA.**

These are summarised in Figure 3.11 and we discuss each in turn below.

Figure 3.11: Factors hindering HIV primary prevention scale up

**Blue refers to issues that can be impacted by Global Fund processes and systems and green refers to country level issues.*

Limited resource envelope and inadequate prioritisation by funders: Despite the Global Fund being the second largest funder of HIV prevention globally, there are limitations with the availability of funding and the prioritisation of HIV prevention interventions for scale-up:

- *Limited resource envelope* is the most significant reason why HIV primary prevention programmes are not taken to scale; this is due to the competing demands on already stretched budgets, and the fact that majority funding is allocated to treatment.[118] At times, donors may be reluctant to invest additional resources if absorption capacity is low. Furthermore, limited domestic funding for HIV prevention is an additional barrier to scale up for prevention activities. Of our case study countries, only Ukraine, while not due to transition, has developed an ambitious transition strategy to shift funding for 'essential' HIV prevention packages for PWID, MSM and SW to the MoH. A considerable number of country case studies (e.g. Philippines, Indonesia, Côte d'Ivoire, Ethiopia) and a portfolio analysis outlier country (Kenya) indicate that the allocation of domestic resources to ensure sustainability is currently sub-optimal, with limited or no domestic funding. In Indonesia, although the Government funds general population prevention, care, support and treatment, no domestic funding was allocated to primary prevention in KPs between 2017 and 2020.
- *Limited prioritisation of HIV prevention interventions:* Within available funding envelopes, not all funders (including governments and other donors) are prioritising prevention. While the Global Fund funding is increasing, it has still not reached the 25% benchmark advocated by the GPC. Furthermore, country governments have not been prioritising, and thus funding, prevention interventions, beyond prevention for the general population.

[118] Another reason for limited Global Fund resource envelopes are due to the economic status of countries, which means that countries categorised by the World Bank as middle-income receive less HIV funding. This latter situation affects countries such as Botswana and Angola, which despite being middle-income countries, still have health systems challenges.

Structural barriers: KPs face a number of structural barriers which impact their vulnerability to HIV and access to HIV services. In particular, many countries' legal and policy environments are not supportive of HIV prevention interventions due to punitive and discriminatory laws and policies. For example: 92 countries (out of 151 reporting) criminalise HIV transmission, non-disclosure or exposure; 129 countries (out of 149 reporting) criminalise any aspect of sex work ; 69 countries (of 194 reporting) criminalise same sex sexual relations; 111 countries (of 134 reporting) criminalise drug use or possession; and 32 countries (of 134 reporting) criminalise and/or prosecute TG.[119] Overall these barriers fuel stigma and discrimination amongst KP, create barriers to reporting abuse and violence, and prevent KP from accessing health services, especially HIV-related services. Although some progress is being made such as Botswana having decriminalised same sex sexual relations in 2019 and the most recent data from population-based surveys showing that there have been improvements on HIV-related stigma and discrimination in Eastern and Southern Africa[120], structural barriers continue to hinder progress to the HIV epidemic. Existing evidence points to the critical role of including interventions that address the structural barriers in countries' HIV responses to tackle HIV vulnerability, especially for KP.[121] Through Strategic Objective 3, the Global Fund recognises the importance of structural barriers in impacting HIV vulnerability and access to HIV services, especially for KP. Although there has been increased attention/ mention of structural barriers in funding requests as well as focus of Global Fund investments through matching funds and strategic initiatives, these efforts are in their nascence and as noted by the TRP they require increased focus and scale: "*country programs and associated funding requests should pay increased attention to human rights and gender equality as well as continue to stress community programming that reduces barriers to access*."[122]

Inadequate participation of prevention groups in national coordination mechanisms: There is also a wider challenge in some countries beyond the CCM structure per se, wherein prevention groups are not actively participating in the national strategic processes to drive domestic resource allocation to support scale-up, breaking the link between what is funded through the Global Fund and what is scaled up by governments. Whilst this was raised in global level consultations, it has not been noted to be an issue in our country case studies.

Transition challenges, including challenges integrating small/ pilot projects into national programmes and challenges of governments taking on social contracting of CSOs for HIV prevention programmes.

- *Challenges integrating small/ pilot projects into national programmes for a few reasons including (i) challenges linking KP programmes to health care services:* Stakeholders noted that in a number of countries, KP programmes need to be linked up to health care services and facilities but due to a lack of political will and stigma and discrimination, they haven't been; and (ii) challenges for countries to scale up pilot projects which are supported by the Global Fund (and other donors) to a national scale if they are considered to be (too) expensive or not seen as national priorities.
- *Challenge with governments taking on Global Fund funding of CSOs through social contracting mechanisms:* For some countries social contracting is a new approach and one which can offer sustainable financial income for CSOs who offer prevention services. However, there are challenges in the operationalisation of social contracting that need to be carefully considered as shown by the example of Ukraine in the box below.

Inadequate guidance and insufficient TA on taking HIV prevention programmes to scale: Global Fund HIV technical guidance for KPs recommends taking interventions to scale is important and states that at least 90% of KPs need to be covered for impact, encouraging applicants to do so.[123] However there is little operational guidance and

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[119] UNAIDS (2020) Seizing the moment, tackling entrenched inequalities to end epidemics; Global AIDS Report 2020, p.156-160

[120] UNAIDS (2020) Seizing the moment, tackling entrenched inequalities to end epidemics; Global AIDS Report 2020, p.51

[121] STRIVE Research Consortium (2019) Addressing the Structural drivers of HIV: a STRIVE synthesis, London School of Hygiene and Tropical Medicine

[122] The Global Fund (2019), The Technical Review Panel's Observations on the 2017-2019 Allocation Cycle October 2019

[123] The Global Fund (2019): Technical brief on HIV and key populations; programming at scale with sex workers, men who have sex with men, transgender people, people who inject drugs, and people in prison and other closed settings

technical support available by partners to guide countries on scaling up of interventions. This is further heightened by challenges with regards to TA, which is crucial to the scale up of HIV prevention programmes, including importantly for NSP development (as discussed in Section 3.2.3).

Achievements and challenges of scaling-up HIV prevention interventions through social contracting

In **Botswana**, Global Fund support has contributed to the government accepting to establish a social contracting system for KP services to be provided by CSOs. The Global Fund together with the USG are supporting capacity building of the government on the establishment of social contracting systems as well as building capacity of the CSOs to provide prevention services.

In **Ukraine**, a specific "20%-50%-80% Transition Plan" for transition of prevention activities supported by the Global Fund to domestic budgets was developed and approved by the MOH in 2017. As per plan, the Government was due to take over management of 20% of the outreach basic package in 2018, with absorption of management and cost of 50% and 80% of the outreach basic package in 2019 and 2020, respectively. Ukraine's Transition Plan is unique and successful in the region given: (i) its focus on a key area of transition that is often a major challenge; (ii) bold aim to make unprecedented systemic changes in the mechanism of funding public health services delivered by CSOs; and (iii) very ambitious targets for full domestic funding of these services within three years. The first procurements using domestic funding for KVP prevention services through the national e-procurement platform were organised in 2019, with multiple delays and contracting issues that provided important lessons learnt for improvement, including price dumping and changing contract provisions. The Global Fund was asked to provide bridge funding to ensure continuation of services in several regions. In 2020, the lots were tendered, the process went more smoothly with less interruption in services, and various modifications were included based on lessons learned from 2019. NGO PRs would remain responsible for procurement of HIV prevention consumables (needles, condoms, etc.) and for provision of TA to contracted CBOs. Stakeholders interviewed were appreciative about the government taking responsibility for KP services.

To ensure the implementation of the social contracting system as intended and mitigate risks of disruption of HIV prevention services, the Global Fund made the implementation of the transition plan a grant condition.

3.3.5. Measurement of HIV primary prevention investments

RQ 7: To what extent has progress on HIV prevention investments been appropriately set and measured?

This question considers the extent to which Global Fund-supported HIV prevention interventions are appropriately measured and reported upon within Global Fund systems including measurement of KPIs and Global Fund country grant M&E (i.e. indicators and data included in grants based on the modular framework indicators). We also consider challenges within measurement. A summary of the main findings for each of these areas is presented in the table below, followed by more details on the evidence base and analysis.

Area of review	Key findings
Overall approach to M&E	• The Global Fund lacks an overarching framework/ approach to the results it aims to achieve through its investments in HIV prevention, making it challenging to measure, report and interpret its achievements.
Strategy KPI framework	• At a strategy level, the Global Fund monitors progress on HIV prevention through the reporting of a number of KPIs which have helped to focus attention on HIV prevention, although these are not comprehensive, indicating a need to maintain close monitoring through programmatic indicators. The indicators and targets for the KPIs have also presented challenges for measurement.
Grant M&E	• The limited availability and quality of data, especially population size estimates for KVPs, is one of the major issues with reporting, monitoring and target-setting for HIV prevention interventions. • At the country level, there is a focus on outputs/ coverage indicators, rather than measuring prevention-related outcomes and achievements. In addition, despite the improvements made to the Modular Framework, a number of limitations remain with regards to monitoring results.

Overall approach to M&E

(B) **The Global Fund lacks an overarching framework/ approach to the results it aims to achieve through its investments in HIV prevention, making it challenging to measure, report and interpret its achievements**. Consultations with the Global Fund Secretariat and others indicate that the Global Fund does not have a well-defined overarching framework for HIV prevention and lacks clarity on the results it wants to achieve through its investments. Progress on HIV prevention results is monitored and reported through both the strategic-level KPIs and through programmatic monitoring of grant-level results. However, there is a disconnect between these two levels. For example, while the Global Fund KPIs do include some prevention-based indicators, these do not capture the detailed data that is collected at the country level, both in terms of frequency and scope. KPI5 includes coverage data on KPs, which is informed by programmatic data that is collected (though as discussed below, an interim indicator has been used for 2017-19), but coverage of prevention services for other populations (particularly AGYW in relevant countries) is not captured. This has resulted in the absence of comprehensive monitoring and reporting of HIV prevention results.[124] Furthermore, stakeholders noted that results reporting is generally quantitative and often does not capture the longer-term qualitative changes that are key in prevention programmes.

Strategy KPI framework

(B) **At a strategy level, the Global Fund monitors progress on HIV prevention through the reporting of a number of KPIs which have helped to focus attention on HIV prevention, although these are not comprehensive, indicating a need to maintain close monitoring through programmatic indicators. The indicators and targets for the KPIs have also presented challenges for measurement.** In particular, we note the following:

- The Global Fund included a number of HIV prevention-based indicators in its overall KPI framework for the 2017-22 strategic period; specifically, indicators related to VMMCs carried out (as part of KPI 2), number of people reached with prevention interventions (KPI 5), and reduction in HIV incidence in AGYW (KPI 8, which was previously not captured in the overall KPIs), as well as its overall HIV incidence indicator captured as part of KPI 1. This has helped to focus attention on these HIV prevention areas. However, there are no KPIs to closely monitor comprehensive condom programming, PrEP nor SRH services for men and boys, meaning that not all HIV prevention interventions outlined in the GPC pillars or interventions highlighted as important by the Global Fund (in the case of SRH services for men and boys, referenced in the Global Fund's HIV information note as a sixth important intervention) have a corresponding KPI to measure progress/ results. While we do not consider that these interventions should be included as strategic KPIs per se, close monitoring of these areas through programmatic monitoring is still needed to track progress on HIV prevention.
- The ability to monitor and report on the strategic KPIs for HIV prevention is limited by inadequate indicators, and missing targets (e.g. KPI 5) as well as challenges measuring incidence over the short life cycle of a grant. The indicators to measure HIV prevention interventions as defined in the KPIs are underpinned by a number of limitations:
    - HIV incidence reduction, which is an indicator in both KPI 1 and KPI 8, is not adequate to show progress in the short timeframe of Global Fund grants, given both the time lag in HIV prevention programmes to show results, as well as the fact that the measurement of incidence estimates is modelled and not based on routine data collection.
    - Service coverage of KPs, which is the indicator of KPI 5, is not actually being measured as part of the Strategic KPI reporting;[125] instead an 'interim indicator' is being used to report on the "*percentage of target countries with data collection mechanisms in place to report on coverage of an evidence-*

[124] Both stakeholders and the recent SR2020 (forthcoming) have highlighted a lack of linkages and integration of monitoring activities across Global Fund levels to enable adequate tracking of implementation progress.

[125] However, we understand that service coverage of KPs is being measured at country level, where the information is available.

informed package of services"[126] due to lack of available national-level data.[127] As such, given data challenges, at present, only an interim result is being measured and is not reflective of actual results per se.

- At the KPI level, there are shortcomings with respect to the targets of HIV prevention interventions amongst KVPs. Although KPI 5 was designed to measure the coverage of KVPs reached with a package of treatment and prevention services, the KPI does not define a coverage target (presumably because of challenges with accurately estimating population sizes), hindering the Global Fund's ability to monitor progress on the coverage of HIV prevention investments. On the other hand, although KPI 8 (reduction in HIV incidence in women aged 15-24 years old) has an associated target (58% over the 2015-2022 period), this is was found to be overly ambitious by both Global Fund Secretariat and partners.

Grant M&E

(A) **The limited availability and quality of data, especially population size estimates for KVPs, is one of the major issues with reporting, monitoring and target-setting for HIV prevention interventions.** The availability and quality of data being reported for HIV prevention interventions constitutes a challenge for accurate monitoring and reporting of progress and results. Key challenges are as follows:

- **Population size estimates:** Target-setting for KVP HIV prevention interventions is hampered by challenges associated with estimating KVP population sizes. There was general consensus amongst stakeholders of the difficulties in defining and verifying an accurate population size (denominator) for KVPs, which is often under-estimated due to issues around data collection (i.e. hidden, reachable/ unreachable groups etc.). This is an issue for the assessment of the success of coverage interventions – as targets for KVPs interventions are often under-estimated, they affect the measurement of the impact that HIV prevention interventions. The Global Fund has placed a significant emphasis on strengthening data systems in countries to enable them to have a better understanding of the population sizes and needs of KVPs. Key investments include HIV BBS as well as population sex estimates (PSE) of KVPs. There have been some notable improvements in mapping and population size estimates thanks to Global Fund investments.[128] However, an ongoing challenge is that KVPs size estimates need to be updated regularly but this needs to be balanced with the fact that mapping exercises (such as BBSs and PSEs) are expensive and time-intensive, and cannot be carried out on a yearly basis.[129,130]

- **Disaggregated data:** The collection of more precise and reliable data, such as data disaggregated by KVP group and better availability of time-series data by KVP groups, is hampered by sensitive issues around data collection for KVPs, specifically around confidentiality and anonymity of KVPs. More generally, the Global Fund's current monitoring systems do not regularly collect disaggregated data on either KVPs nor AGYW

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[126] Global Fund (2019) Key Performance Indicators Definitions and Methodology, Version 2.0: February 2019, Guide to understanding the Global Fund Key Performance Indicator definitions, methodology and reporting schedule

[127] The OIG audit report on the Global Fund KPI framework in 2019 noted that: "*Challenges persist in the collection of data for three KPIs. For KPI 5 (Service coverage for key populations) […], interim indicators are being used to monitor performance, as data to measure the principle of the designed KPI are not available*". Source: Global Fund (2019) OIG Follow-up report on KPI.

[128] "At the end of 2016, the Global Fund invested in programmatic mapping and size estimates for KPs at risk to HIV. This resulted in 22 countries producing robust size estimates for transgender women and using it for programme design. Further, due to Global Fund investments, of the 65 countries that have size estimates for KPs at the end of 2018, all except Jordan and Lebanon, have good quality size estimates for FSW based on a rigorous methodology. Having accurate size estimates allowed countries to invest more resources in focused programs. This notably contributed to increased investments in programs for FSW in Cuba, Eritrea, Papua New Guinea, Nepal, Cape Verde, Kenya, Cameroon and Bhutan in the 2017-2019 allocation period." Global Fund (2019) Investing in the future: Women and Girls in all their diversity.

[129] Global Fund HIV Information Note (2019), p.14

[130] Recent guidance has been issued by UNAIDS to address the challenge of size estimates for MSM, one of the key population groups where size estimates can be challenging to ascertain (https://www.unaids.org/sites/default/files/media_asset/2020-recommended-population-size-estimates-of-men-who-have-sex-with-men_en.pdf).

that would enable programmes to be able to plan and implement services more effectively. While the Global Fund will need to balance requiring a more detailed breakdown of data on people being reached with prevention services without overburdening countries with monitoring activities, a number of consultees and reports (particularly PCE reports) have highlighted that more disaggregated data is needed to improve prevention programming. Beyond Global Fund grants, this issue has been noted in other reports[131] highlighting the need for more sub-national data in order to allow for more targeted prevention programming.

- **Absence of a defined approach to measuring the quality of HIV prevention services:** Although the Global Funds tends to report progress and results in a more quantitative manner, stakeholders have noted improvements in the measurement of prevention services, notably through the use of case studies and community-based monitoring approaches. Furthermore, both stakeholders and the recent SR2020 highlighted the role of evaluations as key tools for performance monitoring and learning, especially when they are embedded into programme grants from the outset. However, to date grant-level evaluations at the Global Fund have not been conducted systematically (SR2020 found that evaluations are taking place at the Global Fund but with limited coordination, utility and prioritisation of learning needs) and their learning has been primarily focussed on Secretariat-level processes and activities rather than learnings from grant performance.[132]

- **Double-counting of beneficiaries:** A more minor issue noted at the global level and in some countries is that for a number of prevention interventions, implementers are often reaching the same populations with either the same or different prevention services. This has meant that, in the case of service coverage estimates, individuals may have been double counted, as they may be receiving services from multiple providers. Reaching the same individuals creates monitoring challenges when it comes to highlighting the progress and results of HIV prevention programmes. To that end, recently efforts have been made on Global Fund-supported programmes to reduce data duplication, e.g. for AGYW, the Global Fund AGYW Measurement Framework provides some guidance on "*steps to ensuring unique counting of beneficiaries because of service layering*".[133]

The above-noted data challenges are well known and long-running, and there is no easy or quick solution to improve the data. However, the implication is that intervention design, programming, implementation and achievements are hindered, and as such, there needs to be ongoing concerted efforts at improvements in data measurement. In this respect, the review has noted that the Global Fund has started to support efforts to improve the monitoring of the quality of services through providing support for community-based monitoring, which helps to understand whether services are available and accessible by the communities targeted. However, despite the benefits related to this type of monitoring, it is not yet being prioritised by countries and as a result, countries are not receiving the financial and technical support needed to subsequently take it to scale.

(A) At the country level, there is a focus on outputs/ coverage indicators, rather than measuring prevention-related outcomes and achievements. In addition, despite the improvements made to the Modular Framework, a number of limitations remain with regards to monitoring results. Specifically, we note the following key issues:

- At the grant-level, Global Fund country grants include a performance framework which details impact, outcome and coverage indicators, each with associated targets and a timeline for reporting.[134] However,

[131] These include UNAIDS (2020) Global AIDS Monitoring 2021; indicators for monitoring the 2016 Political Declaration on Ending AIDS; 2020 UNAIDS Guidance, and UNAIDS (2020) Prevailing against pandemics by putting people at the centre; World AIDS Day report 2020

[132] Euro Health Group, Itad, UCSF (forthcoming), The Global Fund Strategic Review 2020, Final Report

[133] The Global Fund (2018) The Global Fund Measurement Framework for Adolescent Girls and Young Women Programmes

[134] See Global Fund (2019), Modular Framework Handbook, for a detailed list of indicators that the Global Fund seeks to monitor under its performance frameworks.

evidence from country case studies suggests the following issues with regards to monitoring and reporting of HIV prevention interventions:

- **Greater focus on outputs/ coverage, leading to limited analysis of the progress and results achieved** by the grants and in-depth analysis about the meaning of those results. For example, in Jamaica, the monitoring of the Global Fund's activities failed to pick up how the populations reached are changing their behaviour, despite behaviour change activities being a key component of the programme. Similarly, in Indonesia, the focus has been on quantitative indicators and targets (in terms of numbers reached) rather than on the quality of outreach and network penetration which are as relevant in HIV prevention for KVPs - recent reports about Indonesia highlight that coverage targets have been achieved, but the outcomes of outreach in terms of behavioural change are varied and less documented. In South Africa, the programme indicators in NFM1 were designed in such a way that the focus is on the achievement of the quantitative targets (such as the number of AGYW reached), rather than on the quality of the programmes delivered (and thus the ensuing behaviour change), however a positive change in this regard has been the introduction of the AGYW evaluation which, while there has been some challenges with implementation, has produced insightful results beyond outputs and coverage which have been particularly useful for a new intervention.[135,136]
- **Evolving targets and denominators with limited time series on results:** reprogramming of KVP targets across years has resulted in missed targets due to issues with denominators being revised upwards and CSOs reaching the same individuals with their services (double-counting) (e.g. in Jamaica) as well as shown in the portfolio analysis where despite the number of KPs being reached in GPC countries between 2017-2019 increasing, the coverage targets being met did not have the same positive trend.
- **The level of ambition of KVP targets varies across grants, an issue which is compounded by the challenge of accurately estimating KVP population sizes.** This issue has also been identified in the SR2020 review which noted that in the PCE countries that are able to meet their KVP targets, the level of ambition of the targets is insufficient to reach impact objectives and coverage levels for KVPs.[137] Similarly, the TRP also noted that "*HIV targets, while broadly in line with international commitments, failed to adequately target sufficient coverage of KVPs considering size estimates*".[138] This was also an issue in some country case studies such as Ukraine where grant performance was almost 100% but the 2020 December coverage targets are set at 56% of the country's KP (PWID) population, reflecting a national performance that is low in comparison to UNAIDS target of 90% coverage.

- Despite the improvements made to the Modular Framework (as discussed in Section 3.2.2), a number of limitations remain with regards to monitoring results. Key issues include:
  - There are gaps with the adequacy of the indicators being included in the Modular Framework as being too "removed" from the actual intervention (e.g. keeping more girls in school is quite distant from lower HIV incidence). Therefore in instances like these where the results chain between inputs and prevention impact are insufficiently clear, it is more challenging to assess the impact on strategic indicators and targets, such as HIV incidence reduction.

[135] OIG (2017) Audit Report: Global Fund Grants to the Republic of South Africa, GF-OIG-17-014, 19 July 2017

[136] Discussion Paper on the Planning and Scoping of the Global Fund SA AGYW Evaluation In Implementation Period 2– Reflections on lessons learnt in Implementation Period 1, and way forward

[137] Euro Health Group, Itad, UCSF (forthcoming), The Global Fund Strategic Review 2020, Final Report

[138] TRP 2020-2022 lessons learned window 1 report, p.5

- The structure of the Modular Framework does not promote integration of interventions across modules, for example human-rights, gender and other cross-cutting intervention are programmed separately, which might undermine key linkages to achieve results and impact.

3.4. CONTRIBUTIONS AND RESULTS

The fourth pillar of the review identifies the extent to which the Global Fund has contributed to HIV prevention efforts and results at global and country levels.

3.4.1. Contribution to HIV prevention efforts and results

RQ 8: To what extent and how has the Global Fund contributed to HIV prevention efforts and results?

This section summarises the results for Global Fund investments in HIV prevention. It is based primarily on aggregated data provided by the Global Fund Programmatic Results and Impact team, which is based on information collected as part of country programmes between 2017 and 2019.[139] In addition to the overall analysis of all countries discussed below, we have specifically looked at results for GPC countries, which are detailed in Appendix D as well as country case studies data. As discussed under Section 3.3.5, the Global Fund does not systematically collect outcome data within its monitoring systems, and as such the results below do not include this analysis. Select relevant aspects on results from our country case studies are included in a box at the end of the section. A summary of the main findings for each of these areas is presented in the table below, followed by more details on the evidence base and analysis.

Key findings

- Since the Global Fund was established in 2002, new HIV infections in countries supported by the Global Fund have fallen by 44%. Trends in more recent years have continued to follow previous long-term trends. Despite these long-term reductions in new HIV infections overall, progress has not been extensive and uniform, and global Fast Track targets for a 75% reduction in new HIV infections by 2020 will not be met.
- The total number of KVPs reached as part of Global Fund-supported programmes has fallen slightly since 2017. However it is not clear whether this is being driven by a reduction in the total number of people being reached or changes in the definitions of population groups as defined in Global Fund grants. In addition these coverage numbers may reflect changes in funding for KVP programmes in instances where this has been taken on through other funding sources.
- Results have been mixed in terms of the extent to which countries have been meeting their coverage targets set as part of countries' Performance Framework. A lower proportion of countries met their SW coverage targets over time, while a higher proportion have met TG and opioid substitution therapy targets. Based on consultations, many stakeholders noted that coverage of KVPs overall is below what the Global Fund would like to be achieved, and what is set out in the UN Political Declaration on ending AIDS.
- Based on the Global Fund's programmatic data available, the number of AGYW reached through Global Fund programmes increased from 367,000 in 2018 to 1.5 million in 2019, suggesting a large ramp-up in AGYW-supported programmes. This has been coupled by an increase in the number of countries meeting their coverage targets. Based on the Global Fund's analysis under KPI8, current trends suggest that the 13 priority countries are projected to reduce HIV incidence among AGYW by between 47% and 64% by 2022, suggesting that the target of 58% could be met.
- The Global Fund's programmatic results data also suggests that the 14 countries included in the KPI2 target for of 22 million males circumcised by 2022 is going to be met, with 12.2 million carried out to date. However, given that VMMC is largely funded by PEPFAR, it is recognised by the Global Fund that its contribution to this is relatively limited.
- More than 20,000 people were recorded as receiving access to PrEP services in 2019 across five countries that reported data related to this, an increase from 6,600 in 2019. This suggests that PrEP is currently being rolled out on a relatively small scale across Global Fund programmes, and is just 1% of the global total.

[139] While we note that this data has been validated internally by the Global Fund, we understand from consultations that in earlier years of this period it is possible that some data, particularly coverage data, may have been double-counted, and as such there may be some inconsistencies when comparing data across different years.

New HIV infections[140]

(A) Since the Global Fund was established in 2002, new HIV infections in countries supported by the Global Fund have fallen by 44%.[141] **Trends in more recent years have continued to follow previous long-term trends. Despite these long-term reductions in new HIV infections overall, progress has not been extensive and uniform, and global Fast Track targets for a 75% reduction in new HIV infections by 2020 will not be met.** According to the Global Fund 2020 Results Report, had there been no prevention nor treatment of HIV in these countries, the number of people newly infected with HIV each would have increased by 181%, based on previous trends in infections. This suggests that significant progress has been made since the organisation's establishment on tackling HIV, driven by both its support for prevention and treatment of HIV, as well as contributions of countries and other global partners. This overall progress has been driven particularly by reductions in incidence in countries with high burdens of HIV, particularly Southern and Eastern African countries where generalised epidemics exist. Based on the analysis of data since 2017, trends have tended to continue along this long-term path.

As mentioned in Section 1, progress has not been uniform across countries and many countries will not achieve the 2020 target to reduce new infections by 75% from the 2010 baseline. Globally, between 2010 and 2019, new HIV infections have reduced from 2.1 million to 1.7 million (1.2 million– 2.2 million confidence interval), or by 23%, far below the target.[142] While estimates suggest that some regions such as Eastern and Southern Africa, which accounted for 38% reduction in new infections, other regions have experienced a rise in new infections, including Eastern Europe and Central Asia, where new infections have risen by 72%, as well as the Middle East and North Africa (22% increase) and Latin America (21% increase). These figures show that despite Global Fund countries making some progress, much more is needed to ensure that ambitious global targets related to reducing HIV incidence and prevalence are met.

KVP coverage

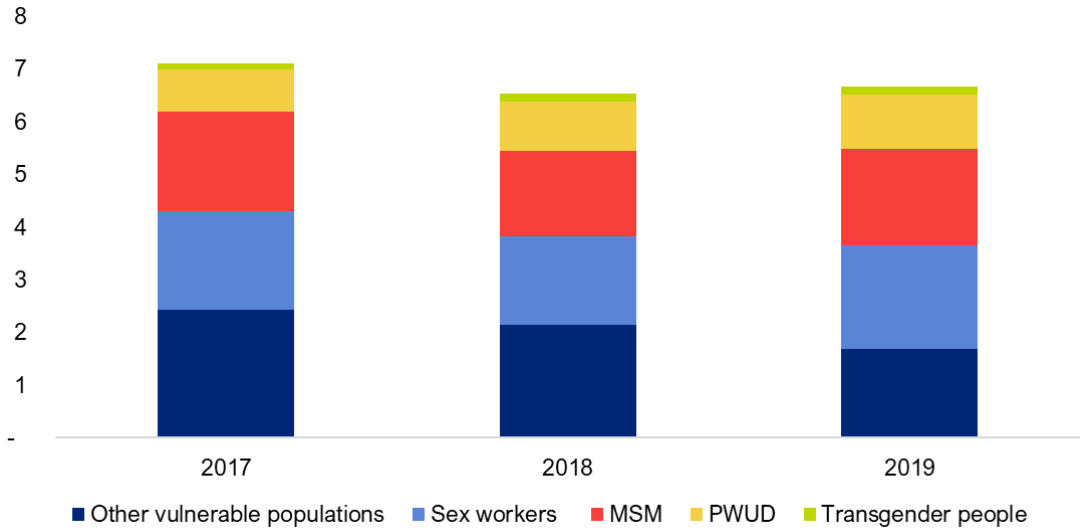
(C) The total number of KVPs reached as part of Global Fund-supported programmes has fallen slightly since 2017. However it is not clear whether this is being driven by a reduction in the total number of people being reached or changes in the definitions of population groups as defined in Global Fund grants. In addition, these coverage numbers may reflect changes in funding for KVP programmes in instances where this has been taken on through other funding sources. As shown in Figure 3.12 below, the total number of KVPs reached fell from 7.2 million in 2017 to 6.7 million in 2019. The reduction in this figure has been driven by a reduction in reach of other vulnerable populations, which fell from 2.4 million in 2017 to 1.7 million in 2019. Countries that experienced particularly large drops in other vulnerable populations reached include Ethiopia (745,000 in 2017 to 349,000 in 2019), South Sudan (443,000 to 254,000) and Thailand (211,000 to 13,500). Rather than the number of people being reached in this population falling per se, one factor that may explain this change is changing definitions in Global Fund programming meaning that some groups may have been moved into other categories that have specifically been highlighted. Coverage levels of the KVPs reached where specific indicators are included in the Global Fund's Modular Framework have remained relatively stable. PWUD, on the other hand, have increased from 807,000 in 2017 to 1.03 million in 2019, largely driven by increases in people reached in Ukraine (150,000 more people reached in 2019 compared to 2017), Iran (nearly 70,000 more reached) and Viet Nam (70,000 more reached).

[140] It is important to note that the extent to which new infections of HIV occur is determined by a range of factors beyond the investments made by the Global Fund, and as such trends in incidence are only somewhat attributable to the Global Fund. CEPA have not analysed the extent to which the long-term trends are attributable to the Global Fund, given that this is beyond the timeframe that is considered within scope for this review.

[141] Global Fund (2020), Results Report

[142] Source: UNAIDS data provided by the TERG

Figure 3.12: Total number of KVPs reached across all countries funded by the Global Fund (millions)



Source: Global Fund data

While the above data indicates the total number of people reached by Global Fund-supported programmes, these figures do not include the total number of individuals in countries that have been reached through all prevention programmes implemented in the countries. In addition, the above data may reflect changes in the number of people reached through Global fund-supported programmes driven by a change in funding source for these activities (e.g. there could be a reduction in people reached through Global Fund-supported programmes if this funding is taken over by other funding partners).[143]

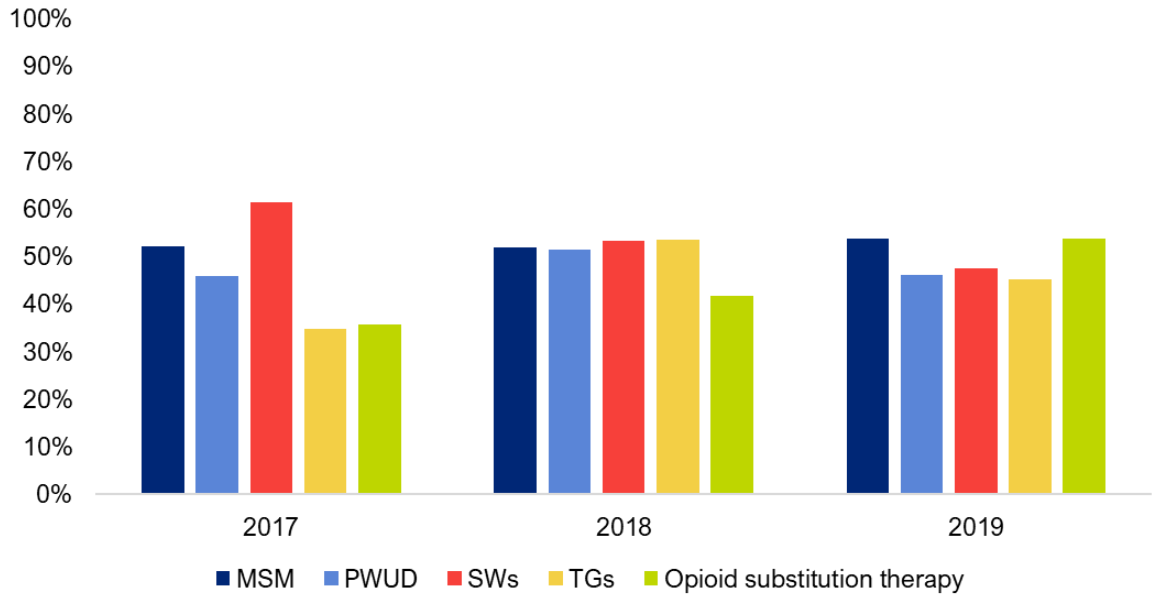
(A) Results have been mixed in terms of the extent to which countries have been meeting their coverage targets set within countries' Performance Frameworks. A lower proportion of countries met their SW coverage targets over time, while a higher proportion have met TG and opioid substitution therapy targets. Based on consultations, many stakeholders noted that coverage of KVPs overall is below that which the Global Fund would like to be achieved, and that which is set out in the UN Political Declaration. As shown in Figure 3.13 below, the extent to which countries have met their percentage coverage targets for KVPs has been mixed. For example:

- For SW, the proportion of countries meeting their coverage targets **has fallen from 61% in 2017 to 47% in 2019**, with the number of countries in the overall sample remaining relatively stable. These overall figures mask a high variation in individual country performance. For example, 20 countries in the sample were able to achieve their targets every year, while 25 countries failed to achieve their targets in any of the years.
- On the other hand, the proportion of countries meeting their **TG targets has increased from 35% of 23 countries in 2017 to 54% of 28 countries in 2018, while falling to 45% of 31 countries in 2019.** In addition to the proportion increasing, the absolute number of countries achieving targets also increased from eight in 2017 to 14 in 2019, while in 2018 15 countries achieved their targets. As with SW, there was some variation in the extent to which countries were able to achieve their targets across years, with five countries (Bangladesh, Bolivia, Costa Rica, Indonesia and South Africa) achieving their targets in all three years, while 12 countries failed to achieve their targets in any of the years where percentage targets were set, including four countries (Jamaica, Mauritius, Peru and Philippines) failing to achieve their targets across all three years.

[143] In addition to the data presented above, UNAIDS collects coverage data for all KVPs reached within a country, largely sourced from surveys. However, when reviewing this data, we found a number of gaps for certain years, with only a handful of countries having data across years for individual sub-populations, meaning that it was not possible to conduct a meaningful trend analysis. For the countries that did have data from 2016-19, the total number of people reached by programmes increased from 735,000 to 906,000.

- Of the countries that had coverage targets related to the number of people on **opioid substitution therapy,** 36% met their targets in 2017, while 54% achieved their targets in 2019, showing a marked improvement. Morocco was the only country that achieved its targets across all three years, while Kosovo, Kyrgyzstan and Senegal missed their targets in each year.
- Finally, the **overall percentage of countries meeting their MSM and PWUD coverage targets remained relatively stable.**

Figure 3.13: Proportion of countries meeting or exceeding percentage targets across coverage indicators[144]



Source: Global Fund data

Many consultees noted that despite Global Fund and other partners' desires for a greater number of people to be reached with HIV prevention services, overall coverage remains low. For example, despite the 2016 UN Political Declaration calling for 90% of at-risk HIV populations (specifically KVPs and young populations in high prevalence settings), most countries are far below these coverage rates.[145] Primary reasons for this include the general stigma and discrimination and other human rights and gender-based barriers that continues to affect these groups (as described in Sections 3.3 above). In particular, many individuals are concerned about the consequences of identifying as being part of certain groups (particularly MSM and TG) in their communities, which in turn limits their ability to access HIV prevention services (as well as HIV counselling and support in general). In a number of countries, the Global Fund and other international partners are predominantly responsible for funding KVPs, and in some countries politics related to funding activities supporting KVPs remain a challenge, which in practice means that a number of structural and legal barriers to access HIV prevention services continue, and programmes cannot operate at the level of ambition they desire. In addition, coverage of KVPs has been hampered by the lack of funding for HIV prevention from both domestic and international sources, as has more generally been the case with prevention funding (as discussed in Section 3.1.1).

AGYW incidence and coverage

(A) Based on the Global Fund's programmatic data available, the number of AGYW reached through Global Fund programmes increased from 367,000 in 2018 to 1.5 million in 2019, suggesting a large ramp-up in AGYW-supported programmes.[146] This has been coupled by an increase in the number of countries meeting their

[144] Some countries which have targets related solely to absolute numbers have not been included in this analysis.

[145] UNAIDS (2017): 2020 HIV prevention roadmap

[146] Data on AGYW coverage was not available for 2017.

coverage targets. Based on the Global Fund's analysis under KPI8, current trends suggest that the 13 priority countries are projected to reduce HIV incidence among AGYW by between 47% and 64% by 2022, suggesting that the target of 58% could be met.

The main countries that have increased their coverage of AGYW between these years include Mozambique (307,000 additional people reached), Chad (293,000 additional people reached), Tanzania (125,000 additional people reached) and Malawi (115,000 additional people reached). In addition to the significant increase in coverage among these countries, nine of the 15 countries that had targets for AGYW coverage were able to meet their targets in 2019, compared to just one (Tanzania) in 2018. While the data only covers a small number of years, it suggests that there have been significant levels of improvement in coverage of AGYW within Global Fund programmes, and that Global Fund support has been an important contributor to the scale-up of these programmes.

In terms of incidence reduction, recent analysis by the Global Fund of UNAIDS data suggests that by the end of 2019, the 13 priority countries had fallen by 31% from the 2015 baseline.[147] Based on projections made by the Global Fund, incidence is expected to fall further in these countries so that by 2022, reductions from 2015 are expected to reach between 47% and 64%, suggesting that the 58% target is achievable. For this to occur, incidence rates will need to fall by an average of around nine percentage points per year, highlighting the need for continued effort in order to attain these results.[148]

VMMC

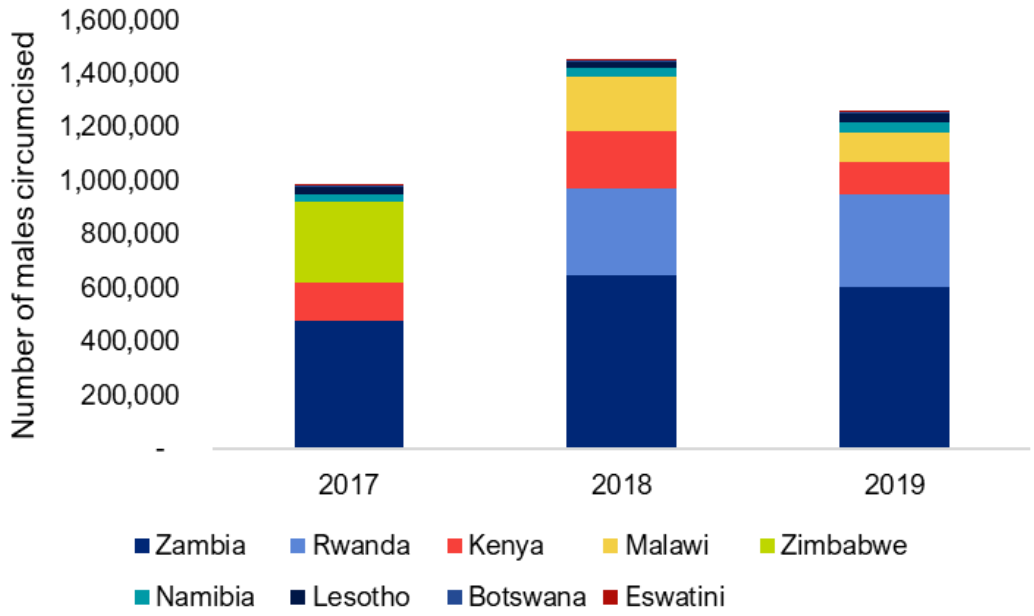
(A) The Global Fund's programmatic results data suggests that the 14 countries included in the KPI2 target for 22 million males to be circumcised by 2022, is going to be met, with 12.2 million circumcisions carried out to date. However, given that VMMC is largely funded by PEPFAR, it is recognised by the Global Fund that its contribution to this is relatively limited in terms of global VMMC efforts. Countries that are projected to contribute most to the achievement of this target include South Africa, Mozambique and Malawi. In terms of the Global Fund's contribution, between 2017 and 2019, 3.7 million VMMCs were carried on programmes supported by the Global Fund in nine countries.[149] Zambia accounted for 47% of these circumcisions, followed by Rwanda (18%) and Kenya (13%). As shown in the figure below, the number of circumcisions since 2017 (985,000) has increased, although 2019 numbers (1.3 million) were lower than in 2018 (1.5 million). The main driver of the lower figures in 2019 compared to 2018 was the reduction in the number of circumcisions carried out in Kenya, Malawi and Zambia, where the number of circumcisions between 2018 and 2019 fell by 99,000, 88,500 and 41,000 respectively.

[147] Global Fund (2020), KPI Report Mid-2020 for AME

[148] CEPA has not reviewed the underlying data behind these projections from the Global Fund.

[149] Zambia, Rwanda, Kenya, Malawi, Zimbabwe, Namibia, Lesotho, Botswana and Eswatini.

Figure 3.14: Total number of males circumcised in Global Fund-supported countries



Source: Global Fund data

These figures show that while Global Fund-supported programmes contributed to 3.7 million male circumcisions, far more were carried out beyond this in these countries, highlighting the importance of other funding. As noted in Section 3, just US$41 million of Global Fund prevention funding was allocated to VMMC between 2015 and 2020. On the other hand, PEPFAR funding for VMMC totalled over US$1 billion between 2015-19 across all countries supported by PEPFAR (or 50% of its funding, see Appendix J for further details). This indicates that this funding is likely to have been the key driver of results in this area.

PrEP

(A) More than 20,000 people were recorded as receiving access to PrEP services in 2019 (across five countries that reported data related to this), an increase from 6,600 in 2019. This suggests that PrEP is currently being rolled out on a relatively small scale across Global Fund programmes, and is just 1% of the global total number of PrEP users. Three countries in particular were responsible for the majority of figures in 2019, namely Thailand (c.10,700), Zimbabwe (c.5,500) and Viet Nam (c.3,800). These figures show that the rollout of PrEP within Global Fund-supported programmes is relatively low, especially when compared to PEPFAR where data for the fourth quarter of 2019 suggested that more than 106,500 people were accessing PrEP through their programmes.[150] In addition, at the end of 2019, global data suggests that more than 600,000 people had been initiated on PrEP, suggesting that Global Fund support for PrEP accounts for just 1% of the global total at present.[151] Consultees confirmed that PrEP rollout among Global Fund programmes has been limited, and where it has been implemented more recently has largely been on a pilot basis.

