EXPERT CONSULTATION ON COSTING HIV RESPONSES IN ASIA

Workshop Report: Bangkok, Thailand, 28-29 October 2010

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Acronyms

ABC model	Activity Based Costing model
ADB	Asian Development Bank
AEM	Asian Epidemic Model
ASAP	AIDS Strategy and Action Plan
CAA	Commission on AIDS in Asia
CEA	Cost Effectiveness Analysis
GDP	Gross Domestic Product
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
HUCC	HIV Unit Cost Calculator
IDU	Injecting Drug User
MBB	Marginal Budgeting for Bottlenecks (MBB)
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MSM	Men who have Sex with Men
NSP	National Strategic Planning
OP	Operational Planning
PR	Principal Recipient
RETA	Resource Estimation Tool for Advocacy
RNM	Resource Needs Model
SDA	Service Delivery Area
SOP	Standard Operation Procedure
WHO	World Health Organisation
UNAIDS RST	Joint United Nations Programme on HIV/AIDS Regional Support Team
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund

Executive Summary

An Expert Consultation on Costing HIV Responses in Asia-Pacific was held from 28 to 29 October 2010 for expert developers and users to assess the usefulness of various costing tools for different purposes, as well as their comparability and complementarities. The meeting outcomes were intended to support the HIV National Strategic Planning process and Global Fund (and other) proposal development at a time when resources are expected to decline, so that countries must prioritize and implement the most cost-effective programmes. A total of thirty-four participants from among development partners and costing tool developers, as well as costing tool users and experts from various institutions attended the meeting.

The meeting was conducted with the following objectives in mind: (1) to assess nine costing tools used in the region based on technical and user criteria; (2) to develop harmonized guidance for countries on appropriate tools for costing the HIV response depending on purpose, focusing on linkages to NSPs, operational planning, project-level planning, and Global Fund and other donor proposal budgets; (3) to consider next steps for dissemination of the experts' costing guidance, piloting any new tools, and meeting technical needs; and (4) to identify organizations that can take forward any further technical development of costing models, and the ensuing technical support and capacity building.

During the meeting, nine commonly used costing tools/models were presented by the developers and expert opinions on them and costing processes in general were obtained. A variety of formats were used throughout the proceedings, including plenary presentations, group work, panel discussions and large group discussions, and before the close of the meeting the proposed outcomes of the meeting were presented and discussed via teleconference with Carlos Avila, Team Leader of Strategic Intelligence and Analysis UNAIDS, Geneva.

From technical review of the costing tools and discussions, the experts came to consensus that five core elements need to be included in a HIV costing tool: (1) calculation of unit costs for intervention services for the key at-risk populations in Asia-Pacific, namely injecting drug users, female and male sex workers and their clients, men who have sex with men, and other country-specific at-risk populations, as well as for lower risk populations; (2) costing of standardized components of service packages for each population that incorporate best-practice recommendations on required elements for interventions ; (3) ability to incorporate intervention coverage targets for different at-risk populations to estimate the cost of scaling-up services over a specific time period; (4) ability to make a financial gap analysis; and (5) instructions on costing procedures (user-friendly manuals).

Operational Planning was considered to be the key level for costing, because it is done more often, annually or biannually, and longer term NSPs need to be linked to the prioritized activity planning. If the above elements are included in a core costing application, additional elements such as cost-effectiveness analysis, budgets for proposals, etc. could be available in compatible, linked, extension models, rather than developing one super-model that fulfills all national costing needs. An Excel-based model is the preferred option since national capacity in Excel is good.

Most significantly, at the meeting the experts concluded that besides the actual costing tool, there are important upstream and downstream issues that need to be addressed to support country costing applications. These include: (1) standard definitions for costing terms such as budgets versus activity plans, unit costs (per package of services or per individual served), etc; (2) standard categories for cost elements such as commodities, treatment regimens, human resources, training costs, travel, etc; (3) standard operating procedures and guidelines for costing; (4) guidance on standard best-practice intervention packages; (5) information on cost effective interventions; (6) national ownership in the costing process; and (7) capacity building on the use of costing tools in countries. However, there are still important gaps on the linkage of costing tools to Global Fund application

The costing experts emphasized that costing cannot be done in isolation. All the costing tools assume a programmatic approach and hence there is a need for linkage with intervention programme experts and implementers to provide guidance on effective standardized packages of services and country-specific unit costs for them.

This thinking meshes well with the UNAIDS strategy of a prevention revolution with expanded treatment (Treatment 2.0) while promoting Human Rights. Business Plans are being developed of rights-based best practice packages, for which activities need to have costs based on actual programmatic data. Only then can we plan to scale up the HIV response based on funding realities and with the human resources to deliver.

The following areas for immediate support by development partners in the area of costing were proposed. Some actions can be undertaken at the global level while others need region-specific input include (1) **Guidelines** on cost-related definitions, cost categories and standard operating procedures for national costing needs; (2) **Costing model development** that incorporates standardized packages of services that can be linked to country-specific unit costs and programme effectiveness; and (3) **Technical Support and Capacity Building** on the commonly used costing tools.

1.0 Introduction

1.1 Background

At present various tools are used to derive cost-related information on the HIV response in countries. These include tools to derive unit costs, estimate total resource needs, cost strategic or operational plans, and to optimize resource allocation, track expenditure and estimate cost effectiveness. There is a lack of information or understanding in many countries among national HIV program managers and planners about the respective use, comparability, and compatibility among different tools. Consultants have personal preferences based on familiarity. For The Global Fund, proposals with separate commodity based budgets have to be derived, and there are problems since the Technical Review Panel cannot compare costs across proposals derived through different methods.

The necessity for an experts meeting on costing to address the technical issues was agreed upon at a teleconference among partners in February 2010. The need was reinforced by the fact that the meeting outcomes could support the National HIV Strategic Planning (NSP) process when the majority of countries in Asia-Pacific are developing new NSPs in 2010-2011 that need to be cost-supported. Also, the meeting would support Global Fund (and other) proposal development at a time when resources are expected to decline, so that countries must prioritize and implement the most cost-effective programmes. Discussions were expected also to include how resource needs estimates for NSPs will link in with Global Fund National Strategy Applications (NSA) to reduce the burden and emphasis on costing, and shift countries to focus on delivering an effective response.

This workshop was attended by a total of thirty-five representatives from development partners and costing tool developers, as well as tool users and experts from various institutions in the region. The meeting was organized by UNAIDS Regional Support Team Asia-Pacific (RST AP), with support from UNAIDS Headquarters in Geneva, the ADB and World Bank-ASAP. The full list of participants and the agenda are presented as Annex 1 and Annex 2 respectively.

1.2 Objectives

The objectives of the meeting were to:

1. assess nine costing tools used in the region based on technical and user criteria;
2. develop harmonized guidance for countries on appropriate tools for costing the HIV response depending on purpose, focusing on linkages to NSPs, operational planning, project-level planning, and Global Fund and other donor proposal budgets;
3. consider next steps for dissemination of the experts' costing guidance, piloting any new tools, and meeting technical needs; and

4. identify organizations that can take forward any further technical development of costing models, and the ensuing technical support and capacity building.

2.0 Proceedings

2.1 Opening session and Background Context to Expert Consultation on Costing HIV responses in Asia Workshop

2.1.1 Mr. Rikard Elfving, HIV/AIDS Coordination Specialist from Asian Development Bank gave the welcoming speech. He hoped that the participants would be able to come up with clear recommendations on how to move forward.

2.1.2 Dr. Amala Reddy, Regional Programme Advisor Strategic Information from UNAIDS Regional Support Team Asia-Pacific presented the background context leading up to the Expert Consultation on Costing HIV Responses in Asia.

Dr. Savitri Ramaiah, the facilitator of the workshop led the introduction of participants by dividing them into smaller groups based on their opinion on the most important reason for developing harmonized guidance on the appropriate tools for costing the HIV and AIDS response. A volunteer from each group then introduced the other group members and listed their core skills and expertise in costing. These included:

- Health economics
- Costing expertise
- Costing model development
- M&E
- Health system
- Strategic Planning
- Management and procurement
- Accounting and public health
- Grassroots experiences

2.2 Session I: The costing situation in Asia as we know it

In the first session, four speakers presented their thoughts on different perspectives on the costing situation in Asia for about 25 - 30 minutes each. In order to maximize the opportunities to clarify doubts and document the group's comments in a short time, the participants were asked to write the key learning points and their questions/comments on each presentation on colour coordinated cards. At the end of the four presentations, the speakers responded to the most frequently asked questions or comments only. Other doubts were clarified through written responses on the second day of the workshop.

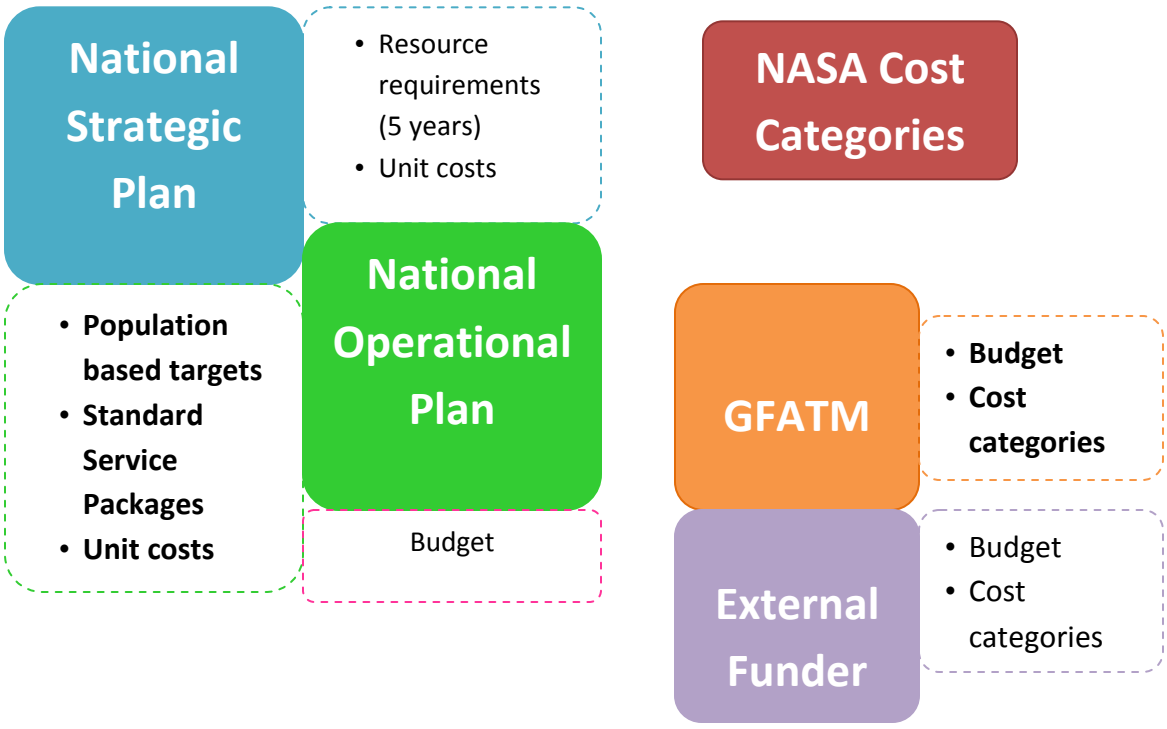
Mr. Michael Hahn , UNAIDS Country Coordinator Thailand presented an overview of the country costing needs in the region in relation to National Strategic Planning (NSP), Operational Planning (OP), Budgeting, and for proposals funding including for The Global Fund. (A copy of the presentation "*Country Costing Needs or Whose Reality Counts*?" is attached as Annex 3.) A key point raised was that with respect to costing the HIV response the scenario is always different in the "ideal world" versus the "reality". Figure 1 depicted that the main objective to do a costed NSP should be to serve as a guiding plan for countries, followed by a cost-supported OP, and then costing for funding proposals to GFATM and other external donors. Whereas, in reality GFATM has become the dominant country costing agenda, which is then following by needs for NSP and OP (Figure 2).

Some of the basic questions asked by decision-makers in countries during the costing process include:

(a) What does it cost to halve the number of new HIV infections in 2 years?
(b) How do we compare with other countries? Do we pay more or less?
(c) What is our benefit to invest in prevention? Why would we invest in harm reduction?
(d) How much does it cost to avert one HIV infection?
(e) What is the total economic loss caused by HIV over the next 10 years? And, what is the net benefit of expanded prevention?
(f) Why is the GFATM proposal on MSM much higher than the resource needs in the operational plan?

Figure 1: The "Ideal World" of costing

Figure 2: The "Country Reality" of costing



The presentation highlighted the fact that the main purpose for costing is to support countries' needs and save time, so that countries have more time delivering interventions. However, instead of helping the country to complete their work faster or make their life easier, the costing process has in fact become complicated by donors who require the same costing information in different formats, especially GFATM, and costing tools are too complex for all but a few experts to use. He differentiated among the needs for strategic planning, which are to define priorities, strategies to deliver services to specific populations, set targets and estimate total resource needs, versus the needs for shorter term activity-based operational plans to deliver standard services to populations using units costs for these packages of services. GFATM, on the other hand, needs activity-based budgets that follow specific cost categories, so that countries need to disaggregate activities into cost categories and "unpack" their standard intervention unit costs from OPs and NSPs.

Thus, we need to think about how we:

(a) Find out the cost for a specific strategy;
(b) Prioritize interventions based on evidence and costs;
(c) Cost an operational plan according to the population based targets as well as standard service packaging and use these costs for other purposes i.e. other funder's proposals; and
(d) Compare costs.

Michael concluded by summarizing the issues faced in costing that need to be addressed:

(a) Costing tools involve different experts, different plans, different tools, different formats and different costs;
(b) Lack of costing standards;
(c) The issue of Project costing (activity-based) versus Programme costing (results-based);
(d) National Strategic Plan Applications for Global Fund; and
(e) Using cost-effectiveness and resource need data for prioritization in the NSP.

2.2.1 Mr. Matthew Blakley talked about The Global Fund and Costing HIV response in Asia including funding decisions, perspectives on costing and budgeting and the challenges and opportunities (A copy of the presentation "*The Global Fund and Costing HIV Responses in Asia*" is attached as Annex 4.). He outlined the guiding principles of The Global Fund, but especially focused on the criteria for funding decisions by GFATM. Some key pre-requisites are the need for a coherent strategy throughout the proposal that responds to the prevailing epidemic situation, a robust gap analysis both programmatic and financial, a budget sufficiently detailed to allow costs of activities to be assessed, a clear workplan with accompanying M&E plan. He stressed the "value for money criterion" of GFATM and its Performance Based Funding that "ensures funding decisions are based on a transparent assessment of results against time-bound targets".

Matthew presented the feedback from the Technical Review Panel (TRP) for Round 9 and Round 8 proposals relevant to costing (Table 1) in four areas, namely, coherency, alignment with national strategy, planning tools and proposal technical assistance as well as targeting.

He also presented the GF perspective on proposal costing approach as below:

(a) Neutral funding platform without specific preferences or requirements on costing approach;
(b) Primary interest is that output from a costing should be directly/indirectly translatable to GF budget, overall proposal/grant requirements;
(c) Reviews of National Strategic Application First Learning Wave suggested that selected costing approach should be appropriate for context; and
(d) Significant challenges created by changing costing approaches during application process.

