Technical guidance note

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Addressing value for money in proposals for the Global Fund to Fight AIDS, Tuberculosis and Malaria

Before getting started:

Look at the following sources of information, which you might refer to in support of your proposal and which the Technical Review Panel might consider when reviewing your application.

- **General**
  - Technical Review Panel report on Round 10 proposals
    http://www.theglobalfund.org/en/trp/reports/#rbc
  - Global Fund applicant disease profile
    http://www.theglobalfund.org/en/application/majorchanges/#adp
  - Performance[1] of previous Global Fund grants
    http://portfolio.theglobalfund.org/?lang=en
  - Global Fund eligibility, counterpart financing and prioritization information note
    http://www.theglobalfund.org/en/application/infonotes
- **HIV/AIDS**
  - UNAIDS country fact sheets
    http://www.unaids.org/en/dataanalysis/tools/aidsinfo/countryfactsheets
  - UNAIDS national AIDS spending assessment (NASA)
    http://www.unaids.org/en/KnowledgeCentre/HIVData/Tracking/Nasa.asp
  - UNAIDS/NASA indicators on financial country responses to AIDS (counterpart financing)
    http://www.unaids.org/en/dataanalysis/tools/nasapublications
  - WHO Global Price Reporting Mechanism (GPRM – latest edition)
    http://www.who.int/hiv/amds/gprm/en
- **TB**
  - WHO Stop TB: global TB country profiles
    http://www.who.int/tb/country/en/index.html
  - WHO 2010 global tb control reports (counterpart financing) http://www.who.int/tb/publications/global_report/en
- **Malaria**
  - Roll Back Malaria country profiles
    http://www.rollbackmalaria.org/countryaction/index.html
  - WHO *World malaria report 2010* (counterpart financing)
    http://www.who.int/malaria/world_malaria_report_2010/en/index.html

1 Where applicable, review "under-spending" on existing grants and address the causes within the Round 11 proposal.

1. Background

The Global Fund to Fight AIDS, Tuberculosis and Malaria is expected to announce its 11th Call for Proposals in August 2011. In the previous round, the Global Fund requested applicants to demonstrate how interventions in their proposals reflected value for money, defined as "using the most cost-effective interventions as appropriate to achieve the desired results."[2] The Global Fund created a dedicated section in Round 10 proposal forms in which applicants had to present the proposal's value for money in one page or less. The Global Fund's Technical Review Panel commented that the dedicated section was less useful for its review purposes, as some applicants appeared confused by the new requirements and could not provide clear answers.[3]

The most critical overall drawbacks the Technical Review Panel found in Round 10 proposals were lack of background information and evidence to justify proposed strategic interventions as well as the lack of clearly defined links between strategic interventions and the unit costs of activities, budget assumptions and additionality. The Technical Review Panel noted that it did consider the overarching concept of value for money as part of the overall proposal review criteria and assessed value for money using the following considerations.

- The proposed activities were both technically sound and reflected appropriate priorities; the disease and national health system were presented in the local context, citing evidence and past performance.
- If activities were both technically sound and reflected appropriate priorities, proposal interventions were measured on their effectiveness in terms of:
  - the design of activities to achieve the desired outcomes and impact
  - coherence and needs assessment
  - implementation model
  - sustainability over time.
- If the Technical Review Panel considered the proposed interventions as appropriate and effective, proposals were measured in terms of efficiency. The Technical Review Panel focused on whether the costs for proposed interventions and activities were appropriate by reviewing the different cost elements of the proposal, including but not limited to unit costs, procurement, training activities, salaries and many others.
- Once all of these considerations were met, the Technical Review Panel ensured that the proposal was in compliance with the Global Fund criteria for additionality.

For Round 11, the Technical Review Panel has signalled increased scrutiny around value for money and will likely focus on justifications for each service delivery area, including the technical appropriateness of the proposed approaches and the evidence presented.

Applicants will be expected to focus on presenting the most effective interventions at the lowest cost (in the most efficient way), recognizing that, if activities are not proposed at the least possible cost, the higher costs should be justified by increased appropriateness, effectiveness and/or sustainability.

2 *Technical guidance note: addressing value for money in Round 10 proposals for the Global Fund to Fight AIDS, Tuberculosis and Malaria*. Geneva, UNAIDS, 2010.

3 *Report of the Technical Review Panel and the Secretariat on Round 10 proposals*. Geneva, Global Fund to Fight AIDS, Tuberculosis and Malaria, 2010.