Key findings from country case studies on grant results

Our country case studies provide more qualitative evidence on results in terms of the value add of Global Fund investments, what have been the main achievements given the country context, and more context to explain the quantitative results. For example:

In **Indonesia**, the Global Fund plays a major role in funding HIV prevention services outside of the capital city, and as such has been an important contributor in this regard. In particular, the programme has been able to achieve several of its coverage targets. However, as with other countries, there is limited evidence on whether these outputs

[150] PEPFAR (2020), Results data

[151] It should be noted that this figure includes high-income countries that are not supported by the Global Fund. For example, the US accounts for around 200,000 global PrEP users, or around one third of the total.

are ultimately leading to outcomes, particularly in terms of changes in behaviour. While there has been a drive to refer KPs for HIV testing in health care facilities, there was less evidence of integration of HIV prevention for KPs, especially in light of the policy, procurement and implementation challenges.

In **Jamaica**, coverage targets across KVPs (including MSM, SW and TG) have been not been achieved across a number of years. While for 2019 some high-level data suggested that Jamaica was significantly below its targets compared to previous years, stakeholders noted that this discrepancy was partly a result of numbers for 2019 not being duplicated, yet targets were not updated to reflect this. Consultees noted that the programme in Jamaica is well-delivered and that most implementing partners had good capacity. However, in general more was needed to be done to ensure that the programme could reach hidden populations of KVPs, particularly MSM and TG, given that many in these sub-groups are reluctant to be identified. Over the long-term, progress with regards to SW has been more promising, with prevalence within this population having fallen from 12% in 1990 to just 2%, according to the latest estimates. Consultees noted this has been driven by SWs being more engaged in promoting HIV prevention and the lower levels of stigma associated with being part of this group, enabling them to access prevention services.

In **Ukraine**, HIV prevention coverage for KVPs is increasing and highest among PWUD, but the scale remains below the global coverage targets. According to the PHC, agreed programme targets have been reached. Progress reports indicate increasing numbers of PWUD, MSM and SW reached year on year through Global Fund-financed services. However, national coverage remains well below the UNAIDS 2020 global prevention targets of 90% coverage for all KVPs, and key informants agree that coverage is not sufficient.

In the **Philippines**, the targets under the Global Fund grants have been largely achieved (pre-COVID-19) but the interventions under NFM2 were considered to be too limited to substantially change the trend in incidence. Having said this, funding was regarded as well targeted to relevant KVPs (with the exception of PWID) and several interventions were introduced and expanded under NFM3 with high potential for results. This includes funding for CHOWs to replace peer educators at social hygiene clinics, as well as clinics run by CBOs, both of which should enable more individuals to be reached with relevant prevention activities. On the other hand, whilst some work has be done on developing online outreach, this has lagged behind the increased use of online platforms by KPs in the country and an earlier and more substantial support of online outreach would have been beneficial.

3.4.2. Integration of grant-supported HIV prevention programmes into HIV strategies and plans and influence on policy environments

RQ 9: How have grant-supported HIV prevention programmes been integrated into HIV strategies and plans? How have HIV grants been used to influence policy environments?

In this question we consider firstly how Global Fund grant-supported programmes have been integrated into national strategies and plans (in instances where they were not previously included such as pilot programmes) and secondly how HIV grants have been used to influence policy environments with regards to prevention. A summary of the main findings for each of these areas is presented in the table below, followed by more details on the evidence base and analysis.

Key findings
• There is some evidence of Global Fund-supported HIV prevention interventions being integrated into national policies and plans, as well as evidence that Global Fund grants have been used to influence policy dialogue on HIV prevention at the country level.

(B) There is some evidence of Global Fund-supported HIV prevention interventions being integrated into national policies and plans, as well as evidence that Global Fund grants have been used to influence policy dialogue on HIV prevention at the country level.

Evidence from country case studies highlight that some Global Fund supported programmes have been integrated into countries' national plans (in instances where they previously were not included). Examples include:

- Ukraine: Global Fund-supported interventions have been incorporated into the national HIV strategy;
- Indonesia: the development of Global Fund's funding requests has contributed to more fully integrating HIV prevention for KVPs into the national strategy and plans for HIV prevention, care and treatment (2020-2024 NSAP), despite some gaps with the more detailed prioritisation of HIV prevention components;

- Botswana: Global Fund support to HIV prevention programming resulted in the Ministry of Health developing and approving national protocols for PreP provision as well as in the government increasing the emphasis on AGYW programming in the new national youth policy;
- Ethiopia: The Global Fund's attention to HIV primary prevention and KVPs has contributed to the government and partners including additional KPs into the 2018 Ethiopia HIV prevention roadmap and the draft NSP for 2021-2025; and
- Nigeria is using Global Fund funding to support its first harm reduction needle exchange programme.

Evidence from country case studies suggests that Global Fund grants are also used to influence policy dialogue on HIV prevention. For example:

- In South Africa**,** the "keeping girls in school" programme is used now as a basis for the programme in schools: it has influenced the SOPs and the policy document which is the guiding document for these services;
- In Ukraine, Global Fund-supported PRs have been effective at policy advocacy.
- In Côte d'Ivoire, human rights barriers funding from the Global Fund has supported the development of a technical note to strengthen advocacy for the revision of the 2014 HIV prevention and protection law, the law on drug use and the institutional framework on sex work. It has also supported the establishment of a human rights observatory monitoring access to health services, including services related to HIV and tuberculosis programming.

However, notwithstanding the positive integration of HIV prevention intervention in national programmes in general there has been slow progress in countries taking on increased levels of domestic funding in support of HIV prevention in plans, especially for prevention programmes for KVPs as noted in Section 3.3.4.

4. CONCLUSIONS

HIV prevention is of significant importance if global targets of reducing HIV incidence are to be met. Since the Global Fund was established in 2002, new HIV infections in countries supported by the Global Fund have fallen by 44%. Yet despite these long-term reductions in new infections overall, progress has not been extensive and uniform, and the global target for a 75% reduction in new infections by 2020 will not be met. In addition, countries are failing to meet global coverage targets for comprehensive HIV prevention services, including for KPs.[152] These trends highlight that despite a global recognition of the importance of HIV primary prevention for eliminating HIV/AIDS, greater prioritisation and improved implementation are needed to ensure efforts are effective in achieving results.

Within this context, our review has highlighted the following:

The Global Fund has increasingly been playing a critical stewardship role for HIV primary prevention at the global level, due in part to being the second largest donor for HIV prevention. There have been a **number of significant achievements and improvements over the recent allocation period** (NFM2):

- Although HIV treatment, care and support remains the dominant budget area supported by the Global Fund, there has been an increased prioritisation of HIV prevention with the proportion of **Global Fund funding allocated to HIV primary prevention of total HIV funding increasing from 10.8% in 2015-2017 to 13.3% in 2018-2020.**
- There has been a **noted trend in Global Fund leadership and technical staff being more committed to supporting primary prevention**, positioning the organisation as an active supporter of this area of work within the partner landscape. In addition, the Global Fund has played an improving and more active role in

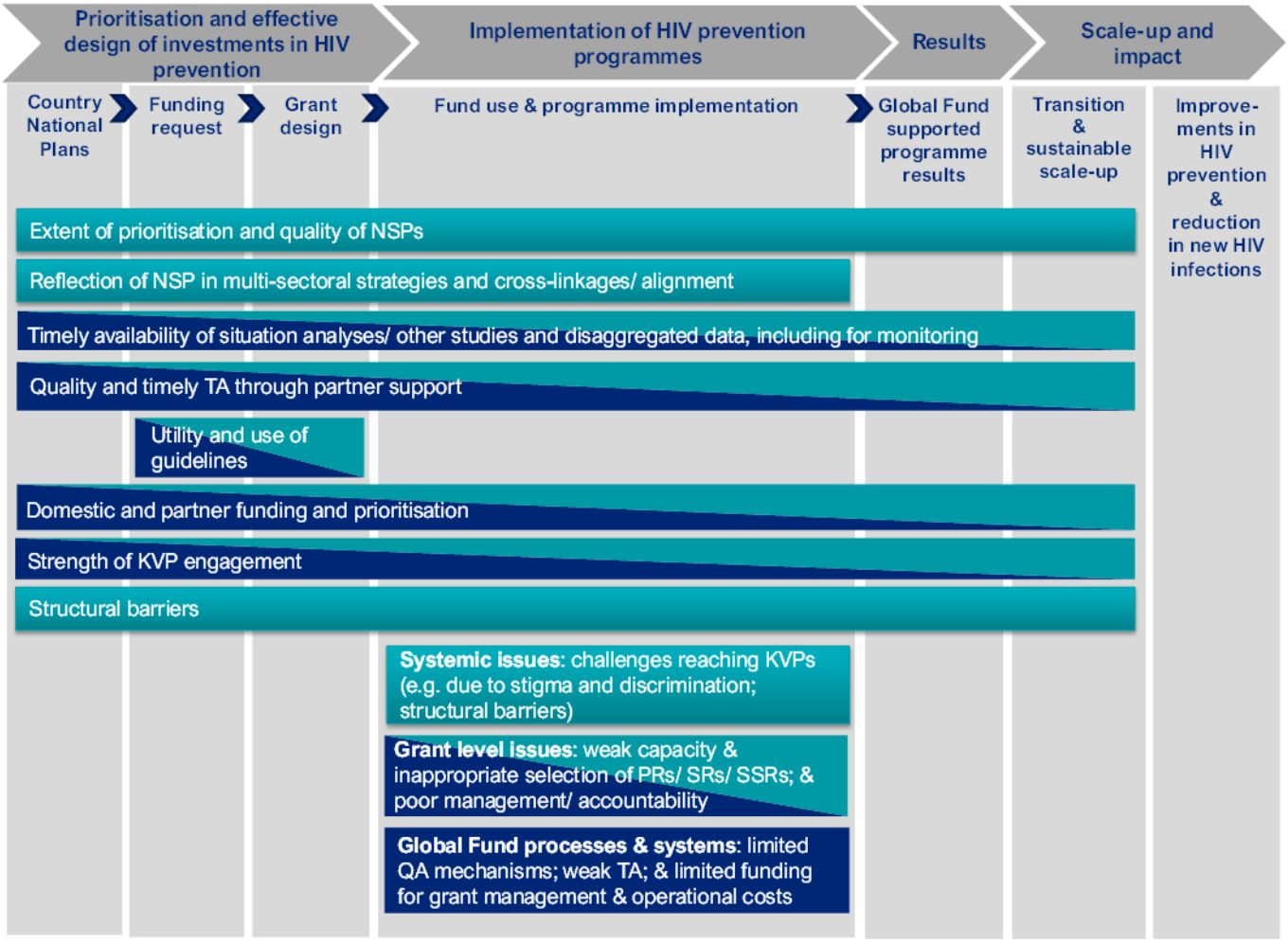
[152] Current trends suggest that incidence reduction targets among AGYW across prioritised countries could be met by 2022.

the GPC and other HIV prevention fora over time, which supports its prominence in the HIV primary prevention agenda.

- The Global Fund has **introduced some key initiatives emphasising HIV primary prevention**, with several types of catalytic investments (strategic initiatives, multi-country funding and matching funding). These catalytic investments have been key for HIV primary prevention investments being included in grants, although the quality of the focus of the interventions could be improved.
- Progress has been made in terms of country grants and HIV prevention interventions supported by the Global Fund as follows:
    - Progress has been made with regards to **better targeting of interventions and higher impact interventions being included in grants.** In particular there has been a shift away from 'generic' general population prevention programmes and shift towards KP programme investments and AGYW investments, with over half of the Global Fund funding for HIV primary prevention supporting KP interventions (59% in 2018-2020) and an increase in AGYW investments to almost a quarter of HIV prevention investments in 2018-2020. Within both these target groups, the Global Fund is supporting high-impact interventions through comprehensive packages of facility- and community-based interventions. Across the country studies for this review, stakeholders have viewed a number of interventions to be very relevant and with good potential for impact.
    - HIV prevention interventions included in funding requests **have been well aligned with NSPs, highlighting the importance of quality NSPs and other relevant strategies** in influencing Global Fund supported-prevention programmes, given the Global Fund's country-led approach. Across the country studies for this review, there have been some good examples of strong NSPs and availability and use of supporting analyses and data in programme design.
- The Global Fund's **partnership approach is considered to be a comparative advantage** for HIV prevention, encouraging wide partnership of country government, civil society, communities and technical partners. Global level coordination and harmonisation with other partners has improved, although some room for improvement remains with regards to coordination with technical partners.
- **KVP engagement is particularly strong in some areas** (e.g. at the global level and during the grant design stage as well as select cases of implementation by KVP organisations), supported by the Global Fund model and systems which are generally well designed, especially in terms of engagement of KVPs at the global level.

However, there are a number of challenges that remain, many of which are at the country level and thus beyond, or only somewhat within, the realms of influence of the Global Fund. This review has highlighted a number of these key issues as well as aspects with regards to Global Fund support and processes for HIV primary prevention which the Global Fund can influence. Figure 4.1. below summarises these issues, which is followed by more details.

Figure 4.1: Key findings



**Blue refers to issues that can be impacted by Global Fund processes and systems and green refers to country level issues. To note: this is a summary figure, which aims to capture and illustrate all the factors affecting the findings of the report. It is not meant to be fully representative of the pathways of the findings (in particular we note that results do not lead to scale up).*

With regards to **Global Fund processes and systems,** key issues include:

- **Although there has been a drive from leadership to prioritise HIV primary prevention, this has not been adequately operationalised across Secretariat teams and in Global Fund processes.** This is due in particular to (i) HIV prevention being a particularly complex technical area and technical knowledge not yet being widespread across the Secretariat, with further capacity building needed; (ii) the 'conceptual framework' for HIV prevention not being adequately understood within the organisation and (iii) decision-making for HIV prevention being distributed amongst a number of teams in the Secretariat which creates a lack of clarity in terms of guidance as well as accountability.

- Whilst noted to be one of the Global Fund's key comparative advantages**, the Global Fund's stewardship role for HIV primary prevention at the country level is more challenging than at the global level, by virtue of its country-led and CCM model.** Notably, this model relies on country-owned and country-proposed approaches to managing the HIV epidemic, which may not always prioritise high impact interventions for HIV primary prevention and limits to some extent the degree to which cost-effective and value for money interventions in HIV prevention are adopted and scaled-up by countries. Furthermore, while engagement of KVPs and communities is generally strong during the design of the funding requests, it tends to be more limited during the implementation of HIV prevention intervention.

- With regards to grant design, management and implementation issues, the following aspects have been highlighted in our review:
    - **Balancing a country-led approach with an optimal investment approach for HIV prevention within the standard Global Fund processes requires further attention and consideration.** Particular issues are whether the suggestive guidance offered by the Global Fund through the written guidance documents provides sufficient direction to countries, especially as the guidance is more theoretical rather than operable (e.g. the guidance on VFM) and challenges with the limited information in funding requests to aid an effective review by the TRP.
    - The **grant making** stage is particularly important given the complexity of the prevention interventions, **but there are concerns as to whether there are adequately standardised and transparent approaches during this stage to ensure prioritisation of HIV prevention and quality programming.**
    - Global Fund **prerequisites for minimum programmatic, financial, and management capacities and systems** may preclude some relevant organisations working in HIV prevention from being PRs or SRs, necessitating further capacity building efforts of these smaller and critical organisations for HIV prevention programme implementation.
    - There are **challenges with retention of HIV prevention interventions in grants after funding requests are submitted** as Global Fund grants decreased by 10% across GPC countries when comparing funding requests to the current budgets. Evidence from case study countries (and select other countries) suggest key reasons for this decline include a re-categorisation of interventions in the Modular Framework and grant consolidation to avoid duplication with other funders. Wider discussions with both global and country stakeholders have also suggested a potential deprioritisation of HIV primary prevention funding, but this review has not been able to gather robust evidence to support this claim. Overall the need for greater transparency in budget developments over time has been highlighted.
    - The Global Fund has several mechanisms to encourage grantees to include high impact HIV prevention in grant design but in contrast, **during grant implementation the Global Fund has relatively limited mechanisms for quality assurance/ quality improvement of Global Fund-supported HIV prevention interventions** (e.g. the quality of CCM monitoring of implementation is variable, limitations to monitoring of results data, reliance on external partners for TA and therefore potential reduced feedback loops for need for grant reprogramming). These can present issues during the implementation stage.
- Although there has been a **greater focus on the provision of TA for HIV prevention by the Global Fund** (e.g. through the Strategic Initiatives)**, this is a key area requiring further attention.** Whilst not specific to HIV prevention, the Global Fund has limited visibility and influence over the TA provided by partners through their set-asides, which constrains the ability of the Global Fund to plan and coordinate TA, enhances the risk of duplication and reduces potential for long-term impact. Specifically for HIV prevention, there are challenges in sourcing TA, especially TA which is multi-sectoral and from experts with up-to-date technical expertise on HIV prevention, and an overreliance on UN agencies, who may not always be best placed to provide TA. Further, in general, TA for the design of grants has been more forthcoming than TA for implementation and monitoring of grants which is an area of key need for countries with regards to HIV primary prevention. In addition, TA for capacity building of PRs/ SRs remains a key area of need.
- Despite the fact that the Global Fund currently has a number of KPIs to track its investments in HIV prevention, **the Global Fund faces a number of challenges in the measurement of HIV prevention progress and results**. In particular:
    - There is a lack of an overarching framework/ approach to the results the Global Fund aims to achieve through its investments in HIV prevention, making it challenging to measure, report and interpret its achievements;

- At the strategic level, some of the KPIs are deemed to be too ambitious and there are shortcomings in relation to the targets, whilst at the grant level, there are specific challenges with regards to the performance framework measurement of HIV prevention interventions and outcomes;
- Further, Global Fund grant monitoring has focused on quantitative measurement of outputs based indicators such as on coverage, rather than adopting systematic approaches to capture the more qualitative nature of the HIV prevention results at the outcome and impact levels.

Key challenges at the country level include:

- **Grant design and scale-up:** There are significant barriers to the inclusion of HIV prevention programmes in funding requests and scale up of these. In particular these include:
  - limited resources, particularly domestic funding;
  - structural barriers (e.g. human rights and legal or policy barriers, criminalisation of KPs) as well as political barriers such as a lack of political will and commitment, especially to the needs of KVPs);
  - inadequate guidance and TA;
  - insufficient prioritisation of HIV prevention in NSPs and related strategies as well as limited availability of data and analyses;
  - whilst improvements have been made with regards to prioritisation of KVPs, there continues to be challenges with most appropriate targeting of resources to populations most in need as well as programming of effective interventions;
  - transition challenges (e.g. challenges with integrating small/ pilot projects into national programmes, limited social contracting including supportive legal frameworks for this).
- **Implementation issues:** There are a number of challenges resulting in less than effective implementation of HIV prevention interventions within Global Fund country grants, including contributing to the relatively slower use/ absorption of funds. These include:
  - systemic issues (e.g. challenge for implementers to reach KVPs especially due to stigma and discrimination and structural issues);
  - the nature of HIV prevention programmes with HIV prevention planning and implementation being particularly complex and therefore requiring greater oversight, coordination and engagement; a larger number of implementers are required and the need for multi-sectoral engagement. In addition, there have been a number of new interventions introduced which has affected implementation;
  - grant level issues, especially weak capacity of PRs, SRs and SSRs as well as potential inappropriate selection of SRs and SSRs; and
  - country issues such as low coordination capacity amongst governments, challenges with devolved structures and conflicts.
- **Measuring progress:** There are a number of challenges with measuring progress and results of HIV prevention interventions that affect Global Fund investments and measurements of these but are not are not unique to Global Fund investments, including: a difficulty of estimating population sizes of KVPs; limited availability of disaggregated data (e.g. by KVP group); and an issue with double-counting of beneficiaries given confidentiality concerns. In addition, there is a focus on outputs/ coverage indicators, rather than measuring prevention-related outcomes and achievements.
- **Sustainability and transition:** There are ongoing sustainability and transition challenges for countries. In particular for HIV prevention programmes this relates to the financial sustainability of KVP programmes, especially where countries are not taking responsibility for these programmes and where community-based programmes have remained relatively silo-ed. In addition, there are challenges around social contracting with

regards to having mechanisms to allow national takeover of support for CSOs when countries transition from Global Fund support.

This review has aimed to understand and interpret the challenges of effectively funding HIV primary prevention efforts at the country level, where a number of issues warrant careful consideration by the Global Fund in terms of how best to ensure value for its monies in this regard. The review has clearly highlighted that given the plethora of issues that impact these interventions in particular, a renewed approach that is better clarified, more engaged and represents somewhat of a departure from standard Global Fund processes and systems is the need of the hour. The next section brings these aspects together to provide select priority recommendations for the Global Fund to consider, some for immediate action and others for a longer term concerted effort.

5. RECOMMENDATIONS

The final section of the report presents recommendations emanating from the review findings and conclusions.

Recommendations are proposed in the following areas:

(i) Global Fund funding, capacity and systems (Section 5.1)

(ii) Facilitating country programming and implementation (Section 5.2)

(iii) M&E and partnerships (Section 5.3)

For each recommendation, we provide a discussion on the scope and content (i.e. the "what") followed by some indications on implementation responsibility and operationalisation (i.e. the "how"). We also highlight relevant timelines for the recommendations, noting that the Global Fund is in the middle of a strategy period (2017-22) and the final funding cycle for the current strategy period has already commenced (although not all countries have applied for the next grant as yet). Where possible, "quick wins" are also highlighted. A final section (Section 5.4) provides a discussion on prioritisation and implementation.

The recommendations aim to be relevant in that they critically consider the specific nature of HIV prevention and what would make sense in this context for the Global Fund to support. The recommendations are also cognisant of the Global Fund's country-led and partnership-based model.

The recommendations are largely based on CEPA's expertise, but also stakeholder feedback. A workshop held with Secretariat and TERG members has contributed to their development and refinement. We also note that several recommendations below are in line with the recent external review conducted for the GPC[153] and that the Global Fund Strategic Review 2020[154] highlights several recommendations below as being relevant for the Global Fund as whole. As such these specific recommendations are not exclusive to HIV primary prevention (e.g. with regards to TA, M&E, partnerships, etc), although below we tailor these aspects to the HIV prevention context.

5.1. GLOBAL FUND FUNDING, CAPACITY AND SYSTEMS

Recommendation 1: Further accelerate the momentum achieved for HIV primary prevention within the Global Fund, in terms of funding as well as capacity.	
Implementation responsibility	Global Fund Secretariat, working with donors/ funders to enhance funding.

[153] Barbara O. de Zalduondo, L. Gelmon and H. Jackson (2020) External Review of the Global HIV Prevention Coalition and 2020 Road Map; Final Report. October 5, 2020

[154] Euro Health Group, Itad, UCSF (forthcoming), The Global Fund Strategic Review 2020, Final Report

Timelines	The component on funding is a long-term concerted effort, including for the next strategy period, but capacity building within the Secretariat is a high priority and immediate "quick win".

The review has highlighted an increasing prioritisation and stewardship for HIV primary prevention by the Global Fund, but funding levels continue to be lower than desired/ needed and there is a need for an organisation-wide understanding and awareness of HIV primary prevention.

In this regard, we recommend:

(i) **Continue to prioritise and increase HIV prevention funding**, by making a strong investment case for investing in prevention to Global Fund donors, and especially to feed into the HIV resource needs analysis that determines overall funding allocations by disease and country. It is recognised that further prioritisation of HIV primary prevention needs to be considered within the constraints of the overall budget envelope and the extensive needs within the HIV response, especially for treatment. Catalytic funding streams such as matching funding and strategic initiatives should also be enhanced for HIV primary prevention, noting their success to date in increasing funding for prevention, although with the need to ensure more strategic and catalytic use of the funds.

(ii) **Build and continue to develop an organisation-wide understanding and recognition for HIV primary prevention,** supported through the development of a conceptual framework that sets out the strategic and technical vision and plan for Global Fund investments in HIV primary prevention, in line with the overall Global Fund Strategy. The framework would need to set out the impact that the Global Fund wants achieve with its monies, in line with global goals and objectives, also considering a longer-term view of intended impact. The Global Fund's position and guidance on HIV primary prevention should be **uniformly communicated and understood** across the Secretariat and stakeholders, so as to support increased capacity in this area. This should be prioritised for the country facing teams that support the development of funding requests as well as facilitate grant making and reprogramming.

(iii) **Additional technical expertise** on HIV primary prevention should be incorporated in the Secretariat to improve technical and management capacity (e.g. to support prioritisation of relevant interventions, monitoring effectiveness and programme adaptation) – whether through additional FTE or secondments from partner organisations, subject to budget constraints.

For (i) above on funding, this needs to be an ongoing long-term concerted effort to increase funding, and new/ enhanced catalytic funding streams may be considered for the next Global Fund strategy. Primary implementation responsibility lies with the Global Fund Secretariat, both the funding teams that work with external donors to raise funding but also the HIV team to help build the case for increased and continued funding.

For (ii) and (iii) on building internal capacity for HIV primary prevention within the Global Fund, we view this as a priority recommendation to be implemented by the Secretariat in the short term (i.e. would serve as a "quick-win").

Recommendation 2: Critically consider select enhancements and deviations from the standardised Global Fund application, approval and reprogramming processes to support strategic investments and programming for HIV primary prevention.	
Implementation responsibility	Global Fund Secretariat to implement most of the recommendations below, with support from technical partners with regards to the recommendations on guidance. Where suggested deviations from the standard Global Fund processes and systems are major, there would be a need for approvals from the Strategy Committee/ Board. The TRP also has implementation responsibility for select recommendations below.
Timelines	There are a mix of recommendations here including some that would need to be implemented for the next strategy and funding cycle (e.g. on guidelines) and others that may be considered already (e.g. with regards to outstanding country applications for the current funding cycle as well as those that have been approved already).

The review has highlighted that there are a number of Global Fund systems and processes that do not work adequately for HIV primary prevention, noting the specific nature of HIV primary prevention as distinct from commodity-based intervention funding.

Notwithstanding the advantage of a standardised grant application and approval process within the Global Fund, we propose a critical consideration of the following options:

(i) **Introduction of more *directive* guidance:** While not intending to flout the principle of country ownership, recognising the challenge with effective programming for HIV primary prevention, we recommend replacing the current *suggestive* guidance with more *directive* guidance, building on available partner guidance but being more clear on what would be funded through Global Fund monies. This could be done through several mechanisms such as through further focusing of the key guidance/ HIV Information Note and/ or broad instructions within the country allocation letters. Another option could be to develop operational guidance by relevant country groupings so as to encourage more effective tailoring of programmes to country context and yet retain some flexibility for countries.

(ii) **Inclusion of additional details in funding requests for TRP review, alongside ensuring alignment of TRP review with partner guidance:** There is a strong case for greater details on HIV primary prevention grants to be included in the funding requests for review by the TRP. More details on intervention design as well as implementation planning should be included, so as to benefit from the TRP expertise to support better design of grants. In addition, there should be adequate discussion and alignment on key prevention areas amongst the TRP to ensure their review aligned with partner recommendations.

(iii) **Development of standardised/ well-defined approaches to support grant making for HIV primary prevention:** There is a need to support country teams during the grant-making stage, so as to ensure the organisation-wide priority is reflected, uniform and consistent approaches are followed across countries, and there is greater tracking/ visibility of the changes/ refinements made to grant design. An option could be to develop detailed operational guidance to support facilitation of this stage. Another option could also be to introduce additional checks during this stage by Secretariat staff with strong expertise in HIV prevention to support quality HIV prevention programming, and/or to provide additional temporary surge support to Global Fund Secretariat teams during this stage. A further option could be including some TRP expertise during the grant-making stage as well (if appropriate).

(iv) **Development of standardised/ well-defined approaches to support reprogramming of prevention grants:** In a similar vein as above, given the reduction in HIV primary prevention funding following reprogramming in several countries, additional guidance and checks should be introduced to ensure that the priority for prevention is retained.

Some of these recommendations (and options within them) would require further consultation and agreement given a relatively strong departure from the standard Global Fund model (e.g. point (i) above on being more directive), however others, may be implemented relatively easily and in the shorter-term (e.g. points (ii) to (iv) above).

5.2. FACILITATING COUNTRY PROGRAMMING AND IMPLEMENTATION

Recommendation 3: Encourage greater prioritisation and focus on HIV primary prevention at the country level.	
Implementation responsibility	While not possible for the Global Fund to affect on its own, with ultimate responsibility with countries, specific actions can be taken by the Secretariat, and in conjunction with partners.
Timelines	To be implemented immediately as additional countries apply for funding and in future funding cycles and strategy periods.

The review has highlighted the need for increased prioritisation and funding of HIV primary prevention within countries, that also are subject to numerous structural and political barriers. While not feasible for the Global Fund to

impact on its own, we provide a few discrete recommendations on actionable areas within the Global Fund purview, as follows:

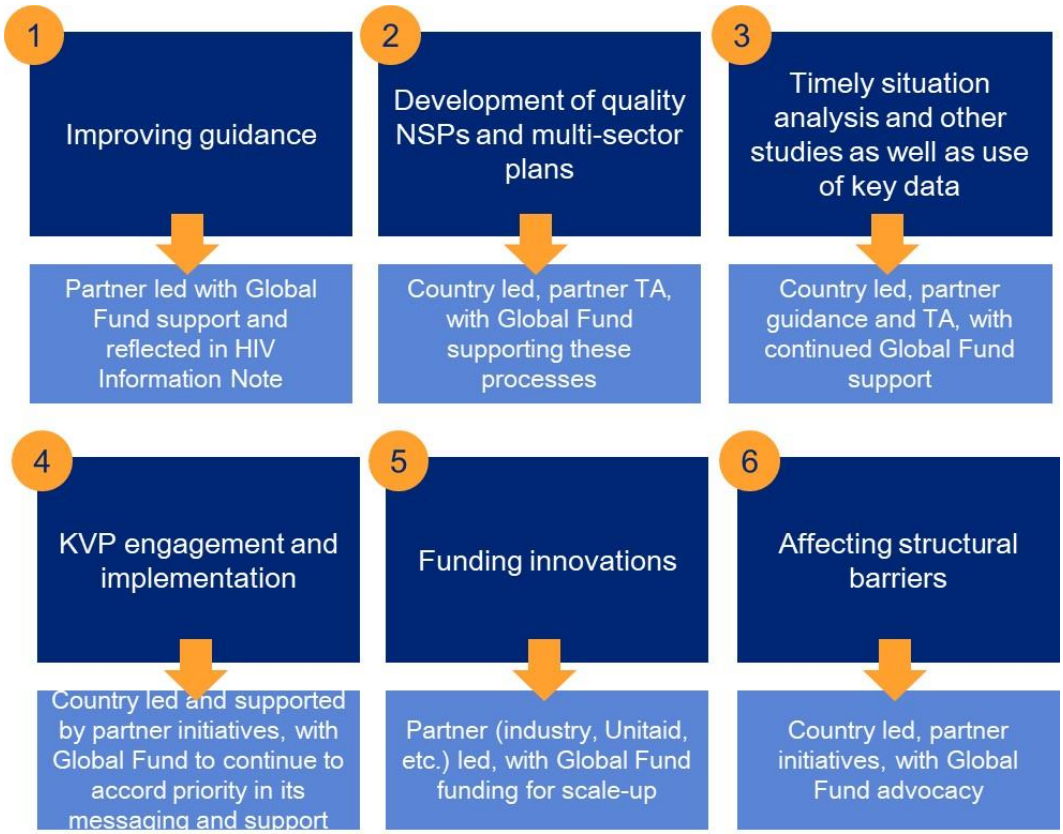
- **Including "soft" conditionalities for governments/ partners to increase and/ or take over HIV primary prevention funding** – i.e. through the allocation letters or by requiring matching funding from implementers.
- **Encourage the use of the PAAR mechanism** provided by the Global Fund to programme additional HIV primary prevention interventions, given this mechanism's noted success in enhancing funding for this area.
- **Continued efforts towards greater advocacy** for HIV primary prevention in general, and effective interventions in particular, at both the global and country levels, in partnership with GPC and other partners.

Recommendation 4: Work with partners and country stakeholders to support more effective and quality programming for HIV primary prevention.	
Implementation responsibility	This is a complex recommendation with country and multi-partner responsibility, with support through the Global Fund.
Timelines	To be implemented immediately as additional countries apply for funding, in the context of existing grants, as well as for future funding cycles and strategy periods.

The review has highlighted challenges with identifying strategic investments and effective grant design. Given the country-led and partnership-based model of the Global Fund, this is not an area that the Global Fund can affect on its own. Rather, countries will need to take a lead and the range of partners (advocacy-based, technical, multi-sectoral) would need to drive change. However, as Global Fund monies are being invested in HIV primary prevention, it also bears the responsibility to steer and/ or facilitate progress.

Figure 5.1 summarises the main areas where we recommend the Global Fund focus its efforts going forward, in an endeavour to support improved country grant design for HIV primary prevention. The key stakeholders for implementation are also highlighted, along with the Global Fund role. Details follow the figure.

Figure 5.1: Main areas to support more effective country programming



More specifically:

- **Improving existing guidance:** Recognising that there is a lot of guidance out there, efforts should be made by key technical partners (UNAIDS, GPC, etc.) to improve their existing guidance as per below, which should be reflected in the Global Fund HIV Information Note (and approach to *directive* guidance as per recommendation 2 above). Key areas for improvement include:
    - *Better focusing the guidances and making them more navigable* – including ensuring the right level of focus and prioritisation within the overall response to the HIV epidemic, simplifying the complex technical and multiple guidances that are available, making them more navigable (e.g. by developing a list of priority guidance documents, a flow chart of what to access when and for what issue, etc.).
    - *Developing VFM related guidance* – For example, the Global Fund should encourage partners to formulate "best buys" for HIV prevention interventions as for example has been done in the non-communicable diseases (NCD) space.[155]
    - *Making guidances more operable* – including encouraging partners to work together to develop more operational guidances (i.e. interpreting the complex technical guidance to practical realities at the country level by highlighting best practices or working through problems/ decision-trees, etc.). The UNAIDS AGYW prioritisation tool is a good example in this regard.
- **Development of quality NSPs and multi-sectoral plans:** Continue to support the development of quality NSPs with appropriate reflection of HIV prevention needs, through provision of TA through partners as appropriate, alongside TA/ support to bring together related strategies and plans that reflect the multi-sectoral nature of HIV primary prevention interventions. It is recognised that this will be a country-led initiative with partner TA support, and the Global Fund has more of a facilitating and leveraging role.
- **Encouraging timely availability of situation analysis and other studies, and importantly, the collection and use of key data:** These are some best practice examples across our country studies on timely availability of supporting analysis to drive selection and design of effective interventions (e.g. in Botswana and Côte d'Ivoire) and these should be encouraged for other countries as well. Data on size of target populations and coverage data should be emphasised for use as well as making available more information to facilitate financial planning/ budgeting (such as on unit costs – while different for countries/ interventions, a range or examples can be provided).
- **Supporting KVP engagement:** Efforts towards improving the quality of KVP engagement in funding request design and grant making processes, through a range of country and partner led initiatives should be continued to be supported by the Global Fund. Where required, capacity of these organisations should be strengthened by relevant TA providers to better represent their constituencies, and enable them to participate meaningfully. Furthermore, the Global Fund should continue to push for the inclusion of CBOs and KVPs in the implementation of HIV prevention programmes (also through its CSS funding) to increase the likelihood of reaching KP groups that otherwise would not be reached through 'traditional' means. We note that there are strict requirements to be eligible as a PR or SR, and we would not recommend reducing these requirements in keeping with the Global Fund's approach to managing financial and fiduciary risks; rather, work at improving capacity of relevant organisations themselves.
- **Funding innovations:** The Global Fund should consider funding more innovative new technologies especially where potentially "game-changing", including potentially new innovations piloted by Unitaid and others, subject to conforming with Global Fund's WHO PQ and other related requirements. Flexibilities should be introduced in grants so as to accommodate "game-changing" innovations within the funding cycle.

[155] https://www.who.int/ncds/management/WHO_Appendix_BestBuys.pdf

- **Affecting structural barriers:** The Global Fund should use its position in the global landscape to affect structural barriers in country, noting that these are complex, slow to change and country-level issues that require country-led movements and updating of legislations as well as are supported through partners (primarily NGOs). This could be through advocating at the global level (in partnership with the GPC and other relevant organisations) or at the country level (through the CCM, Secretariat engagements with governments and partners, etc). Further, the Global Fund should also facilitate greater understanding within the Secretariat on these barriers, and provide relevant TA for countries as appropriate.

Recommendation 5: Introduce relevant measures to support more effective implementation of HIV primary prevention interventions at the country level.	
Implementation responsibility	This recommendation bears country and multi-partner responsibility, with support through the Global Fund.
Timelines	To be implemented immediately as additional countries apply for funding, in the context of existing grants, as well as for future funding cycles and strategy periods.

The review has identified a number of challenges contributing to relatively lower absorption of funds as well as poor implementation of grants.

The following recommendations (and options within these) are proposed:

- **Ensure that appropriate mechanisms are in place to oversee, review and quality assure implementation of HIV primary prevention interventions.** There are a number of options here – e.g. where well-functioning, implementation oversight and QA could be provided by the CCM oversight body and/ or LFA. In other countries it may make sense to involve a partner organisation, or even the Global Fund Secretariat, or at an extreme, a specifically contracted organisation for implementation guidance and monitoring. We propose these more extreme options given the specific nature of HIV primary prevention interventions and the important need to better support implementation as a means to improve the efficacy and results of these interventions. These may be funded through Global Fund grants (e.g. including a specific budget line for this, where appropriate) or through other sources.

- **Continue to support existing initiatives to improve the quality of KVP engagement in grant implementation processes.** The Global Fund and partners should ensure that the KVP engagement involves active participation by KVP associations and networks, not only during the design of funding requests but also during grant making and grant implementation. An example approach could be inviting KVP representatives to grant implementation review meetings.

- **Adequate investment and close monitoring of PR/SR management arrangements and capacity.** As management capacity and delivery on this has been seen to be a key issue impacting implementation of HIV primary prevention grants, it would be important to ensure that management arrangements set out in the grant design are indeed implemented in practice alongside a close monitoring of these arrangements as to whether these are well functioning and if any changes are needed. Again, given this is a pertinent issue for HIV primary prevention, greater focus should be accorded by the Global Fund in ensuring the processes/ systems around its grants effectively pick up this aspect.

Recommendation 6: The Global Fund should consider relevant measures to encourage greater scale-up and transition of funding.	
Implementation responsibility	This is a complex recommendation with country and multi-partner responsibility, and facilitating support through the Global Fund.
Timelines	To be implemented immediately as additional countries apply for funding, in the context of existing grants, as well as for future funding cycles and strategy periods.

Building on recommendation 3 to affect HIV primary prevention funding at the country level, the following may be considered specifically with regards to encouraging greater scale-up and transition of funding:

- Advocate for, build knowledge on and share best practices for approaches to scaling-up and transition across countries, whether in terms of social contracting or public-private mix (PPM) models.
- Linking with recommendation 4 above, the Global Fund should continue to ensure adequate and quality investments in addressing community strengthening, human rights, gender and other structural barriers to services for KVP, and ensure that the outcomes from these investments are monitored and contributing to prevention outcomes.
- The Global Fund should also use its position and participation in the GPC to encourage greater country government accountability for HIV primary prevention outcomes.
- Ensure that Global Fund guidance clearly states the requirement that countries address scaling up coverage of HIV prevention programmes for relevant KPs, and for AGYW and male partners as appropriate given the country context, especially for transition countries. In line with recommendation 2, this guidance could be more *directive* by requiring countries to state their plans for transition upfront, and then report on the evolution of these plans over the grant implementation period so as to potentially better manage any risks earlier on.

Recommendation 7: Continue efforts towards bringing about greater coordination and visibility of TA for HIV prevention, and enhance TA for several unmet needs.	
Implementation responsibility	Partner responsibility, and facilitation/ support/ funding through the Global Fund.
Timelines	To be implemented immediately, although would also require a concerted long-term effort.

We appreciate that there are several ongoing initiatives and efforts to bring about **improved TA coordination, quality and accountability** across the board (i.e. across Global Fund grants for multiple diseases), and these efforts should continue in relation to TA for HIV primary prevention as well.

In addition, specifically in relation to unmet TA needs for HIV primary prevention:

(i) **Encourage the availability of HIV Prevention TA for grant implementation and monitoring** (i.e. beyond the current focus of TA, which is largely on grant design). Several things can be done here such as identifying the main implementation challenges across grants and highlighting these at the country level so that countries are encouraged to request for TA support in relation to these, developing a roster of TA providers with diversified suppliers beyond traditional UN organisations and to include CSOs with relevant implementation capacity, encouraging greater in-country partner involvement (e.g. UNAIDS, WHO, national CSOs/ CBOs, etc. through CCM oversight) during implementation and monitoring so they are encouraged to identify TA needs during these stages, etc and where relevant, such TA should be made more 'visible' by linking to programmatic delivery rather than be viewed as programme management.

(ii) **Encourage the provision of TA that has a multi-sectoral perspective** (as is the need for HIV primary prevention interventions). Identification of relevant partner organisations/ consultant rosters in this regard would be useful, including diversifying beyond the traditional UN partners for TA and using regionally based CSOs with relevant implementation experience.

(iii) Encourage TA to assist countries to achieve greater sustainability and prepare for transition, including supporting long term TA for capacity building**.** This is in line with a recommendation from the recent review of the GPC.[156]

[156] Barbara O. de Zalduondo, L. Gelmon and H. Jackson (2020) External Review of the Global HIV Prevention Coalition and 2020 Road Map; Final Report. October 5, 2020

(iv) **Encourage the provision of TA for programme and financial management for CSO/ NGO/ CBO PRs/ SRs/ SSRs.** Partnerships with relevant organisations (e.g. in the private sector) would facilitate effective availability of this type of TA.

(v) **Work with partners to ensure regular updating of trainers' capacity on programmatic and technical subjects"** so as to facilitate the provision of relevant and up-to-date TA.

Facilitating learning across countries through South-South cooperation will be important for a number of these recommendations, and could include sharing learning between PRs and SRs.

5.3. M&E AND PARTNERSHIPS

Recommendation 8: Introduce improvements in M&E for HIV primary prevention, aligning with partner work in this area.	
Implementation responsibility	Global Fund Secretariat, in coordination with partner guidance on M&E
Timelines	To be implemented immediately as additional countries apply for funding, in the context of existing grants, as well as for future funding cycles and strategy periods.

The following are proposed:

(i) In line with recommendation 1, **develop an overarching framework**, linking grant inputs, outputs and outcomes to the global targets (change) that the Global Fund wants to achieve through its investments in HIV primary prevention. [157] Having this framework will enable the Global Fund to better track progress as well as articulate and assess results. The TOC would also enable the mapping of synergies with other Global Fund programmes and the assumptions underpinning the pathways to change.

(ii) The framework would also elaborate how outputs and outcomes are to be **effectively measured**, ensuring that the focus is not only on coverage/ reach but also on the quality of services delivered and on actual results achieved (i.e. **qualitative aspects** such as behaviour change). The framework should inform the revised KPI framework under the new Global Fund Strategy as well as the grant performance framework, to ensure consistency of indicators. In addition, reviews and other means to obtain qualitative data reflecting progress towards HIV prevention outcomes should be undertaken for more grants.

(iii) During the development of the performance framework for the next Strategy/ strategic period, the Global Fund could **revise some of the HIV prevention related KPIs** to better enable monitoring of prevention progress and results. KPIs should be: (i) ambitious yet achievable, in line with its proposed level of Global Fund and partner investments in HIV prevention; (ii) measurable by ensuring data is available to track and assess progress throughout the strategic period; and (iii) relevant i.e. focus on real results/ aspired change rather than exclusively on coverage type statistics. Countries should also be encouraged to select indicators that reflect both quantity and quality in HIV prevention interventions.

(iv) Continue to invest in the **collection and use of population level data and surveys including behavioural surveys**, especially for KVPs, and coordinate with technical partners to provide up-to-date guidance on data collection, including for sub-national data, and on use in HIV prevention planning and programming.

(v) **Strengthen the linkage between results monitoring and key investments** by ensuring that results data from grants is effectively fed back to improve investment – both by ensuring collection of data that establishes this link as well as by introducing systems for greater coordination between the different Secretariat teams that handle programming and monitoring.

