



# **Technical Brief**

## Value for Money

**Allocation Period 2023-2025**

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# Executive Summary

The COVID-19 pandemic and the current global geo-political landscape have created unprecedented financial distress to all nations. It is therefore imperative to maximize limited resources available to end HIV, tuberculosis and malaria, to achieve global goals by 2030, using the Global Fund Strategy 2023-2028 as an enabler to achieve these goals.<sup>1</sup>

Value for Money (VfM) is a concept that defines how to maximize and sustain quality and equitable health outputs, outcomes and impact for a given level of resources. It is critical in creating fiscal space, reducing wastage and maximizing impact.

This technical brief provides an overview of the VfM framework with guidance for applicants when developing funding requests to the Global Fund, and through the grant-making stage and grant implementation. It also makes references to additional guidance, integrated in the [core information notes and other technical briefs](#).

The VfM Framework proposed by the Global Fund<sup>2</sup> includes five dimensions: effectiveness, efficiency, economy, equity and sustainability (**Box 1**). **Section 1** defines each VfM dimension and their respective sub-element. All five dimensions must be considered in their totality; they cannot be assessed independently or in isolation of one another.

## Box 1: Defining VfM dimensions

**Effectiveness:** to invest in the most impactful interventions, at an appropriate scale to generate the intended results, while strengthening health and community systems and addressing structural barriers to HIV, TB and malaria preventive interventions and treatments.

**Efficiency:** to optimally allocate and utilize resources, to achieve grant outputs and maximize health outcomes, through successful and robust grant management processes.

**Economy:** to use robust procurement systems and resources to purchase the appropriate type of inputs, at the lowest sustainable price, and optimizing program management costs.

**Equity:** to eliminate unnecessary, avoidable, unfair and unjust differences in health between individuals and groups.

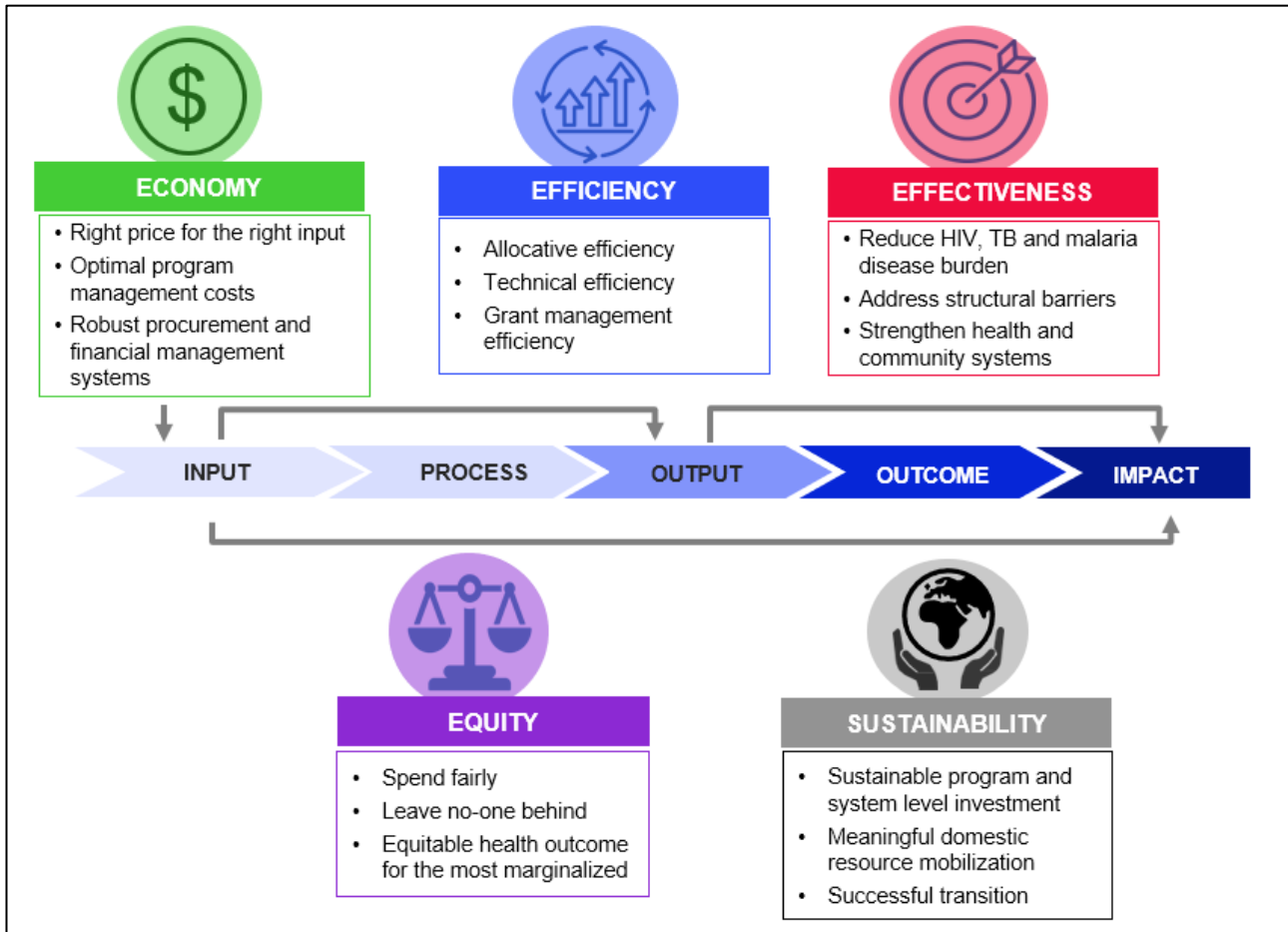
**Sustainability:**<sup>1</sup> to enable a health system to maintain and scale up coverage to a level that provides for the continued control of a public health problem.

**Figure 1** summarizes how VfM can be achieved across the health results chain, from inputs to results, maximizing health impact to end AIDS, TB and malaria. It shows optimization of resource distribution and utilization to achieve maximum outcomes. This can be done through successful processes that transform well rationed inputs at the lowest sustainable prices into quality services. Sustainability and equity should be well-considered across the health results chain.

<sup>1</sup> The Global Fund. Global Fund Strategy (2023-2028): Fighting Pandemics and Building a Healthier and More Equitable World.

<sup>2</sup> Adapted from Department for International Development of the United Kingdom (DFID)'s Approach to Value for Money (2017).

**Figure 1: The VfM Framework Across the Health Results Chain**



When describing the overall efforts to enhance VfM, applicants are encouraged to outline how investment decisions have been made to enhance all VfM dimensions. These dimensions complement each other, but in some cases, applicants will need to find a balance among them, given the country context, overall health strategies, epidemiological trends and gaps, health system capacity constraints, domestic budgets and other donor investments. Applicants are recommended to highlight and explain potential trade-offs made among VfM dimensions and the rationales behind them. **Section 2** provides guidance on how value for money of Global Fund investments should be assessed and applied collectively across the five dimensions.

Refer to **Annex 1** and **2** for specific guidance on how to consider the VfM framework across grant design, application, and implementation. **Annex 2** maps the VfM framework across application forms for the 2023-2025 allocation cycle using the full review application modality as an example, while **Annex 3** provides applicants with options of available tools and methodologies that can guide decisions to enhance efficiency. VfM country examples are included in **Annex 4** and additional references on VfM is provided in **Annex 5**.

**Table 1** below provides guidance on the proposed VfM Global Fund framework.

**Table 1: Overview of VfM Dimensions and Key Consideration for Applicants**

VfM Dimensions	Definition and Guidance
<b>EFFECTIVENESS</b>	The interventions prioritized in the funding requests are based on understanding the epidemiological context, programmatic gaps and barriers. They address disease specific program essentials identified in the Global Fund information notes. They also address system-level and structural barriers and are scaled at enough coverage to contribute towards ending AIDS, TB and malaria. Applicants should refer to the <a href="#">Global Fund information notes and related technical briefs</a> .
	Reduce HIV, TB and malaria disease burden The rationale behind prioritization decisions should be clearly highlighted, including why particular interventions will be more impactful to reduce incidence, morbidity and mortality given the local context, what alternatives and what potential trade-offs were considered, taking existing evidence into account. Detailed gap analysis using disaggregated data can be used to select the most impactful intervention mix and coverage level.
	Address structural barriers Assessing, addressing and removing human rights, gender-related and other structural barriers are essential in demonstrating the success and effectiveness of interventions. The proposed interventions should contribute to non-discrimination, addressing gender related barriers and promoting other key enablers to improve HIV, TB and malaria disease burden outcomes.
	Strengthen health and community systems Applicants are expected to demonstrate how the proposal contributes to strengthening health and community systems. This can be achieved by integrating system level investments (e.g., laboratory systems, supply chains, human resources for health (HRH) and community health workers (CHW), health information systems (HIS) and community systems) to address common bottlenecks across the disease programs and contribute to accelerate in-country results.
<b>EFFICIENCY</b>	The distribution and utilization of resources are optimized to maximize health outputs, outcomes and impact for a given level of resources. Efficiency is about optimizing service delivery and enhancing scalability; it does not necessarily mean continuous reduction in costs. Tools are available to inform evidence-based decision-making (see Annex 3). An increasing number of disease programs are taking advantage of allocative efficiency tools for optimal resource allocation across interventions and population groups. Yet, opportunities remain to improve geographic allocative efficiency, as well as technical efficiency of disease programs and system level investments.
	Allocative efficiency Resources are optimally allocated across interventions, geographies and population groups to maximize output, outcome and impact. Specific attention is made to strengthen and optimize preventive measures to effectively reduce incidence, particularly for HIV and TB. The resource distribution is informed by disaggregated data and evidence, defined through an inclusive and transparent process.
	Technical efficiency The cost structure of programs and services along the care continuum is optimized while achieving the desired health output. At the program level, technical efficiency can be increased through a variety of ways, including choosing appropriate service delivery modalities tailored to country context, achieving sufficiently high volume of services to leverage economies of scale, procuring and using the right types and quantities of inputs for a given intervention, and other cost-saving or impact promoting measures. At the system level, technical efficiency can be achieved through removing duplications and improving integration across health system and delivery platforms, such as supply chains, HIS, laboratory systems, and human resources.
	Grant management efficiency The implementation arrangements, governance and management systems are sound and robust to achieve high absorption rates, generate efficiency gains and mitigate programmatic risks or bottlenecks.

VfM Dimensions	Definition and Guidance
<b>ECONOMY</b>	<p>Inputs to provide essential services are procured at the lowest sustainable prices. However, prioritizing lower prices at the expense of inferior quality products, lesser effective results, or insufficient resources to reach the most disadvantaged population groups, is discouraged. Applicants can refer and adhere to the Global Fund grant budgeting guidelines.</p>
	<p>Right price for the right input</p> <p>Quality services, health and non-health products are procured at the lowest sustainable costs. Further, the feasibility and sustainability analysis of new technologies are conducted to justify the investment, if possible. Economy can be improved by:</p> <ul style="list-style-type: none"> <li>• Using pooled procurement mechanisms to procure health and non-health products and equipment from domestic resources.</li> <li>• Compensating HRH fairly, in line with national human resources procedures and salary scales.</li> <li>• Leveraging online solutions or decentralizing resources to reduce travel costs related to oversight and supervision.</li> </ul>
	<p>Optimal program management costs</p> <p>Program management costs are a critical part of health programs' interventions and should address proper management, risk mitigation and assurance. Yet, specific attention is needed to ensure that their proportion and composition is not excessive, comparable to similar programs in similar country contexts. This can be achieved by simplifying implementation arrangements (e.g., service providers contracts instead of sub-recipients), clear analysis of shared costs or integrated supervision. Country Coordinated Mechanisms (CCM) are encouraged to review and discuss the value of the proposed program management cost and the sustainability of these arrangements.</p>
	<p>Robust procurement and financial management systems</p> <p>Gaps in procurement and financial management systems are identified and addressed. Robust procurement systems are imperative to ensure quality products and services are procured through transparent, competitive, impartial and accountable procedures. Strong financial management systems are also key to support timely and accurate financial reporting, improve absorption of grant funds, enhance the flow or control of funds and mitigate fiduciary risks.</p>
<b>EQUITY</b>	<p>Addressing inequalities in health service availability, utilization and outcomes is a programmatic priority.</p>
	<p>Spend fairly</p> <p>Resource allocation that promotes health equity may require greater resources for targeted interventions for those in greater need. Existing inequities in resource allocation, service delivery and health outcomes are identified. This information is used to select costs and inputs needed to deliver the interventions to promote fair and equitable health outcomes.</p>
	<p>Leave no-one behind</p> <p>The most marginalized populations are reached through high coverage of tailored quality services. Marginalized populations include key vulnerable populations (KVPs), women and girls, mobile population, internally displaced, migrants and refugees, the poorest and those living in remote or hard-to-reach areas. They often face human rights, gender-related and other structural barriers to access quality health services. Failing to reach marginalized populations is considered as not achieving VfM.</p>
	<p>Equitable health outcome for the most marginalized</p> <p>Ultimately, the program achieves substantive equality and equitable outcomes, including through the removal of gender-related, human rights and other structural barriers faced by KVPs (e.g., stigma and discrimination, gender inequality, financial barriers, such as user fees and catastrophic costs). Equality of opportunity – i.e., the same access to the same services – is not, on its own, enough to achieve equitable results.</p>

VfM Dimensions	Definition and Guidance
<b>SUSTAINABILITY</b>	<p>Health programs are able to maintain and scale up service coverage to a level, in line with epidemiological context, that will provide for continued management of a public health problem. System level investments have been considered to ensure continuity of services and related programs supported by the Global Fund, while co-financing commitments are integrated to a meaningful and feasible domestic resource mobilization strategy.</p> <p>Further guidance can be found in the <a href="#">Sustainability, Transition and Co-financing Guidance Note</a>.</p>
	<p><b>Sustainable program and system level investment</b></p> <p>Health and community systems are strengthened to provide and finance services that are efficient, affordable and programmatically feasible to maintain and scale service coverage in the long term. Global Fund investments are integrated, mainstreamed and aligned into existing national systems, instead of maintaining disease specific and stand-alone services.</p> <p>Sustainability can be achieved in several ways, including investing in systems strengthening rather than systems support; investments in resilient and sustainable systems for health (RSSH) are designed to support the delivery of integrated, people-centered health services. This means breaking down disease-specific silos.</p>
	<p><b>Meaningful domestic resource mobilization</b></p> <p>Domestic resources mobilization should be tailored to country contexts. Particular attention should be paid to co-financing of essential commodities or programs targeting KVPs. Funding can be further diversified by leveraging <a href="#">innovative financing options</a> (e.g., blend financing from development banks, Debt2Health, Loan Buy-down) through strategic partnerships with multilateral development banks, partners and expanding the utilization of social contracting.</p> <p>Efforts to sustain investments can be demonstrated by the elaboration of a plan and system to promote and monitor the fulfilment of co-financing requirements to increase quality domestic resources for health and specifically for HIV, TB and malaria.</p>
	<p><b>Successful transition</b></p> <p>It is defined as the process by which domestic health system sustains gains and scales up, as appropriate, priority services and interventions independent of the Global Fund support.</p> <p>While the timeframe for receiving the Global Fund financing and the total allocation amount varies by country, applicants from middle-income countries are strongly encouraged to design and implement grants with the aim of eventual and full transition to domestically-funded and managed response.</p>

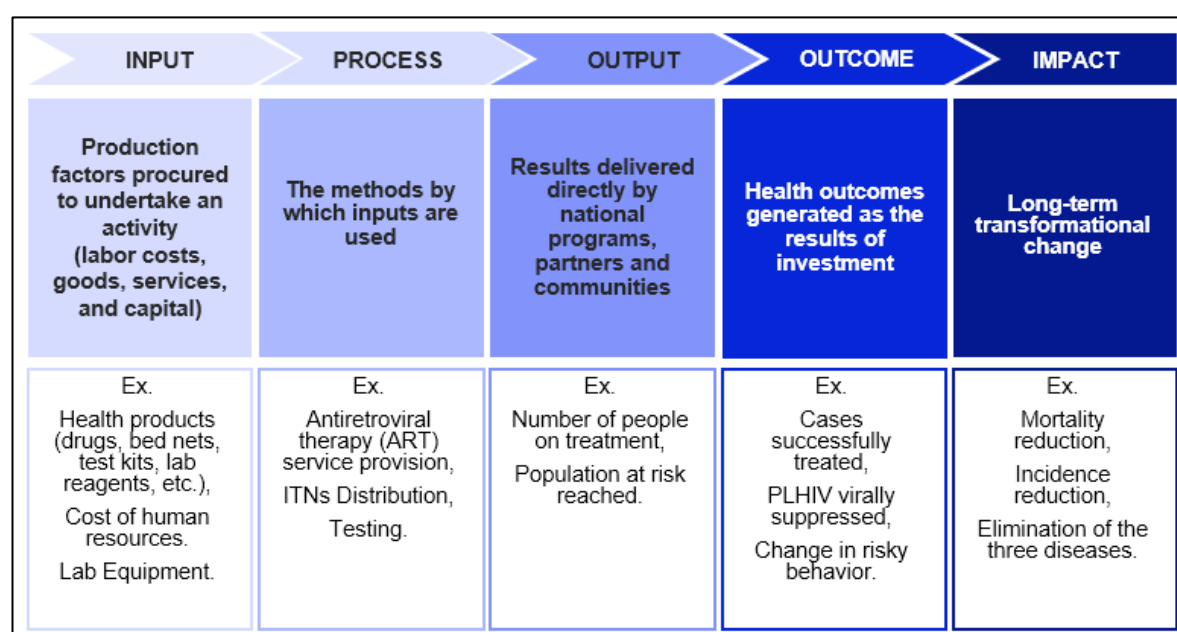


# 1. The Five Dimensions of Value for Money

Value for Money (VfM) is a concept that defines how to maximize and sustain quality and equitable health outputs, outcomes and impact for a given level of resources.