2. Introduction

The Global Fund defines value for money as "using the most cost-effective interventions as appropriate to achieve the desired results".[4]

- Value for money does not mean the lowest cost. The objective is to achieve the greatest impact for the money spent by balancing effectiveness and costs.
- An intervention or programme represents value for money when its cost is justified by an improved outcome; it is the optimal balance between cost and outcome. An example could be as follows: a programme manager justifies higher expenditures for activities such as home-based care for antiretroviral therapy by presenting programme-specific data that demonstrate significant impact on a person's adherence and survival at a reasonable marginal cost.
- The Global Fund sees three critical components of value for money:[5]
  - effectiveness: what the programme will do, measured by outcomes, impact and sustainability and based on evidence, including the local epidemiological context, past performance and international best practice;
  - efficiency: how the programme will achieve its results while minimizing the cost of input, essentially through least-cost procurement and well-organized health delivery systems; and
  - additionality: investment represents additional money to achieve improved outcomes and does not replace other funding sources (note the new minimum thresholds for government counterpart financing).[6]
- A few key principles should be kept in mind in addressing value for money.
  1. Use the context of the latest country epidemiological data to describe how key interventions in the proposal represent the best balance of costs and effectiveness.
  2. Consider the effectiveness of proposed interventions both for short-term outcomes and long-term impact.
  3. Demonstrate how the programme will drive the efficiency of the proposed interventions. Show historical trends in how efficiency has been achieved over time and list examples demonstrating this.
  4. Outline information gaps and how to address them.
  5. Provide continuity from previous proposals – where possible, use historical information to determine service delivery area costs and use this information for budgeting.
  6. If proposed interventions differ from treatment approaches in the past, explain the reason for changing and how the new approach will produce better results.
- The following are low-hanging fruit for demonstrating value for money.
  1. Use international reference pricing for unit costing for pharmaceuticals (such as the WHO Global Price Reporting Mechanism).
  2. Use the latest epidemiological data as the rationale for interventions (such as UNAIDS country fact sheets).
  3. Use international guidelines and best practices as the basis for proposed interventions, such as preventing the mother-to-child transmission of HIV.
  4. Demonstrate clear links between proposed interventions and investments from previous Global Fund grants, other donors and government.
  5. Demonstrate how the programme complies with Global Fund counterpart financing requirements and/or demonstrate how compliance will be achieved during the lifetime of the grant.

4 *Value for money: information note*. Geneva, Global Fund to Fight AIDS, Tuberculosis and Malaria, 2010.

5 *Value for money: information note*. Geneva, Global Fund to Fight AIDS, Tuberculosis and Malaria, 2010.

6 *Eligibility, counterpart financing and prioritization: information note*. Geneva, Global Fund to Fight AIDS, Tuberculosis and Malaria, 2011.

3. Describing value for money: how to address value for money effectively in Round 11 and beyond

The flow chart below provides recommendations for addressing value for money throughout the proposal and across activities.

Effectiveness

- Collect evidence to justify activities. Link activities to outputs. outcomes. impact(s) .
- Source for evidence and background information
- Current status of health system and national program
- Epidemiological background of focus population(s)
- Historical program results - continuation/expansion by success or adaptation by analysis
- International guidelines and/or best practice
- Outline Information Gaps where they exist and explain how you will collect missing data

Efficiency

- Present the selected interventions and associated budgets at the lowest cost (i.e. in most efficient way):
- Use historical programme costs and international reference pricing for budgets
- Hold programme management and overhead budget allocations to a minimum
- Demonstrate programme's efficiency by highlighting how it builds on previous investments

Sustainability

- Demonstrate the overall leadership and coordination by the national government
- Present full analysis of situation - demonstrate which donors and partners are on the ground and what activities they support. Explain how grant request complements other investments (non-duplicative)
- Demonstrate increase in budget contributions by national government over time

Higher-cost interventions are justifiable if you can demonstrate effectively that they lead to greater benefits over time. Proposals must demonstrate increased effectiveness, efficiency and/or sustainability.

4. Describing value for money in service delivery areas

Each service delivery area should describe how the proposed intervention fits into the overall programme strategy and complements existing interventions and what the expected outcomes are. Key elements include the following.

- Deliver a clear rationale for choosing a specific intervention, using the latest epidemiological data and country context.
- Describe the specific expected benefits of the intervention and how you will measure them.
- Provide historical programme data and other references to strengthen your position.
- Make sure that each service delivery area is clearly linked to the overall programme strategy and other service delivery areas.