[157] Recent new AIDS targets were identified for 2025 by UNAIDS. UNAIDS (2020), Prevailing against pandemics by putting people at the centre; World AIDS Day report 2020.

Recommendation 9: Continue further work on "non-traditional" and multi-sectoral partnerships.	
Implementation responsibility	Global Fund Secretariat
Timelines	Some of these may be considered as short-term "quick-wins", and others for a medium-term effort in building partnerships.

Building on recommendation 7 on partnerships for TA, this recommendation is broader on partnerships more generally, in terms of continuing efforts to build relevant partnerships and engagement to support the Global Fund's work on HIV primary prevention.

Recognising that there is already a lot of engagement and effort with the traditional technical partners, the key donors and CSOs/ NGOs, and the HIV community more generally, we single out the following areas for greater focus going forward:

- Strengthen partnership with global and regional NGOs and other organisations working in the area of Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) in order to strengthen integration approaches between HIV prevention responses and SRH services and with community health approaches, in line with the 2025 AIDS targets.[158]
- Make information on Global Fund investments and areas of funding more accessible for partners who are not fully appraised of Global Fund processes and systems (ie. stakeholders outside of the UN community, large donors, large NGOs/ CSOs), whether through the website or other focused information-sharing/ advocacy events and circulars.

5.4. PRIORITISATION AND IMPLEMENTATION

The set of nine recommendations presented above all reflect priority recommendations from our perspective, with some of these for immediate action, and others for longer-term concerted action, although with work to commence on certain aspects in the short-term already. **We highlight that in order to improve effectiveness of HIV primary prevention funding by the Global Fund, there is no "silver bullet" or select recommendations that can achieve this – rather, work is needed towards the whole set of recommendations described above.**

That said, we highlight:

- **Priority recommendations** (and/ or sub-points within recommendations) that the Global Fund should action immediately include recommendation 1 on development of a conceptual framework and its socialisation, recommendation 2 on needed enhancements to the Global Fund application cycle and recommendation 5 on measures to support more effective implementation of HIV prevention interventions within grants. The first of these is an obvious starting point to enhance effectiveness of funding, while the second is a pure systems/ process issue which is within the Global Fund's direct purview. Further, the time is ripe for recommendation 5 with several grants being approved under NFM3.
- **Recommendations for impact** relate to recommendations 4 and 5 in particular on enhancing the quality of programming for HIV primary prevention and the effective implementation of grants respectively. However, these are both complex recommendations with multi-partner and country responsibility and hence a relatively smaller albeit important role for the Global Fund to steer forward in order to obtain VFM of its own monies invested in prevention activities in countries. A first step would be for the Secretariat to consider a detailed implementation plan for actioning these aspects.

[158] UNAIDS (2020), Prevailing against pandemics by putting people at the centre; World AIDS Day report 2020

- **Recommendations relevant to take forward with its core partners** include recommendation 7 on TA and 8 on M&E, where Global Fund's partners would need to take a lead role, with support and/ or facilitation (as appropriate) from the Global Fund.

TERG Thematic Review on HIV Primary Prevention

THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA

18 December 2020

FINAL REPORT – SUPPORTING APPENDICES

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Appendix B CONSULTATIONS CONDUCTED

In this appendix we present the stakeholders consulted and interviewed during the inception phase and core phase of the review.

Table B.1: Stakeholders interviewed during the inception phase

Stakeholder group	Organisation/ Department	Position
TERG	TERG members	Three TERG Focal Points
	TERG Secretariat	Senior Advisor, TERG Secretariat
		Programme Officer, TERG Secretariat
Global Fund Secretariat	Strategy, Investment and Impact	Head, Strategy, Investment & Impact Division
	Technical Advice and Partnerships (TAP)	Senior Advisor, HIV prevention, designated by the Head of TAP
		HIV Advisor, Interim focal point on AGYW
		Senior Disease Advisor HIV
		Disease Adviser HIV
		Health Systems Data Analyst
		HIV Technical Specialist and Data Analyst
	Community, Rights and Gender Unit (CRG)	Head, CRG
		Senior Technical Coordinator, Policy and Strategy
		Senior Technical Coordinator, Human rights
		Senior Technical Coordinator CRG investments
		Technical Advisor, Key Populations, CRG
	Monitoring Evaluation & Country Analysis Team (MECA)	Senior Specialist for HIV, MECA
	Grant management division	Head, Africa and MENA
		Head Impact Africa 2 department
		Head, High Impact Asia department
		Regional Manager, South East Asia
		Regional Manager, Eastern Europe and Central Asia
		Regional Manager, Southern African team
		Senior Fund Portfolio Manager, South East Asia Team
	Finance Team	Specialist, Financial Data and Management Reporting
		Associate specialist, Financial Data and Management Reporting

Stakeholder group	Organisation/ Department	Position
Partners	UNAIDS	Senior Advisor Prevention and focal point for GPC Review
		Senior Adviser HIV Prevention
		Team Leader of HIV Prevention and Coordinator of the GPC Secretariat
		Technical Officer GPC Secretariat
		Focal point for HIV financing and Global AIDS monitoring, Strategic Information Department
	Global HIV Prevention Coalition	Co-chair
	WHO	WHO HIV prevention lead
		Coordinator for HIV strategic information and country planning
	Global Network of People Living with HIV (GNP+)	Executive Director

Table B.2: Global level stakeholder consultations undertaken in the core phase

Stakeholder group	Organisation/ Department	Position
	TERG Secretariat	Senior Advisor, TERG
		Program Officer, TERG Secretariat
Global Fund Secretariat	Office of the Executive Director	Chief of Staff
	Strategy, Investment and Impact	Head, Strategy, Investment & Impact Division,
	Technical Advice and Partnerships (TAP)	Head, Technical Advice and Partnerships
		HIV Prevention Adviser in HIV team
		HIV Advisor, Interim Focal Point on AGYW
		Senior Disease Advisor HIV, TAP
		Disease Advisor HIV
		Specialist, Partnerships & Technical Cooperation
	Community, Rights and Gender Unit (CRG)	Senior Technical Coordinator, Policy and Strategy
		Senior Technical Coordinator, Human rights
		Senior Technical Coordinator CRG Investments
		Technical Advisor, Key Populations
	Strategic Information Department (SI)	Manager, Programmatic Results and Impact

Stakeholder group	Organisation/ Department	Position
		Specialist, Impact Modelling and Program Efficiency
		Senior Health Systems Officer
	Strategy and Policy HUB	Head, Strategy and Policy Hub
	Sustainability, Transition & Cofinancing (STC)	Senior Manager, Sustainability, Transition and Co-financing
	Grant management division	Indonesia Fund Portfolio Manager
		Côte d'Ivoire Fund Portfolio Manager
		Botswana Fund Portfolio Manager
		Jamaica Fund Portfolio Manager
		Philippines Fund Portfolio Manager
		South Africa Fund Portfolio Manager
		Tanzania Fund Portfolio Manager
		Ethiopia Fund Portfolio Manager
		Ukraine Fund Portfolio Manager
		AGYW Focal Point in GMD
		AGYW Focal Point in GMD
	Monitoring Evaluation & Country Analysis Team (MECA)	Senior Specialist for HIV
		MECA Team Member
	KPI Team	Manager, KPI
		KPI Team Member
Global Fund TRP	TRP	Vice-Chair and HIV Focal Point
		Former TRP Member and HIV Expert
		TRP member and HIV expert
Partners	UNAIDS	Deputy Director, Fast Track Initiative
		Special Adviser, coordinator of Global Financing and Technical Support cluster
		Senior Adviser, Prevention
		Senior Advisor for Global Fund Team at UNAIDS. Prevention Focal Point for GPC Review
		Team Leader of HIV Prevention, Coordinator of the GPC Secretariat
		Global Fund cluster
		Chief, Evaluation and Economics Division & Special Adviser, Resource Tracking and Finances
		Resource tracking and market dynamics specialist

Stakeholder group	Organisation/ Department	Position
	Global HIV Prevention Coalition	Co-Chair of GPC as well as Executive Director IPPF
	WHO	WHO HIV Prevention Lead
	UNFPA	Global HIV Adviser
		HIV Specialist
		HIV Specialist
		Global HIV Prevention Advisor
		Regional HIV Specialist, West & Central Africa (WCARO)
		Regional HIV Specialist, Regional Level, East & Southern Africa (ESARO)
		Regional HIV Specialist, Regional Level, Eastern Europe & Central Asia (EECA)
	Bill and Melinda Gates Foundation	Deputy Director in HIV, TB
		Senior Program Officer for HIV
	USAID	HIV Prevention Specialist, KVP team lead
	PEPFAR	DREAMS Adviser on Orphans and Vulnerable Children
		Director for Gender, DREAMS Programme
		KP Expert for PEPFAR in Asia
		KVP Advisor
	US Department of Defence	Technical Director for Prevention, Department of Defence
	CDC	KVP Team Lead
	Alliance for Public Health	Executive Director
		Director of International Programs
	AVAC	Exective Director
	AMFAR	Public Policy Director
		Policy Associate
	Frontline AIDS	Senior Advisor for Prevention
		Global Fund Lead; Part of Developing Country NGO delegation
		HIV Technical Lead; Representative on GPC
		Head of Evidence. Lead Strategic Initiative on Global Fund
		Programmes Lead (focus on work with adolescent girls and young people in all their diversity)
	INPUD	Executive Director

Stakeholder group	Organisation/ Department	Position
	SANPUD	Chair
	MPACT	Executive Director
		Director Public Health Programme
	UNICEF	Head of HIV Programme / Associate Director of Programme Division
	NSWP	Global Fund Global Coordinator
		Senior Programme Officer; Technical Advisor for NSWP and INPUD
	EHRA	Executive Director
	ARASA	Executive Director
		KP Programme Coordinator
	GATE	Director of Programs

Table B.3: Stakeholders who provided feedback during the TERG meetings, June and/or September 2020

Stakeholder group	Organisation/ Department	Position
TERG	TERG Chair	TERG Chair
TERG	TERG members	
Global Fund Secretariat	Executive Director's Office	Chief of Staff
	Strategic Information Department (SI)	Head, Strategic Information
	Strategy Investment and Impact Division	Head, Strategy Investment and Impact Division
	Strategy and Policy Hub	Head, Strategy and Policy Hub
	TAP	Senior Advisor, HIV prevention
	MECA	Senior Specialist
	CRG	Senior technical coordinator
	Strategy Committee	
TRP	TRP	Vice-Chair
Partners	WHO	HIV prevention advisor

Table B.4 Stakeholders interviewed for GPC countries portfolio analysis

Country	Position
Cameroon	Fund Portfolio manager, Cameroon
	Senior Program Officer
Eswatini	Fund Portfolio Manager, Eswatini
	AGYW Specialist
	Public Health and M&E Specialist

	Program Officer
Kenya	Fund Portfolio Manager, Kenya
	Senior Programme Manager
	AGYW specialist
	M&E specialist
	UNAIDS Country Director; KCM Member
Malawi	Fund Portfolio Manager, Malawi
	Global Fund Program Officer
	Director NAC
	Director HIV/AIDS dept. MoH

Appendix C INTERVIEW GUIDES

This appendix includes broad interview guides for global and country level stakeholders. The questions were tailored for specific stakeholders.

C.1. GLOBAL LEVEL STAKEHOLDERS

Role and funding

1. What is the Global Fund's role in countries' funding landscape for HIV primary prevention?
    a. How and to what extent has the Global Fund supported the different types of (priority/ GPC) primary prevention interventions, including addressing structural drivers? What is the Global Fund's comparative advantage compared to other donors?
    b. How and to what extent has the Global Fund aided/ supported (global and country level) advocacy efforts for HIV prevention (especially with regards to funding)?

Stewardship, processes & partnerships

2. How and to what degree have Global Fund stewardship, partnerships, policies and processes been responsive in bringing effective HIV prevention programmes to scale? Please can you provide perspectives on:
    a. stewardship (strategies, policies. technical guidance, other key issues);
    b. grant design, application, approval and management processes;
    c. TA (provision of / funding of TA, and contribution to greater sustainability of funding applicants / implementers); and
    d. partnerships at the global level.

Country grants & implementation

3. How well are Global Fund grants positioned and targeted in a country response to the HIV epidemic?
    a. To what extent are Global Fund country grants being used to invest in evidence-based high impact (both in terms of effectiveness and cost-effectiveness) prevention interventions and approaches tailored to reach the populations in greatest need?
    b. To what extent do countries pay attention to targeting higher-risk groups and to implementing innovative strategies to reach populations with low access to HIV prevention services taking into account their sex, gender, age, risk?
    c. Has Global Fund guidance on design of funding requests with regards to HIV prevention been followed?
    d. What types of issues at the country level contribute to the effectiveness of HIV primary prevention being included in funding requests and grants?
    e. To what extent have prevention interventions been prioritised and maintained during grant making processes? What are key factors in this regard?
    f. To what extent do Global Fund approaches (i) strengthen country ownership of Global Fund-supported prevention programmes; (ii) strengthen alignment to country systems and (iii) promote harmonisation with prevention interventions supported by countries and other main partners?
    g. Have appropriate sustainability drivers been woven into the grant design, particularly for transitioning countries using Global Fund grants?
4. What are key implementation achievements challenges and how effectively have these challenges been addressed in grants?
    a. What are the main achievements, strengths, weaknesses and external challenges related to the implementation of and performance of Global Fund-supported HIV prevention programmes in countries? How do these impact on grant absorption rates?
    b. How effectively have these challenges been addressed in grant implementation?
5. To what extent have HIV prevention investments been appropriately set and measured within Global Fund systems?
    a. How well or less well is progress on HIV prevention investments measured and reported on (including with regards to targets) within Global Fund systems?
    b. What are the main challenges with regards measurement?
6. To what extent have KVPs and associated communities, networks and prevention programme implementers been meaningfully engaged in the design and delivery of HIV prevention efforts?

7. What key (external) factors have facilitated or hindered effective programming for primary HIV prevention at scale?

Contributions & results

8. To what extent and how has the Global Fund contributed to HIV prevention efforts and results?
    a. At the global level, what progress has been made towards Global Fund KPIs and other aggregated indicators across countries supported by the Global Fund with regards to HIV prevention?
    b. What is the added value of Global Fund support? What does the Global Fund do uniquely, differently or better compared to other funding / funders for HIV prevention?
9. How have grant-supported HIV prevention programmes – especially for KVPs and AGYW – been integrated into national or sub-national HIV prevention, care, and treatment HIV strategies and plans?
10. How have HIV grants been used to influence policy environments?

Best practices, conclusions & recommendations

11. Are there any best practices at global, regional and country level which can be replicated and scaled up?
12. How may Global Fund strategy, policies and processes be further improved to enhance primary HIV prevention efforts in a short-term as well as in a long-term strategic way?

C.2. COUNTRY LEVEL STAKEHOLDERS AND GLOBAL FUND COUNTRY TEAMS

These questions will be targeted to country-level stakeholders as well as to Global Fund Country Teams where relevant.

Funding

1. Are there any challenges in the commitment of the government of your country to allocating resources as per its plans and country financing gaps? Has the Global Fund's support to HIV prevention programmes had any impact on your country's domestic spend to these programmes? Is your country reaching the GPC target of spending 25% of your national HIV response budget on prevention?
2. Does your country have adequately costed national plans for HIV prevention? Do these adequately include KVP interventions? Are there any funding gaps for prevention components vis-à-vis estimated need in national strategic plans and/ or global plans?

Grants design and approval

3. Process for grant design and approval
    a. What were the main achievements, strengths, weaknesses and challenges of the grant application and approval processes related to the 2017-2019 Global Fund grants and the 2020-2022 funding cycle for which your country applied?
    b. Did the prioritisation and proportion of HIV prevention programmes included in your grant change during the process from development of the funding request to the grant approval? If so, can you provide more details regarding this process and the justifications that were given?
4. Grant design:
    a. What HIV prevention interventions did your country apply and receive support for in the 2017-19 cycle? Did this include any interventions from the five GPC pillars? Did this include any human rights related or Global Fund catalytic investments? To what degree were these focused on interventions/ approaches which are evidence-based and high impact and/or tailored to reach the populations in greatest need?
    b. What could be done to improve targeting and tailoring of prevention programmes? What could the Global Fund do to support this?

5. Guidance
    a. Did countries find the guidance of the Global Fund on the various components of the HIV response during the grant application process useful? Has the emphasis on the various components of the HIV response changed over the past years? (for example, more or less support to treatment versus prevention)? What can the Global Fund to improve its guidance on HIV primary prevention?
    b. Has the Global Fund's strategy, policies and guidance on and support to HIV prevention programmes contributed to increased visibility of HIV prevention programming as a viable option for your country to consider in its grant applications?

Grant implementation

6. Which are main strengths and achievements and main weaknesses and challenges related to performance of Global Fund-supported HIV prevention programmes in your country/ organisation?
7. Were the prevention programmes delivered with the necessary capacity and at sufficient scale?
8. What more needs to be done to take priority HIV prevention interventions to scale?
9. With regards to challenges with implementation:
    a. Are there challenges related to the quality of programme implementation?
    b. How effectively have implementation challenges been addressed in grant implementation and do they impact on grant absorption rates?
    c. Are there any capacity challenges of Principal Recipients (PRs), Sub-Recipients (SRs) and implementers of prevention programmes in your country to design, deliver, monitor and evaluate high impact programmes?
10. How strong is the engagement of the CCMs, PRs/SRs and implementers with different government sectors and departments and broader ranges stakeholders responsible for programme implementation, including for structural interventions?
11. With regards to TA:
    a. To what extent and how are requests for TA by your country/ organisation coordinated and harmonised with support provided by other partners?
    b. Which type and level of technical support have Global Fund Country Teams, other Global Fund teams and partners provided to your country?
    c. To which extent does/ has Global Fund TA strengthen(ed) in-house capacity of the government, implementers and community organisations and contributed to the sustainability of the strengthened capacity?
12. How do Global Fund approaches strengthen country ownership of Global Fund-supported prevention programmes and strengthen alignment to country systems?
13. To what extent are Global Fund-funded HIV prevention efforts in your country harmonised with interventions funded from domestic sources and other development partner initiatives, e.g. USG/PEPFAR?

Data

14. With regards to data and measurement of progress/ impact to what extent has progress on HIV prevention investments been measured in the national response in your country? Are monitoring frameworks for prevention interventions adequate? Are there any challenges in availability of data, particularly related to KVPs?

Contribution and results

15. To what extent, and how has the Global Fund contributed to HIV prevention efforts and results?
16. Has the Global Fund's support to prevention programmes helped to integrate HIV prevention interventions into primary health care systems?
17. Are the Global Fund- supported HIV prevention interventions included in your countries national sectoral and multisectoral operational plans?

Best practices

18. What elements of your country's HIV prevention programme do you believe can be regarded as best practice? What other best practices in HIV programming could be implemented or scaled up?

Recommendations

19. How may Global Fund strategy, policies and processes be further improved to enhance primary HIV prevention efforts in a short-term as well as in a long-term strategic way?

Appendix D PORTFOLIO ANALYSIS OF GPC COUNTRIES

D.1. INTRODUCTION

This document provides a portfolio analysis of Global Fund grants to the 25 Global Prevention Coalition (GPC) countries which requested and received funding for HIV Prevention interventions, with a focus on HIV prevention grants during the New Funding Model 2 (NFM2) funding cycle (2017-2019). The portfolio analysis aims to determine general trends, as well as positive and negative deviants from the trend, in order to explore lessons. The analysis covers successive phases in grant making: from funding request, budget agreement and development; grant performance and absorption, to cost-effectiveness of HIV prevention interventions.

This is predominantly a quantitative analysis, complemented with a review of key documents[1] and key informant interviews[2] with key stakeholders in four focus countries to put findings into context. The analysis for Global Fund budget and absorption data follows the methodologies that are set out in detail in Annex H and in Annex I.[3] For the direct comparison of funding request data and current budget data, due to varying quality of the submitted funding request data, a simplified definition of HIV primary prevention has been used for the analysis following the Global Fund Modular Framework. Matching funds requested for HIV prevention were added to the allocation funding request for relevant modules. Limitations include exclusion of Lesotho and Myanmar[4] from some analyses due to unavailability of complete data, and incomplete data (e.g. lack of TRP review) for Nigeria.[5] Lastly, this analysis is focused on reasons that explain the reduction in HIV primary prevention funding and does not analyse changes in prioritised above allocation request (PAAR) between prevention and treatment.

Section D.2 of this appendix provides an overview of key findings of this analysis. Section D.3 summarises the analysis of HIV Prevention budgets for the 25 GPC countries who requested and received funding from the Global Fund for HIV prevention interventions. Section 0 summarises the analysis of the differences between the amounts requested by countries for HIV Prevention in their funding requests, with the amount approved for HIV prevention in their grant agreements. Section D.5 provides a summary of the performance by countries towards key Global Fund programme results for HIV prevention. Section D.6 provides a high-level review on how appropriate the choices of interventions for individual countries were, including whether interventions are internationally recognised as being cost-effective. Section **Error! Reference source not found.** provides the summary of the analysis of four countries which we e xplored more in-depth through interviews with Global Fund country teams and country stakeholders to understand the reasons for our observations.

D.2. KEY FINDINGS

Analysis of HIV Prevention budgets for the 25 GPC countries which received Global Fund funding for HIV programming indicates that:

- 13% of the Global Fund overall HIV funding in the current (NFM2) funding cycle is invested in primary HIV prevention.

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[1] Key country grant documents reviewed included the Allocation Letter, Funding Request, and TRP Funding Request Review and Recommendation Form.

[2] Interviews with key informants from countries with positive or negation deviations from the trend: Cameroon, Eswatini, Kenya, and Malawi.

[3] This includes the definition of HIV primary prevention applied the Global Fund HIV team that does not account for any funding for HIV testing even if coded under a HIV prevention module in the Modular Framework.

[4] Lesotho full funding request data not available. Myanmar funding request not verifiable as they applied before the allocation letter was sent.

[5] Funding is only for 18 months; Nigeria received an extension to the previous period following an unsuccessful funding submission in 2017.

- Within the overall HIV prevention budget, allocation is largest for the key population (KP) pillar of the GPC prevention pillars in terms of funding size and in terms of number of countries investing (23), followed by interventions for adolescent girls and young women (AGYW) in 16 countries.
- The total and relative investment in HIV prevention depends on several factors related to the Global Fund (including funding allocation to HIV, availability of catalytic funds and portfolio optimisation, Technical Review Panel (TRP) comments, etc.), as well as country-specific factors (including national priorities, alternative resources and funding gap, national capacities and community/stakeholder involvement in funding request development, etc.).
- Whilst there was a slight increase (4%) in overall Global Fund HIV response programming budget between the NFM2 funding request stage and the current budget,[6] HIV prevention funding decreased by 10% during these stages in the grant. Budgets for KP interventions saw the largest reductions, while general population interventions benefitted from increased budget, a trend happening across the portfolio and within individual countries. Reasons for budget increases across prevention, and for specific interventions, were that additional funds were made available through portfolio optimisation or reprogramming of grant savings from other prevention interventions. There is limited evidence for the reduction in budget for HIV prevention but based on qualitative evidence, these include a deprioritisation of prevention funds, a re-categorisation of interventions in the Modular Framework, as well as a consolidation of the grant to avoid duplication with other funders.
- Implementation performance by countries towards HIV prevention as measured by grant absorption indicates that absorption for HIV prevention interventions (63%) is slightly lower than the absorption rate of 70% for the total Global Fund grants. There does not seem to be a correlation between HIV prevention funds absorption and overall grant absorption; well-performing countries in general terms may or may not absorb HIV prevention funds effectively.
- In terms of HIV prevention results and coverage, 3.1 million KPs were reached across GPC countries with Global Fund funded interventions funded in 2019, 210,000 more than 2017. Absorption and coverage varies greatly between countries, interventions and target populations. Factors associated with performance include partnerships with the United States (US) PEPFAR and technical partners; capacity of principal recipients (PRs) and sub-recipients (SRs) and capacity building; and supportive national strategies and governments for KP and AGYW programming.
- Our high-level review on the relevance and cost-effectiveness of the choice of interventions indicates that across the GPC priority countries, Global Fund investments are appropriate to the type of epidemic. Moreover, proposed and implemented HIV prevention interventions seems to be of high quality in general, which reflects Global Fund incentives for good design and quality assurance.

D.3. HIV PREVENTION BUDGETS

Across all GPC countries analysed, 13% of HIV budgets[7] in the current (NFM2) funding cycle for 2017-2019 are invested in primary HIV prevention.[8] This amounts to a total of over US$500 million, out of a total HIV response budget of almost US$4 billion. As Table D.1 below shows, the proportion of HIV prevention funding varies from 0% of HIV budget allocated to HIV prevention in India (where all HIV prevention interventions are funded from domestic

[6] As of June 2020.

[7] The budget data has been provided by the Global Fund in a single database and is based on June 2020. See Annex H for a more detailed discussion on the method and limitations used. As no comparison are made to other time periods, the analysis in this Annex is presented for the current allocation cycle (NFM2).

[8] This analysis uses the definition of HIV primary prevention that has been used by the Global Fund HIV Prevention team: Testing interventions have been stripped out of prevention modules; and total HIV funding takes consideration of spending for HIV/TB and proportionally 'programme management' and 'resilient and sustainable systems for health' (RSSH).

resources) to over 40% in Botswana. This funding does not cover the entire HIV nor prevention budget, with national governments and PEPFAR in particularly likely to be key sources of funding in some countries. That said, it does show that the prioritisation of prevention funding has varied significantly in Global Fund grants between countries. In most cases, the fact that only a handful of countries are providing a higher proportion of prevention funding within their Global Fund grants than the 25% the GPC recommends for the total HIV programme suggests that many countries are unlikely to be meeting this overall target.

Table D.1 HIV primary prevention budget overview for GPC countries for NFM2 (2017-19)

Country	Total HIV budget	HIV Prevention budget	Proportion HIV prevention
Botswana	14,508,518	5,822,280	40.1%
South Africa	301,100,595	101,848,826	33.8%
Namibia	30,352,466	10,061,073	33.1%
Pakistan	34,956,103	10,580,701	30.3%
Indonesia	92,777,721	24,323,642	29.0%
Ukraine	80,765,620	20,779,946	25.7%
Iran	10,687,697	2,521,240	23.6%
Myanmar	130,010,818	26,661,416	20.5%
Kenya	254,066,566	49,132,155	19.3%
Lesotho	65,332,114	10,200,609	15.6%
Zambia	192,164,679	28,551,259	14.9%
Tanzania	372,092,367	52,652,804	14.2%
Côte d'Ivoire	79,444,659	9,628,760	12.1%
Eswatini	38,926,591	4,485,154	11.5%
Uganda	287,344,337	29,361,503	10.2%
Nigeria	119,004,783	11,892,319	10.0%
Malawi	384,070,105	33,737,364	8.8%
Cameroon	119,542,244	10,363,123	8.7%
Zimbabwe	426,411,022	25,421,730	6.0%
Mozambique	332,570,989	18,198,620	5.5%
Ethiopia	194,160,283	9,110,815	4.7%
Congo (DRC)	120,598,745	5,172,433	4.3%
Ghana	71,801,807	3,004,557	4.2%
Angola	23,110,404	782,473	3.4%
India	151,121,011	-	0.0%
Grand Total	3,926,922,244	504,294,802	13%

Source: Global Fund funding data.

It should be noted that these above figures may exclude some HIV prevention activities that are not classified as such in Global Fund's systems. For example, in Eswatini, stakeholders noted that interventions for older men and taxi drivers are not classified as 'other key and vulnerable population (KVP)' but included under HIV testing or social and behaviour change communication (SBCC).

The HIV prevention budget is generally largest for the KP pillar of the GPC prevention pillars. Table D.2 below shows that 23 GPC priority countries received Global Fund funds for KP programming, a total of over US$216 million.

The second largest investment is for AGYW programming (US$180 million) in 16 GPC countries, followed by general population prevention programming (US$107 million in 14 countries). It should be noted that pillars are not mutually exclusive. India and Uganda are the only two countries that do not have budget for KP interventions, with the former not requesting and HIV prevention funding for KPs, while it is possible that Uganda has classified KP interventions under a different module, possibly HIV testing, as its funding request does include men who have sex with men (MSM), sex workers (SW) and transgender (TG) interventions.[9]

Two countries that have relatively high investments in KP interventions include Cameroon and Kenya. In Cameroon, budget for KP is US$7 million out of US$10 million of HIV prevention funding, given that there is a concentrated epidemic and KP interventions are included in the national strategy, reportedly due to effective advocacy by civil society, and Country Coordinating Mechanism (CCM) commitment. There is also catalytic funding for KP impact. In Kenya 50% of the HIV prevention budget is allocated to KP interventions, which consultees noted is driven by a strong civil society that is engaged in the CCM and country dialogue, as well as by government commitment to KP interventions and willingness not to strictly implement policies regarding criminalisation of KPs.

Pre-exposure prophylaxis (PrEP) and VMMC programming are supported in a relatively small number of countries, reflecting the fact that alternative sources of funding are available. Both VMMC and PrEP are evidence-based high impact interventions, yet few countries have included this in the Global Fund grant. This may be explained by other sources for funding for these programmes, such as national governments or PEPFAR**.** For example, Eswatini is one of the few countries with budget for VMMC, which became available through portfolio optimisation in 2019, after being highlighted by the TRP as a priority for Unfunded Quality Demand (UQD). Malawi also has budget for VMMC, where it was initially not included in the funding request, but in the PAAR because of an anticipated initial funding gap. However, a World Bank loan and change in PEPFAR support for VMMC meant that additional resources were required, and the Global Fund consequently made these available through portfolio optimisation.[10]

Table D.2 *Budget overview for NFM2 for GPC countries per GPC prevention pillar*[11]

Country	KP	AGYW	Condoms	VMMC	PrEP	General Population	Total funding
South Africa	32,619,186	69,229,640	1,372,195	-	5,417,634	-	**101,848,826**
Tanzania	6,862,834	17,486,317	11,877,841	-	-	28,303,653	**52,652,804**
Kenya	24,726,479	10,482,381	5,437,599	94,342	-	13,923,295	**49,132,155**
Malawi	3,313,831	12,444,708	7,240,363	2,000,001	-	17,978,825	**33,737,364**
Uganda	-	10,028,521	18,884,218	-	-	19,332,982	**29,361,503**
Zambia	1,130,889	13,120,873	5,853,739	3,362,783	-	14,299,497	**28,551,259**
Myanmar	26,661,416	-	1,916,883	-	36,828	-	**26,661,416**
Zimbabwe	10,062,949	14,475,611	767,678	-	1,626,887	883,17	**25,421,730**
Indonesia	22,702,934	-	1,353,716	-	602,926	1,620,708	**24,323,642**
Ukraine	20,779,946	-	565,609	-	536,88	-	**20,779,946**
Mozambique	5,504,071	12,215,184	3,046,577	-	-	479,365	**18,198,620**
Pakistan	10,580,701	-	638,819	-	-	-	**10,580,701**

[9] Note that 'misclassification' of activities, are variable interpretation of budget categories is a limitation of this analysis.

[10] Portfolio optimisation can happen when additional funds are identified at the Global Fund Secretariat level. Country teams can apply for additional grant funds, for priority areas that can absorb additional funds, and as approved by the TRP (as part of the PAAR application) and recognised as UQD. Countries compete for these additional funds.

[11] Note that some pillars overlap, e.g. PrEP and KP, resulting in double counting in the HIV prevention budget.

Country	KP	AGYW	Condoms	VMMC	PrEP	General Population	Total funding
Cameroon	7,148,307	3,162,934	1,636,127	-	654,468	51,882	**10,363,123**
Lesotho	1,167,135	4,839,292	302,596	2,857,683	-	4,194,182	**10,200,609**
Namibia	868,95	4,963,628	220,972	3,618,857	-	4,228,495	**10,061,073**
Nigeria	11,815,394	76,925	6,324,150	-	207,349	-	**11,892,319**
Côte d'Ivoire	9,628,760	-	921,233	-	1,983	-	**9,628,760**
Ethiopia	8,800,150	-	2,699,771	-	-	310,665	**9,110,815**
Botswana	1,534,017	4,288,263	106,763	-	449,372	-	**5,822,280**
Congo (DRC)	4,173,656	630,258	3,485,565	-	-	245,248	**5,172,433**
Eswatini	431,31	2,760,466	-	1,281,120	-	1,293,378	**4,485,154**
Ghana	3,004,557	-	16,835	-	-	-	**3,004,557**
Iran	2,521,240	-	-	-	-	-	**2,521,240**
Angola	329,873	452,6	-	-	-	-	**782,473**
India	-	-	-	-	-	-	**-**
Grand Total	**216,368,585**	**180,657,601**	**74,669,249**	**13,214,786**	**9,534,327**	**107,145,345**	**504,294,802**
# Countries	23	16	21	6	9	14	**25**

Source: Global Fund funding data.

D.4. FUNDING REQUEST ANALYSIS

The total HIV prevention budget for 23 GPC countries decreased between the funding request stage and the current budget[12] for NMF2 by 10%, as opposed to an increase of funding for the HIV response overall (4%). In addition to this, significant HIV prevention interventions requested under the PAAR were approved for the UQD.

Table D.3 provides a comparison of each GPC country Global Fund grant from funding request to current grant budget. It shows that in 15 out of 23 countries (65%), the HIV prevention budget decrease was larger than 5%. Only 5 GPC countries saw an increase in HIV prevention budget between the funding request stage and the approved grant.[13] Changes vary from decreases in HIV prevention budgets of up to 61% in Democratic Republic of Congo (DRC) and 51% in Nigeria, to increases of over 30% in Uganda and Zambia. Note that India is an outlier in this table, as the Government agreed to finance all HIV prevention interventions from domestic sources. Iran and Botswana requested a continuation, therefore there were no changes. Please note that matching funds requested were included in the funding request for this analysis.

Table D.3 Change in HIV prevention budget between funding request and current grant budget as of June 2020

	HIV prevention			HIV total		
Country	**Funding Request**	**Budget**	**% Change**	**Funding Request**	**Budget**	**% Change**
India	331,974	0	-100%	155,063,500	158,789,992	2%
DRC	15,935,315	6,252,801	-61%	144,838,513	150,571,769	4%
Nigeria	31,122,861	13,672,934	-56%	121,843,450	121,330,498	0%
Angola	2,035,225	1,130,622	-44%	23,110,399	23,110,396	0%

[12] As of June 2020, including budget implications due to any reprogramming and/or portfolio optimization

[13] In contrast to the budget analysis, this analysis is not stripping out the testing interventions from the prevention modules.

	HIV prevention			HIV total		
Eswatini	6,723,283	4,485,157	-33%	39,612,567	42,512,450	7%
Ghana	5,232,096	3,566,502	-32%	69,113,076	74,598,460	8%
Côte d'Ivoire	15,701,847	11,732,485	-25%	80,497,658	79,444,700	-1%
South Africa	145,518,050	113,920,595	-22%	303,330,292	317,324,489	5%
Mozambique	24,354,964	20,496,344	-16%	301,014,086	342,772,566	14%
Pakistan	12,830,602	10,755,949	-16%	34,956,107	34,956,104	0%
Ethiopia	10,111,935	9,147,207	-10%	194,095,042	194,160,288	0%
Cameroon	17,272,622	15,852,494	-8%	112,316,643	119,542,241	6%
Indonesia	30,114,538	27,668,544	-8%	94,623,766	92,777,714	-2%
Ukraine	24,187,693	22,415,351	-7%	88,963,069	99,374,486	12%
Namibia	11,008,608	10,381,679	-6%	31,118,784	33,329,337	7%
Botswana	6,896,182	6,896,182	0%	16,270,833	16,270,830	0%
Iran	3,618,886	3,618,886	0%	10,687,693	10,687,694	0%
Kenya	49,319,670	49,973,778	1%	236,891,847	254,066,595	7%
Malawi	37,077,144	39,437,588	6%	370,400,899	386,065,481	4%
Tanzania	51,064,014	55,198,692	8%	375,638,375	372,092,334	-1%
Zimbabwe	22,406,057	25,421,726	13%	433,844,277	426,411,012	-2%
Uganda	22,082,819	29,361,502	33%	265,356,718	290,478,976	9%
Zambia	21,115,434	28,567,896	35%	191,394,822	198,660,835	4%
Total	**566,061,819**	**509,954,914**	**-10%**	**3,694,898,980**	**3,839,329,247**	**4%**

Source: Global Fund funding data.

Table D.4 compares the change in total funding for each of the Global Fund HIV prevention funding modules, whereas Table D.5 compares the change by number of countries.

HIV prevention for the general population is the only HIV prevention module for which the budget increased. Table D.4 shows that the decrease in HIV prevention investment is not equal over the different modules. Despite an overall 10% decrease in the budget for HIV prevention, investment in general population prevention interventions saw an increase of 20%, reflecting increases in 8 of 12 countries receiving funds for this module.

Table D.4 Overview of HIV prevention funding changes by Global Fund funding module[14] at the portfolio level

Module	Funding Request	Budget	% Difference
Prevention programs for general population	85,930,041	102,899,282	20%
Prevention programs for adolescents and youth	202,171,794	191,531,069	-5%
Comprehensive prevention programs for people who inject drugs (PWID) and their partners	65,753,740	53,910,067	-18%
Comprehensive prevention programs for SW and their clients	105,270,912	86,040,178	-18%
Prevention programs for other vulnerable populations	15,604,419	12,227,709	-22%

[14] Data quality is affected by inconsistent allocations between countries of certain activities against the Global Fund modular framework. E.g. Ethiopia includes prisoners as an 'other vulnerable population group' instead of under the specific module. This will result in the funding requested and approved for these groups being underestimated, although this is unlikely to be significant.

Module	Funding Request	Budget	% Difference
Comprehensive prevention programs for MSM	74,494,115	52,777,502	-29%
Comprehensive prevention programs for TGs	9,191,882	5,770,221	-37%
Comprehensive programs for people in prisons & closed settings (PIP)	7,644,916	4,798,886	-37%
Prevention Total	**566,061,819**	**509,954,914**	**-10%**
Payment for results	0	3,136,934	100%
Other Program activities-HIV	1,372,164	2,635,238	92%
HIV Testing Services	135,535,849	164,094,132	21%
Program management	321,397,003	381,152,519	19%
Resilient and sustainable systems for health (RSSH)	332,178,341	394,614,354	19%
Treatment, care and support	2,177,508,345	2,246,297,767	3%
TB/HIV	47,910,177	46,485,738	-3%
Programs to reduce human rights-related barriers to HIV services	56,942,268	52,252,787	-8%
PMTCT	55,993,013	38,704,864	-31%
Total HIV Funding	**3,694,898,980**	**3,839,329,247**	**4%**

Source: Global Fund funding data.

Comprehensive KP programmes have been affected the most by budget reductions, including: 1) PIPs with a 37% decrease in budget; 2) PWID with 11 out of 13 countries decreasing budget; 3) MSM with a reduction of US$21.7 million overall and 11 of 18 countries decreasing budget; 4) SWs with 15 out of 20 countries decreasing budget; whereas 6) TGs saw the second largest overall decrease also at 37% but this was driven more by a few numbers of countries with 5 decreasing funding and 4 increasing.

Programmes for AGYW present a mixed picture with regard to budget changes. As this module represents the largest HIV prevention intervention budget line, even a relatively small percentage reduction of 5% meant a large reduction in funding size (over US$10 million). At the same time, half of the 16 countries implementing AGYW programmes saw an increase in budget. This mixed picture may be explained by the large scale and cost of AGYW programming compared to some KP interventions, and by continuing debate around value for money of various intervention components.

Budget revisions for non-prevention HIV modules may impact on HIV prevention investment and impact. It is important to note that budgets also changed for modules that are closely associated with primary HIV prevention modules, for example HIV testing, addressing human rights barriers, and RSSH, especially community systems strengthening. Programmes addressing human rights related barriers to HIV services witnessed a decrease in available budget, while budgets increased significantly for HIV testing (US$30 million). The HIV programme management budget increased in many countries (US$60 million) with some country evidence suggesting that this increase could be related to the decrease in HIV prevention funding mostly due to misclassification (South Africa) and re-programming (Philippines).

Table D.5 Overview of HIV prevention funding change by Global Fund funding module by number of countries

		# Countries			
Module	**Change**	**Increase**	**Decrease**	**Stable[15]**	**Total[16]**

[15] Funding was judged to be stable if the approved budget remained within 5% of the funding request

[16] The total describes the number of countries that funding for relevant module in either the funding request or the budget stage.

		# Countries			
Prevention programs for general population	20%	8	2	2	12
Prevention programs for adolescents and youth	-5%	8	6	2	16
Comprehensive prevention programs for PWID and their partners	-18%	1	11	1	13
Comprehensive prevention programs for SW and their clients	-18%	2	15	3	20
Prevention programs for other vulnerable populations	-22%	6	7	1	14
Comprehensive prevention programs for MSM	-29%	2	11	5	18
Comprehensive prevention programs for TG	-37%	4	5	0	9
Comprehensive programs for people in prisons & closed settings	-37%	2	5	1	8
Prevention Total	**-10%**	**5**	**15**	**3**	**23**
Payment for results	100%	2	0	0	2
Other Program activities-HIV	92%	1	0	0	1
HIV Testing Services	21%	11	4	2	17
Program management	19%	13	6	3	22
Treatment, care and support	3%	5	6	11	22
TB/HIV	-3%	6	11	1	18
Programs to reduce human rights-related barriers to HIV services	-8%	3	7	4	14
PMTCT	-31%	5	11	3	19
Total HIV Funding	**4%**	**8**	**0**	**15**	**23**

Source: Global Fund funding data.

Table D.6 below shows changes in HIV prevention module budgets for each of the GPC countries analysed. Key points to note on this include:

- **There are multiple reasons for changes in overall or specific HIV prevention budgets at the country level.** Several factors can explain why the available budget for HIV prevention may differ from the requested funding, such as: 1) TRP feedback and grant finalisation; 2) within-grant reprogramming and re-budgeting due to savings and underspending; and 3) availability of additional budget for a country's UQD, through portfolio optimisation.
- **TRP comments can be are instrumental in focusing HIV prevention funding**. We reviewed TRP commentary on all the 25 GPC countries. In some countries, investment funding shifted towards more relevant target populations, either KP or AGYW following TRP comments. Examples of funding shifts include Kenya (towards AGYW interventions), Ethiopia (move from general prevention to SW programmes) and Eswatini (towards new target populations, e.g. transport workers).

Table D.6 Change in HIV prevention module budgets for each of the included GPC countries.[17]

Country	HIV response	HIV prevention	MSM	PWID	SW	TG	PIP	AGYW	General prevention	Other VP[18]
Angola	0%	-44%	15%	-	-17%	-	-	-57%	-	-90%
Botswana	0%	0%	0%	-	0%	-	-	0%	-	-
Cameroon	7%	-8%	-58%	37%	-4%	-	62%	43%	-	-38%
Côte d'Ivoire	-1%	-25%	5%	-34%	-18%	-60%	35%	-	-	-36%
DRC	4%	-61%	-32%	-67%	-17%	-99%	-	-86%	-94%	>100%
Eswatini	7%	-33%	-54%	-55%	-51%	-	-	-48%	54%	91%
Ethiopia	0%	-10%	-	-	110%	-	-	-	-92%	-22%
Ghana	8%	-32%	-17%	-	-33%	-	-92%	-100%	-	>100%
India	2%	-100%	-	-	-	-	-	-	-	-100%
Indonesia	-2%	-8%	-2%	-44%	-7%	-33%	-16%	-	>100 %	>100%
Iran	0%	0%	-	0%	0%	-	0%	-	-	0%
Kenya	7%	1%	21%	-6%	-5%	-	-	7%	-3%	-
Malawi	4%	6%	4%	-	-11%	-	-13%	0%	17%	-
Mozambique	14%	-16%	-58%	-98%	-20%	-	-100%	16%	>100%	>100%
Namibia	7%	-6%	-28%	-	60%	145%	-	-12%	0%	-
Nigeria	0%	-56%	-72%	-46%	-48%	>100%	-	>100%	-	-
Pakistan	0%	-16 %	-28%	-11%	-37%	-28%	-	-	-	-
South Africa	5%	-22%	-36%	-13%	-25%	-50%	-	-18%	-	-
Tanzania	-1%	8%	-55%	-28%	-40%	-	-	13%	31%	26%
Uganda	9%	33%	-	-	-	-	-	7%	52%	-
Ukraine	12%	-7%	0%	-8%	-7%	106%	-18%	-	-	-26%
Zambia	4%	35%	-	-	-	-	-	24%	57%	-16%
Zimbabwe	-2%	13%	-33%	-	-12%	>100%	-	30%	>100%	-
Grand Total	**4%**	**-10%**	**-28%**	**-18%**	**-18%**	**-34%**	**-37%**	**-5%**	**20%**	**-22%**
Increased	8	5	2	1	2	4	2	8	8	6
Decreased	0	15	11	11	15	5	5	6	2	7
Stable	15	3	5	1	3	0	1	2	2	1
Count Total	**23**	**23**	**18**	**13**	**20**	**9**	**8**	**16**	**12**	**14**

Source: Global Fund funding data.

