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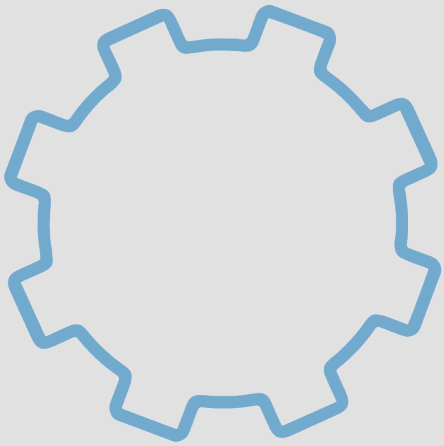
Strategic Prioritization and Costing

A Policy Brief for HIV, TB and malaria CSOs in the LAC region



LAC Platform
The Global Fund's Community Engagement Strategic Initiative
May, 2023

Priorización y Costeo Estratégicos - Documento de Reflexión para las OSC que trabajan en VIH, tuberculosis y malaria en la región de América Latina y el Caribe is a document prepared the Latin America and the Caribbean Regional Platform for Support, Coordination and Communication of Civil Society and Communities (LAC Platform)

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Regional Support, Communication and Coordination Platform for Latin America and the Caribbean (LAC Platform)is an initiative promoted by Via Libre with financial support from the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund).

The Platform is part of several interventions of the Global Fund to support and strengthen community and civil society participation at all levels within their processes. It is a component of the Strategic Initiative for Community Engagement (EI CP).

Introduction

Meaningful engagement and inclusion of people living with and affected by the three diseases are essential to ensure that the Global Fund's investments are informed by a strong evidence- and rights-based approach. Issues such as gender and human rights must become cross-cutting themes in funding applications and grants. Doing so will help maximize the impact and reach of Global Fund grants and strengthen transparency and accountability at the local level.

To ensure that civil society and communities are meaningfully engaged in the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) and the processes related to it, a Community Engagement Strategic Initiative (CE SI) has been launched. It works through three mutually reinforcing components:

Component 1: A short-term Technical Assistance program for communities and civil society groups to engage in national processes related to the Global Fund.

Component 2: Long-term capacity strengthening of HIV, TB and malaria networks and organizations, and

Component 3: Community, Rights and Gender Regional Platforms.

Since 2016, Vía Libre, a civil society organization in Peru, has hosted the Regional Support, Communication and Coordination Platform for Latin America and the Caribbean (LAC Platform) of the Global Fund's CE SI.

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What is the purpose of this document ?

The Global Fund has initiated Grant Cycle 7 (GC7) for 2023-2025. This new cycle incorporates new technical guidelines and partner feedback based on the **Global Fund Strategy Framework 2023-2028**. **Eligible countries** in this new cycle for the three diseases (HIV, TB and Malaria) should prepare their funding requests following the guidelines in the information notes, the corresponding templates and the **Modular Framework Handbook** for the 2023 - 2025 Allocation Period—a guidance document that outlines standard modules, interventions and performance indicators to support the development of funding requests to the GF.

The purpose of the LAC Platform is to support the achievement of the overall goal of the Community Engagement Strategic Initiative: ***Civil society and communities should effectively engage and contribute to the development, implementation and monitoring of programs funded by the Global Fund.*** To this end, four strategic objectives are proposed:

- Enhance community understanding of the Global Fund and its processes by regularly disseminating tailored and targeted information to a broad audience.
- Strengthen coordination of community engagement in national and regional GF grants and related processes, making the processes more efficient and effective.
- Support the development of strategic community capacity building by promoting spaces for peer-to-peer learning, community exchange, and capacity building support.
- Improve community access to Technical Assistance (TA) through information sharing, linkages to TA providers, support in developing TA requests, and capacity building and coordination among TA providers.

In line with the aforementioned objectives, the LAC Platform has prepared this document to support the meaningful engagement of civil society, community-based organizations of people affected by the diseases and key populations (KPs) in preparing funding requests for the GC7 allocation period 2023-2025. This document outlines the experience of the LAC Platform in supporting Civil Society Organizations (CSOs) and KPs from countries in the region in processes related to the Global Fund.