- **Effectiveness:** describe the qualitative targets of service delivery areas in proposals, as they can demonstrate the added value of the activities to the overall programme. For example, a programme that strives to put in place special measures for improving adherence to antiretroviral therapy (thus improving the quality of care) could justify the incremental expenditure by demonstrating how improved adherence will allow more people living with HIV to remain on first-line antiretroviral drug regimens for longer periods of time instead of moving to more expensive second-line antiretroviral drug regimens.
- **Efficiency:** describe how improving the efficiency of service delivery areas will drive down costs based on your quantitative analysis (see the following sections). For example, efficiency might improve from growing experience of health care providers so that, over time, the same number of personnel can treat more individuals and achieve better results.
- **Additionality:** demonstrate the achievement of outcomes that are in addition to what could have been achieved with existing government and other funding sources. For example, Global Fund money is spent on developing a training curriculum for antiretroviral therapy for children and the subsequent implementation of training courses. Meanwhile, government resources are used to build new paediatric wards in provincial and district-level hospitals and other donor resources (such as from UNITAID) are used to procure antiretroviral drugs for children.
- **Sustainability:** programme sustainability is critical to the Global Fund. Describing the cost and operational efficiency is an important component of programme sustainability. Proposals should highlight a few additional points.
  - Highlight the leadership role of the national programme in implementation and coordination.
  - Emphasize the results of the programme to date and any cost-efficiency and improvement in quality that have been recorded.
  - Describe the means for measuring and the frequency with which the programme monitors performance.

A few practical examples of sustainable (cost-reducing) measures:

- Capital expenditure for laboratory equipment can be reduced by establishing a cost-effective, rationalized laboratory system and leasing CD4 machines instead of purchasing them. For example, the national programme of a country in South-East Asia leased multiple CD4 machines in 2005 free of charge from the supplier and negotiated reduced prices for test reagents by agreeing to annual minimum test reagent purchases. The machines were placed at regional laboratories, and a system was designed for all antiretroviral therapy providers (government and nongovernmental organizations) in the region to access testing free of charge. Innovative solutions improving system efficiency and achieving real cost savings are great opportunities to demonstrate value for money.
- Expenses due to waste can be minimized – such as expired medicines and reagents; quantifying historical figures lost to waste and describe methods of minimizing this expense in the future (such as investing in improved forecasting systems and better storage facilities) can drive down service delivery area costs significantly and project improved value for money.

- **Integration and links:** integrating vertical programmes into national health systems is one of the key challenges for health ministries and programme managers across the globe. Using donor funding for vertical programmes, such as HIV, to strengthen other aspects of the general health system represents a great opportunity to showcase value for money. Some practical examples for integration:
  - reducing TB and HIV morbidity by implementing regular TB screening for people living with HIV attending follow-up visits with health care staff; and
  - investing in HIV laboratory monitoring as a key driver for developing laboratory capacity (infrastructure and human) at the provincial and district-level health centres that benefits everyone.

5. Analysing costs: a brief introduction

The following section introduces some simple concepts that allow you to show increased efficiency over time and improvements in value for money by analysing different types of costs or expenses.

1. Expenses that occur once – typically at the onset of a programme – and whose output will be used for many years are called capital expenditure. Example include:
   a. constructing or restoring a building[7]
   b. purchasing vehicles
   c. purchasing laboratory equipment.
2. Expenses that occur on an ongoing basis year by year are called operating expenses. Operating expenses can be broken down into:
   a. variable costs, which generally increase with each additional input or output, such as first-line antiretroviral drugs, commodities and laboratory reagents; and
   b. fixed costs, which generally remain constant, regardless of additional output, such as salaries for health care personnel (see "allocations" below), salaries for programme management and administrative personnel as well as other overhead expenses, such as electricity to operate a hospital, gasoline for transporting medicine and communication.

Here are a few guiding concepts for addressing cost analysis.

1. Start with your capital expenditure. You have two options for this category.[8]
   a. Allocate all capital expenditure to the year in which it occurs, such as year 1 of the programme.
   b. Divide the capital expenditure by a defined number of years (such as the lifetime of the product or the duration of the proposal) and allocate the same proportional amounts to each year.

   If you chose option a, you would expect to see a significant drop in your service delivery area cost per unit from year 1 to year 2. If you chose option b, you would expect to see a constant service delivery area cost per unit for this category, which gradually declines as the allocated capital expenditure is divided by a larger number of output units in each subsequent year.
2. Look at your variable operating costs. They include the cost of medicines, laboratory reagents and consumables. Variable costs per unit would be expected to remain constant in your service delivery area budget as they increase symmetrically to each increase in output.
3. Look at your fixed operating costs: your total fixed costs (salaries and overhead) will remain predominantly constant or increase only slightly regardless of the number of units of output each year, such as the number of patients treated. However, as you divide your fixed costs by an increasing number of units of output each subsequent year, the fixed costs per unit will decline.