TRP comments can be instrumental in focusing HIV prevention funding. In some countries, investment funding shifted towards more relevant target populations, either KP or AGYW, following TRP comments. Examples of funding changes include Kenya and Eswatini, as mentioned above. TRP commentary on KP intervention design led some countries to reduce investment in this area, rather than address criticisms. Our analysis shows that KP modules in funding requests were criticised by the TRP for a range of different reasons, including description, targets,

[17] When a module was not included in the funding request, but included in the budget, the change has been stated as >100%

[18] Other vulnerable populations, e.g. transport workers, migrants, etc.

implementation approach, and level of funding. Examples include DRC, which reduced HIV prevention significantly after comments about geographical prioritisation and targets (although there was an increase in funding for migrant populations). This reduction in KP interventions may reflect limited political support for these populations, or lack of capacity to design or implement quality interventions for KP. Also, Kenya increased its AGYW budget (7%) following TRP feedback considering infections among AGYW are a significant driver in the epidemic. Conversely in Eswatini, AGYW budget halved (-48%) due to program re-design, reflecting TRP recommendations.

Grant agreement finalisation can result in changes in HIV prevention budget lines. During grant approval and finalisation processes, the final scope and scale of interventions, including coverage targets, are agreed, which may result in slight adjustments in budget. Another reason for adjustments at this stage is the re-classification of budgets and activities. For example, in Cameroon the grant budget for MSM (58%) decreased following re-classification of the MSM intervention from HIV prevention to human rights, as most of the MSM work involves contextual interventions. In addition, in Malawi there was some re-classification and rationalising of interventions and budget during grant finalisation, since the funding request was developed under time constraints, which may explain the reduction in budget for SW and prison interventions.

During grant implementation, reprogramming and grant optimisation are the main mechanisms to adjust HIV prevention investment. Grant optimisation generally increases budget for prevention interventions, provided they are approved as UQD. For example, as mentioned previously both Eswatini and Malawi received addition funds for VMMC scale up. Re-programming of HIV prevention funds typically shifts budget from interventions with low absorption or savings to interventions with potential to scale up or high absorption. For example, Kenya increased its MSM intervention budget with 21% thanks to in-grant savings. In Eswatini, the funding gap for KP interventions disappeared when PEPFAR scaled up KP interventions (MSM and SW) to nationwide and Global Fund HIV prevention funding was reprogrammed to 'other KVP' (with a 91% increase), to scale up interventions for transport workers and older men, who are not targeted under PEPFAR support.

Decrease in KP intervention budget is often accompanied by an increase in general population investment. Conversely, all countries that increased funding for interventions targeting general population, decreased funding for KP interventions. At this stage, there has not been sufficient qualitative evidence to determine whether there is a direct relationship between these two trends. This trend is not in line with TRP comments nor with the Global Fund approach to better target HIV prevention. In fact, the TRP suggested for some countries in East and Southern Africa to invest more in KPs and less in general population interventions.

Shifts in investment from HIV prevention to treatment are discouraged by the Global Fund, although in some countries such reallocation has taken place. To ensure that HIV prevention funds are not re-allocated to treatment, Cameroon implements two separate grants, through separate PRs as per the 'dual track approach[19]' (where the non-governmental PR is responsible for HIV prevention and treatment is carried out by the government PR). Re-allocating funds between two PRs requires Grant Approval Committee (GAC) approval, which is a barrier. The dual-track arrangement is agreed between partners and proposed by the CCM in the funding request. In Eswatini on the other hand, HIV prevention budget decreased with 33% and was reallocated to HIV treatment, because a treatment funding gap was identified. In general, in Eswatini HIV prevention is less prioritised than treatment, even though prevention is included in the national AIDS strategy. Prevention for KPs in Eswatini is hampered by legal barriers.[20]

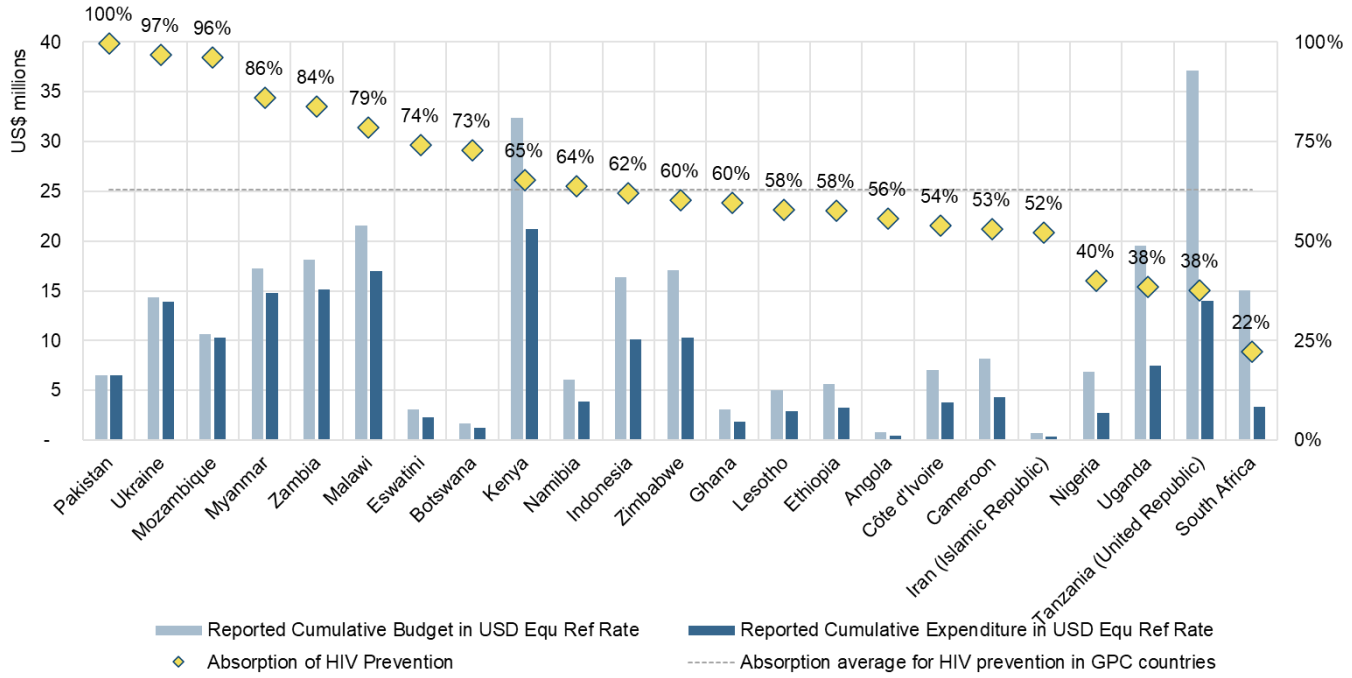
[19] Dual-track financing refers to channelling funds through two "tracks": government and non-government sectors. As part of the Global Fund commitment to strengthen the role of civil society and the private sector in the processes of the Global Fund, CCMs are encouraged to pursue a "dual-track financing" approach in nominating PRs. (Global Fund guidelines for implementers 2015)

[20] Based on key informant interviews.

D.5. PERFORMANCE OF HIV PREVENTION GRANTS

D.5.1. Grant funding absorption

Figure D.1 Absorption rates of Global Fund HIV Primary Prevention grants by GPC countries for NFM2 up to June 2020

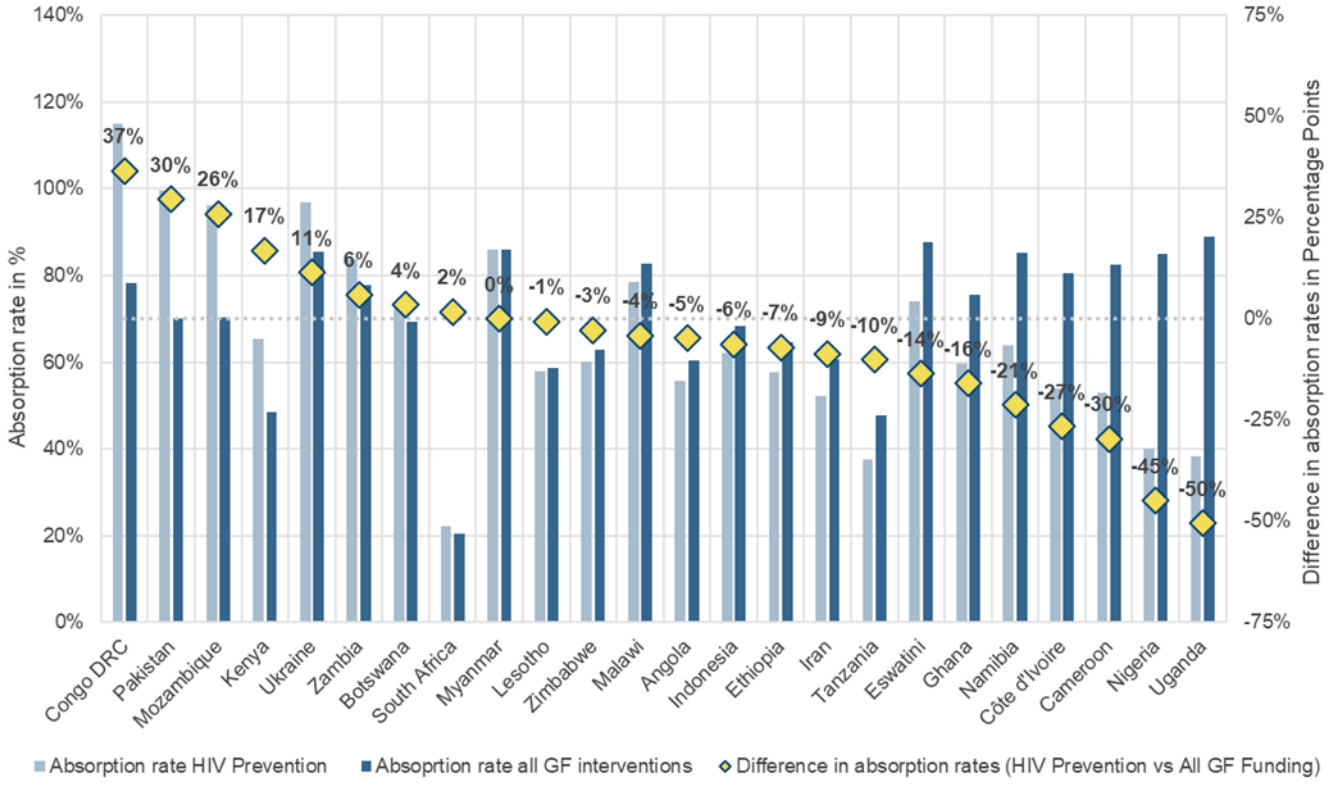


Source: Global Fund funding data.

The absorption rate (as of June 2020) for Global Fund HIV primary prevention grant funding across all 25 GPC countries receiving HIV funding from the Global Fund has been 63% and varied greatly between countries. Absorption of HIV prevention budget is an indicator and precondition of grant performance. Figure D.1 above shows that Pakistan, Ukraine and Mozambique had absorption rates of above 90% of their Global Fund HIV prevention grants. In contrast, Nigeria, Uganda, Tanzania and South Africa had absorption rates of 40% or below.[21] The absorption rate for HIV prevention does not seem to correlate with the size of the HIV prevention budget.

[21] Relative absorption for various HIV prevention interventions is masked in the average.

Figure D.2 Difference in the absorption rates of HIV primary prevention and all Global Fund investments for NFM2



Source: Global Fund funding data.

HIV prevention absorption at 63% in GPC countries is lower than the absorption rate in GPC countries across all Global Fund interventions at 70%. Figure D.2 Difference in the absorption rates of HIV primary prevention and all Global Fund investments for NFM2 above shows that this trend is not driven by a few outlier countries but shows that a similar trend can be observed in the majority of GPC countries (15 out of 24[22]) had lower absorption rates for HIV prevention than for all Global Fund interventions. There are a few countries in which the low absorption rate is explained by national factors unrelated to prevention implementation such as South Africa for which the low absorption for prevention is in line with the low absorption across all Global Fund interventions. However, in the majority of countries there seem to be specific aspects related to the absorption of primary prevention interventions that is illustrated by the large gap in absorption rates between prevention and other intervention with absorption gaps above 25% in Côte D'Ivoire, Cameroun, Nigeria and Uganda.

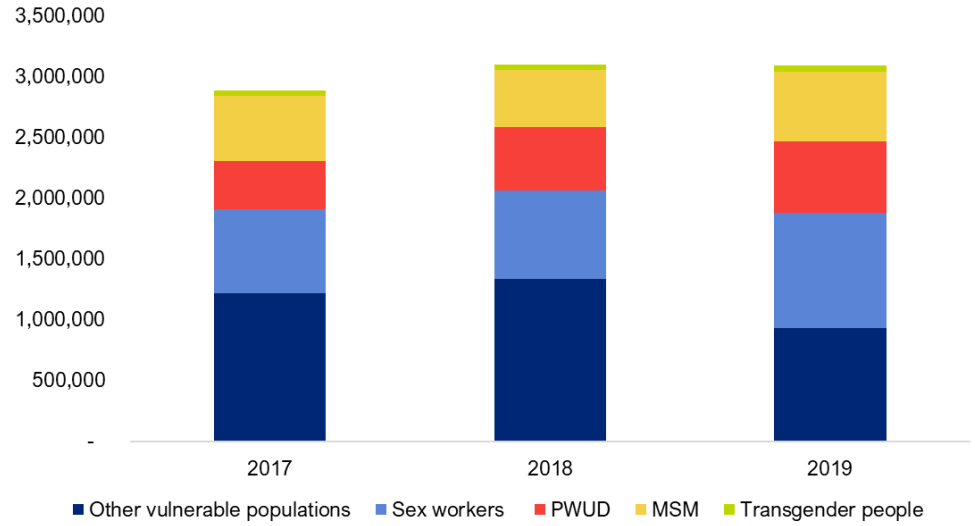
Kenya is one of the few countries with better absorption for HIV prevention than for the Global Fund HIV grant overall. According to country stakeholders interviewed, reasons include strong PR and SRs, and CSO implementers working hand-in-hand with the government. This resulted in having a strong KP programme (including human rights interventions) that made scale-up possible. The country team and specialists from the Global Fund Secretariat also play an active role in helping the PRs with grant implementation. That said, setting up systems for community-led implementation, capacity building, monitoring and evaluation (M&E) and reporting reportedly resulted in a slow start-up of AGYW and KP interventions in Kenya. Cameroon is an example of lower than average absorption of HIV prevention grant funding (53%), with informants suggesting that reasons for this include a slow start across KP and AGYW interventions due to these being initiated only in 2018, requiring initial formative research (e.g. population size estimates), as well as due to the need to design interventions and conduct SR capacity building. AGYW programming also depended on a technical partner for TA, while the ministry of education and private schools were slow to engage.

[22] India has no prevention expenditure as it did not request HIV prevention funding from the Global Fund.

D.5.2. Programme results

A total of 3.1 million KPs were reached across GPC countries through interventions funded by the Global Fund in 2019; 210,000 more people than 2017.[23] Based on Global Fund data available[24], the majority of those reached in 2019 were SWs (960,000), followed by 'other vulnerable populations' (925,000), while MSM and people who use drugs (PWUD) had relatively similar figures in 2019 at 570,000 and 590,000 respectively. The relatively modest increase over the period is mainly driven by increases in the number of SWs in Ethiopia (more than 90,000 additional people reached in 2019 compared to 2017) and Indonesia (nearly 70,000 more people reached), and PWUD in Ukraine (150,000 more people reached in 2019 compared to 2017) and Iran (nearly 70,000 more reached). On the other hand, the number of other vulnerable populations have declined by nearly 300,000 over the period.

Figure D.3 Total KPs reached across GPC countries funded by the Global Fund



Source: Global Fund programmatic data

While the above data indicates the total number of people reached by Global Fund-supported programmes, these figures do not include the total number of individuals in countries that have been reached through all prevention programmes implemented in the countries. In addition, the data presented in this Section may reflect changes in the number of people reached through Global fund-supported programmes driven by a change in funding source for these activities (e.g. there could be a reduction in people reached through Global Fund-supported programmes if this funding is taken over by other funding partners).

Achievement of KP performance targets has been variable across GPC countries and across populations targeted for HIV prevention. Performance targets are set during grant finalisation, and take into account TRP comments and advice of M&E specialists in Global Fund Country Teams and Local Funding Agents (LFAs). Performance typically relates to the number and proportion of people provided with a set of prevention services, against agreed targets. It should be noted that Global Fund targets are not national targets, and that population sizes (the denominator for targets) are not always agreed and regularly updated.

Grant performance depends on collaboration with development and technical partners. In many countries, the Global Fund cooperates closely with other donors, especially PEPFAR, and with UN technical partners. In Cameroon, a positive example is the good relationship of the Global Fund with PEPFAR (especially in the area of treatment, where there is a healthy competition). A negative example is the confusion about the focus of technical assistance from a

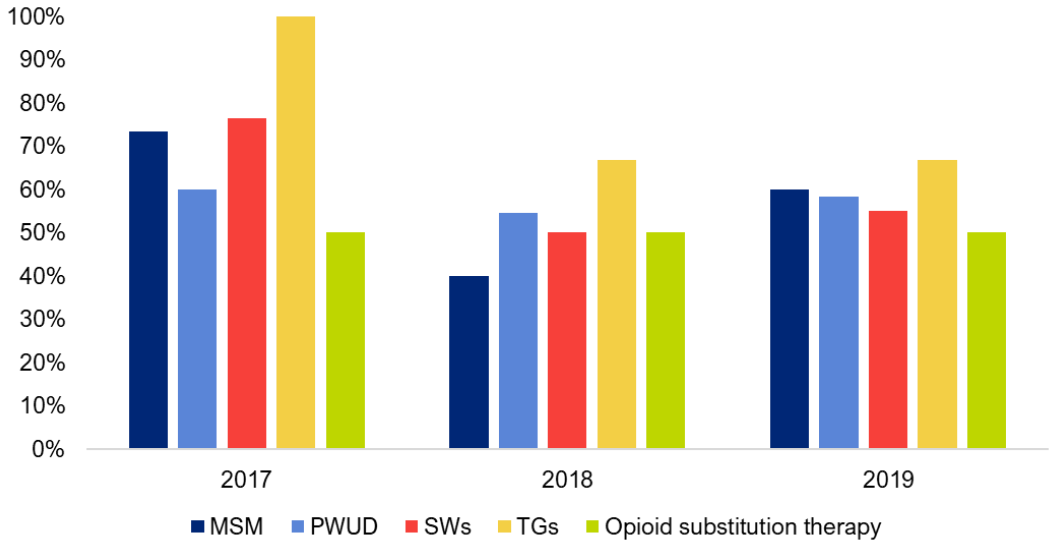
[23] Numbers have been rounded.

[24] We triangulated 1) Key Performance Indicator (KPI) 5 data for populations reached with prevention programmes (KVPs, other vulnerable populations and young people) in the 2017-19 period, allowing comparison of countries meeting performance targets, but not the services provided; 2) survey and underlying programmatic data for KVPs, including a breakdown of services provided but not how intervention packages changed over time and 3) online programmatic results data from the Global Fund online results portal for results related to PrEP services, but these do not include targets. Data on AGYW services are not available.

UN partner for AGYW intervention development, which reportedly resulted in delays. Conversely in Eswatini, performance was below average for MSM and SW intervention coverage reflecting the late start of the programme due to lengthy consultations with PEPFAR, which changed its plans and decided to scale up their MSM and SW interventions to the entire country, including in districts supported by the Global Fund. Eventually the Global Fund and PEPFAR agreed a complementary approach where the Global Fund supports outreach to KPs (demand creation and referral) and PEPFAR supports sites for HIV testing services (HTS) and antiretroviral treatment (ART) initiation.

Figure D.4 below summarises the proportion of GPC countries that were able to achieve or exceed their percentage targets in relation to different KPs.[25] For MSM, Botswana, Ghana, Indonesia, Kenya, Myanmar and Nigeria reached their targets each year. For PWID, Kenya, Tanzania and South Africa were able to achieve or exceed their targets. Countries meeting or exceeding their targets for SW include Ghana, Indonesia, Mozambique, Myanmar and South Africa. For TGs, just three GPC countries had coverage targets, with Indonesia and South Africa meeting their targets for each year, while Pakistan missed its targets for 2018 and 2019, the two years where data is available. Finally, just five GPC countries had targets related to opioid substitution therapy (OST). Both Indonesia and Zanzibar were able to obtain their targets for 2018 and 2019, while Myanmar was only able to meet its targets in 2017 and missed its targets in later years. Ukraine was able to achieve its target for 2017, while in later years targets were not set. South Africa was unable to reach its targets for both years (2018 and 2019) where it had set targets.

Figure D.4 Proportion of GPC countries meeting or exceeding targets across coverage indicators



Source: Global Fund programmatic data

The number of individuals reached as part of Global Fund programmes increased significantly between 2018 and 2019, with many more countries achieving their coverage targets. Based on Global Fund programmatic data, 1.2 million AGYW were reached through Global Fund-supported programmes in 2019, up from less than 367,000 in 2018, suggesting a substantial increase. In addition to this, eight out of 13 countries were able to meet or exceed their AGYW coverage targets for 2019, compared to just one of nine countries in 2018, suggesting a marked improvement in the delivery of these programmes.

D.6. QUALITY OF HIV PREVENTION INTERVENTIONS SUPPORTED

Across the GPC priority countries, the overall Global Fund grant investment seems appropriate to the type of epidemic, and therefore relevant. Grants for countries with concentrated epidemics amongst KPs are supported by the Global Fund for KP interventions, whereas countries with mixed epidemics also include general population

[25] Please note that not all GPC countries are included each year, since some countries may not have targets set for each year, or data for individual years may be missing.

and AGYW investments. Countries may have other sources of funding for priority interventions: some countries such as India use mainly domestic resources to support for KP interventions. PEPFAR is also a large funder of HIV prevention programming in many GPC countries. Therefore, some countries estimate that (components of) HIV prevention interventions are covered by other funding sources and do not request the Global Fund to support these interventions. For example, Eswatini did not request Global Fund to provide funds for condom programming during NFM2 because this was supported by PEPFAR and UNFPA.

Table D.7 Global Fund grant focus versus epidemic type during NMF 2 grant cycle (2017-2019)

	Epidemic		Global Fund supported strategies					
Country	**Mixed**	**Concentrated**	**KP**	**AGYW**	**Condoms**	**VMMC**	**PrEP**	**General Population**
Angola	X		X	X	-	-	-	-
Botswana	X		X	X	X	-	X	-
Cameroon	X		X	X	X	-	X	X
Congo (DRC)	X		X	X	X	-	-	X
Côte d'Ivoire	X		X	-	X	-	X	-
Eswatini	X		X	X	-	X	-	X
Ethiopia	X		X	-	X	-	-	X
Ghana	X		X	-	X	-	-	-
India		X	-	-	-	-	-	-
Indonesia		X	X	-	X	-	X	X
Iran		X	X	-	-	-	-	-
Kenya	X		X	X	X	X	-	X
Lesotho	X		X	X	X	X	-	X
Malawi	X		X	X	X	X	-	X
Mozambique	X		X	X	X	-	-	X
Myanmar		X	X	-	X	-	X	-
Namibia	X		X	X	X	X	-	X
Nigeria	X		X	X	X	-	X	-
Pakistan		X	X	-	X	-	-	-
South Africa	X		X	X	X	-	X	-
Tanzania	X		X	X	X	-	-	X
Uganda	X		-	X	X	-	-	X
Ukraine		X	X	-	X	-	X	-
Zambia	X		X	X	X	X	-	X
Zimbabwe	X		X	X	X	-	X	X

Source: CEPA analysis based on Global Fund reports.

Appendix E COUNTRY CASE STUDIES METHODOLOGY AND DETAILS ON COUNTRY SELECTION

E.1. COUNTRY CASE STUDIES METHODOLOGY

The review has included eight country case studies which involved the following methodology: (i) a focused document review including key Global Fund documents such as funding requests, grant agreements, grant reporting and country documents (e.g. country HIV strategies and operational plans); (ii) data analyses (e.g. relating to HIV prevention funding from the Global Fund; domestic and other international HIV prevention funding based on UNAIDS Financial Dashboard; Global Fund performance target results and country HIV prevention results based on the UNAIDS Global Aids Monitoring reports and AIDS info database) and (iii) approximately 8-10 interviews with key stakeholders (e.g. Ministries of Health, National AIDS Councils, Principal and Sub-Recipients, civil society, CCM members, beneficiaries including key populations, and other key country-level partners).

Criteria for the selection of the countries covered by case studies included: (i) quantum of HIV prevention funding and total HIV funding, (ii) spectrum of countries with high incidence and mix of HIV prevalence; (iii) types of HIV prevention support; (iii) range of geographic regions; (iv) spending by prevention pillar and Global Fund module; (v) proportion of prevention spending of total HIV spending; (vi) logistical factors and (vii) recommendations from inception phase consultations for countries with specific areas of interest.

Due to the COVID-19 restrictions, the majority of the country case studies were undertaken remotely. Where possible, some of the country case studies were undertaken in person by members of the team who are based in these countries (Botswana, Ethiopia, Tanzania).

E.2. COUNTRY CASE STUDY SELECTION

This appendix outlines the methodology applied to determine the country case study selection along with the list of shortlisted countries.

We considered five main overarching criteria to develop a long list of countries from which a smaller list could be derived:

- **Quantum of HIV prevention funding and total HIV funding –** based on the Global Fund budget dataset for the 2017-19 allocation period, the top 20 countries which have received the most funding for HIV prevention were determined.[26] These 20 countries include (ordered by funding size): South Africa, Tanzania, Kenya, Malawi, Myanmar, Uganda, Zambia, Indonesia, Zimbabwe, Ukraine, Mozambique, Cameroon, Viet Nam, Nigeria, Thailand, Côte d'Ivoire, Bangladesh, Pakistan, Namibia and Lesotho.

  We added additional countries that were not in this list, but which are in the top 20 countries by total HIV funding.[27] This included an additional five countries: Ethiopia, India, DRC, Ghana and Haiti.

  A cross-check confirmed that these 25 countries are the key recipients of Global Fund funding by prevention pillar and funding module. This included different population groups as requested in the RFP (AGYW and key

[26] The dataset was received from the Global Fund Finance team on 18th May 2020. Primary HIV prevention was calculated by using the following HIV modules: (i) Comprehensive prevention programmes for MSM; (ii) Comprehensive prevention programmes for PWID and their partners; (iii) Comprehensive prevention programmes for sex workers and their clients; (iv) Comprehensive prevention programmes for transgender people (TGs); (v) Comprehensive programmes for people in prisons and other closed settings; (vi) Prevention programmes for adolescents and youth, in and out of school; (vii) Prevention programmes for general population and (viii) Prevention programmes for other vulnerable populations

[27] Total HIV funding was determined by including all HIV modules in the Global Fund modular framework 2017-19. Budget for programme management were included fully for HIV/AIDS grants and based on a proportional share of the HIV funding within joint HIV/TB grants.

populations including gay men and other MSM, PWID, sex workers, prisoners and transgender people), as well as different prevention pillars such as VMMC.

These countries very closely map against the GPC countries, with 21 out of the selected countries being GPC countries.[28]

- In order to include a spectrum of countries with **high HIV incidence, mix of HIV prevalence and types of HIV prevention support** (i.e. Global Fund HER Adolescent & Young Girls private sector partnership funding, Breaking Barriers Funding, other donor support such as DREAMS), 15 countries (Botswana, Nepal, Senegal, Jamaica, Eswatini, Cambodia, Honduras, Sierra Leone, Philippines, Kyrgyzstan, Benin, South Sudan, Tunisia, Angola, and Rwanda) were added to the top 25 countries. For all these countries, we considered changes in incidence over the past five years.

Utilising these selection criteria, we compiled **a list of 40 countries** as shown in Table E.2.

From this long list, we created **a shortlist of 18 countries** to reflect a mix across the following criteria:

- **Geographic regions:** this includes the African region (West/Central, East and Southern); South-East Asia Region, Western Pacific, European, Eastern Mediterranean Region and Region of the Americas. Whilst the selection did not include all WHO regions, we considered that a suitable cross-selection has been included.
- **Spending by prevention pillar and Global Fund module:** this included spending across each of the prevention pillars and Global Fund modules. The selection ensured a mix between countries with a focus on different pillars especially between countries focusing on AGYW and KVPs respectively. We also ensured to include countries with high spending in activities that could be considered under a wider primary prevention definition (e.g. testing activities and interventions to reduce human-rights related barriers).
- **Proportion of prevention spending of total HIV spending:** to reflect different levels of the proportional share of prevention funding including a low funding share (below 20% share); medium share (20-50%) and high share (above 50%).

This list was complemented by a range of logistical and qualitative factors, including:

- **Existing in-country networks:** Given the needs for country case studies to be conducted remotely, we considered in which countries the CEPA team have existing networks (and countries where CEPA team members are based) that can facilitate and support the process of obtaining comprehensive data in-country.
- **Workload burden on country stakeholders:** we listed countries where other evaluations have recently been undertaken (i.e. Global Fund Strategy Review in 2020 (SR2020) and Prospective Country Evaluations (PCEs)) as well as which countries have already completed their funding request for the 2020-22 allocation cycle (Window 1 countries). At the request of the TERG, we have excluded PCE review countries.
- **Recommendations from early consultations:** these include countries that have been highlighted by stakeholders as offering particularly useful insights for the review. **These aspects are noted in 'qualitative' points below and are based on consultee opinion and have not been further verified.** Factors mentioned included: (i) successes and challenges in HIV prevention programming and results with regard to specific KPs and prevention pillars; (ii) barriers by targeted populations to accessing information and services; and (iii) epidemiological profiles and (iv) whether a country is in a transition phase moving towards the phase-out of Global Fund support.

Based on these criteria, a shortlist of countries was derived and proposed as shown in Table E.1 below. We then divided our shortlist into two groups of countries:

[28] Only Vietnam, Thailand, Bangladesh and Haiti are not Coalition Prevention Countries. GPC countries which are not within the Top 20 countries by HIV prevention funding or total HIV funding include: Angola, Botswana, Brazil, China, Eswatini, Iran, Mexico.

- **Countries we included as country case studies:** Botswana, Côte d'Ivoire, Ethiopia, Indonesia, Jamaica, Philippines. South Africa, Ukraine and Tanzania. Although Tanzania was chosen a country case study, it was not possible to complete this case study.
- **Shortlisted countries which were not selected as first choice for the case studies**: Cameroon, Ethiopia, Haiti,Kenya, Lesotho, Nigeria, Pakistan, Rwanda, Thailand and Zimbabwe.

Table E.1. Key characteristics supporting the selection of country case studies

Country	Characteristics
Nine country case studies	
Botswana	**Characteristics:** Southern Africa; GPC country; rank 5 HIV incidence rate; 21% reduction in HIV incidence over past 5 years **Funding:** Rank 27 HIV Prevention spending; 60% prevention funding share; recipient of HER programme and breaking barriers funding **Qualitative:** *considered to be doing reasonably well in HIV programming with potential to achieve results. One of few countries in East & Southern Africa to have decriminalised homosexuality with potential to explore the implications for KP programming and results.* **Logistics**: Location of CEPA team member
Côte d'Ivoire	**Characteristics:** West Africa; GPC country; rank 29 HIV incidence rate; 33% reduction in HIV incidence over past 5 years **Funding:** Rank 15 in HIV Prevention spending; 15% prevention funding share; recipient of Global Fund breaking barriers support. **Qualitative:** *considered to be doing reasonably well in HIV prevention programming* **Logistics:** strong CEPA network
Ethiopia	**Characteristics:** East Africa; no GPC country; rank 51 HIV incidence rate; 20% reduction in HIV incidence over past 5 years **Funding:** Rank 21 HIV Prevention spending; 5% prevention funding share; recipient of breaking barriers funding **Qualitative:** *N/A* **Logistics:** Location of CEPA team member; SR2020 review country
Indonesia	**Characteristics:** South East Asia; GPC country; rank 62 HIV incidence rate; 25% reduction in HIV incidence over past 5 years **Funding:** Rank 8 HIV Prevention spending; 33% prevention funding share; breaking barriers funding; among top 5 spenders for KPs (especially MSM, sex workers and TGs) and PrEP **Qualitative:** *Rising HIV incidence (MSM, PWID). KP programming not generating expected results. High quality CRG programme. Existence of high human rights barriers.* **Logistics:** Some existing CEPA network
Jamaica	**Characteristics:** Central America and Caribbean; no GPC country; **Funding:** rank 35 HIV Prevention spending; 42% prevention funding share; recipient of breaking barriers funding **Qualitative:** *Improvement in domestic commitment to KP programming* **Logistics:** N/A
Philippines	**Characteristics:** South East Asia; no GPC country; rank 70 HIV incidence rate; 85% increase in HIV incidence over past 5 years **Funding:** Rank 55 HIV Prevention spending; 33% prevention funding share; recipient of breaking barriers funding **Qualitative:** *Rising HIV incidence (MSM, PWID). KP programming impacted by human rights barriers.* **Logistics:** Window 1 application; SR2020 review country

Country	Characteristics
South Africa	**Characteristics:** Southern Africa; GPC country; rank 4 HIV incidence rate and highest absolute burden with 240,000 new infections; 30% reduction in HIV incidence over past 5 years **Funding:** Rank 1 HIV Prevention spending; 54% prevention funding share; recipient of HER and breaking barriers funding; among top 5 recipients for AGYW, KPs and PrEP **Qualitative:** *Reasonable quality design of HIV prevention programmes. Global Fund support focuses on prevention. Example of good community engagement but little impact of AGYW and KP interventions. Existence of human rights barriers.* **Logistics:** N/A
Tanzania	**Characteristics:** East Africa; GPC country; rank 13 HIV incidence rate; 24% reduction in HIV incidence over past 5 years **Funding:** Rank 2 HIV Prevention spending; 16% prevention funding share; HER funding; among top 5 spenders for AGYW and condoms **Qualitative:** *Increased human rights barriers affecting KP programming and results, particularly regarding MSM. Heavy focus on AGYW programming not reaching results.* **Logistics:** Location of CEPA team member
Ukraine	**Characteristics:** Eastern Europe; GPC country; rank 39 HIV incidence rate; 20% increase in incidence over past 5 years **Funding:** Rank 10 HIV Prevention spending; 31% prevention funding share; breaking barriers funding; among top 5 spenders for KPs (especially PWID and people in prisons) **Qualitative:** *Epidemic concentrated amongst KPs. KP prevention programmes good and taken to scale.* **Logistics**: SR2020 review country
Additional shortlisted countries proposed as alternative options	
Cameroon	**Characteristics:** Central Africa; GPC country; rank 15 HIV incidence rate; 33% reduction in HIV incidence over past 5 years **Funding:** Rank 18 HIV Prevention spending; 15% prevention funding share; recipient of breaking barriers and HER funding; among top 5 spenders for PrEP **Qualitative:** *N/A* **Logistics:** SR2020 review country
Haiti	**Characteristics:** Central America and Caribbean; rank 26 HIV incidence rate; 15% reduction in incidence over past 5 years **Funding:** Rank 24 HIV Prevention spending; 13% prevention funding share **Qualitative:** *N/A* **Logistics**: Window 1 application
Kenya	**Characteristics:** East Africa; GPC country; rank 17 HIV incidence rate; 26% reduction in HIV incidence over past 5 years **Funding:** Rank 3 HIV Prevention spending; 21% prevention funding share; recipient of HER and breaking barriers funding; among top 5 spenders for KPs (especially MSM and PWID) and condoms; recipient of Global Fund VMMC support. **Qualitative:** *HIV prevention programme for AGYW is considered well designed and achieving results. Programming for KP is considered good. Limited domestic resources provided.* **Logistics:** Strong existing CEPA network; SR2020 review country

Country	Characteristics
Lesotho	**Characteristics:** Southern Africa; GPC country; rank 2 HIV incidence rate; 31.6% reduction in HIV incidence over past 5 years. **Funding:** Rank 20 in HIV prevention spending: 19% prevention funding share; recipient of Global Fund AGYW funding; recipient of Global Fund VMMC support; recipient of USG DREAMS funding. **Qualitative:** *considered to be doing reasonably well in reducing HIV incidence, however could / should be doing better in view of per capita spending level on prevention.* **Logistics:** N/A
Nigeria	**Characteristics:** West Africa; GPC country; rank 31 HIV incidence rate and top 3 total new HIV infections **Funding:** Rank 14 HIV Prevention spending; 13% prevention funding share; among top 5 spenders for sex workers **Qualitative:** *HIV prevalence and incidence higher among women 15+ than among men 15+, but without wide-scale AGYW prevention efforts. HIV prevention programme reportedly not strong.* **Logistics**: Strong CEPA network; Window 1 application
Pakistan	**Characteristics:** South Asia; GPC country; rank 71 HIV incidence rate; 0% reduction in incidence over past 5 years **Funding:** Rank 18 HIV Prevention spending; 31% prevention funding share; among top 5 spenders for PWIDs **Qualitative:** *Rising HIV incidence (MSM, PWID). Human rights barriers affecting KP programming and results.* **Logistics**: Strong CEPA network; SR2020 review country
Rwanda	**Characteristics:** East Africa; no GPC country; rank 44 HIV incidence rate; 50% reduction in incidence over past 5 years **Funding:** all Global Fund funding is programmed under “Payment for Results” **Qualitative:** *Country with high government ownership of development programmes. Global Fund support is “programme-based”, i.e. aligned to and channelled through government system.* **Logistics:** Existing CEPA network
Thailand	**Characteristics:** South East Asia; rank 71 HIV incidence rate; 33% reduction in incidence over past 5 years **Funding:** Rank 15 HIV Prevention spending; 70% prevention funding share; among top 5 spenders for PWID and prisoners **Qualitative:** *Achieved good prevention results. Close to transitioning from Global Fund (and PEPFAR) funding with considerations regarding sustainability of HIV prevention interventions.* **Logistics:** N/A
Zimbabwe	**Characteristics:** Southern Africa; GPC country; rank 9 HIV incidence rate; 28% reduction in incidence over past 5 years **Funding:** Rank 9 HIV Prevention spending; 7% prevention funding share; recipient of HER programme; among top 5 spenders for AGYW and PrEP **Qualitative:** *Challenging environment, HIV prevention programme well designed and achieving results. Providing additional funding for AGYW and KPs. VMMC programming important, currently funded by other donor (PEPFAR)* **Logistics**: funding application during Window 1 of 2020-2022 funding cycle

Table E.2. below gives a detailed overview for 40 countries of their performance against the proposed selection criteria.

Table E.2. Country Selection Criteria

Country	WHO Region [29]	GPC [30]	Incidence rate [31]			HIV Prevalence [32]	New HIV infections [33]	Total GF HIV prevention funding [34]		Total GF HIV funding [35] US$m	Prevention share of total HIV funding	GF funding initiative [36]	Other donor support [37]	Suggested as countries of interest	Existing CEPA network	Window 1 2020-2022	Other reviews
			Rate per 1000	Rank	5-year change			US$ m	Rank								
South Africa	AFRO	Yes	8.70	4	-29.8%	20.4	240,000	113.9	1	209.5	54%	BB, AGYW	DREAMS, All-In, PEPFAR VMMC	Yes			
Tanzania	AFRO	Yes	2.50	13	-24.2%	4.6	72,000	55.2	2	350.0	16%	AGYW	DREAMS, All-In	Yes	Strong		
Kenya	AFRO	Yes	1.62	17	-26.4%	4.7	46,000	50	3	236.6	21%	BB, AGYW	DREAMS, Linkages, All-In, PEPFAR VMMC	Yes	Strong		SR2020
Malawi	AFRO	Yes	4.40	10	-26.7%	9.2	38,000	39.4	4	352.3	11%	AGYW	DREAMS, Linkages, All-In,			Yes	

[29] The six WHO regions are as follows: African Region (AFRO), Region of the Americas (PAHO), South East Asia Region (SEARO), European Region (EURO), Eastern Mediterranean Region (EMRO) and Western Pacific Region (WPRO).

[30] Flag in case country is a Global Prevention Coalition country

[31] UNAIDS, HIV incidence per 1000 population aged 15-49 in 2018; Source: http://aidsinfo.unaids.org/; Ranked based on all countries with data; Rounding may affect the magnitude of the positive incidence growth for Ukraine and Bangladesh; No data is available for India or Jamaica

[32] UNAIDS, HIV prevalence in population aged 15-49 in 2018. Source: http://aidsinfo.unaids.org/

[33] UNAIDS, New HIV infection in 2018. Source: http://aidsinfo.unaids.org/

[34] Total Global Fund HIV primary prevention funding for the 2017-19 allocation cycle, based on Global Fund budget data received May 2020. Rank calculated on all countries that received Global Fund prevention funding.

[35] Total Global Fund HIV primary prevention funding for the 2017-19 allocation cycle, based on Global Fund budget data received May 2020.

[36] This included Global Fund funding initiatives, including: BB= Breaking Down Barriers to Access; AGYW= AGYW Priority countries HER partnership funding and Global Fund matching funds.

