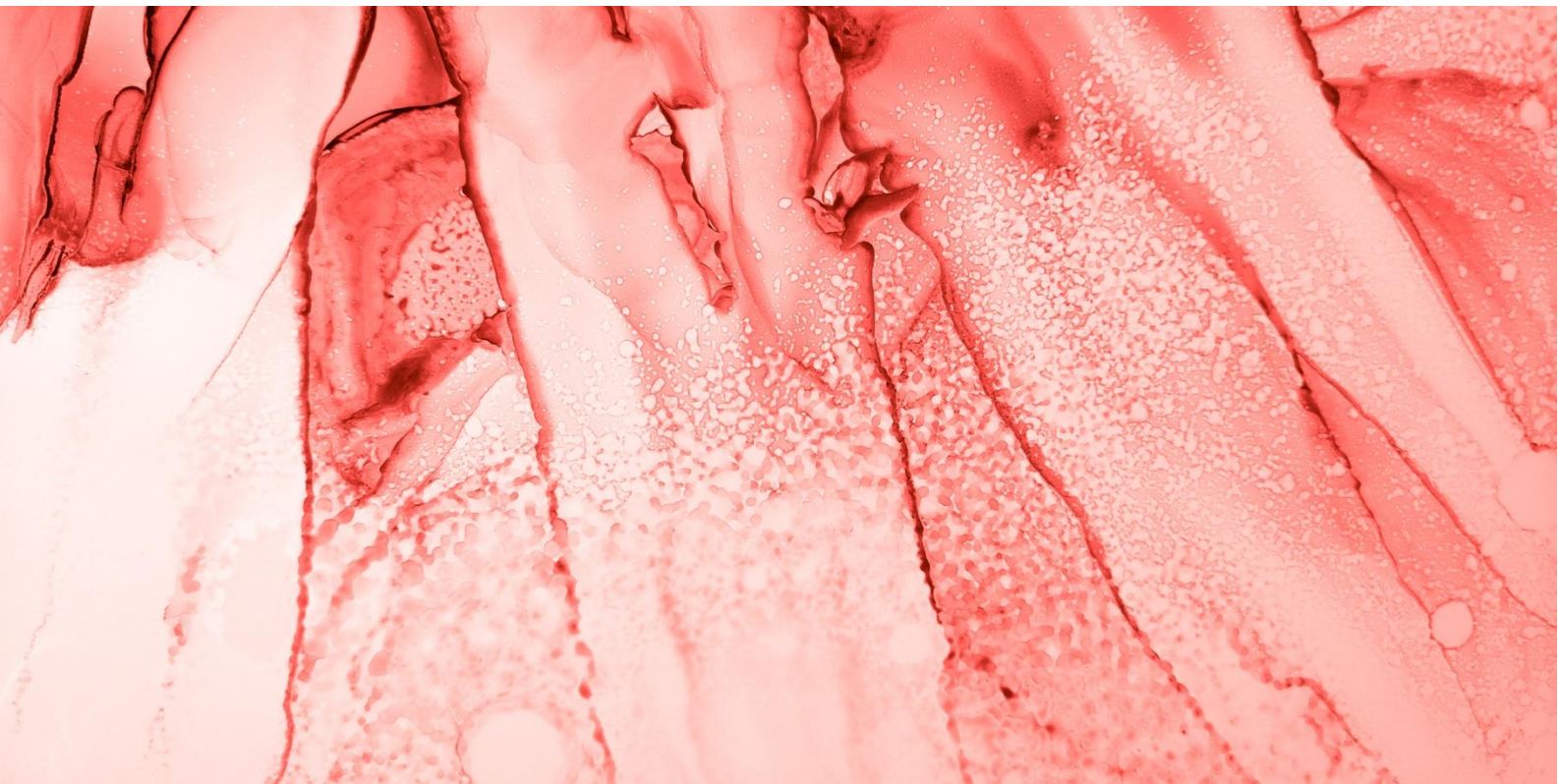




EVALUATION OF UNITAID'S PORTFOLIO OF INVESTMENTS IN ACCELERATING ELIMINATION OF CERVICAL CANCER THROUGH SECONDARY PREVENTION - VOL II

Client: Unitaïd

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ANNEX 1. HYPOTHESIS TESTING – CMO ANALYSIS

This section presents the structured Context–Mechanism–Outcome (CMO) analysis for each of the six programme hypotheses derived from the portfolio Theory of Change. For each hypothesis, contextual conditions, operative mechanisms, and observed outcomes are presented separately, followed by a realist conclusion on what works, for whom, and under what circumstances. Findings references are to the draft evaluation report findings presented in section 3.

H1: Community Delivery & Self-Sampling | ToC level: Output | Linked EQs: 2.1, 2.3, 1.3

Hypothesis: Proof of feasibility of community-based HPV screening service model (using self-sampling) triggers national adoption as a standard service model.

CONTEXT — Varying conditions across settings

Self-sampling was introduced across diverse contexts that shaped its uptake and cascade completion differently:

- Rwanda stands out as a contextually distinct enabler: a pre-existing primary health care infrastructure, digital connectivity, and a performance-based CHW network created conditions for high cascade completion that were not replicable in most other settings (Finding 3.2).
- Resource constraints in Burkina Faso Malawi and Kenya constrained CHW incentives after project closure, undermining the sustainability of community-based delivery (Finding 1.11).
- HIV clinic integration created a stigma association in Kenya and Zimbabwe, where integrating screening with HIV services inadvertently stigmatized CxCa services as being 'for HIV-positive women' (Finding 1.22).
- Weak patient navigation infrastructure was the norm in Phase 1 across the portfolio. (Finding 1.3).
- High cultural modesty norms and male gatekeeping characterized Burkina Faso, Malawi, and parts of Kenya and Philippines. In these settings, the speculum-based VIA examination was a documented deterrent to screening (Finding 1.10).

MECHANISM — How the intervention was expected to work, and what actually triggered change

The hypothesized mechanism was: demonstration of feasibility (community-based outreach services are acceptable and reach never-screened women) → policymaker and provider confidence → national adoption as standard service model.

The mechanism fired partially and with an important split:

- Acceptability mechanism fired strongly. Over 90% of women in community-based outreach models had never previously been screened. (Finding 1.10).
- The cascade completion mechanism required a supplementary mechanism not captured in the original hypothesis: embedded CHW follow-up. The five-country CBSS study (Nigeria, Malawi, Rwanda, Zambia, Zimbabwe) found triage rates above 80% only when self-sampling was coupled with active patient navigation, including CHW phone follow-up and door-to-door tracing. In Rwanda, 90%+ follow-up was achieved through structured Monday–Thursday testing with dedicated Friday follow-up days (Finding 1.5).
- The 'standard service model' mechanism — integration into routinely funded national programmes — did not fire. No project country achieved national scale with domestic financing, and in Burkina

Faso, HPV testing collapsed entirely post-project, while demand from women continued (Finding 2.7).

- A key counterfactual was established: Burkina Faso Phase 2 door-to-door model achieved 94.6% VIA/VAT completion versus 36.4–44.4% in Phase 1, attributable entirely to the CHW follow-up mechanism rather than the self-sampling modality itself (Finding 1.5).

OUTCOME — What resulted in practice

- Outreach services reached a fundamentally different population than facility-based models — first-time screeners, women with modesty barriers, hard-to-reach rural women — confirming the model's value in reaching women with least access to health services (Finding 1.10).
- National guidelines were updated in 12 of 14 countries, representing genuine normative adoption (Finding 2.1). However, services remained donor-dependent in all countries. CHW incentives (transport, airtime, per diem) ceased at project close in Burkina Faso and were uncertain in Malawi and Kenya (Finding 1.11).
- Community models (door-to-door, mobile) showed higher cost per HPV-positive woman triaged than facility-based models, due to lower HPV positivity rates in the general population. This cost differential is a structural barrier to government absorption (Finding 1.10).
- Post-treatment follow-up — the final cascade step — remained critically weak portfolio-wide. Only 17% of HPV-positive women returned for follow-up at any time post-VIA or post-treatment (Finding 1.7).

CONCLUSION — What works, for whom, and under what circumstances

The hypothesis is partially confirmed. Community-based HPV screening demonstrably works for reaching first-time screeners and women with access barriers — particularly in settings with high speculum-avoidance, strong cultural modesty norms, and male gatekeeping — when community models are coupled with embedded CHW follow-up and patient navigation systems. It does not work as a self-sustaining national service model without continued investment in CHW incentives, patient navigation infrastructure, and domestic procurement financing. The hypothesis overstated the automaticity of the pathway from proof of feasibility to national adoption as a standard, routinely funded service.

H2: Integrated Service Delivery & Same-Day Treat | ToC level: Output | Linked EQs: 2.1, 2.2, 2.3

Hypothesis: Integration into existing services plus same-day testing/treatment triggers client convenience and health worker confidence, reducing loss to follow up (LTFU).

CONTEXT — Varying conditions across settings

Integration contexts varied significantly across the portfolio:

- HIV/ART platform integration was the dominant model in Phase 1. It was epidemiologically sound (WLHIV have 3–6 times higher HPV prevalence) and operationally efficient, leveraging existing lab infrastructure, staff, and supply chains (Finding 1.21).
- Integration into reproductive health (FP, MNCH, OPD) was pursued in Phase 2 and reduced stigma where implemented, but was uneven across sites (Finding 1.22).
- Testing platform competition was a structural constraint across the portfolio. GeneXpert machines prioritized running HIV viral load, TB, and COVID-19 testing relative to HPV in Kenya, Burkina Faso,

the Philippines, and most other countries using shared platforms. The median delay from sample collection to HPV result was 28 days in the SUCCESS five-country study (range 16–41 days) (Finding 1.8a).

- Health system capacity varied sharply: Rwanda had established digital infrastructure, CHW networks, and referral systems that enabled rapid result return; Burkina Faso Phase 1 lacked on-site GeneXpert at many sites, necessitating long-distance sample transport (Findings 1.8a, 3.2).
- Stigma associated with HIV clinics was a documented barrier in Kenya and Zimbabwe: women avoided HIV clinic attendance because it disclosed or implied HIV status to household members and community (Finding 1.22). In the Philippines, WLHIV faced double stigma when attending CxCa services not linked to HIV (Finding 4.8).

MECHANISM — How the intervention was expected to work, and what actually triggered change

The hypothesized mechanism was: integrating CxCa into existing services + same-day testing/treatment → client convenience + HW confidence → reduced LTFU.

The mechanism fired incompletely:

- Integration into HIV platforms triggered convenience for WLHIV attending ART clinics but did not generate same-day results due to shared-platform constraints. The 'same-day test-triage-treat' model remained aspirational throughout the portfolio. Near-POC platforms did not function as true POC: same-day results were achieved in only 16% of cases across the 10 CHAI portfolio countries (Finding 1.6).
- HW confidence mechanism fired, but differently than expected. Providers valued HPV testing for reducing diagnostic subjectivity and improving counselling confidence. Task-shifting to nurses and midwives for TA treatment was successfully implemented without adverse events (Findings 1.1, 1.15).
- The cascade improvement mechanism required active patient navigation. Integration alone was insufficient: Burkina Faso Phase 1 showed 63.6% triage linkage for the general population and 44.4% for WLHIV despite integration into HIV services (Finding 1.3).
- The mechanism for reducing stigma through integration into RH/FP platforms did fire where implemented: Kenya and Malawi case studies confirm that integration into reproductive health settings reduced the HIV- association of cervical cancer screening, improved acceptability, and broadened reach (Finding 1.22).

OUTCOME — What resulted in practice

- Integration into RH/FP platforms improved uptake and reduced stigma where implemented, but was less systematically pursued than HIV integration. The mother-daughter vaccination-screening integration opportunity — demonstrated in Nigeria with a 112% increase in HPV vaccination coverage in intervention areas — remained largely unscaled (Finding 1.22).
- No project country achieved routine same-day screen-triage-treat due to shared-platform constraints. Results delays — median 28 days — were the primary driver of LTFU at the results-return step. HPV positive women receiving results over 40 days after sample collection were significantly less likely to return for triage ($p < 0.001$) (Finding 1.8a).

CONCLUSION — What works, for whom, and under what circumstances

The hypothesis is partially confirmed with an important qualification. Integration into existing platforms works for increasing screening volumes and HW efficiency in settings with established service infrastructure, but it does not reduce LTFU on its own — that requires a 'true' Point of Care HPV test, or embedded patient navigation. Same-day screen-triage-treat is not achievable with current near-POC technology on shared

platforms; same-day triage-treat is achievable only with thermal ablation at the triage site, but only for women who have been retained through a follow-up-supported cascade. Integration into RH/FP platforms (rather than solely HIV) works better for reducing stigma and broadening reach. The mechanism fires best in settings with low staff turnover, established referral systems, and available consumables — Rwanda being the clearest enabler example.

H3: Technology Introduction & HW Capability | ToC level: Output | Linked EQs: 2.1, 2.3

Hypothesis: AI-AVE and HPV DNA testing increase HW diagnostic confidence, improving continuity of care.

CONTEXT — Varying conditions across settings

Technology introduction operated across highly varied health system contexts:

- Laboratory infrastructure gaps were pervasive and caused LTFU in HPV based screening cascade outcomes, especially between HPV test and VIA triage. Many sites in Burkina Faso lacked on-site GeneXpert; in Malawi, one district relied on a single four-module GeneXpert. Competition with HIV and TB samples was universal on shared platforms (Finding 1.8a).
- Supply chain fragility was documented across all case studies — stockouts of HPV test kits, reagents, gloves, and TA consumables (probes, power banks) disrupted services in Kenya, Malawi, and Burkina Faso. The 2022 CAMEG warehouse fire in Burkina Faso destroyed all HPV test stocks, causing six months of result delays (Findings 1.8b, 3.3).
- AVE faced a specific contextual challenge: the five-country validation study (2022–2023) confirmed meaningful, but insufficient performance gains over VIA, but commercialization was not pursued, leaving AVE without a market pathway (Finding 1.20).
- HW turnover was severe and near-universal. Kenya, Malawi, and Burkina Faso all documented high staff turnover leaving facilities temporarily without trained providers (Finding 1.16).
- Rwanda's existing digital health infrastructure and pre-service training systems created conditions for more durable technology integration than other settings (Finding 3.2).

MECHANISM — How the intervention was expected to work, and what actually triggered change

The hypothesized mechanism was: AI-AVE and HPV DNA testing increase HW diagnostic confidence → providers use tools consistently → cascade continuity improves.

The mechanism fired differentially across technologies:

- HPV DNA testing: The HW confidence mechanism fired strongly. Providers across all case studies valued HPV testing for removing diagnostic subjectivity. KIs described it as enabling more confident counselling: 'HPV tests are game changers that improved accuracy and acceptability' (Kenya, Finding 1.1). Task-shifting — nurses and midwives trained to interpret results and deliver TA — was successfully implemented across all portfolio countries without adverse events (Finding 1.15).
- However, confidence in the technology did not translate to cascade continuity. HW training alone could not overcome structural barriers (platform competition, result delays, loss to follow up, stockouts) that prevented cascade completion, especially follow up of HPV-positive women with triage.(Finding 1.16).
- AVE: The mechanism fired in research contexts. The external validation study confirmed AI-support increases VIA sensitivity from 36.6% to 71.8% (AI-assisted VIA), enabling same-visit screen-and-treat pathways (Finding 1.18). But it did not reach 90%, the bar for further commercialization. Provider acceptance improved through sensitization and training in Malawi. In Zambia, the visual format

extended an existing trust model (Finding 1.19). However, WHO pre-qualification remained pending at evaluation close, and no commercial pathway was secured — limiting scale of the confidence mechanism beyond demonstration sites (Finding 1.20).

OUTCOME — What resulted in practice

- HPV DNA testing is firmly established as more accurate than VIA (pooled sensitivity 90.4% vs. 36.6%) and was incorporated into national guidelines in 13 of 14 countries. Practical provider confidence was high (Finding 1.1, 2.1).
- AVE doubled VIA sensitivity without reaching HPV test performance levels, and demonstrated clear public health value for same-visit screen-and-treat in settings where HPV testing is not yet widely available. However, commercialization is stalled and WHO prequalification is pending, limiting its deployment (Findings 1.18–1.20).
- Cascade continuity did not improve consistently from technology introduction alone, especially compared to high linkage to treatment in VIA based screening. LTFU remained the decisive operational problem: at 50% LTFU, the effective cost per case found doubles, undermining the financial case for HPV adoption at government level (Finding 1.3).
- Technology introduction created recurring maintenance and consumables gaps that eroded HW capability over time: (Finding 1.16).

CONCLUSION — What works, for whom, and under what circumstances

The hypothesis is partially confirmed. HPV DNA testing reliably increases HW diagnostic confidence and improve capability in settings where training is provided and consumable supply is maintained. For HPV-based screening, the mechanism requires concurrent investment in patient navigation, laboratory system capacity, supply chain stability, and post-training supervision. Thermal ablation (TA) devices enable same day triage and treat, but not same day test and treat. TA works best for providers in facilities with stable staffing, consistent supply chains, and structured supportive supervision. AVE works as a same-visit screen-and-treat tool with demonstrated performance gains, but so far only in demonstration contexts and pending commercialization. The hypothesis overstated the sufficiency of the technology-confidence-continuity pathway.

H4: Proof of Concept & National Adoption | ToC level: Outcome | Linked EQs: 2.1, 3.1, 3.3

Hypothesis: Proof of concept from 'champion countries' triggers national government buy-in, leading to policy and budget inclusion.