The design of the funding request can be guided by the theory of change<sup>3</sup> and VfM across the health results chain (**Figure 2**), working backwards from the intended impact to the selection of inputs. VfM must be contextualized to assess its feasibility considering health gaps, needs and opportunities. Ultimately, VfM dialogues around investment decisions is to surface political debates in a structured, technically focused and constructive manner so those decisions are rationalized rather than being politicized.

**Figure 2: Definition of the Health Production Chain**



## 1.1 Effectiveness

*Effectiveness* is assessed by the extent to which the proposed interventions and activities achieve a set of defined outcome and impact targets, while removing structural barriers and strengthening resilient health systems. To demonstrate effectiveness, a funding request should be strategically focused, technically sound, sufficiently ambitious, and yet operationally affordable and feasible.

<sup>3</sup> United Nations Sustainable Development Group defines the theory of change as a method that explains how a given intervention, or set of interventions, are expected to lead to a specific development change, drawing on a causal analysis based on available evidence.



## **a) Effectiveness in reducing HIV, TB and malaria disease burden**

The funding request should primarily contribute to ending AIDS, TB and malaria as public health threats. To be effective, funding requests need to focus on making catalytic, people-centered investments that place a particular emphasis on reducing new infections across the diseases. The proposed interventions should be based on a demonstrated understanding of the epidemiological context, considering disease burden and its distribution across geographical areas and population groups, key drivers of the epidemic, patterns of transmission, barriers and vulnerabilities and projections of future disease burden. A robust funding request also focuses on incidence reduction of HIV, TB and malaria.

Funding requests should provide clear evidence to justify that the selected interventions are technically sound and in line with normative technical guidance and the review criteria from the Technical Review Panel (TRP).<sup>4</sup> It should address disease specific program essentials, as outlined in [the HIV, TB and Malaria as well as RSSH Information Notes](#), RSSH investment approaches, and best practices to achieve the stated outcomes.<sup>5</sup>

It is important that the outlined interventions in the funding request demonstrate sufficient ambition to reach national strategic plan (NSP) targets and goals that are aligned with global plans and technical strategies. They should contribute to achieving the highest return on investment on the longer term, be operationally feasible, realized with available funding and maintain quality and complement other sources of funding (e.g., domestic and other external resources).

Resource constraints are important considerations in the VfM framework. A limited funding envelope requires countries to carefully prioritize and make choices among effective interventions. Applicants are requested to highlight the rationale of the prioritization among effective interventions, alternatives considered and potential balances made among polarized options. For more information, refer to section 2.1 on assessing VfM across five dimensions: interdependency and trade-offs.

## **b) Effectiveness in addressing structural barriers**

Effectiveness is also achieved when human rights, gender-related and other structural barriers to combatting HIV, TB and malaria are successfully removed. It implies identifying these barriers, understanding their root causes, implementing a comprehensive set of integrated and targeted interventions to remove them and monitor outcomes. Structural barriers are an important root cause of health inequities and can be driven by social, legal, political, economic, environmental and cultural characteristics. It can manifest in issues such as gender inequality, human rights barriers, criminalization, discrimination and harmful social and cultural norms.

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<sup>4</sup> Terms of Reference of the Technical Review Panel – [Review criteria](#)

<sup>5</sup> See [Information Notes on HIV, TB and Malaria](#)

Applicants are encouraged to conduct and apply country-specific equity analysis and assessment of human rights-related barriers to inform comprehensive programs geared at removing barriers and enabling equitable access.

To design programs that are effective in removing human rights-related barriers, applicants can refer to guidance from technical partners, as well as available evidence from [Breaking Down Barriers mid-term and end-term assessments](#). These programs, if implemented at scale and consistently over a period of time, empower communities to know and claim their rights and improve access to, uptake and retention in services.<sup>6</sup>

Lastly, applicants need to demonstrate how the proposed interventions are effective in removing access barriers. To do so, applicants must define the approach to monitor and evaluate the implementation of the interventions, strengthen implementation capacity and assess the effectiveness of the interventions, i.e., whether the barriers are being removed and services are scaling up or whether any adjustments to the program are needed.

Global Fund technical briefs on gender, human rights and HIV, TB and malaria<sup>7</sup> provide further guidance to document structural barriers, better understand their root causes and implement effective programs to address them.

### **c) Effectiveness in strengthening health and community systems**

Effectiveness is achieved when a strong health system is able to deliver high quality HIV, TB and malaria services for all.

Applicants should outline how the proposed RSSH interventions strengthen the health system beyond these interventions and support the overall public health system. Support to health systems primarily focuses on increasing inputs (e.g., vehicles, hardware, meetings, one-off trainings, etc.). However, strengthening the health system is accomplished by more comprehensive changes to performance drivers, such as policies and regulations, organizational structures and coordination across the health system.

Particular attention should be given to strengthening community systems which are a vital part of integrated, people-centered health services and play a critical role in enhancing disease prevention and treatment of HIV, TB and malaria. While aligned with health facilities, community systems have the ability to reach further into communities and find populations with limited access to services and can overcome social and structural barriers to health access.

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<sup>6</sup> Frontline Aids / Global Fund /GIZ A *Practical Guide to Implementing and Scaling up Programmes to Remove Human Rights-related Barriers to HIV Services*, [https://www.theglobalfund.org/media/9731/crg\\_programmeshumanrightsbarriersshivservices\\_guide\\_en.pdf](https://www.theglobalfund.org/media/9731/crg_programmeshumanrightsbarriersshivservices_guide_en.pdf)

<sup>7</sup> The HIV, Human Rights and Gender Equality; TB, Human Rights and Gender; and Malaria, Human Rights and Gender Technical Briefs are available at <https://www.theglobalfund.org/en/funding-model/applying/resources/>

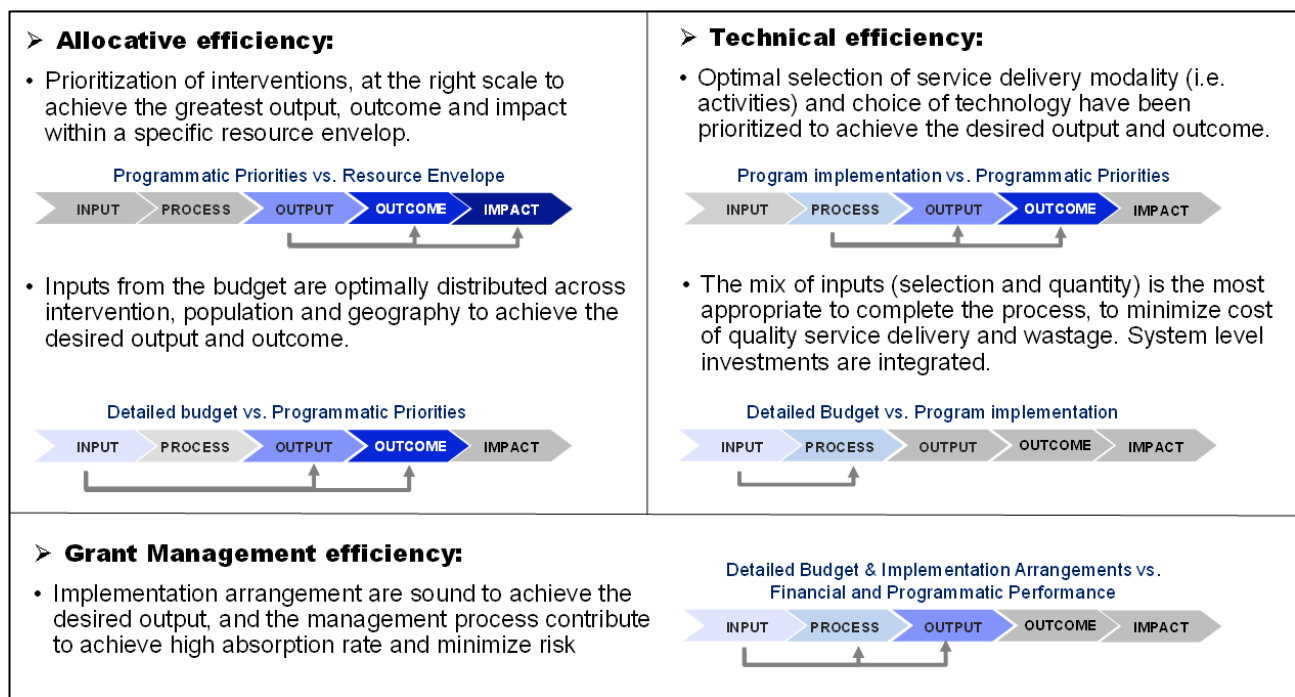
## 1.2 Efficiency

Efficiency is about optimizing service delivery in a given context and enhancing scalability; it does not necessarily mean continuous reduction of costs. **Figure 3** describes different types of efficiency and how it can be considered across the health results chain. It encourages applicants to consider efficiency across different elements of the funding request.

Sources of inefficiency range from inappropriate use of medicines to staff mix, and from inefficient use of health infrastructure to suboptimal quality of care.<sup>8</sup> These findings remain valid today with many opportunities yet to be realized to enhance the efficiency of investments. Efficiency should be considered across Global Fund grants and programs, as well as across national health systems where inefficiencies may limit VfM of Global Fund investments. Refer to **Annex 1** for practical examples.

The number of tools and initiatives to support efficient and evidence-based decision-making has significantly increased in recent years. Applicants are recommended to highlight how these tools have been (or will be) leveraged to inform the process of evidence-based decision-making. While an increasing number of disease programs benefit from efficiency tools (see **Annex 3**) to optimally allocate resources across interventions and population groups, opportunities to further improve allocative efficiency across geographies, technical efficiency of disease programs and overall efficiency at the system level, remain to be leveraged.

**Figure 3: Different Elements of Efficiency Across the Health Result Chain**



<sup>8</sup> WHO (2010): [The world health report: health systems financing: the path to universal coverage](#), Chapter 4 More health for the money. Refer to page 63 for key sources of inefficiencies.

## a) Allocative efficiency

Allocative efficiency is achieved when resources are optimally allocated across disease and system level interventions, geographies and populations to maximize output, outcome and impact. It should contribute to obtaining the greatest return on investment in the longer term.

The applicant needs to demonstrate how HIV, TB and malaria and RSSH interventions that have been prioritized in the funding request achieve the greatest outputs, outcomes and impact and contribute to ending AIDS, TB and malaria. Efficient allocation of resources also requires an optimal distribution of resources across population groups and geographies, to close programmatic gaps and achieve the maximum output per investment.

### The prioritization of interventions to maximize impact

The [Global Fund Modular Framework](#) includes a set of recommended cost-effective interventions. However, in a resource-constrained setting, funding requests are strongly encouraged to explain how modules and interventions are being prioritized, and how resources are being allocated to the most cost-effective interventions to maximize impact.

Funding requests are expected to provide robust analysis, linking investments with needs and expected results. Allocative efficiency analysis, when tailored to national data and context, can be used to define how a current resource envelope can be leveraged to maximize impact through an optimal mix of interventions and coverage levels. Such analysis needs to be country-led and conducted through robust country dialogue processes.

To achieve efficiency **at the program level**, a variety of tools are available to explore how to best prioritize interventions. Costing tools and epidemiological impact models, when applied together, can assess the cost-effectiveness of different interventions and intervention mixes, and identify most efficient scenario, taking into account the resource envelope available. Such tools can also help define the appropriate balance between investments in prevention and in treatment. Strengthening the availability and quality of local data is critical to ensure the robustness of the allocative efficiency analysis.

**At the system level**, allocative efficiency refers to the appropriate resource allocation to strengthen health and community systems in overcoming common bottlenecks across multiple disease control programs. Applicants are encouraged to review the [RSSH Information Note](#) which describes the recommended approach to designing and delivering RSSH investments for maximum efficiency.

Applicants are requested to describe the process through which they identified and prioritized their RSSH investments. RSSH priorities should be aligned with national health sector plans. System-level resource allocation discussions should be well-coordinated among key stakeholders and viewed in the broader context of achieving universal health coverage (UHC) and SDG3.<sup>9</sup>

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<sup>9</sup> This may include dialogue with national and sub-national governments, development partners such as the World Bank and other development banks, health financing institutions (e.g., GFF, Gavi), technical agencies (e.g., WHO, UNICEF, etc.), other donors, civil society, and affected populations.

## Optimal distribution of resources across geographic areas

Significant efficiency gains can be achieved by optimizing the distribution of resources across sub-national areas. Interventions should be implemented in areas where it can maximise their intended outcomes. The prioritization of geographic areas requires a good understanding of epidemiological variations and programmatic gaps across sub-national areas, coupled with reliable financial data. Appropriate granularity of the analysis is key to prioritize at state/province, district or community levels.

Applicants are encouraged to explore the feasibility of applying ***epidemiological impact models at subnational levels*** to design differentiated responses and maximize impact. For instance, stratification exercises and subnational tailoring for malaria programs have been critical in determining the optimal intervention mix.

***Geo-spatial analysis***, such as service accessibility mapping can further inform investment decisions to narrow gaps in service accessibility. It can also be used for micro planning (e.g., ITN distribution campaigns) or optimally defining and distributing inputs and resources to achieve maximum outputs. Geospatial analysis can also be utilized to optimize the distribution of resources dedicated for system strengthening. Such analysis can be used to design and implement more efficient supply chains. It can also be used to strategically locate diagnostic equipment and identify the optimal routes for building sample referral and transport systems (refer to examples related to Diagnostic Network Optimization in Annex 4). Other examples include the optimal deployment of human resources for health (HRH), community health workers (CHW) or volunteers from CSO/CBOs (refer to example from Thailand in Annex 4).

