

EVAH Request for Proposals (RFP): Frequently Asked Questions (FAQ)

This document addresses frequently asked questions regarding the EVAH Call for Proposals submitted by the March 6th deadline for questions. Due to the volume of questions and to ensure applicants have equal access to information, we are unable to respond individually to every inquiry. If you do not see your question addressed here, please refer to the [RFP Overview](#), [Application Guidelines](#), and [Application Portal](#) for more information.

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1. Eligibility & Partnerships – Who can apply and how should consortia be structured?

1. Must the lead applicant be based in an eligible country, or can a consortium be led by a global institution with an in-country co-lead?
 - a. The lead applicant must be legally registered and operational in an eligible region (Sub-Saharan Africa, South Asia, or Southeast Asia), and the Principal Investigator or Project Lead must also be based in the region. A global institution may participate as a partner, but it cannot serve as the lead applicant unless it meets these regional requirements. Consortia are encouraged, and collaborations between international and regional organizations are welcome; however, the project must be led (or co-led operationally) by a region-based institution, and at least 80% of funds should flow to entities in the eligible regions.

2. What qualifies as being “based in the region”? (registration vs operational presence vs majority staffing)
 - a. For the purposes of this call, an organization is considered “based in the region” if it meets all of the following conditions:
 - i. The lead applicant is a legally registered entity in Sub-Saharan Africa, South Asia, or Southeast Asia;
 - ii. The organization is operational in the region (i.e., conducting programmatic activities there);
 - iii. PI or Project Lead is based in the region; and
 - iv. Core project activities, including evaluation and deployment are led or co-led by organizations in the region, with at least 80% of funds flowing to regional entities.
 - b. Having staff or collaborators in the region alone is not sufficient if the legal registration and project leadership requirements are not met. Partnerships with out-of-region institutions are welcome as collaborators.
3. Are AI private companies eligible to serve as the lead applicant?
 - a. Yes. For-profit companies, including private AI companies, are eligible to serve as the lead applicant provided they meet all other eligibility requirements. This includes being a legally registered and operational entity in Sub-Saharan Africa, South Asia, or Southeast Asia, with the PI or Project Lead based in the region.
 - b. The proposal must also include appropriate partners, such as a clinical implementation partner (e.g., Ministry of Health, public facility, or NGO) and evaluation expertise and the project must focus on rigorous evaluation rather than product development.
4. Are UN, AU agencies, or other multilateral organizations eligible to apply?
 - a. Yes. UN agencies, AU agencies, and other multilateral organizations are eligible to apply under this call. However, proposals must meet all other eligibility requirements outlined in the [RFP Overview](#) (pg. 7). Multilateral organizations may therefore apply as lead applicants if they meet these requirements (e.g. through country offices), or as part of a consortium with eligible regional partners.
5. Can a Ministry of Health be the lead applicant?
 - a. Yes. A Ministry of Health is eligible to serve as the lead applicant, as government agencies are among the organization types permitted to apply. However, the Ministry must still meet all standard requirements including being legally registered and operational in an eligible region, designating a Project Lead based in the region, and partnering with organizations that can support implementation and rigorous evaluation where needed.
6. Can applicants submit more than one proposal (e.g., for different countries or tools)?

- a. The RFP does not prohibit a given organization from submitting more than one proposal. Organizations may submit multiple proposals (for example, in different countries or evaluating different tools) as long as each proposal is distinct in scope (i.e. you cannot submit the same project to both Pathway A and B) and independently meets all eligibility and evaluation requirements.
 - b. A PI or project lead within an organization may submit only **one application** as lead applicant through this RFP. The same lead applicant cannot apply for both Pathway A and B. Researchers and partner organizations may participate as co-applicants or collaborators on multiple applications. The roles of co-applicants should be clearly described and justified, to ensure that each partner's involvement is meaningful and not included solely to strengthen the application. Co-applicants or collaborators on multiple proposals must be able to demonstrate that they can dedicate enough time and resources to all projects if all are funded.
 - c. There is no limit to the number of collaborators an application can have but the added value must be clear. There is no minimum time commitment for collaborators.
 - d. Organizations with separate legal entities registered in different countries may submit separate applications, provided each proposal independently meets the eligibility criteria and the countries of implementation are within the eligible regions.
 - e. Applicants should also ensure they have the capacity and partnerships necessary to deliver on each proposed evaluation.
7. What constitutes an acceptable clinical implementation partner?
 - a. An acceptable clinical implementation partner is an organization responsible for delivering real-world health services where the AI-enabled tool will be deployed and evaluated under routine care conditions. This may include:
 - i. A Ministry of Health
 - ii. Public sector health facilities
 - iii. Qualified non-governmental organizations (NGOs) delivering health services
 - iv. Private clinics or health facilities providing frontline primary or community health care services
 - b. These examples are illustrative rather than exhaustive. The key requirement is that the partner is a legitimate service-delivery organization capable of supporting real-world implementation of the tool and enabling the evaluation.
 - c. All proposals must identify at least one clinical implementation partner, and applicants should clearly describe the partner's role in implementation and demonstrate their capacity to support the evaluation.
8. What partnerships are required? What documentation is required to demonstrate a partnership with a health facility or MoH?