CONTEXT — Varying conditions across settings

The political economy of policy adoption differed sharply across the portfolio:

- Strong political leadership was the decisive enabler. Rwanda's alignment with Vision 2050 and First Lady advocacy pre-dated the project and created conditions for rapid policy adoption. South Africa's Deputy Director General and Presidential endorsement (including in the State of the Nation Address) catalyzed resource commitment (Findings 2.1, 2.2).
- Rwanda's model — high-performing, digitally integrated, government-owned — was the portfolio's closest candidate for a formal 'champion country' knowledge export, but even this was not replicated systematically elsewhere (Findings 3.2, 4.6).

- Fiscal space was the universal constraint. Even where political commitment was genuine — Burkina Faso, Malawi, Kenya — the MOH acknowledged inability to finance HPV screening. Burkina Faso's transition plan explicitly stated the Ministry 'cannot support this burden' and reverted to VIA (Finding 2.7).
- Decentralization created variable uptake pathways. In the Philippines, national guidelines were adopted but implementation depended on Local Government Unit (LGU) commitment. Quezon City enacted a legally binding cervical cancer ordinance; other LGUs deprioritized services entirely (Finding 2.4).
- Security crises and competing priorities (Burkina Faso, Malawi) diverted government resources and reduced ministry bandwidth for cervical cancer planning (Findings 2.5, 2.8).
- External financing architecture was transforming during the portfolio. The USG stop-work order on PEPFAR removed an estimated \$5 million annually from Zambia alone; Global Fund GC7 resources for HPV in Burkina Faso were approved but not yet operational at evaluation close (Finding 2.5).

MECHANISM — How the intervention was expected to work, and what actually triggered change

The hypothesized mechanism was: demonstration of proof of concept in 'champion countries' → government confidence in effectiveness → national policy adoption → budget inclusion.

The mechanism fired at the policy level but broke down at the budget level:

- Policy adoption mechanism fired. HPV testing and TA were integrated into national guidelines in 12 of 14 countries by 2023. Governments endorsed WHO 90-70-90 elimination targets and developed national implementation plans and costing exercises (Finding 2.1). The proof-of-concept mechanism clearly operated — demonstration projects shifted provider and policymaker preferences toward HPV-based screening, but not based on learning from 'champion countries' directly.
- The budget mechanism did not fire. Costed national plans existed but were not financed. No project country had procured HPV tests with domestic resources at scale. The Philippines, Guatemala, South Africa, and Rwanda were partial exceptions, with limited domestic procurement, but no country demonstrated national-scale fiscal absorption (Findings 2.3, 2.8).
- An investment-case gap was identified as the specific mechanism failure: governments completed costing exercises but lacked the economic case (cost-per-DALY, return on investment) needed to compete for treasury allocation. The Philippines concluded: 'Costing exercises alone are insufficient; an investment case facilitates parliamentary and local government budget allocations' (Finding 2.3).
- Where the full mechanism fired — South Africa, Rwanda — additional enabling mechanisms were present that are not captured in the original hypothesis: Presidential visibility, First Lady advocacy, pre-existing infrastructure investment, and domestic financing certainty that enabled below-GAP price negotiations (Findings 2.2, 1.24).
- The design assumption 'that demonstrating proof of concept will result in adoption and scale' is explicitly assessed as having 'proved wrong' in Finding 3.10: health systems cannot integrate innovative service models on demonstration evidence alone, without concurrent health system strengthening.

OUTCOME — What resulted in practice

- National guideline adoption: achieved in 12 of 14 countries — a genuine and significant normative outcome (Finding 2.1).
- National budget inclusion: not achieved in any project country at a level sufficient to sustain HPV-based screening. South Africa redirected existing cytology budgets; Rwanda leveraged national insurance. No other country demonstrated self-sustaining domestic procurement (Finding 2.8).

- Post-project service continuity: achieved only partially. In Burkina Faso, HPV testing stopped entirely; in Kenya, counties reverted to VIA; in Malawi, PEPFAR partners sustained WLHIV services but not the general population, and also reverted back to VIA (Findings 2.7, 1.34).
- Scale-up remained elusive universally. Slower-than-anticipated scale-up reflected resource constraints, health system capacity barriers, limited procurement capacity transfer, and political economy factors (Finding 2.4).

CONCLUSION — What works, for whom, and under what circumstances

The hypothesis is partially confirmed for the policy adoption component and not confirmed for the budget inclusion component. Proof of concept from demonstration projects works to shift normative policy in government settings where there is prior health system investment, high-level political champions, and alignment with national development priorities — Rwanda, South Africa, and to a degree the Philippines are the clearest cases. Budget inclusion does not follow automatically from policy adoption without a separate investment-case mechanism that translates costing data into fiscal language for Ministry of Finance audiences. The assumption that evidence of feasibility translates to sustainable government financing was the portfolio's most consequential design error, with lasting consequences for service continuity.

H5: Market Shaping & Price Reduction | ToC level: Outcome | Linked EQs: 2.4, 3.1, 3.2

Hypothesis: Price negotiation and volume procurement trigger MoH procurement otherwise financially infeasible.

CONTEXT — Varying conditions across settings

Market conditions shaped the portfolio's price-reduction strategy from the outset:

- A concentrated supplier landscape — four major manufacturers (Abbott, Hologic, Roche, Cepheid) with platform-specific lock-in — limited the scope of competitive pricing. Each requires a proprietary platform; no generic HPV testing platform existed. Cepheid's GeneXpert, with the highest market share (c.145 countries), required the Hologic ThinPrep solution at an additional \$2.50 per test (Finding 1.24).
- Low domestic procurement volumes in project countries precluded country-level competitive tendering. Ministries of Health were dependent on UNICEF SD or implementing partner procurement rather than direct manufacturer negotiation (Finding 2.4).
- Domestic financing certainty was a lever for below-GAP pricing. Rwanda and South Africa — the only countries with meaningful domestic procurement anchors — achieved prices below global access prices through concurrent insurance integration and domestic budget redirection respectively (Finding 1.24).
- TA market was structurally different: two manufacturers (Liger and Wisap), a smaller and more tractable market, with no platform dependency — creating conditions more amenable to volume guarantee mechanisms (Finding 1.27).

MECHANISM — How the intervention was expected to work, and what actually triggered change

The hypothesized mechanism was: price negotiation + pooled/volume procurement → prices low enough to trigger MoH procurement → increased affordable access.

The mechanism fired at the price reduction level but not at the MoH procurement trigger level:

- HPV price mechanism: CHAI's supplier engagement — Global Access Price (GAP) agreements, demand forecasting, pricing transparency sheets — achieved approximately 40% reduction in HPV test prices. By

2024, GAP agreements covered all four major suppliers, with access prices approaching HIV and TB diagnostic parity (Finding 1.24). However, total landed costs (including laboratory fees, supply chain, sample collection, and platform costs) remained unaffordable: all-in costs ranged from \$9.34 (Qiagen) to \$21.36 (Cepheid) per test. Against a government ability-to-pay threshold of approximately \$2 per test, price reductions were insufficient to trigger domestic procurement (Finding 1.24).

- TA mechanism: The volume guarantee mechanism (committing to procure 6,000 devices over two years) achieved a 43–58% price reduction and expanded access pricing to more than 130 LMICs. The TA market matured sufficiently that Unitaid and CHAI concluded external support was no longer necessary by Phase 3 — the only market shaping component that achieved intended maturation (Finding 1.27).
- A missed mechanism was identified: market shaping tools applied were limited relative to the Unitaid toolkit. Alternative approaches not applied included supporting new manufacturers to enter the market, addressing regulatory bottlenecks, technology transfer and local manufacturing support, and upstream support for true POC HPV test development (Finding 1.23). COVID demonstrated that smaller manufacturers could scale rapidly (e.g., Molbio in India) — a disruptive price-reduction route not pursued (Finding 1.26).
- Price transparency improved — a necessary but insufficient condition. Many buyers, including MOHs, remained unaware of GAP prices; procurement contractual and regulatory barriers prevented eligible buyers from accessing them (Finding 1.24).

OUTCOME — What resulted in practice

- HPV prices reduced by approximately 40% portfolio-wide. TA prices reduced by 43–58% under volume guarantee. These are genuine market shaping achievements (Findings 1.24, 1.27).
- MoH HPV procurement with domestic resources: not achieved at national scale in any project country. Zambia procured 50,000 HPV test kits for the first time in 2025; South Africa redirected cytology budgets; Guatemala negotiated an all-inclusive \$25 package with Roche (Finding 2.8).
- Post-project TA price sustainability is fragile: outside project procurement channels, the TA device price increased from approximately \$1,000 to \$4,000 in Benin through national procurement systems — a critical sustainability gap attributed to monopoly markups and intermediary fees (Finding 1.30).
- Over 600 HPV manufacturers exist globally but only a handful carry WHO prequalification. The pipeline for true POC HPV tests is active, and target product profiles with target prices have been agreed by Unitaid, CHAI, and WHO — but no funded pilot had been initiated at evaluation close (Finding 1.26).

CONCLUSION — What works, for whom, and under what circumstances

The hypothesis is partially confirmed. Market shaping through price negotiation and volume commitment works to reduce prices when applied to relatively mature, small-supplier markets (TA devices) or when combined with large-volume demand aggregation (HPV GAPs). It does not work to trigger MoH procurement when landed costs remain multiples of willingness-to-pay thresholds and when countries lack domestic financing certainty. The mechanism works best in countries with an existing procurement anchor (South Africa, Rwanda) and least in countries with minimal fiscal space and no investment case for secondary prevention. The most significant untested mechanism — disruptive market shaping targeting smaller manufacturers and upstream true POC technology development — was not applied in this portfolio and represents the most consequential missed opportunity.

H6: South-South Learning & Diffusion | ToC level: Long-term outcome | Linked EQs: 3.3, 4.2

Hypothesis: Structured knowledge sharing from early adopters shortens the innovation-to-scale timeline in later-adopter countries.

CONTEXT — Varying conditions across settings

South-South learning operated across a portfolio where structural conditions were not always conducive to formal knowledge transfer:

- Simultaneous implementation across countries reduced the available 'early adopter' advantage: Burkina Faso, Côte d'Ivoire, Kenya, and others were implementing concurrently, limiting opportunities to apply lessons before programme inception (Finding 3.8).
- Language barriers separated Anglophone CHAI countries (Kenya, Malawi, Zambia, Rwanda, Nigeria) from Francophone SUCCESS countries (Burkina Faso, Côte d'Ivoire). Project ECHO addressed this by operating in French, but language remained a structural constraint (Finding 3.8).
- Programme budget prioritization: resources were concentrated on service delivery, training, and commodity procurement, with South-South learning activities de-prioritized and under-resourced (Finding 3.8).
- Structural design: no cross-portfolio learning mechanism was formalized until late in the programme. The two implementing consortia (CHAI and Expertise France/Jhpiego) operated largely independently, with coordination gaps at HQ level (Finding 3.6).
- Rwanda's model — high-performing, digitally integrated, government-owned — was the portfolio's closest candidate for a formal 'champion country' knowledge export, but even this was not replicated systematically elsewhere (Findings 3.2, 4.6).

MECHANISM — How the intervention was expected to work, and what actually triggered change

The hypothesized mechanism was: structured knowledge sharing from early-adopter countries → accelerated learning → shortened innovation-to-scale timelines in later-adopter countries.

The mechanism fired informally but not through structured channels:

- Informal knowledge transfer did occur and was valued. Kenya benefited from peer insights on device deployment from Nigeria and South Africa; Kenya master trainers built capacity in Rwanda and South Africa. This informal diffusion is documented and meaningful (Finding 3.8).
- Jhpiego's institutional knowledge — managing concurrent projects across multiple SUCCESS countries — functioned as an informal transfer mechanism in Burkina Faso, providing more effective knowledge access than formal South-South platforms or global technical assistance such as Project ECHO (Finding 3.8).
- Formal platform outputs were limited. The 2023 Asia-Pacific regional dialogue in Manila brought 76 participants from 55 organizations across 23 countries and raised the Philippine model's visibility. However, follow-up reporting on those dialogues was limited, and the Philippine implementation research was not packaged as a regional practice guide (Finding 3.8).
- Learning capture mechanism was structural not cyclical: learning occurred sporadically and organically rather than through formal, structured mechanisms. In Kenya, insights were not consistently documented or used for real-time programme adaptation. Formalized structures — regional technical working groups, cross-country mentorships, routine knowledge product dissemination — were absent (Finding 3.9).
- Missed synergies were identified. An MSF HPV testing project in Burkina Faso showed no evidence of drawing on SUCCESS lessons despite concurrent implementation in the same country — a concrete demonstration of the cost of absent structured sharing (Finding 3.9).
- Rwanda's continuous adaptation model — revising screening models, adjusting communication, strengthening adverse event monitoring, sharing through white papers and TWGs — offers the most operational benchmark for what structured learning looks like when embedded in programme design (Finding 3.9).

OUTCOME — What resulted in practice

- Policy diffusion via global advocacy did occur: publications, regional dialogues (AFRAVIH, Project ECHO, IPVC conferences, AIDS2024), and national dissemination workshops contributed to normative shifts and guideline updates (Findings 2.1, 3.8).
- Timeline acceleration through South-South learning was not demonstrated at the portfolio level. No country in the evaluation was identified as having meaningfully shortened its innovation-to-scale timeline as a direct result of structured knowledge transfer from an early adopter (Finding 3.8).
- The 'regional momentum' or 'saturation model' — where two or three LMICs achieving 70–90% screening creates peer pressure for others — is proposed as a theory for the next phase, but was not demonstrated in the current period (Finding 4.4).
- Learning did influence programme design iteratively within countries: in Burkina Faso, Phase 1 cascade data directly informed the Phase 2 CHW follow-up model, producing the marked improvement from 44.4% to 94.6% VIA completion. This within-country adaptive learning is the most robustly evidenced form of learning in the portfolio (Findings 1.5, 3.9).

CONCLUSION — What works, for whom, and under what circumstances

The hypothesis is not confirmed in its structured, cross-country form. South-South learning works informally — through shared implementing partner institutional knowledge, peer exchanges between country teams, and publication-based diffusion — and this informal transfer is valued and real. It does not work through formal platforms and regional dialogues when budgets are concentrated on service delivery, implementation is simultaneous rather than sequential, language barriers exist, and no dedicated learning coordination mechanism is built into programme design. The mechanism is most likely to fire when: early-adopter experience is packaged into transferable practice guides (not just publications); when dedicated budget is allocated for learning activities; when cross-consortium coordination platforms are formalized; and when country implementation timelines are sequenced to allow genuine 'early adopter → later adopter' knowledge flow. Within-country adaptive learning — where cascade data from Phase 1 directly informed Phase 2 design — is the strongest demonstrated learning mechanism in the portfolio.

ANNEX 2: EVALUATION QUESTIONS AND KEY FINDINGS

Key evaluation questions & sub-questions	Findings
1. Is the cervical cancer prevention portfolio responsive to needs and contexts?	
EQ1.1 Did the cervical cancer programs respond to country needs and contextual realities? Were there mismatches (if any) between the design assumptions and country-level realities? (Relevance)	- The portfolio lacked a unified theory of change (ToC) until 2023. Working with various result frameworks had implications for monitoring progress and demonstrating effectiveness at portfolio level. - Health systems barriers to HPV testing include platform and laboratory staff capacity constraints, stockouts of tests and consumables, weak referral systems, and data fragmentation. - The project design assumed that external resources would largely pay for service delivery post demonstration, but this did not materialize due to the USG stop-work-order for PEPFAR and reductions in ODA, including in the Global Fund.
EQ1.2. How did Unitaids' cervical cancer interventions interact with those of other partners and broader systems? ¹ (Coherence)	- The design of the portfolio pivoted between phase 1 (demonstrating proof of concept/feasibility of HPV based screening) and phase 2 (service delivery at scale and demonstrating feasibility of elimination); The balance between market-shaping and catalytic-funding roles shifted over the portfolio, with implications for comparative advantage and sustainability that the next phase should weigh. - The current portfolio design missed opportunities for coherence across the HPV vaccination – secondary screening – treatment service continuum, and with other health and social service areas and partners.
EQ1. 3. How did gender norms, roles and relations influence access to, uptake of, and continuity in cervical cancer screening and treatment services — including the roles of women and men as healthcare workers, decision-makers, caregivers and partners — and how were gender considerations addressed in program design (and implementation)? (Equity)	- The portfolio addressed technical access barriers effectively but did not adequately invest in the social, economic, and cultural conditions that enable women to act on technical access. Support for cervical cancer secondary screening is responsive to women's needs, but little pore-project assessment was undertaken in demand-side barriers, including costs, stigma, misinformation and male gatekeeping. Post-treatment abstinence requirements created a distinct and under-addressed barrier to TA acceptance, with disproportionate impact on sex workers. - Civil society engagement shifted from tokenistic to more substantive post-2023, but the shift was recent and unevenly resourced. Community mobilization efforts improved awareness and contributed to screening uptake, but did not achieve the depth needed for transformative demand generation "Equity" in the cervical cancer secondary prevention portfolio is defined as reaching the poorest and most marginalized women, irrespective of need or risk. Evidence on whether gains were equitably distributed between various groups of women is largely absent from portfolio monitoring data (see finding below). While the epidemiological rationale for WLHIV prioritization is well-supported, WLHIV coverage remained below elimination targets in all countries.
2. Is the cervical cancer prevention portfolio responsive to needs and contexts?	
EQ 2.1 To what extent and through what mechanisms did Unitaids' interventions achieve	While HPV DNA testing is more accurate than VIA and generally well-accepted by women and HCWs and enables self-sampling, however same-day screen-triage-treat was generally not feasible in field settings. This results in substantive loss to follow-up at the results return and HPV+ to triage steps. A true point-of-care HPV

¹ Relates to comparative advantage of Unitaids.