7 Certain restrictions apply for using funds from Global Fund for constructing buildings.

8 The Global Fund proposal is based on a cash budget – items are to be budgeted in the period in which the cash payment is expected to be made. For proposal purposes, choose option a.

6. Calculating unit costs for each service delivery area for historical analysis and budgeting purposes

This section provides a sample breakdown of unit costs for each service delivery area that you can use as a reference for historical framework analysis of unit costs for each service delivery area and for budgeting purposes. You may decide whether to select this sample or create an entirely new service delivery area cost matrix as long as the proposal clearly explains all assumptions.

The methods your programme will use to continually monitor and report (internally and externally) the proposed way of measuring the costs will be a critical element of value for money and should be described in great detail.

Steps related to analysis of unit costs for each service delivery area and budget

1. Analyse the historical unit costs for each service delivery area and develop a framework for the unit costs for each service delivery area.
    a. Identify cost drivers in your service delivery area.
    b. Separate them by type of cost (see previous section):
        i. capital expenditure
        ii. operating expenditure (fixed)
        iii. operating expenditure (variable);

    Allocate fixed operating expenses that are not used exclusively by the programme: for example, salaries of general health care staff at the provincial hospital level. One approach is to allocate proportions of salaries and overhead based on the time health workers spent treating patients in a particular category. Try to get a consensus at the health ministry level on what would be appropriate as a rule of thumb for this exercise and then remain consistent throughout your reporting.
2. Use the unit cost framework to develop the budget for each service delivery area and programme.
    a. Where historical unit costs for each service delivery area are not available, explain why.
    b. Create a framework for the unit costs for each service delivery area and explain the assumptions in detail.

A firm understanding and control of the main cost drivers by service delivery area will ensure that programmes meet their operational targets within their resource framework. Frequently monitoring the main cost drivers (monthly or quarterly) will allow programme managers to identify problems (such as a sudden increase in variable costs for a service delivery area) and address them promptly before they can threaten the sustainability of the programme.

Table 1. Sample breakdown of costs (in US dollars) for antiretroviral therapy by service delivery area in a low-income country

Category		Antiretroviral therapy (total – overall national programme)		Antiretroviral therapy (service delivery area): per person per year		Notes/Assumptions
		Year 1	Year 2	Year 1 (target: 20 000 people treated)	Year 2 (target: 30 000 people treated)	
Capital expenditure	Building	–	–	–	–	
	Laboratory equipment	150 000	–	7.5	–	30 000 per machine, five machines; cost applied to year 1
	Vehicles (three)	120 000	–	6.0	–	40 000 per vehicle, three vehicles, cost applied to year 1
Operating expenses (fixed)						
Personnel	Health care staff	5 000 000	5 000 000	250	166.7	Overall national personnel budget for health care staff is US$ 20 million – 25% of time allocated to HIV treatment and care
	Programme management and administration	250 000	250 000	12.5	8.3	500 000 overall budget for programme, 50% of time allocated to antiretroviral therapy
	Monitoring and evaluation	25 000	25 000	1.3	0.8	50 000 for overall monitoring and evaluation, 50% of time allocated to antiretroviral therapy
Gasoline		75 000	75 000	3.8	2.5	150 000, 50% of programme budget allocated to antiretroviral therapy
Office supplies		35 000	35 000	1.8	1.2	70 000, 50% of programme budget allocated to antiretroviral therapy
Training		250 000	250 000	12.5	8.3	250 000 per year for antiretroviral therapy training or annual refresher
Logistics		250 000	250 000	12.5	8.3	250 000 central warehouse rental
Information and communication technology		50 000	50 000	2.5	1.7	100 000, 50% of programme budget – telephone, software licences, e-mail, other allocated to antiretroviral therapy
Other		37 500	37 500	1.9	1.3	75 000, miscellaneous expenses, 50% of programme budget to antiretroviral therapy
Operating costs (variable)						
Antiretroviral drugs		3 594 000	5 391 000	179.7	179.7	Prices from WHO guidelines, assume 90% on first-line drugs (stavudine + lamivudine + nevirapine) and 10% on second-line drugs (abacavir + didanosine + lopinavir with a ritonavir boost)
Laboratory reagents		200 000	300 000	10	10	US$ 5 per test, two tests per person
Medicine for opportunistic infections		539 100	808 650	27	27	15% of funds spent on antiretroviral drugs
Laboratory consumables		30 000	45 000	1.5	1.5	15% of funds spent on laboratory reagents
Total		**10 605 600**	**12 517 150**	**530.3**	**417.2**	

Note: the costs per unit for capital expenditure and fixed expenses decrease, while variable costs remain constant.
See Annex 1 for possible sources of data. You may decide how to set up your cost matrix and allocate your costs. However, to allow for meaningful analysis going forward, you need to maintain cost categories consistently and put in place a monitoring system that allows you to collect the above data input regularly. Programme managers might consider tracking information on a quarterly basis to monitor performance for internal as well as external purposes.

