THE GLOBAL FUND

Value for Money

Technical Brief

Grant Cycle 8

Core Guidance

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1. Introduction

The result of the Global Fund Eighth Replenishment, while still partial, reflects the increasingly challenging global health landscape that the partnership must now navigate. The Global Fund uses 'Value for Money' as a framework to structure expenditure decisions to maximize health impact while considering the needs of most affected populations. Value for Money means making choices: about which interventions work for the health challenge being addressed; where they need to be delivered; to which people in need they need to be delivered; and how they are delivered to avoid waste, duplication or overpaying. Value for Money improves the sustainability of health and community systems to ensure access to services.

This technical brief defines Value for Money and describes its framework, referencing and drawing on guidance from Global Fund partners, including the World Health Organization (WHO). It guides grant applicants, Principal Recipients (PRs) and partners who develop funding requests, participate in grant-making and implement grants. The technical brief focuses on how Value for Money can be measured and used to set priorities and manage trade-offs to improve health impact from limited resources. It should be read in conjunction with other Global Fund guidance, especially the Resilient and Sustainable Systems for Health and Pandemic Preparedness and Response Information Note, the Integration Technical Brief, and the Sustainability, Transition and Co-financing Guidance. All these documents include Value for Money as a core principle and advise how to choose between expenditure options in different contexts.

Countries should consider all sources of funds for disease prevention and primary care, in addition to Global Fund grants, and how they should be allocated to improve Value for Money, including via integration with national public budgeting, expenditure and reporting frameworks so all resources are planned together. Clear visibility of the comparative advantage of different funding sources for different inputs (such as staff, drugs, equipment) and activities (such as technical support to develop plans), is needed to ensure that funding is most efficiently organized. It also involves building domestic budgets that facilitate transition from external to domestic financing over time and supporting sustainability planning.

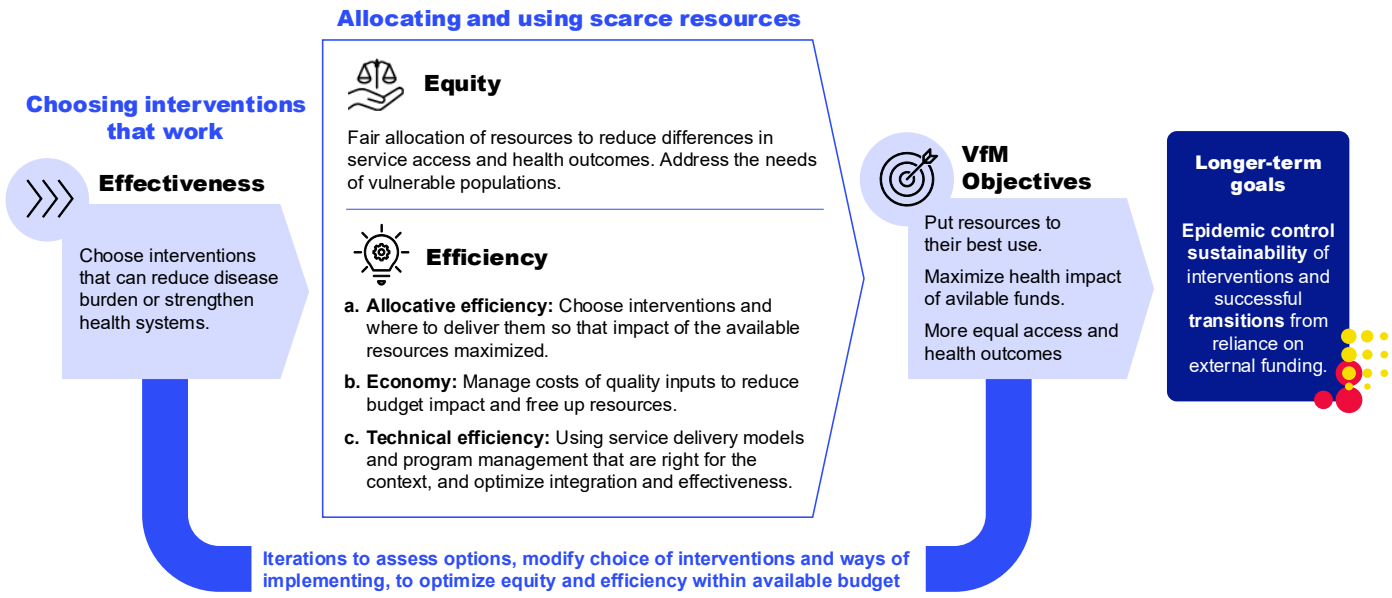
2. The Three Dimensions of Value for Money

The Value for Money framework encompasses three dimensions: effectiveness, efficiency and equity (Figure 1). In Grant Cycle 8 (GC8), the Global Fund's Value for Money framework has been streamlined and includes managing input costs as part of efficiency, and sustainability as one objective for spending limited resources effectively, efficiently and equitably. Sustainability is addressed in the Global Fund Guidance on Sustainability, Transition and Co-financing.

The **effectiveness** of interventions is the fundamental prerequisite for Value for Money. Determining **efficiency** and **equity** also means considering costs and decisions about how to combine interventions, and how and where to deliver them. Most choices in delivering health services affect more than one dimension. It is often not possible to improve all dimensions at

once, so clarifying objectives for each dimension and the trade-offs between them is an important step. The term "intervention" is used frequently: it refers to an organized set of activities and inputs that together deliver a health outcome.

Figure 1: The objectives and three dimensions of the Global Fund's VfM framework



2.1 Effectiveness

Effectiveness refers to how well expenditure[1] achieves the set objectives. Measures of effectiveness depend on the activity or input on which resources are spent. Examples include the number of new cases avoided, the number of new cases diagnosed, treatment impact such as the number of deaths avoided, or the number of people who change their behavior. Effectiveness of interventions and tools is the essential prerequisite for Value for Money. **Ineffective** interventions cannot be VfM; if targeted to the people who need them, **effective** interventions are likely to be VfM in terms of efficiency and equity.

2.2 Efficiency

Efficiency considers how to improve effectiveness for a given level of resources. Efficiency is about choosing between effective interventions and/or better targeting the chosen interventions when resources are limited **(allocative efficiency)**; service delivery models that maximize the effectiveness of limited budgets and avoid duplication and waste **(technical efficiency)**; and managing input costs **(economy)**. A key consideration when assessing efficiency is to review expected changes in effectiveness resulting from efforts to improve economy and technical

[1] "Expenditure" is used consciously because although in a perfect world we would have information to evaluate the effectiveness of a comprehensively-funded service, in many situations we have to just evaluate the effectiveness of one input to that service.

efficiency. If they inadvertently reduce effectiveness, this may mean that Value for Money is not improved, despite reduced costs.

Limited budgets and **opportunity costs** are central concepts for making decisions based on efficiency: when the budget is limited and choosing one intervention means that alternative uses of the resources are no longer possible, their effects are lost, and this loss is an opportunity cost. **Cost-effectiveness (CE)** analysis is a more formal way to compare opportunity costs and make choices that improve efficiency (see Box 1).