Key evaluation questions & sub-questions	Findings
their intended results? (Effectiveness)	test generating actionable results within one clinical encounter could reduce this loss, though technology choice should be context-specific: HPV testing remains effective where patient navigation and laboratory systems are strong; true point-of-care tests and AVE reduce attrition where these systems are weak; and AVE is a pragmatic improvement in rural/last-mile settings without HPV testing access. • Self-sampling is a successful innovation that addressed several access barriers. It has proven acceptable, feasible, and effective in reaching hard-to-reach and never-before-screened women in LMIC. • Integrated service delivery models are useful for reaching the most-at-risk women (WLHIV, sexually active women). Integration of cervical cancer services beyond HIV platforms improved reach and reduced stigma, but remained uneven: deeper integration into reproductive health, family planning, MNCH, and HPV vaccination represents the most significant unrealized opportunity in the portfolio. • Community outreach service models may overwhelm health systems; a strategic trade-off exists between reaching the general population and maintaining focus on high-risk groups. Facility-based services remain the backbone of cervical cancer services even where outreach is active
EQ 2.2 To what extent were women screened positive for precancerous and invasive cervical lesions successfully linked to timely and appropriate treatment services, and how effective were follow-up mechanisms in ensuring continuity of care? (Effectiveness)	• LTFU at the triage step improved substantially over the portfolio period due to strengthened patient navigation and use of community health care workers,. • Long-term follow-up (post VIA or post treatment) and tertiary care access remain critically weak. • Effective follow-up mechanisms include clear referral pathways, SMS notification, phone follow-up, CHW door-to-door tracing, CSO involvement, and male engagement – yet most domestic health budgets in LMICs cannot yet absorb such costs. • While magnitude of LTFU at the different cascade steps varied significantly, conflicting and fragmented measurement of the cascade of care across the portfolio limits meaningful cross-portfolio synthesis.
EQ 2.3 To what extent are women and healthcare workers satisfied with the tools and services introduced (including HPV, self-collection & provider, AI-AVE and TA) and what barriers have they faced in accessing or using them? (Effectiveness)	• Project supported research established that the vast majority of women prefer self-sampling and HPV testing over more invasive (VIA) methods. • TA is received with high satisfaction among HCWs and enables task-shifting; evidence on women's satisfaction is more limited.
EQ2.4 To what extent have market-shaping efforts improved access, affordability, and availability of cervical cancer screening and treatment technologies across countries? Specifically, how efficiently have new technologies (e.g., thermal ablation) been deployed, and what are key bottlenecks? (Effectiveness)	• Project market shaping objectives were clear, but market shaping tools were not fully used. The sustainability of price reductions is uncertain due to as yet immature markets and limited ability to pay by LIMC. • HPV molecular test prices were significantly reduced but landed costs remained unaffordable for project countries. While prices negotiated with the current manufacturers are unlikely to reach affordable levels, there are over 600 HPV test manufacturers that could enter the market with WHO prequalification. • Thermal Ablation device prices reduced significantly due to pooled procurement for project countries and beyond. Affordability remains constrained by the total cost of ownership, including maintenance, spare parts, replacement components, training, and service delivery costs. Same-day triage and TA is contingent on a functioning device; a trained and confident provider present; sufficient consumables; reliable electricity and the woman accepting treatment. • AI-assisted visual examination doubles the sensitivity of VIA, enables same-visit

Key evaluation questions & sub-questions	Findings
	screen & treatment and warrants market shaping support. AVE's limited uptake to date reflects market and ecosystem barriers — including a three-year gap between validation and procurement, and the closure of Global Health Labs. WHO prequalification remains pending, but renewed partner interest and ongoing commercialisation efforts support continued market-shaping investment in AVE. • More affordable and appropriate screening technologies are needed to respond to the key barriers: cost, health system barriers and client preferences.
3. Are services and tools adopted and integrated in global and national strategies?	
EQ3.1 Are the gains from the Unitaids supported work sustainable and scalable? What conditions and mechanisms are likely to support or undermine the sustainability and scalability of Unitaids' contributions beyond the project period? (Sustainability)	• The programme effectively supported countries to integrate HPV testing and thermal ablation into national guidelines through implementation research, and advocacy supported adoption of national cervical cancer elimination policies and strategies, some of which are costed. Costed implementation plans are necessary but insufficient not to unlock domestic budget, without an investment case to convince Finance Ministries. • Transition and sustainability planning was insufficient in some countries, resulting in the end of HPV screening for cervical cancer. Some countries were able to continue or even scale cervical cancer screening services to a limited extent after demonstration projects finished, no project country was able to scale up services nationally.
EQ3.2 Which financing approaches—across public, private, and donor sources—are proving most effective in sustaining affordable HPV screening and treatment services over the long term? What are the true cost drivers of screening and treatment? (Sustainability)	• LIMC ministries face challenges to mobilize domestic resources for secondary screening commodities and services, and there are few examples of meaningful domestic investment. In some countries cervical cancer screening is/may be covered by national health insurance, but that does not automatically translate in universal access. • While the project design assumed that external resources would largely pay for service delivery post demonstration, this did not materialize due to the USG stop-work-order for PEPFAR and reductions in ODA, including in the Global Fund. Most respondents recognize that currently, Unitaids is probably the main international funder of cervical cancer screening services, and that there are no serious other donors in this area.
EQ3.3 Were best practices from early-adopter countries applied to accelerate cervical cancer programming in other countries? (Sustainability)	• Implementing partners facilitated learning within and between project countries, but this lacked a structured design and mechanisms for systematic capture and dissemination of lessons.
4. Is the portfolio implemented efficiently?	
EQ4.1 How timely, cost-efficient, and cost-effective was implementation (considering both allocative efficiency and technical efficiency) and what factors have been considered to ensure that value for money has been achieved from an efficiency standpoint? What mechanisms contributed to efficiency gains in different contexts? (Efficiency)	• Integration of cervical cancer screening into existing services and systems, pooled procurement of equipment, global price negotiations and using UNICEF Supply Division were the most important cost-saving mechanism of the project. Efficiency gains were constrained by supply-chain disruptions and workforce gaps. • While Covid-19 resulted in major delays in project start-up, there were no significant delays in project implementation. Short duration of the initial Portfolio, and subsequent extensions, affected predictability and efficiency. • Stakeholder coordination at country or global level was generally efficient, but working with implementing partners without country presence creates challenges in communication and monitoring of country level progress.
EQ 4.2. Has learning been captured and shared strategically, and how has project learning been	• While there is demand for South-to-South learning, and the project undertook various South-to-South sharing activities, exchange mechanisms from early adopter countries were mainly informal, limiting their influence.

Key evaluation questions & sub-questions	Findings
incorporated in the lifetime of the investments? ² (Efficiency)	
EQ 4.3 How effectively have strategic, implementation and sustainability/scalability risks been identified and managed throughout implementation? (Efficiency)	• Risk management in project implementation was reactive rather than proactive, overall effective, but with fragmented accountability for sustainability and supply chain risks.

² Focus on the portfolio-wide learning. Intervention or country-level learning is addressed throughout the EQs

ANNEX 3: SUMMARY OF PROGRESS TOWARDS PORTFOLIO RESULTS/TOC OUTPUTS AND OUTCOMES

The table below provides a brief overview of progress towards outcomes of the Project, as identified in the Theory of Change developed for the portfolio.

ToC outcome area	Indicator / Achievement	Portfolio – justification for assessment	Assessment
IMMEDIATE OUTCOME 1: Accelerated introduction and adoption of optimal CxCa screen and treat tool and models for secondary prevention (HPV screening, self-sampling, TA and service models)			
HPV testing introduced	Countries with HPV DNA testing operational in national programme	13/14 countries	✓ Achieved
Women screened (HPV test)	Cumulative HPV tests conducted in project-supported facilities (life of project)	~520,000+ total	✓ Achieved
Thermal ablation introduced	TA devices deployed; countries with TA in national guidelines	6,000+ devices across the portfolio (incl. non- project countries) ; 9 CHAI + 4 SUCCESS countries with TA in guidelines	✓ Achieved
Women treated with TA	Cumulative women receiving TA treatment	100,000+	✓ Achieved
Self-sampling introduced	Countries with HPV self-sampling operational; women reached via CBSS	~18,000 through CBSS models	✓ Achieved
AVE introduced	Validation status; countries with AVE in strategic plans	Validation complete; commercialization pending; WHO prequalification pending	ⓘ Partial
IMMEDIATE OUTCOME 2: National conditions in place for sustainable equitable access to CxCa secondary prevention, incl. regulatory, policy and funding plans available in project countries			
National guidelines updated	Countries with HPV testing and/or TA incorporated in national CxCa guidelines	13/14 countries with updated guidelines	✓ Achieved
Costed national elimination plans	Countries with costed national CxCa elimination or scale-up plan developed	~12/14 countries with costed plan or strategic framework	✓ Achieved

ToC outcome area	Indicator / Achievement	Portfolio – justification for assessment	Assessment
Financing commitments secured	Countries with secured multi-source financing (GF, PEPFAR, domestic) beyond Unitaid	~10/14 countries with some GF or domestic financing commitment, however largely dependent on Unitaid funding. Across country case studies most HPV screening reverted to VIA after project closure.	🟡 Partial
Health insurance inclusion	Countries progressing CxCa service inclusion in national health insurance scheme	~4–5 countries with active insurance inclusion pathway	🟡 Partial
IMMEDIATE OUTCOME 3: Increased affordability of HPV tests and TA equipment			
HPV test price reduction	Average % reduction in HPV test price for LMICs vs 2019 baseline	40% average reduction; parity with HIV/TB test pricing achieved for first time	✔ Achieved
TA device price reduction	Average % reduction in TA device price vs 2019 baseline; sustainability of pricing	45% sustained reduction; pricing stable and self-sustaining post-VG exit	✔ Achieved
Landed cost progress	Landed cost per HPV test result (+ collection + transport + cold chain)	GAP achieved; however still largely unaffordable for governments in LMIC	🟡 Partial
IMMEDIATE OUTCOME 4: Stronger partnerships for CxCa programming nationally, regionally, globally			
Global partnerships	Engagement with WHO, Gavi, Global Fund, Africa CDC, PEPFAR on CxCa policy and procurement	WHO, GF, PEPFAR, Gavi engaged; Gavi-screening linkage remains underdeveloped, Global Fund and African CDC requesting for more engagement and sharing of plans and priorities.	🟡 Partial
National coordination mechanisms	Technical working groups or coordination platforms established and functioning	~10/14 countries with formal technical coordination mechanism	✔ Achieved
South-South learning	Regional learning events; peer-country adoption of portfolio tools or models	Evidence base established; but formal peer-learning mechanism limited and in a largely unstructured approach however with recent efforts acknowledged.	🟡 Partial
LONGER-TERM OUTCOME 5: Increased screening & treatment coverage in project countries			
Screening coverage — general population	% eligible women (30–49) screened by end of project; cumulative screening volumes	70% elimination coverage targets not yet met in any country, and the majority of screening still with VIA. Kenya: 48% ever-screened (2024); ~3.4m screened 2019–2025 (25 counties); Rwanda: 21.7% HPV coverage 2024 (target 71% by 2027); Uganda: 850 sites by 2022 SUCCESS: 182,093 cumulative (incl. VIA/cytology) across 4 countries, 139 facilities; Burkina Faso: 38,348 women (21 sites);	🟡 Partial

ToC outcome area	Indicator / Achievement	Portfolio – justification for assessment	Assessment
Screening coverage — WLHIV	% WLHIV on ART screened; HPV positivity documented among WLHIV	Kenya: 41% peak 2024 → 30% 2025 Malawi: WLHIV 43% HPV positive (2019–20 sub-study); Burkina Faso: WLHIV HPV positivity 34.9% vs 19.3% general pop; ~8.2% of all SUCCESS-screened women were WLHIV	🟡 Partial
HPV+ to triage linkage	% HPV-positive women linked to VIA triage; LTFU rate at HPV+→VIA step	Early 5-country pilot 2019–20: 36% linkage; Malawi full programme: 78% linkage CBSS models (Kenya, Rwanda, Zambia, Zimbabwe, Nigeria, Malawi): avg >70% triage linkage Burkina Faso: Phase 1: 63.6% gen pop / 44.4% WLHIV; Phase 2 CBSS: 94.6% (door-to-door) / 91.7% (CSO model); Cote D'Ivoire: 18% within 90 days (lowest); Guatemala and Philippines: ~70%	🟡 Partial
Treatment coverage (precancerous lesions)	% eligible screen-positive women receiving TA treatment; treatment coverage trajectory	9-country trajectory: 54% (2019) → 77% (2023); Uganda: 73% → 86% (2021–22); Malawi: 92% among eligible; Kenya: ~100% suspicious lesions by 2025 Burkina Faso: 94.1% general pop treated; 89.9% WLHIV treated; Cote D'Ivoire Guatemala/ Philippines: treatment rates 87–100% among eligible (IR study)	✅ Achieved
LONGER-TERM OUTCOME 6: Sustainable & efficient programmes ready to deliver in project countries			
Domestic financing secured	Countries with domestic budget line or insurance coverage sufficient to sustain HPV testing post-project	No country fully self-financing. Nigeria - Lagos State: 500% budget increase 2022 Rwanda: CBHI integration progressing; Kenya: SHA integration advanced; Zambia: govt procurement of 50,000 kits 2025. South Africa: NDOH has funds committed for screening, and intent to cover HPV once guidelines updated Guatemala: Comprehensive Cancer Care Law 2024; US\$1m domestic 2023; Burkina Faso: no HPV tests in stock as of May 2026; BF MoH 'cannot support this burden' (Transition Plan 2023)	🟡 Partial
Service continuity post-project	Evidence of HPV testing continuing after Unitaids/project support ended	Malawi: most districts reverted to VIA-only or WLHIV-only (PEPFAR) post-exit; Uganda: continued via GF/PEPFAR; Rwanda: continuing with Unitaids and external donor support Kenya: some counties reverted to VIA in 2025 Zambia: secured multi-source financing (Global Fund, PEPFAR, government procurement),but remains largely donor-dependent and fragile.	🟡 Partial

ToC outcome area	Indicator / Achievement	Portfolio – justification for assessment	Assessment
		Burkina Faso: HPV testing collapsed entirely at all 21 SUCCESS sites post-project (May 2026); Cote d'Ivoire : HPV testing discontinued Guatemala: national budget in some districts continues; Philippines: HTA pending	
HPV market sustainability	HPV test pricing maintained; procurement continuing through domestic or GF/PEPFAR channels	Global Access pricing (GAPs) maintained by 3/4 suppliers; UNICEF SD 80% Unitaaid-funded (2025) — near-total financing dependency; Cepheid reverted from \$10 to \$14.90 post-project; Countries dependent on GF GC7 or donor procurement; no country procuring at domestic budget scale, although in the Philippines some local government units have procured HPV tests using local budgets; Burkina Faso: no HPV tests in stock post-project	🔴 Partial
LONGER-TERM OUTCOME 7: Better integrated CxCa screening into health services for routine delivery			
Integration into HIV platforms	% programme countries with CxCa screening integrated into ART/HIV services as standard practice	CxCa integrated into HIV/ART services in 13/14 countries (all countries except Senegal); Uganda: 850 sites integrated into HIV networks; Rwanda: WLHIV offered screening at every ART visit in SUCCESS countries: CxCa integrated into HIV services; 3/4 national guidelines include WLHIV-specific algorithm (Guatemala pending)	✅ Achieved
Integration into RH/FP/MNCH platforms	Evidence of CxCa screening systematically offered through family planning, ANC, or MNCH services	Kenya: integration into FP and RH services present but less pronounced than HIV integration; Nigeria: integrated into FP/RH at 3 focal states Burkina Faso: opportunistic integration into Family planning/postpartum -trained HCWs in 139 facilities including RH and HIV units; guideline integration confirmed.	🔴 Partial

ANNEX 4 : RECOMMENDED REVISION OF THE TOC FOR THE PORTFOLIO PHASE 2025-2029.

In the first phase of the portfolio, the theory of change was that that Unitaid support as an investor, pathfinder and market shaper, would enable project countries to 1) demonstrate the feasibility of HPV testing and thermal ablation and screening service models in project country contexts; 2) increase the affordability of these new technologies through market shaping; 3) support national policy frameworks to adopt WHO recommended screening methodologies and develop resource mobilisation strategies; 4) increase awareness about cervical cancer screening, and 5) document and share learning across countries, so that project countries would integrate innovative screening and treatment technologies and service models in national cervical cancer programmes and increase coverage, ultimately towards the longer term WHO cervical cancer elimination goals. Underlying assumptions were that 1) innovations would prove effective, cost-effective and acceptable; 2) governments would remain committed to CxCa elimination goals, and 3) that domestic and international funding would become available to scale up screening services beyond demonstration sites.

The second phase of the portfolio, based on the success and lessons from the first phase. moved from demonstrating proof of concept to catalytic funding to 1) enabling selected champion countries to deliver services at scale and address health system barriers; 2) provide evidence for CxCa elimination in LMIC, and share this evidence beyond project countries; and 3) provide market shaping support newer technologies for CxCa screening (true POC HPV tests and AI supported visual examination), and 4) support resource mobilisation from domestic and international sources, so that champion countries achieve the 70-90 elimination targets, ultimately towards the longer term WHO cervical cancer elimination goals. Underlying assumptions are that 1) countries' health systems are robust enough to be able to scale up screening and treatment into existing health services; 2) champion countries will achieve elimination goals (70% eligible women screened and 90% of eligible women treated) and 3) countries are able to sustain service delivery beyond Unitaid catalytic funding with domestic or international funding.