Annex 1. Best practice interventions for HIV treatment and care from the international literature

This annex includes several examples of international best practice interventions. The table is not all-inclusive – other best practice interventions exist. Schwartländer et al. (1) recently published an investment framework that references best practice interventions and describes the role played by critical enablers, both social (such as stigma and equity in access) and programmatic (such as methods to improve retention and incentives for programme participation).

Intervention	Description	Value for money	References
Treatment 2.0	Simplifying HIV treatment delivery systems, including closer integration with other health services and community mobilization Starting treatment early and use it as targeted prevention tool	Essentially a more expensive but also more effective intervention: potentially higher costs due to early initiation of treatment, but lifetime cost of treatment reduced significantly; early antiretroviral therapy also functions as a targeted prevention method	*(2,3)*
Regional Initiative for the Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis in Latin America and the Caribbean	Increase access to programmes for preventing the mother-to-child transmission of HIV for pregnant women living with HIV Upgrade packages to improve the quality and effectiveness of programmes for preventing the mother-to-child transmission of HIV	Higher cost of early initiation of antiretroviral therapy among pregnant women is balanced by the prevention of HIV transmission to the infant and subsequent reduction in lifetime spending related to HIV care and treatment for the child	*(4,5)*
Focus prevention	Focus prevention interventions on key populations at higher risk of HIV infection and transmission instead of the general population	In many countries, HIV prevention activities mainly involve the general population rather than the key populations at higher risk that represent most of the people newly infected with HIV. Identifying key populations at higher risk and focusing activities to them increases the return on investment	*(6,7)*
Medical male circumcision (in settings with generalized epidemics and a low prevalence of male circumcision)	In settings with generalized epidemics with a low prevalence of male circumcision, male circumcision represents a one-time intervention that offers degree of lifelong protection with effectiveness comparable to an acceptable vaccine *(8)*	The upfront cost of intervention is offset by potential lifelong HIV prevention	*(9–12)*
Nutritional support for people living with HIV receiving antiretroviral therapy	Malnutrition is associated with a 2–6 times increased risk of death in the early phase of antiretroviral therapy, irrespective of CD4 counts *(13–16)* Food insecurity is associated with barriers to treatment adherence *(17–20)*	Increase access and adherence to treatment Reduced early mortality after initiation of antiretroviral therapy Earlier recovery and return to productive life	*(21)*

1. Schwartländer B et al. Towards an improved investment approach for an effective response to HIV/AIDS. *Lancet*, 2011, 377:2031–2041.

2. Treatment 2.0. In: *Outlook 2010*. Geneva, UNAIDS, 2010 (http://data.unaids.org/pub/Outlook/2010/20100713_outlook_treatment2_0_en.pdf).

3. *Treatment 2.0: accelerating the second phase of treatment scale-up*. Geneva, World Health Organization, 2010 (http://www.who.int/hiv/events/hirnschall_treatment2.0.pdf).

4. Alonso González M. *Regional Initiative for the Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis in Latin America and the Caribbean: regional monitoring strategy*. Washington, DC, Pan American Health Organization, 2010 (http://www.unicef.org/lac/Regional_Monitoring_Strategy.pdf).

5. *Regional Initiative for the Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis in Latin America and the Caribbean: concept document for the Caribbean*. Washington, DC, Pan American Health Organization, 2010 (ftp://ftp.bhikarry.net/phco/Elimination_Initiative_Concept_Document.pdf).

6. Targeted HIV prevention program: condom promotion for most-at-risk populations [web site]. New York, Population Council, 2011 (http://www.popcouncil.org/projects/45_TargetedHIVPreventionCondomPromotion.asp).

7. Sarkar S, Menser N, McGreevey W. *Cost-effective interventions that focus on most-at-risk populations*. New York, aids2031, 2009 (http://www.aids2031.org/pdfs/cost-effective%20interventions%20that%20focus%20on%20most-at-risk%20populations_16.pdf).

8. *Value for money. Comprehensive Reform Working Group*. Geneva, McKinsey & Company, 2011.

9. Kahn JG, Marseille E, Auvert B. Cost–effectiveness of male circumcision for HIV prevention in a South African setting. *PLoS Medicine*, 2006, 3(12):e517 (http://www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.0030517).

10. *Information package on male circumcision and HIV prevention: insert 1*. Geneva, World Health Organization, 2007 (http://www.who.int/hiv/pub/malecircumcision/infopack_en_1.pdf).