Table 1: Feedback from TRP relevant to costing based on Round 9 and Round 8 GFATM applications

GF Application	Coherency	Alignment with national strategy	Planning tools and proposal technical assistant	Targeting
Round 8	Essential need for coherency and logic between the objectives, program areas (SDAs), the budget, a separate detailed work plan, and the 'performance framework'.	Recommends countries consider preparing proposals less regularly, and when made, draw on the national strategy to describe (and request funding for) gaps to ensure a comprehensive response to the diseases.	Recommends to Stop TB partnership that its budgeting and planning tools be presented to applicants with more flexibility (i.e., less 'bundling') … this may encourage applicants to select out priority interventions most relevant to the specific epidemiological context and national priorities.	Too many proposals there was insufficient thought given to the current epidemiological situation, with inappropriate, unfocused activities proposed for concentrated epidemics.
Round 9	Importance of having proposal narratives that are well aligned and consistent with submitted budgets and work plans.	Rounds-based applicants should ensure that proposals submitted are within the context of existing national plans and frameworks (expenditure and M&E).		

Matthew clarified that the GFATM budgeting guidelines available on the website are intended to help countries, and contrary to the commonly held belief, the template is optional and meant to incorporate some flexibility. A good GFATM budget should have detail, clarity and consistency.

Matthew concluded with observations on the challenges faced by The Global Fund, in particular that by becoming one of the largest funders of HIV programs, it is inherently vulnerable to misallocation of finances and doubtful impact. However, he said that The Global Fund was committed to a common workplan and follow-up, and to work towards improving linkages between Global Fund budget and overall programme costs and strategies. He promised that the meeting outcomes would be seriously considered by GFATM.

The list of questions asked by the participants along with the responses is included in Annex 5.

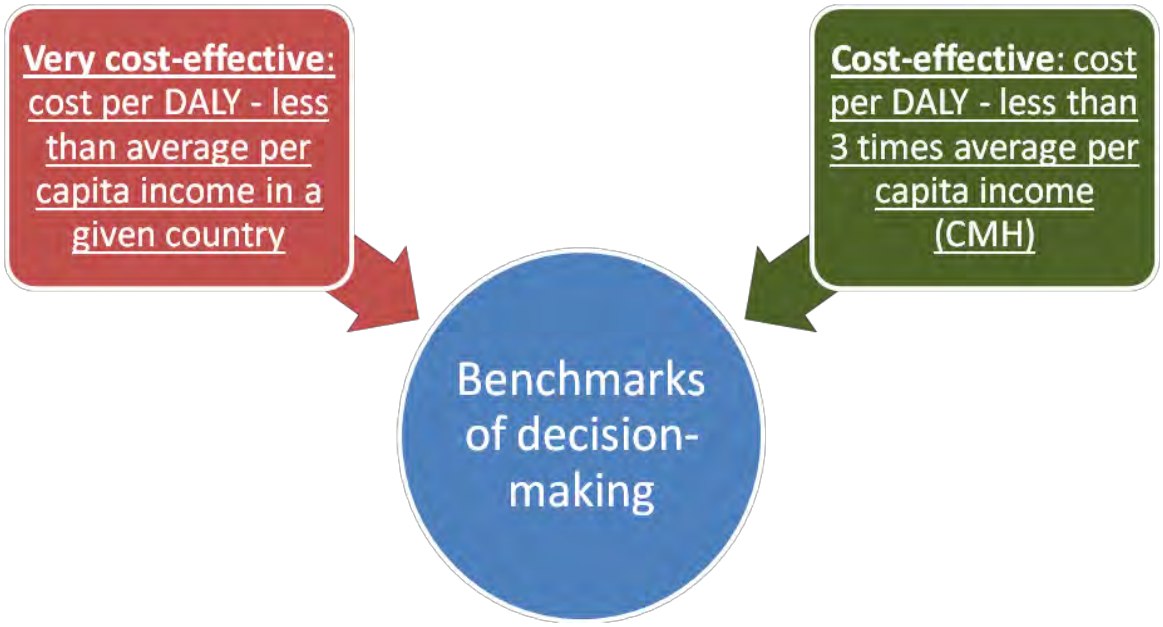
The majority of the participants had concerns about the way Global Fund proposal development is so complicated and yet so necessary that it tends to overwhelm and lead other country planning processes, including costing. Instead of this, the participants suggested that in order to enable countries' responses, The Global Fund needs to:

- demonstrate increased commitment to the concept of "helping PRs building proposals, managing operations";
- strengthen capabilities of countries to develop comprehensive plans based on national requirements, and M&E processes etc;
- articulate the definition and application of what it means by "value for money";
- consider whether Performance Based Funding is perhaps one of the contributing factors to misallocation of funds because some results are not easily measurable or evident within the time period of the grant, especially in low-level epidemics or during the capacity building phase of implementation;
- link GF costing and budgeting with country's costing and budgeting;
- select cost effective intervention "bridges" between NSP and GF costing requirements in spite of different costing tools;
- further adapt and strengthen its processes based on the experiences of economists from 6-8 countries in the region on costs and cost effectiveness; and
- address challenges in planning and disbursement of funds.

2.2.2. Dr. Anita Alban and Ms. Nalyn Siripong presented two papers on Cost effectiveness. Anita shared her experience from reviewing the Cost-effectiveness Analyses of Injecting Drug User Interventions to prevent HIV in Asia. (A copy of the presentation "*Review of Cost-effectiveness Analyses of Injecting Drug User Interventions to prevent HIV in Asia*" is attached as Annex 6). The presentation highlighted the benchmarks of decision- making recommended by WHO (Figure 3) and how cost-effectiveness analysis is an important tool for decision-making.

She used evidence-based results to show that HIV IDU interventions in Asia are very cost-effective at USD 64-325 per DALY, at low and high coverage levels. However, low coverage levels cannot bring down the prevalence rates. As a result, both effectiveness and cost-effectiveness analysis are needed for planning purposes.

Figure3: Benchmarks of decision-making recommended by WHO



Nalyn presented the cost effectiveness analysis tools linked to the AEM model. (A copy of the presentation "*Cost-effectiveness analysis*" is attached as Annex 7). With its cost effectiveness analysis tools the model can help decision makers understand the consequences and impact on the HIV epidemic of different approaches to interventions (or lack thereof) through "scenario building". Although she presented the model as a powerful tool for advocacy and planning, she also stressed the importance of ensuring that this analysis only be conducted with a strong understanding of the epidemic data and its limitations.

The list of questions asked by the participants along with responses is included as Annex 8.

Key learning points documented by the participants at the workshop based on these presentations included:

- It is important to understand that cost-effectiveness should be an integral part of assessing and prioritizing different interventions during strategic planning;
- The existence of only a few studies on cost effectiveness makes it difficult to learn from experiences, hence these studies must be undertaken by independent researchers;
- M&E is vastly underfunded and so is research;

- AEM tool helps prioritize interventions if we have good/reliable data;
- Economies of scale on coverage is important when considering cost-effectiveness;
- Benchmarks for decision-making recommended by WHO on cost-effectiveness;
- Discounting rate is included for both costs and effectiveness/ outcome to accommodate uncertainty over time; and
- Link between coverage and prevalence of IDU means cost-effectiveness is useful but not sufficient to determine how to 'halt and reverse' the epidemic.

Mr. James Moore and Dr. Sudhashree Chandrashekar from the Avahan program of the Bill and Melinda Gates Foundation, India Office, presented the Avahan approach to costing HIV interventions and scaling up. James focused on the Avahan project as the business of prevention at scale with perspectives, methods and issues surrounding the cost estimates for scaling up HIV prevention. (A copy of the presentation "*AVAHAN: The Business of Prevention at Scale AT SCALE-Perspectives, methods, and issues surrounding the cost estimates for scaling up HIV prevention*" is attached as Annex 9). He stressed that optimising investment on project management is required for a successful project, with the understanding of the local context to address the concerns on-the-ground in order to deliver intervention programmes effectively. Nevertheless, for every $100 spent on most-at-risk population (MARPs) at l*east 60% should be spent in grassroots implementation.*

Dr. Sudhashree then presented a paper from the economic analysis perspective. (A copy of the presentation "*Economic analysis of Avahan Interventions in India*" is attached as Annex 10). *She* presented the results generated from the methodological framework of cost analysis that was built along with M&E over 4 years of the Avahan project. She commented that costs incurred at central level during early years were to provide high level technical and management inputs. These were to ensure the quality and consistency of services and supplies, and to develop management systems while scaling up was quantified, and were rarely reported in many studies. Furthermore, the average cost variation within the Avahan project was largely explained by scale, number of NGOs per district, number of Lead Partners (LPs) in the state and project age.

The list of questions asked by the participants along with the presenters' responses is included in Annex 11.

Key learning points from this presentation include:-

- Flexible funding for innovation helps tailor programmes to context; and
- Optimise management costs versus implementation cost to maximize results.

2.3 Session II: What do we want - or think we want?

The main objective of the session was to discuss the requirements of costing models for different country purposes and to develop criteria for effective costing models from technical and users' perspectives. The participants were divided into four purposefully divided working groups. so that each group had members with technical expertise and also expert model users, The groups were asked to develop criteria for costing models that would address national needs for costing of National Strategic Plans, Operational Plans, GF Proposal budgets and for Project-level planning by communities or for other donor funding. The criteria developed by the groups for different costing purposes, as depicted in Table 2, were reported back to the plenary before the next session.

Table 2: Criteria for effective costing models for different costing purposes

National Strategic Plans group	Operational Plans group	Project Planning groups	GF Proposal budgets group
Criteria for outputs – 5 years resource needs	• Has easy interface to model impact; • Has templates and guidelines to establish unit costs; • Has flexibility to adapt to local context; • Links to global fund operational plan; • Defines broad procurement and supply needs; • Defines human resource needs; • Has good user manual; • Has support mechanism to use the tools and address problems in any; • Availability of finances; • Financial gap analysis; • Is compatible with other partners.	***Includes standard categories of principles for proposal***	• Harmonisation with costing for NSP and other HIV programs; • To focus more on results rather than outputs; • Detailed information on unit costs; • Use of same definitions for unit costs for GF, operational plans and NSP; • To cost package of services.

• Provides resource needs per programme area
  ○ –interventions;
  ○ target population;
  ○ geographical area;
• Is compatible with other sector outputs;
• Identifies resource gap.
		• Interventions cost
		• Infrastructure cost
		• Capital cost
		• Administration cost
		• M&E cost	

Criteria for inputs		***Defining information needs***	
• Prioritises programmes and geographical area; • Defines targets per year; • Defines intervention packages; • Calculates unit cost (per package).		• Defining minimum package of services to derive the unit costs	
Data and analysis requirements for inputs		***Should track expenditure***	
• Epidemiological and programme information; • Aggregated and programme costs; • Efficiency and cost effectiveness.		• Track budget versus actual expenditure; • Facilitate periodic review of unit cost; • Is able to analyse outputs; • Is able to analyse programme effectiveness.	

2.4 Session III: What do we have now?

The key purpose of this session was to give the participants an overview of the commonly used costing models. The model developers and consultants at the meeting who were experts on the various costing models gave a 5 to 10 minutes presentation each on a total of eight (8) key models: RNM, GOALS model, Costab model, HUCC model, ABC model, The Asian Costing Tool, RETA and the MBB model. A brief description of each model, its primary purpose, key features, inputs, outputs and disadvantages were discussed. Details of the presentation sets are presented as Annexes 12 – 18.

2.5 Session IV: Costing Models Display for Review by Plenary

All nine models considered at the meeting were displayed for review by the participants at a 'Models Marketplace' of fixed stations with displays on each model outlining key features, as well as hands-on computer access to each model. This session was intended to reinforce the presentations from the previous session and encourage the participants to learn more about the models through their display at the venue.

The expert participants were encouraged to share their opinions on the various models through discussions and through written comments. Based on this initial review of the nine costing models a table of the costing applications, with the strengths and limitations of each model was constructed as in Table3.

Table 3: Expert Review of Some Commonly Used HIV

Models	Purposes	Key features	Inputs	Outputs	Limitations
Resource Needs Model (*Rachel Sanders)*	• To estimate costs of a comprehensive national response (used in national strategic plans or national programmes)	• Used by UNAIDS for Global Resource Needs Estimates since 2001 • Flexible excel based model • Linked with the Goals model to estimate impact of a programme • Built in capacity to estimate scale impacts on unit costs for some services	• Target population • Coverage • Cost of intervention per person reached	• Resources required by intervention and component • Resource gaps	• Input information is not centralized (dispersed over many spreadsheets)
Goals Models (*Rachel Sanders)*	• To estimate the cost and impact of a package of interventions on new infections, treatment and mitigation coverage • To examine different resource allocation scenarios • To align activities and targets with national goals	• Relating expenditures to goals for prevention and care • Ability to estimate impact.	• Budget line items to coverage of services, behavior change and prevention of new infections • Coverage the percentage of the population	Impact and cost – effectiveness by intervention	• Estimates of new infections come from Spectrum and do not reflect interaction dynamics among at-risk groups. • Estimates of behavioral impact related to coverage are not proven in all settings and do not identify necessary quality/dose/frequency standards required to invoke behavior change
INPUT *(Anita Alban)*	• To provides unit costs for key prevention with emphasis on MARPs and treatment interventions at strategic planning level	• EXCEL spreadsheets • Includes only global recognized best practice interventions	• Each programmatic interventions has its own sheet that provides details as well as overview of cost of behaviour change, commodities and services, enabling environment,	• Unit costs for key prevention and treatment interventions	• INPUT model is not appropriate for operational costing. it has worked with estimated norms: cost of a workshop, cost of new clinic etc.