The aim of this policy brief is to help Civil Society Organizations (CSOs) in the Latin American and Caribbean region working in HIV, TB and malaria fields to reflect on their particular situation and the way they work in a changing environment:

- First, on how the epidemic and programmatic data in their own countries has evolved in recent times;
- Second, how to use data for decisions related to which pending gaps should be prioritized;
- Third, whether the service modalities CSOs have been providing need to be reviewed, adapted and how; and
- Fourth, what key aspects CSOs need to take into consideration when costing updated service modalities.

To this end, we expect that after undertaking these four key steps, CSOs will have a better understanding: on how to renew their role in contributing to HIV, TB and malaria national response targets, on how to design equitable and sufficient budget lines for their interventions, and, last but not least, have robust arguments to negotiate fair financing agreements with development partners and/or national authorities.

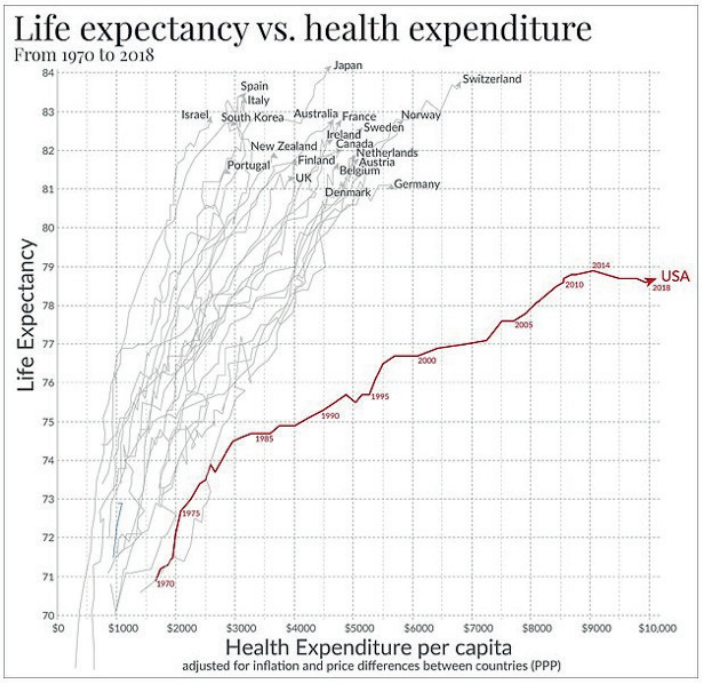
In order to achieve this overall aim, we invite readers on a journey of collective thinking that starts with some broader, basic questions about what investing in health services means as well as its benefits and its limitations. After this step, we will narrow our questions to more specific examples, using the HIV field as reference but also including examples related to TB and malaria. The process will focus on areas where CSOs have been working until the present, and clarifying the reasons why current intervention modalities may require different or innovative approaches. Finally, we will discuss the costing and budget implications of adopting different modalities.

The complex relationship between money and health

Do you think that more money invested in healthcare always means we will obtain better health outcomes?

If your answer is yes, consider the graph below:

Graph 1: Life expectancy vs. health expenditure per capita in selected countries 1970-2018



Source: Wikimedia Commons, 2023

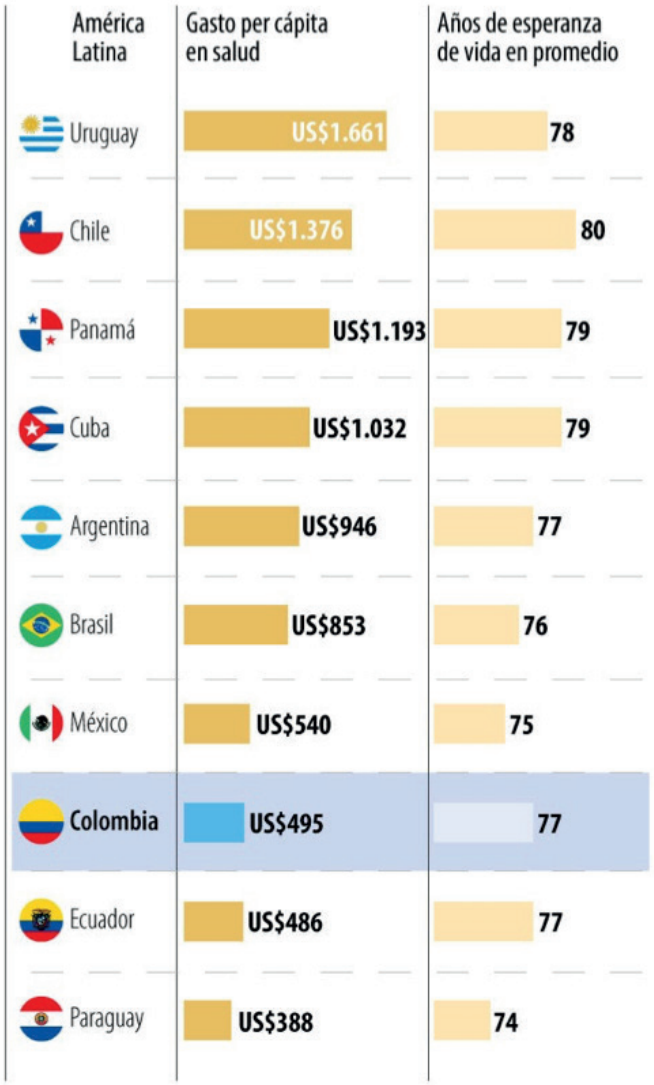
What do you see?