A variety of tools and initiatives are available to help inform decision-makers on strategic, programmatic and operational questions, which can be tailored to country context and needs. More information on available tools is included in **Annex 3**.

In the absence of geospatial modelling, applicants can demonstrate the use of disaggregated data to prioritize geographic areas and plan for an efficient distribution of inputs to the lowest sub-national level.

### **b) Technical efficiency**

Technical efficiency refers to optimizing the cost structure of service delivery in line with the prevention and care continuum while achieving the desired health outputs and outcomes. It can be achieved through a variety of ways, such as by expanding the volume of services to leverage economies of scale, streamlining service provision procedures, integration, identifying the right mix of inputs and other cost-saving or impact enhancing measures.

Technical efficiency at the program level can be improved through ***optimal service delivery modalities***. It requires delivering quality services through efficient service delivery protocols, channels or platforms. For instance, decentralized care, leveraging community services, virtual services and pharmacies constitute highly efficient service delivery models.

Technical efficiency can also be improved through the **integration of system level investment**. This requires removing duplication, improving alignment and enhancing integration across the health system (e.g., supply chains, health information systems and human resources). Cross-programmatic efficiency analyses, such as those recommended by WHO,<sup>10</sup> can shed light on how to identify duplicative and inefficient system level investment and design alternatives accordingly.

Efficiency gains can also be obtained through **selecting the right mix of inputs** for a specific activity, ensuring it is optimal to complete the desired process and achieve a maximum of outputs.

Robust expenditure and costing analyses are essential to inform programs and implementers when identifying the optimal input mix. **Box 2** describes how costing can be utilized to optimize input selection.

Applicants are strongly encouraged to highlight the ongoing and future efforts to optimize the cost of service delivery. Key elements for consideration include:

- Optimal choice and quantity of health products and technologies. Procurement decisions can be rationalized based on cost-effectiveness analysis of a product or technology in comparison with its alternatives, taking into account not only clinical efficacy and cost but also long-term financial implications, programmatic feasibility, and accessibility, acceptability and adherence of beneficiaries into consideration. Applicants can apply Health Technology Assessment (HTA),<sup>11</sup> budget impact analysis<sup>12</sup> or similar approaches to make rational choices.
- Mix and quantity of human resources. Some health systems are overly reliant on using doctors. Task shifting in some settings to less costly human resources, such as nurses and CHWs, can both save financial resources and potentially improve outcomes, as CHWs have an important role in many parts of care, including promoting treatment adherence.
- Travel related costs associated to capacity building. Trainings- and supervision-related costs need to be further scrutinized to avoid non-residential standalone trainings which have limited effectiveness. Trainings should be skills-based (on the job), complemented by post training follow up, mentoring and supportive supervision. Virtual solutions and digitalization represent efficient options when integrated to blended learning approaches.<sup>13</sup> Further integration of trainings and support to national training institutions, strengthening coverage and quality of integrated training and supervision should also be considered. Applicants are also encouraged to consider a payment for results modality to training and other related activities.<sup>14</sup>

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<sup>10</sup> [WHO references and guidelines to conduct cross-programmatic efficiency analysis](#).

<sup>11</sup> HTA is an approach used to inform policy and decision-making in health care, especially on how best to allocate limited funds to health interventions and technologies. The assessment is conducted by interdisciplinary groups. More resources can be found on website of [the International Decision Support Initiative \(iDSI\)](#)

<sup>12</sup> [Budget Impact Analysis-Principles of Good Practice](#)

<sup>13</sup> [UNAIDS and WHO, Policy Brief, Virtual interventions in response to HIV, sexually transmitted infections and viral hepatitis, 2022.](#)

<sup>14</sup> Refer to the Payment for Results section in the [Grant Budgeting Guidelines](#) for more information.



## **Box 2: Importance of costing data**

Robust unit costs of key interventions are the basis of well-costed and prioritized health sector or disease specific NSPs and investment cases.

Applicants are encouraged to routinely conduct costing studies across disease-specific interventions to shed light on cost drivers, better understand cost variations of key interventions across service delivery modalities, platforms, geographies and implementers, informing more efficient service delivery.

It is particularly important to understand the cost of service delivery, including shared costs (e.g., human resources, health facilities) that cover multiple diseases and health needs, as well as costs related to addressing human rights and gender-related barriers to services. Countries are recommended to analyse the underlying cost structure of their health systems and identify system level changes (e.g., streamlining and integration) to enable more efficient service delivery across diseases.

Accurate, adjusted to national or local costs and recently updated service unit costs are also essential to conduct robust cost-effectiveness analysis. There are different costing tools, approaches and methodologies (**see Annex 3**) that applicants could use to build and strengthen unit costs or cost databases to support better planning. See **Annex 5** on disease specific or health sector NSP guidelines as well as other references on costing, including data repository, reference cases and selection of tools.

## **c) Grant management efficiency**

Efficiency can also be achieved by strengthening management and implementation arrangements to facilitate effective program operation from A to Z, including procurement, service delivery, financial management, monitoring and evaluation.

Grant management efficiency refers to the sound implementation arrangements, and robust governance and management of systems to achieve high absorption rates, generate efficiency gains and minimize programmatic risks or bottlenecks.

Applicants are encouraged to procure health products and services strategically through appropriate payment mechanisms to ensure that resources are optimally allocated, robustly budgeted and carefully spent to promote efficiency.

Applicants are encouraged to optimize program management costs and respond to programmatic risks and bottlenecks, including lowering the operational or management costs by identifying cost-effective service providers and implementation arrangements and deploying financial and programmatic risk minimizing measures, ensuring effectiveness, efficiency and sustainability of the Global Fund investments.

Global Fund's investments should be aligned with those of national governments and other partners and funders, as applicable, to leverage equitable responses for maximum efficiency. Countries are strongly encouraged to take the leading role in donor coordination for health systems strengthening, which require larger investments than a single partner can provide.



## 1.3 Economy

Economy implies purchasing quality inputs at the lowest sustainable price, using robust procurement systems and managing financial flows through effective and integrated financial systems. Procurement and financial management shall be conducted to maximize the use of the Global Fund resources and ensure that the goods and/or services are procured effectively and meet the requirements of users. Applicants are encouraged to refer and adhere to the [Global Fund Guidelines for Grant Budgeting](#).

### a) The right prices for the right inputs

Economy implies to obtain the lowest sustainable prices for quality inputs that are required to produce preventive or curative health services. However, prioritizing lower prices at the expense of inferior quality products or inefficient services to reach the most vulnerable population groups, does not represent good value for money.

Applicants are encouraged to conduct a thorough review of service costs and identify the grant cost drivers. For health service delivery, pharmaceuticals and other health products, human resources and equipment are often the key cost drivers.

When procuring these inputs, the following should be considered:

Health products and equipment. The lowest sustainable cost for quality-assured health products<sup>15</sup> means the lowest average price expected to be reliably available throughout the grant implementation period, opposite to a very low spot price that is available only in a specific period and/or may result in a compromise on the quality of service or supply.

The Global Fund does not finance health products purchased at a higher price than the reference price, where one exists. Such reference prices are set based on globally negotiated price lists for specific health and non-health products, either through the Global Fund's Pooled Procurement Mechanism (PPM) (e.g., [Wambo](#)), or negotiations led by partners or partner platforms, such as the Stop TB Partnership's Global Drug Facility (GDF).

Applicants are encouraged to conduct feasibility and sustainability analysis of new technologies to justify investment in them and demonstrate how it will promote holistic, integrated and patient-centered approaches to care. Where possible, choices of technology platforms should be prioritized to maximize polyvalent screening and diagnostic options that serve multiple programmatic agendas. For health products supported by the Global Fund but not procured through its PPM, applicants are strongly encouraged to explore and benchmark international and regional prices. Applicants are also recommended to extend the utilization of PPM for the procurement of health and non-health products and equipment using domestic financing.

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<sup>15</sup> Key health products include: (i) pharmaceutical products; (ii) durable and non-durable in-vitro diagnostic products, microscopes and imaging equipment; (iii) vector control products; and (iv) consumable/single-use health products (including condoms, insecticides, therapeutic nutritional support, general laboratory items and injection syringes), which are financed out of the Global Fund grant funds.

Applicants can refer to the [Procurement & Supply Chain Management Technical Brief](#), as well as to the standards that regulate procurement and management of the health products in the [Guide to the Global Fund Policies on Procurement and Supply Management on Health Products](#), Health Product Management (HPM) section of the [RSSH Information Note](#) and the HPM Annex to the [Global Funds' Sustainability, Transition, and Co-Financing \(STC\) Guidance Note](#).

**Human Resources.** Funding requests should describe how the requested funding supports fair compensation for the right roles at the right scale and system level.

Funding for human resources may include salaries and eligible allowances for HRH, development or contribution to performance-based incentive schemes, and development or contribution to retention schemes. Funding requests must comply with national labour and other laws, supporting decent work and fair pay. It must also adhere to [the Global Fund budgeting guidelines](#) and consider:

- Alignment with national human resource policies, procedures and salary scales.
- Robust justification and rationale for full or partial salary contributions, with particular emphasis on integration, financial sustainability and transitioning.
- Coordination with other development partners to avoid duplication.

More broadly, HRH investments should be informed by the country context, periodic assessments (e.g., through a health labour market analysis), the evidence base and country dialogue, including government HRH stakeholders and other development partners supporting HRH to ensure complementarity. Applicants are suggested to refer to the [RSSH Information Note](#) and the [HRH Technical Brief](#) for more information.

**Travel related costs** represent another area where economies can be achieved, notably by leveraging new technologies, such as virtual solutions, streamlining approaches to training, decentralizing resources for oversight, and promoting integrated supportive supervision. Further guidance on ways to limit and optimize travel related costs can be found in [the Global Fund Guidelines for Grant Budgeting](#).

## **b) Optimal program management costs**

Program management costs are expenses that do not directly contribute to service delivery but are important for successful program implementation, including human resources, travel related costs, external services, non-health equipment, and indirect and overhead costs. Excessive or inappropriate program management costs are indicative of poor VfM because they reduce a country's ability to allocate more resources to service delivery. They also limit the ability of country to absorb the program in the medium and longer terms, impairing program sustainability.

Opportunities to increase economy include simplifying implementation arrangements, including encouraging service provider contracts, rather than sub-recipient agreements. Other opportunities include conducting clear analysis of shared costs where implementers have more than one donor (see section of the [Global Fund Budgeting guidelines](#) on Funding request budget), and supporting integrated supervision as a tool to lower travel related costs.

The CCM is therefore encouraged to scrutinize all implementation arrangements and proposed program management costs, to ensure that they are necessary for efficient and quality service delivery. Particular attention should be given to program management costs in CSO grants and to the integration of program management investments into national systems and processes.

Expenditure reviews from the previous allocation period can also inform the CCM in defining if program management costs are consistent with the Global Fund budgeting guidelines and consistent with local market prices, including human resources, training, equipment, and other costs. Routine analysis of program management investments can also help identify opportunities for integration. Further, costing analysis can also be used to better understand the above-site costs for implementing a specific program and provide visibility to the inputs and processes that could be adjusted to optimize program management costs.

### **c) Robust procurement and financial management processes**

Addressing gaps in procurement and financial management systems is critical to reduce fiduciary risk and enhance VfM. Such systems can be strengthened through advancements in various areas, such as policy development and enforcement, strategic planning, system enhancement, country capacity building for procurement, financial management, audit and investigations or oversight, along the full process of health service provisions.<sup>16</sup>

Robust procurement systems are imperative to ensure quality products and services are procured through transparent, competitive, impartial and accountable procedures.

Strong financial systems are essential to ensure timely and accurate financial reporting, improve absorption of grant funds, enhance the flow or control of funds and mitigate fiduciary risks. The Global Fund recommends using public financial management (PFM) systems to meet [aid-effectiveness and sustainability principles](#). When not possible, applicants should strengthen or optimize routine financial management systems. Additional guidance can be found in the PFM section of the [RSSH Information Note](#).

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<sup>16</sup> For more information on possible approaches to strengthen procurement and financial management systems, review the [Guide to Global Fund Policies on Procurement and Supply Management of Health Products \(June 2021\)](#).

## 1.4 Equity

Equity<sup>17</sup> is achieved when unnecessary and avoidable differences in availability, utilization and outcomes of health services, which are unfair or unjust, are eliminated. This refers to the fair opportunity for everyone to attain their full potential for health and wellbeing, with no person disadvantaged due to social, economic, demographic or geographic differences.

Equity is at the heart of the Global Fund and its vision of “a world free of the burden of AIDS, tuberculosis and malaria with better, equitable health for all.”<sup>18</sup> It underpins effectiveness of investments and their longer-term impact, given that epidemic control and disease elimination efforts can only be successful if no one is left behind. Ignoring pockets of disease in underserved populations leads to resurgences of epidemics and higher costs. Equity considerations are therefore key in assessing the effectiveness of funding requests.

Opportunities to increase equity includes a continued scale-up of service coverage for key and vulnerable populations (KVPs), as well as an increased focus on other disadvantaged and left-behind groups, such as women and girls, the poorest and those living in remote or hard-to-reach areas.

To maximize health equity, applicants should analyze existing inequities in resource allocation, service delivery and health outcomes. Funding requests should then allocate resources to promote more equitable outcomes, recognizing that reaching the most marginalized population may require greater resources for the same, or additional services.

### **Box 3: Who is considered a key and vulnerable populations (KVPs)?**

Key populations are those who are impacted by HIV, TB or malaria and have limited access to services, and confront human rights violations, systematic disenfranchisement, marginalization and criminalization. Those who are at heightened risk but may not meet the criteria above are also considered vulnerable populations. The general definition of KVPs is provided below, however it should be tailored to national contexts and data.

Key populations for HIV: Sex workers, men who have sex with men, transgender populations, people who inject drugs, and people in prisons and other closed settings.

Key populations for TB: Miners, migrants and refugees, indigenous populations, people living with HIV, among others.

Other vulnerable populations: Pregnant women, adolescents and girls, children under 5, refugees, migrants, internally displaced people in malaria-endemic zones, population in hard-to-reach areas, population with the lowest socioeconomic status.

<sup>17</sup> [Equity and Health Inequalities](#)

<sup>18</sup> The Global Fund. Global Fund Strategy (2023-2028): Fighting Pandemics and Building a Healthier and More Equitable World. Geneva: The Global Fund, 2021.

For more information, applicants are encouraged to read the [Global Fund technical brief on human rights](#) and the [technical brief on gender equality](#).

### **a) Input equity: spend fairly**

Addressing inequalities in health access and outcomes should be a programmatic priority, even when the costs of these interventions are higher. Spending fairly refers to the total resources allocated to various communities, as well as the mix of inputs selected for the design of interventions. It means selecting costs and inputs needed to deliver the interventions to promote fair and equitable outcomes for KVPs and the most marginalized, recognizing that this is likely to require targeted interventions at a higher cost.

Consequently, equity should be considered:

- When distributing available resources and prioritizing interventions, populations and geographies. This should be guided by the financing landscape table.
- When defining the implementation arrangements to support and involve CSO/CBOs that can best reach marginalized populations with prevention and treatment services.
- When elaborating the budget to account for all specific activities and potential incremental costs required to effectively reach these populations. The applicant should identify and manage cost drivers appropriately.
- When assessing the coverage of insurance schemes – financial resources should be prioritized to track and ensure the most disadvantaged are well covered to access essential services.