The external evaluation, based on findings and lessons from the first phase, recommends to adjust the ToC for the second phase in the following ways:

1. Because HPV DNA testing remains unaffordable for LMIC, emphasize the role of Unitaid in market shaping for further price reduction of HPV DNA tests
2. Because same-day test & triage remains elusive with HPV DNA tests, emphasize the role of Unitaid in market shaping for marketization of true POC HPV tests, and AI-supported VE methods as same-day alternatives.
3. Because generic health system barriers result in suboptimal service access and use, undertake pre-project and regular follow up health technology assessments, and base catalytic funding support decisions on minimum criteria
4. Because M&E systems are weak and loss to follow up is high, support (global) development and (national) implementation of a standardized CxCa cascade framework and indicators.

- Because domestic and international follow up funding for CxCa services is unlikely post 2030, make sustained catalytic funding conditional on increasing levels of counterpart funding

ANNEX 4.A: TOC IN PORTFOLIO RFP FOR 2025-2030 IMPLEMENTING PARTNERS

This TOC is essentially the same as the 2023 TOC for the current portfolio (2019-2025), and does not fully align with the narrative description in the Investment case to the Unitaid PSC (see below).

Cervical Cancer Unitaid portfolio level Theory of Change (2025-2030)

Problem	Public health need	In LMICs, cervical cancer is a leading cause of cancer-related deaths among women, with women living with HIV at a higher risk due to persistent HPV infection and faster progression to invasive disease. Persistent gaps in access to screening, diagnostics, and treatment drive high morbidity and mortality, especially among the most vulnerable populations. As the global cervical cancer elimination effort reaches its midpoint toward the 90-70-90 targets, urgent action is needed to close these gaps and accelerate progress toward equitable prevention and treatment coverage.		
	Access barriers	Demand & adoption	There is limited domestic and institutional financing for scaling up screening and treatment services. Uptake of high-performing screening and treatment solutions is dependent on national programme readiness*, inclusion in national policies and guidelines, level of awareness of cervical cancer threat and prevention options at all levels, and access to screening outside medical facilities	
		Supply & delivery	Lack of scalable laboratory delivery approaches to efficiently respond to different volumes and variety of sample sources. Lack of a comprehensive IT solution with functionality including efficient patient communication and navigation systems, screening registers, and M&E to ensure timely awareness of screening opportunity and results, patient tracking, and continuum of care	
		Innovation	There are currently no true POC solutions (R&D underway). AI-based triage tools have yet to be validated and quality assured	
Conceptual pathway	Outputs		Expected Outcomes	Impact
	- Advance replicable models to accelerate scale-up and elimination through supporting national cervical cancer programs in priority countries [demand & adoption] - Demonstrate integrated service delivery models within primary healthcare ensuring linkage to care systems are functional [supply & service delivery] - Strengthen CCSE structures to address barriers for CxCa secondary prevention and elimination, with meaningful involvement of people with lived experience [demand & adoption] - Support to advance cost-effective and innovative tools and approaches, such as AI and POC Dx, to expand detection and treatment of HPV and precancerous lesions [innovation] - Strengthen national procurement and supply systems, including policy frameworks to ensure sustainable and affordable supply of commodities and equipment, including diagnostics, treatments and consumables [supply & delivery] - Facilitate sustainable financing commitments (domestic and external) to catalyze broader scale-up of national CxCa programs [demand & adoption] - Establish diverse platforms for knowledge exchange, south-south learning, dissemination, and sharing of best practices to accelerate elimination efforts within and beyond priority countries [demand & adoption]		- Increased and more equitable access to high quality cervical cancer screening & treatment services in priority countries and beyond - Improved continuity of care and treatment completion - Stronger ownership and integrated cervical cancer programs, paving the way for sustainable elimination efforts	- Accelerated progress towards global cervical cancer elimination targets i.e. 70-90 targets for screening and treatment by 2030 - Reduced incidence and mortality from cervical cancer - More resilient and equitable, people-centered health systems and services
Key risks/assumptions	Strategic risks: Shifts in funding for primary prevention, national and global prioritization of the CxCa elimination agenda, and delays in the pipeline of new tools/AI Implementation risks: Limited implementation time, challenges with establishing and building CxCa programs Sustainability/scalability risks: Limited sustainable funding to catalyze the national scale-up of CxCa Assumptions: Cervical cancer secondary prevention and the elimination agenda will remain a priority for partners and national governments			

ANNEX 4B: TOC BASED ON THE UNITAID INVESTMENT CASE ³

Preamble: Comparative advantage Unitaid

Unitaid has established itself as an *investor, influencer and pathfinder* in secondary prevention. Unitaid's role remains critical in ensuring screening and treatment remain possible where countries

³ This theory of change is from the investment case presented to the PSV in late 2025, which is reflected in the RFP for implementing partners in 2026.

want to prioritize elimination, and complements immunization efforts by GAVI and the Gates.

Problem

Public health need:

- Cervical cancer disproportionately affects women in LIMC, where nearly 90% of cervical cancer deaths occur due to limited access to prevention, screening, and treatment services.
- Primary prevention (HPV vaccination) needs to be complemented by secondary prevention: early detection and treatment of precancerous lesions.
- Despite WHO's 90-70-90 elimination targets, progress in secondary prevention remains slow due to structural, financial, and programmatic challenges

Access barriers

- *Demand and Adoption:*
 - > National program readiness and policy integration: requiring costed national strategies.
 - > Low awareness and demand: Women remain unaware, requiring engagement of communities, civil society and people with lived experience.
 - > Access to screening beyond health facilities: requiring decentralized outreach-based and integrated service models.
 - > Limited domestic and institutional financing: reliance on donor support often restricts services to women living with HIV.
- *Supply and Delivery, and Affordability:*
 - > Lack of scalable laboratory delivery approaches: including optimal turnaround times, rapid delivery of test results and sample transport.
 - > HPV tests cost too high for LMICs, even global access pricing
 - > Weak continuum of care, where HPV positive women are lost to follow-up due to fragmented care systems, requiring digital patient tracking, screening registers, and monitoring and evaluation systems.
 - > Limited availability of thermal ablation in primary health centers, leading to further delays.
 - > Procurement and supply barriers: requiring coordination across procurers (in-country and global), to ensure affordability and supply sustainability.
- *Innovation and availability:*
 - > Lack of true point-of-care (POC) solutions: Promising POC diagnostics are developed but require validation and quality-assurance.
 - > Unvalidated (AI)-enhanced visual evaluation tools: this improves visual screening accuracy and efficiency but require validation and regulatory approval.

Conceptual pathway

Inputs

1. Unitaid Funding
2. Country's health system (e.g. human resources, facilities)
3. Grantee (in-kind/ monetary) contribution
4. Other partners' co-funding (public, private, global)

Outputs

1. A subset of ‘champion’ countries⁴ with completed “readiness assessments”
2. Support for service delivery at scale 1) integrated screening in HIV, SRHR and self-care programs plus 2) decentralized screening in community/primary health care settings.
3. Support to address cross-cutting health system, including lab, patient navigation & communication, HMIS, and monitoring & evaluation (based on readiness assessment)
4. CSO grants to raise awareness and advocate for people-centered programmes.
5. National financing strategies for cervical cancer elimination, e.g. leveraging existing national health programs, aligning with GAVI supported immunization, and integrated financing for screening and treatment as essential health interventions.
6. National procurement and supply support: improve procurement mechanisms and address supply chain bottlenecks for screening and treatment commodities
7. Market shaping support for cost reduction of technologies (HPV/TA): including pooled procurement/volume guarantees/coordination with manufacturers & procurement agencies for technologies;
8. Advanced pipeline of innovative screening and treatment technologies; including AI- supported visual examination and true POC HPV tests
9. Evidence that demonstrates that elimination is possible in champion countries.
10. South-to-South learning agenda for countries to share learnings for replication
11. Engagement with key funders, Gates Foundation, Global Financing Facility, Medaccess, Global Fund etc. to align sustainable financing, technical assistance, market shaping, procurement, and transition planning.

Expected Outcomes

In the short to medium term, Unitaaid aims to create the preconditions for elimination by supporting a cohort of “champion” and high burden countries in moving from opportunistic to full-scale, routine national elimination programs:

- scaled up access to and coverage of HPV testing, improve screening accuracy
- improved linkage to treatment and referrals for screen-positive women,
- effective treatment with thermal ablation
- countries in achieving 70-90 targets for national HPV screening and treatment

Impact

- By 2030 reduction in cervical cancer cases and related deaths.
- In 10 years in a subset of countries, avert an additional 126,000 deaths

Key risks/assumptions

- strategic risk: Shifts in national resource allocation priorities result in a decline in momentum for cervical cancer elimination (Mitigation: undertake country readiness assessments to select

⁴ Including Rwanda, South Africa, Kenya and Zambia.

countries with clear commitment to eliminate cervical cancer; integrate with HPV vaccination and CxCa treatment to increase cost-effectiveness; co-design future investments with country governments.)

- Implementation risks: limited time to implement within current funding cycles, challenges to expand national cervical cancer programs, and/or integrate screening in vertical disease programs. (Mitigation learnings across settings, and linkages across the Unitaaid portfolios).
- Sustainability and scalability risks Unavailability of long-term financing for national scale-up. (Mitigation: technical and financial coordination for costing and financing strategies)

ANNEX 4C: PROPOSED TOC FOR 2025-2030 BASED ON EVALUATION LESSONS & RECOMMENDATIONS

Preamble: Comparative advantage Unitaaid

Unitaid's comparative advantage is typically to act as a catalytic investor de-risking promising health innovations and preparing them for adoption by governments and major global health funders. In secondary prevention, Unitaaid established itself as an *investor, influencer and pathfinder*, resulting in validation of innovative screening and treatment technologies (HPV DNA testing, Thermal Ablation, AI-assisted visual examination) and screening models (integrated and outreach). In the next phase Unitaaid's role remains catalytic in ensuring secondary screening innovations remain accessible for countries that prioritize and scale cervical cancer elimination programmes.

Problem

Public health need:

- Cervical cancer disproportionately affects women in LIMC, where nearly 90% of cervical cancer deaths occur due to limited access to prevention, screening, and treatment services.
- Despite WHO's 90-70-90 elimination targets, progress in secondary prevention remains slow due to structural, financial, and programmatic challenges

Access barriers

- *Affordability, Supply and Delivery:*
 - > HPV tests cost too high for LMICs, even global access pricing, requiring additional price reduction strategies
 - > Weak continuum of care, HPV positive women are lost to follow-up due to health system weaknesses, including linkage across the CxCa services cascade and HMIS, requiring individual patient tracking, and national M&E systems capturing the entire elimination cascade.
 - > Procurement and supply barriers: requiring coordination across procurers (in-country and global), to ensure affordability and supply sustainability.
 - > Lack of scalable laboratory delivery approaches: including optimal turnaround times, rapid delivery of test results and sample transport.
- *Innovation and availability:*
 - > Lack of true point-of-care (POC) solutions: Promising POC diagnostics are developed but require validation and quality-assurance.
 - > (AI)-enhanced visual evaluation tools validated but not commercialized: requiring regulatory approval and commercialization.

- *Demand and Adoption:*
 - > Limited domestic and institutional financing: reliance on donor support and despite national program readiness and policy integration exist, resource mobilization strategies, including investment cases for domestic resource allocation, do not exist.
 - > Low awareness and use: Women remain unaware and face gendered socio-economic barriers to access screening, requiring engagement of people with lived experience in service design.

Conceptual pathway

Inputs

1. Unitaid funding and market shaping expertise and connections
2. Country's health system (e.g. human resources, facilities)
3. Grantee (in-kind/ monetary) contribution
4. Other partners' co-funding (public, private, global)

Outputs

1. A subset of 'champion' countries⁵ selected on a positive "health system readiness assessment" i.e. sufficient lab, patient navigation & communication, HMIS, and monitoring & evaluation capacity for CxCa screening at scale. (global)
2. Co-created national service delivery models 1) integrated screening in HIV and SRHR settings targeting women with the highest risk for HPV, plus 2) decentralized screening in community/primary health care settings targeting women with limited access to health services, and 3) service models for linking HPV vaccination, screening and CxCa treatment
3. National procurement and supply support: improve procurement mechanisms and address supply chain bottlenecks for screening and treatment commodities. (national)
4. Evidence that demonstrates that elimination is possible in champion countries.
5. National financing strategies for cervical cancer elimination, including investment cases for secondary prevention targeting national decisionmakers. (national)
6. CSO grants ensure people centered design, e.g. through research, advocacy, or community-led monitoring. (national)
7. Advanced pipeline of innovative screening and treatment technologies; including AI-supported visual examination and true POC HPV tests (global)
8. Engagement with key funders, Gates Foundation, Global Financing Facility, Medaccess, Global Fund etc. to align sustainable financing, technical assistance, market shaping, procurement, and transition planning. (global)
9. A standardized CxCa service cascade, used for national monitoring and global reporting
10. South-to-South learning agenda for countries to share learnings for replication

Expected Outcomes

Preconditions for elimination by supporting a cohort of "champion" and high burden countries in

⁵ Including Rwanda, South Africa, Kenya and Zambia.

moving from opportunistic to full-scale, routine national elimination programs:

- project 'champion' countries achieving 70-90 targets for national HPV screening and treatment
- evidence of learning from champion countries in other LIMC countries

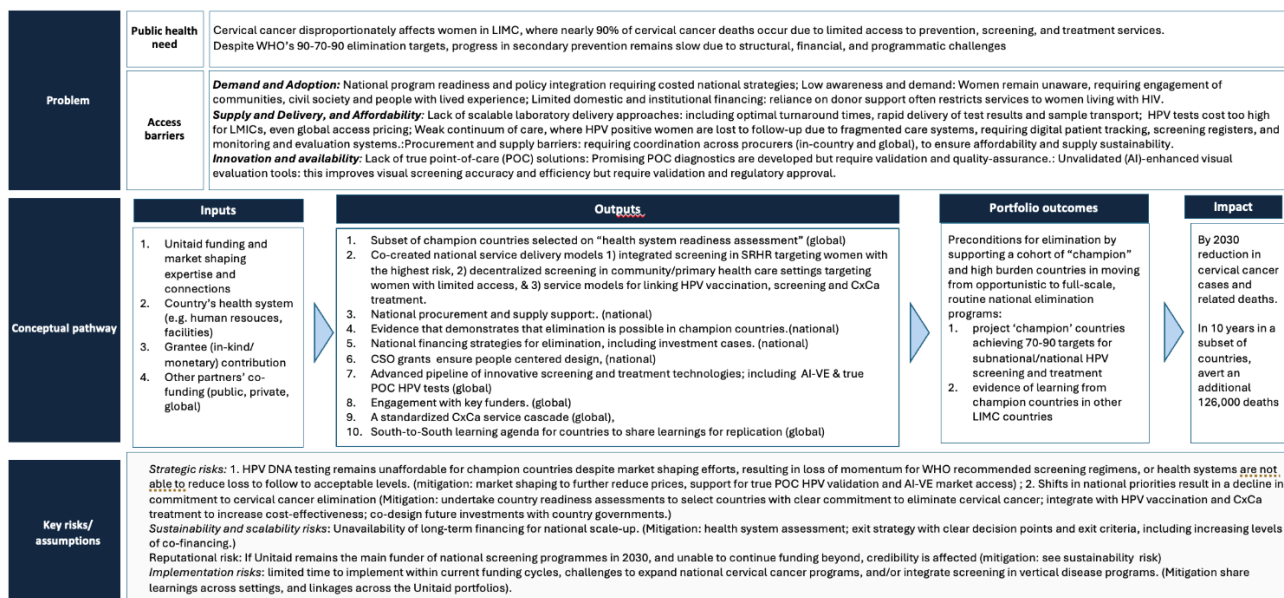
Impact

- By 2030 reduction in cervical cancer cases and related deaths.
- In 10 years in a subset of countries, avert an additional 126,000 deaths

Key risks/assumptions

- Strategic risk: HPV DNA testing remains unaffordable for champion countries despite market shaping efforts, resulting in loss of momentum for WHO recommended screening regimens, or health systems are not able to reduce loss to follow to acceptable levels. (mitigation: market shaping to further reduce prices, support for true POC HPV validation and AI-VE market access)
- Shifts in national priorities result in a decline in commitment to cervical cancer elimination (Mitigation: undertake country readiness assessments to select countries with clear commitment to eliminate cervical cancer; integrate with HPV vaccination and CxCa treatment to increase cost-effectiveness; co-design future investments with country governments.)
- Sustainability and scalability risks: Unavailability of long-term financing for national scale-up. (Mitigation: health system assessment; exit strategy with clear decision points and exit criteria, including increasing levels of co-financing.)
- Reputational risk: If Unitaids remains the main funder of national screening programmes in 2030, and unable to continue funding beyond, credibility is affected (mitigation: see sustainability risk)
- Implementation risks: limited time to implement within current funding cycles, challenges to expand national cervical cancer programs, and/or integrate screening in vertical disease programs. (Mitigation share learnings across settings, and linkages across the Unitaids portfolios).