For many years (up to 2018), worldwide the USA has been the country spending the most on healthcare per capita. Their average life expectancy at birth, however, has been constantly below that of other high-income countries that spend much less. Let's compare the USA with Spain, for example: in 2018, the USA was spending approximately 10,000 USD per capita in healthcare, while their life expectancy was between 78 and 79 years; the same year, Spain spent less than a third of that amount (a little bit more than 3,000 USD per capita), while their life expectancy was between 83 and 84; in other words 5 years higher.

There are many reasons why despite spending more in healthcare, the USA achieves poorer health outcomes in terms of life expectancy than Spain or other countries. Amongst other reasons, the US healthcare service model: increasingly uses very expensive high technology yielding increasingly lower benefits in health and in additional life spans; presents higher barriers to accessing life-saving healthcare for US lower-income populations; invests less in social welfare policies; has greater socio-economic inequities; and has fragile social safety nets to support vulnerable members of families or communities. In this short discussion document, we cannot comment all these factors in detail. The key message nevertheless is clear: investing more in healthcare does not always results in better health outcomes. The outcomes depend on the way the healthcare investment is undertaken, plus other complex social and economic factors.

Latin America is no exception to that trend. See the table below: Uruguay has more than triple the Health Expenditure per Capita compared to Colombia and Ecuador, and yet their life expectancy is only one year higher.

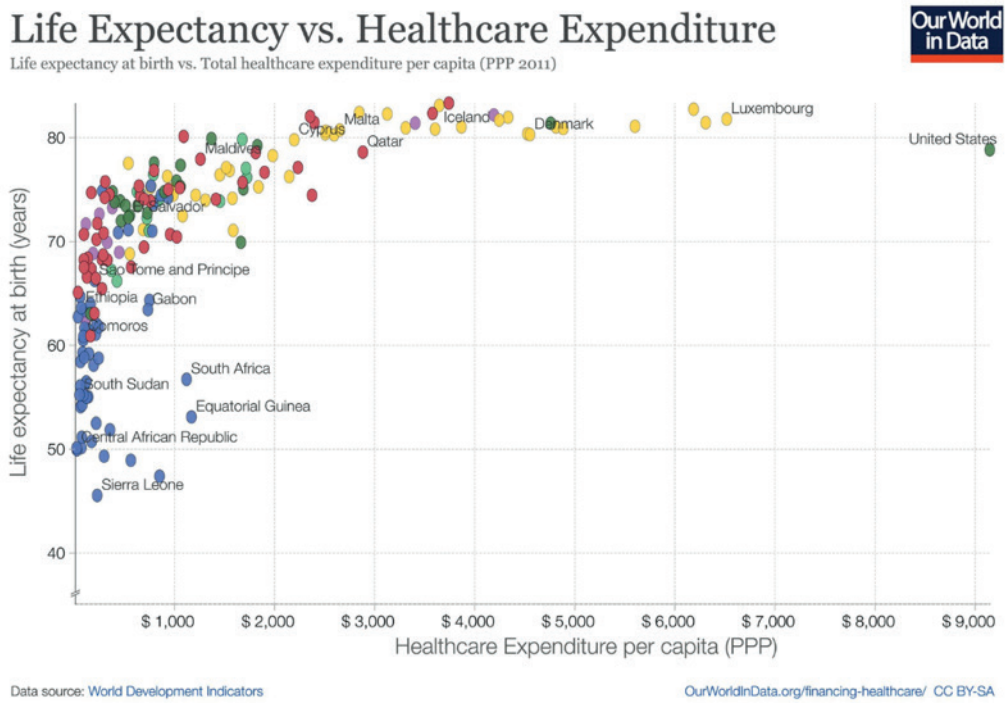
Graph 2: Health Expenditure per Capita and Life Expectancy is a selected group of LAC countries



Source: La República, Colombia, using World Bank Data, 2022.