### **b) Output equity: leave no-one behind**

Equity also implies that the most marginalized populations are reached through a high coverage of tailored quality services. This includes improved access to affordable health products and services for hard-to-reach populations, as well as addressing the human rights, gender-related and other structural barriers.<sup>19</sup> Failing to reach marginalized populations should be considered as poor VfM. Applicants are expected to:

- Identify populations lacking equitable access to essential HIV, TB and malaria services, and the reasons for such inequities, including financial, human rights and gender-related barriers.
- Give specific attention to population located in rural, hard-to reach areas or other areas with limited access to health services.
- Design interventions to address these inequities and their underlying causes. Non-health interventions (e.g., keeping girls in school, addressing gender-based violence,

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<sup>19</sup> Applicants are encouraged to apply the [WHO Innov8 approach for reviewing national health programs to leave no one behind](#).

monitoring and reforming laws, expanding access to justice, supporting poverty reduction) can also contribute to positive health outcomes as they address the long term, wider determinants of health.

- Strengthen health information systems to collect and use disaggregated data to understand inequities in health risks and outcomes and respond appropriately (for example by age, sex and gender, geography and socioeconomic status).
- Monitor user fees, assessing their impact on access to health services and propose remedial actions.

### **c) Outcome equity: equitable health outcomes for the most marginalized**

The programs should be effective and achieve equitable health outcomes for the most marginalized populations. To ensure that interventions are effective, and the intended outcomes are achieved, applicants are encouraged to monitor if the barriers to services are removed and whether inequities are reduced.

Applicants may wish to highlight the efforts made to achieve equity outcomes, including:

- The evidence and process in prioritizing the intervention to propose a comprehensive set of activities to reach KVPs and marginalized groups. Meaningful engagement of communities<sup>20</sup> is needed in the funding request development process and VfM decision-making, as well as in implementation.<sup>21</sup>
- Efforts to evaluate the interventions aimed to reduce inequities, including by measuring performance using data disaggregated by age, sex, gender, geography and other relevant sub-indicators.
- Capacity building activities of community-based organizations in addressing human rights and gender-related barriers, budget advocacy and community-led monitoring of availability, accessibility, acceptability and quality of services, including pre-empting and reporting of stockouts in health facilities or medical dispensaries.

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<sup>20</sup> See information note on [Building RSSH through Global Fund Investments](#).



## 1.5 Sustainability

As per the Global Fund's [Sustainability, Transition, and Co-Financing \(STC\) Policy](#) and the [STC Guidance Note](#), the Global Fund's approach to sustainability focuses on the ability of a health system to maintain and scale up service coverage to a level that provides for the continued control of a public health problem and support efforts to eliminate the three diseases, even after funding from external donors comes to an end.

The Global Fund strongly encourages countries to incorporate sustainability considerations in national planning, funding request development, grant design, co-financing commitments and grant implementation. This is recommended for all countries, regardless of where a country is on the development continuum or their proximity to transition from the Global Fund financing. A sustainable approach to planning and implementation should consider how to maximize impact while balancing short and long-term results, not only with the view of financing available through external support, but also considering the interventions and program costs with domestic financing that will need to take up in the future in order to support continued improvements in service coverage. Applicants are encouraged to ensure that funding requests and national responses consider both immediate and long-term impact of investments, balancing longer-term sustainability and near-term efficiency and effectiveness.

Sustainability considerations cut across many thematic areas, including financial, epidemiological, programmatic, systems-related, governance, and human rights. They depend heavily on specific country and regional contexts, including epidemiological context, structure of the health system, and the reliance on external financing for the health sector and national disease responses. The subsections below underline some key aspects that can strengthen the sustainability of the Global Fund investments.

The [Global Fund's STC Guidance Note](#) provides more information on the Global Fund's overall approach to this critical area, including its efforts to strengthen sustainability, encourage enhanced domestic financing and support countries as they prepare for transition from the Global Fund financing.

### **a) Sustainable program and system level investment**

Sustainable program and system level investments imply that health and community systems are strengthened to provide and finance services that are efficient, affordable and programmatically feasible to maintain and scale service coverage in the long term.

Sustainability can be strengthened in several ways, including through increased investments in systems strengthening rather than systems support. RSSH investments are designed to support the delivery of integrated, people-centered health services, helping to break down disease-specific silos. The integration of system level investments to reduce parallel and duplicative systems is also essential to improve the sustainability of the Global Fund



investments. Practical guidance to support the integration of national disease responses can be found in the [RSSH information note](#). It includes but is not limited to:

- Integration of the three diseases into primary health care (PHC) and funding within the universal health care (UHC) financing strategies and mechanisms.
- Integration of private health sector and community data into national health management information system (HMIS) strategies and plans.
- Integration of CHWs in HRH strategic plans, as well as alignment of community health and HRH strategies.
- Integration of community health systems across diseases and within national strategies and plans.
- Integration of parallel supply chains through holistic and costed national strategic plan for health products management systems.
- Integration of diagnostics services by strengthening the national regulatory systems to benefit the three disease programs and beyond.

To promote access to affordable and quality health products, countries can access the PPM (via [Wambo](#) and via GDF for TB medicines) using domestic financing. The Global Fund will continue supporting countries and regional procurement platforms to build capacity in procurement and supply chain management, local production of pharmaceuticals and other inputs to health services.

One strategy to sustain investments is by moving from a disease-specific, short-term remuneration support to a greater, integrated HRH strategic planning support, aligning workforce development efforts with national sector plans and health financing strategies or sustainability and transition plans. This also includes moving from standalone CHW investments to scaled up integrated community health programs.

## **b) Meaningful domestic resource mobilization**

Domestic resource mobilization (DRM) is essential to end HIV, TB and malaria, particularly given the major shortfall of resources needed to do so.<sup>22</sup> Leveraging the Global Fund's co-financing requirements to improve the domestic financing of health systems and national responses to HIV, TB, and malaria is therefore an essential piece of overall efforts to strengthen sustainability. The Global Fund's co-financing approach is designed to support countries to 1) increase public spending on health; 2) increase resources available for national HIV, TB, and Malaria responses (either be increasing investments and/or improving efficiencies); and 3) progressively absorb specific program costs and interventions essential to HIV, TB, and malaria responses, including those financed by the Global Fund.

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<sup>22</sup> [The Global Fund investment case to the Seventh Replenishment, 2022](#).

Meaningful DRM implies that countries mobilize sufficient resources from public and private domestic sources, to fund high-priority health needs and key health system functions, targeting goods and services that are essential to continue, expand and sustain key interventions. While strategies for DRM will vary by country, particular emphasis should be placed on strengthening overall prioritization and financing of the health sector, increasing financing for interventions that are often reliant on external financing (including essential commodities / health products and / interventions for KVPs), and improved financing of key health system components (e.g., supply chain, HRH).

Considering the global financing landscape for health, and the expected growing global funding gap, countries should plan early for a gradual uptake of program and national response costs financed by the Global Fund, particularly in the case of reduced funding or preparations for full transition from the Global Fund financing. Applicants are encouraged to further diversify their funding by leveraging innovative financing options (e.g., Debt2Health and blended finance with multi-lateral development banks) and to actively consider mechanisms to better embed, align and integrate disease responses within broader health system planning and budgeting processes.

More information on the Global Fund's approach to DRM and co-financing is included in the [Sustainability, Transition, and Co-Financing \(STC\) Guidance Note](#).

### **c) Successful transition**

Transition is defined as the process by which a country, or a country-component, moves towards fully funding and implementing its health programs independent of the Global Fund support, while continuing to sustain the gains achieved and scaling up service coverage as appropriate.<sup>23</sup> In line with this definition, the Global Fund considers a transition to have been successful when national health systems are able to at least maintain and preferably improve, equitable coverage and uptake of services through resilient and sustainable systems for health, even after the Global Fund support has ended.

As part of its broader efforts to strengthen sustainability, the Global Fund encourages countries to strengthen national health planning linked to sustainability and transition, ideally informed by a robust analysis of major sustainability and/or transition risks (often which come in the form of a sustainability assessment or a transition readiness assessment). While strengthened sustainability planning is relevant for all countries, applicants from middle-income countries are strongly encouraged to design and implement grants to eventually and fully transition to domestically funded and managed national responses.

More information on the Global Fund's approach to supporting successful transitions is included in the [Sustainability, Transition, and Co-Financing \(STC\) Guidance Note](#).

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<sup>23</sup> The [Global Fund Sustainability, Transition and Co-financing policy](#).

## 2. Application of the VfM framework

This section provides guidance to apply the VfM framework across the grant life cycle and to consider the appropriate balance among dimensions. Improving VfM will require rationalizing and adapting all investment decisions to enable the most efficient, equitable and sustainable response along the journey, with ending AIDS, TB and malaria as the final goal in the center of policy deliberation.

### 2.1 Assessing VfM across five dimensions: interdependency and trade-offs

VfM must be considered through the totality of all five dimensions; they cannot be assessed independently or in isolation. For instance, VfM is not about:

- Paying the lowest price for products or services without considering its quality and impact.
- Reaching the largest number without considering equitable access to services.
- Prioritizing short-term wins without considering the sustainability of the program.
- Performing well in a single or sub VfM dimensions.

Yet, this does not mean that there must be an equal balance across each dimension. Finding the appropriate balance between the different dimensions requires inclusive and transparent processes through a multidisciplinary and multisectoral approach, with involvement of key stakeholders, including civil society and communities affected by HIV, TB or malaria.<sup>24</sup>

The dialogue and decision-making should be technically focused and evidence based. Applicants are encouraged to leverage the available tools that can guide resource allocation (Annex 3 and Annex 5) and complement them with available analysis, data, evidence, or first-hand information from affected communities.

The balance between the five dimensions should be considered given the country context, epidemiological trends, programmatic gaps, expected results, contributions from other funding sources, available budget, as well as health system capacity constraints. For instance, specific considerations should be given to VfM in countries classified as Challenging Operating Environments (**Box4**). Below is additional guidance that applicants can refer to when seeking for the appropriate balance between VfM dimensions.

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<sup>24</sup> To organize this process, applicants can refer to guidance to identify priorities develop NSPs (Annex 5) as well as to [the Global Fund country dialogue webpage](#), which includes additional guidance to prepare and organize a meaningful country dialogue.

### **Tips to assess VfM across all five dimensions**

- Apply the theory of change and consider how VfM applies across the health results chain. Not all dimensions may be relevant at the same moment in time.
- Most of times, VfM dimensions are complementary and can be enhanced across the grant life cycle. When trade-offs need to be made, which it totally normal, it is critical to ensure inclusive, data-driven and transparent process that is well documented, including to ensure effective engagement of civil society and affected communities in the decision process.
- Align with national strategies, consider long term implications.
- Consider VfM across the entire national planning and implementation cycle, from strategy planning, policy development, to operationalization, program implementation and M&E.
- Assess VfM through the Global Fund grant implementation as a continuous process for improvement.
- Plan evidence and capacity building to support VfM dialogues purposefully.

### **Balancing between equity and efficiency dimensions**

Equity and Efficiency may at times seem to conflict, but their goals are or can be well-aligned in most settings. Improving equity helps to achieve efficiency, and vice versa. Yet, in a scarce resource environment, determining the right balance between efficient resource allocation and equitable access to services can be challenging.

For example, this may imply balancing between reaching relatively better-off populations, residing in easy-to-reach areas, at lower cost, and reaching marginalized populations living in difficult-to-reach localities, at higher cost.

In situations where efficiency and equity may appear to be in direct conflict and point investments in different directions, a balance needs to be found.

- Where greatest burden is among marginalized populations, even if the cost of reaching them is more expensive, it may be more equitable to prioritize marginalized populations. In some cases, in the longer term, the overall return on health investment can be higher, representing a more efficient investment.
- Where the baseline coverage for reaching a specific population is low, focusing on a few sites to accelerate coverage and achieve a higher outcome at lower price may be more efficient.

- Where targeted populations are spread across large geographic areas with the vast majority clustered in a few sites, it is good value for money to first expand the coverage in these sites, while ensuring a minimum level of service is provided to populations in rural or hard-to-reach areas.
- Where costs to reaching a population is excessively high (e.g., vulnerable populations or populations in remote areas), program efficiency analysis can be applied to identify ways to provide quality services through innovative approaches at reduced cost (e.g., task-shifting, multi-month dispensing (MMD), virtual interventions).

Intervention prioritization could be done in a way that balances efficiency and equity goals. For example, qualitative analysis could be carried out to fully recognize the pros and cons of different options to make informed decisions, better balancing efficiency and equity. Resource allocation needs to be done through a transparent and inclusive deliberative process with full engagement of key stakeholders including key, vulnerable and other underserved populations.

### **Balancing between economy and efficiency dimensions**

Similarly, the cost of a new product or technology can appear more costly at first, but its expanded use can bring the overall costs of unit service delivery down over time and create economies of scale. As such, a product or technology that may represent poor economy may be an efficient solution in the mid- or longer-term and shall be well evaluated when making purchasing decisions.

### **Balancing between economy and effectiveness dimensions**

VfM is not about paying the lowest price for products or services at the expense of quality or impact. VfM requires to better understand costs within a country context to deliver the maximum impact for each dollar spent. It focuses on the relationship between costs and outputs/outcomes/impact especially in the longer-term, and not just cost alone. For example, the selection of health products should not let products of cheaper prices trump more expensive alternatives which offer long term effective response to the diseases.

For another example, when procuring antimalarial medicine for children, although dispersible tablets might be slightly more expensive, their higher acceptability and therefore adherence compared to non-dispersible tablets should be recognized to inform product selection.

## **Balancing among efficiency, effectiveness and sustainability dimensions**

An investment should be considered poor VfM if it (a) prioritizes actions which lead to health gains in the short term but not necessarily in the longer term which are key to ultimately end AIDS, TB and malaria; (b) favors the achievement of results in easy settings at lower costs over those requiring dedicated effort in challenging environments, which is ultimately much more effective in tackling diseases; (c) and supports interventions which are financially and programmatically unsustainable. Interventions that can achieve immediate health impact should be balanced with interventions that will lead to higher outcomes but in the long-term. For instance, keeping girls in school or avoiding early pregnancies is likely to generate positive outcomes in the mid and longer-term and should not be deprioritized in exchange of interventions showing quicker impact.

Similarly, funding for program management or disease specific supervision can contribute to immediate result achievement or improvement in quality of care but may be challenging to sustain, while strengthening overall governance and coverage and quality of integrated supportive supervision can build capacity at the relevant systems level, enhancing sustainability.

## **Balancing between investments towards prevention and treatment**

Given the differential impact on the disease burden over time among interventions, applicants will need to find the appropriate balance, for instance, in investing towards reducing mortality or morbidity and reducing incidence. An example could include determining the level of investment in HIV treatment vs prevention interventions. Although HIV treatment as prevention has proven effective in interrupting disease transmission, controlling and ultimately ending the epidemic also requires a combination of HIV prevention tools. One potential trade-off that applicants need to consider is between achieving short-term mortality reduction through treatment vs longer-term mortality reduction by reducing disease transmission and new infections.

## **Balance between disease control and elimination**

Where disease burden or epidemiological status differs significantly sub-nationally, additional questions arise with respect to the allocation of investments. For example, how much of a country's limited resources should be allocated toward malaria control in high endemic vs pre-elimination areas is not an easy question to address. In this example, a technically sound funding request would explain the investment decision(s) in epidemiological terms, supported by a thorough analysis of the most effective interventions to achieve the control and elimination goals, and the anticipated impacts of these interventions together with their linkages and inter-dependencies.

The process, evidence or rational used, as well as results of the policy dialogue aimed to strike the balance of VfM dimensions of the funding request need to be explicitly explained and provided in the narrative of the funding request.