- a. Each proposal must include partners that collectively cover three core functions:
 - i. Clinical implementation partner – a service-delivery organization where the tool will be deployed and evaluated (e.g., Ministry of Health, public or private health facility, or NGO delivering care).
 - ii. Evaluation expertise – an institution or research team capable of conducting rigorous health systems or impact evaluation.
 - iii. Project management/implementation capacity – an organization responsible for coordinating activities and ensuring delivery of the project.
 - b. Collaborations between technologists, health system actors, researchers, and implementers are strongly encouraged, particularly those engaging local health authorities and communities.
 - c. The lead applicant is responsible for assembling the consortium at the time of application. Applicants must have an identified clinical implementation partner in place when submitting the proposal. A letter of support from the clinical implementation partner is required, unless the lead applicant itself serves as the clinical implementation partner.
 - d. Applicants are encouraged to provide evidence that the partnerships are real and operational. This typically includes:
 - i. Letter(s) of support or commitment from the clinical implementation partner (e.g., MoH or health facility) confirming willingness to host deployment and evaluation activities
 - ii. Description of roles and responsibilities of each partner within the proposal narrative
 - iii. Confirmation of access to facilities, staff, and relevant health system workflows necessary for the evaluation
 - e. Other letters of support from partners are optional but encouraged. Formal agreements between partners do not need to be fully executed at the time of application but may be required if the proposal is selected for funding.
 - f. The proposal must clearly show that the evaluation can be conducted in routine care settings and that partners have the capacity to support implementation.
9. Can a technology developer be part of the evaluation team?
- a. Yes. A technology developer (could include startups, private AI companies, academic research labs, digital health vendors, or internal technical teams within NGOs or governments, etc.) may be part of the evaluation team and included in the consortium.
 - b. However, the proposal must still demonstrate independent and rigorous evaluation capacity (e.g., health systems research or impact evaluation expertise), and the project must focus on evidence generation rather than product development. The consortium should clearly define roles to ensure credible evaluation and appropriate collaboration between technologists, implementers, and researchers

10. Can the evaluator and implementer be the same organization?
- Yes, the evaluator and implementer may be the same organization, provided the proposal demonstrates credible and rigorous evaluation capacity and clearly manages potential conflicts of interest. Applicants must show that the team includes appropriate expertise in health systems research or impact evaluation and that the study design supports objective evidence generation (for example, through independent oversight, transparent methods, or separate evaluation personnel within the organization). Consortia that combine implementation and evaluation roles are acceptable as long as the evaluation remains robust and unbiased.
11. Are there opportunities to engage as an implementation or evaluation partner within ongoing proposals?
- We encourage teams to identify consortia where they can partner and support as implementation or evaluation partners. Lead applicants are responsible for assembling appropriate consortium partners.
12. Is a formal data sharing agreement required at application stage?
- No, a formal data sharing agreement is not required at the application stage.
 - However, applicants must describe how they will meet the Global and Open Access expectations of the funders and demonstrate willingness to share findings and contribute to broader evidence synthesis. If selected for funding, projects will be required to comply with the specific data-sharing and access policies of the supporting funder (available in the [Application Guidelines](#), pg. 16, Question 30), at which point formal agreements may be put in place.
13. Does the company that developed the AI tool need to be a formal consortium partner, or can the tool be procured/authorized without the vendor joining?
- The company that developed the AI tool does not need to be a consortium partner. The tool may be procured if this arrangement is sufficient to enable evaluation and appropriate data access. Optional letters of support from technology partners are encouraged where possible.
14. Can project collaborators be based in a country outside of the [eligible ones](#)?
- Yes. The proposal still needs to meet all eligibility requirements, e.g. around where the lead applicant is legally registered and where funds flow, as outlined in the [RFP Overview](#) (pg. 7).
15. Does the PI or research partner need to be employed by the lead applicant organization?
- No. The research partner or PI does not need to be employed by the lead applicant organization. The lead applicant organization may serve in different possible roles within the proposal, e.g. the lead applicant could be the clinical

implementation partner, the research partner, and/or a partner responsible for overall project management. Lead applicants may partner with external research organizations or PIs not employed by the lead applicant organization. Research partners may also serve as the lead applicant, if appropriate, based on the consortia structure.