Now, let's have a look at the chart below.

Graph 3: Life expectancy vs. health expenditure per capita in selected countries 2016



Source: Our World in Data, 2016.

We can see that there are still countries that spend less in health care than the USA and show better life expectancy. In this example, moreover, we also note there are countries that spend much less and have a much lower life expectancy. In fact, there emerges a trend. Following countries from low-levels of healthcare expenditure (Sierra Leone, Central African Republic, or South Sudan) to mid-level (Sao Tome and Principe, El Salvador or Maldives), there is a tendency[1] for a relatively rapid increase in life-expectancy. This illustrates that at low-level of healthcare expenditure, any investment, even if very modest, will tend to yield better health outcomes.

On the other hand, when we look at the difference of countries from mid-level to high-level healthcare expenditure per capita, we observe that gains in life expectancy is not so significant. There is still an outcome, but each time it is lower, until it seems to reach a plateau. At that point, additional investments in healthcare do not produce greater life expectancy. *Why is that?*

1 Please, note that we use soft language on purpose here: we say trend, tendency, tend to. This means that despite exceptions to the rule (Equatorial Guinea, South Africa), most countries behave in a similar pattern.

The reason is an economic law known as the law of diminishing returns. The original law of diminishing returns says that after an optimal level of capacity is reached, adding an additional factor of production will actually result in smaller increases in output (outcomes, benefits) unless we change the conditions under which the production is implemented. In the case of CSOs working on HIV, malaria and TB, when we apply this concept to investments in healthcare, the law of the diminishing returns shows that, once we have reached a certain threshold, additional investments (in terms of an additional unit of money, of human resources or of any other types of resources) will yield less health outcomes, unless we change where or how we use those resources, when available, to ensure more cost-effective interventions. In other words, after we have surpassed a threshold, obtaining each additional unit of health outcome will be more costly; or the marginal cost of reaching an additional unit of health outcome is incrementally more expensive.

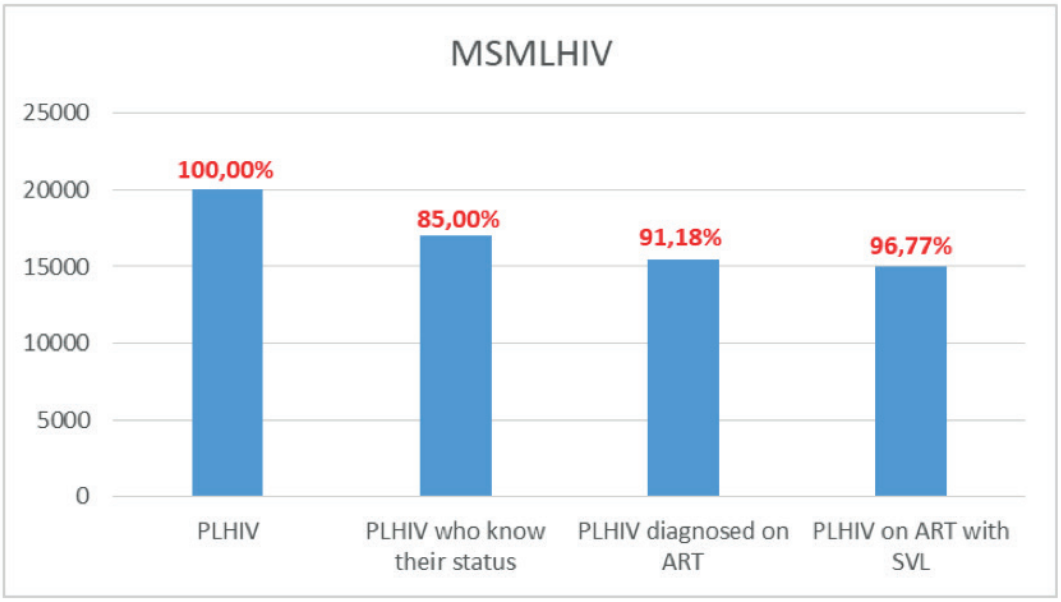
Volume of Resources and Programmatic Outcomes

Why is this relevant for civil society organizations (CSOs) working in the fields of HIV, TB and malaria?