A set of interventions is considered **allocatively efficient** if overall effectiveness cannot be increased by reallocating available resources to different interventions or inputs. Allocative efficiency must be considered at the level of an entire disease program or health system, including but not limited to Global Fund resources. Replacing less cost-effective with more cost-effective interventions improves allocative efficiency because doing so either: (a) delivers more effectiveness with the same resources; and/or (b) generates savings with equal effectiveness. This can help to deploy resources in areas where they maximize health impact, and/or generate savings to fund effective interventions. Targeting can improve efficiency, but it can also adversely affect costs or effectiveness (for example, if it requires complex procedures to access a service).

Box 1: Using cost effectiveness analysis to guide efficient resource allocation

Cost effectiveness (CE) analysis measures the cost per unit of additional effectiveness gained from an intervention compared to an alternative. It is the main tool used to improve allocative efficiency in the health sector. CE is expressed as an incremental CE ratio (ICER), calculated by dividing the difference in costs by a quantitative measure of the difference in effectiveness. This means that CE always expresses incremental cost per incremental effect of an intervention compared to something else. This comparator, which must always be stated for the assessment to be meaningful, is usually the best alternative to the intervention being appraised.

A higher ICER implies more cost per unit of effect, i.e. lower CE. A lower ICER implies higher CE. Sometimes, ICERs are also compared to a general CE threshold set in a health system. To compare many different interventions with each other, CE is often expressed as cost per quality-adjusted life year (QALY) gained or disability-adjusted life year (DALY) averted. However, provided that it is able to capture all the effects and opportunity costs across the interventions compared, another measure of health outcome or proxies for it can be used in basic CE analysis.

Further guidance can be obtained from health economists, disease specialists and the references provided in Annex 2.

‘Cost-effective’ does not always mean less expensive. A more expensive intervention can be more cost-effective than an alternative if it is also more effective. But CE must be considered together with budget impact, to test ‘affordability’ within realistic budgets. Cost-effective choices that are ‘unaffordable’ at scale signal a need to try to reduce input costs, mobilize more resources, or reallocate funds from less impactful uses in health and other sectors.

Technical efficiency aims to ensure that chosen cost-effective interventions are delivered as intended, using delivery models that avoid duplication, utilize available budgets as intended, and use program management arrangements appropriate for the context. Integration of HIV, TB and malaria services into community-based and primary care is a priority in GC8, and one of its objectives is to improve technical efficiency.

Economy aims to ensure that chosen cost-effective interventions are delivered at the lowest possible cost by reducing input costs without losing effectiveness or sustainability.

2.3 Equity

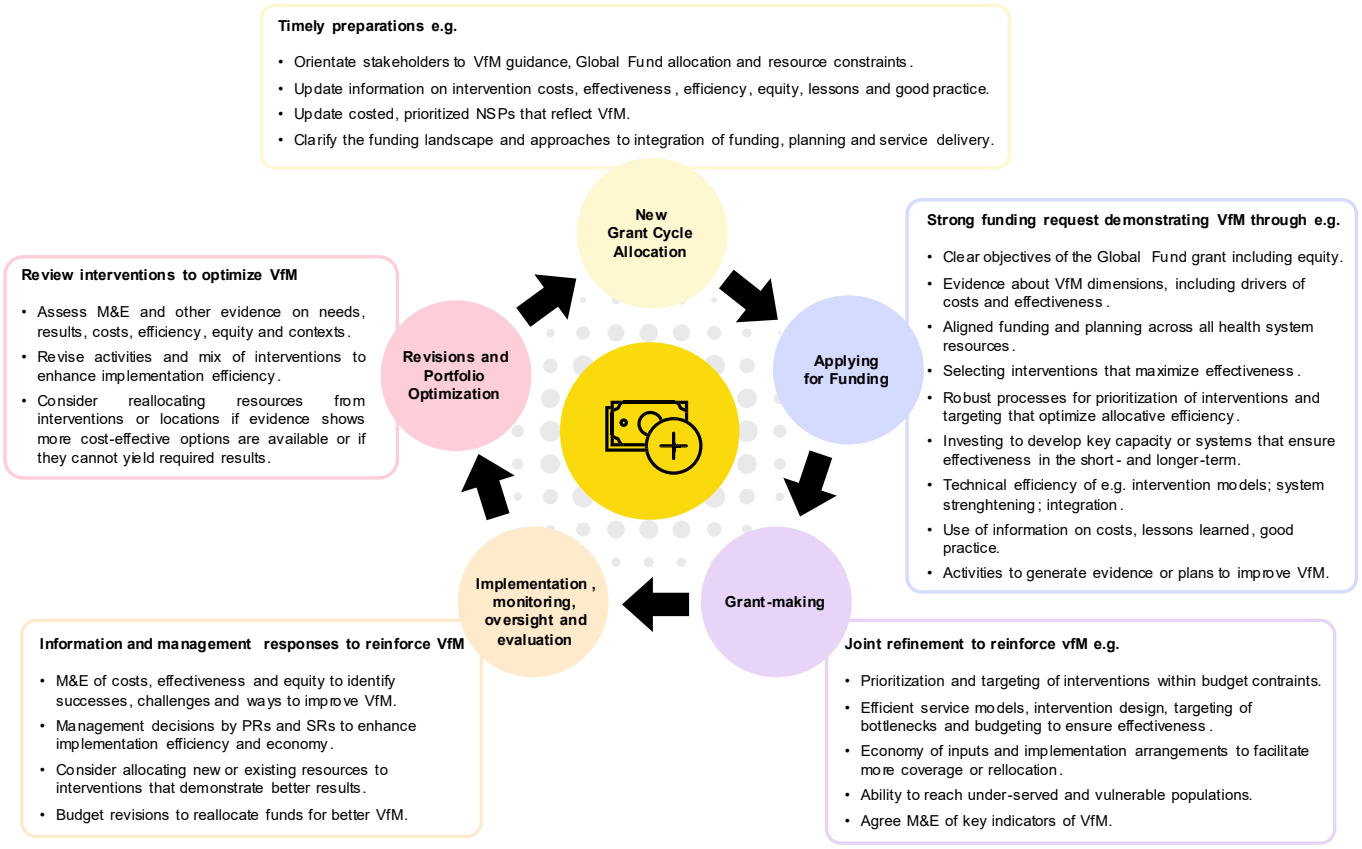
Equity means ensuring that resources are allocated in ways that reduce access barriers to health services, reduce inequality of health outcomes and meet the needs of key, vulnerable and marginalized populations that are at highest risk for HIV, TB or malaria or are underserved. It means **fair** distribution of inputs (and not equal distribution) according to need: different groups may require different levels of expenditure to achieve comparable health outcomes.

