

Annexes

Annex 1: Guiding Questions for VfM (checklist)

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

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

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

Ideal service delivery modality:

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

Integration of system level investments:

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

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

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

Examples on ideal service delivery modality:

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

Examples on integration:

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

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

Examples to select the right input mix and quantity:

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



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

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

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

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

Full Review Application Form

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