Let's take an example from a given LAC (Latin America and the Caribbean) country: Country X. In this example, we will consider men who have sex with men (MSM) and HIV to illustrate the point, but it could be applicable nevertheless to other key populations. While the example uses HIV to construct the thread of arguments, we will cite other examples referring to TB and malaria as well.

In this hypothetical scenario, Country X has declared that they are committed to further reduce the incidence of new HIV cases and AIDS-related mortality. One key way to achieve this is by making sure all people living with HIV (PLHIV) know their status and are linked and retained in care, including effective antiretroviral therapy (ART).

Here we have the Treatment and Care Cascade of MSM living with HIV of Country X:



In this example, the Population Size Estimate of MSM is 100,000. The HIV prevalence among them is 20%, which means that around 20,000 MSM are living with HIV. Of those, 85% (17,000) already know their status. From the ones who know their status, 91.18% (15,500) are on ART, of which 96.77% (15,000) show a suppressed viral load. This data tells us that if we are able to identify the gap of MSMLHIV who do not know their status, there will be little barriers for them to link to care, start ART and attain suppression of the viral load (SVL). This, in turn, means that our main gap is in the first pillar: the percentage of MSMLHIV who know their status.

As a consequence, when discussing data-driven budget allocation, the priority is clear: among MSM, more resources should be allocated to increase case identification than to linkage and retention in care. This is not only relevant to reduce HIV transmission and better health for PLHIV;

Allocative Efficiency means distributing our resources in a way that we obtain the results that are better aligned with our goals and objectives.

it is also important because investing in areas where major gaps exist will give us better returns than in areas where the gaps are more modest. That's what we call "Allocative Efficiency": each dollar invested in identifying new cases (from this current baseline) will give us better results at the end of the cascade (in terms of more PLHIV with SVL) than each dollar invested in linkage or retention to care.

Until now, Country X has been implementing a dual approach to identify new cases of PLHIV among MSM: testing offer through the primary health care system, including a selected number of friendly sites across large cities; and peer outreach implemented by CSOs in hotspots. However, the positivity yields[2] of the testing offer has been declining since 2020 in both types of providers, but more so in the CSO-led offer. The testing coverage among MSM meanwhile has remained more or less the same.

In other words, Country X has been able to find most of the MSMLHIV through their dual offer approach, but the current modalities are showing signs of fatigue, as they find fewer and fewer cases for the same number of people tested. What to do?

One possibility would be to review the way current modalities are being implemented and how resources are being used and then identify how to gain efficiencies. This would allow Country X to try to expand coverage and potentially find additional cases with the same, revised approach and the same budget. That's we would call applying "Technical Efficiency".

Aunque es beneficioso intentar que las modalidades actuales sean más eficientes, descubriremos que, por muy perfecta que sea esa eficiencia, la modalidad dará cada vez menos resultados: acabará alcanzando su techo. ¿A qué se debe esto?

Technical Efficiency means obtaining the maximum result with the resources available or, the other way around, using the minimum resources possible to obtain the desired result.

Not all MSM are equal. Not all of them have the same identity, such as recognizing themselves as MSM or gay men, or are open about their practices, or have the same personal networks, or come from similar socio-economic situations. The 85% of MSMLHIV already diagnosed were accessible through the modalities offered to them up until now. But most likely the remaining 15% have different characteristics: they may be married to a woman and have children, or have multiple male and female partners, or are richer or poorer than the average MSM, or homeless, or are male sex workers who identify as heterosexual, or use more drugs, or a combination of several of such factors. We usually call them hard-to-reach MSM populations, but in fact, they are hard-to-reach with current outreach approaches, but not necessarily so hard to reach with alternative approaches. What if we try something different?