Equity and efficiency are often aligned. In many cases, allocating resources to populations at high risk or with high need results in large health gains for the cost incurred, increasing both equity and efficiency. However, there might also be difficult trade-offs between them. A common example is between urban and rural areas. In many countries, urban dwellers are more affluent and healthier than rural populations but also easier and less expensive to reach with health services. If efficiency alone drives decision-making, those poorer rural groups will be at increased risk of being left behind. Resource allocation decisions should ensure those people that are disadvantaged are not being further disadvantaged in the pursuit of efficiency. Inequity may also undermine long-term epidemic control and therefore long-term efficiency. Achieving outcomes for marginalized groups may also mean effective epidemic control in the general population, for example, by addressing treatment coverage for adult men to protect the adolescent girls and young women who are their partners.

3. Value for Money in the Global Fund Grant Life Cycle

Value for Money can be improved across the grant life cycle, as described in figure 2. However, more focus should be placed on preparatory work for funding requests, grant-making Principal Recipient reporting and investment management, and revisions and portfolio optimization. This section highlights the varying relevance of Value for Money dimensions in each of those stages.

Figure 2. Steps to enhance value for money in every stage of the grant life cycle



3.1 Planning for the Funding Request

Applicants should work with relevant stakeholders such as communities, funders including finance ministries, and private sector partners to discuss budget constraints and consider Value for Money throughout planning and development of funding requests. As Value for Money relies on data and evidence, in advance of developing funding requests, applicants should consider which sources of data and evidence will be used to inform resource allocation choices, including lessons learned from previous grants. This is particularly important for countries facing allocation reductions.

Funding requests should demonstrate resource allocation choices that achieve effectiveness, balancing efficiency and equity. They should also be grounded in Value for Money-driven policy and strategy, such as strategic plans with up-to-date costings and prioritization of interventions based on evidence or estimates of costs and effectiveness. Funding requests should show how Value for Money evidence drives resource allocation, demonstrate technical efficiencies from changes such as better targeting or integration, and explain how trade-offs between efficiency and equity have been made through stakeholder input. Integration, including of health financing, drives efficiency and is a priority in GC8 (see section 2.3 of the Integration Technical Brief). Value

for Money analysis and evidence used for funding requests should be introduced to wider budgeting and sustainability planning processes that include domestic finance.

3.2 Grant-making

During grant-making, the Global Fund and countries determine how a grant will be implemented and evaluated to deliver Value for Money. Each Principal Recipient elaborates a detailed budget, disaggregates targets, and confirms implementation arrangements, including the plans for service delivery. The Global Fund supports Principal Recipients throughout this process, to improve efficiency and keep focus on equity, confirm the prioritization of interventions within budget constraints and apply the results of analyses so service models, intervention design and targeting are most efficient. It is also the stage for joint planning, including between grant funds and domestic finance, using domestic budget frameworks, and design of shared investments across disease components to improve system-level integration. Implementation arrangements and detailed budgets defined during grant-making will have significant relevance for economy, ability to achieve impact – including reaching people most affected through community systems – and the longer-term sustainability of Global Fund-supported programs. For guidance on sustainability and integration, refer to the Global Fund Guidance on Sustainability, Transition and Co-financing and the Technical Brief on Integration. Monitoring and evaluation (M&E) plans should include indicators that Principal Recipients can use to track Value for Money, including: disaggregated modular framework indicators that provide insights into effectiveness, efficiency and equity; tailored work plan tracking measures that track progress in implementing Value for Money improvement; and active consideration of cost data alongside programmatic data to understand how well resources are being translated into impact.

3.3 Grant Implementation Monitoring, Evaluation and Oversight

Principal Recipient reporting and active investment management are at the core of ensuring Value for Money during grant implementation. They allow for the assessment of performance and costs, leading to management decisions that can improve economy and technical efficiency during grant execution. In addition, Monitoring and Evaluation that allows Principal Recipients and sub-recipients to track performance at a more granular level than the performance framework (e.g., sub-national analysis, more frequent reporting) can inform management decisions to optimize resource allocation further and improve Value for Money in all dimensions, particularly equity. To do this, Monitoring and Evaluation should use financial and program information together: an intervention that does not deliver expected results may need to be adapted, and budget revisions may enable the reallocation of funds to interventions showing better results and VfM.

3.4 Grant Revisions and Portfolio Optimization

Grant revisions allow for the adjustment of Global Fund investments to changing contexts and requirements during grant implementation. This can include emerging or improved evidence, or analysis of the effectiveness, efficiency or equity of existing investments. For example, if analysis

suggests that allocative efficiency can be enhanced by adjusting the mix of interventions funded by a grant, then this could be a strong basis for portfolio optimization. Examples of grant revision for this purpose include: additional funding revision (allocating extra funds to enhance overall Value for Money, including introducing new, more cost-effective interventions); program revision (changing the implementation approach of interventions funded by the grant or reallocating to more cost-effective interventions); and/or budget revision (to reallocate funds to enhance Value for Money).

4. Improving Value for Money across Three Dimensions

Applicants developing funding requests, with support from partners, make resource allocation choices that determine whether a country and its grants achieve disease control objectives. Improving one Value for Money dimension often enhances Value for Money in another, but there may also be difficult trade-offs between dimensions. Because grants finance broader national health objectives and interact with domestic and external funds, national public financial management systems can provide a strong framework to manage all resources, track expenditure against national objectives and ensure that grants complement other resources to maximize overall program effectiveness and sustainability.

4.1 Effectiveness

Effectiveness is particularly important when creating the funding request and during the revisions and portfolio optimization stages of the grant life cycle, when significant reallocation of resources between interventions may occur.

The Global Fund's Modular Framework Handbook illustrates a comprehensive set of effective intervention packages. Their specific effectiveness depends on the targeted population, epidemiology, costs and how well they are implemented in practice. Beyond interventions that directly improve prevention, diagnosis and treatment, interventions to strengthen health or community systems should be selected where they have demonstrable effect on prevention, diagnosis and treatment outcomes. In selecting interventions from the modular framework, funding requests and grant revisions should refer to costed and prioritized national strategic plans and disease-specific guidance, and show consideration of:

- Evidence of burden of disease; program / cascade gaps and barriers to access, and the distribution of gaps and barriers across geographical areas and population groups; drivers of the epidemic; patterns of transmission and vulnerabilities; and projections of future disease burden.
- Effective interventions that match each context with explanation of the rationale and process followed for prioritization between them (i.e., why selected interventions are better than alternatives), in line with Global Fund and WHO technical guidance and the TRP guidelines.

- Health and community system investments, including training and supervision, with a clear and evidence-based rationale for their effectiveness within the local context and support to the overall public health system.

Selected effectiveness questions are shown in Annex 1, examples include:	
Are proposed interventions shown to reduce HIV, TB and/or malaria?	Are interventions aligned with the latest technical guidance for this context?
Are health and community systems strong?	Has analysis of system bottlenecks been used to prioritize investments in disease programs, health systems and community systems to deliver program targets? Is the analysis reflected in a clear joint plan, with funding gaps identified?

4.2 Efficiency

(a) Allocative Efficiency

Allocative efficiency should be considered in combination with effectiveness. It is particularly important during the funding request and revision and portfolio optimization stages of the grant life cycle.