#### **Box 4: Application of VfM in Challenging Operating Environments**

[Challenging Operating Environments \(COEs\)](#) refer to countries or unstable parts of countries or regions, characterized by weak governance, poor access to health services, limited capacity, and fragility due to man-made or natural crises. The COE policy provides detailed guidance to maximize access to essential services, coverage and impact in such contexts, based on the following principles:

- **Flexibility.** The grant management approach is tailored to country contexts to increase impact through enhanced grant design, implementation, management and assurance. Such flexibilities reduce administrative burden and facilitate more effective service delivery to populations in need.
- **Partnerships.** The Global Fund optimizes partnerships in COEs to address implementation weaknesses and strengthen grant performance. Given that the Global Fund does not have in-country presence, operational collaboration with development, humanitarian, civil society, private sector and non-traditional partners are essential for impact, especially in COEs.
- **Innovations.** New approaches are encouraged throughout the grant cycle to maximize results in COEs.

A differentiated approach to manage COE portfolios in an agile and timely manner may be needed to increase access to health services and impact of Global Fund investments, while building resilient systems to respond to crises and/or emergencies. When balancing between VfM dimensions, applicants are encouraged to consider the following:

- **Effectiveness and equity dimensions** are the core elements and constitute the greatest focus. Differentiated implementation modalities aim to leave no-one behind by ensuring equitable access to quality health services.
- **Efficiency dimension:** allocative efficiency remains important but limited data quality may prevent countries from conducting such analysis. Given that implementing quality programs in COE countries may necessitate more costly and comprehensive service delivery modalities that may increase service unit costs, the importance given to technical efficiency may be lessened. However, flexibilities from the COE policy aim to strengthen efficiency in program management and implementation.
- **Economy** dimension will need to be considered against increased flexibilities and differentiated implementation arrangements, as the cost of doing business in such contexts can be higher. Applicants will need to balance how higher unit prices can improve access to quality services.
- **Sustainability** dimension remains an objective with the vision to move from emergency to RSSH/sustainability (refer to [RSSH Info Note](#) for more information). Applicants should consider an appropriate mix of humanitarian and systems strengthening approaches that focus on building resilience.

Applicants can refer to the Annex 4 where an example from Mali is included.



## 2.2 VfM across the grant life cycle

Applicants are strongly encouraged to make efforts to achieve VfM throughout the Global Fund grant life cycle, from the funding request to grant closure. **Figure 4** provides a stepwise view of the VfM priority areas in each of the key stages of the Global Fund grant life cycle.

Everyone engaged in designing, financing, delivering, monitoring and regulating programs is responsible for securing VfM. Country Coordinating Mechanisms (CCMs) are strongly encouraged to work with key stakeholders to integrate VfM considerations throughout all aspects of the development of the funding request and its implementation.<sup>25</sup> The Global Fund Secretariat and technical partners can play a role in supporting CCMs in facilitating VfM discussions.<sup>26</sup>

### Before applying for funding

VfM should be considered far in advance of the receipt of the Global Fund Allocation Letter. To ensure meaningful participation of all relevant stakeholders, CCMs are encouraged to widely disseminate the content of this technical brief to their constituencies and integrate the VfM concept into its discussions. VfM should also be considered when developing National Strategic Plans (NSP), through a participatory approach.

Funding requests and NSPs should be data driven and informed by evidence. Applicants are therefore encouraged to reflect far in advance which strategic questions must be answered, and which analysis would be required to inform the upcoming funding request. Applicants can refer to Annex 1 for guiding questions and Annex 3 for existing tools and methodologies to answer them.

### Applying for funding

Greater focus is expected at different steps of the review process now that VfM has been embedded in the application material of the 2023-2025 allocation period. The TRP will consider whether sufficient considerations have been made to VfM in the funding request and the feasibility required to be carried out during grant implementation. A mapping of VfM across the Full Review application form can be found in Annex 2.

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<sup>25</sup> Key stakeholder may include ministers of health and finance, national disease program managers, health partners and funders, service providers, communities, regulatory entities, and beneficiaries.

<sup>26</sup> Applicants are encouraged to consider needed analysis and country dialogue in advance to strengthen VfM aspect of their funding requests. Technical and funding agencies may have resources available to provide the support needed. The Global Fund, through its Strategic Initiatives for instance, provides technical assistance to countries to improve VfM of their programs and systems. Some of such assistance is dedicated to support the strengthening of NSP and funding request development.

## **Grant-making**

A country's funding request is turned into one or more grants through the process of grant-making. This process sets out how and when a grant's activities will be implemented and evaluated, to ensure VfM will be achieved through the implementation period.

During grant-making, detailed budgets are elaborated for each Principal Recipient (PR), targets are disaggregated, and implementation arrangements are confirmed. At the same time, service delivery modalities and approaches to implement the approved interventions are clarified (e.g., applying MMD or using virtual tools to facilitate access to services). All these steps are essential to achieve efficiency gains and secure economies in unit prices of inputs.

Grant-making also gives an opportunity to identify, across disease components, areas of shared investments and co-prioritization that could lead to great system level integration and efficiency gains.

Grant-making is also the right moment to identify programmatic and operational risks that may limit VfM through grant implementation. This allows PR and the Global Fund to define, plan and implement mitigating actions to reduce such risks.

## **Grant implementation, monitoring and evaluation**

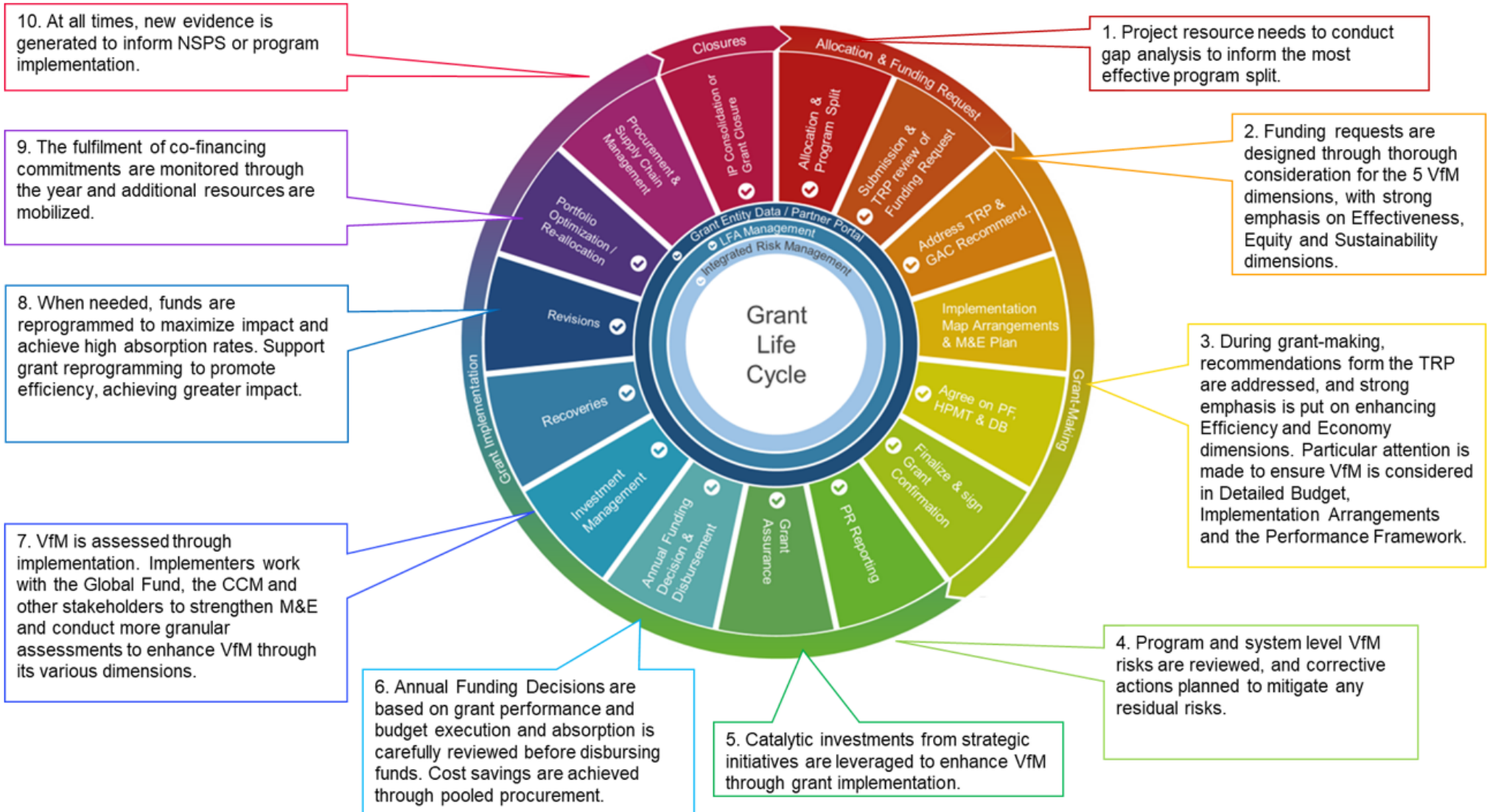
The effective implementation and monitoring of grants is at the core of the work to end HIV, TB and malaria as epidemics. It is through implementation that the concept of VfM will materialize and deliver on the expected output, outcome and impact. Grant performance assessment and monitoring and evaluation (M&E) is therefore critical to assess performance, identify gaps and take corrective actions.

The following can be considered:

- Design and implement a solid M&E plan that will allow the PRs/SRs to increase the granularity and frequency of their performance and gaps analysis, going beyond the performance framework (e.g., sub-national analysis).
- Utilize tools through grant implementation to enhance VfM (e.g., geospatial analysis to support operationalization of programs).
- Monitor and analyze financial data, beyond the progress update and disbursement request (PU/DR) template to improve flow of funds, assess grant absorption at all levels, or timely reprogram savings.

The Global Fund investments should not be assessed in isolation of national monitoring processes and systems. Applicants are therefore encouraged to consider how the programmatic performance of grants are reviewed as part of the wider M&E system and how funding absorptions are considered in conjunction with PFM assessments.

**Figure 4: Ten Steps to Enhance VfM Across the Grant Life Cycle**



## List of Abbreviations

<b>ACT</b>	Artemisinin-based combination therapy
<b>ART</b>	Antiretroviral therapy
<b>BDB</b>	Breaking Down Barrier (initiative)
<b>CBM</b>	Community-based monitoring
<b>CBO</b>	Community-based organizations
<b>CCM</b>	Country Coordination Mechanism
<b>CEA</b>	Cost effectiveness analysis
<b>CHOICE</b>	WHO-Choosing Interventions that are Cost-Effective
<b>CHW</b>	Community health worker
<b>COE</b>	Challenging operating environment
<b>CSO</b>	Civil society organization
<b>CSS</b>	Community systems strengthening
<b>DRM</b>	Domestic resource mobilization
<b>DSD</b>	Differentiated Service Delivery
<b>DQA</b>	Data quality assessments
<b>Gavi</b>	Global Alliance for Vaccine Initiative
<b>GDF</b>	Global Drug Facility
<b>GFF</b>	Global Financing Facility
<b>HIS</b>	Health information system
<b>HPM</b>	Health product management
<b>HRH</b>	Human resources for health
<b>HTA</b>	Health Technology Assessment
<b>KVPs</b>	Key and vulnerable populations
<b>MMD</b>	Multi-month dispensing (of medicines)
<b>NSP</b>	National strategic plan
<b>PPM</b>	Pooled Procurement Mechanism
<b>RSSH</b>	Resilient and sustainable systems for health
<b>STC</b>	Sustainability, transition, and co-financing
<b>TRP</b>	Technical Review Panel
<b>UHC</b>	Universal health coverage
<b>VfM</b>	Value for money

# Annexes

## Annex 1: Guiding Questions for VfM (checklist)

VfM Dimension	Key questions and considerations during grant design and implementation	Examples of efforts to enhance VfM
<b>EFFECTIVENESS</b> Reducing HIV, TB and malaria disease burden	<p><b><i>Does the funding request contribute to advance disease control, maximize impact and meet global targets?</i></b></p> <ul style="list-style-type: none"> <li>• The proposed activities and targets are the result of a robust gap analysis, disaggregated by intervention, population groups and geography.</li> <li>• The proposed interventions are aligned with the latest guidance from technical partners and aligned with recommendation in the <a href="#">information notes for HIV, TB, malaria and RSSH to improve program essentials</a>.</li> <li>• Processes are in place to assess and improve the quality of services.</li> </ul>	<ul style="list-style-type: none"> <li>✓ Granular cascade analyses are regularly updated to monitor progress and adjust interventions to remaining gaps and needs.</li> <li>✓ Quality of services is assessed through supportive supervision, exit surveys, spot checks, etc.</li> <li>✓ Supportive supervision and on-the-job capacity building to strengthen quality of services at point of care.</li> </ul>
<b>EFFECTIVENESS</b> Addressing structural barriers to combatting HIV, TB and malaria	<p><b><i>Does the funding request clearly outline and address the structural barriers to access services and propose an evidence-based approach to remove them?</i></b></p> <ul style="list-style-type: none"> <li>• Barriers to access services and root causes have been clearly identified and are monitored using both quantitative and qualitative information.</li> <li>• The program applies a theory of change and an evidence-based approach to remove structural barriers. Interventions are comprehensive and appropriate.</li> <li>• The interventions to remove structural barriers are integrated into and enabling the disease programs. They are not duplicative or implemented through parallel systems.</li> <li>• Monitoring and evaluation approach to monitor if barriers are effectively being removed and contributing to increased access to services.</li> </ul>	<ul style="list-style-type: none"> <li>✓ Assessments of barriers and community-led monitoring data used to inform programmatic responses.</li> <li>✓ Utilization of the Global Fund technical briefs to design a comprehensive and integrated human rights program.</li> <li>✓ Human rights interventions are integrated in KVP programs to maximize impact.</li> </ul>
<b>EFFECTIVENESS</b> Strengthening health and community related systems to combatting HIV, TB and malaria	<p><b><i>Are adequate resources allocated to strengthen the health and community systems to address shared bottlenecks for the delivery of health services?</i></b></p> <ul style="list-style-type: none"> <li>• Robust analysis of shared health and community system bottlenecks across the disease programs is used to prioritize investments in health and community systems to deliver on HIV, TB and malaria, including on HRH, HIS, supply chains, laboratory systems, community systems, health governance, etc.</li> <li>• People-centered health services are supported by strong community systems and delivered across disease programs in primary health care.</li> <li>• Proposed RSSH interventions are not limited to the support of health systems but clearly outline how they will strengthen health systems.</li> <li>• RSSH funding gap clearly outlined in the <a href="#">RSSH gaps and priorities annex</a>.</li> </ul>	<ul style="list-style-type: none"> <li>✓ Disease situation rooms contribute to generating regular analysis, promoting data utilization to inform programmatic decisions and address gaps in health information systems.</li> <li>✓ Private sector is leveraged for the last mile distribution to improve on-shelf availability.</li> <li>✓ Service quality is enhanced by moving from short-term support to HRH for in-service training to more effective interventions, responding to integrated service delivery and quality priorities.</li> </ul>