11. *Scaling up male circumcision programmes in the eastern and southern Africa region. Country update meeting to share lessons, explore opportunities and overcome challenges to scale-up: a sub-regional consultation, Arusha, United Republic of Tanzania, 8–10 June 2010*. Geneva, World Health Organization, 2007 (http://www.who.int/hiv/pub/malecircumcision/country_progress_meeting_report_jun10.pdf).

12. Clearinghouse on Male Circumcision for HIV Prevention [web site]. Geneva, Clearinghouse on Male Circumcision for HIV Prevention, 2011 (http://www.malecircumcision.org).

13. Zachariah R et al. Risk factors for high early mortality in patients on antiretroviral treatment in a rural district of Malawi. *AIDS*, 2006, 20:S2355–S2360.

14. Paton NI et al. The impact of malnutrition on survival and CD4 count response in HIV-infected patients starting antiretroviral therapy. *HIV Medicine*, 2006, 7:S323–S330.

15. Van der Sande M et al. Body mass index at time of HIV diagnosis: a strong and independent predictor of survival. *Journal of Acquired Immune Deficiency Syndromes*, 2004, 37:S1288–S1294.

16. Weiser S et al. The association between food insecurity and mortality among HIV infected individuals on HAART. *Journal of Acquired Immune Deficiency Syndromes*, 2009, 52:S342–S349.

17. Seyoum E et al. *ART scale-up in Ethiopia: successes and challenges*. Addis Ababa, Ethiopia HIV/AIDS Prevention and Control Office, Plan, Monitoring and Evaluation Directorate, 2009.

18. Au JT et al. Access to adequate nutrition is a major potential obstacle to antiretroviral adherence among HIV-infected individuals in Rwanda. *AIDS*, 2006, 20:2116–2118.

19. Kalichman SC et al. Food insufficiency and medication adherence among people living with HIV/AIDS in urban and peri-urban settings. *Prevention Science*, [Epub ahead of print].

20. Franke MF et al. Food insufficiency is a risk factor for suboptimal antiretroviral therapy adherence among HIV-infected adults in urban Peru. *AIDS Behavior*, [Epub ahead of print].

21. *Cost of providing nutritional support for people living with HIV adults receiving TB treatment, orphans and vulnerable children and pregnant women*. Geneva, UNAIDS, 2010 (http://data.unaids.org/pub/BaseDocument/2010/20100506_cost_nutritional_support_en.pdf).

Annex 2. Summary of value for money

Category	What to do	Sources of information
Unit costs of health products, pharmaceuticals and commodities	Use historical programme costs and international reference guides such as the WHO Global Price Reporting Mechanism for budgets. If prices are higher than reference guides, provide justification and steps towards achieving better prices in future.	Global Price Reporting Mechanism [web site]. Geneva, World Health Organization, 2011 (http://www.who.int/hiv/amds/gprm/en).
Epidemiological background of target populations	"Know your epidemic" – use national epidemiological data, refined by geography, population group, sex, socioeconomic status and other parameters (depending on the target population). Use epidemiological data as a critical rationale for proposed interventions and target to the highest need and potential impact.	Epidemiology [web site]. Geneva, UNAIDS, 2011 (http://www.unaids.org/en/dataanalysis/epidemiology). AIDSinfo country fact sheets [web site]. Geneva, UNAIDS, 2011 (http://www.unaids.org/en/dataanalysis/tools/aidsinfo/countryfactsheets).
Building on previous investment	Demonstrate how the proposed interventions build on previous Global Fund grants and those by other donors and partners by activity and geography. Tools include: ◆ listing of previous investment by Global Fund and/or other donors and governments; ◆ a visual map of the country to highlight where various donors are active; and ◆ other tools to demonstrate that proposed investment projects are complementary rather than duplicative.	Grant portfolio [online database]. Geneva, Global Fund to Fight AIDS, Tuberculosis and Malaria (http://portfolio.theglobalfund.org/en/Home/Index). National programme data Representative offices of large multilateral and bilateral donors, international nongovernmental organizations and technical assistance providers
Continuation, expansion of successful interventions or adaptation based on analysis	Show how proposed investment is based on positive historical performance of previous interventions. Present data that demonstrate the success of previous interventions as a rationale for proposed new expenditure related to continuing and/or expanding programmes. If proposed interventions represent a change to previous programme activities, an explanation of proposed changes should be included that (a) presents data that show poor performance of previous activities, (b) includes thorough analysis of flaws that led to poor programme performance and (c) demonstrates how new interventions will avoid repeating similar mistakes.	Grant portfolio [online database]. Geneva, Global Fund to Fight AIDS, Tuberculosis and Malaria, 2011 (http://portfolio.theglobalfund.org/en/Home/Index). National programme data Representative offices of large multilateral and bilateral donors, international nongovernmental organizations and technical assistance providers