Funding requests and revisions should refer to national strategic plans and disease-specific guidance, and should:

- Explain which modules and interventions are prioritized above others based on CE, including long-term CE, which may justify tackling areas with higher cost or less impact in the short term, such as system capacity building or treatment resistance.
- Introduce available evidence about cost and cost-effectiveness to rationalize use of health products and technologies based on CE, cost, feasibility and acceptability to target populations in the local context, including where possible understanding cost implications for households.
- Deploy standard tools for modelling to allocate resources across interventions, population groups and geographic areas. These tools can assess CE of different interventions and intervention mixes, including the appropriate balance between investments in prevention and treatment (see Annex 2). The prioritization of geographic areas and target populations requires data about epidemiology, program gaps and access barriers disaggregated to the appropriate level, coupled with reliable cost and budget allocation data, as used, for example, for malaria sub-national tailoring. Where modelling is not possible, countries should link expenditure data to disease burden or outcomes, using tools such as basic expenditure mapping.
- Consider, in the absence of modelling, the use of sub-national data to guide the reallocation of resources to areas with higher burden of disease and/or identified program gaps. Such analysis should be country-led and guided by robust country dialogue processes.

- Carry out budget impact or similar analyses, modelling the overall cost implications of new interventions or changes to the mix of interventions.

It can be difficult to estimate CE in practice because it requires detailed data on the full cost of delivering interventions and their effectiveness in the specific context. However, improving CE can follow some general rules:

- Highly effective interventions tend to be cost-effective, unless they are substantially more expensive than alternatives.
- Cost effectiveness can usually be improved by choosing the least expensive of two similarly effective interventions.[2]
- Targeting interventions to areas, populations or bottlenecks in the treatment cascade where impact is higher than average (e.g., reaching populations with high risk but low screening coverage) tends to boost effectiveness more than costs.
- Reducing the cost of an intervention tends to improve its CE.

Allocative efficiency questions are shown in Annex 1, with examples below	
Are programs selecting interventions that maximize impact of available resources?	• Are resources (from the Global Fund and other sources) being allocated to activities and targeted based on evidence and analysis of their cost-effectiveness? • Does targeting prioritize subpopulations, locations and bottlenecks in the treatment cascade that will most improve yields and outcomes? • Are planning and budgeting for HIV, TB, malaria and RSSH integrated across funding sources to reflect their comparative advantages, e.g., lower input costs, sustainability?

When many alternative interventions exist for disease prevention and treatment and/or there are significant variations in effectiveness and cost, modelling might be required. Annex 2 summarizes tools for analysis of allocative efficiency and provides guidance about funding technical assistance.

Examples:

Since 2019, the Guatemalan government has taken over nearly all procurement of antiretrovirals (ARV), transitioned to tenofovir, lamivudine and dolutegravir (TLD) and reduced the number of ARV regimens from 1,289 in 2019 to 45. This has generated estimated savings of US$8.4 million per year, without reducing the number of people living with HIV who are on treatment.

[2] It is also important to consider resilience of service delivery, for example, relying on one manufacturer may risk interruptions in future.

Optimization of ARV expenditure has allowed domestic resources to be reallocated to tests and reagents, bringing domestic financing to 93% of total HIV expenditure by 2022.

In Malaysia, the Ministry of Health used the Optima HIV Model in 2023 to project the effect of four alternative HIV service delivery scenarios. The model showed that rapid pre-exposure prophylaxis (PrEP) combined with first-line TLD-based treatment would be most effective and was the only scenario that could reach the 2030 target of 90% incidence reduction. It also showed that reallocating resources from lower-risk and prevention-saturated areas to PrEP and outreach for populations at highest risk (men who have sex with men, and trans and gender-diverse people) could reduce infections with the same or lower total spending, and that combining government funding for PrEP with a user co-payment was the most cost-effective PrEP financing model.

In the Democratic Republic of the Congo, the Program Quality and Efficiency approach integrated presumptive TB screening into outpatient departments of high-volume health facilities. TB notifications rose by 58%, and between 2023 and 2024, over 2 million people were screened, confirming 63,000 cases, 94% of whom started treatment. With only 37 screenings per case detected — compared to an estimated 154 per case for routine approaches — the number and costs of negative tests performed per case detected dramatically reduced. The estimated total cost per TB case identified using the new approach (US$860) was over 70% lower than routine approaches (US$3,380). The intervention demonstrated strong CE and improved notification rates, especially in underserved provinces. Integration into routine services reduced duplication and enabled sustained impact.

(b) Economy

Economy needs to be considered in all stages of the Global Fund grant life cycle. It is particularly relevant during funding request development, when considering the unit costs and overall budget impact of interventions and determining implementation models; grant-making, when agreeing on the budget; and throughout grant implementation, when monitoring actual costs of interventions and identifying potential savings.

The following are important when considering economy:

- The Global Fund Guidelines for Grant Budgeting. Inputs should be budgeted at the lowest sustainable costs, i.e., costs that can realistically be sustained through the grant life cycle and for longer-term viability.
- Which systems will be used to procure effective products and services transparently and at competitive prices, whether funded by Global Fund or other sources. The Global Fund does not finance health products at a higher price than reference prices, which are based on globally negotiated prices, e.g., through the Global Fund Pooled Procurement Mechanism (PPM/wambo.org).[3] For health products supported by the Global Fund but not procured through PPM/Wambo.org, applicants must benchmark against international and regional

[3] The pooled procurement mechanism is recommended for the procurement of health and non-health products using domestic funding and funding from other donors.

prices. Applicants can refer to the Global Fund Guidance on Procurement and Supply Chain and standards that regulate procurement and management of health products in the Guidelines for Health Product Procurement and Supply Management, the Health Product Management section of the RSSH and PPR Information Note and the Health Product Management Annex to the Sustainability, Transition and Co-Financing Guidance Note.

- How grant-funded interventions will be regularly reviewed to identify cost drivers and steps taken to reduce costs. Examples include optimizing implementation arrangements, ensuring accountability in service provider contracts, consolidating the number of Sub-recipients, analyzing shared costs where implementers are funded by various donors or ensuring that the indirect and overhead charges of a provider are reasonable.

In many countries, a large proportion of Global Fund grant budgets and government co-financing commitments are for the purchase of health products. Rationalizing their use and reducing unit costs are strong levers to improve economy and to enhance allocative efficiency and equity.

Economy questions are shown in Annex 1, with examples below	
Are programs paying the right price for the right inputs?	• Have the main cost drivers in programs and health systems been identified? • Are remuneration and recruitment for human resources for health appropriately aligned to national rates and guidelines to achieve sustainability?
Have program management costs been optimized?	Has the program management budget been reviewed and rationalized against appropriate benchmarks and understanding of shared costs?
Are procurement, supply and financial management systems robust?	• Are procurement plans linked with program targets and good quantification? • Have steps been taken to ensure low prices for products of the required quality, e.g., procurement reforms, market intelligence, procurement planning systems?

Examples:

In Ecuador, moving to pooled ARV procurement through the PAHO Strategic Fund combined with regimen optimization, saved US$85 million over 10 years, representing a 65% cost reduction that freed up resources to increase ARV coverage.