The figure below presents the proposed ToC for 2025-2030 based on Evaluation lessons and recommendations



ANNEX 5. EVALUATION MATRIX

Evaluation criteria (DAC)	Key evaluation questions	Sub-questions	Hypotheses tested ⁶	Sources of data	
				Documents	KII/FGD
Relevance	1. Is the cervical cancer prevention portfolio responsive to needs and contexts?	EQ1.1 Did the cervical cancer programs respond to country needs and contextual realities? Were there mismatches (if any) between the design assumptions and country-level realities?	H1, H2	Needs assessments Project agreements Project reports Evaluations/ studies	Unitaid programme team Implementers Country stakeholders Service users, CHW
Coherence		EQ1.2. How did Unitaid's cervical cancer interventions interact with those of other partners and broader systems? ⁷	H4, H5, H6	Project agreements Project progress reports Evaluations/ studies	Unitaid team Implementors MoH staff Global CxCa actors (Gavi, Gates, IUCC, etc)
Equity		EQ1. 3. How did gender norms, roles and relations influence access to, uptake of, and continuity in cervical cancer screening and treatment services — including the roles of women and men as healthcare workers, decision-makers, caregivers and partners — and how were gender considerations addressed in program design (and implementation)?	H3	Project agreements Project progress reports Evaluations/ studies	Unitaid programme team Implementers Country stakeholders Service users, CHW
Effectiveness	2. Did the portfolio achieve intended outcomes?	EQ 2.1 To what extent and through what mechanisms did Unitaid's interventions achieve their intended results?	H1, H2, H3, H4, H5	Project agreements Project progress reports Evaluations/ studies	Implementers Country stakeholders
Effectiveness		EQ 2.2 To what extent were women screened positive for precancerous and invasive cervical lesions successfully linked to timely and appropriate treatment services, and how effective were follow-up mechanisms in ensuring continuity of care?	H2, H4	Project progress reports Evaluations/ studies	Implementers Country stakeholders

⁶ H1 Community delivery & self-sampling, H2 Integrated service delivery & same-day treat, H3 Technology introduction & HW capability, H4 Proof of concept & national adoption, H5 Market shaping & price reduction, H6 Equity & gender-responsive design, H7 South-South learning & diffusion

⁷ Relates to comparative advantage of Unitaid.

Evaluation criteria (DAC)	Key evaluation questions	Sub-questions	Hypotheses tested ⁶	Sources of data	
				Documents	KII/FGD
Effectiveness		EQ 2.3 To what extent are women and healthcare workers satisfied with the tools and services introduced (including HPV, self-collection & provider, AI-AVE and TA) and what barriers have they faced in accessing or using them?	H1, H2, H3	Project progress reports Evaluations/ studies	Service users representatives of target groups CHW, service providers
Effectiveness, Relevance		EQ2.4 To what extent have market-shaping efforts improved access, affordability, and availability of cervical cancer screening and treatment technologies across countries? Specifically, how efficiently have new technologies (e.g., thermal ablation) been deployed, and what are key bottlenecks?	H5	Project progress reports Evaluations/ studies	Unitaid programme team Implementers Country stakeholders MoH supply department Service users, CHW Suppliers/manufacturers
Sustainability	3. Are services and tools adopted and integrated in global and national strategies?	EQ3.1 Are the gains from the Unitaid supported work sustainable and scalable? What conditions and mechanisms are likely to support or undermine the sustainability and scalability of Unitaid's contributions beyond the project period?	H4	National guidelines on CxCa screening Global normative guidance Project progress reports Evaluations/ studies	Global partners Unitaid programme team Implementers Country stakeholders
Sustainability, Efficiency		EQ3.2 Which financing approaches—across public, private, and donor sources—are proving most effective in sustaining affordable HPV screening and treatment services over the long term? What are the true cost drivers of screening and treatment?	H4	National CxCa policies and strategies National costing data Project progress reports Evaluations/ studies	Unitaid programme team Implementers Country stakeholders (MoH)
Sustainability		EQ3.3 Were best practices from early-adopter countries applied to accelerate cervical cancer programming in other countries?	H4, H6	Portfolio progress reports Best practice papers Evaluations/ studies National strategies Global guidelines	Global partners Unitaid programme team Implementers Country stakeholders
Efficiency	4. Is the portfolio implemented efficiently?	EQ4.1 How timely, cost-efficient, and cost-effective was implementation (considering both allocative efficiency and technical efficiency) and what factors have been considered to ensure that value for money has been achieved from an	H1, H2, H3, H4, H5, H6	Portfolio progress reports Portfolio financial reports	Global partners Unitaid programme team Implementers Country stakeholders

Evaluation criteria (DAC)	Key evaluation questions	Sub-questions	Hypotheses tested ⁶	Sources of data	
				Documents	KII/FGD
		efficiency standpoint? What mechanisms contributed to efficiency gains in different contexts?		Project progress & financial reports Evaluations	
Efficiency		EQ 4.2. Has learning been captured and shared strategically, and how has project learning been incorporated in the lifetime of the investments? ⁸	H6	Portfolio progress reports Project progress & financial reports Document about national, regional and global learning events	Global partners Unitaid programme team Implementers Country stakeholders
Efficiency		EQ 4.3 How effectively have strategic, implementation and sustainability/scalability risks been identified and managed throughout implementation?	H4, H5, H6	Risk strategy and progress reports Portfolio progress reports Portfolio financial reports, Project progress & financial reports Evaluations	Global partners Unitaid programme team Implementers Country stakeholders

⁸ Focus on the portfolio-wide learning. Intervention or country-level learning is addressed throughout the EQs

ANNEX 6. HYPOTHESES AND CMO CONFIGURATIONS

H1 Community-based and self-sampling delivery models	
Hypothesis	Demonstrating that community-based HPV self-sampling is feasible, acceptable, and effective in resource-constrained settings triggers health system confidence and political will for national adoption of community delivery as a standard service model — increasing screening coverage among women who would not otherwise access facility-based services. Condition: <i>This effect is contingent on contexts where distance, stigma, or gender norms constitute the primary barrier to access, and where community health worker infrastructure exists to sustain delivery beyond the pilot phase.</i>
Links	EQs & learning themes: EQ2.1, EQ2.3, EQ1.3 Learning Themes 1 and 3
H2 Integrated service delivery and same-day screen-and-treat	
Hypothesis	Integrating cervical cancer screening into existing high-contact health services — HIV/ART, MNCH, family planning — combined lab optimization work and patient navigation tools allowing for same-day HPV testing and thermal ablation treatment, triggers client convenience and health worker confidence simultaneously, reducing loss to follow-up and increasing treatment completion rates. Condition: <i>This effect holds only where sufficient equipment is functional and maintained, staff are trained and confident in using it, and referral and follow-up systems are in place. In settings without these prerequisites, integration increases service contact without improving continuity of care.</i>
Links	EQs & learning themes: EQ2.1, EQ2.2, EQ2.3 Learning Themes 1 and 2
H3 Technology introduction and health worker capability	
Hypothesis	Introducing AI-assisted visual examination (AI-AVE), Thermal Ablation and HPV DNA testing increases health worker diagnostic confidence and willingness to treat precancerous lesions on the same day — improving continuity of care and reducing the proportion of women lost between screening and treatment. Condition: <i>This effect is contingent on health workers receiving adequate initial training and ongoing technical support, and on the technology being perceived as reliable and contextually appropriate. Where training is insufficient or technology is perceived as a replacement for clinical judgement rather than an aid to it, uptake and sustained use will be limited.</i>

Links	EQs & learning themes: EQ2.1, EQ2.3 Learning Theme 1
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H4 Proof of concept and national policy adoption	
Hypothesis	Demonstrating proof of concept for effective and affordable cervical cancer secondary prevention service delivery models in a small number of demonstration sites triggers national government confidence and buy-in, has catalytic impact, leading to inclusion of screening and treatment in national strategies, health insurance packages, and domestic budget allocations. Through the following mechanisms Condition: <i>This effect depends on political will for women's health being present at senior government level, and on implementing partners actively investing in policy translation — translating evidence into the formats and relationships that drive national decision-making. In the absence of either, proof of concept generates publications but not policy change.</i>
Links	EQs & learning themes: EQ2.1, EQ3.1, EQ3.3 Learning Theme 4
H5 Market shaping and price reduction	
Hypothesis	Negotiating reduced prices for HPV tests and volume procurement of thermal ablation devices triggers procurement decisions by ministries of health that would not otherwise have been financially feasible — expanding access to technologies and catalysing market entry by a broader range of suppliers. Condition: <i>The sustainability of this effect depends critically on whether lower prices become embedded in global procurement frameworks and national budgets rather than remaining conditional on Unitaids continued market facilitation. Where domestic procurement capacity and supply chain integration remain weak, access gains will not outlast the project period.</i>
Links	EQs & learning themes: EQ2.4, EQ3.1, EQ3.2 Learning Themes 1 and 5
H6 South-South learning and diffusion of innovation	
Hypothesis	Structured knowledge sharing from early-adopter champion countries — through regional networks, peer learning exchanges, documented best practice, advocacy and knowledge products — triggers accelerated adoption of proven approaches in later-adopter countries and adaptation to different contexts, thus shortening the time from innovation demonstration to national-scale implementation. Condition: <i>This effect is contingent on the receiving country having a sufficiently similar contextual profile (health system maturity, disease burden, policy environment) to make adaptation viable, and on the presence of national champions with the authority and mandate to drive uptake. Passive dissemination without active facilitation and peer exchange does not reliably trigger adoption.</i>

Links	EQs & learning themes: EQ3.3, EQ4.2 Learning Theme 6
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ANNEX 7. DATA COLLECTION TOOLS

ANNEX 7A: KI interview guide global/regional key informants⁹

Introduction (read to interviewee)

- Thank you for agreeing to participate in this interview.
 - The purpose of this discussion is to understand your perspectives and experiences with the Unitaïd funded support for CxCa screening services
 - Your responses will help assess Unitaïd's impact so far, and lessons for the next phase.
 - Participation is voluntary, and your responses will be kept confidential.
 - With your permission, I would like to take notes / record this interview.
 - Do you have any questions before we begin?
-

Background information

1. Can you briefly describe your relationship with Unitaïd and the cervical cancer work?
-

Is the programme responsive to needs and contexts? (Probe as relevant)

1. In what contexts do you think the programme is most and least responsive, and why?
 2. How and under what conditions does the programme address inequities in access and outcomes (including gender-related barriers)?
 3. For whom does the programme work (or not work), and why?
 4. What adaptations to programme design are needed for the next phase, and in which contexts would these improve effectiveness?
-

What have been the key outcomes of the Unitaïd supported activities? (Probe as relevant)

1. What outcomes have been achieved by the programme, and how do these vary across contexts? what unintended outcomes have emerged
 2. What contextual factors enable or constrain the programme's effectiveness across settings? (
 3. What challenges or barriers have affected implementation and outcomes, and in which contexts?
 4. What key lessons emerge about what works, for whom, and under what conditions?
 5. How can these insights be used to improve programme impact and scalability in future phases?
 6. How do service users and providers perceive and respond to the programme, and how do these responses influence outcomes?
 7. For whom is the programme most and least effective, particularly among vulnerable or high-risk populations, and why?
 8. How can the programme be made more impactful?
-

⁹ Note this is a guide: i.e. questions will be tailored to the key informant's relevant experience with the portfolio. Not everybody will be asked each question.

Are services and tools integrated in national strategies? (Probe as relevant)

1. To what extent, and in which contexts, have programme services and tools been integrated into national policies, strategies, and health systems? How does this integration influence sustainability and scale-up?
 2. What plans and capacities exist at national and subnational levels to maintain services after current funding ends?
 3. How and under what conditions do experiences from ‘champion’ countries influence adoption and scale-up in other countries? What mechanisms (e.g., learning, demonstration effects, policy transfer) drive or limit this diffusion?
 4. Where has the programme achieved sustainable and scalable outcomes, and where has it not—and why?
-

Is the programme implemented efficiently by Unitaaid and implementing partners? (Probe as relevant)

How efficient was the programme implemented at national level?

1. What contextual factors enable or constrain efficient implementation (e.g., system capacity, procurement processes, partner coordination)?
2. How and why do issues such as delays or cost variations emerge in different contexts?
3. How are risks identified, assessed, and managed at global and country level?

How efficient was the programme implemented at portfolio level?

4. Does the programme have a learning strategy? How does the programme generate, use, and share learning to improve efficiency and performance over time?
 5. Does the programme have a risk management strategy? How are risks identified, assessed, and managed at global levels, and how does this influence implementation efficiency?
 6. In which contexts are risk management approaches most and least effective, and why?
 7. Where has the programme achieved efficient implementation, and where has it not—and why?
 8. Was the portfolio budget used in the right way? And human resources?
-

Lessons learned & recommendations

1. What are the key lessons about what works, for whom, in what circumstances, and why across the programme?
 2. Which lessons are context-specific, and which are transferable across settings—and why?
 3. Under what conditions can successful approaches be adapted or scaled in other contexts?
 4. Based on the evidence, what adaptations to programme design, implementation, or partnerships are needed to improve effectiveness, equity, and sustainability?
 5. In which contexts are these recommendations most likely to be effective, and why?
-

Closing

- Is there anything else you would like to add?

Annex 7B: KI interview guide country case studies

Introduction (Read to interviewee)

- Thank you for agreeing to participate in this interview.
 - The purpose of this discussion is to understand your perspectives and experiences with the Unitaïd funded support for cervical cancer screening services
 - Your responses will help assess Unitaïd’s impact so far, and lessons for the next phase.
 - Participation is voluntary, and your responses will be kept confidential.
 - With your permission, I would like to take notes / record this interview.
 - Do you have any questions before we begin?
-

Background information

- Can you briefly describe your role in relation to this cervical cancer programme?
 - How long have you been involved with the programme?
-

Is the programme responsive to needs and contexts? (Probe as relevant)

1. What was this programme designed to address and in which context?
 2. For which groups of women is the programme most and least relevant, and how well does it respond to their needs in different contexts??
 3. How and under what conditions does the cervical cancer programme align with national health priorities and strategies? How does this alignment influence programme implementation and uptake??
 4. How do health service providers and other key stakeholders perceive and respond to the programme, and how does this shape implementation and outcome?
 5. Have the national and/or population needs changed since the programme started and how has the programme adapted to remain responsive?
-

What have been the key achievements of the Unitaïd supported activities? (Probe as relevant)

1. From your perspective, what were the main goals or objectives of the Unitaïd-supported cervical cancer programme? How do these goals make sense in the context where you work?
 2. Since the programme started, what changes have you noticed in cervical cancer screening and treatment—both short-term and longer-term? Can you explain why these changes happened??
 3. What worked well during implementation? and what did not work? Why?¹⁰
 4. What challenges or barriers were encountered?
 5. For women who test positive, how well do you think the programme ensured they received follow-up treatment? In what situations does this process work best, and when does it break down?
 6. Do you think the programme reaches the women who need it most, such as high-risk or vulnerable groups? What makes it easier or harder to reach these women? (climate change?)
-

¹⁰ Ask specifics for each innovation that was introduced in the country, - see also hypotheses

7. How do health service providers and the women using the services respond to the programme? How do their attitudes or behaviours influence whether the programme is successful?
 8. What have you learned about barriers to access for women – specific vulnerable populations?
 9. What factors in your country or health system help the programme work well, and what factors make it more difficult? How do these conditions affect outcomes?
 10. How has the programme influenced the availability, affordability, or use of new cervical cancer technologies, like HPV testing or thermal ablation? Are there any bottlenecks that limit their impact [*this is about market shaping*]?
-

Are services and tools integrated in national strategies? (Probe as relevant)

1. To what extent are cervical cancer screening services and tools part of national strategies or standard service packages? In what ways does this integration work well, and where are the gaps?
 2. Is there a plan to maintain these services once current funding ends? How was this plan developed, and what factors make it more or less likely to succeed?
 3. What factors in your country or health system help the programme sustain its services? What factors make sustainability more difficult?
 4. How do the way services are organized or financed affect their sustainability? Are certain models or approaches more effective in your context?
 5. How are lessons and best practices from your country shared regionally or globally? Have experiences from other countries influenced your own programme, and if so, how?
-

Is the programme implemented efficiently? (Probe as relevant)

1. How well do the programme's resources—funding, staffing, and materials—meet the needs of implementation in your context? Are there areas where resources worked well or fell short, and why?
 2. Were there delays or cost overruns during implementation? What caused them, and how did they affect the programme's results in different settings?
-

Lessons Learned & Recommendations

1. Looking back, what do you see as the key lessons from the programme? Can you explain how these lessons played out in your context, for example regarding:
 - Continuum of care
 - Sustainable Financing
 - Programming at Scale
 - South-South learning
 - Commodity supply and delivery
 - Equity in access
2. In your experience, what factors or conditions made these approaches work well, and what factors limited their effectiveness? **How did context influence outcomes?"**
3. If you were redesigning the programme, what would you do differently, and why? How would these changes address specific challenges you have seen?

Annex 7C: FGD guide for community interviews

Introduction (Read to participants)

- Thank you for agreeing to participate in this discussion.
 - We are speaking with community members, to understand experiences with cervical cancer screening services supported by the programme. Including women who have used the services, women who could benefit but have NOT used the services, and community health workers
 - Your perspectives will help us understand what is working well and what could be improved.
 - Your participation is voluntary and your responses will be kept confidential.
 - With your permission, I would like to take notes / record the discussion.
 - Do you have any questions before we begin?
-

Background Information

1. Are you familiar with cervical cancer screening services available in this area?
 2. Have you used the services, or otherwise what is your connection to the services?
 3. How did you first hear about these services?
-

Does the programme respond to the needs of women? (probe as relevant)

1. In your opinion, how important are cervical cancer screening services for women in this community?
 2. Who do you think most needs these services?
 3. Do women in your community know about cervical cancer and screening?
 4. Are the services accessible for women in your community? Why or why not?
 5. Are there groups of women who may find it harder to access screening? (Probe: rural women, young women, older women, women with disabilities, low-income women, migrants, etc.)
-

What are your experiences with the Programme? (probe as relevant)

1. Have women in your community used the screening services?
 2. What have you heard about their experiences?
 3. What aspects of the services work well?
 4. What challenges or problems have women faced when trying to access screening? Probe if needed: Distance to facilities, Cost, Waiting times, Fear or stigma, Lack of information, Cultural barriers
-

Do women who screen positive have access to follow up services? (probe as relevant)

1. What happens if a woman receives a positive screening result?
 2. Do women in the community receive the treatment or follow-up care they need?
 3. Are there barriers that prevent women from treatment or follow-up visits?
-

Are the cervical cancer screening services promoted well (probe as relevant)

1. Have there been awareness activities about cervical cancer screening in the community?
 2. What types of activities have been most helpful? (e.g., community meetings, radio, health workers)
 3. What could be done to improve awareness and encourage more women to get screened?
-

Equity and Inclusion

1. Do all women in the community have equal access to screening services?
 2. Which groups of women might be left out or underserved?
 3. What could be done to ensure that vulnerable women can access screening and care?
-

Sustainability and Future Needs

1. Do you think these services should continue in the future?
 2. What would help ensure that women can continue accessing screening and treatment?
 3. What role could the community play in supporting these services?
-

Lessons and Recommendations

1. What have been the biggest benefits of this programme for women in your community?
 2. What improvements would you suggest for the next phase of the programme?
-

Closing

- Is there anything else you would like to share about cervical cancer screening services in your community?
- Thank you very much for your time and insights.