Models	Purposes	Key features	Inputs	Outputs	Limitations
			programme management, investments and M&E.		
Costab model (*John Cameron)*	• To help financial analysts, project economists, and engineers estimate project cost which include interest charges, front-end and commitment fees during project implementation, following ADB's standards.	• Database costing tool • Used to analyse, summarize and present project financial and economic costs • A robust model which can be readily altered to suite operators needs	• Develop model structure – components, sub-components, expenditure and procurement accounts • Unit costs and progamme targets • Operator training	• Cumulative costs according to investment and operational costing, components e.g. prevention and sub components such as MSM, units • Expenditure Accounts • Cumulative data according to financiers • Procurement methods • Introduce analysis of physical contingencies , price contingencies, local inflation, international inflation, identification of local currency requirements and foreign exchange, identification of taxes on all inputs and economic cost versus financial cost	• Difficult to set up • Not particularly user friendly - but ok • Not supported difficulties with latest software • Weak manual
HUCC model	• To help HIV/AIDS costing practitioners develop unit cost data which, in turn, can be used as input for the calculation	• Excel file • WHO cost categories • Could be a companion model for Costab • Calculation of regimes	• Base data input	• Provides a summary of unit costs- before and after apply overheads • Total cost based on user-entry of	• Service packages for prevention for MARPs is not explicitly setup

Models	Purposes	Key features	Inputs	Outputs	Limitations
	of costs for national HIV/AIDS prevention, care, and treatment programmes.			population targets [	
ABC Model (*John Cameron)*	• To examine the impact of different coverage levels, unit cost reductions and various combinations of strategic plan activities to determine how best to live within overall funding constraints.	• Excel based • Logical menu-driven sequence of steps • Level of detail up to the user • Allows mapping of expenditure types to government accounting framework • Supports complete cycle of planning, budgeting, operations and evaluation • Inflation capability at users discretion • Financing gap analysis • Unit cost report • Templates for M&E & training • Coverts results to format suitable for Global Fund Proposals	• Basic data • Targets and coverage levels • Unit cost	Estimate budget that follows GFATM template	• Too big for Excel • Thorough understanding and training needed to be able to used effectively
Asian Model (*Kazayuki Uji)*	• To estimate unit costs and total resource needs	• Strong alignment with the Commission on AIDS in Asia Report • Onsite unit cost calculation function and resource needs estimations • Enhanced analytical functions • Target-based approach • User friendly • Direct importation of data from RETA model for the MSM community	• Project-level expenses for the unit cost • Unit cost • Population estimates • Specific target	• Unit cost • Resource needs estimations • Resource availability • Resource allocation in terms of expected impact as per Commission on AIDS in Asia	• Simplicity sometimes compromises the accuracy (e.g. Use of *average* unit cost) • It does not say anything about future course of epidemic

Models	Purposes	Key features	Inputs	Outputs	Limitations
RETA (Brad Otto)	• To assist community advocates and their partners in expanding the evidence base for advocacy for increasing resource allocation to effectively scale up HIV prevention programmes for men who have sex with men	• Different languages • Microsoft Office Excel spreadsheet • specific to men who have sex with men and breaks down into sub-populations, addressing prevention and enabling environment	• Population size • Population coverage scale up target • Costing information (detailed budget)	• Annual cost of comprehensive package of services • Estimated annual funding gaps	• Addresses only one target population - working towards providing similar tools for FSW and IDU but even then, this tool cannot estimate total resource needs for the response
Marginal Budgeting for Bottle (MBB) for MDGs (Kway Myint Aung)	• To establish evidence based policy, planning, costing and budgeting at country and district level.	• Not exclusively for HIV/AIDS but MDG • Selections of languages • Comparison scenarios • Compare group • Default database in absence of local data	• Demographic data • Epidemiology data • Health system • Health intervention • Coverage • Macro economics	• Cost and impacts • Cost gap • Cost breakdown - programmes - Funding sources - NSP and etc • Human resources needs	• Does not address the whole HIV response but only elements that pertain to maternal and child health

Note: Some of the general limitations of all the costing models are:

- They are highly dependent on validity of data inputs used on population sizes and unit costs; and
- Inputs for several require data from Spectrum or other epidemic projection models for population size and ART estimates.

2.6 Integrating gender perspectives and programmes into costing of HIV responses

Day 2 started with a presentation related to gender perspectives. Ms. Jane Wilson presented a paper on integrating gender perspectives and programmes into costing of HIV responses. This presentation was to remind the international, regional and country participants that gender issues need to be taken into consideration during project planning. A lot of progress has been made in this respect, with nine countries showing progress in gender issues, i.e. gender analysis, men and boy's sexuality programmes, and leadership programmes for positive women. Jane highlighted three (3) key recommendations at the presentation: (a) to jointly generate better evidence and increased understanding of the specific needs of women and girls in the context of HIV and ensure tailored national AIDS responses ("knowing your epidemic and response"); (b) to translate political commitments into scaled-up action and resources that address the rights and needs of women and girls in the context of HIV; and (c) to champion leadership for an enabling environment that promotes and protects women's and girls' human rights and their empowerment in the context of HIV. Gender issues related to project planning need to be have HIV costing attached in order to move forward. Some participants questioned the effectiveness of 'gender-centered' programmes and suggested that evidence of their effectiveness and impact are required before countries should be advised to implement and cost such interventions.

A copy of the gender presentation is attached as Annex 19.

2.7 Session V: How do the costing models relate to what we want?

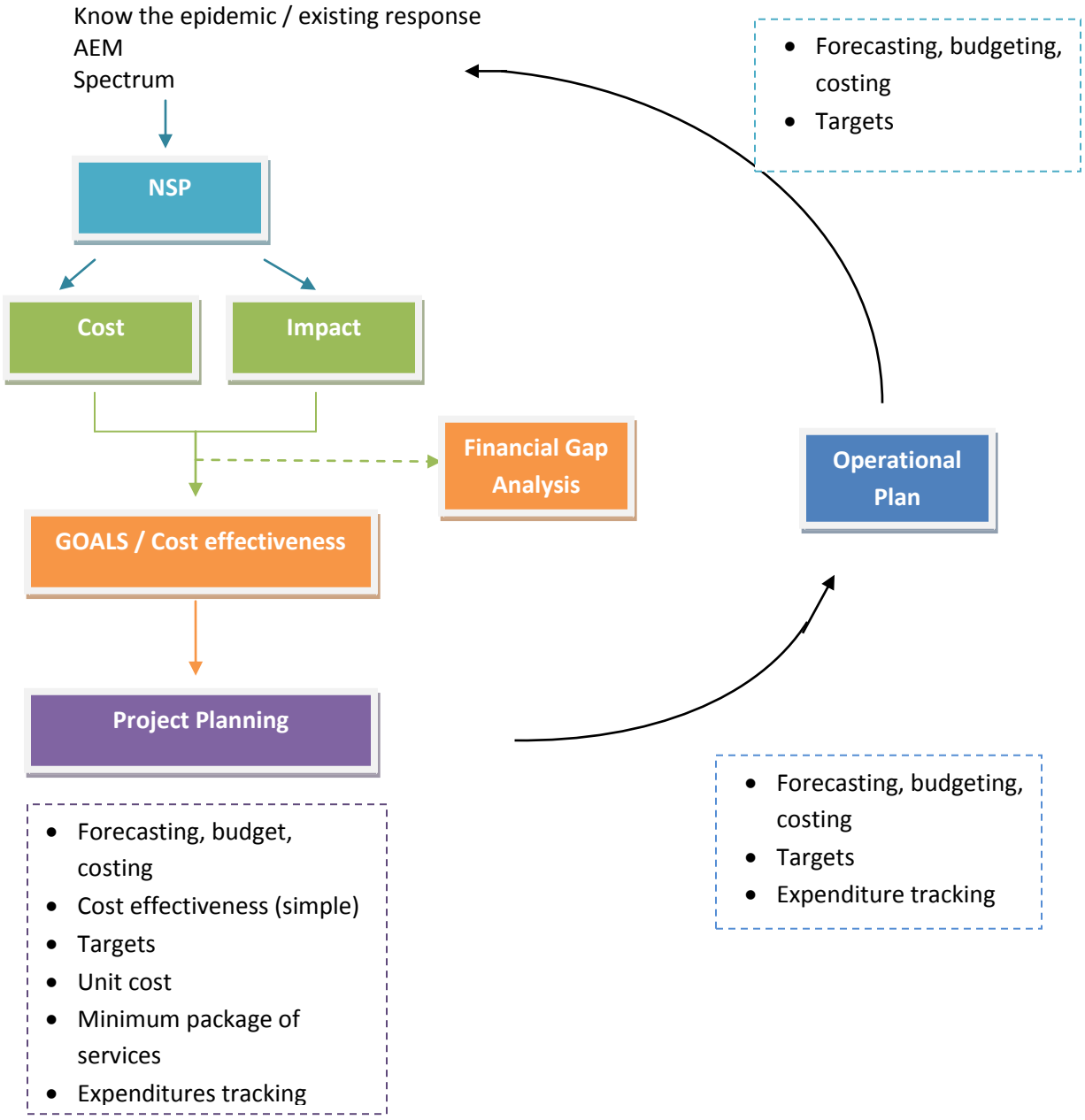
2.7.1 The same four working groups from Day 1 discussed and built consensus on (a) country guidance on important issues identified as needing to be addressed for costing projects, an Operational Plan and a National Strategic Plan; and (b) how the existing costing tools help address these issues. The discussion was based on the summary of needs and criteria determined on Day 1 as stated below:

1. Forecasting, budgeting , costing
2. Unit cost of intervention elements
3. Linkages
    a. Project to OP to NSP
    b. Outcome and impact
4. Costing procedures
5. Resource tracking
6. Targets
7. Cost effectiveness
8. Minimum package of services

9. Financial gap analysis

By using the *pyramiding* method, the original four working groups were merged into two working groups. Each respective group was required to convince the other to build consensus on the outcome through in-depth discussion. The two groups presented their outcomes to the plenary (Figures 4 and 5), and finally they were combined again into one group that arrived at a single group consensus (Figure 6).

Figure 4: Group 1 presentation



Mr. Taoufik Bakkali, Senior Monitoring and Evaluation Advisor, UNAIDS India, presented the Group 1 idea to the plenary on how the costing models related to what we want. The participants expressed themselves from two different perspectives, namely, (1) what are the requirements from costing tools, and (2) how to use them/ what to use. They looked at the different linkages between a National Strategic Plan, an Operation Plan and Project Planning and how each needs to have harmonized costing procedures and tools (see Figure 1). The group emphasized that before staring the process of NSP, it is important to know the epidemic and the existing response. This generates information on projecting targets, which serve as the input for developing and comparing different strategies. During the planning process, the elements which guide decision-making process are cost and impact, leading to assessment of the cost effectiveness. One of the issues raised during the discussion was the likelihood that measuring cost effectiveness may be beyond the features of costing tools. They concluded that two separate tools might be required to look at the cost and impact respectively, with each set of tools being comparable and complementary.

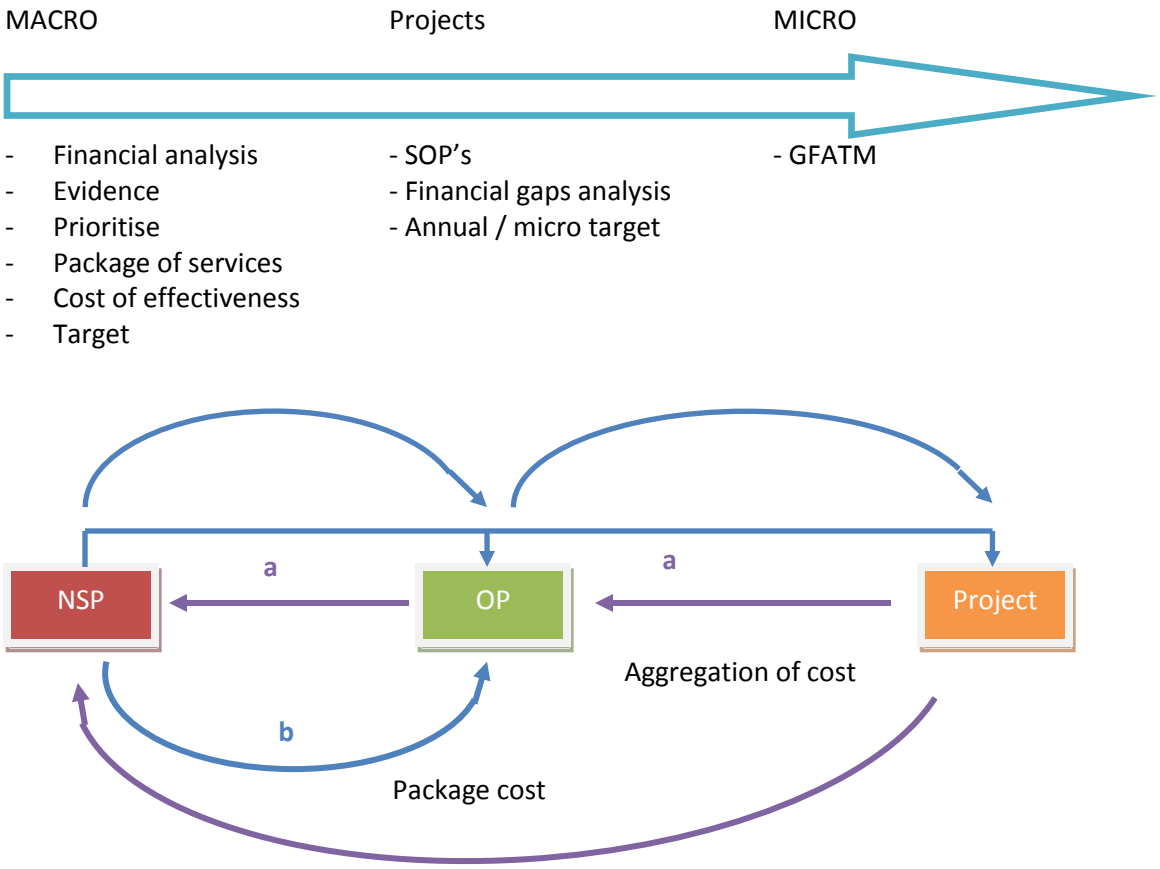
The group observed that costing requires a significant level of information gathered from project-level implementers, such as defining unit costs for strategic or operation planning. There was some discussion about the prevalent dissimilarity of cost categories, for example, cost categories between budgeting and expenditure tracking using information from NASA or National Health Accounts led to difficulties to fit the information into the costing tools. For this reason, the group stressed that standardisation of cost categories across different processes is necessary.

Based on the nine desired costing elements defined earlier, Group 1 agreed that the five core key elements for a costing tool and the cross cutting issues are:

1. Unit Costs
2. Costing procedures
3. Target setting
4. Packaging of services
5. Financial gap analysis

Unit costs used in a cost estimation tool need to be harmonized with existing information coming from programs and/or calculated with other tools. The tool itself should follow standardised costing procedures so that calculations are made consistently across different interventions and important components are included. It should consider different target setting scenarios so that the impact can be projected when changes in targets are made. The package of services considered should be based on best practices, and cost effectiveness analysis is also important. In some situations, financial gap analysis is also very helpful and necessary.

Figure 5: Group 2 presentation



Mr. Michael Hahn, UNAIDS Thailand Country Coordinator, presented to the plenary the Group 2 idea on how the costing models relate to what we want. The group presented their analysis that costing-related activities need to proceed in two directions:

(a) From micro to macro level i.e. from project level to NSP through aggregation: Financial data from the project level is required to calculate the unit cost of services as inputs for the NSP, with information such as evidence-based effective intervention programmes, prioritization, cost effectiveness, etc. required.

(b) From macro to micro level i.e. from NSP to project level: The minimum package of best practice services prioritized in the National Strategy should be used to inform and provide costing information for activities in the operational plan, which in turn should inform the project level.

There were a few issues that Group 2 highlighted as follows:

1. The group discussed a major limitation of the current tools – inability to disaggregate costing data from macro to micro level and vice versa, such as project level data to

aggregate for NSP, which then has to be repackaged (disaggregated) to meet the costing requirements of The Global Fund.

2. The group also highlighted the disconnect normally observed between programmes and planning, although synchronization is called for. Strategic planning typically gets translated from the top planners to field level yet the financial information moves from bottom to top, but there is limited harmonization. Thus costing experts are dependent on project level implementers to provide detailed costing data in order to make a resource needs estimate of the NSP. Yet often the data used by costing experts in resource needs tools for NSP are not supplied in a usable form or are based on proxy data from other countries. Thus, the main issue here was that countries required capacity in delivering plans based on high-quality epidemiological and program data, and need to understand that costing and programmes are closely interrelated.
3. Another concern expressed was a lack of standardised procedures/ guidelines on costing; which leads to reinvention of the tools again and again.
4. The group felt a strong need for an agreement on the definitions used – such as budgeting versus costing. Only once the definitions are well defined and explained can we make an accurate cost estimate that will also estimate the coverage needed to reverse the epidemic.