A Zimbabwe costing study[4] that yielded more accurate costs of TB diagnosis and treatment reduced the estimate of the TB national strategic plan funding gap from US$62 million to US$23

[4] Chirenda, J., Nhlema Simwaka, B., Sandy, C. et al. A feasibility study using time-driven activity-based costing as a management tool for provider cost estimation: lessons from the national TB control program in Zimbabwe in 2018. BMC Health Serv Res 21, 242 (2021).

million and informed better prioritization. Community-based TB screening was found to be efficient due to lower long-term costs per case identified despite higher start-up costs.

Box 2: Interpreting and using unit cost data to improve efficiency

A unit cost is the cost of providing a single unit of input (e.g., drugs, test kits), output (e.g., person tested for HIV, person-year of HIV treatment, clinic visit) or outcome (e.g., new case diagnosed, person virally suppressed). The unit cost of interventions is important information for efficient health sector planning and management. Firstly, unit costs are key for developing costed, prioritized national strategic plans or investment cases. Secondly, unit costs are part of any assessment of VfM in terms of efficiency. Programs should cost key interventions to understand how costs and cost drivers vary by service delivery modality, geography and implementer. This informs decisions to allocate resources to more efficient interventions or underserved areas, or targeted interventions to manage specific costs.

Programs and services seldom have perfect evidence to guide decisions about efficient resource allocation and implementation. However, planners can use unit cost data from their own and other contexts to identify ways to increase efficiency during program design or implementation. Fairly crude unit cost estimates can identify priorities for VfM. If needed, further monitoring or analyses can be done to understand how different strategies affect both costs and results of services.

High unit costs relative to other interventions, service models or contexts signal that efficiencies may be possible. Sub-unit costs (e.g., for drugs, test kits or human resources) help to identify where the main cost drivers of an intervention lie, to focus cost reduction efforts. Studies of different sites, contexts or service models can suggest modifications to reduce costs. For example, unit costs tend to be lower in locations serving higher patient volumes (economies of scale) or screening groups with higher prevalence (leading to lower costs per positive diagnosis).

Some caution is required in using unit cost estimates. Firstly, unit costs of inputs or services give limited information on outcomes. Cutting costs may reduce desired health outcomes. Secondly, the service or intervention model used to estimate unit costs must be comparable to those in the context under assessment. And all relevant direct and indirect costs must have been included in the unit costs, including costs to clients or those met by other programs. In addition, adjustments for inflation, exchange rates, market prices and different staff costs may be needed. These factors often make it particularly challenging to compare unit costs between countries.

Sensitivity analysis can help to assess whether conclusions are robust despite uncertainty about key data. A large difference in CE with adequate comparability and limited sensitivity can be sufficient to inform some important decisions. However, accuracy of unit costs may be particularly important for some purposes, e.g., including HIV, TB and malaria services into benefits packages for social health insurance models. Annex 2 describes tools, guidelines,

data repositories and reference cases to develop unit costs and cost databases to support better planning, including national strategic plans.

(c) Technical Efficiency

Technical efficiency needs to be considered in all phases of the grant life cycle. It is relevant when developing the funding request and determining implementation approaches, during grant-making, when agreeing on detailed grant budgets, throughout grant implementation and monitoring, and when identifying potential for further integration.

The RSSH and PPR Information Note and the Integration Technical Brief guide the design and delivery of RSSH investments for maximum efficiency. Principal Recipients and Country Coordinating Mechanisms should pay particular attention to integrated delivery of HIV, TB and malaria services within community-based and primary health care systems. Integration includes moving to common financing, delivery, program management and data systems across programs and integrating financing and delivery of interventions into national systems wherever possible. Blended finance and pooling of funds to support integrated packages and alignment with national budgeting and planning processes improve transparency and allow better planning for technical efficiency. HIV services can be integrated into decentralized community services in many contexts. The location of diagnostic equipment funded by grants must be based on national health infrastructure strategies alongside synchronized investments in referral systems. Implementation arrangements should be defined with reference to comprehensive national health, primary care, community health and health financing strategies, where these exist. This helps avoid program management costs that are higher than necessary as this undermines sustainability. More guidance is in the Integration Technical Brief.

Example: In Burkina Faso, resources from the Global Fund, other donors and the government to pay for community health workers are pooled by the public treasury and paid through a single, mobile phone-based payment system.

The following should also be considered in improving technical efficiency:

- How program management arrangements will help to deliver interventions as planned, achieve program targets and control costs. The Country Coordinating Mechanism should scrutinize implementation arrangements and program management costs to ensure their appropriateness for delivering quality services. This can include payment for results, where appropriate.[5]
- How RSSH funding will strengthen coordination among stakeholders and components of the health system to make progress towards universal health coverage.[6] Consider **which** investments are made **where** to maximize impact of national strategies.

[5] Refer to the payment for results section in the Grant Budgeting Guidelines for more information.
[6] This may include dialogue with national and sub-national government health authorities, development finance partners, technical agencies, civil society and affected populations.

- How Global Fund grants support remuneration of human resources for health (HRH), taking a holistic view, including salaries, allowances and performance incentives. These arrangements should be informed by assessments, such as health labor market analysis, and should be aligned to national pay scales to allow for effective transition from Global Fund support and integration into national financing schemes. Refer to the RSSH and PPR Information Note and the Integration Technical Brief for more information.
- On-the-job training, complemented by follow-up, mentoring and supportive supervision. Digital solutions are efficient when integrated within blended learning.[7] Integration of training support should be prioritized and payment for results can be considered.[8]
- How financial management systems will be used and gaps addressed. Strong financial systems ensure timely and accurate financial reporting, address absorption bottlenecks, enhance the flow and control of funds and mitigate fiduciary risk. The use of national public financial management systems, including key budget cycle pillars of budget formulation, execution and oversight, is essential to achieve sustainability, effective transition and long-term impact of investments in HIV, TB and malaria programs. Public financial management systems can be funded through grants or co-financing commitments.
- The quantities, prices and mix of human resources (e.g., using task-shifting or task sharing to save resources and potentially improve effectiveness by delivering interventions closer to target populations, including through community health workers).

Technical efficiency questions are shown in Annex 1, with examples below	
Are programs implementing interventions with as little wastage of resources and duplication as possible?	• Is differentiated service delivery used to improve access to services e.g., by leveraging community health workers / task sharing? • Are planning, budgeting and M&E integrated across funding sources to reduce duplication? • Has integration of disease and primary health care services, programs and health systems been used to enhance efficiency? Is this informed by sound analysis and M&E? • Does budgeting use lessons from previous implementation and from identified inefficiencies? Are processes in place to identify and respond to resource wastage or underutilization? • Have travel-related costs been rationalized to limit costs but maintain effectiveness of key functions in the context?

Example: Following a comprehensive Health Labor Market Assessment, the Government of Zimbabwe identified causes of health worker attrition limiting the sustainability of HRH investments. In response, the government launched the National Health Workforce Strategy to

[7] UNAIDS and WHO, Policy Brief, Virtual interventions in response to HIV, sexually transmitted infections and viral hepatitis, 2022.
[8] Refer to the payment for results section in the Grant Budgeting Guidelines for more information.

expand training, create jobs and improve retention. It also committed to a Health Workforce Investment Compact, along with all development partners, to establish a joint framework to co-invest in the priorities of the National Human Resources for Health Strategic Plan, align pay scales and scale up the domestic contribution to total HRH remuneration.