16. Does the lead applicant or project lead need to be an academic researcher or employed at a research institution?
 - a. No.
17. Does the proposed evaluation need to occur where the lead applicant organization is legally registered?
 - a. The proposed evaluation does not need to take place in the same country that the lead applicant organization is legally registered if they are also legally operating in additional countries in the region.
18. Our local country office is registered but not a separate legal entity from headquarters, which are outside of eligible regions—can we be the lead applicant?
 - a. Yes, as long as the country office is legally registered and operational in one of the eligible regions.
19. If a company has legal entities registered in two different countries, would it be possible for the company to participate in evaluations in two different countries under separate applications?
 - a. Yes. The two countries must be eligible and based in Africa, Asia or Southeast Asia.
20. Do applicants need to obtain any country-specific government or regulatory approvals to receive funding—for example, FCRA approval in India?

Applicants must comply with all local legal requirements and all funder terms (Wellcome Trust, Gates Foundation, and Novo Nordisk Foundation). Applicants should be prepared to meet country-specific regulations (e.g., foreign contribution rules) as applicable.

2. Tool Eligibility & Readiness

21. Will the call only accept proposals related to AI-enabled clinical decision support tools (CDSTs)?
 - a. Yes. This call specifically supports evaluations of AI-enabled clinical decision support tools (CDSTs) that assist frontline community and primary health care

workers in making clinical decisions (e.g., triage, diagnosis, referral) within routine care workflows.

- b. Projects focused on other types of digital or AI solutions such as patient-facing apps, standalone chatbots not integrated into provider workflows, management dashboards for policymakers, or general AI model development are not eligible.

22. What qualifies as an AI-enabled CDST? Is my AI tool eligible for this RFP?

- a. An AI-enabled clinical decision support tool (CDST) is a digital tool that uses artificial intelligence methods (e.g., machine learning, predictive models, computer vision, or language/voice processing) to assist frontline community or primary health care workers in making clinical decisions during routine care.
- b. To qualify under this call, the tool must:
 - i. Support clinical decision-making including, but not limited to, triage, diagnosis, referral, or treatment guidance
 - ii. Be used by frontline health workers (not patients directly) in [eligible countries](#)
 - iii. Be integrated into real-world care workflows and service delivery systems, rather than operating as a standalone application
 - iv. Have moved beyond proof-of-concept, with demonstrated performance in validation studies and readiness for deployment
 - v. Generate actionable guidance at the point of care
- c. Tools that are purely patient-facing, administrative dashboards, standalone chatbots without workflow integration, supply-stock alert systems, or general AI research/model development do not qualify. For more information, please see the “Eligibility” sections of the [RFP Overview](#) (pg. 7) and [Application Guidelines](#) (pg. 2).

23. What validation is required to be “ready for deployment” (Pathway A and B)?

- a. For the purposes of this call, “ready for deployment at scale” does not necessarily require national or multi-country deployment. Rather, it refers to tools that are sufficiently mature and stable within real-world care settings to support rigorous evaluation of their effects on clinical decisions, health outcomes, or system performance. Both pathways require tools to be beyond proof-of-concept with demonstrable accuracy and performance through prior validation or implementation evidence, such as pilot deployments, validation studies, usability testing, or documented performance in real-world or simulated care settings. . Pathway A emphasizes real-world deployment and systems integration evidence; Pathway B requires maturity suitable for rigorous impact evaluation at scale. The tool should be stable enough to support deployment in routine workflows and evaluation of its effects on care delivery.