2 The positivity yield is the number of positive cases found every 100 people tested. It is expressed as a percentage.

For instance, when MSM access testing services and the result is negative, we can better assess if they engage in HIV-related risk practices. If the result of the assessment is that they are at risk, we should offer them Pre-Exposure Prophylaxis (PrEP). Additionally, we can invite them to share the contact details of their partners so we can reach out to them in order to offer prevention and testing services. If they decline to provide details about their partners, we can offer them individual self-tests to share with those partners. We are complementing (or replacing, if necessary) the traditional peer-based outreach with a new modality that is thought to be more effective to access hard-to-reach MSM.

When we interpret that a given intervention is offering an outcome that does not compensate the investment of resources we make, we need to consider whether adapting and using those resources in a different way, i.e. a new modality, will give us a better result. This is again *Allocative Efficiency.*

This new approach will presumably yield better results, but the cost to achieving those results may be different. To start with, the cost per unit of results gained depends on the target indicator. If the target is testing coverage, the cost per MSM tested may be more expensive in the new modality than in the current one; we need to mobilize more and more specialized resources to reach out and test hard-to-reach MSM. If, however, the desired result is defined in terms of number of positive cases identified, the unit cost of the new modality will more likely be equal or perhaps even lower that the current one. We can expect to diagnose more HIV cases via the navigation of networks of negative MSM with risk practices than through peer-led outreach among all MSM, regardless of their level of risk.

These are crucial considerations when CSO prioritize activities and cost them: whether the investment is worthy depends not on the overall necessary budget only, but also on the cost per each unit of results we wish to achieve. That unit cost depends on how we define the desired outcome. In our example, if the outcome is defined in terms of testing coverage, the unit cost will be lower with the current strategy, because what matters is how many MSM we test, not whether we find positive cases. If the outcome is the number or proportion of HIV cases identified of the total number of people tested, the new approaches will more likely show a lower unit cost.

There is something else. The law of the diminishing returns will also affect the new testing outreach modalities for MSM at some point. Shifting from 85% to 90% of MSMLHIV who know their status will be challenging, but we expect that an innovative approach (using networks of negative MSM at substantial risk for example) will help us get there. Once we have reached the 90%, the next 5 percentage points (up to 95%) will be even more challenging to attain, and the final 5% even more (100%!), if even possible. This means that, as we succeed, each time we will be trying to reach people who are harder to reach than the ones already reached. In other words, the cost to reach each additional unit of result (new HIV case identified) will be incremental.

The same thinking frame can be applied to TB and malaria as illustrated in the following examples.

In TB, one key task CSOs help to accomplish is identifying and reaching out to respiratory symptomatic people in the community. The success of that task can be measured against the estimated target of people with TB who have not yet been identified within a given period. As the number of respiratory symptomatic people reached, and hence, of newly identified TB cases, gets close to the estimated target, reaching each new case will more difficult over time, i.e., it will be more costly. The level of saturation of the indicator will tell you that the cost of identifying each additional new TB case won't be constant, but incremental. This is unless a new modality of reaching TB-suspected respiratory symptomatic people is designed and implemented in order to overcome the limitations of the previous one. Even the new modality will reach a saturation level at some point, following the law of diminished returns, and should then be reevaluated and probably replaced by a different one. This is an ongoing process until the targets are achieved.

Similarly, the distribution of insecticide-treated bednets to prevent malaria will have a lower cost for the percentage of the population easiest to reach. As that percentage decreases, the cost of the distribution will increase: each time, community health workers will need to go further away, or overcome more challenging geographical barriers, or invest in more cultural and linguistic resources to mediate between users and health providers. After a certain threshold, the unit cost to access each new household and provide bednets for family members will be more costly.