4.3 Equity

Equity is a core dimension of the VfM framework and must be considered throughout the grant life cycle in combination with efficiency, ensuring that investments explicitly aim to close health access and outcome gaps for those at highest risk of HIV, TB and malaria, including the poorest and most vulnerable populations, with marginalized groups defined as per the context. It is particularly important when making major resource allocation choices, including when developing the funding request and in the revisions and portfolio optimization stages of the Global Fund grant life cycle. Equity must also guide grant implementation, with disaggregated monitoring of intervention delivery and outcomes in target population groups to ensure that equity is not jeopardized by technical inefficiencies or the pursuit of economy. Where such trade-offs exist, they require particular attention.

Equity within Value for Money means systematically understanding and responding to where and why inequities in health access and outcomes exist. This requires using disaggregated data, community insights, and program evidence to identify populations facing the greatest gaps and the reasons behind them, whether geographic, socio-economic, demographic including sex and gender or linked to stigma and discrimination on the basis of these characteristics. By embedding this analysis into funding requests and program design, countries can ensure that investments explicitly target underserved groups and that resource allocation considers equity and efficiency.

The following should be considered:[9]

- **Defining equity-efficiency trade-offs:** Where particular groups are harder or costlier to reach, clearly articulate what equity and efficiency mean in the local context, describe potential trade-offs (e.g., reaching more people vs reaching the most vulnerable people), and explain how an acceptable balance has been achieved. Qualitative analysis of pros and cons for equity and efficiency of different scenarios should be described.[10]
- **Assessing evidence of system-level and structural barriers to accessing services**, such as those caused by poverty, gender inequality, disability status, stigma, discrimination or legal barriers, especially for groups at high risk of HIV, TB or malaria, and assessing the root causes of those barriers.

[9] Annex 1 provides additional guiding questions for considering equity.
[10] Applicants are encouraged to apply the WHO Innov8 approach for reviewing national health programs to leave no-one behind.

- **Prioritization of equity-oriented interventions:** Selection of interventions targeting populations at high risk or facing worse health access and outcomes, or demonstrated as effective to tackle structural barriers, including through strengthening community systems.
- How service delivery, including enabling interventions indirectly related to health, will **close gaps between the general population and key and vulnerable populations**. The involvement of civil society and community-based organizations is critical, as they are best placed to reach key and vulnerable populations, especially those that are hard to reach.
- How **health information systems** are used and will be improved to collect and use disaggregated data to understand inequities and respond appropriately (for example, by age, sex and gender, geography and socioeconomic status). This includes involvement of community-based organizations in M&E.
- Where Global Fund grants can supplement **national health insurance schemes** to improve access of key and vulnerable populations to HIV, TB and malaria services and other prevention and primary care.
- Identify ways in which costs, effectiveness or efficiencies can be managed to improve CE or budget space for equity-enhancing interventions.

Equity questions are shown in Annex 1, with examples below	
Do objectives, plans, budgets, implementation and monitoring clearly reflect needs and barriers, and improve equity?	• Is resource allocation for most-at-risk populations based on analysis of inequities in risk, access, outcomes and the costs of serving them? • Are program performance, resource allocation and outcomes clearly disaggregated by age, sex/gender, geography, socioeconomic status and key and vulnerable population status to assess inequity? • Are HRH-CHW deployed in areas of greatest need and enabled to provide equitable, inclusive care? Are women and community members equitably represented in the workforce and remunerated, protected and safeguarded?

Example: In Côte d'Ivoire, Nigeria and Zambia, for example, the Global Fund finances national health insurance premiums for key and vulnerable populations, including people living with HIV and/or with drug-resistant TB. This improves access to primary care for these populations, in addition to strengthening national financing schemes to fund essential health services and support long-term sustainability of priority interventions.

Annex 1: Guiding Questions to assess VfM in grant design and implementation

Effectiveness

Interventions known to reduce HIV, TB and malaria

1. Are interventions aligned with latest guidance from technical partners and Global Fund Information Notes and Program Essentials?
2. Are processes in place to ensure effectiveness and quality of services in practice (e.g. supportive supervision, spot checks etc?)

Interventions known to address structural barriers to accessing services

3. Have barriers to service access, and their root causes, been identified? Will they be monitored effectively? Are interventions to remove structural barriers integrated into disease programs? Are they based on a theory of change, evidence-based approaches and in line with Global Fund technical briefs on a comprehensive, integrated human rights approach?

Strong health and community systems

4. Has analysis of shared health and community system bottlenecks across disease programs been used to prioritize investments in these systems to deliver on HIV, TB and malaria? Have all relevant systems been considered (e.g. HRH, HIS, supply chain, laboratory systems, community systems, governance)?
5. Is the analysis reflected in a clear joint plan or strategy, with funding gaps outlined in the RSSH gaps and priorities annex?
6. Are services supported by strong community systems, disease programs, and primary health care systems?
7. Do proposed RSSH interventions explain how they will strengthen health system performance, and build on lessons of what interventions really work?
8. Are investments in health workers, capacity building and performance improvement based on evidence of what works? Is impact on performance monitored? Are conditions of employment and deployment adequate to ensure effectiveness in the context?

Efficiency

Allocative efficiency - Selecting the right interventions that can maximize impact of available resources

9. Is planning and budgeting for HIV, TB and malaria service delivery and RSSH integrated across all Global Fund, partner and domestic sources of funding? Are interventions matched to funders' comparative advantages? For example, some may have ability to reduce input costs, or link funding to strategic co-financing commitments. External funding may be better for introducing a new intervention, but government funding may be better for sustainable support of primary health care health workers.
10. Are available resources from the Global Fund and other sources allocated to activities and targeted based on evidence and analysis of which interventions are cost effective for:
    a. overall program allocations;
    b. specific interventions; and
    c. targeting sub-populations, locations and bottlenecks in service cascades which can result in greatest improvements in yield and outcomes?

    Examples include impact modelling coupled with costing, or analysis to optimize location of services and equipment, and transport systems.
11. Are proposed interventions and inputs tailored to epidemiological, social and economic characteristics of groups that need them? For example, subnational tailoring of malaria programs or an optimal mix for vector control; targeting interventions to populations where yield in new TB diagnosis will be higher.
12. Has CE evidence been used to decide whether to adopt / scale up new services or technologies? Are the interventions routinely reviewed using current management, epidemiological and service information, to optimize CE in practice?
13. Is enough priority given to investments required for downstream outcomes, such as systems and capacity development?

Technical efficiency – Implementing interventions in a way that achieves maximum impact with allocated resources.