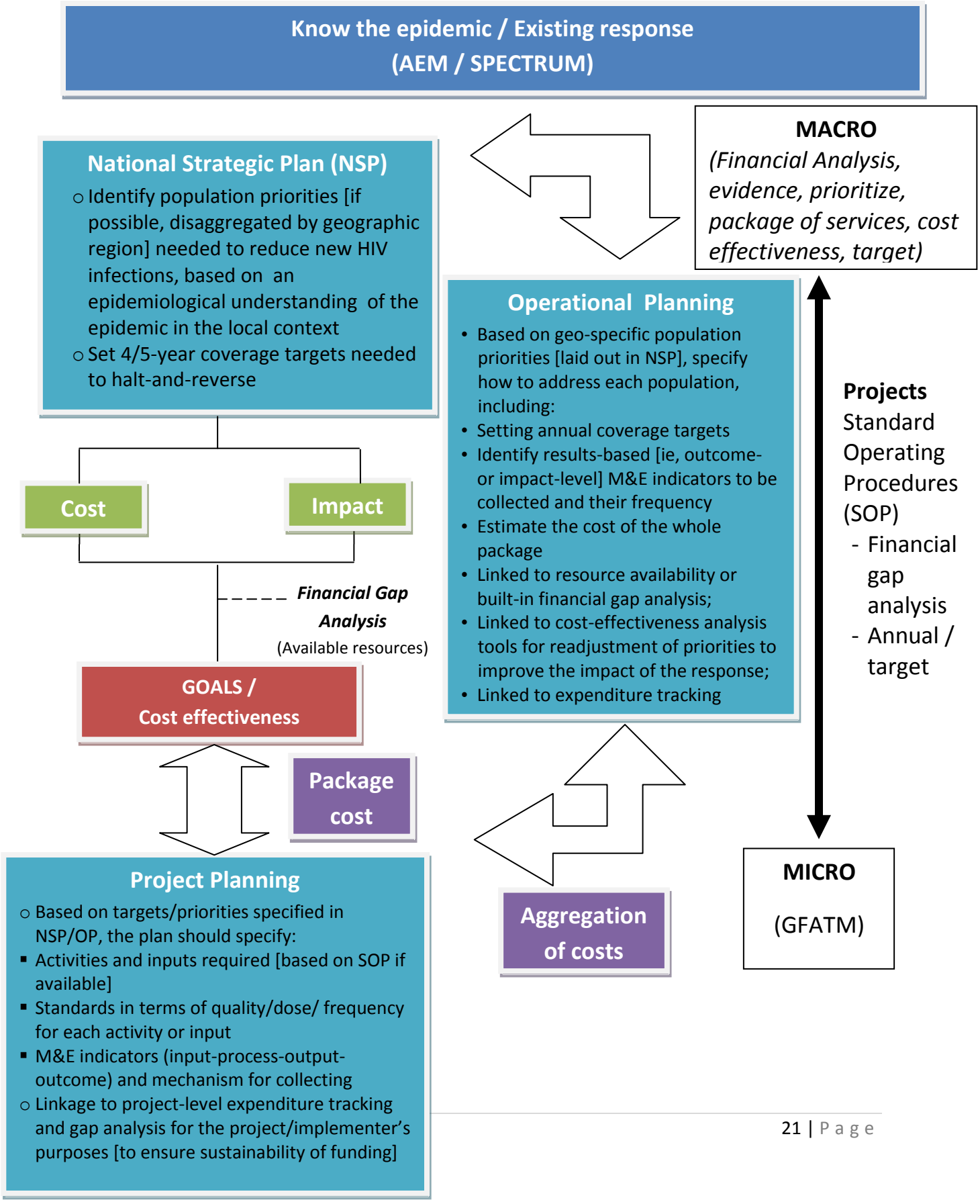
2.8 Session VI: Getting to where we want to be?

2.8.1 Mr Steve Kraus, Regional Director of UNAIDS RSTAP, the session chair, gave a welcome note to all participants and thanked them for their involvement. He expressed a special thanks to the participants from national programmes, governments and The Global Fund.

Mr Carlos Avila, Team Leader of Strategic Intelligence and Analysis from UNAIDS Geneva, joined the meeting on the last afternoon via videoconference. He explained that UNAIDS Geneva is focusing in a more holistic way on investment in the AIDS response and its benefits. He highlighted the issue of costing and its connection to programme effectiveness. He emphasized that effectiveness should be based on the recommendations from the Commission on AIDS in Asia Report. Currently, the region is still under-investing in programmes on the most-at-risk population. Costing efforts need to move ahead to demonstrate the case for AIDS spending by identifying where the money has been invested and how to maximize the impact. Lastly, it is important for funding partners to fund the most effective programmes. He shared with participants that a costing tool is being developed to cost 7 elements for effective interventions that promote Human Rights of key populations, and that Geneva would be looking for country collaboration to test this model.

Figure 6 summarizes the consensus built from the group work on guidance for countries on the linkages in the costing process

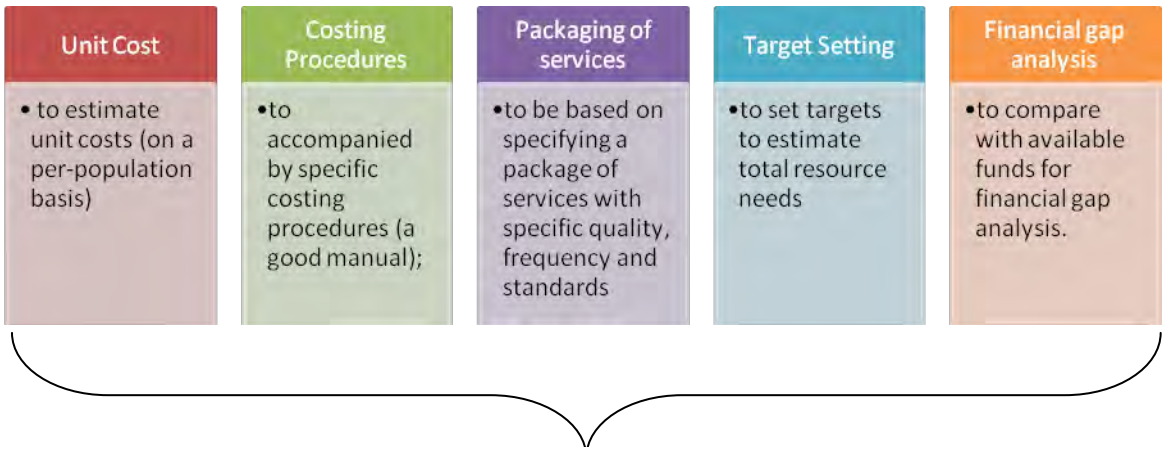
Figure 6: Linkage between the National Strategic Plan, Operation Plan, and Project Planning and how they fit into the costing process at country level



Based on the country costing process consensus were derived the five key elements that are required in a costing tool as shown in Figure 7 and described below:

1. Calculation of **unit costs for intervention services for the key at-risk populations** in Asia-Pacific, namely injecting drug users, female and male sex workers and their clients, men who have sex with men, and other country-specific at-risk populations, as well as for lower risk populations
2. **Costing of standardized components of service packages for each population that incorporate best-practice recommendations** on required elements for interventions
3. Ability to **incorporate intervention coverage targets** for different at-risk populations to estimate the cost of scaling-up services over a specific time period
4. Ability to make a **financial gap analysis**.
5. Instructions on costing procedures (**user-friendly manuals**)

Figure 7: Key elements of a costing tool



1. Linkage to / compatibility to cost effectiveness analysis tool;
2. Flexibility of output/ input;
3. Adaptable to local situation/ needs

Operational Planning was considered to be the key level for costing, because it is done more often, annually or biannually, and longer term NSPs need to be linked to the prioritized activity planning.

The costing experts emphasized that costing cannot be done in isolation. All the costing tools assume a programmatic approach and hence there is a need for linkage with intervention programme experts and implementers to provide guidance on effective standardized

packages of services and country-specific unit costs for them. Flexibility is needed because the level of details required for NSP and OP were different.

Costing tools should aggregate or extrapolate cost data from a lower-level (usually the project-level) to the operational/ strategic plans at the provincial or national level (from micro to macro level). Specifically, most tools should use (1) unit costs from the project-level and (2) coverage targets from the strategic or operational plan, to achieve a costed national strategic plan that estimates total resource needs. Once having assessed or projected available resources, countries would be able to perform a gap analysis. Based on this assessment, they could then conduct cost-effectiveness analysis to prioritize activities within current resource constraints.

At the moment, there is no 'super model' which can accommodate all the needs. The existing models that try to incorporate multiple elements often become totally complicated and hard to operate. Some people suggested during the discussion that there may be need for developing a new tool to address all of the needs, but most agreed that if the above elements are included in a core costing application, additional elements such as cost-effectiveness analysis, budgets for proposals, etc. could be available in compatible, linked, extension models, rather than developing one super-model that fulfills all national costing needs. An Excel-based model is the preferred option since national capacity in Excel is good.

Most significantly, at the meeting the experts concluded that besides the actual costing tool, there are important upstream and downstream issues that need to be addressed to support country costing applications. These include:

- Standard definitions for costing terms such as budgets versus activity plans, unit costs (per package of services or per individual served), etc.
- Standard categories for cost elements such as commodities, treatment regimens, human resources, training costs, travel, etc.
- Standard operating procedures and guidelines for costing
- Guidance on standard best-practice intervention packages.
- Information on cost effective interventions
- National ownership in the costing process
- Capacity building on the use of costing tools in countries

Most of the group agreed that in the future, an ideal tool should also facilitate an additional option that allows countries to conduct the reverse process: that is, based on their national (or provincial-level plan), it should allow planners to parcel out one sub-project or sub-section (by geographic region, sub-population, and/or specific project) in order to request funding from any other donors such as Global Fund. This would ideally occur at or just before or after the gap analysis phase.

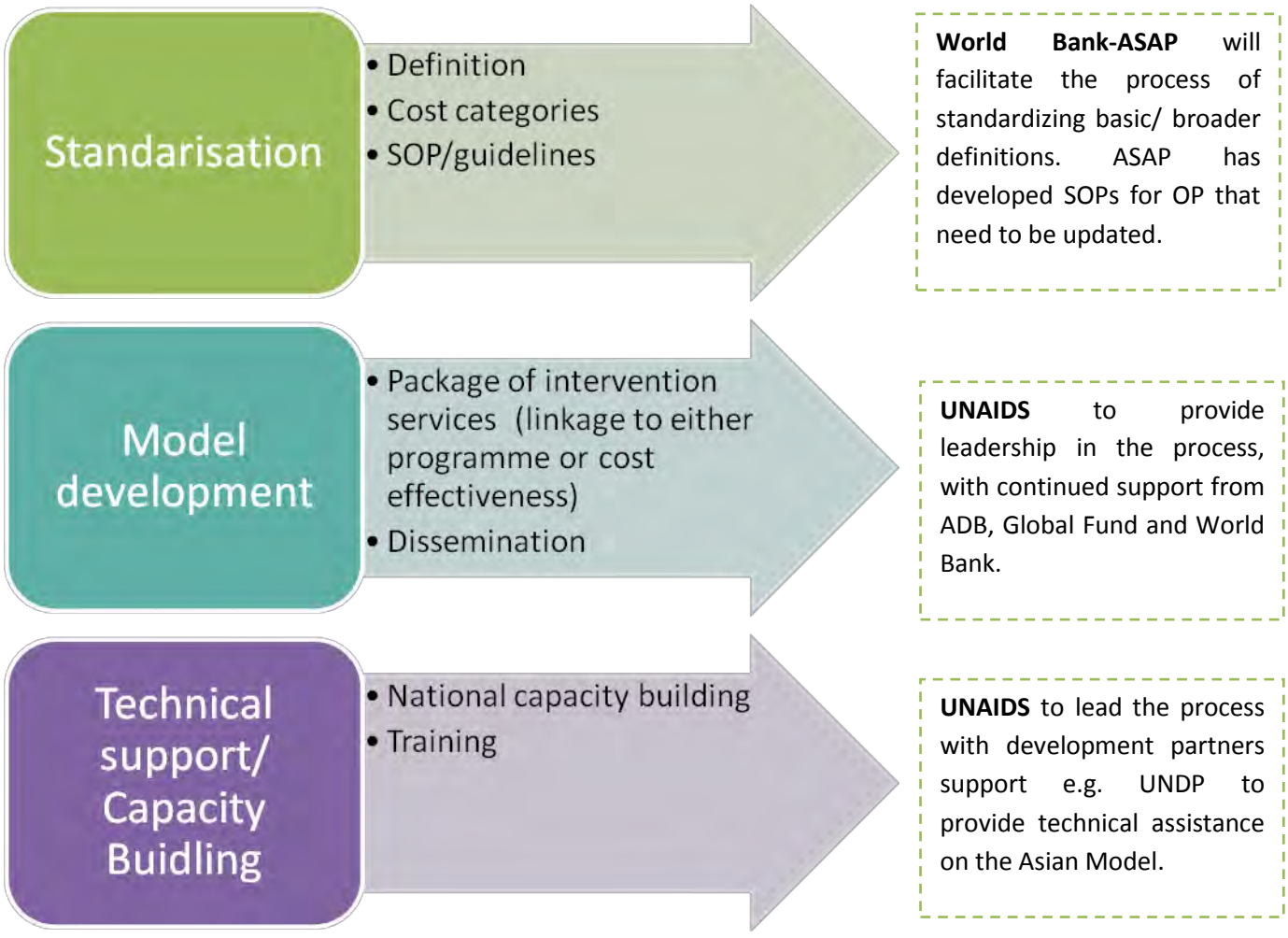
Lastly, the group suggested that costing requires an iterative process, but most planning occurs on specific time cycles; so the tool should be easy to use but also easy to modify or change, and create scenarios for comparison and plan for different circumstances.

After eliciting the opinions of national participants from Thailand, Bangladesh, Philippines, India and Indonesia; Steve summarized four (4) important issues to consider during the process of costing and in the corresponding tools.

1. Importance of national ownership in the process;
2. Building national capacity;
3. Microsoft Excel has advantages, especially since the region has Excel-related skills, but there is a need to keep it simple;
4. Effective SOP and guidelines.

2.8.2 Three main areas were identified In terms of future actions for partners to provide country guidance, namely guidelines and standardization, model development and technical support as indicated in Figure 8. Some actions can be undertaken at the global level while others need region-specific input.

Figure 8: Future actions to provide country guidance



3.0 Closing Remarks on Way Forward and Support

The Consultation ended with closing remarks from the development partners present: World Bank-ASAP, UNDP, The Global Fund, ADB, and UNAIDS RST.

3.1 **Mr Clifford Cortez, Practice Leader – HIV, Health and Development, UNDP Asia Pacific Regional Center** emphasized the importance of national ownership during the costing process, where costing linked to strategic planning needs to be the basis for all external input such as from donors and The Global Fund. He further stressed that country costing analysis needs to take into consideration all elements of cost, including human resources, training, enabling environment, account for differences in the costs to implement government services, successful civil society responses, etc. Moreover, the critical issue faced by the Asia Pacific is the issue of concentrated epidemics, and IDUs, FSW and their clients, MSM and Transgender have to be key partners in costing analysis He contended that if plans are costed in cooperation and while building the capacity of national partners, it will empower them and lead towards stronger national ownership. This, in turn, will make donors more likely to fund and support elements of the national strategy, instead of creating separate parallel reporting and budgeting processes. He pledged UNDP's continued support to the development of costing tools based on input from the field level, and by giving technical assistance support to training in the Asian model, with UNAIDS / ADB taking the lead. As UNDP is the leading agency on gender equity, human rights and MSM, it will certainly highlight these critical issues to be included in the resource needs estimates in this region.