24. Can one application evaluate more than one AI-enabled CDST?
- Yes, if the [research design allows for a rigorous evaluation of both tools](#).
25. Do AI-enabled CDSTs include tools that support frontline workers in supply chain decision-making, such as stock availability assessments, stockout risk alerts, and reorder decisions?
- AI-enabled CDSTs assist frontline community or primary health care workers in making clinical decisions during routine care. Supply chain decision-making tools are not eligible.
26. If the proposed AI tool is owned by a company based outside of the [eligible regions](#), is the project still eligible?
- Yes, [provided the project meets all eligibility criteria \(e.g., where the lead applicant is legally registered and operational\) and complies with funders' access and data-sharing policies. See the \[RFP Overview\]\(#\) \(pg. 7\) for full eligibility criteria and the \[Application Guidelines\]\(#\) \(pg. 16, Question 30\) for funders' access and data sharing policies.](#)
27. Does prior AI tool validation need to be in the exact evaluation geography?
- Not necessarily. Applicants should document prior performance and contextual relevance and explain how the tool will be safely adapted and monitored locally. Proposals should include plans for performance and safety monitoring in the new context and comply with local approvals.
28. Can the same AI tool be evaluated in multiple proposals (e.g., in different countries or health system contexts, or using different evaluation pathways)?
- Yes. However, a PI or project lead within an organization may submit only one application as lead applicant.
29. Is it necessary to have a purpose-built, fine-tuned AI model, or can a wrapper of an existing LLM work as well?
- Either is acceptable. Please describe clearly whether your solution is based on a wrapper of an existing LLM or not.

3. Pathway Selection (A vs B)

30. What are the funding pathways? How do they differ? How should applicants determine whether their project fits Pathway A or Pathway B?
- [For additional guidance on what is considered under Pathways A and B, please see the dedicated \[FAQ here\]\(#\).](#)

31. If a tool is deployed but only integrated in a limited number of facilities (e.g., within a district, region, or sub-region), which pathway applies?
- The appropriate pathway depends on what evidence the study can realistically generate:
 - Pathway A is appropriate if the evaluation will primarily examine implementation questions such as take-up, usability, workflow fit, adoption, training needs, or operational feasibility and the tool is not yet stable enough across sites to measure reliable outcome impacts.
 - Pathway B may be appropriate if the tool is already functioning consistently across multiple facilities and the study design can rigorously measure effects on clinical decisions, health outcomes, efficiency, or equity in a way that could inform policy or scale-up decisions.
 - In short, limited geographic coverage does not automatically determine the pathway — the key factor is whether the study will generate implementation readiness evidence or conduct piloting to inform a future impact evaluation (Pathway A) or generate decision-grade impact evidence (Pathway B)
32. Can a project begin in Pathway A and transition to Pathway B during the grant?
- No. A proposal must apply to one pathway only, and projects cannot transition from Pathway A to Pathway B during the same grant.
 - Pathway A is intended to generate implementation and readiness evidence that may inform a future, separate impact evaluation, while Pathway B supports studies already prepared to measure real-world impacts at scale.
33. What if our study includes both implementation and impact questions?
- Applicants should choose the pathway aligned with the primary objective of the evaluation. Secondary outcomes from the other domain may be included but should not drive pathway selection.
34. Can one institution submit an application for both Pathway A and B ?
- Yes. However, a single project or the same evaluation cannot be submitted to both pathways. Each proposal must align with only one pathway. In addition, the same lead applicant cannot apply for both Pathway A and B.
35. If a project is funded under Pathway A, may the team apply in a future round for Pathway B using Pathway A findings?
- We expect this will be feasible and encouraged, pending final subsequent RFPs' thematic priorities.
36. Is there a preferred evaluation method for Pathway A and B?
- No, a range of methods are considered for both pathways. Please propose the research method most appropriate for your research question and context.

4. Evaluation Design and Methods

37. What evaluation methods are acceptable?

- a. The call accepts a range of methods for generating real-world evidence. Examples include, but are not limited to:
 - i. Randomized evaluations (including cluster or stepped-wedge designs), including A/B testing and adaptive and pragmatic trials
 - ii. Quasi-experimental designs (e.g., matched comparisons, difference-in-differences, regression discontinuity, interrupted time series)
 - iii. Health Technology Assessments
 - iv. Mixed-methods studies combining quantitative and qualitative approaches
 - v. Exploratory analyses, including economic analysis and analysis on secondary outcomes
- b. Applicants should choose the method most appropriate for their research question, context, and stage of the tool.

38. What qualifies as a ‘rigorous evaluation’?

- a. A rigorous evaluation is one that can produce credible and decision-relevant evidence about the effects of the tool. In practice, this means the study:
 - i. Uses a clear comparison strategy to estimate what would have happened without the tool
 - ii. Minimizes bias and confounding
 - iii. Is adequately powered and analytically justified
 - iv. Uses reliable data sources and predefined outcomes
 - v. Transparently documents methods and assumptions
 - vi. Matches the strength of the design to the claims being made (e.g., feasibility vs impact)
 - vii. Is ethically sound, with appropriate approvals in place where needed.
- b. The evaluation must be strong enough to support conclusions appropriate to the selected pathway (implementation readiness for Pathway A or impact and policy relevance for Pathway B).