[37] Support from other donors: DREAMS= USG (USAID) DREAMS project targeting AGYW; Linkages = USG (USAID) LINKAGES project targeting KP; All-in = UNAIDS-led All-In initiative for adolescents

Country	WHO Region [29]	GPC [30]	Incidence rate [31]			HIV Prevalence [32]	New HIV infections [33]	Total GF HIV prevention funding [34]		Total GF HIV funding [35] US$m	Prevention share of total HIV funding	GF funding initiative [36]	Other donor support [37]	Suggested as countries of interest	Existing CEPA network	Window 1 2020-2022	Other reviews
			Rate per 1000	Rank	5-year change			US$ m	Rank								
													PEPFAR VMMC				
Myanmar	SEARO	Yes	0.30	62	-40.0%	0.8	11,000	30.9	5	116.8	26%				Strong	Yes	PCE
Uganda	AFRO	Yes	2.60	11	-39.5%	5.7	53,000	29.4	6	288.8	10%	BB, AGYW	DREAMS, All-In, PEPFAR VMMC	Yes		Yes	PCE
Zambia	AFRO	Yes	5.67	7	-20.3%	11	48,000	28.6	7	167.3	17%	AGYW	DREAMS, All-In, PEPFAR VMMC	Yes	Moderate		
Indonesia	SEARO	Yes	0.30	62	-25.0%	0.4	46,000	27.7	8	84.0	33%	BB	Linkages, All-In	Yes	Moderate		
Zimbabwe	AFRO	Yes	4.86	9	-27.7%	12	38,000	25.4	9	368.5	7%	AGYW	DREAMS, All-In, PEPFAR VMMC	Yes		Yes	
Ukraine	EURO	Yes	0.60	39	20.0%	1	12,000	22.4	10	72.6	31%	BB	All-In	Yes			SR2020
Mozambique	AFRO	Yes	10.10	3	-17.9%	12	150,000	20.5	11	316.1	6%	BB, AGYW	DREAMS, Linkages, All-In, PEPFAR VMMC	Yes	Strong		PCE
Cameroon	AFRO	Yes	1.60	18	-33.3%	3.6	23,000	15.9	12	103.9	15%	BB, AGYW	Linkages, All-In				SR2020
Viet Nam	WPRO	No	0.10	94	-50.0%	0.3	5700	15.6	13	57.4	27%						SR2020
Nigeria	AFRO	Yes	1.02	31	-8.1%	1.5	130,000	13.7	14	106.2	13%		All-In	Yes	Strong	Yes	
Thailand	SEARO	No	0.20	71	-33.3%	1.1	6400	12.6	15	18.0	70%		Linkages, All-In	Yes			
Côte d'Ivoire	AFRO	Yes	1.08	29	-31.6%	2.6	17,000	11.7	16	76.3	15%	BB	Linkages, All-In	Yes	Strong		
Bangladesh	SEARO	No	0.02	136	100.0%	<0.1	1600	11.2	17	21.0	53%					Yes	

Country	WHO Region [29]	GPC [30]	Incidence rate [31]			HIV Prevalence [32]	New HIV infections [33]	Total GF HIV prevention funding [34]		Total GF HIV funding [35] US$m	Prevention share of total HIV funding	GF funding initiative [36]	Other donor support [37]	Suggested as countries of interest	Existing CEPA network	Window 1 2020-2022	Other reviews
			Rate per 1000	Rank	5-year change			US$ m	Rank								
Pakistan	EMRO	Yes	0.20	71	0.0%	0.1	22,000	10.8	18	34.3	31%			Yes	Strong		SR2020
Namibia	AFRO	Yes	4.90	8	-35.5%	11.8	6100	10.4	19	28.7	36%	AGYW	All-In, PEPFAR VMMC		Moderate	Yes	
Lesotho	AFRO	Yes	13.40	2	-31.6%	23.6	13,000	10.4	20	55.6	19%	AGYW	DREAMS, All-In, PEPFAR VMMC				
Ethiopia	AFRO	Yes	0.40	51	-20.0%	1	23,000	9.1	21	193.1	5%		All-In, PEPFAR VMMC		Strong		SR2020
Haiti	PAHO	No	1.10	26	-15.4%	2	7300	7.4	24	56.4	13%		Linkages, All-In			Yes	
Nepal	SEARO	No	0.05	121	-44.4%	0.1	<1000	7.2	26	23.5	31%	BB			Moderate		SR2020
Botswana	AFRO	Yes	7.40	5	-22.1%	20.3	8500	6.9	27	11.6	60%	BB, AGYW	Linkages, All-In	Yes	Strong		
Congo, D.R.	AFRO	Yes	0.30	62	-25.0%	0.8	19,000	6.3	28	113.0	6%	BB	Linkages, All-In	Yes		Yes	PCE
Senegal	AFRO	No	0.10	94	0.0%	0.4	1300	5.6	31	25.9	21%	BB		Yes			PCE
Jamaica	PAHO	No	...		…	...	...	4.6	35	10.9	42%	BB	Linkages	Yes			
Eswatini	AFRO	Yes	15.40	1	-35.8%	27.3	7800	4.5	36	33.4	13%	AGYW	DREAMS				SR2020
Cambodia	WPRO	No	0.10	94	-50.0%	0.5	<1000	3.9	41	39.7	10%		Linkages	Yes			PCE
Honduras	PAHO	No	0.10	94	0.0%	0.3	<1000	3.6	49	10.7	34%	BB	Linkages				
Ghana	AFRO	Yes	1.10	26	-8.3%	1.7	20,000	3.6	51	61.6	6%	BB	Linkages	Yes			
Sierra Leone	AFRO	No	0.90	33	-18.2%	1.5	4100	3.5	53	35.6	10%	BB					
Philippines	WPRO	No	0.24	70	84.6%	0.1	13,000	3.3	55	10.2	33%	BB		Yes		Yes	SR2020
Kyrgyzstan	EURO	No	0.20	71	-33.3%	0.2	<1000	3.2	56	9.1	35%	BB				Yes	
Benin	AFRO	No	0.58	43	-18.3%	1	3800	2.6	59	30.3	9%	BB					

Country	WHO Region [29]	GPC [30]	Incidence rate [31]			HIV Prevalence [32]	New HIV infections [33]	Total GF HIV prevention funding [34]		Total GF HIV funding [35] US$m	Prevention share of total HIV funding	GF funding initiative [36]	Other donor support [37]	Suggested as countries of interest	Existing CEPA network	Window 1 2020-2022	Other reviews
			Rate per 1000	Rank	5-year change			US$ m	Rank								
South Sudan	EMRO	No	2.60	11	4.0%	2.5	19,000	1.8	67	31.1	6%		Linkages		Strong		
Tunisia	EMRO	No	0.04	125	0.0%	<0.1	<500	1.5	73	4.8	31%	BB					
Angola	AFRO	Yes	1.60	18	-15.8%	2	28,000	1.1	78	22.2	5%		Linkages		Moderate		
India	SEARO	Yes	...		…	...	...	0	104	130.2	0%		Linkages, All-In	Yes	Strong		
Rwanda	AFRO	No	0.50	44	-50.0%	2.5	3,600	#N/A	#N/A	#N/A	#N/A		All-in	Yes			

Appendix F GLOBAL FUND HIV INFORMATION NOTES OVER TIME

This appendix provides an overview of the Global Fund HIV Information Notes from 2014, 2016 and 2019. This includes appraisal of the change in the focus and content between the different note versions as well as suggestions for further improvements.

F.1. THE IMPORTANCE OF HIV PREVENTION INTERVENTIONS

The content of Global Fund HIV Information Note has improved since 2016 (and 2014) and the 2019 version is generally better structured but there are still gaps. In particular:

- Improvements **in the 2019 information note include more emphasis on HIV prevention and strategic information to inform the prioritisation of populations and interventions.** Among prioritised interventions across HIV cascade, the 2019 Global Fund Information Note starts with a) Prioritised interventions across the HIV cascade; b) Scale up of HIV prevention services; and c) Strategic information.

  By contrast the 2014 and 2016 Global Fund Information Note versions presented HIV prevention in the framework of combination prevention (combined with treatment) and key populations and human rights and gender were at the bottom of the list of thematic/cross-cutting areas.

- There still seems to be an **imbalance between prevention and treatment reflected** both in the Summary of prioritised interventions on page 16 (Box 3) and in the "prioritized and strongly encouraged interventions" on pages 7-12. The treatment section in the 2019 note is elaborate, comprehensive and applies to most contexts compared to the prevention section which remains unspecific and relies on readers referring to WHO and other guidance, instead of spelling out more detail.

- The note seems to **assume prior knowledge of prevention interventions** for different epidemic settings and key populations and relies on the modular framework guidance. Core components of HIV prevention should be equally reflected and not simply rely on the modules which are useful but may be read by fewer decision-makers and/or planners.

F.2. WHETHER THERE IS CLEAR GUIDANCE ON HOW TO DETERMINE WHICH INTERVENTIONS SHOULD BE PRIORITISED

All (2014. 2016 and 2019) Information Notes referenced the "know your epidemic" to inform country prioritisation and response – However only the 2019 info note makes strategic information explicit and separates it as a component.

Despite the intent, the Summary of prioritized interventions (Box 3. page 16) only mentions two "interventions" under Strategic information and fails to include integrated bio-behavioural surveillance Bio-behavioural surveys (IBBS), population size estimates (PSE) among key populations or periodic Data Quality Assessments (DQA).[38] IBBS surveys (and PSE) are crucial tools for HIV surveillance in key populations as well as to provide Global Fund and programmes critical outcome and impact data among key populations they serve.

Pictorials with an active link to a best practice or source document are helpful in providing quick access to useful details when designing a grant proposal. The short **best practice/case studies** provide helpful examples on ways to improve efficiency in delivering services by integrating HRH in facility and community services.

The overall sense is of a desire to include as much information as possible which may become counterproductive - there may be a disconnect between the amount and complexity of technical guidance and the capacity in countries to review and navigate all the reference documents (especially if not in their native language).

[38] Routine review of data tracking people along the HIV prevention, testing and treatment cascade and HIV case surveillance.

Given the amount of other guidance referred to, the format of the Global Fund Information Note could be more synthetic by including a decision-making tool/flow-chart which provides the overarching frame of the process and guides readers/countries through the phased process of developing their proposal (with more diagrams/visuals and less text). This could include the following steps: 1) understanding broad principles/options; 2) strategic information based on epidemic context/options; 3) prioritising and developing interventions based on available country strategic information/options; and 4) improving the country's ability to measure outcomes of HIV prevention/options.

Table F.1 Global Fund Information Note: Strategic Investments for HIV Programs (2014, 2016 and 2019)

HIV Information Note area	2014	2016	2019
General approach	• HIV strategic investment approach to develop Global Fund concept notes [Understand, Design, Deliver, Sustain]. Concept notes replace previous Global Fund proposal documents and are the principal mechanism to request and access Global Fund funding under the New Funding Model (NFM).	• Priority setting and focus more important than ever before - need to accelerate & fast track measures to reverse the HIV epidemic in order to achieve the global goal of ending it by 2030.	• Note revised compared to last funding cycle. • Explains the "what" using the HIV cascade: prevention, testing, treatment & care, & retention, & cross-cutting human rights & strategic information needs. • Also covers the "how", including collecting the right data to designing effective programs, & delivering quality services to prevent HIV transmission, improve HIV diagnosis, treatment and care.
Importance of HIV prevention interventions (in relation to other areas)	• Five thematic areas and cross-cutting areas (p1). Key populations are last on the list. • Emphasis on high-impact interventions like Combination prevention which integrates prevention and treatment. • Not clear how the 8 high-impact interventions (p5) fit with the 5 thematic areas.	• Five thematic areas and X-cutting areas (p1). • Key populations and human rights and gender have been given higher importance.	• Better structured than previous Information Note (list of activities). • Stronger emphasis on a) prioritised interventions across HIV cascade; b) scale up of HIV prevention services; and c) strategic information.
Which interventions and which populations to target	• Six thematic & cross-cutting areas (KVPs listed last). • Refers to know your epidemic and assume it is being done.	• State critical types of data for strategic allocation of HIV investments (p12).	• Prioritises 3 steps for prioritisation: (a) know your epidemic; (b) select interventions to maximise impact, (c) select "strongly encouraged interventions". • Good complements on HIV prevention in different populations. • Links to Global Fund technical brief on AGYW (2017) and to Global Fund Information Note on SW-MSM-TG (2014).

HIV Information Note area	2014	2016	2019
			• Updated menu of HIV modules in annex (pp1-82).
Clear guidance on how to determine which interventions should be prioritised?	• Assumes country" knows its epidemic", relies on existing NSP with clear prevention priorities (=long-term outlook, 10+ yrs). • Guidance seems fragmented. • List of interventions modules in annex (pp30-38).		• Links to other guidance documents helps countries prioritise, but may also confuse and create potential disconnect between complexity of the guidance and country capacity.
How to choose whether countries should prioritise prevention over treatment.	• Guidance on treatment is clear and explicit but not very detailed for prevention. • No emphasis on integration of prevention and treatment.	• Guidance on treatment is clear and explicit but not very detailed for prevention. • What does "integration of prevention and treatment" mean for key populations?	• Balance HIV treatment and HIV prevention. • Prioritise interventions at sufficient coverage and scale to have an impact. • Address populations with greatest HIV burden and barriers to accessing services. • Rapid scale-up of new and innovative medicines and technologies, as recommended by the WHO and other normative agencies.
How to determine which interventions are cost-effective	• Abstract, no concrete guidance – use country data		• Encouraged to apply HIV resource allocation tools and models to compare different intervention scenarios and to identify optimal package that maximizes impact with available resources.[39]
Guidance clarity of documents? (e.g. all the embedded links to source documents)	• High number of links and references.	• Provides short abstract of Key Technical Guidance related to HIV (pp9-10) – good but at end of document.	• Paper clip indicating link to other technical guidance is good BUT too many in-text references, which will confuse the reader. Suggest to leave clip in but separate paragraph text from in-text references.

[39] E.g. AIDS Impact Model (AIM), Goals Model (embedded in Spectrum suite), AIDS Epidemic Model (AEM), Optima-HIV61 and STAR (Socio-Technical Allocation of Resources),62 and WHO-CHOosing Interventions that are Cost-Effective (CHOICE).

Appendix G HIV PREVENTION PARTNER GUIDANCE

This appendix analyses recent technical guidance developed by partners of the Global Fund engaged in various aspects of the design of and implementation of HIV prevention programmes.

G.1. FUNDING REQUEST DESIGN

Evidence-based and context-sensitive technical guidance is an important enabler in developing well-designed HIV prevention strategies, country funding requests and programmes appropriate to the HIV epidemic and context. We reviewed recent technical guidance on HIV and STI prevention and TB for Key and Vulnerable populations (KVP) and Adolescent Girls and Young Women (AGYW) published by various partner organisations since 2014. The levels of guidance documents reviewed are summarised below in Table G.1.

The key technical guidance documents reviewed fall into three broad categories:

a. Strategic guidance documents such as those developed by the Global Prevention Coalition (GPC), UNAIDS and WHO;

b. Consolidated technical guidance and updated policy briefs on national prevention programme components provided by WHO, PEPFAR, Stop TB Partnership, IFF and other partners; and

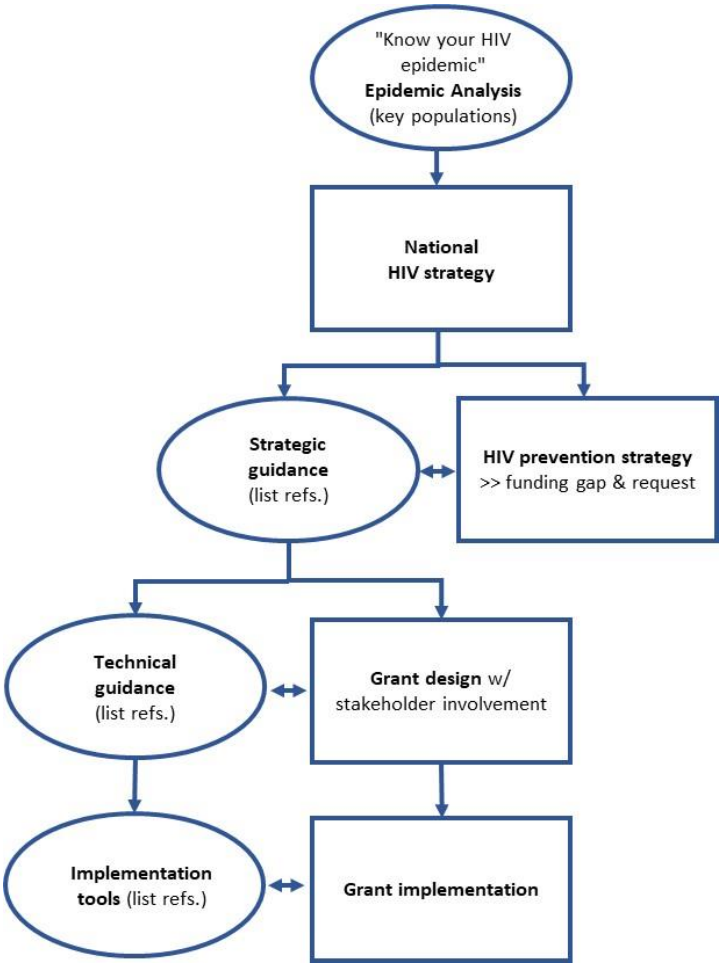
c. Tools detailing implementation approaches for inter-related interventions with key vulnerable populations – for programme managers, NGOs implementing programmes, KVP communities.

Strategic guidance lay out the rationale, principles for HIV prevention approaches and type of activity for different population groups and contexts (e.g. trusted access platforms, safe spaces, structural interventions). They provide links to key resource and evidence underpinning each approach and are primarily designed for national-level HIV grant and programme design, for programme managers and planners. Most recent strategic guidance provide good conceptual frameworks appropriate for national level grant design, development and planning and are clear. However, they may require adaptation or translation to maximise their value, accessibility and use.

The **consolidated technical guidance** and updated policy briefs on national programme components for different KVPs are the go-to technical guidance for programme managers that describe programme intervention and service delivery components required for different populations and epidemic contexts. They focus on *what* to implement for each KVP.

Finally, the **Implementation tools** detail practical approaches to implementing inter-related HIV interventions for key vulnerable populations in different contexts and settings. These tools aim to support field implementers, NGOs and civil society in mobilising for, planning and implementing sets of interventions with key populations. Their focus is more on *how* to implement for each KVP.

Figure G.1: Levels of partner technical guidance on HIV Prevention



G.2. GRANT & PROGRAMME DESIGN AND IMPLEMENTATION

The quality, robustness and scope of technical guidance for HIV prevention has generally improved and they are generally better structured with frameworks and visuals that add clarity. Implementation tools and technical guidance especially, explicitly consider the central role and involvement of communities affected, as well as the importance of structural factors and barriers to be addressed at all stages of programming. Taken together these resources provide robust, relevant and complementary guidance for different stages in designing, developing and implementing HIV (and TB) prevention.

Recent technical guidance is wide-ranging, grounded in evidence (sometimes almost too much) and covers all relevant programme components for different HIV epidemics and populations; including Pre-exposure Prophylaxis (PreP) in selected settings.

However guidance documents have also multiplied in number with different levels and approaches, even for the same target KVP which may lead to confusion among country partners. Therefore, a potential **challenge** for country stakeholders is to navigate the multitude of available resources when designing HIV prevention strategies and grant submissions as the purpose of, and differences between guidance materials are not always made clear. This may be more confusing when the working language in a country is not English, whereas most guidance documents are only available in English.

- One **solution** would be for the Global Fund or the GPC to develop a unifying or umbrella technical guidance framework that maps, connects and signposts related and relevant resources and systematically embeds links to related resources so as to help country partners/stakeholders navigate varied resources and find what they need quickly and easily. Active weblinks in a document are a best practice example which can also

help users navigate, make relevant connections and find the guidance they need easily (e.g. in 2017 "Implementing Comprehensive HIV and HCV Programmes with People Who Inject Drugs: Practical Approaches for Collaborative Interventions").

- A complementary **solution** would be to develop a decision-tree or flowchart to help users match their country and epidemic context (Know your epidemic), response and target population(s) to the technical guidance they need. This flowchart would start from the epidemic context and characterisation, to guide users through a series of questions to identify guidance relevant to their specific needs. The Global Fund could develop such a framework with the support of technical partners.
- Finally, given the length of some technical guidance documents, developing short versions like the WHO "policy briefs" or MGH "solutions reports" may help increases their visibility, ease of access and use.

G.3. MEANINGFUL ENGAGEMENT OF KVPS

As mentioned above, most recent technical guidance (especially implementation tools) highlight the central role and leadership of communities affected and propose practical approaches to engaging with them, reinforced by case studies and country examples. Evidence-informed approaches to dealing with structural factors and barriers are also included in most tools for KVP to inform the design and planning of interventions from situation analysis to implementation.

Table G.1: Key Technical Guidance for HIV Prevention

Type of guidance	Target population	Year	Short title	Target audience	Publishing organisation
Strategic Guidance	Key Vulnerable Populations	2019	Closing the prevention gap among key populations	Policy-makers, programme managers, national-level	GPC
	KVP	2020	Considerations in planning & budgeting for a key population platform to deliver scaled, quality HIV prevention & treat.	National-level grant designers, programme and budget planners;	GPC
	General, KVP	No date?	Strengthen condom Programmes & Markets in Africa	National policy-makers, structural	GPC
	General, AGYW, KVP	2018	Recommendations to reach "Fast-Track" condom use targets 1. Insights & recommendations; 2. Funding Landscape for Condom Programming	Government, donors & partners to improve design interventions & systems.	GPC Guidance (Mann Global Health, MGH)
	General, AGYW, KVP	2018	MGH condom programming policy briefs - Solution reports 1. Market stewardship and facilitation 2. CP analytics & market intelligence; 3. Opportunities & Challenges of free condom distribution 4. Sustainability of condom social marketing programmes	Governments, donors & implementing partners to design interventions to improve distribution of free condoms.	GPC Guidance (Mann Global Health, MGH)
	AGYW	2020	Investments into HIV Prevention Programmes among Adolescent Girls and Young Women	National-level planners, programme managers	GPC

Type of guidance	Target population	Year	Short title	Target audience	Publishing organisation
	AGYW	2020	Women, adolescent girls and the HIV response	Central level stakeholders & leaders	UNAIDS
Technical Guidelines	General, AGYW, KVP	2020	The Condom Planning Package 1. Strategic Operational Planning; 2.Developing a Situation Analysis; 3.Identifying strategic priorities for condom programmes 4.Develop a Monitoring, Evaluation & Programme Improvement plan.	Country stewards/planners (individuals and groups responsible for developing & stewarding programmes.	GPC Guidance (Mann Global Health, MGH)
	KVP	2014	HIV prevention diagnosis and treatment for KVP: *Consolidated guidelines*	Health-care providers, programme managers, NGOs, public health policy-makers w/in health & other ministries.	WHO (UNAIDS, UNFPA, UNHR, HRP)
	KVP	2019	Policy brief (update) on HIV prevention diagnosis and treatment for KVP	National programme managers, service providers, incl. from community-based programmes	WHO (UNAIDS, UNDP, UNFPA, UNODC)
	Women living with HIV, AGYW	2017	Sexual and reproductive health and rights of women living with HIV	Front-line health-care providers, programme managers & public health policy-makers w/in MoH.	WHO (UNAIDS, UNFPA, UNHR, HRP)
	Young KVP	2017	Sexual & reproductive health services for Young Key populations in Eastern Europe and Central Asia.	Programme managers, policy-makers, NGOs implementing SRH and/or HIV (EECA).	IPPF, UNFPA
	KVP	No date	Global Plan to End TB: and key vulnerable, underserved, or at-risk populations.	National govts, UN Agencies, local and global health worker collectives	Stop TB partnership, UNOPS, GFATM
	KVP	2019	Prevention and control of STIs in the era of Pre-exposure prophylaxis (PrEP)	Not specified- generic, national health care providers, planners & policy-makers.	
	KVP	2018	Safety & Security Toolkit: Strengthening Implementation of HIV Programmes for & with KVP	Field implementers, programmes managers, NGOs, civil society	Int'l AIDS Alliance, USAID, PEPFAR, LINKAGES.
Implemen-tation tools	KVP	2013	KP implementing tool - HIV and STI Programmes with Sex Workers:	Field implementers, programmes managers, NGOs, civil society	WHO, UNFPA, UNAIDS, Global Network of Sex Work Projects, WB
	KVP	2017	KP implementing tool - HIV and HCV Programmes with People Who Inject Drugs:	Field implementers, programmes managers, NGOs, civil society	UNODC, INPUD, UNAIDS,

Type of guidance	Target population	Year	Short title	Target audience	Publishing organisation
					UNDP, UNFPA, USAID
	KVP	2016	KP implementing tool - - HIV and STI Programmes with Men Who Have Sex with Men:	Field implementers, programmes managers, NGOs, civil society	UNFPA, Global Forum MSM-HIV, UNDP, WHO, USAID, PEPFAR, WB
	KVP	2016	KP implementing tool - HIV and STI Programmes with Transgender People:	Field implementers, programmes managers, NGOs, civil society	UNDP, IRGT: A Global Network of TG Women and HIV, UNFPA, UCSF, John Hopkins SPH, WHO, UNAIDS, USAID
	KVP	2017	Implementation tools for Pre-exposure prophylaxis – *Modules 1-9*	Health care providers, leaders counsellors, community educators & advocates….	WHO
	Gen population incl. AGYW	2014	UNAIDS 2014 | GUIDANCE NOTE - Resource kit for high-impact programming Social & behaviour change programming	Not specified. Likely programme planners/ managers.	UNAIDS, UNFPA
	Gen population	2014	UNAIDS 2014 | Guidance note Condom & lubricant programming	Not specified. Likely programme planners /managers.	UNAIDS, UNFPA
	Gen population	2014	UNAIDS 2016 Guidance note Health community systems to systems for health	Not specified. Likely programme planners/ managers.	

Note: HIV Technical Guidance shared by Global Fund team

Appendix H BUDGET ANALYSIS

Appendix H provides an analysis of the Global Fund budget for HIV primary prevention between 2015 and 2020. The budget data from the Global Fund is the best approximation of what the Global Fund has funded with regards to HIV primary prevention over the past six years. This section is building on the budget analysis conducted by the Global Fund HIV Prevention Team that was shared with CEPA in July 2020.

The appendix is structured as follows: (i) Section H.1. outlines the methodology and key limitations, (ii) Section H.2 provides the findings across the budget periods and (iii) Section H.3 provides a deep-dive for each of the GPC pillars.

H.1. METHODOLOGY & LIMITATIONS

H.1.1. Methodology

The analysis was conducted using Global Fund budget data coded against the Modular Framework for NMF2 (allocation period 2017-19). The budget data includes grants approved and available as of June 2020, which includes changes that have been made through reprogramming or grant optimisation since grant making. The budget data includes funding from (i) the within allocation funding for countries; (ii) matching funding and (iii) funding received through the PAAR process. The following approaches have been used with regards to the methodology – where possible aligning the approach with the one used by the Global Fund HIV Prevention Team:

- ***Definition of HIV Primary Prevention:*** HIV primary prevention has been defined as all HIV Prevention Comprehensive Programmes modules in the Modular Framework. Following the Global Fund HIV Prevention Team, all testing interventions in these modules were stripped out of the total budget to ensure that only primary prevention interventions are included. This approach also has the advantage of allowing for more robust comparisons over time as different approaches have been used in the different Modular Frameworks with regard to coding testing and prevention interventions. PMTCT interventions have not been included in the definition of primary prevention. Similarly, reducing human rights related barriers was not included in the definition of primary prevention. However, it is considered an important "enabling factor" and as such has been reported separately.

- ***Definition of Total HIV:*** The calculation of HIV total budget takes into account HIV/AIDS, HIV/TB combined component and multi-component grants. For the latter two types of grants, the proportion of HIV vs TB funding (or TB and Malaria for the multi-component) was calculated for the joint grant. This proportion was then applied to other related funding in the grant such as: Programme costs, HIV/TB combined costs or RSSH activity. The assumption is that investments in Program management, RSSH, TB/HIV modules or other combined activities are proportionate to the TB and HIV budget, respectively. While this assumption is not necessarily always accurate, it serves as a guide to roughly capture the true size of the HIV budget.

- ***Prevention Pillars:*** The Global Fund interventions have also been analysed against the GPC prevention pillars using the allocation of interventions to pillars as set out by the Global Fund HIV Prevention Team. Importantly, the prevention pillars are not mutually exclusive as they cover both target populations (AGYWs and KPs) and prevention activities and tools (condoms, VMMC and PrEP). As such, some interventions can be classified under more than one pillar.

- ***Comparison across budget periods rather than allocation cycles:*** Following the Global Fund HIV Prevention Team, the analysis has been conducted by using budget periods rather than allocation cycles. This means that budgets have been grouped across years for which they have been budgeted rather than grouped based on their allocation cycle. Two three year budget periods have been selected for the analysis namely 2015-2017 and 2018-2020. Using this approach means that part of the funding provided under NFM1 is included in the second budget period in case it is budgeted for 2018. Similarly, the analysis also included Global Fund ROUND based investments that have been budgeted for the 2015-17 time period. The key advantage of this approach is that discrepancies are avoided when, for example, the implementation period

and allocation utilisation period do not coincide due to continuation (e.g. in the case of Nigeria the NFM1 extended by 18 months).

A key change compared to the approach by the Global Fund HIV Prevention Team has been to define the budget periods as three year intervals rather than five year intervals. This means that investment budgeted for 2021-2022 is not included, nor was investment in 2013-14. Using three year cycles was considered to offer a more accurate picture of the trend in HIV prevention budgets. This is especially due to the case of South Africa that uses a different timing for the grants (running from 2019-22) and using five year cycles would show an increase in HIV prevention budget by around US$50 million even though the analysis of the budget for HIV prevention across the last two allocation periods has in fact slightly declined. Additionally, using three year cycles also allows to compare the funding directly to NFM3 once the allocation is completed.

H.1.2. Limitations

There are a range of limitations with regard to the analysis including:

- ***Data quality issues*** such as: (i) misclassifications against the modular framework; (ii) some missing data on budget year; (iii) *use of* "payment for results" intervention classifications in countries like Rwanda for all HIV funding, not allowing for a more granular analysis.
- ***No Strategic Initiative funding included:*** Funding from Strategic Initiatives is not included in the Global Fund database.
- ***Contextual background:*** it was not within the scope of the analysis to set the Global Fund investments into the specific context for each country with regard to investments from domestic sources (e.g. the case in India with regard to HIV prevention) or from other international Partners such as PEPFAR. Such a detailed analysis has been conducted for the nine country case studies that have been conducted as part of this evaluation.
- ***Differences across time periods:*** there have been different approaches with regard to the coding of Global Fund funding data such as the use of a different modular framework. Some of this has been mitigated (e.g. by taking out testing from prevention activities) but some limitations remain as data might be more incomplete in the database for early years of the analysis.

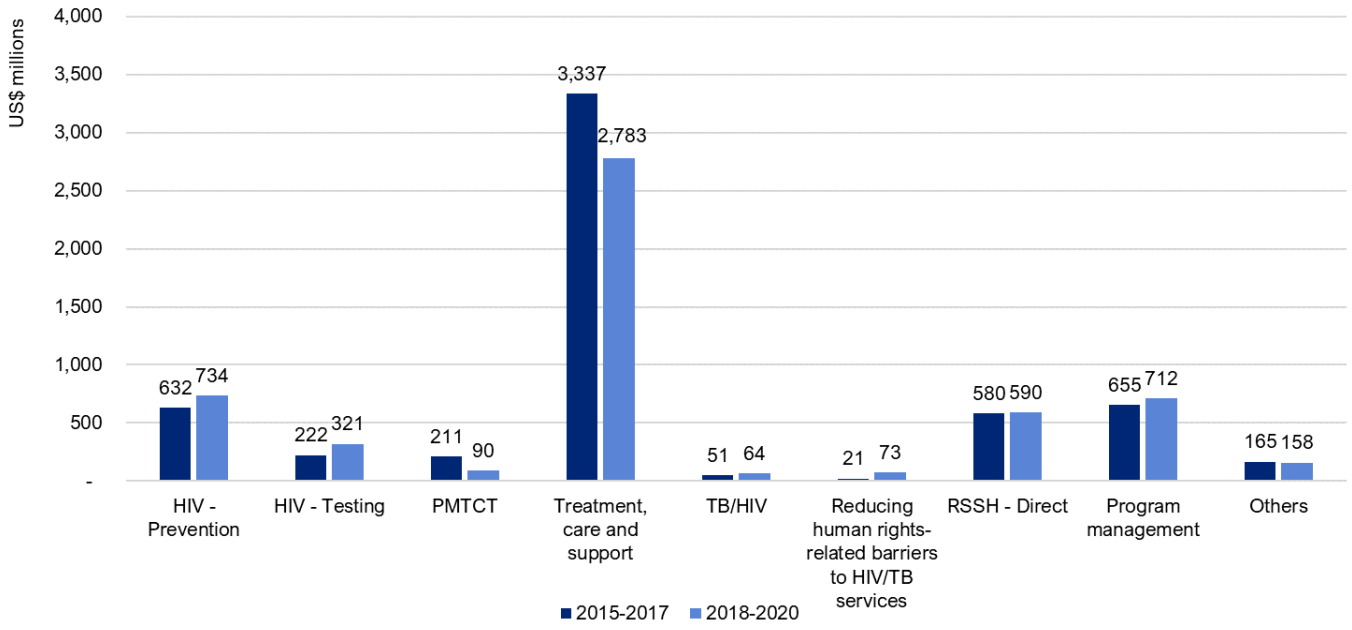
H.2. Findings – Budget Periods

H.2.1. Overall HIV prevention trends

Trends in HIV primary prevention funding between budget periods

The Global Fund budget has increased by around US$ 102.2 million from US$ 631.9 million in 2015-17 to US$ 734.1 million in 2018-20. This is an increase of 16%. In contrast, total HIV budget from the Global Fund has declined slightly by 6% from US$ 5.87 billion to US$5.52 billion. Figure H.1 below shows the budgets for HIV primary prevention and other HIV interventions for both the budget periods of 2015-2017, and 2018-2020.

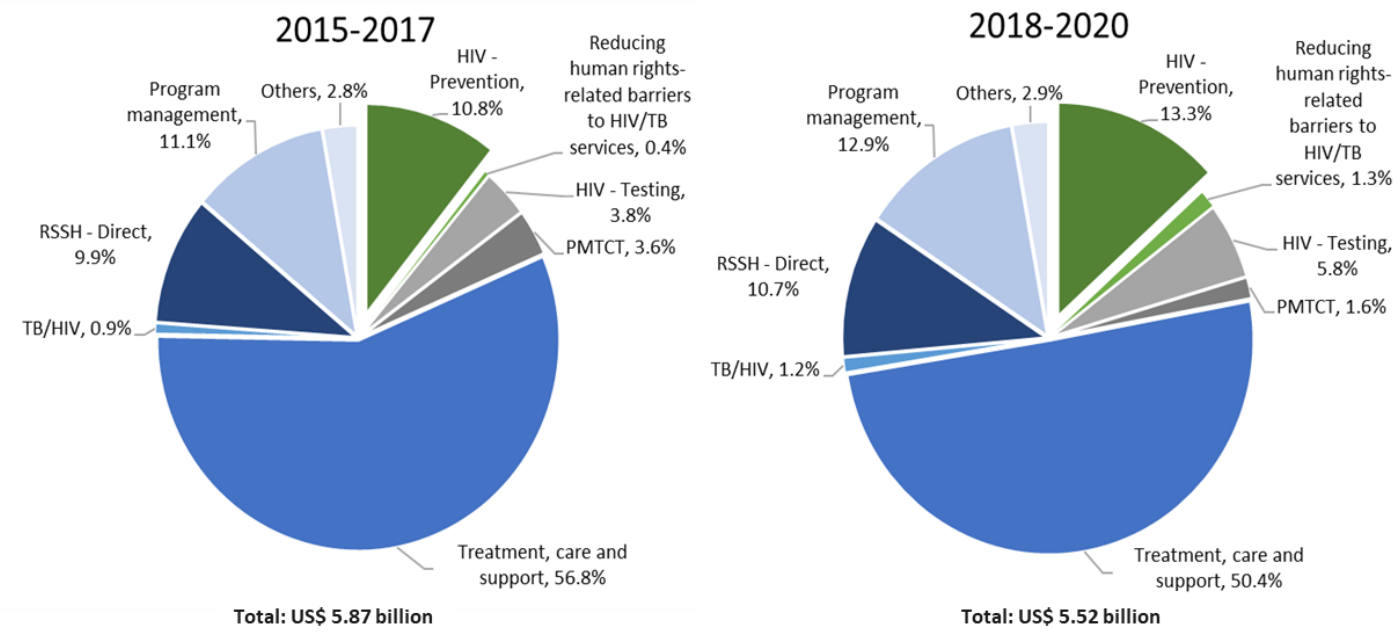
Figure H.1 Global Fund budgets for HIV primary prevention and other HIV intervention by budget periods



Most HIV modules increased over the two budget periods, with the exception of PMTCT and treatment care and support, the latter dropping by around 17%, but still constituting the largest budget item. The budget for reducing human-rights related barriers increased strongly from US$ 21millon to US$ 73 million (248%).

Figure H.2 below shows the proportion of the overall budget spent on each HIV module for both the 2015-2017 and 2018-2020 budget periods.

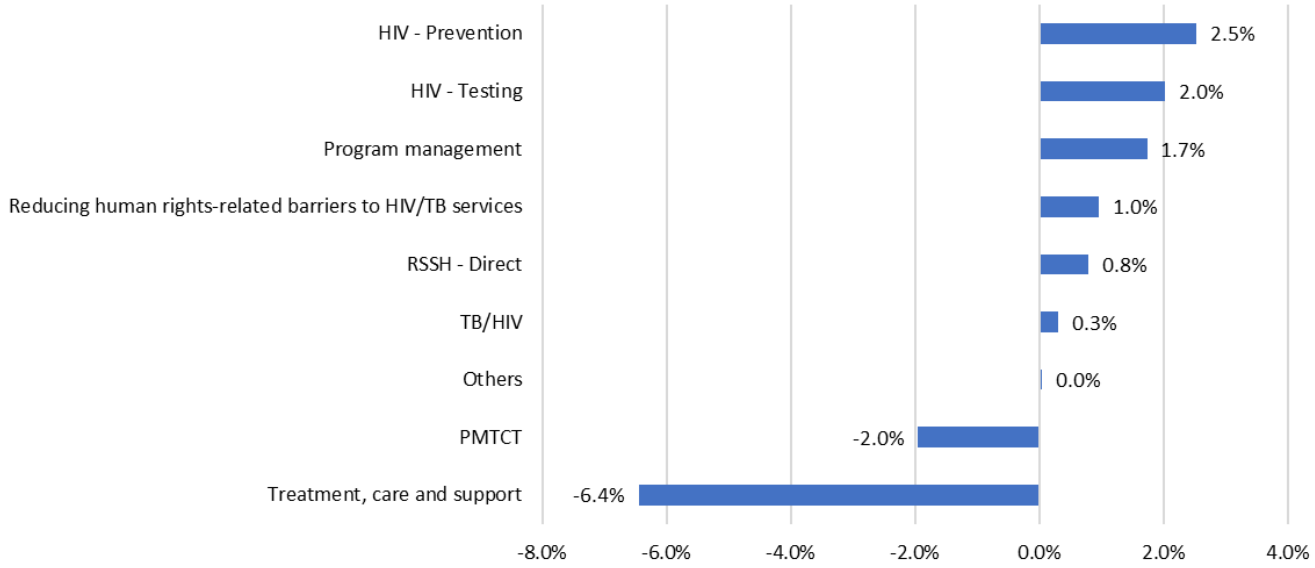
Figure H.2: Global Fund budget proportion of HIV modules by budget periods



HIV prevention increased its share of the budget between the two periods, changing from the third largest module (10.8% of the budget), to the second largest (13.3% of the budget). Treatment, care and support is significantly larger than all other modules in both periods, receiving over 50% of the budget in both. Program management and RSSH also receive c.10% of the budget in both periods.

Figure H.3 below shows the percentage point changes in the budget proportion received for the different HIV modules between the 2015-2017 and 2018-2020 budget periods.

Figure H.3: Percentage Point changes in budget proportion of HIV modules between 2015-2017 and 2018-2020

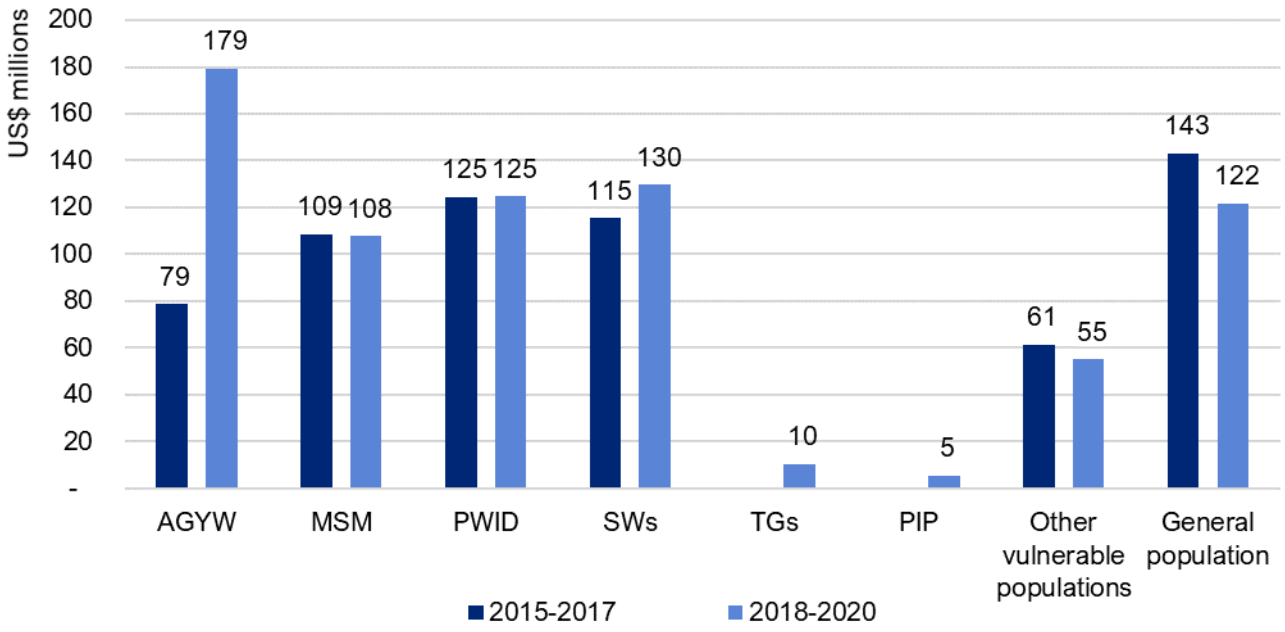


HIV prevention (2.5%) had the largest increase in proportion of the budget between the two periods; HIV testing (2.0%) and program management (1.7%) also had significant increases. Treatment care and support had a significantly greater decrease in percentage of the budget (-6.4%) than any other module, however as stated above, this is in the context of receiving over 50% of the overall budget. PMTCT had the second largest decrease (-2.0%), receiving only 1.6% in the second period.

Target population

Figure H.4 below shows the split of the HIV prevention budget by target population and budget period.

Figure H.4: HIV primary prevention budget by target population and budget period



The majority of modules remain relatively stable between the two funding periods. AGYW is the only module to have a significant percentage and absolute increase, with US$ 100 million in extra funding (127%). TGs and PIPs received funding in the 2018-2020 period, having received nothing in the 2015-2017 period. However, for TGs, this is also driven by the reclassification of TG interventions, which were included in the MSM module prior to NFM2. The general population module had the most significant reduction (-15 %) between the two periods.

Table H.1 below shows the proportion of the HIV prevention funding provided to each target population for both the 2015-2017 and 2018-2020 budget periods.

Table H.1: Proportion of target population as percentage of total HIV prevention funding by period

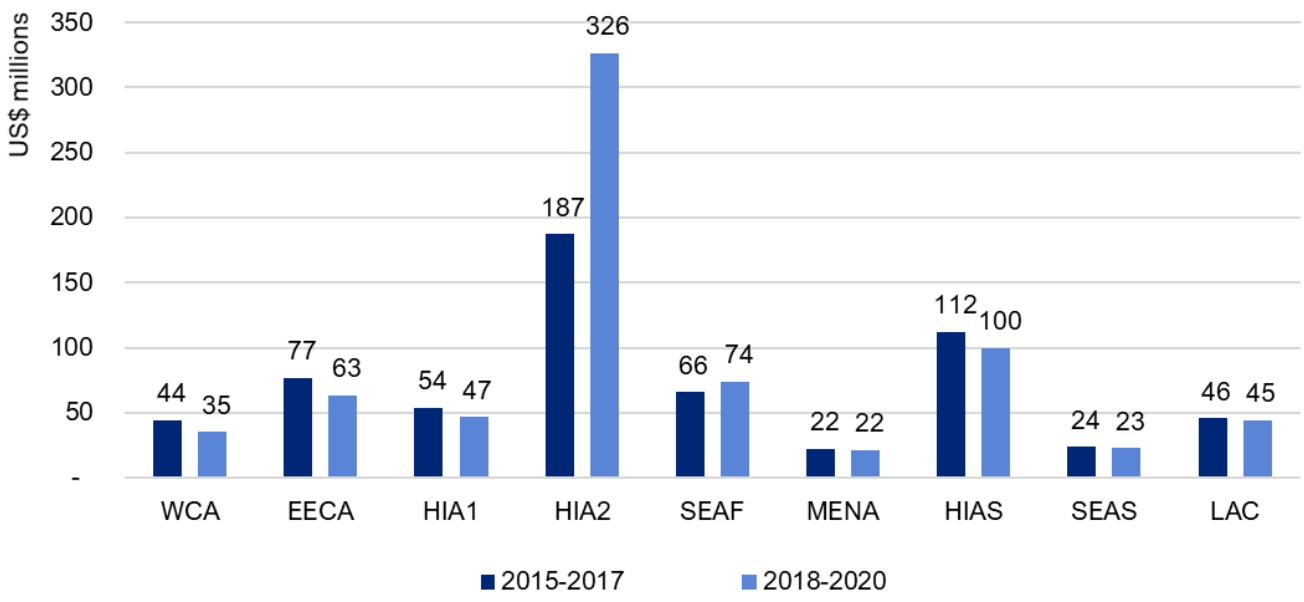
	AGYW	KPs							General Population
		MSM	*SWs*	*TGs*	*PWIDs*	*PIPs*	*Other*	Total KP	
2015-17	**12%**	17%	18%	0%	20%	0%	10%	**65%**	**23%**
2018-20	**24%**	15%	18%	1%	17%	1%	8%	**59%**	**17%**

The proportion of the HIV prevention budget going to KPs decreases between the two periods, accompanied by an increase in the AGYW module by over 10% percentage points to 24% of the overall prevention budget. SWs, MSM, and PWIDs are the largest KP modules in both periods, receiving between 15% and 20% in both. TGs and PIPs are the smallest, receiving no funding in the earlier period and 1% in the later period.