VfM Dimension	Key questions and considerations during grant design and implementation	Examples of efforts to enhance VfM
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">EFFICIENCY</p> <p>Allocative efficiency</p>	<p><b><i>Are resources optimally allocated across interventions, geographies and population groups to maximize output, outcome and impact?</i></b></p> <p><u>Optimal distribution across interventions and population groups:</u></p> <ul style="list-style-type: none"> <li>• Available resources are strategically allocated across interventions and population groups to maximize the impact of respective disease programs. Interventions have been prioritized based on evidence within the available resource envelope to maximize health outcome, following a robust funding gap analysis.</li> <li>• Population coverage gaps are well identified through the service cascade, by sub-groups, age and gender, and resources are allocated to specific interventions, activities and inputs that are tailored to their needs.</li> </ul> <p><u>Distribution across geographic areas:</u></p> <ul style="list-style-type: none"> <li>• The distribution of resources to sub-national areas (region/district/municipality) is informed by epidemiological trends and programmatic gaps to achieve the greatest impact.</li> <li>• The distribution of inputs is optimized to align to location of patients and ensure each input contributes to reach a maximum of outputs.</li> </ul>	<ul style="list-style-type: none"> <li>✓ Impact modelling coupled with costing are used to prioritize interventions within a limited resource envelope, identifying the right intervention mix to reduce incidence, achieve greater impact and return on investment.</li> <li>✓ Stratification exercises and subnational tailoring for malaria programs are used to determine the optimal intervention mix to vector control.</li> <li>✓ Geospatial analysis is used to strategically locate diagnostic equipment and identify the optimal routes for building sample referral and transport systems.</li> <li>✓ Countries provide evidence and rationale to explain budget allocation decisions across all levels (health systems, disease areas, interventions, populations, sub-national areas).</li> <li>✓ Applicants use patient volume data, consider programmatic gaps (e.g., lost to follow up) and/or conduct geospatial service accessibility mapping to optimally recruit and distribute CHW.</li> </ul>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">EFFICIENCY</p> <p>Grant management efficiency</p>	<p><b><i>Are implementation arrangements (IA) sound and designed to optimize program management costs and respond to programmatic risks and bottlenecks?</i></b></p> <ul style="list-style-type: none"> <li>• IA are streamlined by reducing unnecessary layers of implementer and strengthening site-level investments.</li> <li>• IA are informed by financial mapping of services and complement other funding sources.</li> </ul> <p><b><i>Are governance and management systems strong to achieve high absorption rates of the Global Fund grants and when it is needed, rapidly adjust to reprogram and generate efficiency gains?</i></b></p> <ul style="list-style-type: none"> <li>• Financial absorption is regularly monitored at all levels and corrective actions taken to address low absorption, using standardized processes.</li> <li>• Program management costs are benchmarked and tracked over time to ensure lean but effective program management.</li> <li>• The CCM has carefully reviewed the PR/SR performance and capacity to deliver. Corrective actions are defined to mitigate risks.</li> </ul>	<ul style="list-style-type: none"> <li>✓ IA options are well explored with PRs and SRs being competitively chosen based on competency, performance and cost.</li> <li>✓ Routine financial management systems are developed and tailored to the Global Fund CSO grants to support grant management through routine resource tracking, human resources management and programmatic monitoring.</li> <li>✓ The Global Fund investments are managed through the Public Financial Information System (IFMIS) to meet both government and the Global Fund's budgeting, accounting and financial reporting needs.</li> <li>✓ Leverage the Global Fund grant funding or initiatives to undertake a diagnostic review of Public Financial Management system, to highlight strengths and improvement opportunities.</li> </ul>



***Does the funding request demonstrate technical efficiency? Will the proposed activities and budget assumptions contribute to achieve the greatest outcome and greatest quantity of outputs with resources invested?***

Ideal service delivery modality:

- The service delivery modalities (i.e., level of service, processes and activities to implement an intervention) are the most appropriate to provide quality services and reach the greatest outputs.
- Diagnostic approaches are well designed to result in finding more cases and improve the yield.
- Digital health technologies are leveraged to improve access to services, linkage to care or adherence.
- Community services are well integrated into health services to reach more patients.

Integration of system level investments:

- The proposed system level investments avoid parallel and duplicative disease specific management systems (e.g., health information systems, human resources, laboratory systems, and supply chains).
- Service delivery is integrated to PHC platforms to achieve both economies of scope (i.e., providing two types of health services (e.g., HIV testing and TB testing) together results in a lower cost than providing them separately) and economies of scale.
- Laboratory service delivery are integrated and optimized through systems integration, multi-disease testing laboratory equipment, improving instrument placement strategies, and optimizing referral networks.

Selecting the right mix and quantity of inputs to achieve more outputs:

- The proposed budget builds on lessons learned from previous implementation periods, addresses previous inefficiencies, and aims to achieve economies of scale.
- Variation of service unit costs across SR or sub-national areas are reviewed and analyzed to identify potential efficiency gains.
- Projections are made to identify interventions or geographic areas where economies of scale can be achieved, such as providing larger quantity of the same service (e.g., testing, or treatment) to reduce the average cost of service provision).
- Conduct cost-effectiveness analysis to rationalize new product/technology adoption and scale up.
- Processes are in place to minimize wastage and underutilization of resources.

Examples on ideal service delivery modality:

- ✓ Adopt more efficient drug refill or patient visit schedules. Leverage CHW and pharmacies.
- ✓ Expand active index-based testing and contact tracing.
- ✓ Move services from hospital-based delivery to out-patient services and primary health care (PHC) facilities to lower the cost-of-service provision and improve access.
- ✓ Private sector is leveraged to improve accessibility and quality of health services.
- ✓ Optimize laboratory testing algorithms to avoid unnecessary double testing.
- ✓ Use virtual tools to provide tailored services to marginalized or hard to reach populations.

Examples on integration:

- ✓ Adopt a systems approach to address common bottlenecks in service delivery across the three diseases, such as stock-outs or HRH shortages.
- ✓ Provide integrated service delivery through PHC facilities, community health workers, as well as community-led and based organizations.

Strengthen sample transport systems to optimize the use of laboratory equipment across diseases.

Examples to select the right input mix and quantity:

- ✓ Cost-effectiveness analysis conducted to decide when and where pyrethroid-piperonyl butoxide (PBO) nets should be deployed.
- ✓ Costing studies and detailed expenditure reviews are done to carefully select and quantify inputs.
- ✓ Task-shifting to less costly human resources (e.g., nurses or CHWs) can save financial resources and improve service outcome.
- ✓ Improve supply chain management system to reduce drug expiration and wastage.








VfM Dimension	Key questions and considerations during grant design and implementation	Examples of efforts to enhance VfM
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>ECONOMY</b></p> <p>Right prices for the right inputs</p>	<p><b><i>Have cost drivers been identified and efforts made to ensure that the lowest costs are obtained for quality health products and other key inputs necessary to provide services?</i></b></p> <p><u>Health products and equipment:</u></p> <ul style="list-style-type: none"> <li>● Health products are affordable and chosen to maximize acceptability and adherence.</li> <li>● System is put in place to monitor the price of health products procurement with a strategy to achieve the lowest sustainable costs, near international pooled procurement prices.</li> </ul> <p><u>Human resources / travel related / other costs:</u></p> <ul style="list-style-type: none"> <li>● Staff salary scales are aligned to local market and follow national guidelines.</li> <li>● Non-health equipment is procured through pooled procurement mechanisms.</li> <li>● Travel related costs are rationalized and maintained when necessary.</li> </ul>	<ul style="list-style-type: none"> <li>✓ Countries are procuring health products and equipment through pooled procurement mechanisms, including for health products procured with domestic resources.</li> <li>✓ Recipients have conducted a market review of salaries, to establish benchmarks for Global Fund grants, which improves economy but also reinforces its sustainability.</li> <li>✓ Annual per diem rates are agreed among donors and, where feasible, aligned to national policy.</li> </ul>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>ECONOMY</b></p> <p>Optimal program management costs</p>	<p><b><i>Have efforts been made to minimize program management (PM) costs at the Principal Recipient and Sub-recipient level?</i></b></p> <ul style="list-style-type: none"> <li>● The number of staff for PM has been rationalized and there is an appropriate balance between program management staff and staff involved in grant implementation.</li> <li>● Shared costs are analyzed where implementers have more than one donor.</li> <li>● Particular attention was given to salary of program management staff.</li> <li>● Governance related expenses have been duly considered and prioritization has been made following a balance between their expected outcome and other priority gaps.</li> <li>● Assets procured from previous funding cycle are accounted for and utilized in the upcoming implementation period.</li> </ul>	<ul style="list-style-type: none"> <li>✓ When feasible, PRs use service provider contracts rather than SR agreements to reduce program management costs and simplify reporting.</li> <li>✓ An expenditure review of program management costs, compared with budget amounts from the previous allocation period can inform if program management costs are consistent with the budgeting guidelines and consistent with local market prices.</li> <li>✓ Capacity building of staff operating at site level is strengthened through continuous supportive supervision instead of one-off meetings or expensive trainings that can have limited results.</li> </ul>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>ECONOMY</b></p> <p>Robust procurement and financial management systems</p>	<p><b><i>Are procurement and financial management systems robust to procure goods and services on a timely manner and manage resources following due process?</i></b></p> <p><u>Procurement systems:</u></p> <ul style="list-style-type: none"> <li>● Procurement plans are consistent with the programmatic targets.</li> <li>● Health products are procured, transported, distributed, and managed efficiently, reducing stock-outs and wastage?</li> </ul> <p><u>Financial Management systems.</u></p> <ul style="list-style-type: none"> <li>● Gaps in public financial management (PFM) systems are identified and addressed to minimize fiduciary risk and improve monitoring of the Global Fund investments.</li> <li>● Routine financial management is used to complement PFM systems.</li> </ul>	<ul style="list-style-type: none"> <li>✓ In close collaboration with national governments and partners, procurement processes are redesigned and built to ensure efficient procurement of health products.</li> <li>✓ Specific assessments are carried out to comprehensively review and strengthen PFM (e.g., CO-link initiative).</li> <li>✓ A system is in place at the PR and SR level to prevent, monitor and address non-compliant expenditures.</li> </ul>

VfM Dimension	Key questions and considerations during grant design and implementation	Examples of efforts to enhance VfM
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>EQUITY</b></p> <p>Spend fairly</p>	<p><b><i>Does the funding request allocate a fair share of resources to KVP programs, recognizing that greater resources are required for greater needs, along with an appropriate mix of inputs for the design of interventions?</i></b></p> <ul style="list-style-type: none"> <li>● The funding request includes a fair share of resources to reach the most at-risk populations through a population-based approach that addresses equity, human rights and gender-related barriers.</li> <li>● All specific activities and potential incremental costs required to effectively reach these populations is accounted for. Applicants should identify and manage cost drivers appropriately.</li> <li>● Adequate resources are allocated to build (and sustain) community responses to promote service access, uptake and retention.</li> </ul>	<ul style="list-style-type: none"> <li>✓ Detailed analytical costing study to outline the incremental cost of reach KVPs and marginalized groups.</li> <li>✓ Payment of health insurance fees provided to KVPs and marginalized groups to improve their access to health services.</li> <li>✓ Integrate equity into cost-effectiveness analysis including allocative efficiency analysis to inform equitable resources allocation.</li> </ul>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>EQUITY</b></p> <p>Leave no-one behind</p>	<p><b><i>Is the funding request based on a sound analysis of inequities in risk and vulnerability, service access, uptake and retention and health outcomes? Are the most marginalized populations reached through high coverage of tailored quality services?</i></b></p> <ul style="list-style-type: none"> <li>● The funding request is based on robust analysis, disaggregated to understand inequities in access to essential HIV, TB and malaria services and health outcomes (by age, sex/gender, geography or socioeconomic status).</li> <li>● The funding request identifies the reasons for such inequities, including financial, human rights and gender-related barriers.</li> <li>● Interventions to address barriers are designed, resourced and implemented to scale up coverage.</li> <li>● Targets will contribute to high service coverage among KVPs and marginalized populations.</li> </ul>	<ul style="list-style-type: none"> <li>✓ Treatment cascade analysis by key population, gender, age groups and location can help identify population groups not sufficiently targeted with diagnostic interventions</li> <li>✓ Utilization of community-led monitoring (CLM) and consultation process among communities is important to understand the barriers and root causes that prevent them from accessing and adhering to health services.</li> <li>✓ User fees are monitored and their impact on access to services is assessed, along with proposed remedial actions.</li> <li>✓ Communities are empowered to know their rights and claim equitable access to services.</li> </ul>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>EQUITY</b></p> <p>Equitable health outcomes for the most marginalized</p>	<p><b><i>Are investments targeting marginalized populations translated into equitable health outcomes?</i></b></p> <ul style="list-style-type: none"> <li>● The funding request includes a comprehensive set of activities to reach KVPs and the most marginalized and remove the underlying barriers to equitable health outcomes, aligned to technical recommendations and based on evidence and best practices.</li> <li>● Communities are involved in the design of the funding request development process and VfM decision-making.</li> <li>● Activities are funded to monitor and evaluate interventions aimed at reducing inequities.</li> </ul>	<ul style="list-style-type: none"> <li>✓ Commitment to routinely collect and analyze disaggregated data to inform program design and adaptation.</li> <li>✓ Measuring performance against reducing inequities, using disaggregated indicators.</li> <li>✓ Progress assessments, such as in the frame of the Breaking Down-Barriers initiative are used to assess how human rights-related barriers are being removed.</li> </ul>

VfM Dimension	Key questions and considerations during grant design and implementation	Examples of efforts to enhance VfM
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">SUSTAINABILITY</p> <p>Sustainable program and system level investment</p>	<p><b><i>Does the funding request appropriately balance near-term efficiency and effectiveness against longer-term sustainability?</i></b></p> <ul style="list-style-type: none"> <li>● RSSH resource allocation is the result of a wider discussion, based on national health sector plan and is not limited to a disease program prioritization.</li> <li>● The funding request visions a pathway to ensure that service delivery is affordable and programmatically feasible for national governments to take over in the future.</li> <li>● System level investments are integrated and targeted to strengthen national systems instead of supporting parallel systems that are unsustainable.</li> <li>● The introduction of new technologies is informed by strong epidemiological and financial justification considering both near and long-term programmatic goals, especially in circumstances where such introduction will incur higher up-front costs or have long-term financial implications.</li> </ul>	<ul style="list-style-type: none"> <li>✓ Strengthening national health-financing leadership, governance and organizational capacity to accelerate the achievement of UHC and SDG3.</li> <li>✓ Laboratory investments are considered across the entire health sector and aim to benefit multi-disease requirements, and not only to address needs specific to disease components.</li> <li>✓ Moving from standalone CHW investments to scaled up integrated community health programs.</li> <li>✓ Investments in health information system consider the linkages and shared functionality with other health information systems, such as laboratory, logistics, human resources, and finance information systems.</li> </ul>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">SUSTAINABILITY</p> <p>Meaningful domestic resource mobilization</p>	<p><b><i>Are domestic resources allocated to HIV, TB and malaria increasing to sustain the growth of the programs and ensure that national targets can be effectively achieved?</i></b></p> <ul style="list-style-type: none"> <li>● The funding request is complemented by a co-financing commitment that covers critical gaps in HIV, TB and malaria (e.g., commodities, key population programs), with defined timelines and process to monitor its fulfilment.</li> <li>● Co-financing is integrated into a wider strategy for increasing resource mobilization for the three diseases and universal health coverage, including through leveraging innovative financing options or expanding the utilization of social contracting.</li> <li>● Tracking of cashflow, program budgeting, fiscal space analysis and resource needs estimates are regularly updated to monitor gaps and inform strategic and timely resource mobilization.</li> </ul>	<ul style="list-style-type: none"> <li>✓ HIV, TB and malaria services are integrated to national UHC strategies and financial mechanisms.</li> <li>✓ National governments leverage loans by multi-lateral development banks to crowd in resources towards fully funding RSSH priorities.</li> <li>✓ The CCM has planned and budgeted activities to support community-based organizations to advocate for increased domestic resources mobilization and fulfilment of co-financing requirements.</li> <li>✓ Conducting resource tracking or budget analysis to understand gaps and avoiding duplication of donor funding.</li> </ul>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">SUSTAINABILITY</p> <p>Successful transition</p>	<p><b><i>Are funding requests from middle-income countries designed with the aim of eventual and full transition to domestically funded and managed programs?</i></b></p> <ul style="list-style-type: none"> <li>● The funding request integrates Global Fund-supported services into the national health systems and provides synergies with investments from domestic governments and other development partners.</li> <li>● Barriers are removed to enhance government financing of services provided by communities and civil society.</li> </ul>	<ul style="list-style-type: none"> <li>✓ Shifting from established parallel systems to integrated country-owned systems, with processes and investments related to needs clearly laid out.</li> <li>✓ Integrate Global Fund investments into national budgets and national financial schemes, such as national insurance schemes.</li> <li>✓ Assessing and addressing legal, administrative, political or resource bottleneck for social contracting.</li> </ul>