Annex 7D: In country interview guide for market shaping and supply chain

Date

Name of respondent

Position

HPV tests:

Q1. Over the project period (2019-2025):

- 1a. How many tests have been procured?
- 1b. How are they procured? (Through UNICEF, MOH procurement channels, CHAI, other?)
- 1c. How were they funded? Unitaid, own government sources, partner (please specify)
- 1d. Could you identify brand and provide prices of tests? *The test prices vary from: Abbott \$6.24, Roche from \$7.90, Hologic from \$9 and Cepheid \$14. Note that these prices may not include international transport costs. If reluctant, an indication that the price is over \$20 per test may be sufficient, though scale will be important. Over \$20? Over \$30? Over \$40 etc?*
- 1e. How many women have benefitted from the use of the tests?
- 1f. Where are HPV tests available? (All facilities? Some facilities? Urban, peri-urban, remote?)
- 1g. How are they distributed?
- 1h. From records, are there any HPV tests in stock? How many months of stock they keep?
- 1i. Any stockouts or supply interruptions?
- 1j. What is the cost to the user?
- 1k. What would you say is the major barrier (s) to access and scale up?

Thermal Ablation (TA) Tools

Q2. Over the project period (2019-2025):

- 2a. How many TAs have been procured?
- 2b. How are they procured? (Through MOH procurement channels, CHAI, other?)
- 2c. How were they funded? Unitaid, own government sources, partner (please specify)
- 2d. Unitaid deployed 6,200 TA tools in 26 countries. *I should know the number that went into each country.* Where were the TA tools deployed (criteria for facility allocation)? Is there any stock at central level? Is there any preference over one TA device than other based on the manufacturer? They are only two, why? Are repairs an issue
- 2e. How were these tools distributed?
- 2f. How is the usage of these tools reported/monitored? *(CHAI expects each TA to be used 2,000 times each)*
- 2g. What is the cost to the user?
- 2h. What have been the key challenges in using these tools?

AVE

Q3 Have AVE been introduced? If so:

- 3a. At which stage is the introduction been? Pilot, research, validation stage or finished product
- 3b. Where is AVE been deployed?
- 3c. Do you pay a license fee? Other costs such as telephone/Wi-Fi costs?
- 3d. What are the challenges encountered?

ANNEX 8. STAKEHOLDER MAPPING

Global level	
Unitaid	Executive Director
	Programmes team
	Strategy team
	Results & MEL team
	Finance Officer
Clinton Health Access Initiative (CHAI)	Global team
Expertise France	Global team
WHO	Cervical Cancer Elimination team Cancer & NCD teams Internal Agency for Research on Cancer
Global Partner organisations	Global Fund Gates Foundation Gavi HPV vaccine team FIND women's health team UNICEF supply division
Global organisations and foundations	Elekta Foundation EPICC consortium UICC HPV Prevention and Control Board Global Health Labs (HPV test team)
Manufacturers and suppliers	Abbott Hologic Roche Cepheid Liger Wisap
Regional level	
WHO	Regional Office staff
Regional NGOs	African Cervical Health Alliance, ACHA
Country level	
Implementing partners	CHAI Country teams JHPIEGO WHO country offices
Government	MoH NCD, HIV & cancer departments MoH Lab departments MoH procurement & supply department
UN	UNFPA, UNICEF
Academia and non-government	NGOs, Researchers, Public health specialist etc
Service level	
Health facilities	Service providers, (Community) Health workers Service users (and their partners)
CBOs	CBOs representing women, WLHIV, rural women, etc. National SRHR/PHC/cancer NGOs and platforms

ANNEX 9. KEY STAKEHOLDERS INTERVIEWED OR PARTICIPATING IN FGDS

Org	Position
Secretariat Unitaid	
Unitaid	Executive Director
Unitaid	Strategy Senior Technical Manager
Unitaid	Strategy Technical Manager
Unitaid	Programme Manager
Unitaid (Former)	Former Procurement Officer
Unitaid	Team Lead (Results-MEL)
Unitaid	Procurement Officer
Unitaid	Programme Officer
Unitaid	Project officer
Unitaid	Finance Officer
CHAI HQ	
CHAI HQ	Senior Programme Director (NCD / Cervical Cancer)
CHAI HQ	Portfolio Lead (Cervical Cancer)
CHAI HQ	Vice President for Health Systems and NCDs, CHAI Global
CHAI HQ	Senior Programme Officer (Diagnostics and Market Shaping), CHAI Global
CHAI HQ	Programme manager
Expertise France	
Expertise France HQ	Director
Expertise France HQ	Technical Director, Health Department
Jhpeigo HQ	Team Leader (SUCCESS Programme)
WHO	
WHO	Cross-Cutting Specialist, NCDs and Special Initiatives, WHO Geneva
WHO	Executive Officer and Policy Advisor, Office of the Director General
WHO	Epidemiologist and Technical Officer for Surveillance in the WHO Department of HIV, TB, Hepatitis, and STIs
WHO	Consultant
Community and Civil Society Organisations	
African Cervical Health Alliance, ACHA	Secretariat Lead
UICC	Director, Capacity Building
MedAccess	Investments Director
Other partners	
Elekta Foundation	President
Gavi	Head, HPV Vaccine Programme
Ex FIND/ Now Gates Foundation	Diagnostics R&D consultant, Kenya

Org	Position
Gates Foundation	Deputy Director STI & Gynaecology
EPICC consortium	Lead
International Atomic Energy Agency IAEA	Health System Analyst
Africa CDC	Technical Officer, NCD and Mental Health
UNICEF SD	Contracts Specialist
USG /PEPFAR	Senior Diagnostics Advisor
Consultant CHAI / Global Health Labs	Former Head of Research, Product Development and Commercialisation
Global Fund	Senior Disease Advisor (HIV Comorbidities and Co-infections)
Suppliers	
Hologic	Director, Global Health Strategy
Roche	
Cepheid	Senior director Portfolio women's health
Portfolio - Learning themes	
CHAI Rwanda	Senior Programme Manager, NCD Programmes
Teal sisters, Zambia	Founder
Cervical Cancer Prevention Programme, Zambia	Clinician and former National Manager, Cervical Cancer Prevention Programme, Zambia
Friends of Africa, Zambia	Professor, Zambia
BLUESQUARE	Country Lead, Côte d'Ivoire
CHAI South Africa	Programme managers
CHAI Nigeria	Program Lead & Program Officer
Government Medical College, India	Head of Department, Gynaecology, Bhopal, MP, India
CHAI Zambia	Programme Manager (Cervical Cancer)

Interviews and FGDs conducted in-country across 4 country case studies (Burkina Faso, Malawi, Kenya and the Philippines – see country case study report annexes

ANNEX 10. OVERVIEW OF TA DEVICES

Table: Thermal Ablation devices procured and distributed through implementing partners

Country	TA device allocation		
	<i>Liger</i>	<i>Wisap</i>	<i>Total</i>
CHAI to project countries			
Nigeria	792	380	1172
Kenya	790	310	1100
Rwanda	625	286	911
India	405	194	599
Malawi	335	235	570
Zambia	260	90	350
Uganda	170	80	250
Zimbabwe	129	52	181
Senegal		68	68
South Africa	10	10	20
Sub Total	3,516	1,705	5,221
CHAI to EF and other countries			
Papua New Guinea (EPICC partners)		79	79
Cameroon	30	30	60
Cambodia	20	30	50
Eswatini	25	25	50
Myanmar	25	25	50
Tanzania	25	25	50
Ethiopia		50	50
Liberia	20	20	40
Cote d'Ivoire (SUCCESS partners)		17	17

El Salvador	15		15
Burkina Faso (SUCCESS partners)		13	13
Peru	12		12
Guatemala (SUCCESS partners)		10	10
Paraguay		10	10
Philippines (SUCCESS partners)		10	10
Zambia (UNC)	3		3
Antigua and Barbuda	3		3
Other (training devices)	1	1	2
Sub Total	179	345	524
Total CHAI ¹¹	3,695	2,050	5,745
Total Expertise France			200
Total WHO			150
Total all implementing partners			6,095

¹¹ Source: CHAI

Table: Thermal Ablation device distribution in case study countries

Countries	Kenya	Malawi	Burkina Faso	Philippines
TA per CHAI reports	1,100	570	13 from CHAI	10 from CHAI
TA confirmed in case study	1,200	570	61 (13+48 from EF)	?
Additional donations/provisions	Roche for initial calibration	Roche for initial calibration		250 from WHO
Distribution	Facilities L2 to 6	330 facilities, 3 devices in high-volume facilities	NA	All 30 project facilities
Devices retained at central level	100 (for training)	NA	NA	Some (for CLAMS ¹² facilities)
Monitoring system for TA device status	KHIS2 and referenced with TA database	CxCa district coordinators report device status to national CxCa coordinator; CHAI supports monitoring through integration into a centralized CxCa data system. Database updated quarterly.	NA	Project monitoring tool (CMT)
Challenges reported in cast studies <u>Kenya:</u> • High turnover of trained HCWs. Provider hesitancy in device use. • Device issues: WISAP: charging challenges after prolonged non-use Liger: minimal reported issues • Incomplete documentation: Older reporting tools (MOH 711) lack fields for TA, limiting data capture <u>Malawi:</u> • High provider turnover despite continuous training efforts. Frequent staff rotations, transfers, and attrition lead to loss of trained personnel, disrupt continuity of services, and increase the need for recurrent training and mentorship to maintain service quality. • Limited real-time monitoring and maintenance of the devices. • High initial investment costs, including training and equipment				

¹² Centralized Laboratory Model for HPV DNA Screening – a Jhpiego project

- 64 out of ± 506 devices are non-functional, mainly due to probe degradation and power bank failures, which require maintenance or replacement

Burkina Faso:

- During the warranty period, issues troubleshooted with manufacturer. Shipping costs for repairs often exceeded the value of the procurement.

Philippines:

- health worker competency degraded in facilities with insufficient case volumes
- More than 50% of TA devices concentrated in tertiary facilities during Phase 1 (COVID-19 pandemic service adjustment), limiting primary-care equity

ANNEX 11. NATIONAL POLICY ADOPTION AND FINANCING - ACROSS 14 PROJECT COUNTRIES

Table 1: National policy adoption status across 14 project countries

Country	HPV testing in national guidelines	TA in national guidelines	Costed implementation plan	Date of HPV guideline adoption	Date of TA guideline adoption	Date of costed plan	Notes and sources
CHAI focal countries (India, Kenya, Malawi, Nigeria, Rwanda, Senegal, South Africa, Uganda, Zambia, Zimbabwe)							
Kenya	Yes	Yes	Yes	2018	~2021	2025	HPV guidelines: 2018 National Cancer Screening Guidelines adopted HPV DNA testing as the recommended screening method (KII Preliminary Findings Synthesis, Finding 2.1c: 'Kenya guidelines adopted HPV DNA testing as primary screening method in 2018'; Kenya Case Study, 'Kenya National Cancer Screening and Early Diagnosis Guidelines'). NOTE: VIA remained the dominant method in practice (88% of screening) throughout the portfolio period (Kenya Case Study, conclusions). TA guidelines: TA incorporated into national guidelines during scale-up; confirmed across nine CHAI countries (CHAI Closure Report 2025, p. 26). Specific formal adoption date not documented in sources reviewed — estimated ~2021 based on programme scale-up timeline. Costed plan: National Cervical Cancer Elimination Action Plan 2025–2030, MoH Kenya (Kenya Case Study). CHAI also supported guideline revisions, strategic planning, and commodity quantification (CHAI Closure Report, p. 6).
Malawi	Yes	Yes	Yes	2019	~2022	2022	HPV guidelines: Cervical cancer service-delivery guidelines revised in 2019 to include HPV DNA testing as the preferred primary screening modality (Malawi Case Study, 'service-delivery guidelines were revised in 2019 to include HPV DNA testing as the preferred primary screening modality'). Current guidelines under revision with WHO support (2026). TA guidelines: TA deployed and confirmed in national guidelines per CHAI Closure Report (nine CHAI countries). Specific formal date not documented — estimated ~2022 (scale-up period). Costed plan:

Country	HPV testing in national guidelines	TA in national guidelines	Costed implementation plan	Date of HPV guideline adoption	Date of TA guideline adoption	Date of costing plan	Notes and sources
							National Cervical Cancer Prevention and Control Strategic Plan 2022–2026 co-developed and costing with MoH Accelerated elimination plan to 2030 in development (Malawi Case Study)
Nigeria	Yes	Yes	Yes	~2020	~2020	2023	HPV guidelines: HPV integrated onto existing PCR platforms and institutionalised through national training materials and ToTs from 2020; National Strategic Plan 2023–2027 includes HPV targets (CHAI Closure Report, p. 43). Specific formal guideline publication date not documented — estimated ~2020. TA guidelines: TA deployed from 2020 alongside HPV; confirmed in national guidelines across nine CHAI countries (CHAI Closure Report, p. 26). Costed plan: National Strategic Plan 2023–2027 includes 'dedicated cervical cancer targets and costing interventions' (CHAI Closure Report, p. 8). WHO-supported costing plan for Nigeria 2017–2021 referenced in Global SUCCESS IR Study Report (2024).
Rwanda	Yes	Yes	Yes	~2021	~2021	2024	HPV guidelines: CHAI helped update Rwanda's national multiyear cervical cancer prevention and control strategy and integrate HPV testing into national point-of-care guidelines; country expanded to 850 sites by 2022 (CHAI Closure Report, p. 6). Specific formal date not documented — estimated ~2021. TA guidelines: Confirmed across nine CHAI countries (CHAI Closure Report, p. 26). Costed plan: Accelerated Plan for Elimination of Cervical Cancer in Rwanda (2024–2027); US\$38.4M total, co-developed with CHAI; released 2024 (CHAI Closure Report, pp. 5–6; MoH Rwanda). Plan includes 90-70-90 targets and six strategic objectives.
Zambia	Yes	Yes	Yes	~2021	~2021	2022	HPV guidelines: Guideline development and early HPV pilots on GeneXpert and Hologic platforms documented from 2020–2021 (CHAI Closure Report, p. 44: 'laying the groundwork for HPV testing through guideline development and early pilots'). HPV indicators integrated into national dashboards (CHAI Closure Report, p. 6). Specific formal adoption date not documented — estimated ~2021. TA guidelines: TA deployed nationwide; confirmed across nine CHAI countries (CHAI Closure Report, p. 26). Costed plan: National Cervical Cancer Strategic Plan (NCCSP) 2022–2026 developed with CHAI support; provided financing roadmap and enabled integration of HPV testing into national specimen transport networks (CHAI Closure Report, p. 8).