Region

Figure H.5 shows the HIV prevention budget across the Global Fund regions for the 2015-2017 and 2018-2020 budget periods.

Figure H.5: HIV prevention budget by Global Fund region and budget periods



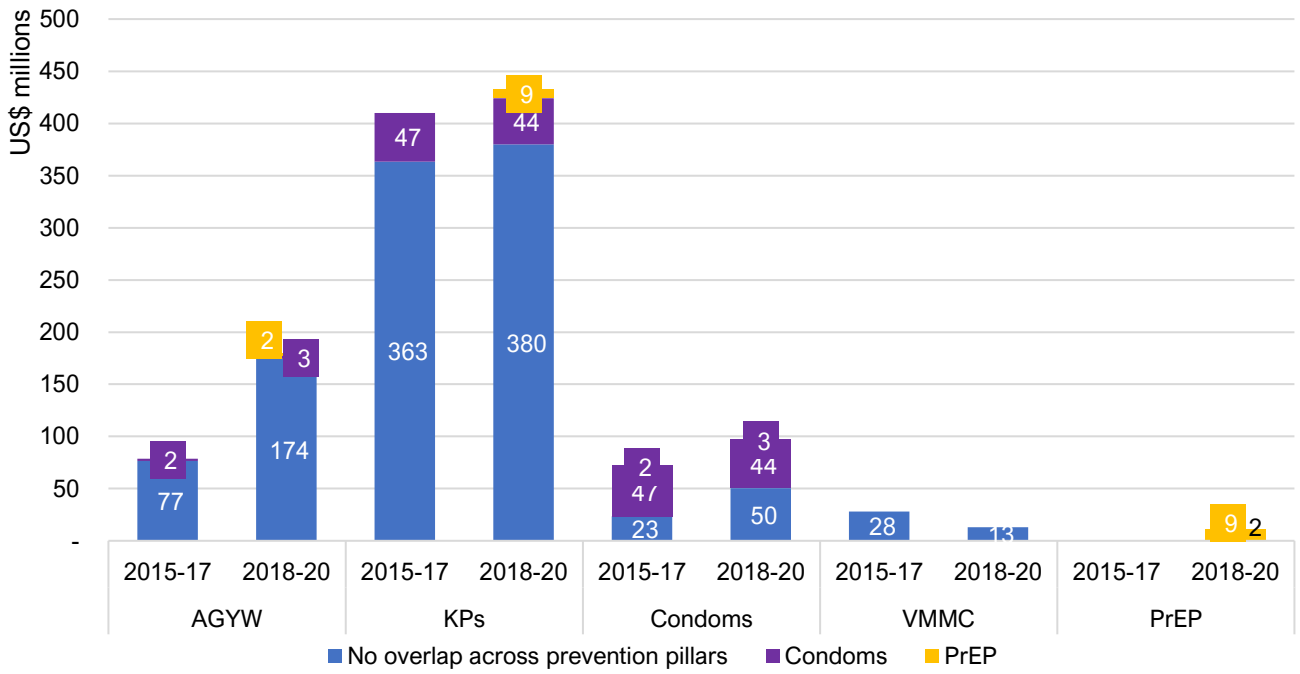
The increase in HIV prevention funding from 2015-2017 to 2018-2020 is mostly driven by increases in the High Impact African 2 (HIA2) region with substantial increases in the following countries (in order of magnitude): Tanzania, South Africa, Kenya, Zambia, Mozambique, Uganda and Zimbabwe. Funding for HIV prevention also increased in the Southern and Eastern Africa (SEAF) region, driven predominately by increases in Malawi, Lesotho and Botswana.[40] However, HIV primary prevention funding remained stable or decreased in all other Global Fund regions.

GPC Prevention Pillars

Figure H.6: below shows the prevention budget provided for the GPC prevention pillars for both the 2015-2017 and 2018-2020 budget periods

Figure H.6: HIV prevention budget by GPC prevention pillar and budget periods

[40] These counties are not classified as High Impact Africa 2 but instead are classified under the Southern and Eastern Africa region

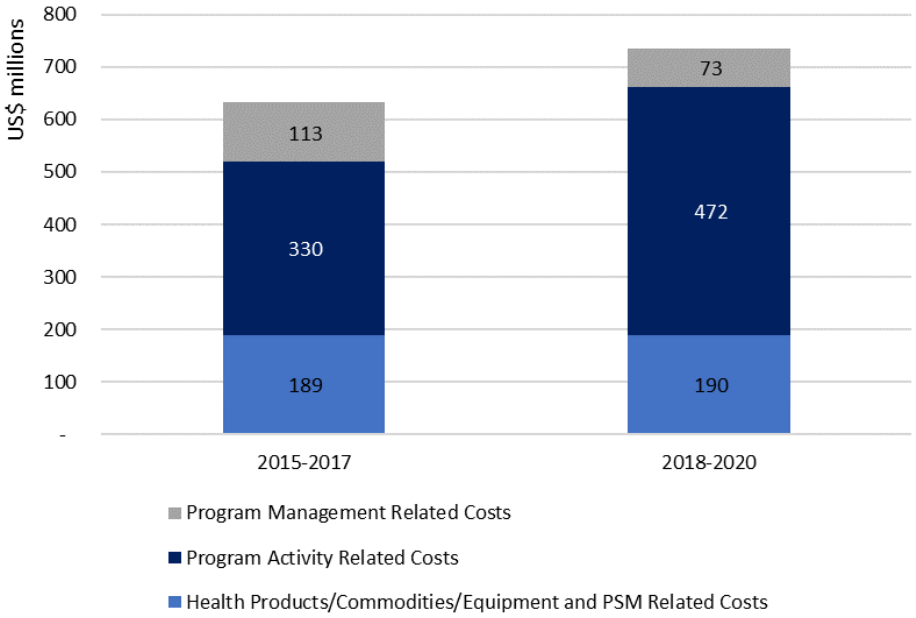


KPs received significantly more funding in both budget periods than any other GPC pillar. AGYW and Condoms were the second and third most funded pillars, however AGYW had a much more significant increase in funding between the two periods, increasing by over 100%. VMMC and PrEP receive the least funding of the five pillars, with PrEP only receiving funding in the second of the periods.

By cost category

Figure H.7 shows the amount of prevention funding provided to different cost categories for the 2015-2017 and 2018-2020 budget periods.

Figure H.7: HIV prevention budget by major cost category and budget periods

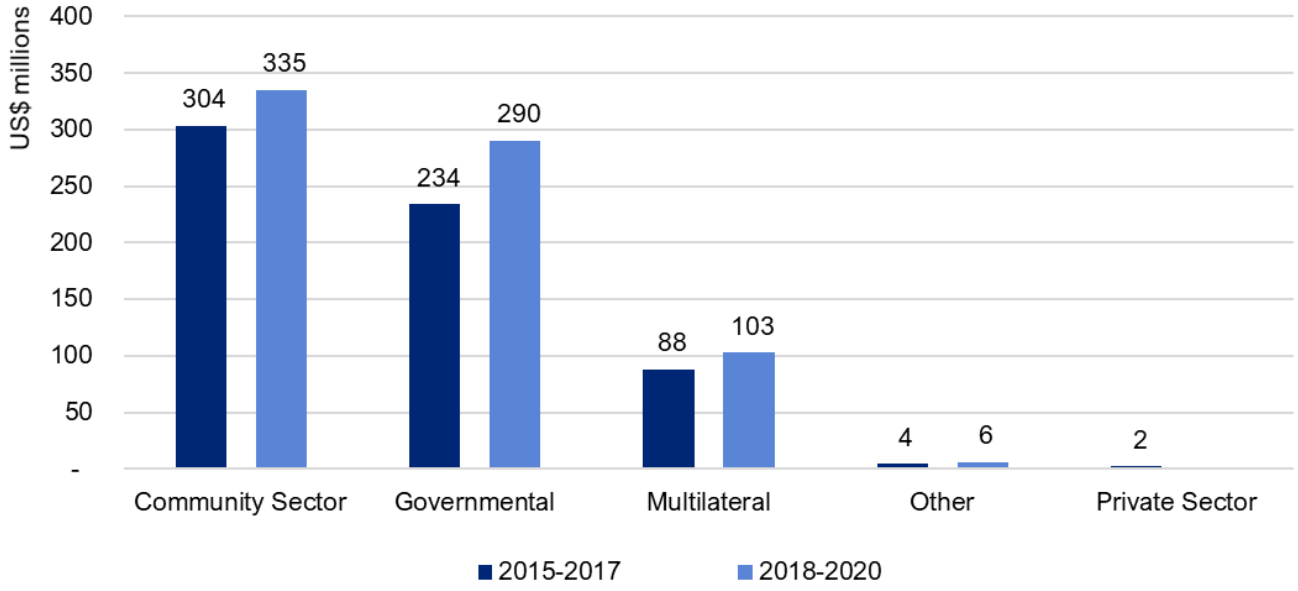


Program Activity Related Costs is the largest costs category in both periods, receiving over 50% in the first period and over 60% in the second period. It is also the only category to receive increased funding between the periods, increasing by 43% (US$ 142 million); the Health Products / Commodities / Equipment and PSM Related Costs category remained stable, and the smallest category, Program Management Related Costs, reduced by US$ 40 million (35%).

PR type

Figure H.8 below shows the HIV prevention budget for the different major cost categories for the 2015-2017 and 2018-2020 budget periods.

Figure H.8: HIV prevention budget by major cost category and budget periods



The community sector and governmental costs are the largest costs categories in both periods, with community sector costs totalling US$ 335 million for 2018-2020 and governmental costs totalling US$ 290 million for the same period. Multilateral costs were the third highest with c.US$ 100 million in both periods, whilst other costs and private sector costs were negligible. Community sector costs, governmental, and multilateral costs all increased between the two periods, with governmental costs increasing the most (US$ 56 million).

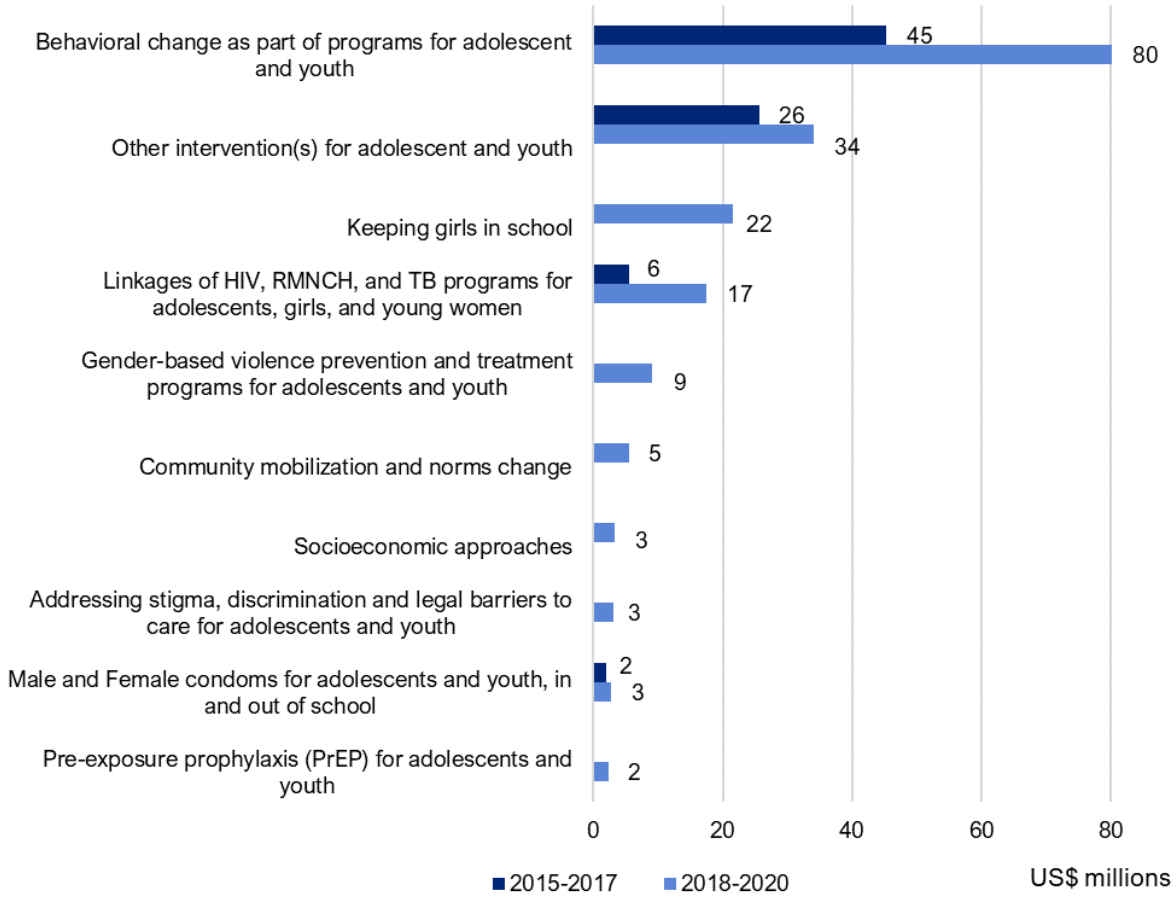
H.3. GPC Prevention Pillar Deep-dives

This section provides a deep-dive for each of the GPC prevention pillars.

AGYW

Figure H.9 below shows the funding for different interventions in the AGYW module for both the 2015-2017 and 2018-2020 budget periods.

Figure H.9: Funding for AGYW interventions by budget periods

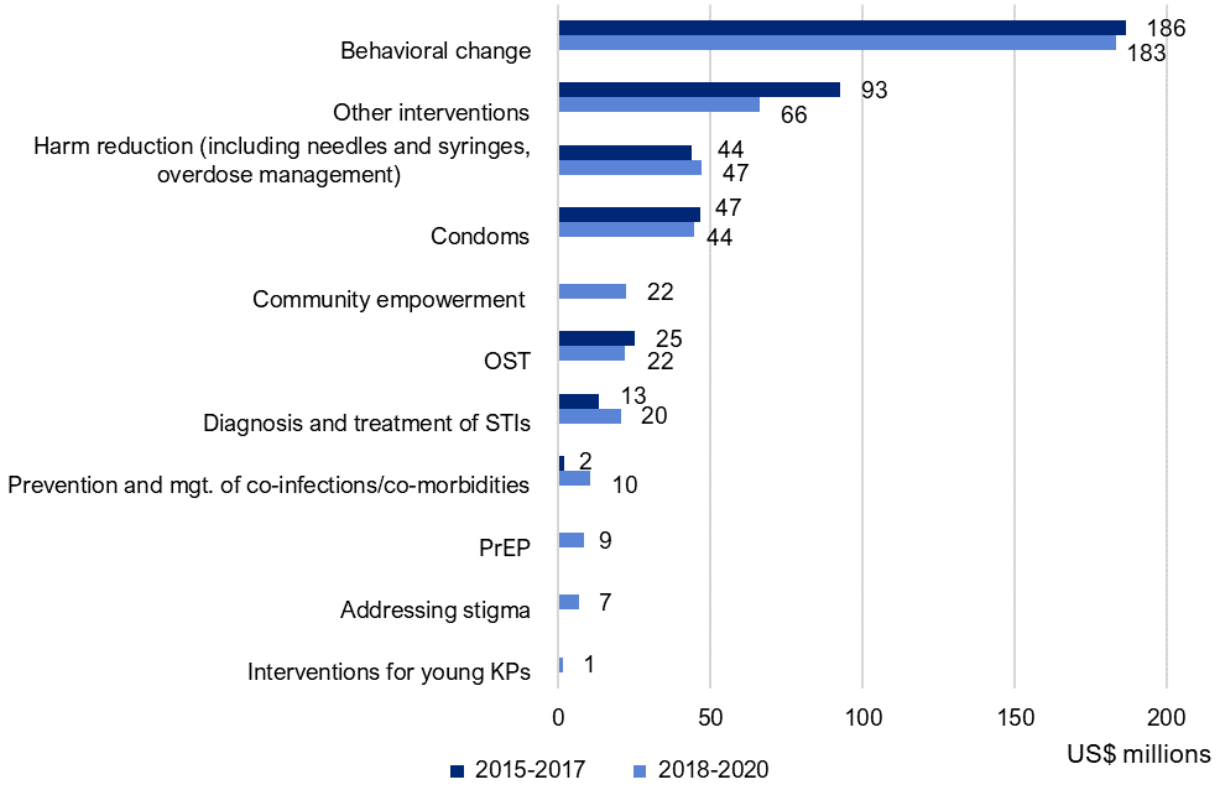


Behavioural change as part of programs for adolescents and youth receives the most funding in both budget periods, with over 57% of the overall budget in 2015-2017 and 45% in 2018-2020. A number of interventions received funding in the second period, having received no funding in the first, the largest of which were the keeping girls in school (US$ 22 million) and gender-based violence prevention treatment programs for adolescents and youth (US$ 9 million).

KPs

Figure H.10 below shows the split in funding between different KP interventions for both the 2015-2017 and 2018-2020 budget periods.

Figure H.10: Funding for KP interventions by budget periods

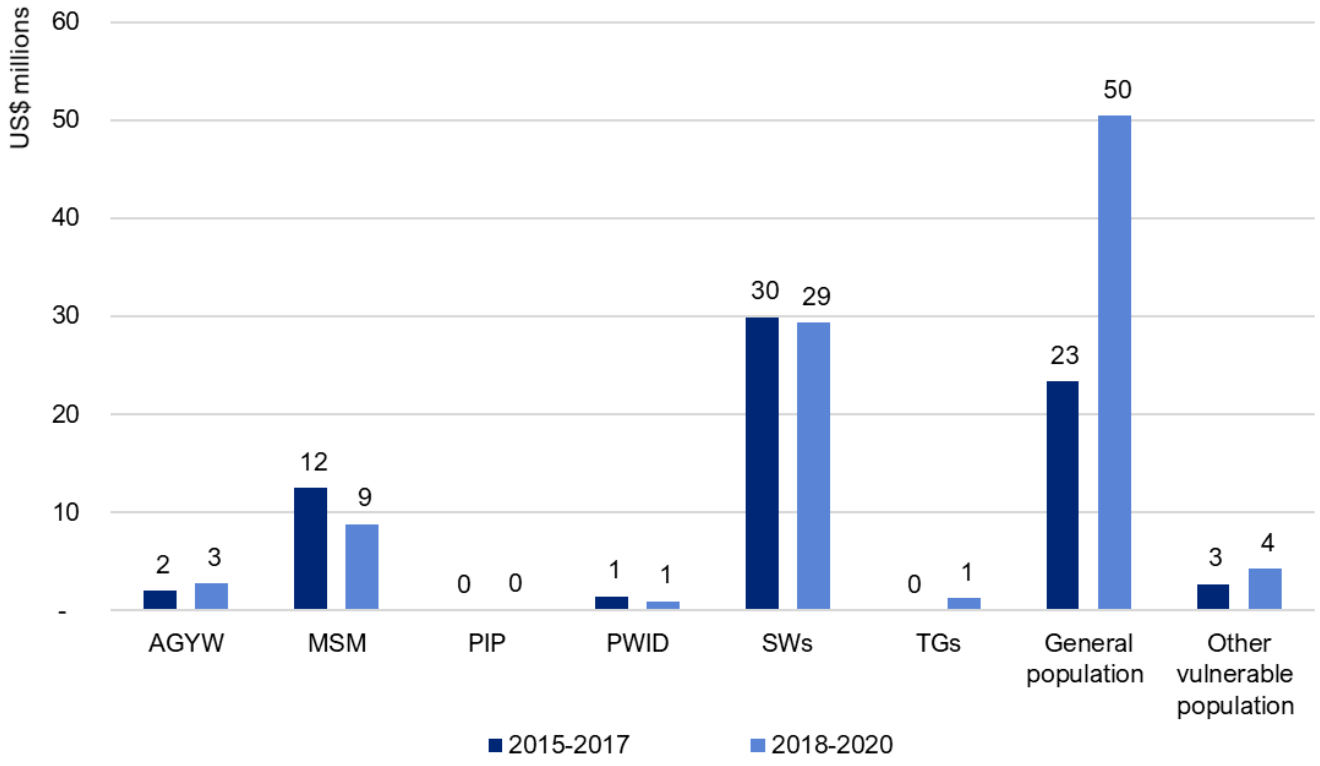


Behavioural change interventions receive the most funding in both periods, with over 40% of the overall budget; harm reduction (including needles and syringes, overdose management) and condoms also receive significant amounts. The distribution of funding between interventions is relatively stable between periods, however several interventions received funding for the first time: community empowerment (US$ 22 million); PrEP (US$ 9 million); addressing stigma (US$ 7 million); and interventions for young KPs (US$ 1 million). There remains a high proportion of interventions that have been coded under "other interventions", with this being the second biggest funding category.

Condoms

Figure H.11 below shows the distribution of funding for condoms between different target population groups for both the 2015-2017 and 2018-2020 budget periods.

Figure H.11: Funding for condoms by target population and budget periods

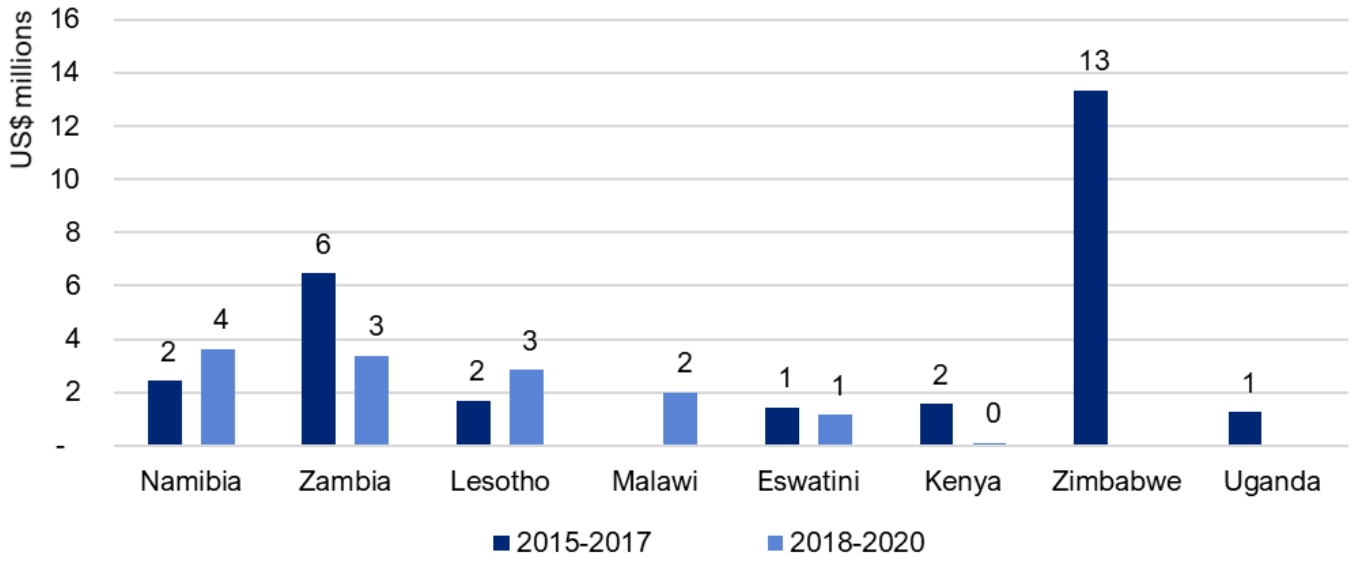


Three groups received the majority of funding for condoms in both budget periods: MSM, SWs and the general population. SWs received the most funding in the first of the funding period, with US$ 30 million, which remained stable for the second period. Funding for the general population more than doubled between the two periods, from US$ 23 million to US$ 50 million, which was over 50% of all funding for the second period. MSM received c. US$ 10 million for both periods.

VMMC

Figure H.12 below shows the distribution of funding for VMMC between different countries for both the 2015-2017 and 2018-2020 budget periods.

Figure H12: Funding for VMMC by countries and budget periods

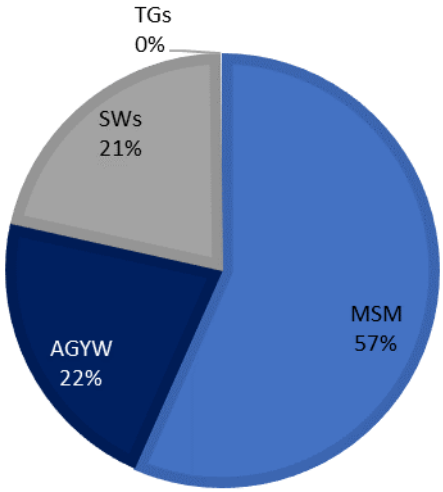


Overall, funding for VMMC declined significantly between the two periods, from US$27m to US$13m. The reduction is driven by a reduction of US$13m for Zimbabwe (100%) and US$3m for Zambia (50%). Increases in funding are observed in some countries, including Nambia's funding doubling to US$4m and Malawi receiving no funding in the first period, but US$ 2 million in the second period.

PrEP

Figure H.13 below shows the proportion of the funding for PrEP by the target populations for the 2018-2020 budget period.

Figure H.13: Funding for PrEP by target population and budget periods



PrEP funding was only provided in the second budget period (c. US$ 11 million). MSM received the most funding, with over 50%, while AGYW and SWs receiving around 20% each, and TGs received no funding.

Appendix I ABSORPTION RATE ANALYSIS

Appendix I provides an overview of the analysis of the absorption rate of HIV primary prevention which is based on the ratio of the amount actually spent (i.e. the expenditure on HIV primary prevention) and the amount initially budgeted. This section is building on and is aligned with the absorption analysis conducted by the Global Fund HIV Prevention Team.

The Appendix is structured as follows: (i) Section B.1. outlines the methodology and key limitations and (ii) Section B.2 provides the findings across the whole Global Fund Portfolio.

I.1. Methodology & Limitations

Methodology

This section is building on and is aligned with the absorption analysis conducted by the Global Fund HIV Prevention Team which was shared with CEPA in July 2020. The data is based on a Global Fund extract from June 2020. The approach follows the Global Fund HIV Prevention Team including:

- The in-country absorption indicator represents the ratio between the amount actually spent and the amount initially budgeted from the beginning of 2018 up until the end of 2019. The in-country absorption has been calculated as following: cumulative reported expenditure / cumulative reported budget.
- The analysis is conducted with a cumulative approach **for NFM2 only**. Date of extract is 15 June 2020, and only includes reports received up to this point with Global Fund validated expenditure.
- The same approach to HIV primary prevention as for the budget analysis is used (e.g. HIV testing interventions are not included in primary prevention; PMTCT is not included; and prevention pillars are not mutually exclusive).
- The focus of interpreting the absorption rate should be relative – e.g. through comparing the absorption rate of prevention funding to other HIV interventions / the overall portfolio.
- Analysis is based on all countries in the Global Fund portfolio and are complemented by country examples that provide another layer for comparison.

Limitations

A key limitation of the analysis is that the spending under the current grant has not been completed. Countries often trail their budget targets in the first two years and then "catch-up" in spending in the final year of the grant cycle. **As such it is important that the findings on the absorption rates are not considered in absolute terms – but that they are interpreted relative to the absorption rates of other Global Fund interventions.**

The same data quality issues as outlined under the budget analysis apply, such as misclassifications, and a few undefined interventions.

Sensitivity testing

One limitation of the analysis is that the absorption rate differences might be driven by general country-specific barriers for absorption rather than barriers specific to HIV prevention. This can have an impact on the results if case countries have disproportionally high prevention spending and very low absorption rates. This is the case for South Africa, which has very high prevention spending and very low absorption rates (around 22% for prevention and other Global Fund interventions). As result, the analyses were also conducted with an iteration excluding South Africa, to ensure that the results are not just driven by one single country. Where applicable, we have reported on the results without South Africa.

I.2. FINDINGS – WHOLE PORTFOLIO

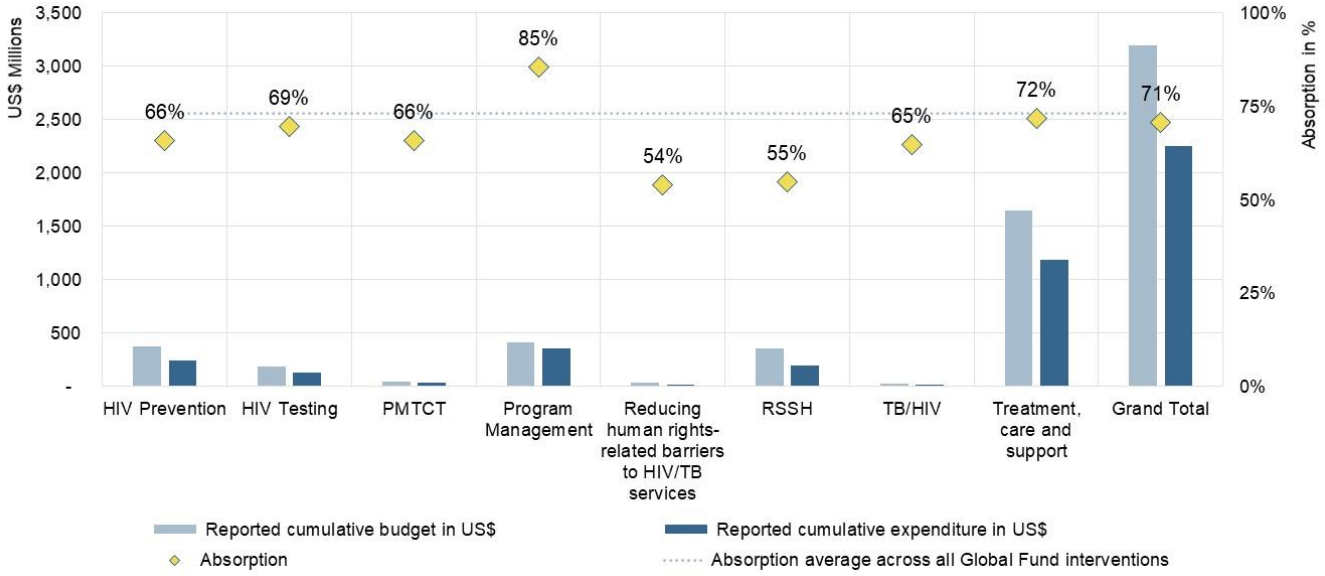
I.2.1. HIV Primary Prevention Absorption

Absorption by components and modules

The analysis shows that HIV primary prevention has an **absorption rate of 66%,** which is below both the average absorption rate across all HIV intervention (71%) and the average absorption rate across all Global Fund interventions (73%).

Figure I.1 below shows the absorption rate of HIV primary prevention compared to other HIV modules, showing the general absorption rate of 73% as a benchmark.

Figure I.1: Absorption rate of HIV Primary Prevention compared to other HIV modules



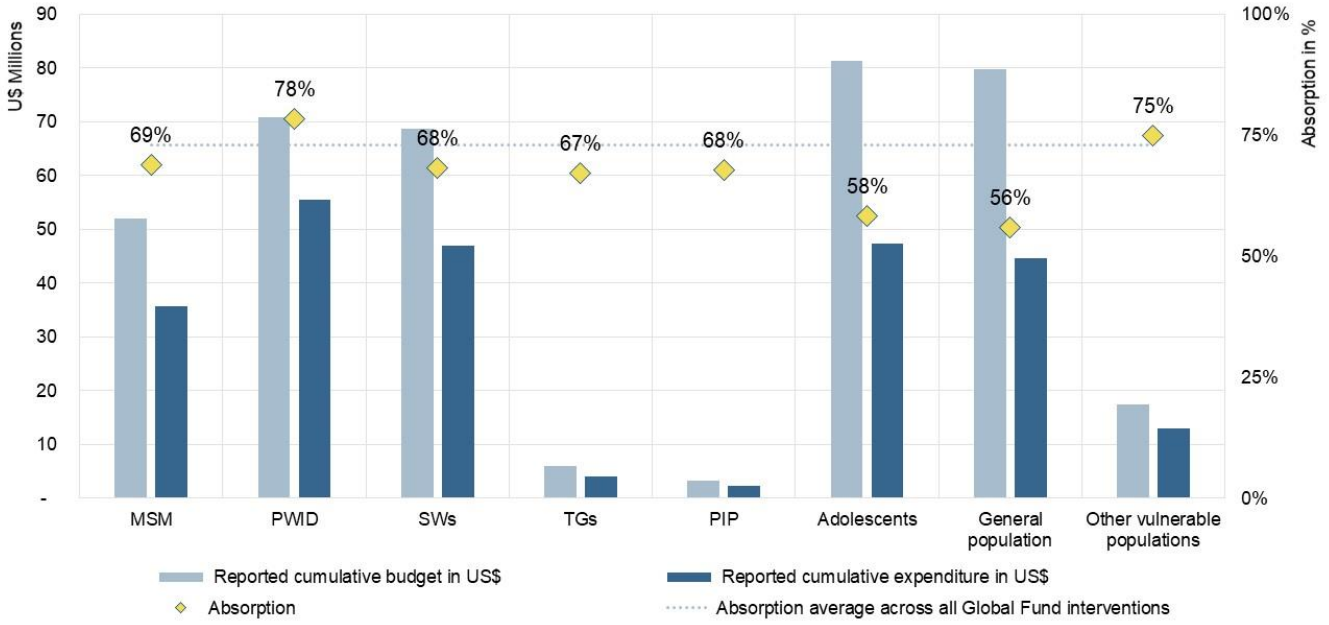
The analysis shows that the absorption for prevention is below absorption for treatment, care and support (72%), as well as absorption for testing (69%). The only modules with substantially lower absorption are: reducing human rights-related barriers (54%) and RSSH investment (55%).

When South Africa is excluded from the analysis, the absorption rate for HIV primary prevention increased to 68% (an increase of around 1.8 percentage points), whereas the overall absorption rate stays stable. This shows that both the lower absorption of prevention is a trend across the wider portfolio, and that the inclusion of South Africa makes this effect more pronounced (roughly being a driver for one third of the differences between HIV prevention absorption and absorption of all Global Fund interventions).

By target population

Figure I.2 below shows the HIV primary prevention absorption rates by target population.

Figure I.2: Absorption rate of HIV Primary Prevention by target population



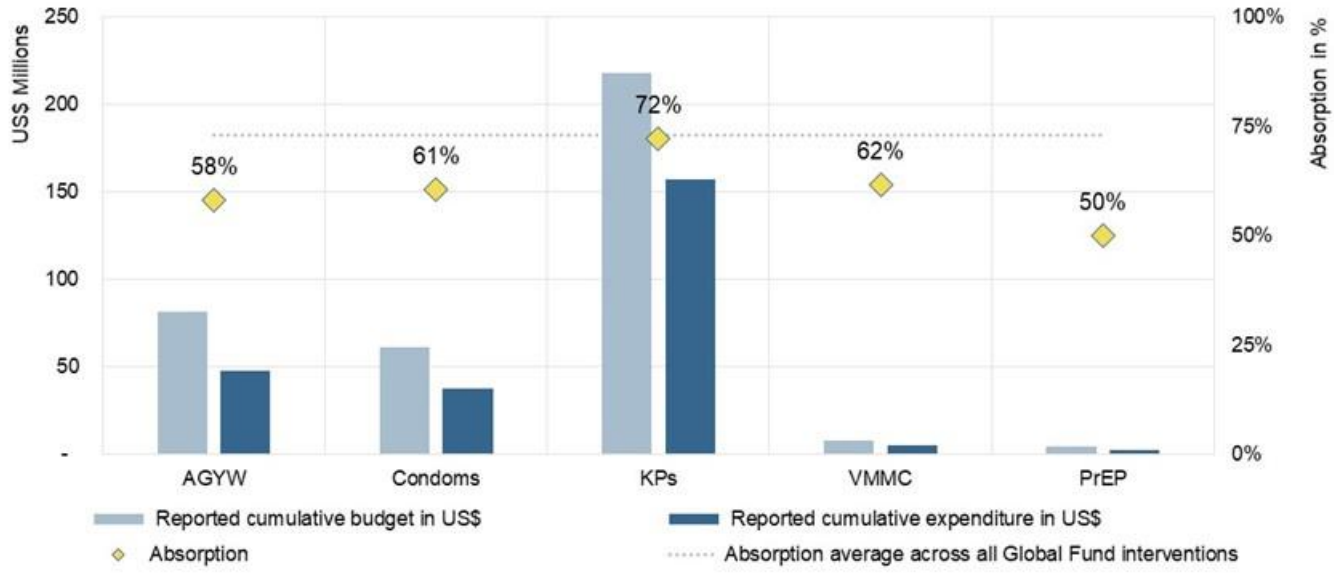
The analysis shows that PWID (78%) and other vulnerable population (75%) activities have a relatively high absorption rate whereas AGYW (58%) and general population (56%) activities have lower absorption rates. Other KP interventions are somewhere in the middle including MSM (69%), SWs (67%), TGs (67%) and PIPs (68%). This analysis suggests that countries do face higher barriers in terms of effectively spending on AGYW and general population interventions.

This trend is confirmed when South Africa is excluded, however, the AGYW absorption increases from 58% to 63%.

By prevention pillar

Figure I.3 below shows the HIV primary prevention absorption rates by prevention pillar.

Figure I.3: Absorption rate of HIV Primary Prevention by prevention pillar

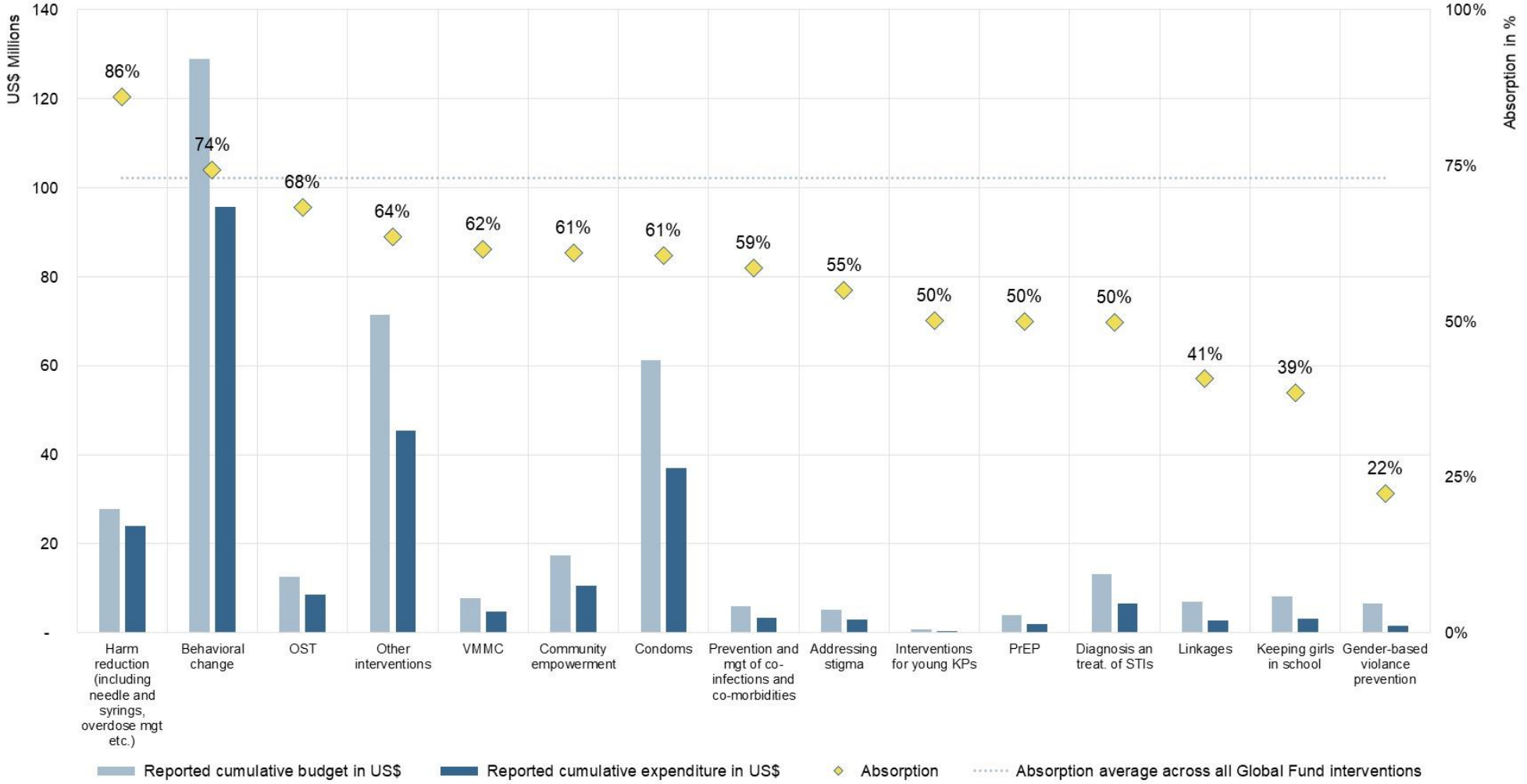


The analysis by prevention pillar shows that KPs interventions have the highest absorption rate, even above the average of all Global Fund interventions. In contrast, PrEP (50%) and AGYW (58%) are trailing, and condoms (61%) and VMMC (62%) are also well below the average.

By intervention

Figure I.4 below shows the HIV primary prevention absorption rates by intervention.