3.2 **Ms Elizabeth Mziray, World Bank-ASAP** stated that Asia is different from other regions in that there are already identified key affected populations which drive the HIV/AIDS epidemic in this region. Therefore, World Bank-ASAP will support those programmes that are in line with the epidemic within the region. During a time of resource constraints, it is more difficult to make the case for additional resources without strategic planning showing allocative efficiency. Thus, evidence-based prioritization and the assessment of cost effectiveness of programmes are important for decision makers. World Bank-ASAP is committed to working together with UNAIDS to facilitate the process of disseminating these guidelines and standardizing basic costing definitions and categories.

3.3 **Mr Matthew Blakely, Senior Technical Officer, Program Effectiveness Team, The Global Fund** expressed commitment to follow up with what had been discussed in the meeting. He said that he had learnt a lot from the discussions and could see the benefits from the meeting. He would advise TGF to do as much as they can to help untangle the costing process that has become complicated.

3.4 **Mr Jacques Jeugmans, Practice Leader – Health, ADB** expressed commitment to continue supporting UNAIDS in the planning and costing process. He stressed the need for results-based management and how tools can support that. It is important to link costing tools to help governments and costing experts see what is the next step in prioritizing the programme based on results available and better allocation of the available resources. As such, he suggested it will be useful to involve government personnel at pre-costing and post costing meetings.

3.5 **Mr Steve Kraus, Regional Director, UNAIDS RST,** thanked the participants for their participation. He emphasized that for the first time in the last 15 years resources are declining compared to the previous year. The total global resource need is US $24 billion. With TGF replenishment, only a little extra funding is available. Thus, the challenge is to prioritize for results and allow government and civil society to use resources to make a difference. Members States of TGF governance board need to speak up if we want to change and simplify costing procedures for TGF grants. The Asian voice should be stronger because we understand the nature of the epidemic in Asia and what works. Lastly, Mr Kraus expressed his thanks for the support of Jacques Jeugmans who will retire from ADB soon.

Dr. Amala Reddy ended the workshop by expressing her gratitude to everyone for participating so actively and transparently. She said that the workshop had been useful and will help UNAIDS address the issues surrounding costing tools and future development. At the end of the consultation the group had been able to reach a useful consensus on what are the important issues and needs around costing within the Asia context; that each costing tool has its own strengths and weaknesses to be considered according to the context for use; and that perhaps rather than one super tool that would be able to accommodate every need, linked compatible tools for different needs can be developed.

Annexes

Annex 1 Agenda

Expert Consultation on Costing HIV Responses in Asia - Pacific
28-29 October 2010

Banglampoo Meeting Room, 6th floor
Amari Watergate Hotel, Bangkok

Consultation Objectives:

1) To assess the costing tools commonly used in countries in Asia-Pacific based on a set of technical and user criteria developed at the meeting.

2) To develop harmonized guidance for countries in Asia-Pacific on the appropriate tools for costing the HIV response depending on intended purpose (unit costing, resource needs estimation, operational planning, cost effectiveness analysis, etc.)

3) To consider next steps for country level coordination for dissemination of costing guidance and piloting costing tools, and for identifying technical needs and ensuing technical support and capacity building

4) To identify organizations that will take forward any further technical development of costing models, and the ensuing technical support and capacity building.

DAY 1	**Agenda**	
8:30-9:00	**Registration and Coffee**	
9:00-9:15	**Welcome Remarks**	*Rikard Elfving*
9:15-9:30	**Setting the Context for Expert Meeting on Costing**	*Amala Reddy*
9:30-10:00	**Introduction**	*Savitri Ramaiah*
Session I	**The costing situation in Asia as we know it**	
10:00-10:30	Country costing needs in the region	*Michael Hahn*
10:30-10:55	COFFEE BREAK	
11:00-11:25	Global Fund Proposal Costing Needs	*Matthew Blakely*
11:25-11:50	Unit cost approaches and Cost effectiveness	*Anita Alban and Nalyn Siripong*
11:50-12:15	The Avahan approach to costing HIV interventions and scaling up	*James Moore and Sudhashree Chandrashekar*
12:15-13:30	LUNCH	
13:30-14:00 (10 min per presentation)	Addressing key concerns and clarifying important doubts	*Matthew Blakely* *Anita Alban and Nalyn Siripong* *James Moore*

DAY 1	Agenda	
Session II	**What do we want - or think we want? Developing Criteria**	
14:00-15:00	Working Groups discuss requirements of costing models for different country purposes and considering different perspectives (technical and users)	*Working Groups formed to consider costing for:* ▪ *National Strategic Plans* ▪ *Operational Plans* ▪ *GF Proposal budgets* ▪ *Project planning and for other funding institutions*
14:30-15:00	COFFEE SERVICE AVAILABLE	
15:00-15:30 *(5 min x 4 groups)*	Key elements to be considered for different costing purposes established	*Report back of 4 groups review to plenary*
Session III	**What do we have now? Review of currently available costing models**	
15:30-16:15 *(5-10 mins each)*	Brief descriptions of inputs and key features of commonly used costing models presented to plenary by model developers	
	Resource Needs Model	*Rachel Sanders*
	CostTab model and ABC Model	*John Cameron*
	The Asian HIV/AIDS Resource Needs Estimation and Costing Tool	*Kazayuki Uji and Amala Reddy*
	Resource Estimation Tool for Advocacy (RETA)	*Brad Otto*
	Marginal Budgeting for Bottlenecks (MBB) for MDGs	*Kway Myint Aung*
Session IV	**Costing Models Display for Review by Plenary**	
16:15-17:30	1. INPUT (UNAIDS-ADB): *Anita Alban* 2. HUCC - HIV unit cost calculator (WHO-ASAP): *John Cameron* 3. Resource Needs Model: *Futures Institute – Rachel Sanders* 4. CostTab model (World Bank): *John Cameron* 5. The Asian HIV/AIDS Resource Needs Estimation and Costing Model (UNDP-UNAIDS-ADB): *Amala Reddy/Kazayuki Uji* 6. ABC Model (ASAP): *John Cameron* 7. RETA (USAID/Health Policy Initiative and Burnet Institute): *Brad Otto* 8. AEM-Cost Effectiveness Tool (East-West	*Models Marketplace:* *Fixed stations with displays on each model outlining key features and hands-on computer access to model*

DAY 1	Agenda	
	Center): *Nalyn Siripong* 9. Marginal Budgeting for Bottlenecks (MBB) for MDGs (UNICEF) *Kway Myint Aung*	
17:30-18:30	Welcome Reception at: **Krungthep Suite, 4th Floor**	

DAY 2	Agenda	
9:00-9:15	**Recap of Day 1 main issues**	*Savitri Ramaiah*
9.15-9:45	**Integrating gender perspectives and programs into costing of HIV responses**	*Jane Wilson*
Session V	**How do the costing models relate to what we want? Developing country guidance**	
9:45-10:45	Working Groups revisit outputs of previous day and assess how available tools meet country costing needs	*Working Groups as before*
10:00-10:30	COFFEE SERVICE AVAILABLE	
10:45-12:00	Arriving at a consensus on guidance for countries on costing tools based on synthesis of group work on needs versus tools available	*Savitri Ramaiah* *Amala Reddy*
12:00-13:30	LUNCH	
Session VI	**Getting to where we want to be**	*Chairman: Steve Kraus*
13:30-14:00	Arriving at consensus continued	
14:00-15:00	Overview of consensus on guidance for countries on costing tools Agenda for future actions to provide country guidance and any technical work required • Coordination for dissemination of costing guidance • Coordination of technical support and capacity building • Technical developments (such as adapting existing tools to meet specific country needs) and piloting approach	*National participant* *Plenary discussion*
15:00-15:30	COFFEE BREAK	
15:30-16:15	• Roles and mechanism to take the agreed actions forward	*Savitri Ramaiah* *Amala Reddy* *with video conference link to Carlos Avila and Swarup Sarkar*
16:15-17:00	Closing Remarks on Way Forward and Support	*Clifton Cortez* *Elizabeth Mziray* *Matthew Blakely* *Jacques Jeugmans / Rikard Elfving* *Steve Kraus*

Annex 2 Participant list

Expert Consultation on Costing HIV Responses in Asia - Pacific
28-29 October 2010
Banglampoo Meeting Room, 6th floor
Amari Watergate Hotel, Bangkok

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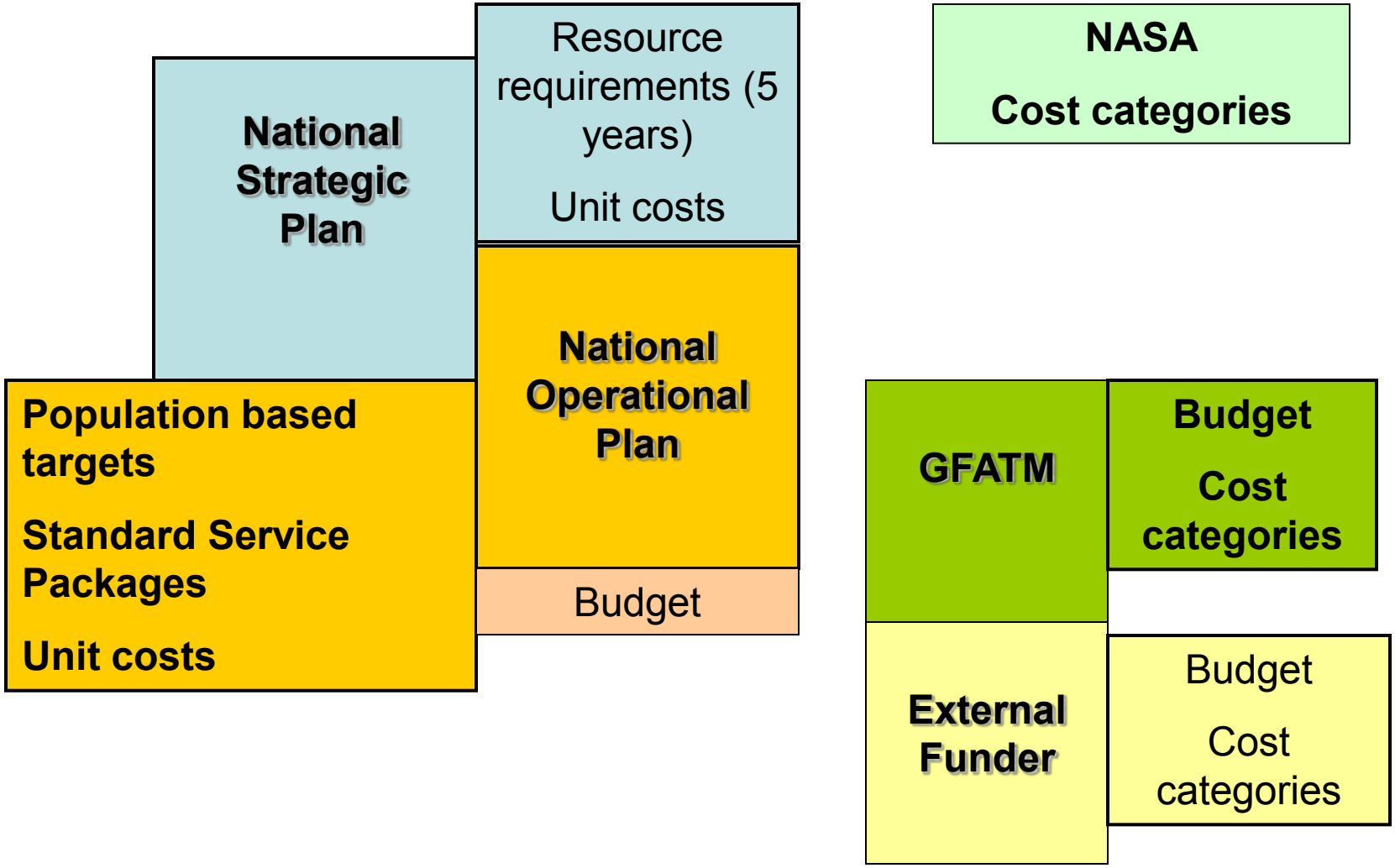
Annex 3 Country Costing Needs or Whose Reality Counts? by Michael Hahn

Country Costing Needs
or
Whose Reality Counts?

Michael Hahn
UCC Thailand

The “Ideal World”

The “Country Reality”



Questions Asked by Decision Makers in Countries

- What does it cost to halve the number of new HIV infections in 2 years?
- How do we compare with other countries? Do we pay more or less?
- What is our benefit to invest in prevention? Why would we invest in harm reduction?
- How much does it cost to avert 1 HIV infection?
- What is the total economic loss caused by HIV over the next 10 years? And, what is the net benefit of expanded prevention?
- Why is the GFATM proposal on MSM much higher than the resource needs in the operational plan?

The Big "2 1/2"

Strategy

- Defining key strategies (decisions) guiding resource allocation (prioritization)
- Leads to population based targets and definition of service standards (QA/QC)
- Estimate resource needs with a minimum of operational details for medium term
- Unit costs as planning figures

Operational Plan

- Translate strategic guidance into concrete targets and activities.
- Includes population based targets with standard services
- Costed for shorter time period
- Use of unit costs costing the minimum package
- Still resource need rather than concrete budget

GFATM

- Proposal budgets are activity based and follow specific cost categories
- Need for countries to "disaggregate" activities in cost categories and to "unpack" standard unit costs

How Can We...

- Find out what a specific strategy costs?
- Prioritize interventions based on evidence and costs?
- Cost an operational plan according to our targets and standard service packaging and use these costs for other purposes (proposals)?
- Compare costs?
- Make our lives easier...

Issues

- Different experts, different plans, different tools, different formats, different costs
- Lack of costing standards
- Project costing (activity based) versus Programme costing (results based)
- National Strategic Plan Applications (GF)
- Using cost-effectiveness and resource need data for prioritization in the NSP

Thank You!

Annex 4 The Global Fund and Costing HIV Responses in Asia by Matthew Blakley

Investing in our future
The Global Fund
To Fight AIDS, Tuberculosis and Malaria

The Global Fund and Costing HIV Responses in Asia

28 October 2010

Matthew Blakley
Performance, Impact and Effectiveness Unit

Overview

- Background
- Funding decisions
- Perspective on costing, budgeting
- Challenges, opportunities

Background

Global Fund Guiding Principles

1. Operate as a **financial instrument**, not an implementing entity
2. Make available and leverage **additional financial resources**
3. Support programs that reflect **national ownership** and respect country-led formulation and implementation
4. Operate in a **balanced manner** in terms of different regions, diseases and interventions
5. Pursue an integrated, balanced approach to **prevention, treatment and care**
6. Evaluate proposals through **independent review processes**
7. Establish a **simplified, rapid and innovative grant-making process** and operate **transparently**, with **accountability**. The fund should make use of existing international mechanisms and health plans.
8. Focus on **performance** by linking resources to the achievement of clear, measurable and sustainable results.