39. Can before–after studies qualify?

- a. Generally not on their own. Simple pre–post comparisons without an appropriate counterfactual typically do not provide sufficiently rigorous evidence, especially for Pathway B. Applicants should incorporate a comparison strategy (e.g., matched controls, interrupted time series, or other quasi-experimental approaches).

40. Are formal power calculations required?

- a. Yes for Pathway B. For Pathway A, formal hypothesis-testing power calculations are not always required, but applicants should justify sample size in relation to study objectives (e.g., feasibility, usability, or adoption estimates).
41. Are surrogate or intermediate outcomes acceptable?
- a. Yes, when justified. If direct health outcomes are rare or infeasible to measure within the study timeframe, applicants may use validated intermediate outcomes (e.g., diagnostic accuracy, guideline adherence); particularly in Pathway A. For Pathway B, applicants should explain how the outcomes support decision-making.
42. Is cost-effectiveness analysis required?
- a. A full economic evaluation is not mandatory for all studies, but applicants are strongly encouraged to assess efficiency, costs and cost-effectiveness, or resource implications. Pathway B studies should include stronger economic evidence where feasible.
43. Can projects include both implementation research and impact evaluation components?
- a. Yes. A project may include both implementation research and impact evaluation components from a methodological perspective. Mixed-methods designs are acceptable and often encouraged where they strengthen interpretation of findings (for example, pairing outcome measurement with process evaluation). However, the study must still be structured around a primary evaluation objective aligned to a single pathway:
 - i. If the core methodology focuses on feasibility, adoption, workflow integration, and operational performance → Pathway A
 - ii. If the core methodology is designed to estimate causal effects on clinical decisions, health outcomes, efficiency, or equity → Pathway B
 - b. Additional analyses can complement the primary evaluation but should not dilute the rigor or clarity of the main study design

5. Budget and Scope of Supported Costs

44. Can you provide more budget guidance on what costs are unallowable, or how funds will be disbursed?
- a. If you are selected for funding, you may be asked to submit a revised budget following the funders' budget guidelines (Wellcome Trust, Gates Foundation, and Novo Nordisk Foundation), which is why we have left the budget template and guidance intentionally high-level and easy to complete, as you can expect to be asked to provide additional budget details and receive further guidance further in the due diligence process.

- b. We ask you to please refer to the [budget guidelines](#) and use the budget template on the [RFP homepage](#). Complete the template to the best of your ability following these guidelines and prepare an accompanying budget narrative. **Funds are intended for evaluation and necessary implementation to support that evaluation.**
 - c. Reviewers will take into account whether your proposed budget seems commensurate with the scope, duration, and complexity of the work proposed and value-for-money, so prepare a **reasonable and well-justified budget**.
 - d. Similarly, how funds will be disbursed and what payment schedules are possible will be determined with the lead funder.
45. Are subawards to multiple partners allowed?
- a. Yes. The responsibility of subaward and the associated due diligence will rest on the primary implementing institutions. At least 80 percent of funds must flow to Sub-Saharan Africa, South Asia, or Southeast Asia-based entities. Fees to non-regional vendors or partners count toward the remaining 20 percent cap. Applicants should budget accordingly and justify any near-miss exceptional cases in their budget narrative.
46. The budget template does not include room for organizations other than the lead organization. How should we include costs associated with technical support for the project that my organization will propose?
- a. Costs associated with partner organizations, including technical collaborators or subawardees, may be included within the lead applicant's budget. Applicants should incorporate these costs in the relevant budget categories and clearly describe the role of each partner and associated costs in the budget narrative. If the proposal is selected to proceed, additional detail on partner budgets and subawards may be requested during the due diligence stage in accordance with the requirements of the assigned lead funder.
47. If the lead applicant or consortium includes an Indian entity without FCRA, can funds flow via an FCRA compliant prime while the non-FCRA entity acts as evaluation partner/subawardee?
- a. EVAH does not prescribe specific national funding flow structures, but proposals must comply with all applicable national regulations governing foreign funding in the countries where partners are based. Where required by local law (e.g., India's FCRA requirements), funds may flow through an eligible or compliant prime institution, provided that the overall consortium structure remains compliant with the RFP requirements. Applicants are responsible for ensuring that their proposed financial and partnership arrangements comply with all applicable regulatory requirements.