14. Are service delivery approaches and models selected to deliver the greatest quantity of quality services (e.g. by leveraging CHWs or pharmacies)?
15. Are case-finding approaches designed to maximize yield with available budgets, and to prioritize under-served people appropriately?
16. Are innovative low-cost health technologies and differentiated approaches (e.g. task-shifting/sharing, new regimens or guidelines, digital solutions, shifts from inpatient to ambulatory care) leveraged to improve service access or adherence, or lower costs while achieving outcomes?
17. Are disease services appropriately integrated with each other (e.g., combined HIV and TB testing) and primary health care to achieve efficiencies and a more patient-centered approach? Are community services integrated with health services to reach more people in need?
18. Are system investments (e.g., information systems, human resources, laboratory systems, and supply chains) integrated to avoid duplicative inefficiency? Are they informed by analysis and prioritization of important health system bottlenecks to service delivery?

19. Has budgeting drawn on lessons from implementation, including analyses of inefficiencies? Are fund flows designed to be predictable, so services can be delivered as designed?
20. Have service costing and expenditure reviews been carried out to quantify and select inputs to service delivery? Has variation of service unit costs been analyzed by factors such as implementer, scale or location to identify potential efficiency gains, and acted on?
21. Have processes been established to identify wastage and underutilization of resources and take action?
22. Is planning, budgeting and M&E for HIV, TB and malaria and RSSH integrated across all partner and domestic sources of funding, to increase synergy and reduce duplication at all levels? Are functions allocated to implementers according to their comparative advantages in reducing costs and sustaining effectiveness?
23. Are co-financing commitments used to support government to ensure its priority functions and system reforms are funded and implemented efficiently?
24. Are HRH, including CHW, being deployed and developed efficiently for short- and longer-term objectives? Have analyses identified the best number and mix of HRH to meet service needs within budget? Do HRH allocations prioritize the primary health care workforce to provide integrated services that improve access? Is the distribution of HRH-CHW optimized to address workloads, and reach priority populations? Is HRH-CHW capacity building and performance improvement being implemented in efficient ways? Is there evidence that an efficient mix of capacity building interventions is used (e.g. in-service, pre-service, clinical mentoring, continuous quality improvement, virtual/hybrid)? Have opportunities been taken to integrate training and supervision across interventions and diseases, and when targeting priority sites, areas and issues? Will supervision prioritize integrated technical content? Has efficient return for the required training and supervision inputs, and participant time been considered?
25. Have travel-related costs been rationalized to limit costs while maintaining effectiveness of key functions in the national context?

Economy – Right price for the right input

26. Have the main cost drivers in the programs and health systems been identified?
27. Have steps been taken to obtain quality health products and other inputs at the lowest prices? These may include procurement reforms, pooled procurement, and use of domestic resources. Is a system in place to monitor product procurement prices alongside a strategy to achieve the lowest sustainable costs? Are tools (e.g. reference pricing, standardized specifications, market intelligence) and Global Fund support being used to ensure low prices, manage procurement lead times, and others etc?
28. Are HR salary scales, benefits and per diems appropriately aligned to national rates and guidelines to achieve economy and sustainability? Is recruitment transparent, competitive and robust?

Economy - Optimal program management costs

29. Has the program management budget been reviewed and rationalized, and compared with previous allocation periods? Is there appropriate balance between program management and grant implementation, consistency with budgeting guidelines, and use of assets from previous grants?
30. Is the Principal Recipient using service provider contracts that help to control program management costs and simplify reporting? Have shared costs been analyzed where implementers have more than one donor to ensure economical and equitable distribution of costs?

Robust procurement, supply and financial management systems

31. Are procurement plans consistent with program targets and robust quantification? Are health products procured, distributed and managed efficiently to reduce stock-outs and wastage, in collaboration with government and partners? Are supply chain costs and wastage managed at all stages from delivery from suppliers to sub-national distribution (e.g. through outsourcing, information systems, inventory management processes, route optimization and fleet management)?
32. Are public financial management (PFM) systems weaknesses reviewed and addressed to minimize fiduciary risk and improve monitoring of Global Fund investments? Are public financial management system initiatives adequate to ensure performance of government functions or services on which Global Fund interventions depend to have impact?

Equity

33. Are resources allocated to serve most-at-risk populations proportionate to their needs, based on analysis of differences in risk, access, uptake, retention and outcomes, and the specific costs of serving them, including support to tackle structural barriers and community-led responses?
34. Are program performance, resource allocation and health outcomes disaggregated by age, sex, geography, socioeconomic and key and vulnerable population status to give a clear picture of accessibility? Is this clear in the funding request? Does the funding request identify reasons for inequities (e.g. financial, human rights and gender-related barriers), and include programs to address barriers? Are communities involved in monitoring performance, funding and outcomes?
35. Is equity adequately considered in any assessments of efficiency?
36. Are best practice, evidence-driven interventions to address barriers designed, resourced and implemented at scale, with involvement of communities? Are targets set to achieve high service coverage among key, vulnerable and marginalized populations?

37. Are HRH-CHW deployed in areas of greatest need? Have service providers' capabilities to provide equitable, inclusive care been addressed? Are women equally represented and remunerated in the workforce? Are women and other vulnerable populations in HRH-CHW adequately protected and safeguarded?

Annex 1: Analysis and planning tools, guides and evidence resources[11]

Value for Money is delivered through effective systems for performance monitoring, financial management, procurement, health worker support, project management and more, which are all subjects of other Global Fund guidance. The tables below focus on tools and resources for choosing which interventions to deliver where, with limited resources, and how to organize service delivery. Some of those resources are provided by the developers as a public good and are available for download and use, with instructions for use. Where this is not the case, a link is provided to a resource that describes the tool.

Focus	Tool / Methods	Description	Tool / Method / developer[12]
HIV	AIDS Impact Model	Projects HIV burden (people living with HIV; HIV infections, AIDS cases and deaths) and optimal intervention and coverage mix to maximize impact under a given resource envelope.	Avenir Health / Spectrum
	AIDS Epidemic Model (AEM)	Projects current and future HIV infections and antiretroviral therapy needs in a given period. An Intervention Workbook assesses program impacts and costs; an Impact Analysis Workbook compares scenarios. The Model is primarily used for concentrated HIV epidemics in Asian countries and can inform optimal intervention mix for a given resource envelope.	East-West Center
	Optima HIV	Optima HIV can improve efficiency by identifying how funding can be optimally allocated across interventions to maximize impact, at national or sub-national level. User-defined key populations and targeted interventions can be included, and health or epidemic outcomes estimated under actual or optimal spending scenarios.	Optima Consortium for Decision Science

[11] Methods, approaches and tools covering other dimensions of VfM can be found in the HIV, TB, Malaria and RSSH-PPR Information Notes and various Technical Briefs referred in this document.
[12] Co-developers or collaborators of some of the tools can be found on the website of the tools.