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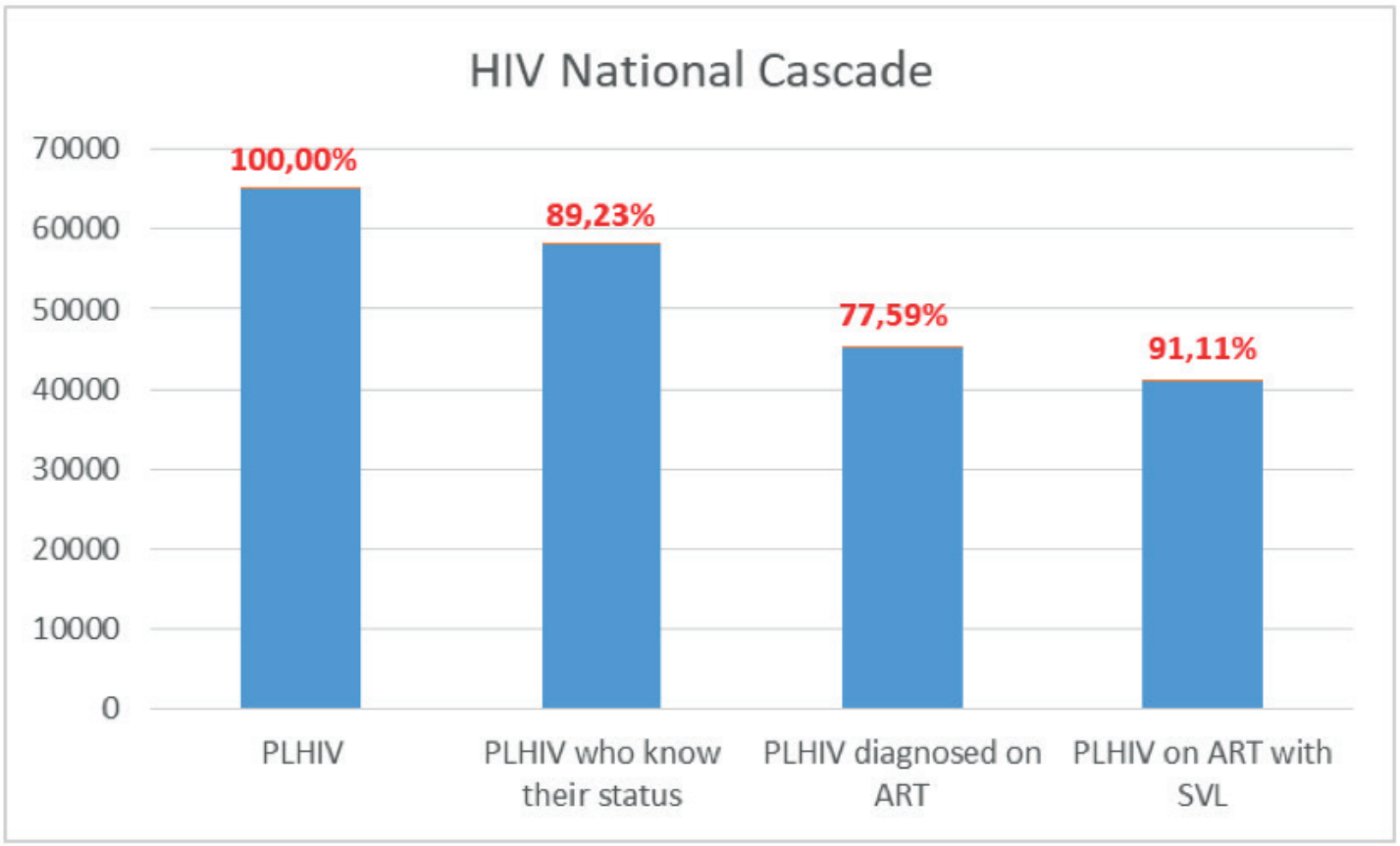
Smart Prioritization and Smart Costing

To continue discussing prioritization and costing, we will continue with an HIV example. Here we have Country Y's HIV National Cascade for all PLHIV.



In this example, we note that the percentage of PLHIV who know their status has reached almost 90%. We can also see that if people are on treatment, the likelihood that their viral load will be suppressed is very high. Kudos to Country Y for their success regarding these indicators. There is, however, an important gap: around 13,000 people who have been diagnosed are not on antiretroviral therapy. This may be due to a problem in linkage to care, to retention in care, or a combination of both. Using an allocative efficiency lens, it is clear for stakeholders in Country Y that addressing this gap should be a priority for the next National Strategic Plan. How can we help them?

Let's discuss the current situation. Country Y has been implementing support to PLHIV both to link new diagnoses to healthcare services and to strengthen adherence to therapy. While this approach has helped reduced the gap between those diagnosed and those in care in the past, in recent years the indicator has risen more slowly over time. In other terms, the current model to support linkage and care is affected by the law of diminishing returns.