Figure I.4: Absorption rate of HIV Primary Prevention by intervention



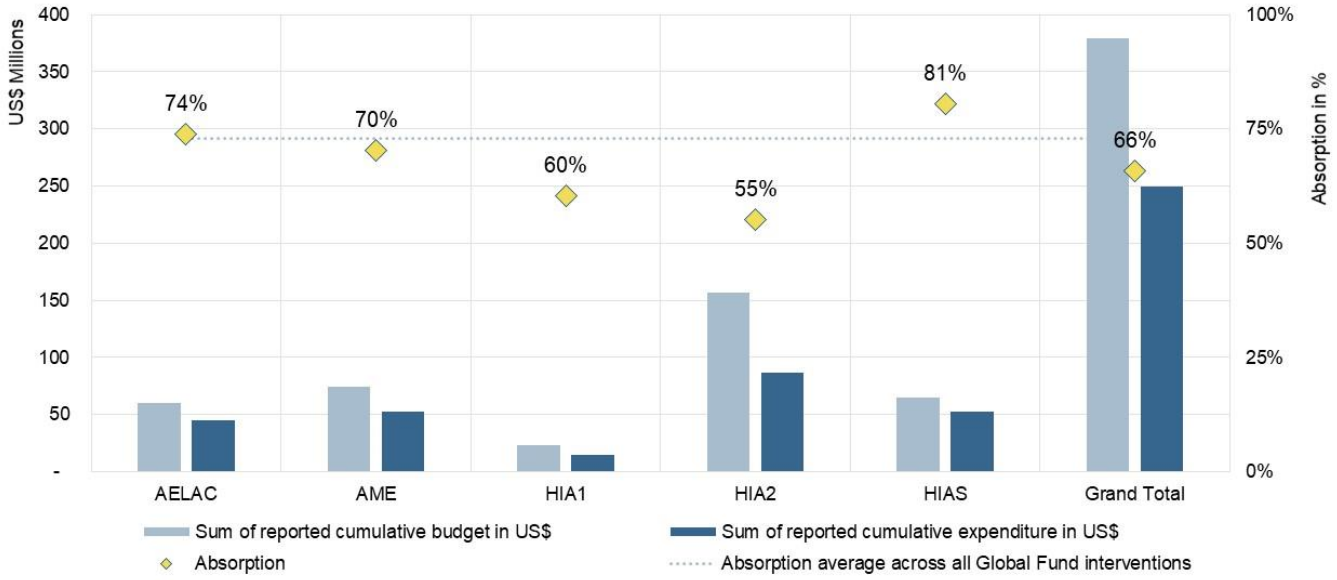
There is a wide difference in the absorption rate of HIV primary prevention interventions. At the upper-end there is harm reduction (86%), behavioral change (74%) and OST (68%), whilst keeping girls in school (39%) and gender-based violence prevention (22%) are at the low end. This is in line with the findings from the target population groups

that PWIDs intervention have higher absorption rate interventions whereas AGYW have lower. A potential reason for this might be the increase in commodity costing for harm reduction and OST compared with AGYW.

By region

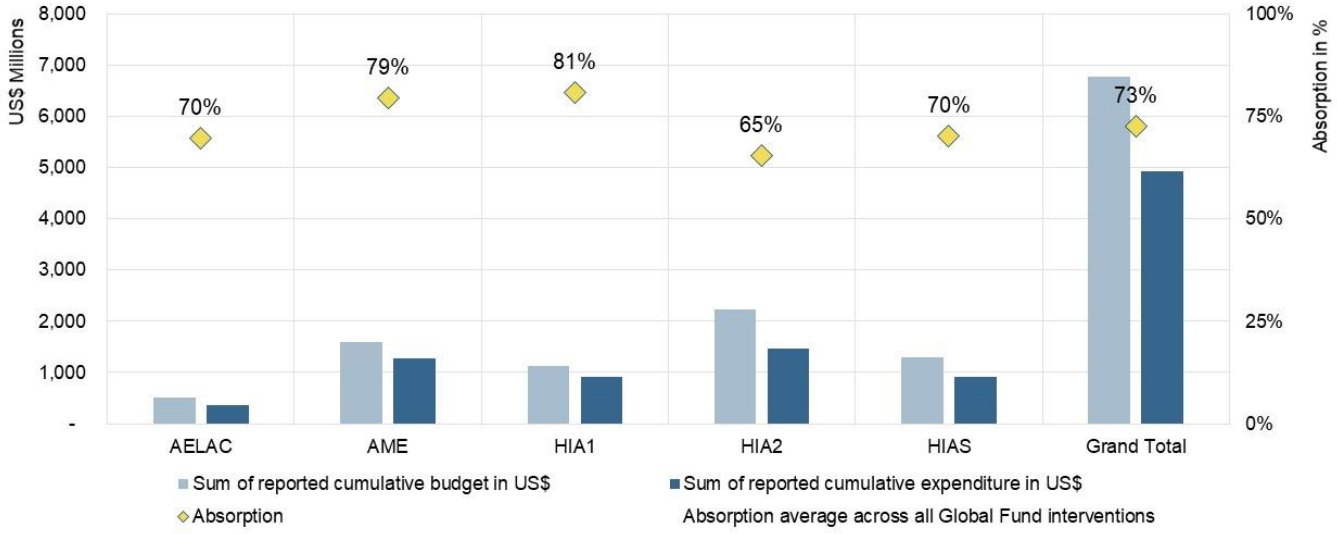
Figure I.5 below shows the HIV primary prevention absorption rates by region.

Figure I.5: Absorption rate of HIV Primary Prevention by region



The analysis shows that the lowest absorption rates for HIV primary prevention are in High Impact African countries – predominately in HIA2. In contrast, figures are higher in High Impact Asian countries. Figure I.6 below provides the same analysis for the absorption rates for all Global Fund investment.

Figure I.6: Absorption rate of all Global Fund investment by region



The comparison shows that HIV prevention absorption rates in HIAS and AELAC seem to be higher than the regional average of all Global Fund investment, whereas this is not the case for all of the other regions. Importantly, while the HIA2 region has a lower absorption rate across all Global Fund interventions, the absorption is still around 10% higher than for HIV primary prevention.

Appendix J WIDER FUNDING LANDSCAPE ANALYSIS

This Appendix provides additional analysis on the funding for HIV primary prevention at the international and domestic level. Section J.1 focuses on international donor funding and Section J.2 on domestic funding.

J.1. INTERNATIONAL DONOR FUNDING

The Global Fund funding trend is put into the context of the wider donor landscape for HIV prevention. The analysis used data from PEPFAR and IHME, with the findings from the latter dataset being presented directly in the main report. This section provides some additional findings on the methods and findings of the PEPFAR data.

Methodology

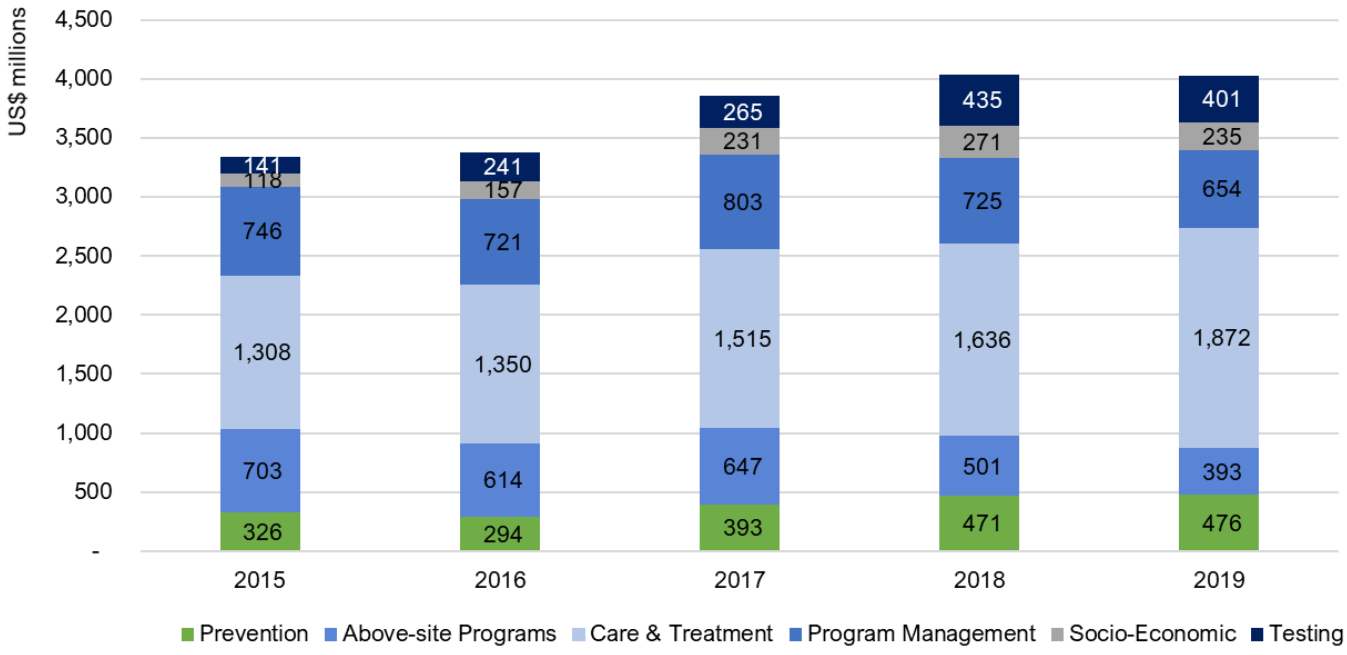
The analysis was conducted using annual PEPFAR expenditure data for the years 2015 to 2019, downloaded from the PEPFAR website in July 2020.[41] The expenditure data was considered to be the best dataset to capture what PEPFAR actually funded in a given year over the 2015 -2019 time period.

The expenditure data has been coded against PEPFAR's programme areas, which include: (i) Care & treatment, (ii) HIV testing services, (iii) Prevention, (iv) Socio-economic, (v) Above site programs, and (vi) Program management. HIV primary prevention was considered to be best represented by the prevention programme area. The socio-economic programme area includes "enabling factors" such as interventions aimed to reduce human-rights related barriers.

Findings

Figure J.1 below shows PEPFAR HIV funding by programme area.

Figure J.1: PEPAR HIV funding by programme area and year



PEPFAR funding for HIV prevention is around 12% of all HIV funding (US$ 476 million out of US$ 4.03 billion) in 2019, while treatment and care is 46% (US$ 1.87 billion out of US$ 4.03 billion). Similar to the Global Fund, PEPFAR has also increased the proportion of its HIV prevention spending moderately, from a previous level of 10% of all HIV spending in 2015, to ~12% in 2019 (an increase from US$ 326 million in 2015 to US$ 476 million in 2019).

[41] PEPFAR Financial Management Dashboard (2020). Accessed at: https://data.pepfar.gov/dashboards

Additionally, there has also been an increase in "Socio-economic" interventions from US$ 118 million to US$ 235 million, representing an increase in proportion of funding from 3.5% to 5.8%.

Table J.1 below shows the PEPFAR funding composition for HIV prevention between 2015 and 2019.

Table J.1: PEPFAR funding composition for HIV prevention between 2015 and 2019[42]

	2015	2016	2017	2018	2019
Comm. mobilization, behaviour & norms change				80,488,594	91,409,836
Condom & Lubricant Programming				17,434,489	23,606,600
Medication assisted treatment	5,264,965	4,237,012	3,784,409	4,913,969	4,299,770
Not Disaggregated				88,879,667	84,673,634
Not Specified	150,520,815	146,678,901	181,660,623		
PrEP				17,519,286	16,822,939
VMMC	169,953,814	142,999,312	207,485,682	262,027,087	254,705,486
Total	**325,739,594**	**293,915,225**	**392,930,714**	**471,263,092**	**475,518,265**

PEPFAR's HIV prevention funding is focused heavily on VMMC, with over 50% of funding going to VMMC programmes over the last 5 years. The Funding for VMMC increased from US$ 170 million in 2015 (52% of all HIV prevention funding) to US$ 476 million in 2019 (54%). In 2019, PrEP made up 6% of total PEPFAR HIV prevention spending. In contrast to the Global Fund, communication mobilisation, behaviour and norm change interventions only make up 20% of all funding in 2019.

J.2. DOMESTIC FUNDING

Methodology

As outlined in the main report, there is a lack of robust data on funding for HIV primary prevention, especially in terms of domestic funding. The work conducted by UNAIDS under the Global AIDS Monitoring is useful progress, however, at this stage, our review of the available data concluded that the data has too many gaps to allow for a meaningful analysis of trends to be conducted across countries and time. [43] We have been drawing on the UNAIDS data for specific country case studies were robust data has been available. One other source that presents estimates on the domestic funding for HIV prevention is the data reported by countries to the Global Fund as part of the grant making process.

The reported data from countries uses high-level programmatic areas to allocate HIV domestic, international and Global Fund funding. As such, the dataset does not directly correspond to the Global Fund modular framework. The available data has been coded into a single HIV prevention category when the funding description related to: (i) prevention; (ii) condoms; (iii) VMMC; (iv) human rights; (v) STIs or (vi) other targeted interventions at KPs. This high-level coding is less precise than the Global Fund specific funding analyses. Further limitation of the data includes:

- It is only available for 22 "high impact" countries[44] for which the Global Fund has cleaned the data and shared the dataset in October 2020;

[42] While there always had been a separate expenditure code for VMMC, prevention funding was only more fully disentangled from 2018 onwards.

[43] https://hivfinancial.unaids.org/hivfinancialdashboards.html#

[44] Bangladesh, Burkina Faso, Cambodia, Côte d'Ivoire, Ethiopia, Ghana, India, Indonesia, Kenya, Malawi, Mali, Mozambique, Myanmar, Pakistan, Philippines, South Africa, Tanzania (United Republic), Thailand, Uganda, Viet Nam, Zambia, Zimbabwe

- The data is an estimate of spending for the 2018-2020 period and, as such, is forward looking and does not represent final spending from countries.

Despite the shortcomings, the analysis still provides a coherent approach to comparing data over a large set of key countries, with regard to their external and domestic HIV spending.

Findings

The domestic and international donor funding analysis is provided in Table J.2 below:

Table J.2 Domestic and donor funding composition for HIV and HIV prevention for 2018-2020 of 22 high-impact countries in US$ millions

Country	Prevention funding				Other HIV funding				Proportion Prevention	Above 25%
	Domestic	Other donors	Global Fund	Total	Domestic	Other donors	Global Fund	Total		
Bangladesh	15	3	12	**30**	17	2	10	**29**	51.3%	1
Burkina Faso	13	0	8	**21**	45	3	35	**83**	20.1%	0
Cambodia	0	2	4	**6**	27	5	37	**69**	8.3%	0
Côte d'Ivoire	1	100	11	**112**	115	352	63	**530**	17.5%	0
Ethiopia	27	65	21	**113**	63	316	171	**550**	17.1%	0
Ghana	7	-	2	**9**	137	37	54	**229**	3.9%	0
India	291	26	-	**317**	1,006	-	141	**1,147**	21.7%	0
Indonesia	97	9	31	**138**	164	37	61	**262**	34.5%	1
Kenya	24	517	61	**601**	79	1,201	181	**1,461**	29.2%	1
Malawi	7	43	37	**88**	4	292	343	**639**	12.0%	0
Mali	5	20	4	**29**	11	2	47	**60**	32.4%	1
Mozambique	1	99	23	**123**	41	905	273	**1,218**	9.2%	0
Myanmar	3	14	29	**46**	37	20	101	**158**	22.7%	0
Pakistan	14	-	11	**25**	14	2	24	**40**	38.4%	1
Philippines	33	0	5	**38**	231	4	4	**239**	13.7%	0
South Africa	426	293	126	**846**	9,398	1,783	199	**11,379**	6.9%	0
Tanzania	55	318	47	**420**	118	803	328	**1,249**	25.2%	1
Thailand	73	13	12	**98**	710	32	9	**750**	11.5%	0
Uganda	7	188	46	**240**	177	953	212	**1,343**	15.2%	0
Viet Nam	38	-	16	**53**	125	7	44	**176**	23.3%	0
Zambia	-	73	27	**100**	179	482	158	**819**	10.9%	0
Zimbabwe	24	104	18	**146**	76	412	408	**897**	14.0%	0

Country	Prevention funding				Other HIV funding				Proportion Prevention	Above 25%
	Domestic	Other donors	Global Fund	Total	Domestic	Other donors	Global Fund	Total		
Total	**1,161**	**1,889**	**551**	**3,602**	**12,775**	**7,649**	**2,903**	**23,328**	**13.4%**	**6**

The data on the planned investments for the 2018-2020 period for 22 “High Impact countries” suggests that on average only around 13.4% of total HIV funding was for HIV prevention within the 2018-20 period. Of the 22 countries, only six countries had HIV prevention funding proportions above 25% (Bangladesh, Indonesia, Kenya, Mali, Pakistan and Tanzania). Moreover, the self-reported data of all 22 countries suggests a lower share of domestic funding for prevention activities (c.32%) compared to non-prevention activities (c.55%). Prevention funding in particular seems to be dependent on non-Global Fund donor funding, as it was the highest identified source of funding for prevention activities (53%), with Global Fund funding only making up 15% of all HIV prevention funding. This is contrasted with other HIV funding, where domestic funding (54.8%) leads, followed by other donor funding (32.8%), and Global Fund funding (12.4%).

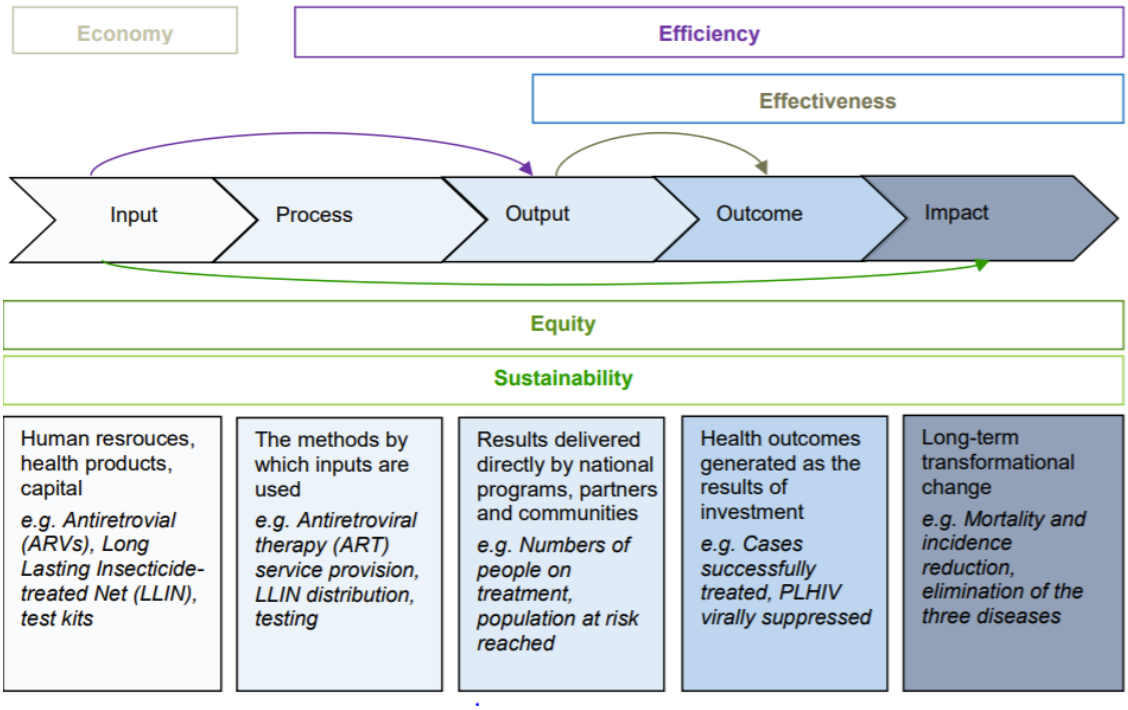
Appendix K VALUE FOR MONEY AND COST-EFFECTIVENESS REVIEW

This appendix firstly summarises how the Global Fund has considered VfM more generally (Section K.1). It then provides more detail regarding the key findings highlighted in the main review report with regards to VFM (Section K.2). Finally It also provides details of the rapid review carried out by our evaluation team into evidence on the cost-effectiveness of HIV prevention interventions (Section K.3).

K.1. SUMMARY OF GLOBAL FUND'S APPROACH TO VFM

The Global Fund defines VfM as "a concept to concept that defines how to maximize and sustain equitable and quality outputs, outcomes or impact for a given level of resources."[45] Figure K.1 below summarises how linkages are considered within the different components of VfM.

Figure K.1 Health production chain and VfM



Source: Global Fund

For HIV primary prevention:

- **Inputs** include the financial and human resources used to deliver prevention programmes. This includes Global Fund, domestic and external funding, human resources such as staff to deliver programmes (both in terms of HCWs as well as CSOs), as well as other resources such as commodities (e.g. condoms), as well as wider data and health information systems to monitor interventions.
- **Processes** refer to the specific interventions that are employed to deliver the inputs, which in the context of HIV prevention includes the different activities carried out in relation to primary prevention activities (e.g. behaviour change interventions, prevention workshops and condom distribution carried out by implementing partners).

[45] Global Fund (2019), Value for Money Technical Brief.

- **Outputs** refer to the direct results delivered from the HIV programmes, which may include coverage indicators in relation to the number of people reached, condoms distributed, people receiving PrEP, or male circumcisions performed.
- **Outcomes** are the changes in following the interventions, which in the context of HIV interventions largely refer to behavioural changes that result from HIV prevention activities, such as increase contraceptive usage, reduction in high risk behaviour or adherence to PrEP.
- **Impacts** refers to the long-term transformational changes brought about by the prevention interventions, which ultimately includes HIV incidence and, in turn, mortality and morbidity reduction.

In the context of the components mentioned, Global Fund programmes collect data and information primarily on costs, particularly the funding allocated to different prevention activities. In addition, output indicators in terms of coverage data for different interventions are regularly reported on in country programmes. However, as outlined in the 2019 PCE report, which specifically analysed VfM, there continues to be misalignment between Global Fund's financial and programmatic report tools, making it difficult to analyse VfM in this regard. The review also highlighted that Global Fund's systems do not capture data on budgets, expenditure of activities at the sub-national level, limiting the extent to which within-country VfM analysis can be conducted.[46]

In addition, data on outcomes is not collected systematically on Global Fund programmes, largely due to the difficulty and cost of obtaining data. While collecting this data on a regular and systematic basis as is currently done for output data would not be feasible, the absence of periodic monitoring of this information means that it is unclear in many programmes whether outputs are ultimately leading to intended outcomes being achieved. Countries often rely on this information as part of biomedical surveys, including DHS and other national surveys, which are not carried out on a regular basis, and in many cases it is not clear whether the Global Fund is collecting the relevant information that these surveys produce in a systematic manner.

In the context of Global Fund's monitoring, impact data such as HIV incidence informs its KPI1 indicator. But such data is modelled, as opposed to observed data, based on UNAIDS Spectrum/Goals models for Africa and Asian Epidemic Model (AEM) for Asia. While the lack of regular monitoring of actual incidence data is not a specific issue of the Global Fund, it highlights the challenges of monitoring the impact pathway for HIV prevention, and shows that in order to understand this better more resources are needed to enable accurate assessments of VfM to be carried out, both at the global and country level.

K.2. DETAIL REGARDING THE KEY FINDINGS REGARDING VFM

Global Fund has developed guidance on VFM, which although has been seen as useful, more guidance on VFM in specific HIV documentation (including the HIV Information Note) is thought to be beneficial for countries. In addition, countries have been unable to draw on a consolidated source of information provided by the Global Fund or partners to determine what are "best buys" for prevention interventions.

The latest Global Fund VFM guidance in November 2019 is intended to provide countries with guidance on how they should design their grants based on VFM considerations. The focus is particularly on economy, efficiency and equity (effectiveness and sustainability are considered in separate guidance notes), and provides information on what factors should be considered when developing funding requests in relation to these.

While Global Fund's VFM guidance provides details on the principles that should be considered for VFM, consolidated guidance on what interventions should be considered as most effective and cost-effective does not exist in the overarching VFM guidance (which is appropriate as its not specific to diseases) nor is it available in other Global Fund technical guidance. In addition, consolidated guidance on what specific interventions constitute "best buys" does not exist. A key reason for this might be that evidence related to the effectiveness and cost-effectiveness of interventions depends on different country contexts and can vary significantly (see below), but a consolidated, high-level summary of evidence related to different prevention interventions could be useful to countries looking to understand how

[46] Euro Health Group (2019), Global Fund Prospective Country Evaluation: 2019 Synthesis Report.

country HIV prevention grants could be designed with VFM in mind. One example of this has recently been developed by WHO for non-communicable diseases (NCDs), which could offer lessons for how to consolidate available evidence related to HIV prevention.[47]

Assessing and determining whether prevention interventions are achieving VFM remains a challenge, primarily due to the lack of suitable data.

The Global Fund defines VFM as "a concept that defines how to maximize and sustain equitable and quality outputs, outcomes or impact for a given level of resources."[48] Global Fund programmes collect data and information primarily on resources (or inputs), particularly the funding allocated to different prevention activities. In addition, output indicators in terms of coverage data for different interventions are regularly reported on in country programmes. However, as outlined in the 2019 PCE synthesis report, which specifically analysed VFM, there continues to be misalignment between Global Fund's financial and programmatic reporting tools, making it difficult to analyse VFM in this regard.[49] While there is extensive disaggregation of financial information, Global Fund results information continues to be relatively high-level, making it difficult to link inputs directly to outputs. The review also highlighted that Global Fund's systems do not capture data on budgets, expenditure of activities at the sub-national level, limiting the extent to which within-country VFM analysis can be conducted.[50]

In addition, data on outcomes has not been collected extensively on Global Fund programmes, largely due to the difficulty and cost of obtaining data. While collecting this data on a regular and systematic basis as is currently done for output data would not be feasible, the absence of periodic monitoring of this information means that it is unclear in many programmes whether outputs are ultimately leading to intended outcomes being achieved. Countries often rely on this information as part of biomedical surveys, including DHS and other national surveys, which are not carried out on a regular basis, and in many cases it is not clear whether the Global Fund's monitoring systems include the most up to date surveys in a number of countries.

In the context of Global Fund's monitoring, impact data such as HIV incidence informs its KPI1 indicator. But such data is modelled, as opposed to observed data, based on UNAIDS Spectrum/Goals models for Africa and Asian Epidemic Model (AEM) for Asia. While the lack of regular monitoring of actual incidence data is not a specific issue of the Global Fund as the Global Fund aims to support national responses and does not aim to establish its own parallel M&E system, it highlights the challenges of monitoring the impact pathway for HIV prevention, and shows that in order to understand this better more resources are needed to enable accurate assessments of VFM to be carried out, both at the global and country level.

While it is unclear the extent to which countries are using Global Fund guidance in the development of their grants, the extent to which VFM has been considered as part of country grant assessments has been mixed.

While the guidance is based on internationally recognised principles and methods for assessing VFM, and includes some useful links for countries on how VFM can be applied in specific country contexts (for example, providing links to country unit cost estimates for different interventions via the Unit Cost Study Repository), consultations and country case study analysis suggests that such guidance is not used extensively by country partners in the design of their HIV prevention grants. A number of global and country stakeholders noted the absence of more detailed, specific guidance related to VFM in key Global Fund documentation such as HIV Information Note, has made incorporating VFM considerations into HIV prevention grants a challenge. Overall, recent TRP reviews suggest that countries have not always prioritised VFM in their funding requests. For example, in the 2020 review of grants, the TRP noted that countries have often requested funding for technological advances when requests for basic services were missing, and recommended that countries prioritise getting the basics right before making requests for relatively costly items.[51]

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[47] WHO (2017). Tackling NCDs: 'best buys' and other recommended interventions for the prevention and control of noncommunicable diseases.

[48] Global Fund (2019), Value for Money Technical Brief

[49] The Global Fund (2019): 2019 Prospective Country Evaluation synthesis report

[50] Euro Health Group (2019), Global Fund Prospective Country Evaluation: 2019 Synthesis Report

[51] Global Fund (2020), Technical Review Panel Lessons Learned Window 2.

However we note that in some instances costly interventions such as PrEP, if well targeted, could be appropriate based on the cost per infection averted. In addition, recent reviews have found that sometimes VFM considerations can be overridden by other factors in Global Fund grants, specifically that when it comes to prioritising Global Fund resources for interventions, political decisions can take precedence over VFM considerations.[52]

That said, VFM considerations have been considered as part of some TRP reviews and assessments by the Secretariat of grants, which has ensured that VFM has been given more consideration. We reviewed TRP commentary on all the 25 GPC countries for NFM2: in some countries, investment funding shifted towards more relevant target populations, either KP or AGYW following TRP comments. Examples where funding shifted include Kenya (AGYW), Ethiopia (move from general prevention to SW) and Eswatini (towards new target populations, e.g. transport workers).

While it has been raised in recent PCE reports that Global Fund has generally made less progress on achieving equity in its investments, the focus on KVPs within Global Fund's prevention work suggests that this is an area where greater efforts are being made to ensure that access to prevention and other HIV counselling support is being increased for more marginalised populations, thus contributing to achieving equity in investments.

Based on a review of studies assessing the cost-effectiveness of prevention interventions, those that are suggested to be highly cost-effective include condom promotion and distribution as well as VMMC. On the other hand, PrEP is considered cost-effective only when provided for KVPs. Evidence on behavioural change interventions is far more limited, yet this has accounted for the largest proportion of Global Fund interventions across populations and as such this warrants further investigation.[53]

- The team has reviewed 38 documents assessing the cost-effectiveness of HIV prevention interventions. Details of this are provided in Appendix K. Overall, studies have found that condom promotion and distribution, when implemented effectively, is considered one of the most cost-effective interventions for HIV prevention, and in some cases can be cost-saving. VMMC has also been found to be highly-cost effective, as well as cost-saving in East and Southern Africa. PrEP interventions have generally been found to be less cost-effective than other interventions, largely because of the cost associated with it. That said, PrEP can be regarded as cost-effective if targeted at high-risk populations, such as KVPs. But in order to be cost-effective particularly high-risk individuals should be targeted, and patients will need to adhere to medication to ensure its effectiveness.

- As shown below, in terms of types of interventions, behaviour change interventions have been prioritised for KPs, accounting for nearly US$ 183 million of expenditure between 2018-2020 (40% of KP funding), with condom distribution only receiving US$ 44 million (10%). Despite these types of interventions being prioritised, the evidence on behaviour change interventions is generally far more limited. For example, a recent literature review analysing the cost-effectiveness of different HIV prevention interventions in Sub-Saharan Africa found that just one of the 60 studies analysed the cost-effectiveness of behaviour change interventions.[54] For the study that had been carried out, it found that in the context of Eastern and Southern African countries (Eswatini, Tanzania, Uganda and Zambia), reducing concurrency among high-risk individuals averts the most HIV infections when compared to increasing monogamy and general partnership reduction.[55] The study also estimated that, based on its modelled assumptions, a campaign that costs US$ 1 per person annually is likely cost-saving, and reduces concurrency by 9% on average. Outside of Sub-Saharan Africa, some studies focusing on KVPs have found that behavioural change interventions can be highly cost-effective when implemented as part of a comprehensive package of prevention activities,

[52] Euro Health Group (2020), The Global Fund Strategic Review 2020: Final Report Vol I.

[53] Social, behavioural Communication Change (SBCC) component of Global Fund grants includes a large variety of activities (e.g. peer support, outreach workers, social mobilisation, community outreach) and as such these need to be considered on an individual basis to fully determine VFM.

[54] Sarkar et. al. (2019), Cost-effectiveness of HIV Prevention Interventions in Sub-Saharan Africa: A Systematic Review.

[55] Enns et al. (2011), Assessing Effectiveness and Cost-Effectiveness for Concurrency Reduction for HIV Prevention.

including condom promotion, peer outreach, education and treatment for other STIs.[56] This is also supported by a handful of studies that have looked at behaviour change interventions as part of a comprehensive package of interventions to reduce HIV incidence in AGYW, as discussed below.

The above evidence suggests that there is a large gap in the evidence on the cost-effectiveness of social and behaviour change interventions (alongside significant measurement challenges with this), yet despite this SBCC interventions have accounted for a significant proportion of Global Fund-supported HIV prevention interventions. However, we note that the SBCC component of Global Fund grants includes a large variety of activities, not just behaviour change interventions and as such these need to be considered on an individual basis. In order to fully determine that interventions/ intervention mix are cost-effective and in what context, more detailed research is needed going forward.

AGYW interventions have also been prioritised in recent years, but qualitative evidence suggests countries are not clear on what constitutes VFM interventions for AGYW, and instead have relied on precedent from other programmes when choosing interventions. That said, evidence reviewed on the effectiveness and cost-effectiveness of some AGYW interventions suggests that interventions can be cost-effective, although more evidence from country settings is needed going forward.

Global Fund's investments in HIV prevention for AGYW have increased in recent years. For example, investments in AGYW accounted for US$ 179 million in prevention expenditure for 2018-20 across Global Fund countries, the second highest when measuring expenditure by GPC prevention pillars after KVPs. Similar to KVPs, most funding has been provided to support behaviour change interventions, as highlighted in Figure 3.6. These investments aim to contribute to the Global Fund's KPI 8 objective of reducing incidence in HIV in AGYW populations across 13 priority countries[57] by 55% between 2017 and 2022.

However, while investments for AGYW have been welcomed, there is an ongoing debate on investment choices given (i) effectiveness considerations are contested and (ii) some interventions may be effective in terms of aspects which are more distally related to HIV (e.g. keeping girls in school) while others are more closely linked to reducing HIV transmission. This ongoing debate raises concerns regarding whether interventions for AGYW are really delivering VFM from an HIV perspective.

In the context of Global Fund's investment, many countries interventions' were informed by the intervention approach of PEPFAR's DREAMS programme. Based on a recent evaluation of four settings where DREAMS has been implemented since 2016:[58]

- The programme has been able to **reach a large number of AGYW beneficiaries**, and uptake of services has improved over time.
- In terms of **outcomes,** the evaluation found that across all settings knowledge of HIV status and social support provided, while in some settings there was also evidence the programme had contributed to improvements in self-efficacy, greater use of condoms, reduced pregnancy, reductions in sexual partners, higher school attendance and a reduction in unmet need for contraception (though the achievement of these outcomes varied between sites).

[56] For example, a detailed study of the Avahan programme in India showed that a comprehensive prevention package for FSW, which included condom distribution, peer outreach, education and treatment of STIs had a mean incremental cost effectiveness ratio (ICER) of US$ 46/ disability-adjusted life year (DALY) averted and an incremental cost of US$ 785/HIV infection averted when assessed across 22 districts, suggesting that comprehensive prevention packages for these populations can be highly cost-effective interventions. See Vassall et al. (2014), Cost-effectiveness of HIV prevention for high-risk groups at scale: an economic evaluation of the Avahan programme in south India, for further details.

[57] Botswana, Cameroon, Eswatini, Kenya, Lesotho, Malawi, Mozambique, Namibia, South Africa, Tanzania, Uganda, Zambia and Zimbabwe.

[58] LSHTM (2020), What is the evidence of DREAMS' impact? Findings from an independent evaluation of DREAMS in 4 diverse settings.

- The evaluation found no evidence of impact on emotional or sexual violence, HSV-2 incidence or sexual reproductive health or violence outcomes in one district.
- While incidence in these areas declined over the implementation period, this trend started before DREAMS was implemented, and **the evaluators found no evidence that the rate of incidence declines changed as a result of the programme.** That said, in some settings there was some initial signs that the programme could be impacting incidence but more longer-term data was needed to improve the power of these findings.

While many consultees noted that the DREAMS programme is an experimental and relatively high-cost intervention, the evaluation did not specifically analyse whether it has delivered VFM, and as such it is not clear at this stage whether this has been achieved.

In addition to this, our rapid review of studies analysing the cost-effectiveness of interventions aimed specifically at women included the following findings:

- One review of 36 publications analysing the effectiveness and cost-effectiveness of various HIV interventions for women suggested the median incremental cost effectiveness ratios (ICERs) for different interventions were as follows: couple counselling for the prevention of vertical transmission (US$ 17 per disability-adjusted life year (DALY) averted); expanded female condom distribution (US$ 24-1,499 per DALY averted); and post-exposure prophylaxis (PEP) for rape survivors (US$ 2,120-2,729 per DALY averted).[59] **All of the above interventions were determined to be cost-effective by the review,** suggesting that interventions deemed less cost-effective would require greater consideration of their budget implications when determining whether to include them in prevention programmes.
- **The above review also determined that cash transfers** for schoolgirls and school support for orphan girls may also be cost-effective in generalized epidemic settings (US$ 212-912 per DALY averted).[60] The effect of cash transfers for schooling is also supported by a study in Botswana, which found that each additional year of secondary schooling led to an absolute reduction in the cumulative risk of HIV infection of 8.1 percentage points for all genders, and 11.6 percentage points among women.[61] Based on our funding analysis of AGYW interventions, nearly US$ 29million, or 13% of the total AGYW prevention budget for NFM2, was allocated to keeping girls within school, with most countries implementing this support having generalised epidemics, suggesting that some countries are adopting interventions that based on this evidence are cost-effective.
- Studies analysing the **cost-effectiveness of PrEP for AGYW** have concluded that in some circumstances, PrEP can be cost-effective should the cost of products such as microbicides be lower than US$ 1 (in the context of South Africa), and in some scenarios cost-savings. Based on an analysis of funding data, US$ 4.7million or just 2% of AGYW prevention funding was allocated to PrEP, suggesting it has been relatively limited in Global Fund countries, possibly due to the prohibitive cost of PrEP limiting more widespread use.

While these above studies suggest that these interventions can be cost-effective, many of them rely on modelling assumptions, which assume that implementation of programmes is happening effectively. As is the case with behaviour change interventions in general, real-world evidence on the extent AGYW programmes can be cost-effective are limited, and more detailed evidence is needed to support countries making more nuanced, informed decisions going forward.

Finally, we note that more recently, **there has been an increasing consideration of incidence levels by location** as geographical prioritisation affects cost-effectiveness given that the greater the transmission is in a location, the

[59] Remme et al. (2014), The cost and cost-effectiveness of gender-responsive interventions for HIV: a systematic review

[60] Ibid.

[61] De Neve et al. (2015), Length of secondary schooling and risk of HIV infection in Botswana: evidence from a natural experiment.

more likely the intervention will have an effect. This principle is core to the UNAIDS AGYW prioritisation tool, a new tool which has provided guidance in this regard.[62]

K.3. EVIDENCE FROM A RAPID REVIEW OF HIV PREVENTION INTERVENTIONS

Table K.1 below summarises the findings from 38 reports reviewed as part of a rapid review of assessing the cost-effectiveness of HIV prevention interventions.[63] Based on this review we found that the majority of studies have utilised assumptions-based models when considering cost-effectiveness of prevention interventions. Many of these interventions have also analysed biomedical interventions related to preventions, such as PrEP. On the other hand, we identified eight that had analysed behavioural change interventions, suggesting that research into the effectiveness of such interventions is relatively limited.[64] Eight of the studies reviewed discussed the cost-effectiveness of condom programming, some of which include literature reviews of multiple reports. Considering the five GPC prevention, the findings from these key studies can be summarised as follows:

- For **condom promotion**, a range of studies demonstrated that condom promotion and use are among the most cost-effective of HIV prevention interventions, and in many cases are cost-saving. For example, a systematic review of HIV interventions identified from studies in Vietnam that condom promotion in high risk populations had costs per DALY averted between US$103 and US$302, well within accepted criteria to determine interventions as cost-effective.[65] The same study highlighted that in Nigeria condom promotion was highlighted as the most effective prevention strategy for serodiscordant couples, while it also highlighted that a study examining the benefits of woman's condom promotion in sub-Saharan Africa found costs ranging from US$107 – US$303 per DALY averted.[66]

- A recent review of 60 HIV prevention studies across Sub-Saharan Africa found just **one study that specifically looked at behaviour change**, highlighting that studies assessing these types of interventions have been limited.[67] For the study that had been carried out, it found that in the context of Eastern and Southern African countries (eSwatini, Tanzania, Uganda and Zambia), reducing concurrency among high-risk individuals averts the most HIV infections when compared to increasing monogamy and general partnership reduction.[68] The study also estimated that, based on its modelled assumptions**, a campaign that costs US$1 per person annually is likely cost-saving, and reduces concurrency by 9% on average.**

- In South Africa**,** a recent study looked at how cost effectiveness estimates of different interventions changed when considering these in combination with other interventions. For example, based on modelled assessments, while **condom programming and VMMC were seen as cost saving when considered on its own and in combination with other interventions as part of an optimised prevention packages, the cost effectiveness (measured by cost per life year saved) reduced for behavioural change campaigns**

[62] UNAIDS (2020), Decision-making Aide for Investments into HIV Prevention Programmes among Adolescent Girls and Young Women. Version for use in 2020 planning processes March 2020

[63] Please note that this has been a rapid literature review, as opposed to a comprehensive academic review of research into HIV prevention interventions. Given its nature, some studies may not have been included in the review undertaken by the evaluation team.

[64] Please note that this has been a rapid literature review, as opposed to a comprehensive academic review of research into HIV prevention interventions. Given its nature, some studies may not have been included in the review undertaken by the evaluation team.

[65] Jacobsen et al. (2016), Modeling the Cost-Effectiveness in HIV Prevention.

[66] Ibid.

[67] Sarkar et. al. (2019), Cost-effectiveness of HIV Prevention Interventions in Sub-Saharan Africa: A Systematic Review.

[68] Enns et al. (2011), Assessing Effectiveness and Cost-Effectiveness for Concurrency Reduction for HIV Prevention.

promoting testing and avoiding multiple sexual partners significantly, although it was still determined to be cost-effective.[69]

- **In the context of FSWs,** a systematic global review of gender-related HIV prevention interventions found that female condom promotion for sex workers and gender empowerment activities were found to be cost-effective interventions across a number of studies.[70] A detailed study of the Avahan programme in India showed that a comprehensive prevention package for FSW, which included condom distribution, peer outreach, education and treatment of sexually-transmitted infections (STIs) had a mean incremental cost effectiveness ratio (ICER) of US$46/DALY averted and an incremental cost of US$785/HIV infection averted when assessed across 22 districts, suggesting that comprehensive prevention packages for these populations can be highly cost-effective interventions.[71]

- Studies into **VMMC have found that interventions tended to be cost-effective or even cost-saving**, suggesting that, at least in countries with generalised epidemics, VMMC should be included as part of overall prevention strategies. In addition to the evidence of VMMC being cost-saving mentioned above, early reviews of the cost-effectiveness of these programmes have found these interventions to be consistently cost-effective, while a recent review in Sub-Saharan Africa found VMMC to be comparably cost-effective compared to other interventions such as structural interventions and PrEP.[7273]

- **With regards to PrEP,** most studies have found that because of the cost of medicines, such an approach is not always cost-effective when compared to other interventions. However, in most studies targeted PrEP at high-risk populations was believed to be cost-effective. For example, many studies concluded that should PrEP be **targeted at sexually active MSM, such programmes would be cost-effective in these settings**. Some studies such as the Mitchell's et al. analysis of sero-discordant couples in Nigeria, as mentioned previously, found PrEP to be far less cost-effective when compared to condom promotion and treatment-as-prevention, but when impact is measured in terms of infections averted, PrEP with condom promotion prevented double the number of infections as condom promotion alone, though the study This suggests that when PrEP is deemed cost-effective, it should be included as part of wider prevention packages to reduce HIV incidence.

Further details regarding the studies reviewed are provided in Table K.1 below.

[69] Chiu et al. (2017), Designing an optimal HIV programme for South Africa: Does the optimal package change when diminishing returns are considered?

[7070] Remme et al. (2014), The cost and cost-effectiveness of gender-responsive interventions for HIV: a systematic review.

[71] Vassall et al. (2014), Cost-effectiveness of HIV prevention for high-risk groups at scale: an economic evaluation of the Avahan programme in south India.

[72] Uthman et al. (2010), Economic Evaluations of Adult Male Circumcision for Prevention of Heterosexual Acquisition of HIV in Men in Sub-Saharan Africa: A Systematic Review.

[73] Sarkar et al. (2019), Cost-effectiveness of HIV Prevention Interventions in Sub-Saharan Africa: A Systematic Review.