Focus	Tool / Methods	Description	Tool / Method / developer[12]
TB	Australian TB Modelling Network (AuTnMN)	Assists national TB programs to identify cost-effective TB control interventions that will maximize impact against TB.	Australian TB Modelling Network
	Imperial TB Model	The Model links the TB care cascade to transmission to identify which improvements in the cascade can yield greatest impact. With country-specific cost data, the model can also inform what intervention scenarios are most cost-effective, to guide strategic planning.	Imperial College London
	Optima TB	Identifies 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 Impact and Modelling Estimates (TIME)	Estimates TB burden among a population targeted for a specific TB intervention or intervention mix, and projects service volumes needed for an impactful response to TB.	KNCV
Malaria	Elimination Scenario Planning	Assesses technical, financial and programmatic feasibility of achieving malaria elimination based on existing program coverage, interventions selected and resource availability.	Imperial College London and WHO
	Epidemiological MODeling (EMOD) malaria modelling	Simulates changes in malaria transmission dynamics based on chosen malaria control interventions.	Institute of Disease Modelling
	OpenMalaria	Simulates changes in malaria transmission dynamics based on chosen malaria control interventions.	Swiss TPH
	Optima Malaria	Identifies how funding can be optimally allocated across malaria interventions to maximize impact at national and sub-national level. 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
	Spectrum Malaria	Projects malaria intervention coverage and expected impact on malaria prevalence, cases and mortality. Projections consider available resources and relative costs and CE of changing strategic plans. Specific to sub-Saharan Africa.	Avenir Health
Health Systems	Health Intervention Prioritization Tool (HIPtool)	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

Focus	Tool / Methods	Description	Tool / Method / developer[12]
	WHO-Choosing Interventions That Are Cost Effective	Designed to facilitate country level CE analysis of a wide range of health interventions across disease programs to inform priority setting for health development overall.	World Health Organization
	Cross-program Efficiency Analysis	A diagnostic approach to enable countries to look across health programs that are part of their health system to detect "cross-program" 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
	Financial Evaluation of Investments in Public Health Supply Chains	A free online course providing a framework and method for financial evaluation of investment options in supply chains against alternative courses of action, to guide decisions about CE of investments and efficient use of scarce resources.	Jointly by the Global Fund and Empower School of Health
	Health Technology Assessment Toolkit	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 health benefit packages.	International Decision Support Initiative (iDSI)
	Fair Choices Tool	A tool to support health sector priority-setting in low- and middle-income countries. Users build national health benefit packages from 100 interventions from 82 countries and can forecast and optimize their impact on outcomes such as life expectancy, financial risk protection, and equity.	University of Bergen (UiB) in association with DCP4.
Equity tools			
Health systems	Health Equity Assessment Toolkit	Software application to explore, analyze and report on health inequalities, using disaggregated data and summary measures of health inequality. Results can be visualized in graphs, maps and tables and can be exported and saved in different formats.	WHO
Budget impact analysis tools			
Health systems	Budget impact template	Assesses expected changes in health expenditure upon implementation of new interventions. Budget impact analysis evaluates the affordability of sustaining new	National Institute for Health and Care Excellence

Focus	Tool / Methods	Description	Tool / Method / developer[12]
		interventions. Countries can adapt the template to their own context, to obtain insights on whether or not to adopt a new technology or intervention mix[13].	
Extended CE analysis			
Health systems	Socio-Technical Allocation of Resources	Facilitates policy dialogue among decision makers to identify and prioritize health interventions using CE and other factors such as equity and feasibility.	London School of Economics
	Extended Cost-Effectiveness Analysis Resource Pack	Curated by the Center for Health Decision Science to provide broad exposure to ECEA, which introduces equity considerations alongside VfM considerations, including rationale, methods and applications.	Harvard Center for Health Decision Science
	Distributional Cost-Effectiveness Analysis Resource Pack	Wide range of explanatory resources and practical tools for use in understanding and applying DCEA, which introduces equity considerations alongside VfM considerations.	York University Centre for Health Economics
Costing			
HIV and other diseases	Activity-based Costing and Management	Generates patient-level cost data to promote efficiencies in care delivery, optimization of care over the patient's treatment cycle, and inform 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	Value TB Costing Tool	Supports estimation of unit costs of providing multiple TB interventions from the healthcare providers' perspective, to inform efficient and fair prioritization and planning of TB services.	World Health Organization
Resources needs estimates / budgeting			
Health systems	IHT / OneHealth Tool	Supports costing and budgeting for program target setting across different disease programs. A key focus is on integrated health planning and strengthening of health systems.	WHO / Interagency Working Group on Costing / Avenir Health
Geospatial analysis			

[13] See also: Sullivan SD et al. Budget Impact Analysis-Principles of Good Practice.

Focus	Tool / Methods	Description	Tool / Method / developer[12]
Health systems	AccessMod (Version 5)	Leverages geographic information systems to display geographic coverage and population access to health facility and service networks. It can be used to scale up coverage by identifying new health facility sites and optimal deployment of CHWs or health technologies that maximize access, reduce access times, or improve efficiency.	WHO, UNICEF, University of Geneva, Health GeoLab
	Reveal	Open-source geospatial intelligence tool to plan and manage efficient and equitable public health campaigns and precisely flag coverage gaps to inform real-time responses and program adjustments.	Akros
	OptiDx	Open-access Diagnostic Network Optimization tool for maximizing diagnostic capacity from limited resources. The tool can be used to strategically link the optimization to national health priorities across multiple disease programs.	FIND, USAID-PSM, Coupa Software
TB	MATCH approach	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

Other guidance	Description	Developer / author
VfM frameworks and guides	A Practical Guide to VfM in the Health Sector in Africa	ADB / WHO
	iDSI Reference Case for Economic Evaluation	iDSI
	Sustaining priority HIV, viral hepatitis and STI services in a changing funding landscape: operational guidance from the WHO	WHO
Guidance for developing NSPs and national health strategic plans	Checklist and reference list for developing and reviewing a national strategic plan for HIV	UNAIDS
	Guidance for National Strategic Planning for TB	WHO
	Manual for Developing National Malaria Strategic Plans	WHO AFRO
	JANS Tool and Guidelines	UHC 2030
Health technology assessment, budget impact analysis and incremental CE ratios for priority-setting	ICER meta-regression for HIV, TB and Malaria interventions	IHME
	Health Technology Assessment resources	WHO
	Budget Impact Analysis-Principles of Good Practice	Sullivan et al 2014
	Cost-Effectiveness Analysis (CEA) Registry	Tufts

Other guidance	Description	Developer / author
Efficiency and inefficiency	Cross-program efficiency analysis for health systems	WHO
	Tackling Wasteful Spending on Health	OECD
	Improving Technical Efficiency in Health Spending in Africa	CABRI
Equity	Health inequality monitoring: harnessing data to advance health equity	WHO
	Roll Back Malaria Matchbox Toolkit: identifying barriers impeding equity and integrated people-centered care in malaria programs, and how to address them	RBM
	Framework and Toolkit for understanding and addressing HIV-related inequalities: identifying inequalities having a substantial impact on the HIV epidemic in a particular context, and priority actions to tackle them	UNAIDS
HIV and TB costing data repositories, reference cases and guidance on tools	Unit cost study repository	GHCC
	Reference Case for Estimating the Costs of Global Health Services and Interventions	LSHTM
	Guidance for Selecting Methods and Tools for HIV Economics Studies	Genesis