When we look closer at the current modalities of support, we may note that they were non-differentiated, in the sense that support to linkage and to retention was offered to all PLHIV, regardless of their conditions or needs. Their specific needs, it should be noted, were not necessarily assessed. Not all PLHIV are equal and not all of them require the same support. Thanks to current activities, Country Y has been able to reach almost 78% of all diagnosed PLHIV on ART. These are the ones "easiest" to access with the current approach. Would we able to reach the remaining 22% by just expanding the current support offer, even if we undertake to increase its technical efficiency? This will depend on whether the remaining 22% carry the same personal characteristics of their peers who have been already reached. This is probably not the case. Those who were not "easy" to link to care will most likely show more complex conditions such as: extreme poverty, homelessness, substance use, mental health issues, long working hours in the informal sector, night work (including sex work), migration and mobility, violence, including gender violence, as well as other factors.

Identifying and supporting PLHIV who are more difficult to link and retain in care will require an analysis on how services might best be adapted to their needs. First, we must be able to identify the risks associated to persons who are lost-to-follow-up, either at linkage or at retention to care.

Assessing that risk can be done using a set of simple questions during HIV diagnoses or during visits to HIV care sites and may help identify the risk in advance, identify personal needs and provide specifically tailored multi-disciplinary interventions to prevent lost-to-follow-up. Each person is different and each case should be managed individually.

What do we do about the budget we have available to help PLHIV link and retain in care in these cases? In Country Y, we will need to create at least two lines of work: one for the PLHIV on ART who are not at risk and do not require help, or who require basic help or support upon demand; or the other one, for persons who require more complex, resource-intensive interventions in order to avoid being lost-to-follow-up. The unit cost of retaining one person on ART and obtaining SVL is not only higher in the second group: it will be incrementally more expensive. As we scale up from 78% of diagnosed PLHIV on ART to 85%, and from there to 90%, and then to at least 95%, each percentage point we want to gain of people on ART and with SVL will be increasingly costly.

You could do similar exercises regarding treatment for TB, where reaching targets in many countries is suboptimal, or for malaria, where required services are not always provided due to misdiagnosis or other obstacles. To the end, reaching the last mile of people to be treated for any of the three diseases face a similar challenge: the incremental cost for each additional person on treatment, including the incremental cost of the services which CSOs provide to help each of them access or be retained on treatment.

In Summary

Many countries in the Latin American and Caribbean region have made considerable progress in reducing the gaps in their HIV cascades, either in national or KP-cascades, as well as in regards to their TB and malaria indicator gaps. Important challenges remain, however, and must be addressed. The largest gaps need to be addressed not only to provide opportunities for people to access services that will help them prevent any of the three diseases or, if they are living with one of the diseases, help them to live longer and have a better quality of life (HIV) or be cured (TB and malaria), but also because it is more cost-effective. Investing where the largest gaps are, compare to other gaps, will yield better health results for each unit of resources invested.

In HIV, TB and malaria there are not populations hard to reach per se. Being hard to reach or not depends on the outreach strategy you use. Change to the appropriate strategy, and they might not be hard to reach anymore… until one reaches a new saturation point where the remaining population is (once again) hard to reach, but only in relation to the previously-innovative-now-obsolete strategy. The fact that each additional innovation is harder to design says less about the target populations than about your capacity to find new ways to reach them.

There is a cautionary note: no modality will last forever. Precisely when we have reached a saturation threshold for any given health result indicator (and HIV, TB and malaria are not exceptions to that rule), obtaining each additional unit of outcome will have an incremental cost – it will be increasingly higher.

When negotiating their participation to the national HIV, TB and malaria response, CSOs have the opportunity to increase the value of their contributions by making sure they select the gaps that are most relevant, and offer the service modalities that are specific to persons hardest to reach. In this process it is vital not to take for granted that their characteristics and needs are the same as for the people they were able to support up until now. CSOs must pay close attention to the fact that the service modalities adapted to the needs of people hardest to reach, link and retain in care will have different costs according to the characteristics of the person to be supported. And that those costs will increase as they succeed in bridging the gap, because reaching each new target level will require more and/or more specialized resources than the previous ones.

CSOs in LAC countries face a very challenging financing scenario. Following their transition and sustainability policy, Global Fund support is meant to be progressively reduced as countries change their epidemic situation and in terms of their income-per-capita status. In parallel, national authorities are often reluctant to finance CSO-led services in a way that is sufficient for effective services as well as fair and sustainable for the organizations. In such scenarios, prioritization criteria to allocate the limited available resources is fundamental.

This document was designed to help you think about, and act on those scenarios in a strategic way.

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