Background

Global Fund HIV/AIDS financing

HIV/AIDS Grants: Coverage by Country (Rounds 1-9)

Source:
Global Fund
Grant Data

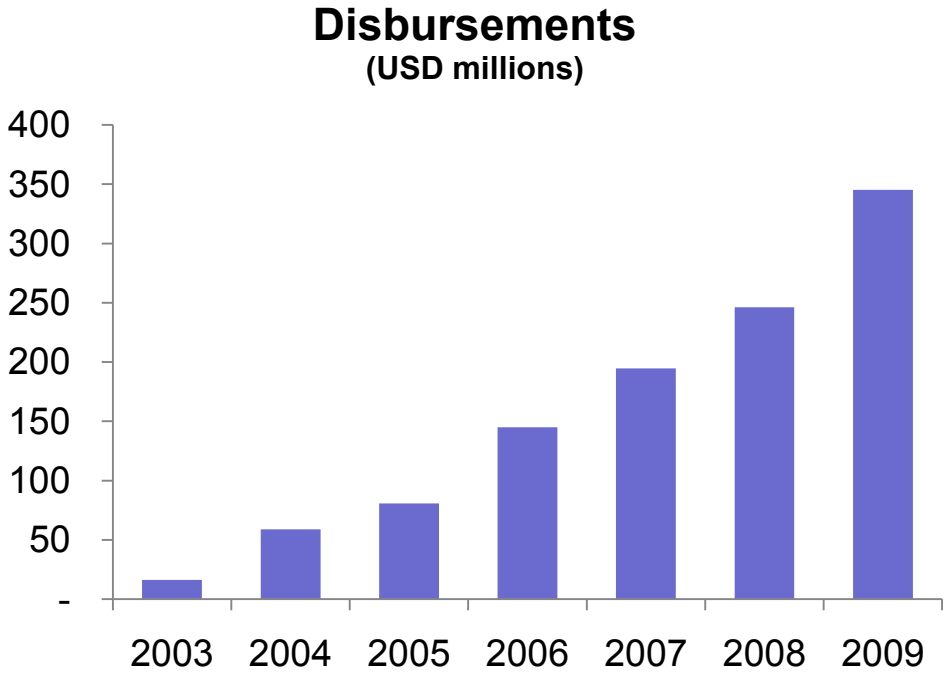
140 countries

US$ 10.8 billion (Approved Grant Amount)

US$ 17.4 billion (Total Lifetime Budget)

Background

GF HIV/AIDS financing and results in Asia



$345M disbursed in 2009; average 34% increase YoY for last three years

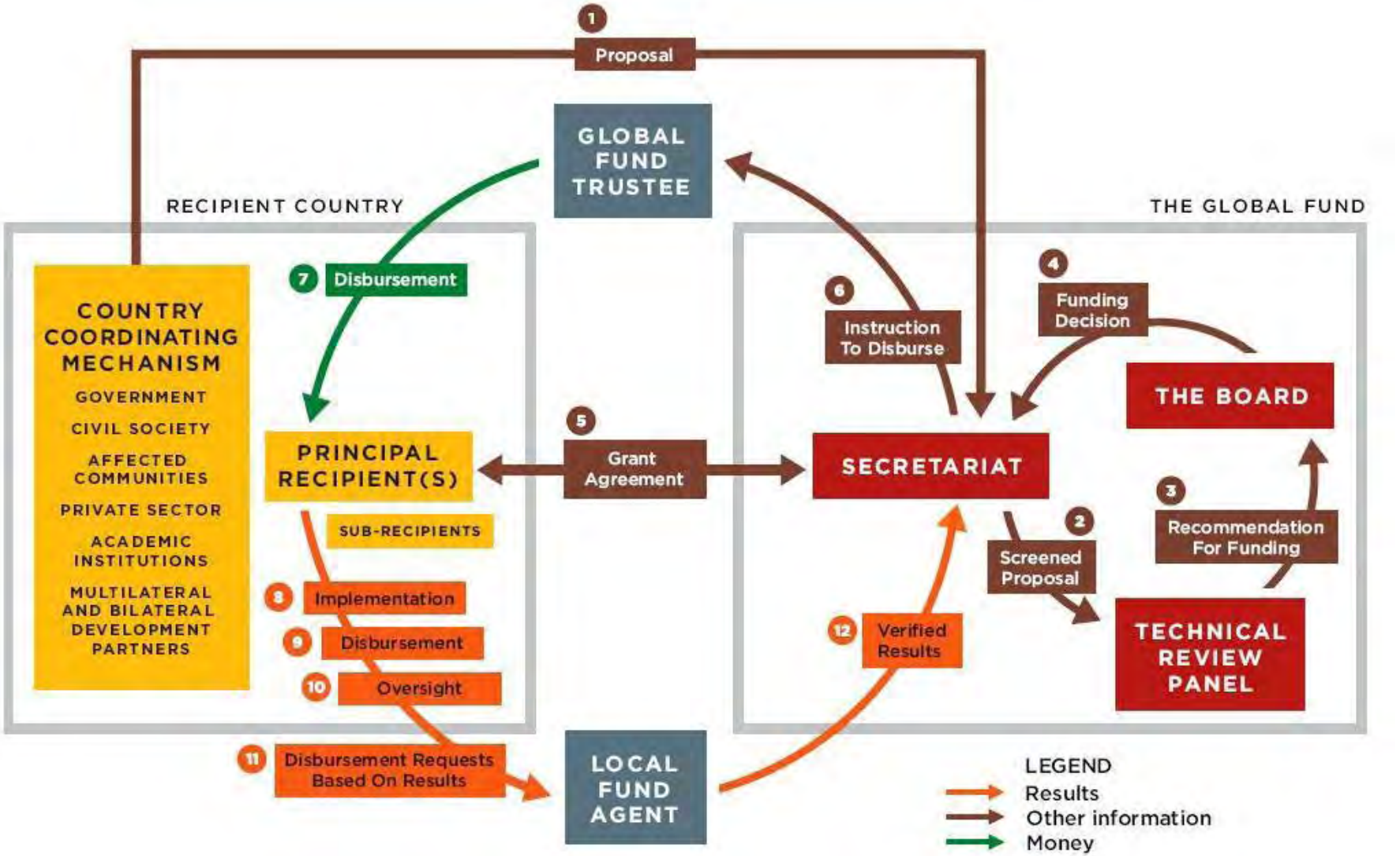
Results as of 2009 Include:

- 383,000 people currently on ART
- 29M HCT sessions provided
- 65,660 pregnant women receiving ARVs for PMTCT
- 238M condoms distributed
- 1.3M cases of STIs treated
- 218,000 TB/HIV services provided

Figures for GF regions of SWA and EAP. Results as of end 2009. All results cumulative except ART.

Background

GF model and grant cycle



Funding decision criteria

TRP Criteria

- Soundness of approach
- Feasibility
- Potential for sustainability and impact
- Details set out in Guidelines for Proposals and TRP TORs

www.theglobalfund.org/documents/trp/TRP_TOR_en.pdf

Attributes Considered in National Strategy Review

Soundness of:

- Situation analysis and programming
- Process
- Finance and Auditing
- Implementation and management
- Results, Monitoring and Review

theglobalfund.org/documents/board/20/GF-BM20-11_TRP_ReportToBoard.pdf

Funding decisions

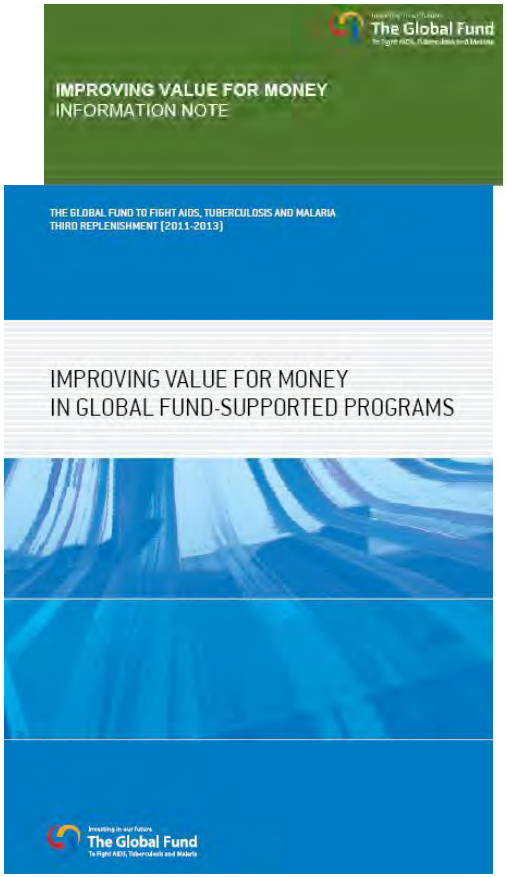
Minimum fundamental pre-requisites –TRP R8

- Responds directly to current, documented, epidemiological situation
- **A coherent strategy throughout proposal**
- **Robust gap analysis, both programmatic and financial**
- Clear and realistic analysis of implementation and absorptive capacity constraints
- Clear M&E plan
- Address drivers of epidemic
- **A budget sufficiently detailed to allow costs of activities to be assessed**
- **A workplan that makes clear timing, sequencing, responsibility**
- Planned outcomes that address epi data and demonstrate how additional investment will improve outcomes for most at risk

Funding decisions

Emphasis on value for money criterion

- **Defined as** optimal use of resources to achieve the intended outcomes over the short and long-term.
- **Means** using the most cost-effective interventions to reach desired results
  - **Taking into account service quality, technical appropriateness, timeliness, targeting of at-risk populations, etc as well as costs**
- Does **not** necessarily mean selecting least expensive interventions.
- Includes ensuring Global Fund financing is **additional and achieving sustainable results**



Implications at the country level, in proposals

Demonstrate existing, improving value for money

Measure, assess unit costs and benefits of key products and services

Funding decisions

National strategy review consideration e.g.

ATTRIBUTES RELATED TO FINANCE & AUDITING

- **Expenditure framework**[1] with the following characteristics:
  - Comprehensive, realistic **budget/costing** of the program areas covered by the national strategy[2]
  - Financial **gap analysis** – including a specification of known financial pledges against the budget from key domestic and international funding sources…It also includes costed scenarios, e.g. low, medium, high – or (results-based, needs-based and resource-based) scenarios)
  - Specification of the approach for **allocating funds:** to **sub-national level** using an appropriate, equitable resource-allocation formula; and to **priority program areas** to **non-state actors** (including civil society organizations, private sector, and, where applicable, people living with HIV) and **across government *sectors*** ***(where relevant)***

[…]

1: In addition Medium Term Expenditure Framework desirable

2: Costing to:

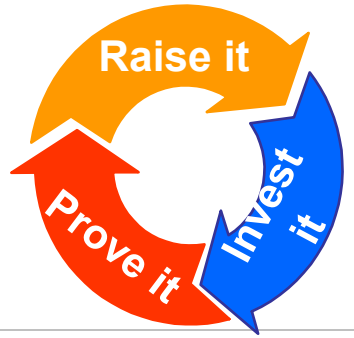
- preferably be commensurate with timeframe of national strategy and according to more or less optimistic planning scenarios
- include all relevant functions (in particular monitoring & evaluation, financial management, procurement and program management)

Funding decisions

Performance based funding (PBF)

PBF ensures that funding decisions are based on a transparent assessment of results against time-bound targets, through:

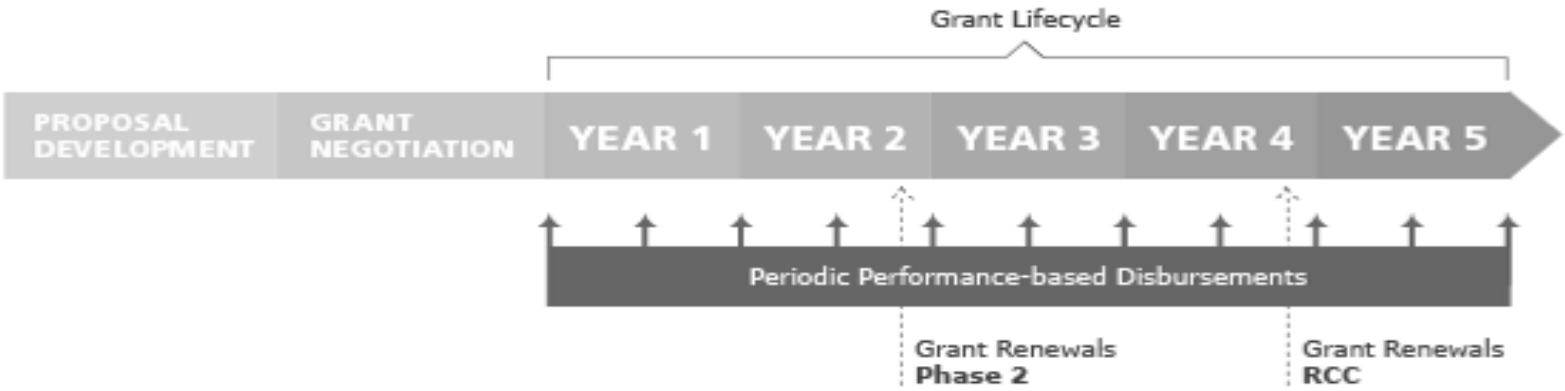
1. Link funding to the **achievement of country-owned objectives** and targets
2. Ensure that money is spent on delivering **services for people in need**
3. Provide **incentives** for grantees to focus on programmatic results and timely implementation
4. Encourage **learning to strengthen capacities** and improve program implementation
5. Invest in **measurement systems** and promote the use of evidence for decision-making
6. Provide a **tool for grant oversight** and monitoring within countries and by the Global Fund Secretariat
7. **Free-up committed resources** from non-performing grants for re-allocation to programs where results can be achieved



Funding decisions

PBF integration into grant cycle

PBF is integrated into <u>every</u> phase of the lifecycle of a Global Fund grant:



1. Country-owned proposal development:

Funding requests comprising program activities, indicators and time-bound targets defined by the countries themselves.

2. Grant negotiation:

Legal contract with performance targets to measure the achievements of the grant. Investments are made to strengthen M&E systems.

3. Performance-based disbursements:

Periodic disbursements (every 3, 6 or 12 months) based on programmatic results, financial performance and program management.

4. Grant renewal:

Continued funding decisions based on a comprehensive program review incorporating an evaluation of outcomes and impact.

