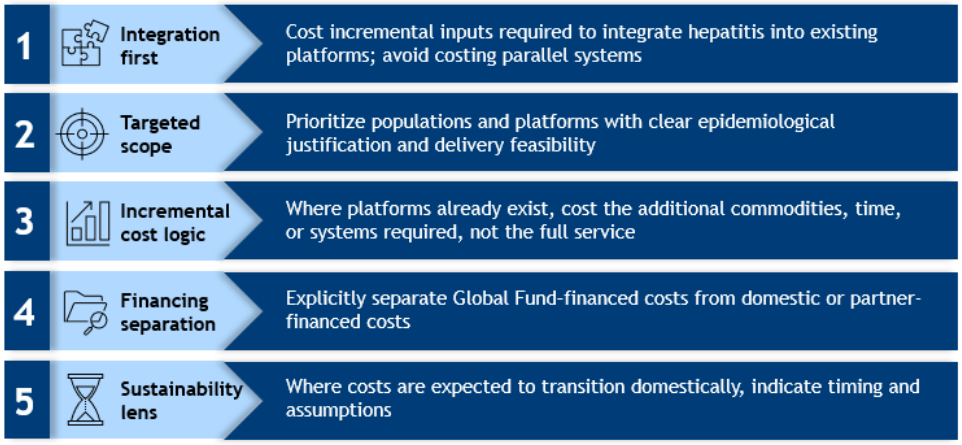
Costing and Budgeting Guide

What is this: Practical costing framework aligned to GC8 Program Essentials, with illustrative unit costs, clear GF-financed vs domestic/partner cost boundaries, commodity guidance, and VfM framing by population group.

Who it's for: Finance staff, principal recipients, technical advisors supporting budget development

How to use: Apply after finalizing your ambition and PE anchors using the Readiness Scorecard and Country Assessment Template. Go directly to the PE section(s) relevant to your selected population package. There is no need to work through all sections. Cost only in-scope, integrated interventions. Use national unit costs where possible and document all assumptions. Clearly separate GF-financed from non-GF-financed costs.

I. Costing principles under GC8



II. Costing by Program Essential anchor

II.A. Program Essential 16 — Coinfection Management in HIV Care

For Population I: People Living with HIV (PLHIV)

GF-financed cost categories — typical inclusions:

- Anti-HCV rapid diagnostic tests (targeted screening within HIV care, for eligible PLHIV)
- HCV RNA VL for confirmatory testing and treatment monitoring
- HCV treatment — DAA regimens (pan-genotypic preferred for cost-efficiency)
- HBsAg tests (targeted, for PLHIV populations most at risk)
- HBV DNA VL (confirmatory testing where indicated)
- Incremental service delivery costs — additional clinical time, counselling, linkage support within ART clinic workflows
- Provider training and mentorship (integrated with existing HIV clinical training)
- Quality assurance — integrated clinical supervision
- Data and reporting adaptations — hepatitis cascade integration into HIV HMIS and registers

Costs typically not requested from GF:

- Untargeted HCV or HBV screening outside HIV care platforms (explicitly lower-priority under GC8)
- Standalone hepatitis clinics or parallel service delivery infrastructure
- HBV vaccine commodity costs (map to domestic or partner)
- Full ART clinic platform costs — only incremental additions are GF-eligible

Volume driver guidance:

- Primary volume driver for HCV: number of PLHIV on ART × estimated HCV prevalence in this population × screening frequency per protocol
- Primary volume driver for HBV: number of PLHIV most at risk × estimated HBsAg positivity rate
- Primary volume driver for treatment: number screened positive × expected treatment uptake rate × DAA regimen cost
- Use TCS-11 (proportion of people starting ART tested for HCV) as the anchor indicator for volume estimation where applicable

Costing notes for TRP credibility:

- Justify epidemiological targeting — show why HCV or HBV burden among PLHIV in your country justifies the investment
- Demonstrate cost efficiency — HCV services delivered through existing ART platforms have significantly lower unit costs than standalone delivery; quantify this where possible
- Separate confirmatory testing costs from screening costs — these sit at different points in the cascade and have different volume assumptions
- Where shared laboratory infrastructure is used for both HIV viral load and HCV testing, cost only the incremental reagent and consumable costs, not the full platform cost
- Clearly define the referral pathway and turnaround time assumptions for confirmatory testing — TRP will scrutinize feasibility

II.B. Program Essential 3 — Harm Reduction Services

For Population II: PUD and other key and vulnerable populations

GF-financed cost categories — typical inclusions:

- Needles, syringes and safe injecting equipment: Sterile needles/syringes (low dead space preferred to reduce HIV/HCV transmission), sterile water, filters, spoons/cookers, tourniquets, acidifiers, and safe disposal supplies
- OAMT commodities: Methadone or buprenorphine procurement and distribution, including take-home dosing models and long-acting depot buprenorphine where available
- Naloxone for overdose prevention and management, including community distribution
- Wound care at harm reduction sites
- HCV and HBV screening and treatment integrated into harm reduction platforms: Anti-HCV RDTs, HCV RNA confirmatory testing, DAA treatment (pan-genotypic), HBsAg screening
- Human resources: Peer outreach workers, community health workers, lay providers for testing and distribution
- Safe spaces: Drop-in centers, mobile clinics, vending machines, automated distribution sites
- Service delivery support: All activities related to service delivery for the above interventions

Costs typically not requested from GF or lower priority:

- Vertical/single-disease workforce cadres not integrated into national HRH or community health strategies
- Ad hoc, workshop-based refresher training — replaced by integrated supportive supervision
- PrEP diagnostics and services beyond WHO's minimum service delivery package
- Stand-alone VMMC services