48. Transferring grant funds outside the country is legally complex and requires central bank approval, but some research costs will need to be directed outside of the country. Is it acceptable for some research-related expenses (e.g., salaries, travel, overhead) to be budgeted outside the country, provided that at least 80% of total funds still flow to the local region? If possible, how can this be done?
- The lead applicant organization must be based in Sub-Saharan Africa, South Asia, or Southeast Asia, and at least 80% of project costs must flow to these regions. Within this framework, it is acceptable for certain research-related expenses (e.g., salaries, travel, or overhead) to be budgeted outside of these countries. Please ensure that the budget clearly indicates which organization will incur each cost. If your proposal is successful, the assigned funder will work with you to structure the grant in a way that complies with their policies.
49. Can commercialization preparation costs be included?
- No. The grant cannot support commercial preparation, market expansion, software or product development, or product rollout beyond what is necessary to conduct the evaluation.
50. Can funding be used for software adaptation needed for evaluation?
- In general, software and product development will **not** be funded. Limited software adaptation *may* be supported *only* if it is necessary to enable the evaluation (for example, configuration, integration, localization, or minor modifications required for deployment in the study setting).
 - However, the funding cannot be used for core product development, model training, or major feature expansion. The call funds evaluation and evidence generation, not research and development of the tool itself.
51. Is there a cap on indirect costs in this RFP?
- Indirect costs are capped at 20 percent of direct costs in the application stage. If an application progresses to the next stage, the applicable indirect cost rate will be determined based on the requirements of the respective funder financing the work, in line with the relevant tripartite agreements.
52. Can licensing fees for the AI tool be included?
- Yes, if the fee is necessary to operate the tool for the purposes of the evaluation. The budget should only cover access required for the study and not ongoing commercial deployment beyond the evaluation period.
53. Can cloud hosting or API usage fees be included?
- Yes, when required to run the tool during the evaluation period and proportionate to the scale of the study.

6. Geographic & Setting Questions

54. Where must the evaluation be conducted? Must the evaluation occur only in eligible countries?
- All evaluations must occur in low- and middle-income countries within Sub-Saharan Africa, South Asia, and/or Southeast Asia. For the full list of eligible countries, refer to [this document](#). If your evaluation takes place in a country not on the list, it will not be funded.
55. Can multi-country evaluations be submitted?
- Yes. Multi-country evaluations may be submitted, provided all study sites are located in eligible low- and middle-income countries within Sub-Saharan Africa, South Asia, or Southeast Asia.
 - Applicants should clearly justify the multi-country design, ensure the study remains analytically coherent and feasible, and demonstrate appropriate partnerships and leadership within the regions of focus. Researchers are encouraged to set realistic expectations when planning multi-country projects and should consider the recommended project durations — 3–12 months for Pathway A and 12–24 months for Pathway B.
56. What qualifies as a primary health care (PHC) setting? Would a low-complexity district hospital qualify as a “primary health care” setting, provided the frontline clinical staff (nurses, clinical officers, or physicians) are the users of the AI tool?
- PHC settings include first-contact care delivered at community or outpatient level, such as community health worker programs, health centers, dispensaries, and outpatient primary care clinics. The key requirement is that the tool supports frontline decision-making within routine service delivery pathways.
57. Who counts as a “frontline and primary health care” worker? Do informal providers count?
- Frontline workers are community and primary health care providers operating within PHC settings (e.g., CHWs, primary care clinicians) who use the CDST within routine workflows, supervision, and referral pathways. ICU/acute-ward/emergency medicine/oncology/radiology/etc. tools are not eligible unless clearly integrated with frontline PHC pathways.
58. Are private or faith-based facilities eligible settings?
- Yes. Public, private, and faith-based facilities are eligible provided they deliver routine primary or community health care and support real-world implementation of the tool.
59. Can disease-specific programs (e.g., maternal health, TB, HIV) qualify?

- a. Yes, if the tool supports frontline clinical decision-making within routine PHC workflows rather than a vertical research-only intervention.
60. Can study sites be added after the project begins?
- a. Generally no. Study sites should be clearly specified at application. Any later additions would require funder approval.