Category	What to do	Sources of information
Service delivery area costing	Analyse the projected service delivery costs per unit. For example, costs per unit might show a declining historical trend and/or a projected future decline because of increasing output and/or enhanced efficiency. Alternatively, the costs per unit of proposed interventions might actually increase relative to historical costs per unit – for example, if new interventions incorporate costly improvements to the quality of services (which should be mirrored by improvements in proposed outcomes) or an expansion of successful interventions to more geographically remote areas for which higher costs per unit are required to maintain the same quality of services.	
Monitoring and evaluation	Describe the current national monitoring and evaluation system and explain how well it has functioned in the past. If additional measures are required to monitor the performance of the programme, explain how investment will be structured to strengthen national monitoring and evaluation as well.	*Monitoring and evaluation toolkit: HIV, tuberculosis and malaria and health systems strengthening. Part 1. The M&E system and Global Fund M&E requirements.* Geneva, Global Fund to Fight AIDS, Tuberculosis and Malaria, 2010 (http://www.theglobalfund.org/documents/me/M_E_Toolkit.pdf).
Additionality	Demonstrate that Global Fund grants are non-duplicative and fill gaps in areas underfunded by government sources and other donors. Investment represents additional money to achieve improved outcomes and does not replace other funding sources. In Round 11, the Global Fund has introduced a new counterpart financing policy, requiring governments to meet minimum thresholds for government contributions (for example, low-income countries must fund at least 5% of the disease programme). When government contribution is below the minimum threshold, an action plan for moving towards the threshold must be presented.	National programme data Information notes [web site]. Geneva, Global Fund to Fight AIDS, Tuberculosis and Malaria (http://www.theglobalfund.org/en/application/infonotes).
Country ownership	Demonstrate national leadership in country response and proposal development. Country ownership is also emphasized by significant co-investment by the national government and projected increase in government funding for critical interventions, which also strengthens the sustainability of the programme. One country in Africa demonstrated this effectively in Round 10 by explaining that the government could cover 50% of all expenditure for purchasing antiretroviral drugs during the lifetime of the proposal.	National programme data
Programme management, administration, training and overhead	Minimize overhead and programme management costs. As a percentage of total budget, overhead costs, training, salaries and other administrative costs should be below or the same as historical percentages. Any training and/or conference attendance should be linked to employee functions and should be measurable in terms of expected outcome.	*Practical tips for preparing for programme and financial management audits*. Geneva, UNAIDS, 2011.

Annex 3. Additional guidelines from the Global Fund for service delivery area budgets

The Global Fund suggests using the table on summary budget by service delivery area and corresponding outputs in the performance framework, using the following calculation:

$$\text{Expected service delivery area per unit cost (total)} + \frac{\text{Relevant proposal budget item}}{\text{Corresponding output}} = \text{Adjustments added to include relevant cost components covered by other funding sources}$$

More detailed budget information may be necessary in cases where one service delivery area supports multiple outputs or if the full cost of an activity is split over multiple service delivery areas.

Provide additional analysis and explanation when output targets are not directly tied to the grant but represent a larger number than the grant will finance directly.

If portions of the service delivery area will be funded through other sources, adjustments need to be added to arrive at the full unit cost for the service delivery area.

When resources (such as personnel or facilities) will be shared with other activities, allocate only the relevant portion of that resource's cost to the service delivery and explain the allocation calculation or assumption.

Provide available contextual information for expected unit costs. For example, explain why an expected unit cost appears high or low or why a trend over time is expected.

Include comparisons to reference points (benchmarks – such as historical or global) that the programme used when determining its budget and interpreting any significant differences.

Be sure to provide a clear explanation of your assumptions for declining or increasing per unit costs within the proposal.

Increases in programme costs and/or addition of new service delivery areas in proposals are not necessarily a bad thing, as long as you provide a clear explanation for additional costs. For example, to reach out to the populations that are the most difficult to reach or most hidden, programmes might have to increase expenditure for outreach to serve populations at higher risk. Thus, even though this approach is more costly, it can still demonstrate value for money.

Annex 4. Current and long-term Global Fund objectives for value for money in supported programmes9 (from the Global Fund value for money framework)

1. Contextual information in proposal and grant reviews, such as the cost of DOTS per person.
2. Indicators for programme planning and budgeting, such as country A setting a target of reducing the cost of antiretroviral therapy per person per year from US$ 1000 to US$ 900 by 2012.
3. Input to evaluations on cost per life saved or per disability-adjusted life-year gained, such as to support investment decisions.