Table K.1 Summary of HIV prevention cost-effectiveness studies reviewed

No.	Author	Title	Year	Abstract	Geography	Prevention activity
1	Chiu et al.	Designing an optimal HIV programme for South Africa: Does the optimal package change when diminishing returns are considered?	2017	Chiu et al. analysed the incremental cost effectiveness ratio (ICER) of 16 HIV interventions based on a well-calibrated epidemiological model that accounted for interaction and non-linear scale-up effects, a custom cost model, and an optimisation routine that iteratively added the most cost-effective intervention onto a rolling baseline before evaluating all remaining options. The rank order of interventions did not differ substantially between the two methods- in each, increasing condom availability and male medical circumcision were found to be most cost-effective, followed by anti-retroviral therapy at current guidelines. However, interventions were less cost-effective throughout when evaluated under the optimisation method, indicating substantial diminishing marginal returns, with ICERs being on average 437% higher under our optimisation routine..	South Africa	VMMC; Condom distribution and promotion; Behavioural change; PrEP; AGYW
2	Tran et al.	The cost-effectiveness and budget impact of Vietnam's methadone maintenance treatment programme in HIV prevention and treatment among injection drug users	2012	Tran et al. analysed the cost-effectiveness and budget impact of the methadone maintenance treatment (MMT) programme in HIV prevention and treatment among injection drug users (DUs) in Vietnam. The incremental cost-effectiveness ratio (ICER) of MMT in HIV prevention was US$3,324 per one averted HIV case. The decision model showed that the cost-effectiveness ratio of MMT and non-MMT strategies was US$480 and US$204 per 1 quality-adjusted life year (QALY), equivalent to 0.43 and 0.18 times the gross domestic product per capita (GDPpc). The ICER for MMT versus non-MMT strategy was US$1964, approximately 1.76 times the GDPpc/QALY, classifying MMT as a cost-effective intervention. At the willingness to pay threshold of three times the GDPpc, the probability of MMT and non-MMT strategies being cost-effective was 80.3 and 19.7%, respectively. The budget impact of scaling up MMT from 2011 to 2015 will be US$97 million for 65% coverage or US$49 million for treating 80,000 DUs. The results indicated that MMT was cost-effective in HIV prevention and treatment among DUs who were opioid dependent.	Vietnam	KVP - PWID
3	Vassall et al.	Cost-effectiveness of HIV prevention for high-risk groups at scale: an economic evaluation of the Avahan programme in south India	2014	Avahan is a large-scale, HIV preventive intervention, targeting high-risk populations in south India. Vassall et al. assessed the cost-effectiveness of Avahan to inform global and national funding institutions who are considering investing in worldwide HIV prevention in concentrated epidemics. Avahan reached roughly 150 000 high-risk individuals between 2004 and 2008 in the 22 districts studied, at a mean cost per person reached of US$327 during the 4 years. This reach resulted in an estimated 61 000 HIV infections.	India	Combination programme, including KVPs, condom promotion and distribution and behavioural change.

4	Vassall et al.	Community Mobilisation and Empowerment Interventions as Part of HIV Prevention for Female Sex Workers in Southern India: A Cost-Effectiveness Analysis	2014	An ingredients approach was used to estimate economic costs in US$ 2011 from an HIV programme perspective of CM and empowerment interventions over a seven year period (2004–2011). Incremental impact, in terms of HIV infections averted, was estimated using a two-stage process. The incremental costs of CM and empowerment were US$307,711 in Belgaum and US$592,903 in Bellary over seven years (2004–2011). Over a 7-year period (2004–2011) the mean (standard deviation, sd.) number of HIV infections averted through CM and empowerment is estimated to be 1257 (308) in Belgaum and 2775 (1260) in Bellary. This translates in a mean (sd.) incremental cost per disability adjusted life year (DALY) averted of US$14.12 (3.68) in Belgaum and US$13.48 (6.80) for Bellary - well below the World Health Organisation recommended willingness to pay threshold for India. When savings from ART are taken into account, investments in CM and empowerment are cost saving. The findings suggest that CM and empowerment is, at worst, highly cost-effective and, at best, a cost-saving investment from an HIV programme perspective. CM and empowerment interventions should therefore be considered as core components of HIV prevention programmes for FSWs.	India - Belgaum	KVP - FSW. Behavioural change.
5	Kessler et al.	Evaluating the impact of prioritization of antiretroviral pre-exposure prophylaxis in New York	2014	Using a model accounting for both sexual and parenteral transmission of HIV Kessler et al. compare different prioritization strategies (PPS) for PrEP to two scenarios—no PrEP and PrEP for all susceptible at-risk individuals. The PPS included PrEP for all MSM, only high-risk MSM, high-risk heterosexuals, and injection drug users, and all combinations of these four strategies. Initial assumptions regarding PrEP included a 44% reduction in HIV transmission, 50% uptake in the prioritized population and an annual cost per person of $9,762. Prioritization to all MSM results in a 19% reduction in new HIV infections. Compared to PrEP for all persons at-risk this PPS retains 79% of the preventative effect at 15% of the total cost. PrEP prioritized to only high-risk MSM results in a reduction in new HIV infections of 15%. This PPS retains 60% of the preventative effect at 6% of the total cost. There are diminishing returns when PrEP utilization is expanded beyond this group. PrEP implementation is relatively cost-inefficient under our initial assumptions. Our results suggest that PrEP should first be promoted among MSM who are at particularly high-risk of HIV acquisition. Further expansion beyond this group may be cost-effective, but is unlikely to be cost-saving.	US	KVP - MSM & PWID; PrEP; condom distribution and promotion
6	Chen et al.	Clinical Effectiveness and Cost-Effectiveness of HIV Pre-Exposure Prophylaxis in Men Who	2014	Chen et al. introduce a practical model of HIV acquisition, including both a personalized risk calculator for clinical management and a cost-effectiveness calculator for population-level decisions. With standard PrEP adherence and national epidemiologic parameters, the estimated NNT was 64 (95% uncertainty	US	KVP - MSM ; PrEP

		Have Sex with Men: Risk Calculators for Real-World Decision-Making		range: 26, 176) at a cost of US$160,000 (cost saving, US$740,000) per QALY – comparable to other published models. With high (35%) HIV prevalence, the NNT was 35 (21, 57), and cost per QALY was US$27,000 (cost saving, US$160,000), and with high PrEP adherence, the NNT was 30 (14, 69), and cost per QALY was US$3,000 (cost saving, US$200,000). In contrast, for monogamous, serodiscordant relationships with partner antiretroviral therapy use, the NNT was 90 (39, 157) and cost per QALY was US$280,000 (US$14,000, US$670,000). PrEP results vary widely across individuals and populations. Risk calculators may aid in patient education, clinical decision-making, and cost-effectiveness evaluation.		
7	Schneider et al.	A cost-effectiveness analysis of HIV preexposure prophylaxis for men who have sex with men in Australia	2014	Schneider et al. used a stochastic agent-based model of HIV transmission and progression to simulate the clinical and cost outcomes of different strategies of providing PrEP to men who have sex with men (MSM) in New South Wales (NSW), Australia. Model outcomes were reported as incremental cost-effectiveness ratios (ICERs) in 2013 Australian dollars per quality-adjusted life-year gained (QALYG). The use of PrEP in 10%-30% of the entire NSW MSM population was projected to cost an additional $316-$952 million over the course of 10 years, and cost >$400 000 per QALYG compared with the status quo. Targeting MSM with sexual partners ranging between >10 to >50 partners within 6 months cost an additional $31-$331 million dollars, and cost >$110 000 per QALYG compared with the status quo. We found that preexposure prophylaxis is most cost-effective when targeted for HIV-negative MSM in a discordant regular partnership. The ICERs ranged between $8399 and $11 575, for coverage ranging between 15% and 30%, respectively. Targeting HIV-negative MSM in a discordant regular partnership is a cost-effective intervention. However, this highly targeted strategy would not have large population-level impact. Other scenarios are unlikely to be cost-effective.	Australia	KVP - MSM ; PrEP
8	Alistar et al.	Effectiveness and Cost Effectiveness of Oral Pre-Exposure Prophylaxis in a Portfolio of Prevention Programs for Injection Drug Users in Mixed HIV Epidemics	2014	Alistar et al. developed a dynamic compartmental model of the HIV epidemic in a population of non-IDUs, IDUs who inject opiates, and IDUs in MMT, adding an oral PrEP program (tenofovir/emtricitabine, 49% susceptibility reduction) for uninfected IDUs. A combination of PrEP for 50% of IDUs and MMT lowered HIV prevalence the most in both IDUs and the general population. ART combined with MMT and PrEP (50% access) averted the most infections (14,267). For a PrEP cost of $950, the most cost-effective strategy was MMT, at US$520/QALY gained versus no intervention. The next most cost-effective strategy consisted of MMT and ART, costing US$1,000/QALY gained compared to MMT alone. Further adding PrEP (25% access) was also cost effective by World Health Organization standards, at US$1,700/QALY gained. PrEP alone became as cost effective as MMT at a cost of US$650, and cost saving at US$370 or less. Oral	Ukraine	KVP - IDUs; PrEP

				PrEP for IDUs can be part of an effective and cost-effective strategy to control HIV in regions where injection drug use is a significant driver of the epidemic. Where budgets are limited, focusing on MMT and ART access should be the priority, unless PrEP has low cost.		
9	Mabileau et al.	HIV-serodiscordant couples desiring a child: 'treatment as prevention,' preexposure prophylaxis, or medically assisted procreation?	2015	Mabileau sought to assess the residual risk of HIV transmission, cost, and cost-effectiveness of various strategies that can help fertile HIV-uninfected female/HIV-1-infected male on combination antiretroviral therapy with plasma HIV RNA <50 copies/mL couples to have a child: (1) unprotected sexual intercourse (treatment as prevention); (2) treatment as prevention limited to fertile days (targeting fertile days); (3) treatment as prevention with preexposure prophylaxis (tenofovir/emtricitabine); (4) treatment as prevention and preexposure prophylaxis limited to fertile days; or (5) medically assisted procreation (MAP). The HIV transmission risk was highest with treatment as prevention and lowest for MAP (5.4 and 0.0 HIV-infected women/10,000 pregnancies, respectively). Targeting fertile days was more effective than preexposure prophylaxis (0.9 vs 1.8) and associated with lowest costs. Preexposure prophylaxis limited to fertile days was more effective than targeting fertile days (0.3 vs 0.9) with a cost-effectiveness ratio of €1,130,000/life year saved; MAP cost-effectiveness ratio when compared with preexposure prophylaxis limited to fertile days was €3,600,000/life year saved. Results were robust to multiple sensitivity analyses. Targeting fertile days is associated with a low risk of HIV transmission in fertile HIV-uninfected female/male with controlled HIV-1 infection couples. The risk is lower with preexposure prophylaxis limited to fertile days, or MAP, but these strategies are associated with unfavorable cost-effectiveness ratios under their current costs.	France	PrEP; General population
10	Alistar et al.	Comparative effectiveness and cost-effectiveness of antiretroviral therapy and pre-exposure prophylaxis for HIV prevention in South Africa	2014	Alistar et al. developed a dynamic mathematical model of the HIV epidemic in South Africa's adult population. Scaling up ART to 50% of eligible individuals averts 1,513,000 infections over 20 years (Guidelines) and 3,591,000 infections (Universal). Universal ART is the most cost-effective strategy at any scale ($160-$220/QALY versus comparable scale Guidelines ART expansion). General PrEP is costly and provides limited benefits beyond ART scale-up ($7,680/QALY to add 100% PrEP to 50% Universal ART). Cost-effectiveness of General PrEP becomes less favorable when ART is widely given ($12,640/QALY gained when added to 100% Universal ART). If feasible, Focused PrEP is cost saving or highly cost effective versus status quo and when added to ART strategies. Expanded ART coverage to individuals in early disease stages may be more cost-effective than current guidelines. PrEP can be cost-saving if delivered to individuals at increased risk of infection.	South Africa	PrEP

11	Ying et al.	Cost-effectiveness of pre-exposure prophylaxis targeted to high-risk serodiscordant couples as a bridge to sustained ART use in Kampala, Uganda	2015	To estimate the real world delivery costs of PrEP, Ying et al. conducted micro-costing and time and motion analyses in an open-label prospective study of PrEP and ART delivery targeted to high-risk serodiscordant couples in Uganda (the Partners Demonstration Project). The annual cost of PrEP and ART delivery for serodiscordant couples was US$1,058 per couple in the study setting and US$453 in the government setting. The portion of the programme cost due to PrEP was US$408 and US$92 per couple per year in the study and government settings, respectively. Over 10 years, a programme of PrEP and ART for high-risk serodiscordant couples was projected to avert 43% of HIV infections compared to current practice with an ICER of US$1,340 per infection averted. This was comparable to ART expansion alone, which would avert 37% of infections with an ICER of US$1,452. Using Uganda's gross domestic product per capita of US$1,681 as a threshold, PrEP and ART for high-risk persons have the potential for synergistic action and are cost-effective in preventing HIV infections in high prevalence settings. The annual cost of PrEP in this programme is less than $100 per serodiscordant couple if implemented in public clinics.	Uganda	PrEP
12	Jewell et al.	Estimating the cost-effectiveness of pre-exposure prophylaxis to reduce HIV-1 and HSV-2 incidence in HIV-serodiscordant couples in South Africa	2015	Jewell et al. incorporated HSV-2 acquisition, transmission, and interaction with HIV-1 into a microsimulation model of heterosexual HIV-1 serodiscordant couples in South Africa, with use of PrEP for the HIV-1 uninfected partner prior to ART initiation for the HIV-1 1infected partner, and for one year thereafter. They estimate the cost per disability-adjusted life-year (DALY) averted for two scenarios, one in which PrEP has no effect on reducing HSV-2 acquisition, and one in which there is a 33% reduction. After a twenty-year intervention, the cost per DALY averted is estimated to be $10,383 and $9,757, respectively--a 6% reduction, given the additional benefit of reduced HSV-2 acquisition. If all couples are discordant for both HIV-1 and HSV-2, the cost per DALY averted falls to $1,445, which shows that the impact is limited by HSV-2 concordance in couples. After a 20-year PrEP intervention, the cost per DALY averted with a reduction in HSV-2 is estimated to be modestly lower than without any effect, providing an increase of health benefits in addition to HIV-1 prevention at no extra cost. The small degree of the effect is in part due to a high prevalence of HSV-2 infection in HIV-1 serodiscordant couples in South Africa.	South Africa	PrEP
13	Cremin et al.	Seasonal PrEP for partners of migrant miners in southern Mozambique: a highly	2015	A mathematical model was used to represent population-level adult heterosexual HIV transmission in Gaza Province. Providing time-limited PrEP to the partners of migrant miners, as opposed to providing PrEP all year, would improve the cost per infection averted by 7.5-fold. For the cost per infection averted to be below US$3,000, at least 85% of PrEP users would need to be good adherers and PrEP	Mozambique	PrEP

		focused PrEP intervention		would need to be cheaper than US$115 per person per year. Uncertainty regarding incidence of HIV transmission among partners of miners each year in December has a strong influence on estimates of cost per infection averted. Providing time-limited PrEP to partners of migrant miners in Gaza Province during periods of increased exposure would be a novel strategy for providing PrEP. This strategy would allow for a better prioritized intervention, with the potential to improve the efficiency of a PrEP intervention considerably, as well as providing important reproductive health benefits.		
14	Nichols et al.	Cost-effectiveness of PrEP in HIV/AIDS control in Zambia: a stochastic league approach	2014	Nichols et a;. use mathematical modeling to compare the cost-effectiveness and economic affordability of antiretroviral-based prevention strategies in rural Macha, Zambia. All scenarios will reduce the prevalence from 6.2% (interquartile range, 5.8%-6.6%) in 2014 to about 1% after 40 years. Compared with the baseline, 16% of infections will be averted with prioritized PrEP plus treatment at CD4 <350, 34% with treatment at CD4 <500, and 59% with nonprioritized PrEP plus treatment at CD4 <500. Only treating at CD4 <500 is cost effective: ICER of $62 ($46-$75). Nonprioritized PrEP plus treating at CD4 <500 is borderline cost effective: ICER of $5861 ($3959-$8483). Initiating treatment at CD4 <500 requires a budget increase from $20 million to $25 million over 40 years, with a 96.7% probability of being the optimal intervention. PrEP should only be considered when the budget exceeds $180 million.Treatment initiation at CD4 <500 is a cost-effective HIV prevention approach that will require a modest increase in budget. Although adding PrEP will avert more infections, it is not economically feasible, as it requires a 10-fold increase in budget.	Zambia	PrEP
15	Pham et al.	Estimating the Cost-Effectiveness of HIV Prevention Programmes in Vietnam, 2006-2010: A Modelling Study	2015	Vietnam has been largely reliant on international support in its HIV response. Over 2006-2010, a total of US$480 million was invested in its HIV programmes, more than 70% of which came from international sources. This study investigates the potential epidemiological impacts of these programmes and their cost-effectiveness. Based on observed prevalence reductions amongst most population groups, and plausible counterfactuals, modelling suggested that antiretroviral therapy (ART) and prevention programmes over 2006-2010 have averted an estimated 50,600 new infections and 42,600 deaths, resulting in 401,600 fewer DALYs across all population groups. HIV programmes in Vietnam have cost an estimated US$1,972 , US$2,344 , and US$248 for each averted infection, death, and DALY, respectively. The prevention programmes were estimated to have led to a total of 401,550 fewer DALYs over 2006–2010. Condom programmes for MSM was seen as being the most cost-effective, followed by TasP, condom promotion for FSW and needle syringe programmes. MMT was not estimated to have resulted in significant benefits. The evaluation suggests that HIV programmes in Vietnam have most likely had benefits that are	Vietnam	Condom distribution and promotion; KVPs - PWID, FSW and MSM

				cost-effective. ART and direct HIV prevention were the most cost-effective interventions in reducing HIV disease burden.		
16	Menon et al.	Costs and Impacts of Scaling up Voluntary Medical Male Circumcision in Tanzania	2014	Given the proven effectiveness of voluntary medical male circumcision (VMMC) in preventing the spread of HIV, Tanzania is scaling up VMMC as an HIV prevention strategy. This study informs policymakers about the potential costs and benefits of scaling up VMMC services in Tanzania. Increasing VMMC could substantially reduce HIV infection. Scaling up adult VMMC to reach 87.9% coverage by 2015 would avert nearly 23,000 new adult HIV infections through 2015 and an additional 167,500 from 2016 through 2025—at an additional cost of US$253.7 million through 2015 and US$302.3 million from 2016 through 2025. Average cost per HIV infection averted would be US$11,300 during 2010–2015 and US$3,200 during 2010–2025. Scaling up VMMC in Tanzania will yield significant net benefits (benefits of treatment costs averted minus the cost of performing circumcisions) in the long run—around US$4,200 in net benefits for each infection averted. VMMC could have an immediate impact on HIV transmission, but the full impact on prevalence and deaths will only be apparent in the longer term because VMMC averts infections some years into the future among people who have been circumcised. Given the health and economic benefits of investing in VMMC, the scale-up of services should continue to be a central component of the national HIV prevention strategy in Tanzania.	Tanzania	VMMC
17	Terris-Prestholt et al.	Cost-effectiveness of tenofovir gel in urban South Africa: model projections of HIV impact and threshold product prices	2014	This study uses the trial findings to estimate the population-level impact of the gel on HIV and HSV-2 transmission, and price thresholds at which widespread product introduction would be as cost-effective as male circumcision in urban South Africa. Using plausible assumptions about product introduction, the study predicts that tenofovir gel use could lead to a 12.5% and 4.9% reduction in HIV and HSV-2 incidence respectively, by year 15. Microbicide introduction is predicted to be highly cost-effective (under $300 per DALY averted), though the dose price would need to be just $0.12 to be equally cost-effective as male circumcision. A single dose or highly effective (83% HIV efficacy per sex-act) regimen would allow for more realistic threshold prices ($0.25 and $0.33 per dose, respectively). These findings show that an effective coitally-dependent microbicide could reduce HIV incidence by 12.5% in this setting, if current condom use is maintained. For microbicides to be in the range of the most cost-effective HIV prevention interventions, product costs will need to decrease substantially.	South Africa	PrEP; AGYW
18	Walkensky et al.	The Cost-effectiveness of Pre-Exposure Prophylaxis for HIV	2012	Walkensky et al. linked data from recent trials to a computer model of HIV acquisition, screening, and care to project lifetime HIV risk, life expectancy (LE), costs, and cost-effectiveness, using 2 PrEP-related strategies among	South Africa	PrEP; AGYW

		Infection in South African Women		heterosexual South African women: (1) women receiving no PrEP and (2) women receiving PrEP (a tenofovir-based vaginal microbicide). Among South African women, PrEP reduced mean lifetime HIV risk from 40% to 27% and increased population discounted (undiscounted) LE from 22.51 (41.66) to 23.48 (44.48) years. Lifetime costs of care increased from US$7,280 to US$9,890 per woman, resulting in an incremental cost-effectiveness ratio of US$2,700/year of life saved, and may, under optimistic assumptions, achieve cost savings. Under baseline HIV infection incidence assumptions, PrEP was not cost saving, even assuming an efficacy >60% and a cost <$1. At an HIV infection incidence of 9.1%/year, PrEP achieved cost savings at efficacies ≥50%. PrEP in South African women is very cost-effective by South African standards, conferring excellent value under virtually all plausible data scenarios. Although optimistic assumptions would be required to achieve cost savings, these represent important benchmarks for future PrEP study design.		
19	Uthman et al.	Economic Evaluations of Adult Male Circumcision for Prevention of Heterosexual Acquisition of HIV in Men in Sub-Saharan Africa: A Systematic Review	2010	The aim of this study was to systematically review economic evaluations on adult male circumcision (AMC) for prevention of heterosexual acquisition of HIV in men. All published economic evaluations offered the same conclusion that AMC is cost-effective and potentially cost-saving for prevention of heterosexual acquisition of HIV in men. On these grounds, AMC may be seen as a promising new form of strategy for prevention of HIV and should be implemented in conjunction with other evidence-based prevention methods.	Sub-Saharan Africa	VMMC
20	Mitchell et al.	Modelling the impact and cost-effectiveness of combination prevention amongst HIV serodiscordant couples in Nigeria	2015	The objective of this study was to estimate the impact and cost-effectiveness of treatment as prevention (TasP), pre-exposure prophylaxis (PrEP) and condom promotion for serodiscordant couples in Nigeria. Substantial benefits came from scaling up ART to all HIV-positive partners according to 2010 national guidelines, with additional smaller benefits of providing TasP, PrEP or condom promotion. Compared with a baseline of offering ART to all HIV-positive partners at the 2010 national guidelines, condom promotion was the most cost-effective strategy [US$1206/disability-adjusted-life-year (DALY)], the next most cost-effective intervention was to additionally give TasP to HIV-positive partners (incremental cost-effectiveness ratio US$1,607/DALY), followed by additionally giving PrEP to HIV-negative partners until their HIV-positive partners initiate ART (US$7,870/DALY). When impact was measured in terms of infections averted, PrEP with condom promotion prevented double the number of infections as condom promotion alone. The first priority intervention for serodiscordant couples in Nigeria should be scaled up ART access for HIV-positive partners. Subsequent incremental benefits are greatest with condom promotion and TasP, followed by PrEP.	Nigeria	PrEP; Condom promotion and distribution

21	Mvundura et al.	Estimating the hypothetical dual health impact and cost-effectiveness of the Woman's Condom in selected sub-Saharan African countries	2015	Myundura et al. sought to estimate the potential dual health impact and cost-effectiveness of a Woman's Condom distribution program in 13 sub-Saharan African countries with HIV prevalence rates >4% among adults aged 15–49 years. Programming 100,000 Woman's Condoms in each of 13 countries in sub-Saharan Africa during a 1-year period could potentially prevent 194 pregnancies and an average of 21 HIV infections in each country. When using the World Health Organization CHOosing Interventions that are Cost-Effective (WHO-CHOICE) criteria as a threshold to infer the potential cost-effectiveness of the Woman's Condom, we found that the Woman's Condom would be considered cost-effective. This was a first and successful attempt to estimate the impact of dual protection of female condoms. The health impact is greater for the use of the Woman's Condom as an HIV prevention method than for contraception. Dual use of the Woman's Condom increases the overall health impact. The Woman's Condom was found to be very cost-effective in all 13 countries in our sample.	Sub-Saharan Africa	AGYW; Condom Distribution & Promotion
22	Suraratdecha et al.	Cost and cost-effectiveness analysis of pre-exposure prophylaxis among men who have sex with men in two hospitals in Thailand	2018	Suraratdecha et al estimated the costs associated with PrEP provision among men having sex with men (MSM) participating in a facility-based, prospective observational cohort study: the Test, Treat and Prevent HIV Programme in Thailand. Drug costs accounted for 82.5% of the total cost of providing PrEP, followed by lab testing (8.2%) and personnel costs (7.8%). The estimated costs of providing the PrEP package in accordance with the national recommendation ranges from US$223 to US$311 per person per year. Based on our modelling results, they estimated that PrEP would be cost-effective when provided to either high-risk or all MSM. However, we found that the programme would be approximately 32% more cost-effective if offered to high-risk MSM than it would be if offered to all MSM, with an incremental cost-effectiveness ratio of US$4,836 per disability-adjusted life years (DALY) averted and US$7,089 per DALY averted respectively. Cost-effectiveness acceptability curves demonstrate that 80% of scenarios would be cost-effective when PrEP is provided solely to higher-risk MSM. While the high drug cost poses a budgeting challenge, incorporating PrEP delivery into an existing ART programme could be a cost-effective strategy to prevent HIV infections among MSM in Thailand.	Thailand	PrEP; KVP - MSM
23	Kelly et al.	The global Optima HIV allocative efficiency model: targeting resources in efforts to end AIDS	2018	Kelly ey al. used the Optima HIV model to estimate how global HIV resources could be retargeted for greatest epidemiological effect and how many additional new infections could be averted by 2030. Without additional funding, if countries were to optimally allocate their HIV resources from 2016 to 2030, an additional 7·4 million (uncertainty range 3·9 million-14·0 million) new infections could be averted, representing a 26% (uncertainty range 13-50%) incidence reduction. Redistribution of international funds between countries could avert a further 1·9	Global	KVP; General prevention services

				million infections, which represents a 33% (uncertainty range 20-58%) incidence reduction overall. To reduce HIV incidence by 90% relative to 2010, more than a three-fold increase of current annual funds will be necessary until 2030. The most common priorities for optimal resource reallocation are to scale up treatment and prevention programmes targeting key populations at greatest risk in each setting. Prioritisation of other HIV programmes depends on the epidemiology and cost-effectiveness of service delivery in each setting as well as resource availability. Further reductions in global HIV incidence are possible through improved targeting of international and national HIV resources.		
24	Wilson et al.	The cost-effectiveness of harm reduction	2014	This commentary discusses the evidence of effectiveness of the packages of harm reduction services and their cost-effectiveness with respect to HIV-related outcomes as well as estimate resources required to meet global and regional coverage targets. NSPs have been shown to be safe and very effective in reducing HIV transmission in diverse settings; there are many historical and very recent examples in diverse settings where the absence of, or reduction in, NSPs have resulted in exploding HIV epidemics compared to controlled epidemics with NSP implementation. NSPs are relatively inexpensive to implement and highly cost-effective according to commonly used willingness-to-pay thresholds. There is strong evidence that substitution therapy is effective, reducing the risk of HIV acquisition by 54% on average among PWID. OST is relatively expensive to implement when only HIV outcomes are considered; other societal benefits substantially improve the cost-effectiveness ratios to be highly favourable. Many studies have shown that ART is cost-effective for keeping people alive but there is only weak supportive, but growing evidence, of the additional effectiveness and cost-effectiveness of ART as prevention among PWID. Packages of combined harm reduction approaches are highly likely to be more effective and cost-effective than partial approaches. The coverage of harm reduction programs remains extremely low across the world. The total annual costs of scaling up each of the harm reduction strategies from current coverage levels, by region, to meet WHO guideline coverage targets are high with ART greatest, followed by OST and then NSPs. But scale-up of all three approaches is essential. These interventions can be cost-effective by most thresholds in the short-term and cost-saving in the long-term.	Global	KVP - PWID
25	Alistar et al.	Effectiveness and Cost Effectiveness of Expanding Harm Reduction and Antiretroviral Therapy in a Mixed HIV Epidemic: A	2011	Alistar et al. estimated the effectiveness and cost-effectiveness of strategies for expanding methadone substitution therapy programs and ART in mixed HIV epidemics, using Ukraine as a case study. Without incremental interventions, HIV prevalence reached 67.2% (IDUs) and 0.88% (non-IDUs) after 20 years. Offering methadone substitution therapy to 25% of IDUs reduced prevalence most effectively (to 53.1% IDUs, 0.80% non-IDUs), and was most cost-effective,	Ukraine	KVP - PWID

		Modeling Analysis for Ukraine		averting 4,700 infections and adding 76,000 QALYs compared with no intervention at US$530/QALY gained. Expanding both ART (80% coverage of those eligible for ART according to WHO criteria) and methadone substitution therapy (25% coverage) was the next most cost-effective strategy, adding 105,000 QALYs at US$1,120/QALY gained versus the methadone substitution therapy-only strategy and averting 8,300 infections versus no intervention. Expanding only ART (80% coverage) added 38,000 QALYs at US$2,240/QALY gained versus the methadone substitution therapy-only strategy, and averted 4,080 infections versus no intervention. Offering ART to 80% of non-IDUs eligible for treatment by WHO criteria, but only 10% of IDUs, averted only 1,800 infections versus no intervention and was not cost effective. Methadone substitution therapy is a highly cost-effective option for the growing mixed HIV epidemic in Ukraine. A strategy that expands both methadone substitution therapy and ART to high levels is the most effective intervention, and is very cost effective by WHO criteria. When expanding ART, access to methadone substitution therapy provides additional benefit in infections averted. Our findings are potentially relevant to other settings with mixed HIV epidemics.		
26	Jenkins et al.	Measuring the impact of needle exchange programs among injecting drug users through the National Behavioural Surveillance in Bangladesh	2001	Using National HIV Behavioral Surveillance data, the impact of a needle exchange program (NEP) on sharing behaviour among injecting drug users in two cities was measured. Results showed positive changes that varied with the different settings. Those who reported utilizing the NEP were compared with those who did not. Differences in Dhaka were significant for the average proportion of needles shared but not for the proportion of men who ever shared in the last week. In Rajshahi, where professional injectors were the norm, the impact of an NEP was greater and affected both the proportion of needles shared as well as the proportion of men never sharing. Behavioural surveillance methods have the potential to measure intervention impact through comparative analysis in certain settings.	Bangladesh	KVP - PWID
27	Wilson et al.	Evaluating the Cost-effectiveness of Needle-syringe Exchange Programs in Kazakhstan in Period of 2000-2010	2012	NSEPs aim to prevent HIV and hepatitis C infection among injecting drug users. During 2000– 2010 their implementation in Kazakhstan cost a total of US$17 million but has yielded substantial epidemiological and economic returns and proven to be effective and extremely good value for money. There is strong evidence that the scale-up of NSEPs has led to decreases in the frequency of sharing injecting equipment among people who inject drugs. It is estimated that over the period 2000-2010, NSEPs prevented 2,205-2,720 new HIV cases, 435-934 HIV-related deaths, and 20,941-24,715 cases of hepatitis C. During 2000-2010, an estimated 78,606 to 85,670 QALYs were gained by averting new HIV and hepatitis C cases as a result of implementation of NSEPs. The vast majority of QALYs gained was due to averted cases of hepatitis C. The average cost per	Kazakhstan	KVP - PWID

				QALY gained was calculated to be US$132-147 (for reference, the standard threshold for cost-effectiveness in Kazakhstan is US$9,136 per QALY gained). Thus, NSEPs in Kazakhstan are extremely cost-effective. The infections averted during the period 2000-2010 will lead to further savings in health consequences and costs in the future. The benefits of the investment in NSEPs in 2000-2010 include an estimated lifetime gain of 322,905 to 388,954 QALYs. Overall, the average cost per QALY gained when considering lifetime benefits is estimated to be US$23 – 31.		
28	Guinness et al.	The cost-effectiveness of consistent and early intervention of harm reduction for injecting drug users in Bangladesh	2009	The study assesses the cost-effectiveness of the CARE-SHAKTI harm reduction intervention for injecting drug users (IDUs) over a 3-year period, the impact on the cost-effectiveness of stopping after 3 years and how the cost-effectiveness might vary with baseline HIV prevalence. The cost per HIV infection prevented over the first 3 years was US$110.4. The incremental cost-effectiveness of continuing the intervention for a further year, relative to stopping at the end of year 3, is US$97 if behaviour returns to pre-intervention patterns. When baseline IDU HIV prevalence is increased to 40%, the number of HIV infections averted is halved for the 3-year period and the cost per HIV infection prevented doubles to US$228. The analysis confirms that harm reduction activities are cost-effective. Early intervention is more cost-effective than delaying activities, although this should not preclude later intervention. Starting harm reduction activities when IDU HIV prevalence reaches as high as 40% is still cost-effective. Continuing harm reduction activities once a project has matured is vital to sustaining its impact and cost-effectiveness.	Bangladesh	KVP - PWID
29	Baird et al.	Effect of a cash transfer programme for schooling on prevalence of HIV and herpes simplex type 2 in Malawi: a cluster randomised trial	2012	The study assessed the efficacy of a cash transfer programme to reduce the risk of sexually transmitted infections in young women. 88 enumeration areas were assigned to receive the intervention and 88 as controls. For the 1289 individuals enrolled in school at baseline with complete interview and biomarker data, weighted HIV prevalence at 18 month follow-up was 1·2% (seven of 490 participants) in the combined intervention group versus 3·0% (17 of 799 participants) in the control group (adjusted odds ratio [OR] 0·36, 95% CI 0·14–0·91); weighted HSV-2 prevalence was 0·7% (five of 488 participants) versus 3·0% (27 of 796 participants; adjusted OR 0·24, 0·09–0·65). In the intervention group, we noted no difference between conditional versus unconditional intervention groups for weighted HIV prevalence (3/235 [1%] vs 4/255 [2%]) or weighted HSV-2 prevalence (4/233 [1%] vs 1/255 [<1%]). For individuals who had already dropped out of school at baseline, we detected no significant difference between intervention and control groups for weighted HIV prevalence (23/210 [10%] vs 17/207 [8%]) or weighted HSV-2 prevalence	Malawi	AGYW

				(17/211 [8%] vs 17/208 [8%]). Cash transfer programmes can reduce HIV and HSV-2 infections in adolescent schoolgirls in low-income settings. Structural interventions that do not directly target sexual behaviour change can be important components of HIV prevention strategies. By use of the average household transfer size (US$10 per month) and the high administrative costs of our cash transfer experiment, the study calculated that the cost of averting a primary HIV infection is US$12 500 in 2009 dollars. However, because intervention effect did not differ by transfer amount, we suspect that the minimum transfer amount of US$5 per month would be equally effective. Combination of this amount with a more realistic administrative cost of about 15% of total programme costs for a scaled up cash transfer programme would yield a cost of only US$5,000 per HIV infection averted.		
30	Remme et al.	The cost and cost-effectiveness of gender-responsive interventions for HIV: a systematic review	2014	The study assesses current evidence on what forms of gender-responsive intervention may enhance the effectiveness of basic HIV programmes and be cost-effective. The effectiveness search identified 36 publications, reporting on the effectiveness of 22 HIV interventions with a gender focus. Of these, 11 types of interventions had a corresponding/comparable costing or cost-effectiveness study. The findings suggest that couple counselling for the prevention of vertical transmission; gender empowerment, community mobilization, and female condom promotion for female sex workers; expanded female condom distribution for the general population; and post-exposure HIV prophylaxis for rape survivors are cost-effective HIV interventions. Cash transfers for schoolgirls and school support for orphan girls may also be cost-effective in generalized epidemic settings. Seven studies provided CERs in terms of costs pernHIV infection averted, HIV DALY averted or HIV QALY gained. This evidence suggests that couple counselling for the prevention of vertical transmission (US$17 per DALY averted); gender empowerment community mobilization for FSWs (US$1,319 per DALY averted); female condom promotion for FSWs (US$32-56 per DALY averted); expanded female condom distribution (US$241-499 per DALY averted);and PEP for rape survivors (US$2120-2729 per DALY averted) are cost-effective HIV interventions, with CERs well below the respective countries' GDP per capita (WHO's threshold). By including orphan quality of life as an HIV outcome and various cost scenarios, we find that school support for orphan girls (US$6 per QALY gained) and cash transfers for schoolgirls (US$212-912 per DALY averted) could also be cost-effective in generalized epidemics. There has been limited research to assess the cost-effectiveness of interventions that seek to address women's needs and transform harmful gender norms. The review identified several promising, cost-effective interventions that merit	Global	AGYW; Condom Distribution & Promotion; Behavioural change

				consideration as critical enablers in HIV investment approaches, as well as highlight that broader gender and development interventions can have positive HIV impacts.		
31	De Neve et al.	Length of secondary schooling and risk of HIV infection in Botswana: evidence from a natural experiment	2015	A 1996 policy reform changed the grade structure of secondary school in Botswana and increased educational attainment. The study used this reform as a 'natural experiment' to identify the causal effect of schooling on HIV infection. Data on HIV biomarkers and demographics were obtained from the 2004 and Each additional year of secondary schooling induced by the policy change led to an absolute reduction in the cumulative risk of HIV infection of 8.1% points (p = 0·008), relative to a baseline prevalence of 25.6%. Effects were particularly large among women (11.6% points, p = 0·046). Results were robust to a wide array of sensitivity analyses. Secondary school was cost-effective as an HIV prevention intervention by standard metrics. Additional years of secondary schooling had a large protective effect against HIV risk, particularly for women, in Botswana. Increasing progression through secondary school may be a cost-effective HIV prevention measure in HIV-endemic settings, in addition to yielding other societal benefits.	Botswana	AGYW; General behaviour change
32	Kessler et al.	Targeting an alcohol intervention cost effectively to persons living with HIV/AIDS in East Africa	2015	The results analyses if targeting a cognitive behavior therapy (CBT) based intervention aimed at reducing hazardous alcohol consumption to HIV infected persons in East Africa would have a favorable value at costs that are feasible for scale-up. Based on computer modelling, an intervention targeted to HIV infected patients could prevent 18,000 new infections and add 46,000 QALYs compared to the null scenario. Narrowing the prioritized population to only HIV infected patients in pre ART phases of care results in 15,000 infections averted, the addition of 21,000 QALYs, while prioritizing based on an unsuppressed HIV 1 viral load test results in 8,300 new infections averted and adds 6,000 additional QALYs. The results suggest that targeting a cognitive based treatment aimed at reducing hazardous alcohol consumption to subgroups of HIV infected patients provides favorable value in comparison with other beneficial strategies for HIV prevention and control in this region. It may even be cost saving under certain circumstances.	East Africa	Behavioural change
33	Sarkar et al.	Cost-effectiveness of HIV Prevention Interventions in Sub-Saharan Africa: A Systematic Review	2019	The study reviewed the evidence from economic evaluations of HIV prevention interventions in sub-Saharan Africa to help inform the allocation of limited resources. 60 studies met the full inclusion criteria. Prevention of mother-to-child transmission interventions had the lowest median CERs ($1144/HIV infection averted and $191/DALY averted), while pre-exposure prophylaxis interventions had the highest ($13,267/HIA and $799/DALY averted). Structural interventions (partner notification, cash transfer programs) have similar CERs ($3576/HIA and	Sub-Saharan Africa	PrEP; Structural interventions; VMMC; KVPs; AGYW; Behavioural change

				$392/DALY averted) to male circumcision ($2965/HIA) and were more favourable to treatment-as-prevention interventions ($7903/HIA and $890/DALY averted). Most interventions showed increased cost-effectiveness when prioritizing specific target groups based on age and risk. The presented cost-effectiveness information can aid policy makers and other stakeholders as they develop guidelines and programming for HIV prevention plans in resource-constrained settings.		
34	Fieno et al.	The promise and limitations of cash transfer programs for HIV prevention	2014	This article examines elements of a successful cash transfer program from Latin America and discusses challenges inherent in scaling-up such programs. The authors attempt a cost simulation of a cash transfer program for HIV prevention in South Africa comparing its cost and relative effectiveness – in number of HIV infections averted – against other prevention interventions. If a cash transfer program were to be taken to scale, the intervention would not have a substantial effect on decreasing the force of the epidemic in middle- and low-income countries. The integration of cash transfer programs into other sectors and linking them to a broader objective such as girls' educational attainment may be one way of addressing doubts raised by the authors regarding their value for HIV prevention.	South Africa	Structural barriers
35	Remme et al.	Financing structural interventions: going beyond HIV-only value for money assessments	2014	The authors investigate this hypothesis by examining the consequences of alternative financing approaches. They find that efficient structural interventions may be less likely to be prioritized, financed and taken to scale where sectors evaluate their options in isolation. A co-financing approach minimizes welfare loss and could be incorporated in a sector budgeting perspective. Structural interventions may be under-implemented and their cross-sectoral benefits foregone. Co-financing provides an opportunity for multiple HIV, health and development objectives to be achieved simultaneously, but will require effective cross-sectoral coordination mechanisms for planning, implementation and financing.	Malawi	AGYW; structural barriers
36	Rutstein et al.	Cost-effectiveness of provider-based HIV partner notification in urban Malawi	2013	Provider-initiated partner notification for HIV effectively identifies new cases of HIV in sub-Saharan Africa, but is not widely implemented. The objective of this study was to determine whether provider-based HIV partner notification strategies are cost-effective for preventing HIV transmission compared with passive referral. Based on estimated transmissions in a 5000-person cohort, provider and contract notification averted 27.9 and 27.5 new infections, respectively, compared with passive referral. The incremental cost-effectiveness ratio (ICER) was US$3,560 per HIV transmission averted for contract notification compared with passive referral. Provider notification was more expensive and slightly more effective than contract notification, yielding an ICER of US$51,421	Malawi	Structural barriers

				per transmission averted. ICERs were sensitive to the proportion of partners not contacted, but likely HIV positive and the probability of transmission if not on antiretroviral therapy. The costs per new case identified were US$36 (provider), US$18 (contract) and US$8 (passive). The costs per partner tested were US$19 (provider), US$9 (contract) and US$4 (passive). We conclude that, in this population, provider-based notification strategies are potentially cost-effective for identifying new cases of HIV. These strategies offer a simple, effective and easily implementable opportunity to control HIV transmission.		
37	Enns et al.	Assessing effectiveness and cost-effectiveness of concurrency reduction for HIV prevention	2011	The authors estimated the effectiveness and cost-effectiveness of changes in concurrent sexual partnerships in reducing the spread of HIV in sub-Saharan Africa. They found (based on modelling) that reducing concurrency among high-risk individuals averts the most infections and increasing monogamy the least (11.7% versus 8.7% reduction in new infections, on average, for a 10% reduction in concurrent partnerships). A campaign that costs US$1 per person annually is likely cost-saving if it reduces concurrency by 9% on average, given our baseline estimates of concurrency. In sensitivity analysis, the rank ordering of behaviour change scenarios was unaffected by potential over-estimation of concurrency, though the number of infections averted decreased and the cost per HIV infection averted increased. Concurrency reduction programmes may be effective and cost-effective in reducing HIV incidence in sub-Saharan Africa if they can achieve even modest impacts at similar costs to past mass media campaigns in the region. Reduced concurrency among high-risk individuals appears to be most effective in reducing HIV incidence, but concurrency reduction in other risk groups may yield nearly as much benefit.	Swaziland, Tanzania, Uganda and Zambia	Behavioural change; KVPs
38	Jacobsen et al.	Modeling and Cost-Effectiveness in HIV Prevention	2016	This paper briefly reviews concepts in modelling and cost-effectiveness methodology, then examines results of recently published cost-effectiveness analyses on the following HIV prevention strategies: condoms and circumcision, behavioural or community-based interventions, prevention of mother to child transmission, HIV testing, pre-exposure prophylaxis, and treatment as prevention. It finds that the majority of published studies demonstrate cost-effectiveness; however, not all interventions are affordable. It urges continued research on combination strategies and methodologies that take into account willingness to pay and budgetary impact.	Global	VMMC; Condom distribution and promotion; Behavioural change; PrEP;

UK

Queens House

55-56 Lincoln's Inn Fields

London WC2A 3LJ

T. **+44 (0)20 7269 0210**

E. **info@cepa.co.uk**

www.cepa.co.uk

Australia

Level 20, Tower 2 Darling Park

201 Sussex St

Sydney NSW2000

T. **+61 2 9006 1307**

E. **info@cepa.net.au**

www.cepa.net.au

 cepa-ltd  @cepaltd