Costing related requirements in proposals

- Financial gap analysis table
  - Requests overall national program financial need
  - Explanation of how developed, inclusive, additional
- Detailed and summary budgets for GF-requested funding
  - 5-year budget (2 years of quarterly costs, next 3 years annual)
  - Explanation of budget, HR, large expenditures, service cost assumptions (R10)
- Justifying overall proposal strategy
  - How were costs considered, optimized in selection of approach, interventions
- Costing model or report often included as annex

National Strategy Applications and costing

- Requests for GF financing based primarily on an existing national strategy:
  - National strategy documentation presented for “joint assessment” against attributes using an agreed, shared (non-GF-specific) process
  - Use the „jointly assessed“ strategy as the primary basis for applications for financing from different funders
- Many overlaps with round-based channel application in terms of costing
- Some differences, for example:
  - may use national budget classifications
  - time period flexibility to meet planning cycle
- Review guidelines when available for 2nd Learning Wave

GF perspective on costing approach

Approach to costing

- Neutral funding platform without specific preferences or requirements on costing approach;
- Primary interest is that output from a costing should be directly/indirectly translatable to GF budget, overall proposal/grant requirements

Lessons learned

- Reviews of NSA FLW *suggest* important that **selected costing approach should be appropriate for context**
- Significant **challenges created by changing costing approaches** during application process

GF budgeting guidelines (Oct-2010)

- Contains guidance on high-level principles
- Budget requirements at all stages of grant
- Detailed guidance on:
  - Foreign exchange rates
  - Human resource costs
  - Travel and subsistence
  - Living support to clients/target populations
- Next version of guideline will cover other cost categories

More information:
www.theglobalfund.org/documents/core/guidelines/Core_BudgetingInGlobalFundGrants%20_Guideline_en.pdf

GF budget template

- **Template is optional**
  - But many applicants use it or similar format

http://www.theglobalfund.org/en/applicationmaterials/documentlistsingle/

- **Includes structure that supports:**
  - link to workplan, key assumptions;
  - summary of the budget by service delivery area and by cost category;
  - Years 1-2: sufficient detail to demonstrate how all unit quantities, unit costs were calculated.
  - Years 3-5: information to show the basis for the forecast budget amounts were determined.
- **Flexibility to expand**
  - Consider what additional information in budget would **assist reviewer in assessing reasonableness** of unit costs, value for money
  - Applicants **can include calculations that relate item unit costs to costs per service/output**

GF costing and budgeting

GF budget template

Reference N.	Objective	Service Delivery Area (SDA)	Activity	Directly related indicator	Timing Q1	Q2	Q3	Q4	Reference to Previous Rounds	Responsible for Implementing Entity Type	Assumptions
1	1	1.2 Improving Diagnosis	1. Develop and Print facilities & communities SOPS for improving diagnosis						No reference	MOH	MoH	see SDA 1.2 Activity 1
2	1	1.2 Improving Diagnosis	2.Support 1000 community Health Nurses to Undertake contact tracing		x	x	x	x	No reference	MOH	MoH	see SDA 1.2 Activity 2
3	1	1.2 Improving Diagnosis	3. Establish new microscopy centers for newly created needy districts(infrastructure, excluding equipment)	1.1				x	No reference	MOH	MoH	see SDA 1.2 Activity 3
4a	1	1.2 Improving Diagnosis	4.aRepair/upgrade existing laboratories	1.2		x			Not in Yr 5 of R5 grant	MOH	MoH	see SDA 1.2 Activity 4a
4b	1	1.2 Improving Diagnosis	4.b Provide microscopes	1.2				x	Not in Yr 5 of R5 grant	MOH	MoH	see SDA 1.2 Activity 4b
5a	1	1.2 Improving Diagnosis	5a. Provide laboratory supplies (excluding microscopes) for new laboratories	1.1	x				Not in Yr 5 of R5 grant	MOH	MoH	see SDA 1.2 Activity 5a
5b												
5c												

Cost category	Measurement unit	Unit cost year 1	Quarter 1 Quantity	Quarter 1 Total amount	Quarter 2 Quantity	Quarter 2 Total amount	Quarter 3 Quantity	Quarter 3 Total amount	Quarter 4 Quantity	Quarter 4 Total amount	Total Quantity Year 1	Total Year 1
Training	Cost per guideline	5.33	0.0	0.0		0.0		0.0		0.0	0.0	0
Human Resources	Cost per visit/quarter	25,000.00	1.0	25,000.0	1.0	25,000.0	1.0	25,000.0	1.0	25,000.0	4.0	100,000
Health Products and Health Equipment	Cost/centre	15,000.00	0.0	0.0		0.0		0.0	5.0	75,000.0	5.0	75,000
Infrastructure and Other Equipment	cost/laboratory upgraded	7,000.00		0.0	25.0	175,000.0		0.0		0.0	25.0	175,000
Health Products and Health Equipment	cost/microscope	3,500.00		0.0		0.0		0.0	10.0	35,000.0	10.0	35,000
Health Products and Health Equipment	cost/laboratory	4,651.00	5.0	23,255.0		0.0		0.0		0.0	5.0	23,255
Health Products and Health Equipment	Total cost per year	188,833.00	1.0	188,833.0		0.0		0.0		0.0	1.0	188,833
Health Products and Health Equipment	Cost per procurement per distribution cmear	100	327,895.0	327,895.0		0.0		0.0		0.0	327,895.0	327,895

http://www.theglobalfund.org/en/applicationmaterials/documentlistsingle/

What makes a good GF budget?

DETAIL

- Financial Information showing sufficient detail allows TRP to better understand the reasonableness of the budget and demonstrates preparation and knowledge by the applicant

CLARITY

- Clear information presented logically allows TRP to understand the relationship between the cost of the proposal and the implementation strategy

CONSISTENCY

- Between Financial Information in Proposal
- With Workplan
- With Performance Framework
- With Proposal implementation Strategy

General TRP feedback relevant to costing (1)

Coherency

- Importance of having **proposal narratives that are well aligned** and consistent with submitted **budgets and work plans** (R9)
- Essential **need for coherency and logic** between the objectives, program areas (SDAs), the budget, a separate detailed work plan, and the 'performance framework'. (R8)

Alignment with national strategy

- Rounds-based applicants should ensure that **proposals submitted are within the context of existing national plans and frameworks** (expenditure and M&E) (R9)
- Recommends countries consider **preparing proposals less regularly**, and when made, **draw on the national strategy** to describe (and request funding for) gaps to ensure a **comprehensive response** to the diseases (R8)

General TRP feedback relevant to costing (2)

Planning tools and proposal TA

- Recommends to Stop TB partnership that its **budgeting and planning tools be presented to applicants with more flexibility** (i.e., less 'bundling')…this may **encourage applicants to select out priority interventions most relevant** to the specific epidemiological context and national priorities (R8).
- Roll Back Malaria's provision of **targeted proposal development support** is instrumental to the **increasingly stronger proposals**. This does, however, make it more difficult to determine the extent to which the proposals reflect ownership by the country.

Targeting

- Too many proposals there was insufficient thought given to the current epidemiological situation, with inappropriate, unfocused activities proposed for concentrated epidemics. (R8, 9)

Potential challenges the GF faces

- By becoming one of the largest funders, GF is inherently vulnerable to misallocation of financing and doubtful impact
- Due to the standard budget structure, the link between costs and overall program goals, targeting, allocative efficiency, etc. can be difficult
- Risk of over-focus on setting and achieving high quantitative outputs at low cost without regard to targeting, quality of services, appropriateness, etc.
- Tendency to translate to services focus, divorced from people

Examples of the challenge

- Funds committed for Sex Worker Prevention:
  - $27.5 million was estimated to have been specifically allocated in Asia grants for sex work prevention across the first six rounds.
  - represents less than 4% of all approvals, about $6M/year
  - A number of grants have broad allocation of resources targeting MARPs, however these grants cannot be included in analysis as sex workers reached are not identified as part of programme monitoring.

Opportunity for improvement

- This group can contribute to addressing the vulnerability of misallocations that GF faces
- Ensuring the development and use of costing tools that encourage selection of optimal targeting, strategy, and implementation approach
- Improving link between GF financing and overall program to ensure that proposal/grant reviews evaluate progress against program strategy

Challenges and opportunities

GF commitment

- Commitment to common workplan and follow-ups
- Work towards improving how GF budget maintains links to overall program costs and strategies

Investing in our future
The Global Fund
To Fight AIDS, Tuberculosis and Malaria

The Global Fund and Costing HIV Responses in Asia

28 October 2010

Matthew Blakley
Performance, Impact and Effectiveness Unit

Annex 5 The list of Q & A on Global Fund

The Global Fund and Costing HIV Responses in Asia - Matthew Blakely

No	***Questions***	***Answers***
1.	*What are the other variables used if not "least expensive" intervention?*	We indicated in our guidelines (http://www.theglobalfund.org/en/applicationmaterials/documentlistsingle/) that the Global Fund considers value for money to not necessarily be the least expensive intervention but those that have the greatest health impact for the amount of money spent, including appropriate targeting of at-risk populations. Specifically, proposals should not only consider the cost of goods and services, but also take account of the mix of quality, resource use, technical appropriateness, and timeliness to judge whether or not, when taken together there is good value found among these elements.
2.	*What does GFATM mean by "sustainable result" with respect to value for money considerations>*	In Round 10 materials (http://www.theglobalfund.org/en/applicationmaterials/documentlistsingle/) the Global Fund specified that proposals were not required to demonstrate financial self-sufficiency for the targeted interventions by the end of the proposal term. However, applicants for funding should include how the proposal is addressing issues such as capacity to absorb increased resources and recurrent expenditures, and how national planning frameworks are seeking to increase available financial and non-financial resources to ensure effective prevention and control of the diseases.
3.	*Does not necessarily means selecting least expensive – How do you ensure that?* *→ Nowadays SR selection becomes a system like bidding, which not*	There are multiple initiatives underway to include a more holistic review of value for money components in the assessment of proposals and grants. For example, in Round 10 there was clear guidance provided to both applicants and the TRP that value for money was not necessarily the least expensive interventions. Similarly the periodic review of grants under the new grant architecture will include an improved broader view of value for money. SR

	necessarily took quality as major factor, instead lowest lost gets more preference?	selection is not an area that we have specifically addressed. However, the recent proposals should have been flexible enough that an applicant could have included a different approach for SR selection as part of its overall approach to ensuring value for money.
4.	*Is performance mean expenditure?* *→ At the end of the day, concerns are how much are spent on the quarter / year?*	No, this is not the intention. Comparing expenditures versus budget should be just one component of what is considered in evaluating the overall performance of a grant.
5.	*Value for money include efficiency? (lowest unit cost for quality output?)*	Yes, we indicated in our guidelines that value for money could be thought of as including economy (assesses the cost of inputs), efficiency (assesses productivity or the outputs that are achieved with given inputs), and effectiveness (assesses the impact of spending against its objectives)
6.	*Is it good to use default values for resource need/ budgets?*	Discussed yesterday. In general, would expect that proposal and grant reviews prefer avoiding "default values" where possible and using the costs that are appropriate for the local context.
7.	*How to ensure data on costs – country specific to be used?*	Not certain if I understand this question. As above, would expect that budgeting and grant reviews will generally prefer that costs be appropriate for the local context.
8.	*How is "performance" measured and ensured in budgeting?*	This should be covered in the following document on performance based funding http://www.theglobalfund.org/documents/7_pp_guidelines_performancebasedfunding_4_en.pdf as well as on budget expectations http://www.theglobalfund.org/documents/core/guidelines/Core_BudgetingInGlobalFundGrants%20_Guideline_en.pdf
9.	*How are phase 2 funding decisions*	There is extensive information available on Phase 2 here:

	made and how much is it dependent on proving impact?	http://www.theglobalfund.org/en/phase2/ Decisions to continue a grant's funding for Phase 2 are made after analysis of several documents, including the PR's report on program results, an assessment of performance completed by the CCM and a verification of program results provided by the country's LFA. The decision is also made taking into account contextual information relevant to program implementation in the country. Contextual information may include disease circumstances, program environments such as political commitment, donor environment, financial situation or natural disasters. Actual program results are measured against agreed targets detailed in the Grant Agreement. An overview of what will be considered in the Periodic Review under the new grant architecture is included in this document http://www.theglobalfund.org/documents/grantarchitecture/Fact_Sheet_for_Implementers_en.pdf, ;will it include an in-depth evaluation of programmatic performance, a more prominent role for impact achieved, and the efficient use of funding.
10.	*If you can address the delays in reporting M&E data form the recipient countries?*	Not certain if I know the specific reference of this question. However, benefits of the new grant architecture should include improved alignment with in-country review processes, fewer reviews per country due to consolidation of grants and, in general less frequent reviews to the extent that these areas are contributing to delays.
11.	*How can local capacity be developed to make strong proposals?*	While not specifically related to proposal development, the CCM guidelines include a recommendation that all proposals include a plan for obtaining technical assistance as needed to strengthen CCM functioning and for capacity building in fulfilling its responsibilities for oversight of program implementation. Additional information is available here: http://www.theglobalfund.org/documents/ccm/Guidelines_CCMPurposeStructu

		reComposition_en.pdf
12.	*Sustainability issues of GF fund vs in line contribution of government's strategy*	See response to #2 above.
13.	*What kind of info is being asked for to direct or justify a targeting strategy?*	There are high-level suggestions provided in the proposal guidelines (http://www.theglobalfund.org/documents/rounds/10/R10_Guidelines_Single_en.pdf), as well as the information notes (http://www.theglobalfund.org/en/applicationfaq/?lang=en) that cover specific populations and interventions with links to partner technical guidance.
14.	*Would modes of transmission analysis qualify?*	Please refer to #13.
15.	*The statement that the GF has "no specific preferences on requirement" for the costing approach used seems to contradict the experience coming from countries where the GF process seems to supersede the country's NSP and OP development process. What effort is the Global Fund making to ensure that GF proposals are aligned to NSP and OP in country?*	Discussed yesterday.

16.	*Based on previous proposals, has GF developed a range of unit costs for major interventions?*	Discussed yesterday.
17.	*New guideline of GF?*	Not certain if I understand what this question is specifically referring to; please clarify to me if would like response.
18.	*More flexible to country specific needs?*	Not certain if I understand what this question is specifically referring to; please clarify to me if would like response.

Annex 6 Review of Cost-effectiveness Analyses of Injecting Drug User Interventions to prevent HIV in Asia, by Anita Alban

Review of Cost-effectiveness Analyses of Injecting Drug User Interventions to prevent HIV in Asia

Authors: Anita Alban, Ditte Hjorth Hansen, Celie Manuel

Presenter: Anita Alban

iHEA Congress, Beijing China
15-17 July 2009.
Extract 28/10 2010 Bangkok

The study is targeted at the strategic decision-making level

- Are current responses effective and cost-effective?
- What is the scale-up perspective?
- Priority Setting of Injecting Drug User (IDU) interventions in Asia

Benchmarks for decision-making (WHO)

- **Very cost-effective**: cost per DALY: less than average per capita income in a given country
- **Cost-effective**: cost per DALY: less than 3 times average per capita income (CMH)

- **Results:** IDU HIV interventions in Asia: USD **64-325** per DALY **= very cost-effective**

CEA of IDU HIV interventions: Comparative analysis I

Country	Reference year of analysis	HIV Prevalen-ce %	Estimated no of IDUs	Regular reach Coverage	Impact first 1-3 years - HIV averted	Cost-effectiveness ratio, HIVA
Dhaka Bangladesh	2001/02	2.40%	6500	80%	3 years 6873	USD 64-200 per HIV averted
Kathmandu Nepal	2003	68%	5000	20%, 30%, 60%	3 years 1188-1751-3278	USD 74-57 per HIV averted
Karachi Pakistan	2006	26%	12500	7%, 30%, 60%	3 years 763-1322-2086	USD 146-325 per HIV averted
Odessa Ukraine	1999	54%	21800	20-38%	1 Year 1069	USD 97 per HIV averted
Svetlogorsk Belarus	2002	74%	1100 plus	43-63%	2 Year 176-221	USD 323-359 per HIV averted