9 *Improving value for money*. Geneva, Global Fund to Fight AIDS, Tuberculosis and Malaria, 2011 (http://www.theglobalfund.org/en/performance/effectiveness/value/improving/?lang=en).

Annex 5. Global Fund measurement of value for money[10]

By level

Level	Type of measurement	Example
1	Unit price per health product	Price per antiretroviral drug tablet Price per insecticide-treated bed-net
2	Unit cost per service delivery (output)	Cost per person receiving antiretroviral therapy Cost per insecticide-treated bed-net distributed Cost per person treated under DOTS
3	Unit cost per service delivery (outcome)	Cost per insecticide-treated bed-net hung Cost per patient cured under DOTS
4	Cost–effectiveness (impact)	Cost per life saved or cost per death averted by anti-retroviral therapy, DOTS or insecticide-treated bed-nets

By disease, method and source[11]

TB: DOTS treatment:

- WHO Stop TB database by country: cost per person treated under DOTS and cost per person cured under DOTS.

HIV: antiretroviral therapy:

- In-depth, bottom-up programme-level costing studies available from selected sites
- Antiretroviral drug pricing reported in the WHO Global Price Reporting Mechanism
- UNGASS, national AIDS spending assessment and universal access reports
- Analysis of grant expenditure data on antiretroviral therapy reported by supported programmes through the Global Fund enhanced financial reporting system

Malaria: insecticide-treated bed-net distribution:

- WHO Global Malaria Programme annual country reports calculating the expenditure per distributed net
- Bed-net procurement pricing reported to the WHO Global Price Reporting Mechanism

10 *Value for money framework*. Geneva, Global Fund to Fight AIDS, Tuberculosis and Malaria, 2011 (http://www.theglobalfund.org/en/performance/effectiveness/value/framework/?lang=en).

11 *How is value for money measured?* Geneva, Global Fund to Fight AIDS, Tuberculosis and Malaria, 2011 (http://www.theglobalfund.org/en/performance/effectiveness/value/measured/?lang=en).

Annex 6. Estimates of unit costs for key interventions in Global Fund programmes (2008)[12]

A recent Global Fund report produced these figures, which represent very preliminary calculations. The Global Fund does not intend countries to use these figures for benchmarking. Since these data are publicly available, they have been included for clarification purposes.

Service and cost unit	National income level and unit cost estimate (range)		Data sources
Long-lasting insecticidal bed-net distributed to a person or family at risk of malaria	All incomes	**US$ 7.3** (6.7–8.0)	Global Fund price and quality reporting systems and in-depth costing studies
DOTS per person with TB	Low income	**US$ 150** (138–191)	Annual expenditure reporting by national TB programmes to the WHO Stop TB Department
	Lower-middle income	**US$ 173** (151–177)	
	Upper-middle income	**US$ 1023** (956–3148)	
Antiretroviral therapy per person per year (first line)	Low income	**US$ 553** (538-572)	Antiretroviral drug prices reported to the WHO Global Price Reporting system, in-depth antiretroviral therapy costing studies, UNGASS expenditure reporting
	Lower-middle income	**US$ 675** (654-708)	
	Upper-middle income	**US$ 776** (729-803)	
Antiretroviral therapy per person per year (second line)	Low income	**US$ 1351** (1324–1488)	
	Lower-middle income	**US$ 1803** (1533–2331)	
	Upper-middle income	**US$ 3305** (2408–5223)	

- The Global Fund is redesigning how it is providing funding to countries. In the new grant architecture, each principal recipient will receive a single stream of funding, and the programme will be comprehensively reviewed every three years. Under this new model, the measurement of the programme-level unit costs of services is integrated systematically into the performance-based funding model.
- With support from technical partners such as WHO, countries will be guided to measure and report service unit costs for key interventions in the programmes at regular intervals (along with quality and impact data) to facilitate value-for-money assessments. This assessment will inform key decision-making stages of the funding cycle, such as evaluations of proposals by the Technical Review Panel and decisions on continued funding.
- Currently unit costs remain only one of the criteria used in decision-making. The purpose is to make countries aware of unit costs and achieve efficiency savings by setting feasible targets for improving unit costs without reducing service delivery targets (Global Fund, March 2010).
- It is important to bear in mind that higher up-front costs (unit or otherwise) are acceptable if justified because of greater benefits accrued over time (financial or otherwise).

12 *Improving value for money in Global Fund–supported programs.* Geneva, Global Fund to Fight AIDS, Tuberculosis and Malaria, 2010.

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