7. Data Governance & Sharing

61. What are the specific Global Access requirements?
- a. Funded projects must comply with the Global and Open Access policies of each funder (Wellcome, Gates Foundation, and Novo Nordisk Foundation). In general, this means applicants must:
 - i. Describe how the project will advance equitable access to the evidence and benefits generated
 - ii. Share findings in ways that contribute to broader learning and public health use
 - iii. Allow results to be synthesized with other EVAH studies
 - iv. Follow the specific data-sharing, publication, and intellectual property requirements of the supporting funder
 - v. Detailed obligations will be finalized after award and aligned with the applicable funder's policy framework.
62. Must patient-level data be publicly shared?
- a. No. Patient privacy and local regulations take priority. Applicants are not required to publicly release identifiable or sensitive patient-level data. However, projects must share results and evidence in a manner that supports broader learning, and may be asked to provide appropriately de-identified or controlled-access data where feasible and compliant with local laws and ethics approvals.
 - b. EVAH does not require research data to be hosted or transferred outside the country where the study is conducted; data management arrangements should comply with applicable national regulations, institutional policies, and ethics approvals.
63. Can proprietary AI models be evaluated?
- a. Yes, as long as the model evaluation is part of a real-world evaluation (e.g., not *only* an in silico or in the lab evaluation). Proprietary tools are eligible. Participation in EVAH does not require open-sourcing the model.
64. Will funders require open-sourcing of the algorithm?
- a. No. Global Access policies focus on access to evidence and public health benefit, not mandatory release of proprietary source code.

65. Can organizations retain intellectual property rights?
- a. Yes. Organizations may retain ownership of their technology. However, applicants must demonstrate that the outcomes of the research can inform public health decision-making and that access to the benefits of the research will not be unreasonably restricted.
66. ●Does Global Access affect commercialization plans?
- a. Commercialization is permitted. Applicants should describe how reasonable pricing, licensing, or distribution plans will support equitable access in low- and middle-income settings consistent with Global Access principles.

8. Equity, Ethics & Responsible AI

67. What documentation must be submitted regarding ethics approval?
- a. Ethics approval is not required at the application stage. However, applicants should describe the anticipated ethical considerations and the process for obtaining approvals in all relevant jurisdictions.
 - b. For studies involving human subjects, IRB approvals (including local IRBs and permits) are required before award contracting and any human subjects work. Applicants must follow funder clinical trial and evaluation policies as applicable. Please see the [Application Guidelines](#) for links to funders' clinical trial policies (pg. 9, Question 14) and evaluation policies (pg. 16, Question 30).
 - c. Applicants are also responsible for ensuring that the evaluation complies with any applicable national regulatory requirements for digital health tools or medical devices in the countries where the study will take place.
 - d. If selected for funding, projects will be required to obtain approval from the appropriate institutional and/or national ethics review bodies before study activities involving human participants or identifiable data begin, and to comply with applicable clinical trials and data governance policies of the supporting funder.
68. Must applicants conduct community engagement activities?
- a. Community engagement is not a mandatory standalone requirement, but applicants are strongly encouraged to include appropriate stakeholder and community engagement where it strengthens ethical conduct, trust, usability, and interpretation of findings.
 - b. Proposals should demonstrate how relevant stakeholders, such as frontline health workers, supervisors, patients, or local health authorities will be involved as needed to support responsible implementation and evaluation.
69. Are patient consent models specified?

- a. No specific patient consent model is prescribed in the RFP. Applicants should select consent approaches appropriate to their study design, data sources, and local regulations (e.g., individual consent, waiver of consent for routine data use, or institutional approvals).
 - b. All consent procedures must be approved by the relevant ethics review bodies and comply with national regulations and the applicable policies of the supporting funder.
70. Must applicants assess algorithmic bias?
- a. Applicants are encouraged to examine performance across relevant population subgroups (e.g., gender, age, geography, or cadre) where feasible. The goal is to understand whether the tool performs differently across populations and to interpret implications for equitable use.
71. Must patients be informed that AI is being used?
- a. Applicants should follow local ethics guidance and regulatory requirements. Where appropriate, patient-facing communication should support transparency and trust while remaining practical within routine care workflows.
72. Is a human-in-the-loop required?
- a. Tools should support, not replace, clinical decision-making by frontline health workers. The evaluation should reflect real-world supervision and accountability structures within the health system.
73. What safety monitoring is expected?
- a. Applicants should describe procedures for identifying and managing potential harms, incorrect recommendations, or adverse events during the evaluation. Monitoring approaches should be proportionate to the level of risk posed by the intervention.
74. Are special safeguards required for image, voice, or biometric data?
- a. Applicants should follow applicable privacy laws, ethics approvals, and data protection standards appropriate to the sensitivity of the data collected.
75. Are independent oversight committees required?
- a. Not universally required. Higher-risk studies may warrant additional oversight, which applicants should justify based on the intervention and context.