Volume driver guidance:

- Primary volume driver for HCV screening: estimated number of PUD reached through NSP/OST × HCV antibody prevalence × screening frequency per protocol
- Primary volume driver for confirmatory testing: number screened antibody-positive × expected linkage-to-confirmation rate
- Primary volume driver for treatment: number confirmed viremic × expected treatment uptake rate × DAA regimen cost
- For HBV: number of PUD accessing harm reduction services × estimated HBsAg prevalence

Costing notes for TRP credibility:

- User preferences matter - don't assume one-size-fits-all commodity mix
- Monitor cost of service delivery by limiting the range of add-on services, minimizing non-essential staff, and extending reach of outreach including online approaches
- Explore distribution beyond drop-in centers: pharmacy-voucher schemes, vending machines, automated sites — show TRP you're thinking about reach efficiency
- No conditionality: Offer safe injecting equipment without requirements for 1:1 exchange, identity documents, or police interference
- OAMT efficiency: For OAMT, show plans for take-home dosing to reduce delivery costs, and assess regionally manufactured commodities for lower prices. If long-acting depot buprenorphine is available, assess whether it simplifies delivery and reduces program costs
- Sustainability: Include a clear plan for progressive domestic take-up of OAMT commodities and HR costs
- Safety and security: Budget for safety of implementers and service users in hostile environments
- Allocative efficiency: Use data to justify the optimal mix of interventions based on transmission patterns and location-specific incidence

II.C. Program Essential 5 — SRH Screening and Treatment for People at Increased Risk

For Population II: PUD and other key and vulnerable populations (new for GC8)

GF-financed cost categories — typical inclusions:

- PEP for all potential HIV exposures, including as part of post-rape care, at facility and community levels
- Integrated basic STI services and syndromic STI management — including RDTs, dual HIV/syphilis test kits, and antimicrobials for syndromic management
- Cervical cancer screening and secondary prevention — thermal ablation devices and consumables for women accessing HIV services
- HCV testing and treatment in harm reduction services in countries with high levels of HIV/HCV co-infection — anti-HCV RDTs, HCV RNA confirmatory tests, and DAA regimens (explicitly listed as a priority activity)
- HBsAg testing and management for individuals accessing HIV prevention platforms who are at high risk of HBV, such as key and vulnerable populations
- Post-rape care — emergency contraception, PEP, pregnancy testing, and referral to survivor support services

- Service integration costs — adapting existing SRH/family planning/adolescent health platforms to include HIV/STI/hepatitis testing and PrEP initiation
- Referral networks for gender-based violence response and survivor support

Costs typically not requested from GF or lower priority:

- STI molecular (etiological) diagnosis investments (e.g., Xpert CT/NG for chlamydia and gonorrhea) — explicitly listed as lower priority in the Info Note
- Untargeted adult HBV screening — explicitly listed as lower priority
- Vaccine commodity procurement (HBV, HPV) — beyond GF scope, though vaccination service delivery can be supported
- Advanced laboratory infrastructure for STI diagnosis — supported primarily through lab system strengthening

Volume driver guidance:

- Primary volume driver for screening: estimated number of key and vulnerable population members reached through SRH/community-based services × hepatitis prevalence estimates × screening frequency
- Primary volume driver for confirmatory testing: number screened positive × expected linkage-to-confirmation rate
- Primary volume driver for treatment: number confirmed positive × treatment uptake rate × DAA/antiviral regimen cost
- Use KVP size estimates from validated sources (e.g., IBBS, Spectrum-based estimates, or program data) as the denominator

Costing notes for TRP credibility:

- Integration is the framing: through low-cost and low-threshold delivery models, especially community-based harm reduction services for PUD
- Multiplex testing for efficiency: Use dual HIV/syphilis RDTs and the forthcoming WHO-prequalified triple test (HBV/syphilis/HIV) to realize diagnostic efficiencies
- Delineate from PE3: Where PE5 overlaps with PE3 (harm reduction), clearly state which populations and service delivery points fall under each PE to avoid double-counting. PE5 should cover key and vulnerable populations reached through SRH/community platforms not already covered by harm reduction
- Task shifting: Use lay providers for RDTs and task-sharing for PrEP/STI follow-up to demonstrate value for money
- Gender-responsive budgeting: Ensure costs address structural drivers of gender-related health inequalities, including access to post-violence care
- Targeted HBV screening: If requesting HBsAg testing for key and vulnerable populations, provide epidemiological justification for why this population has elevated HBV risk — "untargeted adult HBV screening" is explicitly flagged as lower priority

II.D. Program Essential 11 – Triple Elimination in ANC

For Population III: Pregnant women, breastfeeding women and infants

Typical cost categories to include (GF-financed):

- HBsAg test kits (ANC-based testing only)
- Syphilis test kits where not already funded through other sources
- TDF for HBV prophylaxis for eligible HBsAg-positive pregnant women

- Postnatal infant prophylaxis service delivery costs
- Integrated service delivery support for HBV birth dose vaccination (not vaccine commodity cost)
- Incremental service delivery costs — counselling time, supervision, linkage support
- Provider training and mentorship (integrated with ANC and PMTCT training)
- Quality assurance and supportive supervision
- Data and reporting adaptations — ANC register updates, DHIS2 integration, LIS linkage

Costs typically not requested from GF:

- HBV vaccine commodities (birth dose, routine doses)
- Long-term HBV treatment beyond pregnancy
- HBIG procurement (unless explicitly justified and co-financed)

Costing notes for TRP credibility:

- Use number of ANC attendees × testing frequency as the primary volume driver
- Avoid “per facility” costing unless justified by wide variability
- Clearly state assumptions on re-testing (if any)