## Annex 2: Mapping of VfM Across the Funding Request Application Form

### Full Review Application Form

Question	Effectiveness	Efficiency	Economy	Equity	Sustainability
<b>Section 1: Funding Request and Rationale</b>					
1.1 Prioritized request (including Prioritised Above Allocation Request (PAAR))					
1.2 Rationale					
1.3 Context					
1.4 Lessons learned					
1.5 Focus of application requirements					
1.6 Matching Funds (if applicable)					
<b>Section 2: Maximizing Impact</b>					
2.1 Ending AIDS, TB and malaria					
2.2 Resilient and sustainable systems for health					
2.3 Engagement and leadership of most affected communities					
2.4 Health equity, gender equality and human rights					
2.5 Sustainability, Domestic Financing and Resource Mobilization					
2.6 Pandemic preparedness					
<b>Section 3: Implementation</b>					
3.1 Implementation arrangements					
3.2 Key risk and mitigation measures					
<b>Annexes</b>					
Detailed budget					
Health Product Management Template					
Performance Framework					
Programmatic Gap Tables					
Financial Landscape Table					
Implementation arrangement map					
National strategic plans					

### Annex 3: Available Tools and Methods to Enhance Efficiency<sup>27</sup>

Type of tool	Disease program	Tool/Methods	Description	Tool/Method developer <sup>28</sup>
Allocative efficiency	HIV	<a href="#">AIM/Goals model</a>	Projects HIV burden (PLHIV; HIV infections, AIDS cases and deaths) and optimal intervention and coverage mix to maximize impact under a given resource envelope.	Avenir Health
		<a href="#">AIDS Epidemic Model (AEM)</a>	Projects current and future HIV infections and ART needs at a given period. Has an Intervention workbook component for assessing program impacts and costs and a separate Impact Analysis workbook for comparing scenarios. The Model is primarily used for concentrated HIV epidemics in Asian country settings and can inform optimal intervention mix for a given resource envelope.	East-West Center
		<a href="#">Optima HIV</a>	Optima HIV can improve spending efficiency by identifying how new or existing funding can be optimally allocated across interventions to maximize impact, at national or sub-national levels. User-defined key populations and targeted interventions can be included, and health or epidemic outcomes estimated under specified or optimal spending scenarios.	Optima Consortium for Decision Science
	TB	<a href="#">Australian Tuberculosis Modelling Network (AuTnMN)</a>	Assists national TB programs to identify cost-effective TB control interventions that will maximize impact against TB.	Australian Tuberculosis Modelling Network
		<a href="#">Imperial TB Model</a>	The Model links the tuberculosis care cascade to transmission with the aim of identifying which improvements in the cascade can yield the greatest effect on incidence and mortality. Provided with country-specific cost data, the model can also inform what intervention scenarios can be most cost-effective to guide strategic planning of national programs. Models are developed specifically for each country.	Imperial College London
		<a href="#">Optima TB</a>	Optima TB can identify how new or existing funding can be optimally allocated across interventions to maximize impact, at national or sub-national levels. User-defined key populations and targeted interventions can be included, and health or epidemic outcomes estimated under specified or optimal spending scenarios.	Optima Consortium for Decision Science
		<a href="#">TB Impact and Modelling Estimates (TIME)</a>	Estimates TB burden among population targeted for a specific TB intervention or intervention mix and projects service volumes needed for an impactful response to TB.	TB Modelling Group - London School of Hygiene and Tropical Medicine
	Malaria	<a href="#">Elimination Scenario Planning</a>	Models and assesses technical, financial and programmatic feasibilities of achieving malaria elimination based on existing program coverage, interventions selected and resource availability.	Imperial College London

<sup>27</sup> Methods, approaches and tools covering other dimensions of VfM can be found in Annex 5 of this document, or in the [HIV, TB, Malaria and RSSH Information Notes and various Technical Briefs](#) referred in this document.

<sup>28</sup> Co-developers or collaborators of some of the tools can be found on the website of the tools.

		<a href="#">Epidemiological MODeling (EMOD) malaria modelling</a>	Simulates changes in malaria transmission dynamics based on interactions with malaria control interventions.	Institute of Disease Modelling
		<a href="#">Malaria Elimination Transmission and Costing (MEMTC)</a>	Estimates the rate of decline and costs towards malaria elimination. It incorporates transmission dynamics, seasonality and intervention coverage specific for each country against <i>P. falciparum</i> and <i>P vivax</i> malaria.	Mahidol Oxford Tropical Medicine Research Unit
		<a href="#">OpenMalaria</a>	Simulates the impact of malaria interventions against changes in malaria vector transmission dynamics.	Swiss TPH
		<a href="#">Optima Malaria</a>	Tool that can improve spending efficiency by identifying how funding can be optimally allocated across malaria interventions to maximize impact at national and sub-national levels. User-defined key populations and targeted interventions can be included, and health or epidemic outcomes estimated under specified or optimal spending scenarios.	Optima Consortium for Decision Science
		<a href="#">Spectrum Malaria</a>	Projects malaria intervention coverage and its expected impact on malaria prevalence, cases and mortality. The projections consider available resources and the relative costs and cost-effectiveness of changing strategic plans or policies. It is specific to sub-Saharan African region.	Avenir Health
	Health Systems	<a href="#">Health Intervention Prioritization Tool (HIPtool)</a>	Assists policymakers to identify health funding priorities and target coverage across diseases at country level for a given level of available resources. The tool incorporates context-specific disease burden data and their respective effectiveness on intervention effectiveness.	University College London
		<a href="#">WHO-Choosing Interventions That Are Cost Effective (WHO-CHOICE)</a>	Designed to facilitate country level cost-effectiveness analysis of a wide range of health interventions across disease programs to inform priority setting for health development overall.	World Health Organization
		<a href="#">Cross-programmatic Efficiency Analysis</a>	A diagnostic approach to enable countries to look across health programs that are part of their health system to detect “cross-programmatic” inefficiencies. The approach uses applied health system analysis to unpack vertical programs by their functional components and places them within the context of the broader health system	World Health Organization
		<a href="#">Financial Evaluation of Investments in Public Health Supply Chains</a>	Description: "A free-online course designed to provide framework and method for supply chain professionals to make a financial evaluation of investment options against alternative course of actions and guide their decisions about the cost-effectiveness of their investments and efficient use of scarce resources	Jointly by the Global Fund and Empower School of Health
	Health product & technology; health programs.	<a href="#">Health Technology Assessment Toolkit</a>	Aims to systematically document the expected cost and effectiveness/benefit consequences of new health technologies such as drugs, medical equipment, diagnostic techniques and public health programs to inform the adoption of a new technology or inform priority setting including the creation of an essential medicines list and a health benefit packages for UHC.	International Decision Support Initiative (iDSI)



<b>Budget impact analysis</b>	Applicable for an intervention or intervention mix	<a href="#">Budget impact template</a>	Assessment of expected financial changes in health expenditure upon implementation of new intervention/interventions. Budget impact analysis evaluates the affordability of implementing and sustaining new intervention. Countries can adapt this template to their own settings, to obtain insights whether or not to adopt a new technology or intervention mix given its budget implications to ensure affordability and sustainability.	National Institute for Health and Care Excellence
<b>Extended cost-effectiveness</b>	Health systems	<a href="#">Socio-Technical Allocation of Resources (STAR)</a>	Facilitates policy dialogue among health decision-makers to identify and prioritize interventions across different health areas incorporating cost-effectiveness and other factors such as equity and feasibility.	London School of Economics
<b>Costing</b>	HIV and other diseases	<a href="#">Activity-based Costing and Management</a>	Generate patient-level cost data that will promote local efficiencies in care delivery, optimization of care over the patient's treatment cycle, and inform policymakers' strategic planning, budgeting, resource allocation and program implementation for high-quality HIV care and related services.	Harvard Business School, Heller School for Social Policy and Management
	TB	<a href="#">Value TB Costing Tool</a>	Supports collection and estimation of unit costs of providing multiple TB interventions from the healthcare providers' perspective. The estimates can then be used to inform for efficient and fair prioritization and planning for TB services.	World Health Organization
<b>Resources needs estimates/ Budgeting</b>	Health systems	<a href="#">OneHealth</a>	Supports costing and budgeting of resources needs across the health sectors, linking national strategic objectives to programmatic targets set across different disease programs. A key focus of OneHealth is on integrated health planning and strengthening of health systems.	Interagency Working Group on Costing / Avenir Health
<b>Geospatial analysis</b>	Health systems	<a href="#">AccessMod (Version 5)</a>	Leverages Geographical Information Systems (GIS) technology to visually display geographic coverage and population access to existing health facility and service networks. The tool can be used in scaling up health facility coverage by identifying new sites that maximizes geographic coverage and reducing access times and optimally deploying CHWs or health technologies to improve service access and efficiency.	WHO, UNICEF, University of Geneva, Health GeoLab
		<a href="#">ArcGIS</a>	Licensed software tool that combines geographic information system technology with demographic to aid planning of health facility networks and population access to health services.	Esri
		<a href="#">Reveal</a>	Open-source spatial intelligence tool supporting end to end campaign management including web-based planning workflows, in-field spatial guidance and real-time geolocated household monitoring of last-mile health service delivery. Outcomes include a precise understanding of coverage intervention gaps designed to inform real-time in-field responses and program strategy adjustments.	Akros
		<a href="#">OptiDx</a>	Open-access Diagnostic Network Optimization (DNO) tool aimed at maximizing limited diagnostic capacity in low resource settings whilst achieving a high overall efficiency. The tool can be used to strategically link the optimization to national health priorities across multiple disease programs.	FIND, USAID-PSM, Coupa Software
	TB	<a href="#">MATCH approach</a>	Combines GIS and surveillance data to inform health policy and planning geared towards sub-national tailoring of interventions around TB and investment decisions.	KIT Royal Institute



## Annex 4: Examples of Efforts to Improve VfM

### Examples of enhanced Economy

#### Reforming procurement and contract management in Ethiopia to reduce cost and improve predictability of health products

In 2017, Ethiopia started major reforms of its Central Medical Stores (Ethiopia Pharmaceutical Supply Agency). As part of these efforts, Ethiopia has established long term framework agreements to procure ARVs, HIV testing kits, anti-malarial drugs, among others. The agreements included:

- Performance measures to achieve lowest sustainable prices without compromising reliable delivery.
- Incentives for manufacturers to over-perform, a measure deemed critical for ensuring alignment with the Global Fund's market shaping efforts.

This initiative has ensured commodity security for the country and has resulted in significant savings from unit cost reductions made possible through higher volumes and better demand predictability for suppliers.

#### Reforming human resources management in Tanzania

Tanzania Country Coordinating Committee conducted a human resources reform exercise which included a review of the management and coordination structure as well as an assessment of salary scales and performance management matrix related to employees funded under the Global Fund grant.

While the objective of achieving economy was not the primary intent of the review, it yielded savings ranging from 3% to 25% for different staff positions which concluded with a total HR budget of USD 16 million. The positions funded by the Global Fund were consolidated across all grants and included Program Management Units, central level staff within the disease programs as well as health workers at subnational level and aligned to the government salary scale with a post adjustment to reflect the fact that posts were non-pensionable as contract employees.

#### Leveraging pooled procurement mechanisms to procure key commodities with domestic resources at a lower sustainable cost.

Countries such as Comoros, and Guyana, that have made purchases using domestic resources on Wambo have benefitted from reduced product prices, as a result of order volume aggregates negotiated by the GFs Pooled Procurement Mechanism (PPM).

In smaller LMICs that do not have the advantage of price reduction based on volume aggregation, the combination of PPM and Wambo has been a game-changer that significantly increases the procurement of high-quality medications and health products, which they may not afford if they procured directly with the manufacturer.

#### Improving government visibility on health expenditure through improved financial management systems in Zimbabwe

In Zimbabwe, investments were made on leveraging the existing PFM information system (i.e., integrated financial management information systems (IFMIS)) to meet both government and the Global Fund's budgeting, accounting and financial reporting needs.

Working with the Ministry of Finance, a grant management module was configured in the IFMIS platform to enable accounting and report automation as part of rendering accountability on Global Fund transactions.

This also supported greater government visibility on resources in the health sector, supporting resource tracking of government and Global Fund funding and expenditures at sub-national or district level.

## Examples of enhanced Efficiency

### Stratification exercise to prioritize malaria intervention-mix by subnational area

Through the High Burden to High Impact (HBHI) initiative, Burkina Faso, Cameroon, DRC, Ghana, Mali, Mozambique, Niger, Nigeria, Tanzania and Uganda benefited from sophisticated analytical support to prioritize intervention mix tailored to subnational epidemiological and programmatic settings (e.g., malaria incidence, prevalence, seasonality, insecticide resistance, service accessibility, and impactful intervention existing). Countries used malaria impact modelling tools (e.g., OpenMalaria, EMOD-Malaria, Imperial College malaria transmission model) to simulate the impact of different malaria intervention scenarios to define the most impactful intervention combination to guide malaria response.

These analyses have then been used to inform NSPs and the Global Fund's application process of its 2018-2020 allocation cycle. The Global Fund's TRP highlighted HBHI initiative as a good example of using data to guide the choice of interventions. Such analysis coupled with financial data can provide analytical insights to define the most cost-effective intervention mixes to maximize impact within available resource envelope.

([WHO technical brief for Global Fund malaria funding requests 2020-22](#), p.4-18)

### Increased health output in Uganda through optimized investment in human resources.

Uganda implemented an HRH information system to map HRH against HIV program data and highlight gaps in service delivery. This was used to support the design of affordable incentive package to attract HRH to rural areas with high HIV burden. The MoH used the results to get MoF to fund 7,211 new HWs and double pay for doctors in rural areas.

HRH improvements were then associated with 97% increase in number of people tested for HIV, and a 15% increase in number of PLHIV started on CTX prophylaxis.

Further, routine data was used to identify program quality gaps and define priority areas for improvement. Decentralized QI teams were used to pilot change monitor success and replicate best practices. ([Jaskiewicz et al., AIDS. 2016](#))

### Geospatial analysis to optimize the scale and deployment of community health workers (CHW) in Sierra Leone

The Ministry of Health and Sanitation (MOHS) of Sierra Leone conducted a geospatial analysis to optimize the scale and deployment of CHWs. Contrary to national policy, most CHWs (64.5%) were deployed within 3 km of a health facility, instead of beyond 3 km of a health facility. Optimized CHW networks were more efficiently deployed than existing networks by 22.4%–71.9%, depending on targeting metric. Based on these results, the MOHS reduced the CHW workforce by roughly 40% and ensured CHWs were recruited from and deployed to communities that would optimize access to services for the population.

Furthermore, the rightsizing and retargeting effort by the MOHS may enable future discussions on a sustainable financing pathway for CHWs, inclusive of inclusive of increasing domestic financing. Cote d'Ivoire and Mali have recently conducted a similar analysis. Countries in sub-Saharan Africa with similar interest in optimizing the scale and deployment of their CHW workforce in the context of broader HRH and health sector planning may look to Sierra Leone as an exemplar model from which to learn.