9. Submission, Review Process and Award Management

76. Are there WizeHive word/character limits?

- a. The online portal includes defined fields and limits, which are also outlined in the [Application Guidelines](#). Applicants should consult the Application Guidelines and [WizeHive instructions](#) for formatting and troubleshooting tips (e.g., use an alternate browser or incognito mode), and if not answered, reach out to application_help@povertyactionlab.org and copy evah@povertyactionlab.org.
77. Are late submissions considered?
- a. No.
78. How should scientific references be incorporated into the application?
- a. You may upload an appendix of references for your proposal in section 5c under “Additional Attachments.”
79. Will applicants receive reviewer comments and funding outcomes?
- a. All applicants will be notified of the funding outcome once a determination has been made by the funders. Due to the volume of submissions, detailed reviewer comments may not be provided to all applicants, and any additional feedback shared will be at the discretion of the program.
80. Who makes the final funding decision?
- a. Final funding decisions are made by the Wellcome Trust, Gates Foundation, and Novo Nordisk Foundation, according to their internal approval processes.
81. Can the project start before the agreement is signed?
- a. No. Project activities involving grant funds may only begin after the grant agreement is fully executed.
82. Can projects start before regulatory approval?
- a. No. All research projects must seek ethics approvals before commencing any research activities, especially enrollment of research participants.
83. Who will manage EVAH grants?
- a. Grants will be managed by the Wellcome Trust, Gates Foundation, and Novo Nordisk Foundation.

10. Proposal Evaluation & Selection

84. Is there an initial eligibility screening?
- a. Yes. All submissions first undergo an administrative and eligibility review to confirm they meet the basic requirements of the RFP (e.g., applicant eligibility, pathway selection, and completeness of materials). Only eligible proposals proceed to full technical review.
85. What are common reasons proposals may be not selected?
- a. Common reasons may include:

- i. Misalignment with the objectives of the selected funding pathway or scope of the RFP
 - ii. Insufficient rigor in the proposed evaluation design
 - iii. Lack of a credible implementation setting or partnerships
 - iv. The tool not meeting readiness requirements (e.g., still in development)
 - v. Limited relevance for real-world decision-making
- 86. How will proposals be scored across pathways?
 - a. Applications are reviewed relative to the expectations of their chosen pathway rather than directly compared across pathways. While both pathways consider factors like overall relevance, feasibility, strength of partnerships, and potential contribution to evidence, the emphasis differs. Please see the [FAQ on Pathway A and B](#).
- 87. Can reviewers recommend moving a proposal to a different pathway?
 - a. Applicants should carefully select the most appropriate pathway. During review, proposals may receive guidance or recommendations, but funding decisions will be based on the pathway applied for.
- 88. Will multiple awards be made per country?
 - a. There is no fixed limit on the number of awards per country. Funding decisions will be based on the quality, feasibility, and relevance of each proposal, as well as the overall portfolio balance across topics and geographies. The final funding decisions will be made by the funders.
- 89. How is innovation vs scalability weighted?
 - a. Both innovation and scalability are considered, but the primary emphasis is on the proposal's potential to generate decision-relevant evidence for real-world health system use.
 - b. Innovative approaches are welcome; however, proposals should demonstrate a credible pathway for implementation within routine care and, where appropriate, future scale-up. Tools that are novel but lack a clear integration pathway or readiness for evaluation will be less competitive than those capable of producing actionable evidence for health system decision-making.
- 90. Are previously funded pilots eligible?
 - a. Yes. Previously funded pilots are eligible, provided the proposed project focuses on generating new, rigorous evidence aligned with the objectives of the call (e.g., real-world implementation or impact evaluation). Prior piloting work that informs your current research can also be advantageous, especially for Pathway B proposals (e.g. using evidence from prior piloting to inform power calculations).

- b. The funding cannot be used to repeat earlier pilot activities or for product development; instead, the proposal should advance evaluation beyond prior feasibility work and address unanswered questions relevant to the RFP's priorities.
- 91. Will unsuccessful applicants be encouraged to reapply?
 - a. Future funding opportunities may be announced, and applicants may consider submitting revised proposals if appropriate.
- 92. If my proposed study compares a CDST's performance to the standard of care, how will it be scored?
 - a. Studies will be scored based on their overall policy relevance, technical design, feasibility and strength of partnerships, and potential contribution to evidence, including incremental learnings on how AI-enabled CDSTs perform relative to existing options e.g. in settings where evidence is limited. Studies that help advance broader understanding or foundational principles for the field (e.g., how training data, implementation strategies, provider behavior, or other underlying mechanisms influence CDST integration and impact) may be considered particularly innovative and valuable.