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Country	HPV testing in national guidelines	TA in national guidelines	Costed implementation plan	Date of HPV guideline adoption	Date of TA guideline adoption	Date of costed plan	Notes and sources
Zimbabwe	Yes	Yes	Not confirmed	~2022	~2022	Not confirmed	HPV guidelines: Cervical cancer technical committees established in Zimbabwe with CHAI support; HPV integrated into service delivery (CHAI Closure Report, p. 6). Formal guideline adoption date not documented in sources reviewed — estimated ~2022 based on programme timeline (Zimbabwe added to Phase I in 2022 per CHAI performance data). TA guidelines: Confirmed across nine CHAI countries (CHAI Closure Report, p. 26). Costed plan: No costed elimination plan confirmed in documents reviewed. CBSS study operational 2024–2025 but no standalone multi-year costed plan is evidenced.
Uganda	Yes	Yes	Not confirmed	~2021	~2021	Not confirmed	HPV guidelines: CHAI helped update Uganda's national multiyear cervical cancer prevention and control strategy and integrate HPV testing into national point-of-care guidelines; expansion to 850 sites by 2022 (CHAI Closure Report, p. 6). Specific formal date not documented — estimated ~2021. TA guidelines: TA deployed across Health Centre IIIs; confirmed across nine CHAI countries (CHAI Closure Report, p. 26). Costed plan: No standalone costed elimination plan confirmed in documents reviewed. The multiyear strategy provides a framework but is not described as fully costed in sources reviewed.
Senegal	Yes	Yes	Partial	~2020	~2020	Partial	HPV guidelines: Senegal participated in the five-country Phase I implementation study 2019–2020 (BMJ Open 2023); HPV testing integrated into national service delivery. CHAI supported 'costed national scale-up plan and integration of HPV testing across multiple laboratory platforms (GeneXpert, Abbott m2000, Cobas 480)' (CHAI Closure Report, p. 6). Specific formal adoption date not documented — estimated ~2020. TA guidelines: Confirmed across nine CHAI countries (CHAI Closure Report, p. 26). Costed plan: A costed scale-up plan was developed with CHAI support (CHAI Closure Report, p. 6), but the plan document itself is not in the project folder. Described as 'partial' pending confirmation of scope and formal status.
South Africa	Yes	Yes	Yes*	Pre-2019	Pre-2019	May 2026	HPV guidelines: South Africa adopted HPV-based screening prior to Unitaid investment; political leadership engaged at head-of-state level (KII Synthesis, Finding 2.1c). CHAI supported large-scale HPV feasibility demonstration across three provinces (CHAI Closure Report, p. 7). TA guidelines: Confirmed across nine CHAI countries (CHAI Closure Report, p. 26). Costed plan: National cervical cancer elimination strategy launched 8

Country	HPV testing in national guidelines	TA in national guidelines	Costed implementation plan	Date of HPV guideline adoption	Date of TA guideline adoption	Date of costing plan	Notes and sources
							May 2026 (KII Synthesis, Finding 2.1c; 'Unitaid 2024, strategic framework for elimination of cervical cancer in South Africa' cited in Kenya Case Study references). NOTE (*): Launch date falls outside the 2019–2025 evaluation period. South Africa was a designed Phase I feasibility exit.
India	N/A (VIA)	Yes	Not confirmed	N/A	~2021	Not confirmed	HPV guidelines: India's Unitaid-supported programme was VIA-based; HPV DNA testing was not the primary screening modality. Political engagement at head-of-state level noted (KII Synthesis). TA guidelines: TA deployed and confirmed across nine CHAI countries (CHAI Closure Report, p. 26). Specific formal date not documented — estimated ~2021. Costed plan: Government capacity-building and replicable models supported, but a standalone costing plan is not confirmed in documents reviewed.
SUCCESS focal countries — Expertise France / JHPIEGO (Burkina Faso, Côte d'Ivoire, Guatemala, Philippines)							
Burkina Faso	Yes	Yes	Partial	Dec 2024	Dec 2024	Partial	HPV guidelines: National Guidelines for HPV Screening and Thermal Ablation validated December 2024 (Burkina Faso Case Study, reference [13]: 'National Guidelines for HPV Screening and Thermal Ablation, Ministry of Health Burkina Faso, validated December 2024'). Earlier draft work on training documents began November 2020 (SUCCESS 2020 Annual Report). A series of workshops in 2023 to develop, validate and finalise national cervical cancer prevention guidelines was documented (SUCCESS 2023 Annual Report). TA guidelines: Included in the December 2024 guidelines document. Costed plan: Costing integrated into scale-up plan, reliant on donor support; Global Fund GC7 allocation for HPV tests included (SUCCESS 2024 Annual Report; SUCCESS 2023 Annual Report). A fully government-owned, standalone costing elimination plan is not confirmed — marked 'partial' given ongoing political/security instability and donor dependency.
Côte d'Ivoire	Yes	Yes	Partial	Jun 2023	Jun 2023	Partial	HPV guidelines: National CxCa Prevention Standards and Guidelines completed at national validation workshop, June 2023, with SUCCESS support (SUCCESS 2023 Annual Report: 'Cote d'Ivoire, through SUCCESS support held a national validation workshop in June which resulted in the completion of the National CxCa Prevention

Country	HPV testing in national guidelines	TA in national guidelines	Costed implementation plan	Date of HPV guideline adoption	Date of TA guideline adoption	Date of costed plan	Notes and sources
							Standards and Guidelines'). Revision process begun 2020 (SUCCESS 2020 Annual Report). TA guidelines: Included in the June 2023 guidelines. Costed plan: Global Fund GC7 allocation secured (30,000 HPV tests) with SUCCESS support (SUCCESS 2023 Annual Report). C4P costing process initiated. No standalone costed elimination plan confirmed — marked 'partial'. KII Synthesis notes domestic financing outcomes were more limited than Philippines/Guatemala due to system maturity constraints.
Guatemala	Yes	Yes	Yes	Dec 2020	Dec 2020	Mar 2024	HPV guidelines: New CECAP guidelines officially published by MOH December 2020, including preventive, screening and treatment guidelines and data management (SUCCESS 2020 Annual Report: 'the MOH officially published the new CECAP guidelines in December 2020'). WLHIV guidelines added to national strategic plan (SUCCESS 2023 Annual Report). TA guidelines: Included in December 2020 CECAP guidelines. Costed plan: Comprehensive Cancer Care Law enacted March 2024, bolstering domestic funding (SUCCESS 2024 Annual Report). MSPAS earmarked budget for HPV tests and TA equipment; districts manage procurement from national budget (SUCCESS 2023 Annual Report). C4P costing process completed. Described as 'Yes' on basis of legal/budgetary framework, though no standalone multi-year elimination strategy document is confirmed.
Philippines	Yes	Yes	Yes	~2023–2024	~2023–2024	2025	HPV guidelines: Clinical guidelines progressed through DOH approvals from 2023; delayed by change of DOH Secretary (SUCCESS 2023 Annual Report). National Operational Plan for Secondary Prevention Strategies 2025–2025 and National Cervical Cancer Elimination Strategy 2025–2028 supported by SUCCESS, establishing policy and governance frameworks (SUCCESS 2024 Annual Report). Quezon City Ordinance 3285-2024 (August 2024) transitioned to HPV testing at local level. TA guidelines: Included in the national operational plan. Costed plan: C4P costing validation concluded July 2024; National Operational Plan and Elimination Strategy 2025–2028 with costed components (SUCCESS 2024 Annual Report: 'has helped the DOH plan and advocate for financial, human resources, and capital investments for scaling-up CCE in the Philippines').

Key

Yes	Confirmed in documents reviewed	Partial	Some elements confirmed; plan incomplete or not fully government-owned
Not confirmed	No direct source found in documents reviewed	N/A	Not applicable — see note

General notes

1. HPV guidelines: 'Yes' indicates HPV DNA testing has been adopted as the recommended primary or co-primary screening method in a formally published national guideline, strategy, or MoH-endorsed protocol. A tilde (~) on dates denotes an estimate inferred from programme scale-up timelines, not an explicitly stated date in documents reviewed.
2. TA guidelines: The CHAI Final Closure Report (2025, p. 26) states that all nine CHAI focal countries incorporated TA into national guidelines during the portfolio period. Specific adoption year-dates are not systematically documented; estimates are based on deployment and training timelines in annual reports.
3. Costed plan: 'Yes' requires a formally adopted document including multi-year targets, commodity quantification, and a budget framework. 'Partial' means costing work is documented and financing secured (e.g. through GF GC7) but a standalone, fully government-owned plan is not confirmed. 'Not confirmed' means no such document is evidenced in sources reviewed.
4. Kenya caveat: HPV testing was adopted in national screening guidelines in 2018, but VIA remained the dominant method in practice during the portfolio period (88% of screening). The 'Yes' reflects guideline adoption, not implementation scale.
5. India: India's Unitaids-supported programme was VIA-based. TA guideline adoption confirmed for CHAI's nine countries including India.
6. South Africa: Designed Phase I feasibility exit. National elimination strategy launched 8 May 2026 — post-portfolio period.
7. Burkina Faso and Côte d'Ivoire guideline dates: Earlier training document drafts and revision processes began in 2020 (SUCCESS 2020 Annual Report). The formal national guideline validation dates cited (December 2024 and June 2023 respectively) represent the point of official MoH validation, not the start of the process.
8. Sources: CHAI Final Closure Report 2019–2025 (April 2026); SUCCESS Annual Reports 2020–2024; Global SUCCESS IR Study Report (Sept 2024); Kenya Case Study (June 2026); Malawi Case Study (June 2026); Burkina Faso Case Study (June 2026); Philippines Case Study; KIIs (May 2026); BMJ Open 2023 five-country HPV implementation study; TA White Paper (April 2025).

Table 2: Sustainable financing: domestic budget and health insurance inclusion

Country	Domestic budget allocation for CxCa screening / treatment	Inclusion in national health insurance / benefit package
Kenya	Partial GF & PEPFAR dominant; HPV kits not in county budgets. GF procured ~60,000 tests (2025).	Partial CxCa screening included in Social Health Authority (SHA) benefit package but limited to women aged 35 and 45; SHA integration advanced but capitation insufficient to cover HPV costs (~\$10–16/test vs. KSh 3,800 capitation).
Malawi	Not confirmed Wholly donor-dependent (Unitaid/CHAI, PEPFAR partners, GF). No domestic budget line confirmed. Districts cannot absorb HPV cartridge costs. GF NFM3 includes a dedicated CxCa budget line.	Not confirmed No health insurance coverage of CxCa screening confirmed in documents reviewed.
Nigeria	Partial State-level allocation documented: Lagos State approved 500% budget increase from 2022; Kebbi State Governor funded 30,000 women. CxCa embedded in state AOPs. ~1.5bn Naira catalytic allocation (KII Synthesis). National-level procurement remains donor-dependent.	Not confirmed No confirmed inclusion in National Health Insurance Scheme (NHIS) in documents reviewed.
Rwanda	Partial Multi-source financing secured, including government, GF, PEPFAR and GAVI — but documents do not confirm a standalone domestic government budget line for HPV screening specifically.	Yes Community-Based Health Insurance (CBHI/Mutuelle de Santé) integration progressed; CHAI supported costing, reimbursement protocols and engagement with Rwanda Social Security Board (RSSB). Yet, domestic financing remains limited and thus fragility.
Zambia	Partial Government (ZAMMSA) purchased 50,000 Cobas HPV kits (2025) — first significant domestic procurement. GF and PEPFAR remain primary sources. CxCa positioned as national health budget priority (NCCSP 2022–2026).	Not confirmed No confirmed inclusion in national health insurance scheme in documents reviewed. PEPFAR stop-work order (2025) exposed near-total donor dependency.
Zimbabwe	Not confirmed No domestic budget allocation confirmed. All 44 PEPFAR sites suspended following stop-work order (2025). ~58,000 HPV procurements halted. Near-	Not confirmed No confirmed health insurance coverage in documents reviewed.

Country	Domestic budget allocation for CxCa screening / treatment	Inclusion in national health insurance / benefit package
	total donor dependency.	
Uganda	Not confirmed No domestic budget allocation confirmed. Scale-up dependent on GF and PEPFAR. No post-portfolio domestic financing mechanism evidenced.	Not confirmed No confirmed health insurance inclusion in documents reviewed.
Senegal	Not confirmed Costed national scale-up plan developed with CHAI, WHO and Enabel, positioning country for donor engagement. Domestic government budget contribution not confirmed.	Not confirmed No confirmed health insurance inclusion in documents reviewed.
South Africa	Partial Confirmed domestic budget allocation for CxCa screening is not clearly evidenced in the documents despite head-of-state political engagement and KII statements.	Partial Cervical cancer screening is provided free of charge as part of the constitutional service benefits framework. Discovery Health (private) cited as insurance precedent. National public insurance inclusion not confirmed for the portfolio period. National strategy expected to address insurance pathway.
India	Not confirmed VIA/TA programme domestic financing was aspirational rather than confirmed.	Not confirmed No confirmed health insurance inclusion in documents reviewed.
Burkina Faso	Not confirmed No domestic budget line for HPV testing created. MoH Transition Plan (Nov 2023) explicitly acknowledged ministry 'cannot support this burden'. GF GC7 targets only 20% of WLHIV. C4P costing shows 70% coverage would cost >USD 10M.	Not confirmed National health insurance scheme (RAMU) does not cover HPV testing, TA, or follow-up care. C4P costing data available to model inclusion but advocacy not yet successful.
Côte d'Ivoire	Not confirmed GF GC7 allocation secured (30,000 HPV tests); eSIGL commodity integration; no domestic budget	Not confirmed No confirmed health insurance inclusion in documents reviewed.
Guatemala	Yes MSPAS earmarked national budget for HPV tests and TA; health districts	Partial Comprehensive Cancer Care Law (March 2024) provides legal basis for

Country	Domestic budget allocation for CxCa screening / treatment	Inclusion in national health insurance / benefit package
	manage procurement from national budget. Comprehensive Cancer Care Law enacted March 2024. Districts covering 31% of Quetzaltenango population in 2024.	coverage. No confirmed inclusion in a specific national health insurance benefit package in documents reviewed.
Philippines	Partial First domestic resource commitment for HPV testing announced late 2025, extending through 2027 (Philippines CS, EQ3.2). LGU-level commitments confirmed: Quezon City Integrated Cancer Control Ordinance (August 2024) placed CxCa on a legally binding local instrument with allocated budget. GF GC7 allocated 20,000 HPV kits for WLHIV. No recurrent national general-population HPV procurement line yet established. DoH domestic procurement under RA 9184 requires 2–3 year establishment period (Philippines CS, EQ3.1).	Partial PhilHealth HTA inclusion of HPV assay kits and TA devices confirmed (Philippines CS, EQ3.1, EQ2.4). PhilHealth YAKAP benefit package update in progress — Q4 2026 target, described as 'ambitious rather than secure'. TA covered; HPV screening benefit remains structurally thin. Treatment covered since 2013 (case rates for procedures, medical management, radiotherapy) but screening package remains narrower and limited to ~30 sites (Philippines CS, EQ3.2). YAKAP covers clinical services only — demand generation and follow-up not funded (Philippines CS, EQ1.2).

Key

Yes	Domestic budget or insurance inclusion confirmed in documents reviewed
Partial	Some elements confirmed (e.g. state-level or sub-national; single donor stream; limited coverage scope; pending formal approval)
Not confirmed	No direct evidence found in documents reviewed

Notes

1. 'Domestic budget allocation' covers any confirmed government (national, state, or district-level) funds earmarked for CxCa screening, HPV test procurement, or treatment commodities. Global Fund and PEPFAR financing are treated as external donor streams.
2. 'Health insurance inclusion' refers to confirmed or in-progress inclusion of HPV testing, thermal ablation, or CxCa screening services in a formal national, social, or community health insurance benefit package or equivalent reimbursement mechanism.

3. Philippines (June 2026 case study): PhilHealth HTA inclusion is confirmed for HPV and TA, but the YAKAP screening benefit package update is targeted for Q4 2026 and is described in KII evidence as 'ambitious rather than secure'. Treatment has been covered since 2013 but screening coverage remains narrow. The first domestic budget commitment was announced in late 2025 (HPV testing through 2027) but no recurrent national general-population procurement line is yet established.
4. Rwanda and the Philippines are the portfolio's strongest performers on insurance inclusion pathway; Guatemala and Nigeria represent the clearest domestic budget mobilisation. All francophone African countries (Burkina Faso, Côte d'Ivoire) and most lower-income CHAI countries remain wholly or predominantly donor-dependent.
5. PEPFAR stop-work orders (2025) exposed near-total donor dependency in Zimbabwe and Zambia — a compounding risk not reflected in pre-2025 documents.
6. Sources: CHAI Final Closure Report 2019–2025; KIIs; Philippines Country Case Study (June 2026); Kenya Case Study (June 2026); Malawi Case Study (June 2026); Burkina Faso Case Study (June 2026); SUCCESS Annual Reports 2022–2024.

ANNEX 12. COUNTRY CASE STUDIES (BURKINA FASO, KENYA, MALAWI AND PHILLIPPINES)

Separate annexes.

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ANNEX 14. TERMS OF REFERENCE

Evaluation of Unitaïd's Portfolio of Investments in Accelerating Elimination of Cervical Cancer through Secondary Prevention

1. PURPOSE

The Terms of Reference (ToR) provide an overall framework for the services to be provided by the Contractor selected under this Request for Proposal (RFP 2025.18). Unitaïd seeks a consultancy firm to conduct an independent evaluation, assessing the impact and learning from Unitaïd's investments in establishing and strengthening cervical cancer secondary prevention programs between 2019 and 2025.

2. DESIRED TIMEFRAME

- Estimated start date: February/March 2026
- Estimated completion date: June/July 2026

3. BACKGROUND

Global Context

Cervical cancer is the fourth most common cancer among women globally, with more than 600,000 new cases and 340,000 deaths annually, most of which occur in low- and middle-income countries (LMICs). In 2020, the World Health Organization (WHO) launched the Global Strategy to Accelerate the Elimination of Cervical Cancer with 90-70-90 targets by 2030; 90% of girls fully vaccinated with HPV vaccine by age 15, 70% of women screened using a high-performance test by ages 35 and 45, and 90% of women with pre-cancer or cancer receiving appropriate treatment. Achieving these targets would make cervical cancer a rare disease, (fewer than 4 cases per 100,000 women per year), effectively eliminating it as a public health problem.

While HPV vaccination remains the long-term solution, secondary prevention - screening and treatment of pre-cancerous lesions- is the most urgent and high impact intervention in the short to medium term, especially in LMICs where vaccination coverage remains low, and screening services are limited. This is also critical for women living with HIV (WLHIV), who face six times higher risk of developing cervical cancer compared to HIV-negative women due to their increased susceptibility to persistent HPV infections.

Unitaid's contribution to cervical cancer elimination

Since 2019, Unitaïd has been a leading global investor in cervical cancer programming, investing over USD 80million focusing on innovative, scalable, and affordable solutions for screening and treatment. Through partnerships with CHAI, Expertise France, WHO/ PAHO and other sub- implementers, Unitaïd has:

- Introduced HPV molecular testing, self-sampling, thermal ablation and LEEP devices, and advanced the development of AI-enhanced visual evaluation tools.
- Reduced prices for HPV tests and thermal ablation devices by 40–45%, increasing affordability.
- Supported screening of over 1.6 million women in at least 14 project countries, and an average of 88% of them were linked to treatment services.
- Piloted introduction of innovative tools and integrated service delivery models within national health systems to facilitate sustainable scale-up.
- Generated operational and clinical evidence that informed WHO guidelines and national policies and implementation plans.