([Oliphant NP et al, BMJ Global Health, 2022](#)).

### Improved efficiency through differentiated HIV service delivery in Uganda and Malawi

Uganda and Malawi are among the growing number of countries scaling up differentiated delivery (DSD) of HIV services. DSD is a client-centered approach to provide tailored services by population, clinical characteristics and context.

The community-based ART delivery model carried out by The AIDS Support Organization (TASO) in Uganda leads to better CD4 evolution and higher retention, with 20% lower unit costs per patient per year, as compared with facility-based ART delivery model.

Community ART Groups (CAGs) in Malawi obtains higher retention rate among CAG members, as compared to non-CAG patients who were also stable patients. The introduction of CAGs leads to a 10% reduction in annual unit costs of service provision and lowers the burden of CAGs members by reducing the number of ART refill visits per person year by over 60%.

### **Return on TB investment analysis to inform TB response and prioritize interventions**

To understand the return on its End TB Strategy and identify priority actions to maximize return to investment, **Thailand** estimated the cost-benefit of a 5-year strategic plan (2017-2021) across different scenarios. The study concluded that Thailand incurred an economic burden from TB of up to 2,150 million USD per year. Even if the new plan would require more investments, it will significantly reduce the disease burden and productivity loss due to TB with a rate of return on investment being 19.6.

In developing its TB NSP 2019-2023, **Kenya** applied the WHO's People-Centered Framework to facilitate a systematic approach to country-led, data-driven and people-centered planning, prioritization and decision-making. Further, a TB model was applied to assess the cost-effectiveness of different interventions and prioritize the most impactful interventions under different resource envelopes. The analysis supported the formulation of the prioritized investment framework for the new NSP and created strong foundation for the subsequent development of subnational operational plans.

### **Applying Diagnostic Network Optimization (DNO) to improve access to laboratory services and utilization of equipment**

DNO is a geospatial network analytics approach to plan diagnostic networks consistent with national health goals and strategies, including universal health coverage.

DNO helps planners and managers analyze the current diagnostic network and recommend the optimal type, number and location of diagnostics and an associated sample referral network that together enable greatest access to services.

**Vietnam** conducted a DNO to optimally distribute existing GeneXpert machines across provinces, as well as define how many additional machines were needed to be acquired and where they needed to be placed to test all presumptive TB cases, while maximizing the overall efficiency of the system. ([World Bank Group, 2020](#)).

**Kenya** conducted a DNO to identify the most efficient and impactful way of scaling up access to TB molecular testing, integrating TB/HIV EID on existing devices, assessing C/DST/LPA laboratories, and designing optimal, integrated sample referral routings. ([FIND, 2018](#)).

### **Cross-programmatic efficiency diagnosis to promote integration and financial management in Ghana**

Ghanaian authorities, with support from WHO conducted a cross-programmatic efficiency assessment to identify specific areas of inefficiency across the HIV, TB, malaria, immunization and MNCH programs that could pose a threat to sustainability.

Amongst other findings, the analysis identified a lack of financial management coordination across governance structures and funding flows as key constraints to an efficient use of funds. It reignited the urgency in rolling out the Ghana Integrated Financial Management Information System in the health sector as a means for accountability and transparency.

This work has supported consensus-building among government authorities and development partners to prioritize detailed work in relation to public financial management systems and program-based budgeting implementation, to better integrate external funds with domestic financing systems, facilitating integrated and coordinating planning for higher system efficiency, effectiveness, and sustainability.

### **Customization and utilization of management systems to improve efficiency of CSO grants in South Africa**

AIDS Foundation South Africa (AFSA), a civil society principal recipient of the Global Fund, in collaboration with [Harmony Systems](#), customized a management system to facilitate and automate monthly compilation of program and financial data, thus improving the management of the grant. The system captures various modules to track funds, monitor programmatic results, and manage human resources and stock.

This system has allowed the PRs and SRs to increase their accountability, by tracking how funds are allocated or spent and gaining greater visibility on service unit costs. Such system can contribute to increased efficiency by monitoring absorption, comparing expenditures and programmatic performance, monitoring stocks and/or performance of HRH. The tool can also be used to elaborate additional value for money analysis, inform resource tracking exercises and provide relevant inputs to NSP development.

## Examples of enhanced Effectiveness

### Enhancing tuberculosis case-finding: a case of quality improvement initiative in Tanzania

A quality improvement (QI) initiative was implemented by the National Tuberculosis and Leprosy Program to enhance TB case-finding. The initiative involved identifying gaps in the quality of services, introducing new tools, improving the work capacity of health care workers through training and mentorship sessions, strengthening laboratory and referral services, and implementing mandatory TB screening of all patients attending health facilities. An evaluation of the approach found over 50% increase in TB case notification, with 9 out of 10 intervention sites reporting increases in their quarterly TB case notifications.

([E. Wandwalo & al, Trop. Med. Infect. Dis. 2022](#))

### Removing human rights related barriers in countries supported by the Breaking Down Barriers (BDB) initiative

The [Global Fund BDB initiative](#) provided unprecedented support and investment in 20 countries to vastly scale up programs to reduce human rights-related barriers to HIV, TB and malaria services. The initiative's theory of change is based on evidence that such barriers increase vulnerability and limits effectiveness. Removing them through a set of recognized and evidence-based interventions improves access to, uptake of and retention in health services.

Midterm assessments showed that countries involved in the initiative are making significant progress, with an average improvement of 0.9 on a 0-5 scale for HIV programming, and 0.6 for TB programming.

### Building an effective supply chain to strengthen essential services in Malawi and Ghana

In **Malawi**, the volumes of supplies required for provision of HIV treatment and care to over 850'000 PLHIV are significant. Malawi overcame this challenge by optimizing procurement planning, shipment scheduling and using the most cost-efficient freight options (i.e., sea freight) to deliver thousands of tons of health products across continents to the country. The in-country supply chain arrangement has been adjudged to be cost efficient and patient-centered. The country consolidated the storage and distribution services and engaged Private Sector Operators to deliver products to over 800 sites on bi-monthly basis at the most efficient rates comparable to private sector.

**Ghana** has undertaken a multi-year supply chain transformation journey touching every aspect of the health product management system, including last mile distribution, warehouse optimization, framework contracting, logistics management information system, and governance. Ghana points to several other critical success factors including highly skilled and competent staff, deep engagement with the strong in-country private sector and partnerships and collaboration among partners with a defined implementation approach that has resulted in a consistent availability of quality health products at all levels in the supply chain.

### Strengthening CLM to identify, address and monitor critical gaps in HIV, TB and malaria programs

Community-led monitoring mechanisms (CLM) have become a critical accountability mechanism in various countries of the sub-Saharan African region. They have contributed to strengthening the accountability of health services by collecting, analyzing and using data from health service delivery sites on quality, availability, accessibility, acceptability, and human rights, to identify critical gaps and improve national responses, providing key evidence for advocacy which led to:

- Quantitative and qualitative data from community-led monitoring mechanisms has led to the elimination of user fees for HIV testing and treatment in **Côte d'Ivoire** ([ITPC, September 2020](#)),
- A reduction of malaria commodity stockouts in 21 primary health centers in **Nigeria** (ACOMIN Nigeria, Feb 2022),
- A drastic reduction in TB medication stock-outs from 95% at the beginning of 2019 to 5% in December 2019 in the **Democratic Republic of the Congo** ([TGF, Feb 2020](#)).



## Examples of enhanced Equity

### A differentiated implementation approach for hard-to-reach and conflict-affected regions in the north and center of Mali

Mali is classified as a Challenging Operating Environment (COE) by the Global Fund and other partners. The Sahel region, including Mali faces a serious humanitarian crisis. Due to armed conflicts, inter-community clashes and food shortages, Mali's humanitarian situation continues to worsen. Most health services in the north and parts of central Mali are only running thanks to humanitarian organizations.

By leveraging the expertise and networks of these humanitarian INGOs, the Global Fund, through the PR, contributed to provide health services, for TB/HIV and RSSH, in areas with access constraints where the PRs do not have the capacity to implement programs. A higher risk trade-off has been agreed, and on-field third level assurance by the LFA and other Global Fund assurance providers is waived due to high insecurity in those regions. Through this differentiated implementation modality, the TB and HIV programs have increased the coverage of prevention and testing services in the poorly accessible and unsafe regions.

### Economic analysis support policy shift in ART provision to immigrants in Botswana

Until recently, non-nationals living with HIV had no access to free ART in Botswana. The human rights baseline assessment, carried out in 2018, identified non-nationals as a vulnerable population who had to pay for ARVs unlike nationals who can get free access to ARVs. This policy resulted in nearly 22,000 PLHIV left without access. Costs of inaction were estimated at 23,000 new infections, additional 116 million USD in HIV and TB treatment, and 30 million USD of economic burden due to productivity loss.

In the development of a plan for a comprehensive response to human rights-related barriers to HIV and TB services, the above analysis was considered alongside equity considerations and the obligations to protect. The plan made clear provisions for removing such equity barriers to enhance access.

The outcome of all these collective efforts resulted in the recent policy shift for Botswana to provide ARV free of charge to non-nationals. [The Breaking Down Barriers \(BDB\) mid-term assessment](#) (2021) attested that the amendment by the Botswana government in 2019 of the "Treat All" policy to extend free antiretroviral therapy to all people living with HIV, including non-citizens, has made an important contribution to leaving no one behind. The assessment commends as a contributing factor the longstanding advocacy of civil society organizations to provide free health services to migrant sex workers.

### Using data to inform investment decisions promoting equity in Zambia, Nigeria and Niger

The use of disaggregated quantitative data or to inform investment and program prioritization as well as program design and implementation is a critical aspect of reaching equity in health outcomes.

**Zambia** used sex and age disaggregated data to hone their Global Fund funding request to focus on specific population groups with investments and program design. This resulted in a more focused funding application including reducing new HIV infections amongst young women aged 20-24, and HIV treatment adherence programs focused on men.

**Nigeria** TB/HIV funding request used data showing a differential in TB smear-positive case notification rates (7.25 for men and 4.63 for women) to focus on improving men's access to TB diagnostic and screening services.

Qualitative data can help countries to understand risk and barriers to services that drive differentials in health outcomes.

**Niger** used a gender analysis to show that economic dependence on male family members curtailed women's ability to attend malaria services, and proposed interventions to address this barrier including radio messaging targeting men's engagement, and an increased number of female CHWs.

## Examples of enhanced Sustainability

### Country efforts to sustain GF investments by investing in integrated service delivery models

**Zimbabwe** has integrated mental health into HIV/TB and COVID-19 interventions to improve adherence to HIV/TB treatments, as well as to expand access to mental health care as a more holistic service for people living with HIV/TB. Specific activities included:

- training and supervision of health professionals on mental health;
- support to screen people who may be experiencing mental health problems; and
- strengthening peer psychosocial support for young people.

**Mali** has strengthened CHW programming in the context of attaining UHC through PHC. The Government of Mali officially recognized CHW as health workers and the first level of the Malian health system, which set a pathway to long-term sustainable financing of CHW. This also contributed to shift away from a piecemeal financing approach toward comprehensive support for strengthening the systems components needed for effective CHW performance.

### Inclusion of HIV treatment in social health insurance in the Dominican Republic

The Dominican Republic is working on the inclusion of HIV treatment in its social health insurance package. As part of this initiative, the Global Fund has coordinated support with key partners to advocate and provide technical assistance and guidance.

Since 2015, the government has approved a national budget to purchase enough ARV drugs for people living with HIV. Aiming to guarantee sustainable financing for ART, the government committed in the 2015–2018 National Strategic Plan to cover ART within its Family Health Insurance (SFS) scheme. This would ensure that regular social insurance contributions by employees, employers and the government can be used to finance affordable treatment for the enrolled population for as long as needed. The inclusion of ART in the SFS represents a positive commitment on the part of the Dominican Republic to ensure the sustained availability of ART, and with it, improve livelihoods of people living with HIV.

### Leveraging blended financing to strengthen primary care in Laos

To leverage additional resources needed to reform its health system and strengthen primary care, the Government of Lao DPR engaged in a US\$36M worth tripartite arrangement with the Global Fund and the World Bank. As part of the project, the Global Fund contributed US\$10M in parallel financing to the Ministry of Health.

The project integrates a broad set of implementation arrangements with a results-based payment component. The joint project also incorporates twelve Disbursement Linked Indicators (DLIs) at provincial and central levels. The project has broader RSSH components such as HMIS and PFM which provides direct benefits to the specific disease programs.

### Enhancing public funding for civil society organizations (CSO) service delivery in upper-middle income countries.

The sustainability of HIV prevention and testing services targeting key and vulnerable populations (KVP) has been a major risk in countries facing transition from Global Fund support.

Countries from Eastern Europe and Central Asia have made progress towards setting-up and development of mechanisms to bring CSO into the provision of health services. **Moldova** is financing several projects implemented by CSOs through a separate stream of funding of the National Insurance Institution. **Serbia** and **Montenegro** are financing CSOs for the delivery of HIV prevention services in combination with Global Fund grants. **Kazakhstan** is hiring outreach workers to support prevention activities, integrated into the national system.

In the Latin America region, **Dominican Republic** initiated domestic funding for key and vulnerable population programs in 2019. Government provided funding to CSOs for prevention and testing of key population groups, including an incentive of US\$ 8-10 for those positives found and registered in the national health system. For 2020-2022 funding cycle, Dominican Republic has agreed to fund between 20-25% of the prevention and testing targets for key populations through contracting of CSOs. The model is now expanding to support to tuberculosis, for the delivery of prevention, treatment and adherence services.

## Annex 5: Additional Information and References

This annex provides key references on VfM framework, guidance to develop national health and disease program strategic plans and the Global Fund funding requests.

VfM frameworks and guides:

- [DFID's Approach to Value for Money](#)
- [Better Value, Better Health Strategy and Implementation Plan for Value for Money in WHO](#)
- [A Practical Guide to Value for Money in the Health Sector in Africa \(ADB/WHO, 2021\)](#)

Guidance to develop NSPs:

- [Strategizing National Health in the 21st Century: A Handbook, WHO, 2016](#)
- [JANS Tool and Guidelines, UHC 2030, 2013](#)
- [Checklist and reference list for developing and reviewing a national strategic plan for HIV, UNAIDS, 2020](#)
- [Guidance for National Strategic Planning for Tuberculosis, WHO, 2022](#)
- [Manual for Developing a National Malaria Strategic Plan, WHO Africa, 2019](#)

Efficiency and sources of inefficiency:

- [WHO, Chapter 4: More Health for the Money, World Health Report 2010, Health Systems Financing the Path to Universal Coverage, 2010](#)
- [Tacking Wasteful Spending on Health, OECD, 2017](#)
- [Improving Technical Efficiency in Health Spending in Africa, CABRI, 2016](#)

Health Technology Assessment, budget impact analysis and incremental cost-effectiveness ratio (ICER) thresholds to inform priority setting and strategic planning:

- [HTA and its application as a tool to inform decision-makers in support of UHC](#)
- [Budget Impact Analysis-Principles of Good Practice](#)
- [What next after GDP-based cost-effectiveness thresholds?](#)
- [Cost-Effectiveness Analysis \(CEA\) Registry](#)
- [Budget Impact Analysis-Principles of Good Practice](#)

HIV and TB costing: data repository, reference case and selection of tools:

- [Global Health Costing Consortium](#)
- [Unit Cost Study Repository \(UCSR\)](#)
- [Reference Case for Estimating the Costs of Global Health Services and Interventions](#)
- [Guidance for Selecting Methods and Tools for HIV Economics Studies](#)