4. SCOPE OF THE EVALUATION

The evaluation will assess Unitaïd’s cervical cancer portfolio from 2019 to 2025, focusing on partner-implemented activities across target countries aimed at advancing secondary prevention through screening and treatment of precancerous lesions. See Annex 2 for an overview of investments. The evaluation will also include case studies in eight countries (four in-depth and four light-touch country case studies) to enable comparative analysis across different contexts and delivery models, identifying transferable lessons and context-specific insights to inform scale-up and future interventions.

The evaluation will not only assess performance and results but will also serve as a key learning exercise to inform Unitaïd’s future investments in cervical cancer elimination. The learning domains identified will be embedded as thematic lines of inquiry throughout the evaluation process. These include:

- **Learning Theme 1: Continuum of care** - understanding how effectively women screened positive for precancerous or invasive cervical lesions were linked to treatment and the effectiveness of follow-up mechanisms.
- **Learning Theme 2: Sustainable Financing** – understanding the cost drivers of screening and treatment and exploring which financing approaches have potential for sustainable scale-up.
- **Learning Theme 3: Programming at Scale**- understanding the factors that drive scale up and effective transition from pilot projects to national-level implementation.
- **Learning Theme 4: South-South learning**- understanding effective mechanisms, including knowledge products, that can be leveraged for regional or south-south collaboration, learning and dissemination.
- **Learning Theme 5: Commodity supply and delivery**-understanding the effectiveness of commodity distribution and utilization, particularly of thermal ablation devices across the facilities.

In addition, the evaluators will be expected to provide targeted support to a separate impact-modelling exercise for the cervical cancer portfolio, such as relevant country-level data and key assumptions; they will not be responsible for conducting the modelling itself.

5. EVALUATION PURPOSE AND OBJECTIVES

Main Objective

To assess the catalytic impact of Unitaïd's investments in establishing and strengthening cervical cancer secondary prevention programs between 2019 and 2025 and to synthesize key learnings to inform more impactful, scalable, and sustainable approaches in future investments in alignment with the elimination agenda.

Specific Objectives

- I. Assess the catalytic impact of Unitaïd's investments in establishing and strengthening cervical cancer secondary prevention programs, including their contribution to advancing countries along the pathway to elimination.
- II. Synthesize learnings on which tools, models, and strategies have worked well (or not), and why, across diverse country contexts; and provide evidence-based actionable recommendations to enhance the design, coordination, implementation, and scale-up of cervical cancer interventions to accelerate progress toward elimination.

6. EVALUATION CRITERIA AND QUESTIONS

The evaluation will be guided by Unitaïd's evaluation framework, which is based on the internationally recognized evaluation framework of the OECD Development Assistance Committee (DAC) principles and criteria for evaluations —relevance, coherence, efficiency, effectiveness, impact, and sustainability.

In addition to assessing performance against these criteria, the evaluation will also align with Unitaïd strategic objectives within its 2023-2027 strategy and its Organizational learning agenda.

The analysis will be informed by theories of change (TOCs) developed throughout the different phases of the project, which articulate Unitaïd's expected pathways to impact. These TOCs will provide the foundation for assessing both intended and emergent outcomes, as well as contextual factors influencing success.

Preliminary evaluation questions, structured around the OECD-DAC criteria and Unitaïd's strategic objectives, are provided in Annex 1 to the ToR. These will be further refined during the inception phase, in consultation with Unitaïd, as needed.

7. EVALUATION METHODOLOGY

The evaluation will adopt a mixed-methods approach that integrates both quantitative and qualitative methods to generate evidence while prioritizing learning. The design will be guided by the OECD-DAC evaluation criteria, Unitaïd's access barriers, and principles of realist and participatory evaluation to explore what worked, for whom, in what contexts, and why. Using a realist lens will help unpack the mechanisms through which Unitaïd's investments have achieved—or failed to achieve—intended outcomes, and how contextual factors shaped the results.

The evaluation will also ensure meaningful engagement of communities and people with lived experiences, civil society champions, healthcare workers and women to the extent possible throughout the evaluation process. Their perspectives will inform the design and refinement of

evaluation tools, through pilot testing, co-defining success (what's working), and the interpretation of findings, ensuring that the evaluation reflects lived realities and promotes shared learning.

The learning agenda questions will serve as a framework for structuring qualitative inquiry and synthesis across countries, ensuring that lessons are actionable and relevant for future Unitaid and partner investments. Data collection methods can include:

a) Document reviews:

- Systematic review of Unitaid project documentation, monitoring data, market analyses, and partner reports, including community and civil society (CCSE) work.
- Desk review of national and global policy documents to contextualize findings within broader elimination efforts.

b) Case studies:

Four (4) in-depth and four (4) light-touch country case studies will be undertaken to generate rich contextual insights and cross-country learning. The proposed countries for this evaluation are Burkina Faso, Kenya, Malawi, and the Philippines for the in-depth case studies, and Guatemala, Senegal, Rwanda and Nigeria for the light-touch case studies.

In-depth case studies will involve the engagement of country-based consultants to conduct field-level data collection and stakeholder consultations. In contrast, light-touch case studies will rely primarily on remote interviews and secondary data review, engaging a broader range of stakeholders at national and regional levels.

The selection of countries is guided by the following criteria:

- **Stage on the pathway to elimination:** representing different points of progress (e.g., early introduction, scale-up, or near-elimination).
- **Diversity of delivery models:** including self-sampling, community-based approaches, and integration with HIV services.
- **Geographic and programmatic diversity:** ensuring representation across different regions and implementation contexts.
- **Community participation and equity considerations:** prioritizing approaches that promote access, inclusion, and sustainable scale-up through community engagement.

Case studies will include analysis of national program data, field-level observations (where feasible), and stakeholder interviews. Findings will focus on understanding what worked, what didn't, and why—emphasizing practical lessons for replication and scale-up.

c) Stakeholder consultation:

- At least 60 semi-structured interviews will be held remotely with external stakeholders

including Ministries of Health, Task forces, Reproductive Health Technical working groups (TWGs) and related thematic TWGs, community and civil society groups as well as funders and other key partners. Interviews will also be conducted with Unitaid staff, implementing

partners, WHO HQ and its regional offices e.g. WPRO, PAHO, other regional bodies (e.g. Africa CDC). Consultants are encouraged to use focus group discussions (in lieu of individual interviews) where relevant .

- Consultations will explore the design logic, implementation processes, and catalytic contributions of Unitaids' investments.

d) Community and User Perspectives

- Inclusion of community and user voices, particularly health care workers, community advocates and beneficiary women, where feasible.
- Methods may include focus group discussions, participatory storytelling, or key informant interviews facilitated by local partners and local consultants.

Evaluators are expected to apply rubrics to assess the strength of evidence and the contribution level to inform the analysis and reporting of findings. Findings should be triangulated across multiple data sources, stakeholder groups, and country contexts.

8. PLACE OF WORK

Work under this evaluation will occur both remotely and in person, as described in the methodology. In-depth country case studies will be carried out in person by national consultants. All other interviews and consultations will be conducted remotely. It is highly preferred that the Evaluators have either a regional/local presence in the country case studies (especially for in- depth country case studies) or have access to local counterparts that can assist the Evaluators in the case studies, including in identifying local stakeholders to be interviewed.

9. MANAGEMENT AND COMMUNICATION

The Evaluators will be expected to participate virtually in an inception/kick-off meeting with Unitaids and to present the final findings to the project team and a broader group of Unitaids staff and partners. In addition, the Evaluators will be expected to provide regular (weekly) status updates to the Unitaids focal point for the evaluation, the Monitoring & Evaluation manager.

10. QUALIFICATION AND SKILLS

Bidders shall propose a multi-disciplinary team of 3-6 experienced evaluators. The team should collectively demonstrate expertise in global health evaluation, community centered evaluation approaches, realist evaluation approaches, reproductive and women's health, and implementation research, with strong analytical and facilitation skills to synthesize evidence and generate actionable learning for Unitaids and partners.

- The Team Leader should have at least ten (10) years of experience leading complex, multi-country evaluations in the field of global health, with a strong understanding of access and equity challenges in LMICs.
- Core team members should each have a minimum of five (5) years of relevant experience in their technical areas.

Essential Qualifications and Experience

- 1) Proven experience conducting multi-country and multi-partner evaluations in global health, and women's health, ideally with a focus on innovation, market shaping, and catalytic investments.
- 2) Strong grounding in evaluation methodologies, including mixed-methods, realist and participatory approaches.
- 3) Demonstrated experience in case study development and learning-oriented evaluations, particularly those emphasizing policy influence, scalability, and sustainability.
- 4) Demonstrated familiarity with WHO's Global Strategy for the Elimination of Cervical Cancer and the Cervical Cancer space.
- 5) Proven ability to facilitate participatory processes and integrate community and user perspectives into evaluations.
- 6) Experience working in resource-limited settings, preferably in Sub-Saharan Africa, Latin America, or Asia.
- 7) Access to local expertise or team members in selected case study countries.
- 8) Appropriate representation and commitment to diversity, ensuring balance across gender, professional backgrounds, skills, and geographic experience.
- 9) Excellent communication skills in written and spoken English; all final deliverables must be submitted in English.
- 10) Country consultants should possess knowledge of relevant local languages (i.e. Burkina Faso - Mooré and French, Kenya-Swahili, Malawi- Chichewa and Phillipines- Filipino, in the case study countries *(CVs of the proposed local consultants must be submitted as part of the technical proposal, along with the CVs of the core team)*).
- 11) At least one team member with expertise in cervical cancer prevention and control and sexual and reproductive health or HIV.
- 12) Knowledge of health market dynamics, financing models, and scaling mechanisms relevant to Unitaid's investments.
- 13) Experience designing or evaluating the implementation of research components.

11. DELIVERABLES

The evaluation will run over five months, with deliverables to be submitted within the targeted timelines in Table 1 below. The aim is to present a final report to Unitaid mid-June 2026, which will feed into other investment decisions.

Table 3: Proposed deliverables and timeframe

Deliverable	Timeline
An inception report outlining the evaluation approach, methodology, data sources and stakeholder engagement plan, list of participants, workplan and data collection tools	Mid-March 2026
Data Collection	Six weeks
First draft report on initial findings- Highlighting emerging findings, themes and country case studies	Early May 2026
Virtual presentation workshop to co-create recommendations with the Project team	Mid-May 2026
Second draft report reflecting feedback received	End-May 2026
Virtual presentation to Unitaïd secretariat, grantees and other key stakeholders, including communities.	End-May 2026
Final evaluation report (with Executive Summary, actionable recommendations and learning agenda, and country case study reports) – including all comments satisfactorily addressed and PowerPoint slides of the evaluation	Mid-June 2026

12. BUDGET

Unitaid is an Organization that is dependent on the budgetary and extra-budgetary contributions it receives for the implementation of its activities. Bidders are, therefore, requested to propose the most appropriate and cost-effective solution that fully meets Unitaid requirements while ensuring a high standard of service.

All bidders are expected to submit their proposed budget in the Financial Proposal (Annex 5 of the RFP). As mentioned under section 8 of this ToR, it is highly preferred that firms have either a regional/local presence in the project countries or have access to local counterparts that can assist the evaluators to minimize the need for international travel, in line with Unitaid's effort in reducing carbon footprints related to the procurement activities.

13. PAYMENT TERMS AND SCHEDULE

For professional fees, payment will be made following satisfactory completion of the ToR and of corresponding detailed invoices, along with a Financial Statement (using the template to be provided by Unitaid) detailing the actual level of effort incurred and breakdown of travel expenses, if any.

For travel costs (subject to agreement with Unitaid), payment will be made per WHO rates and upon submission of invoices indicating actual travel costs with proof of payment. Evaluators will organize all travel logistics, including hotel booking and local transportation. All travels must be arranged in the most economical way, and in line with Unitaid's effort in reducing carbon footprints related to the procurement activities.

Figure 1. Payment schedule

Basis for Payment	Payment Percentage
1. Upon satisfactory completion of the inception report and acceptance by Unitaïd	20% of Professional Fee
2. Upon satisfactory completion of First draft evaluation report and acceptance by Unitaïd	30% of Professional Fee
3. Upon satisfactory completion of Second draft evaluation report and virtual presentation to Unitaïd and partners and acceptance by Unitaïd	30% of Professional Fee
4. Upon satisfactory completion of Final evaluation report (including all comments satisfactorily addressed) and acceptance by Unitaïd	20% of Professional Fee
5. Payment for other costs (if any)	Based on actual delivery

Annex 1.1. Main Evaluation questions (Indicative)**Unitaied Strategic Evaluation Questions Objective criteria**

1. Accelerate the introduction and adoption of key health products	Effectiveness Efficiency	1. To what extent and through what mechanisms did Unitaied's interventions achieve their intended results? 2. To what extent were women screened positive for precancerous and invasive cervical lesions successfully linked to timely and appropriate treatment services, and how effective were follow-up mechanisms in ensuring continuity of care?? 3. To what extent are women and healthcare workers satisfied with the tools and services introduced, (e.g. TA, HPV, self-collection & provider, AI) and what barriers have they faced in accessing or using them? 4. How timely, cost-efficient, and cost-effective was implementation (considering both allocative efficiency and technical efficiency) and what factors have been considered to ensure that value for money has been achieved from an efficiency standpoint? What mechanisms contributed to efficiency gains in different contexts? 5. To what extent have market-shaping efforts improved access, affordability, and availability of cervical cancer screening and treatment technologies across countries? Specifically, how efficiently have new technologies (e.g., thermal ablation) been deployed, and what are key bottlenecks?
2. Create systemic conditions for sustainable, equitable access	Coherence Relevance	6. To what extent did the cervical cancer programs respond to country needs and contextual realities? To what extent were there mismatches (if any) between the design assumptions and country-level realities? 7. To what extent did Unitaied's interventions interact with those of other partners and broader systems?
3. Foster inclusive and demand-driven partnerships for innovation	Sustainability Impact	8. To what extent are the gains from the Unitaied supported work sustainable and scalable? What conditions and mechanisms are likely to support or undermine the sustainability and scalability of Unitaied's contributions beyond the project period? 9. Which financing approaches—across public, private, and donor sources—are proving most effective in sustaining affordable HPV screening and treatment services over the long term? What are the true cost drivers of screening and treatment?
Learning and Risk Mitigation	Crosscutting	10. What lessons have been learned, and how have they been incorporated in the lifetime of the investments? To what extent has this learning been captured and shared, and what influence has it had (or is anticipated to have)? 11. To what extent were lessons and best practices from early-adopter countries and South–South collaboration models effectively captured, adapted, and applied to accelerate uptake of cervical cancer programming strategies across diverse contexts? How are cross-country collaborations and knowledge products supporting continued uptake and institutionalization?

		12. To what extent did gender norms, roles and relations influence access to, uptake of, and continuity in cervical cancer screening and treatment services — including the roles of women and men as healthcare workers, decision-makers, caregivers and partners — and how were gender considerations addressed in program design and implementation? 13. How effectively have strategic, implementation and sustainability/scalability risks been identified and managed throughout implementation?
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Annex 1.2. Overview of geographical scope of Unitaid's portfolio of cervical cancer investments

Investment (Grantee)	Duration	Geographical scope
Clinton Health Access Initiative (CHAI)	Output 1-4: July 2019-April 2023	India, Kenya, Malawi, Nigeria, Rwanda, Senegal, South Africa, Uganda, Zambia, Zimbabwe
	Output 5: April 2020-March 2021	Cameroon, Democratic Republic of Congo, Ethiopia, India, Kenya, Malawi, Mozambique, Nigeria, Rwanda, Senegal, South Africa, Tanzania, Uganda, Zambia, Zimbabwe
	Output 6: Oct 2020-April 2022	Cameroon, Democratic Republic of Congo, Ethiopia, Ghana, Kenya, Malawi, Mozambique, Nigeria, Rwanda, Senegal, South Africa, Uganda, Zambia, Zimbabwe
	Output 7: April 2021-Sept 2022	Ethiopia, Liberia, Nigeria, Rwanda, Uganda
	Output 8: June 2021-Sept 2022	Cameroon, Ghana, Mozambique, Zimbabwe, Ecuador, Guatemala, Burkina Faso, Tanzania, Lesotho, and Peru
	Output 9: Aug 2021-July 2023	Cambodia, Cameroon, DRC, India, Kenya, Laos, Lesotho, Malawi, Nigeria, Vietnam
	Output 10: Nov 2021-Nov 2023	Cambodia, Cameroon, Democratic Republic of Congo, Ethiopia, Ghana, India, Kenya, LATAM Region, Laos, Lesotho, Malawi, Nigeria, Papua New Guinea, Vietnam, Zimbabwe
	Output 11: Dec 2021- Dec 2023	Cameroon, Ecuador, Eswatini, Ghana, Guatemala, Indonesia, Lesotho, Mozambique, South Africa, Zambia, Zimbabwe
	Output 12-16 May 2023- April 2025	Kenya, Malawi, Nigeria, Rwanda, Zambia, Zimbabwe
CHAI	June 2025-May 2027	India, Kenya, Malawi, Nigeria, Rwanda, South Africa, Zambia, Zimbabwe
Expertise France	Output 1-4: Dec 2019- Sept 2024 Output 5-9: Dec 2023- April 2026	Burkina Faso, Côte d'Ivoire, Guatemala, Philippines
Expertise France	July 2025-Dec 2026	Myanmar and the Philippines
In addition, there is a WHO enabler, PAHO and GAVI investments.		