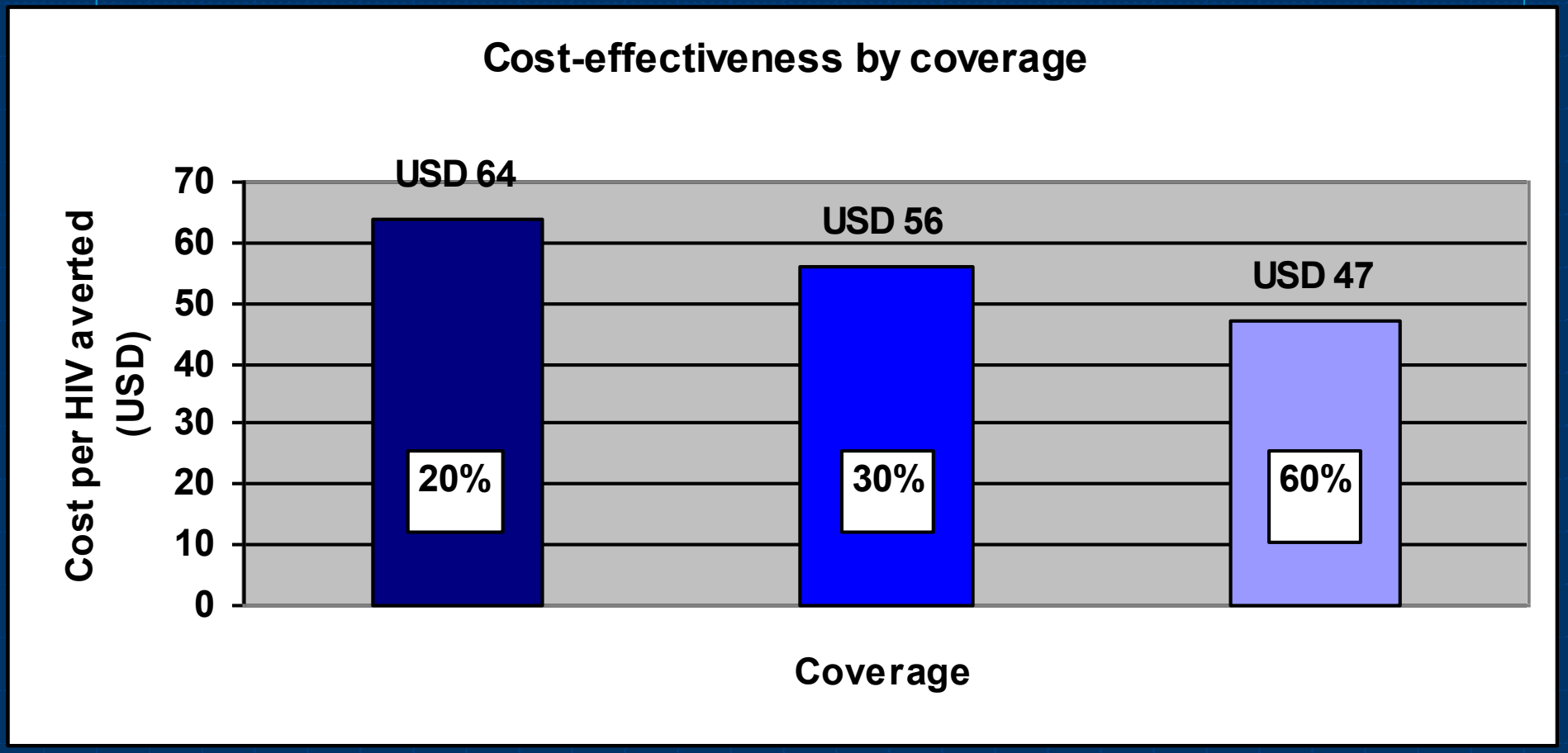
Sources: Alban et al 2007; Alban and Manuel 2008; Guinness et al 2006; Kumaranayake et al 2004; Vickerman et al 2006

CEA of IDU HIV interventions: Comparative analysis II

Country	Reference year of analysis	HIV Prevalence %	Estimated no of IDUs	Discount rate	Cost-effectiveness ratio, HIVA PPP$ 2004	Cost-effectiveness ratio, DALY PPP$ 2004	GDP per capita PPP$ 2004
Dhaka Bangladesh	2001/02	2.40%	6500	3%*	1905 per HIV averted	74 per DALY	1870
Kathmandu Nepal	2003	68%	5000	3%	779-1016 per HIV averted	27-69 per DALY	1490
Karachi Pakistan	2006	26%	12500	3%	2228-4950 per HIV averted	137-289 per DALY	2225

3 years perspective, 2004 PPP USD

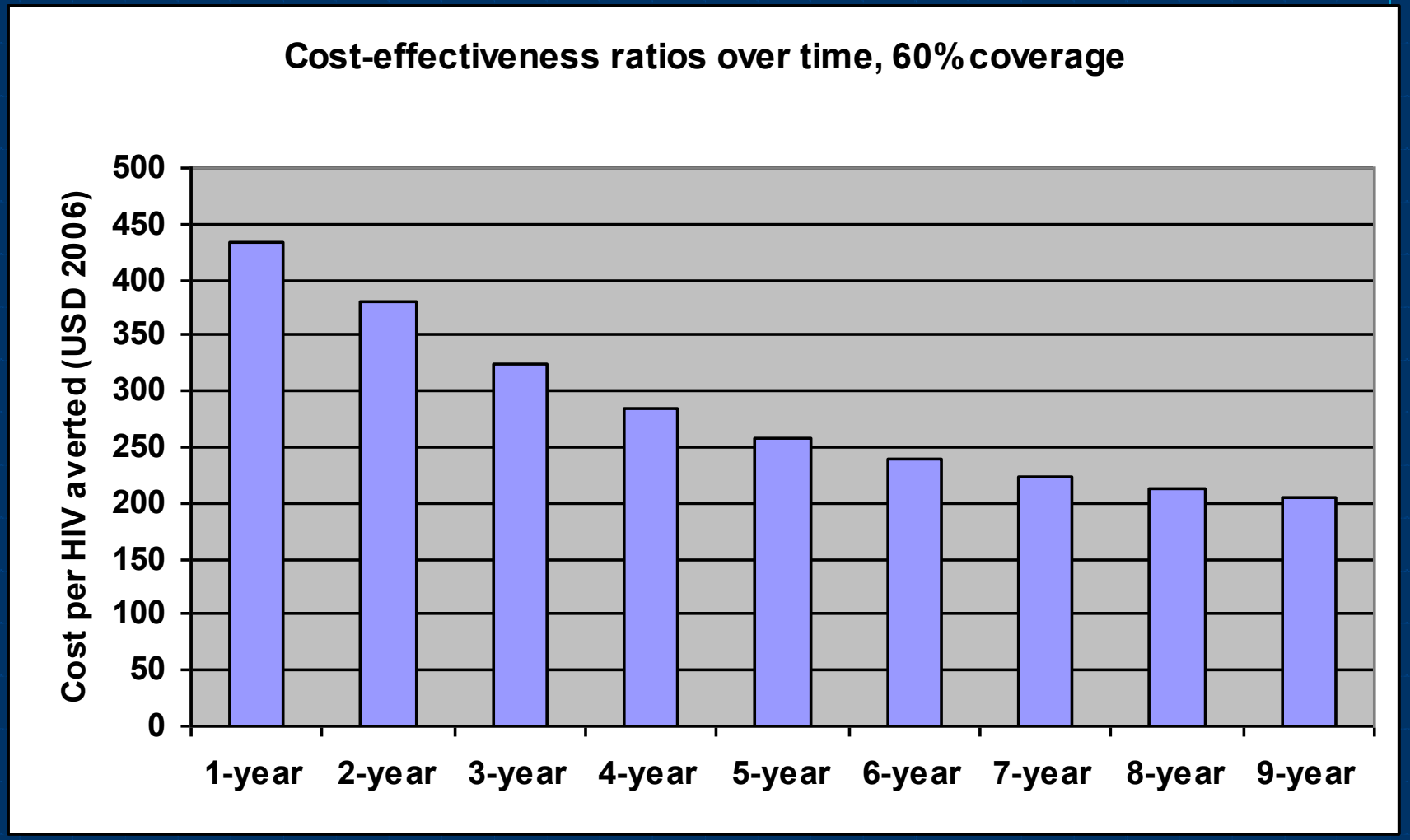
IDU Kathmandu: CER decreases by coverage, 5 years perspective



3% discount rate of benefits

Alban, Manuel 2008, ADB

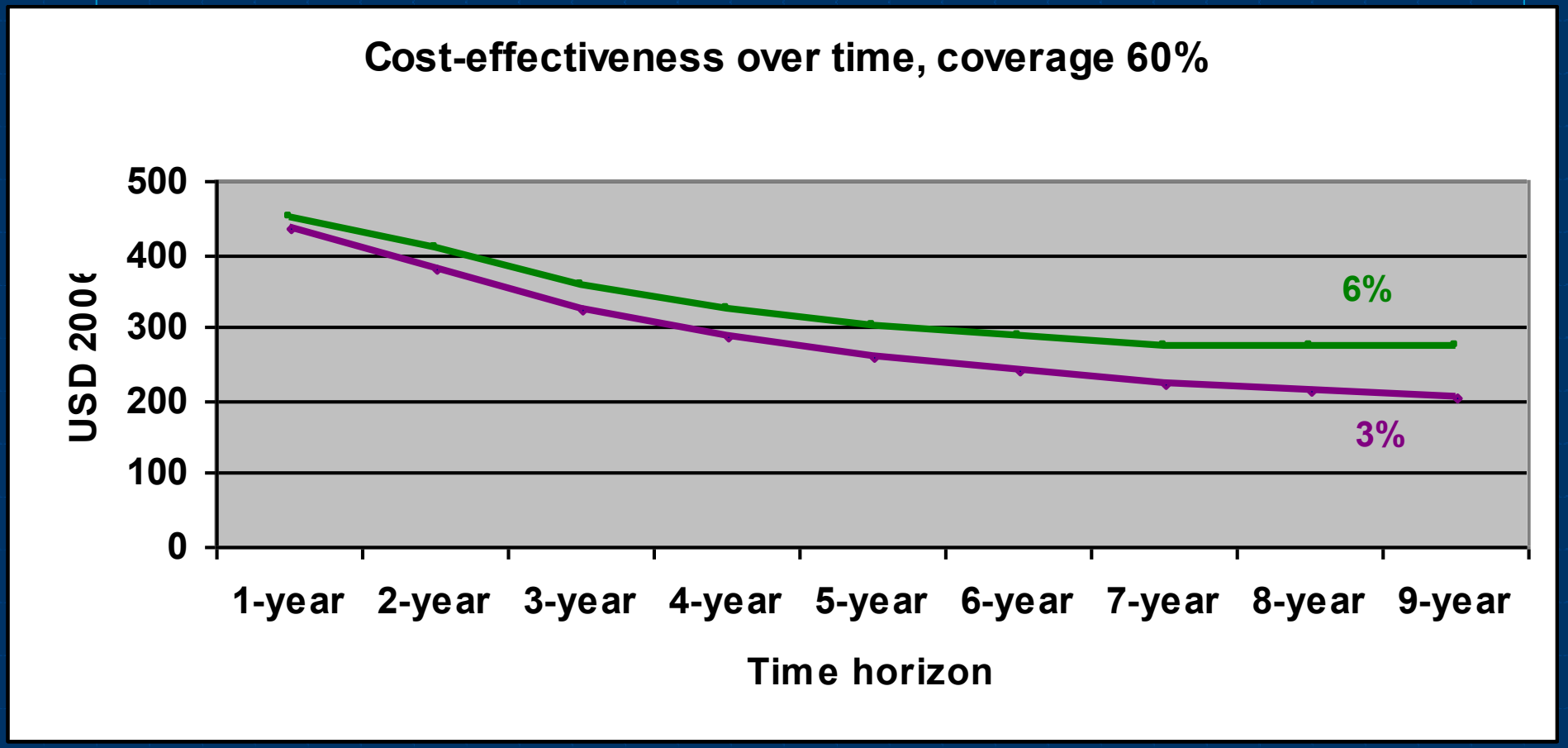
IDU Karachi: Cumulative CERs, nine-year perspective



3% discount rate of benefits

Alban et al 2007

High discount rates changes the slope of the CER curve



Alban et al 2007

Conclusions I

- HIV IDU interventions in Asia are very cost-effective at low and high coverage levels
- However, low coverage levels cannot bring down the prevalence rates!!

- CER of IDU interventions must be complemented by ability to reduce prevalence rates among IDUs

Conclusions II

- Cost-effectiveness analyses is an important tool for decision-making
- Supplementary knowledge needed on Cost-effectiveness of IDU HIV approaches including methadone
- Few studies makes it difficult to learn from experiences

Conclusions III

- Studies must be undertaken by independant researchers
- M&E&R is vastly underfunded to ensure effective and efficient HIV interventions
- More and easier to handle effectiveness models are needed for planning purposes. Will AEM rapid CEA results do the trick?

Thank you

Get the paper, forward comments, ask questions:

aa@easeint.com

Annex 7 Cost-effectiveness analysis, by Nayln Siripong

Cost-effectiveness analysis

Nalyn Siripong, East-West Center

October 28, 2010

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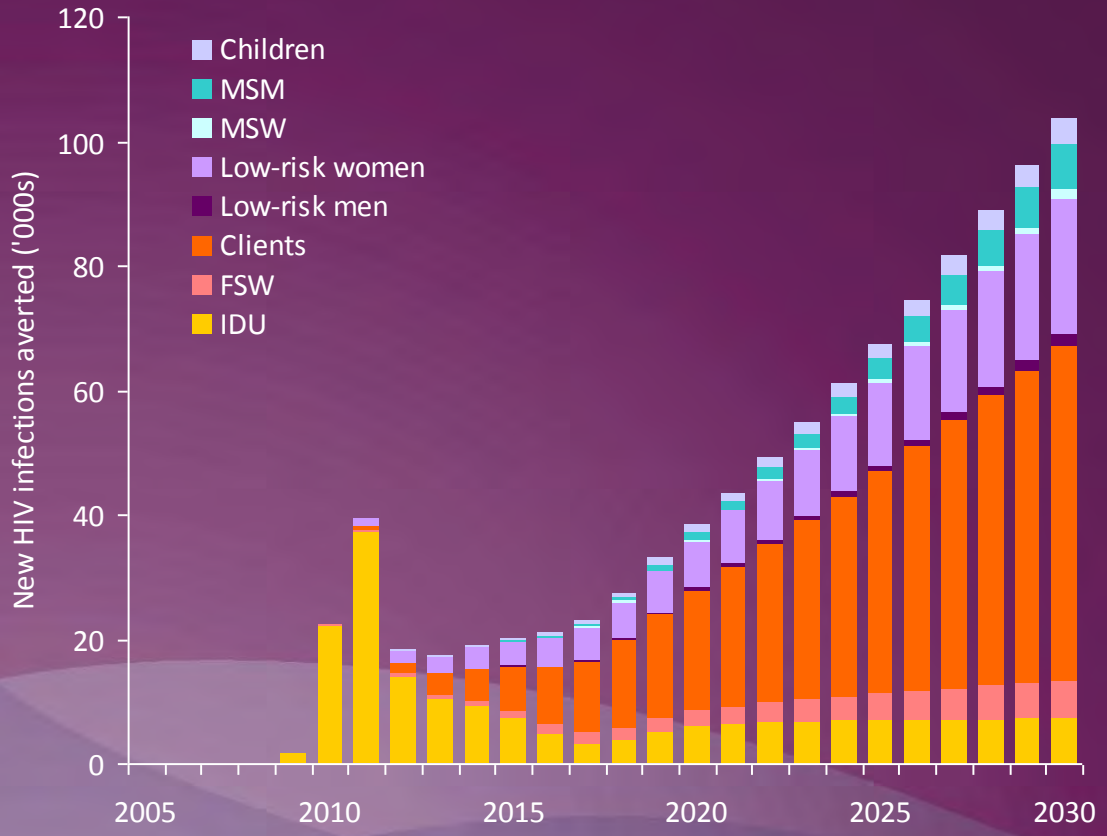
What is the goal of scenario building in HIV?

- To help decision makers understand the consequences of their actions and their impact on the HIV epidemic

- To provide them the information (costs, infections averted, approaches needed, etc.) to make decisions with maximum effects

Broader impacts of targeted interventions:

Impacts of successful early harm reduction



- 192,000 IDU infections
- 60,000 FSW infections
- 460,000 client infections
- 200,000 infections in low-risk adult populations
- 50,000 infections in MSM
- 30,000 infections in children

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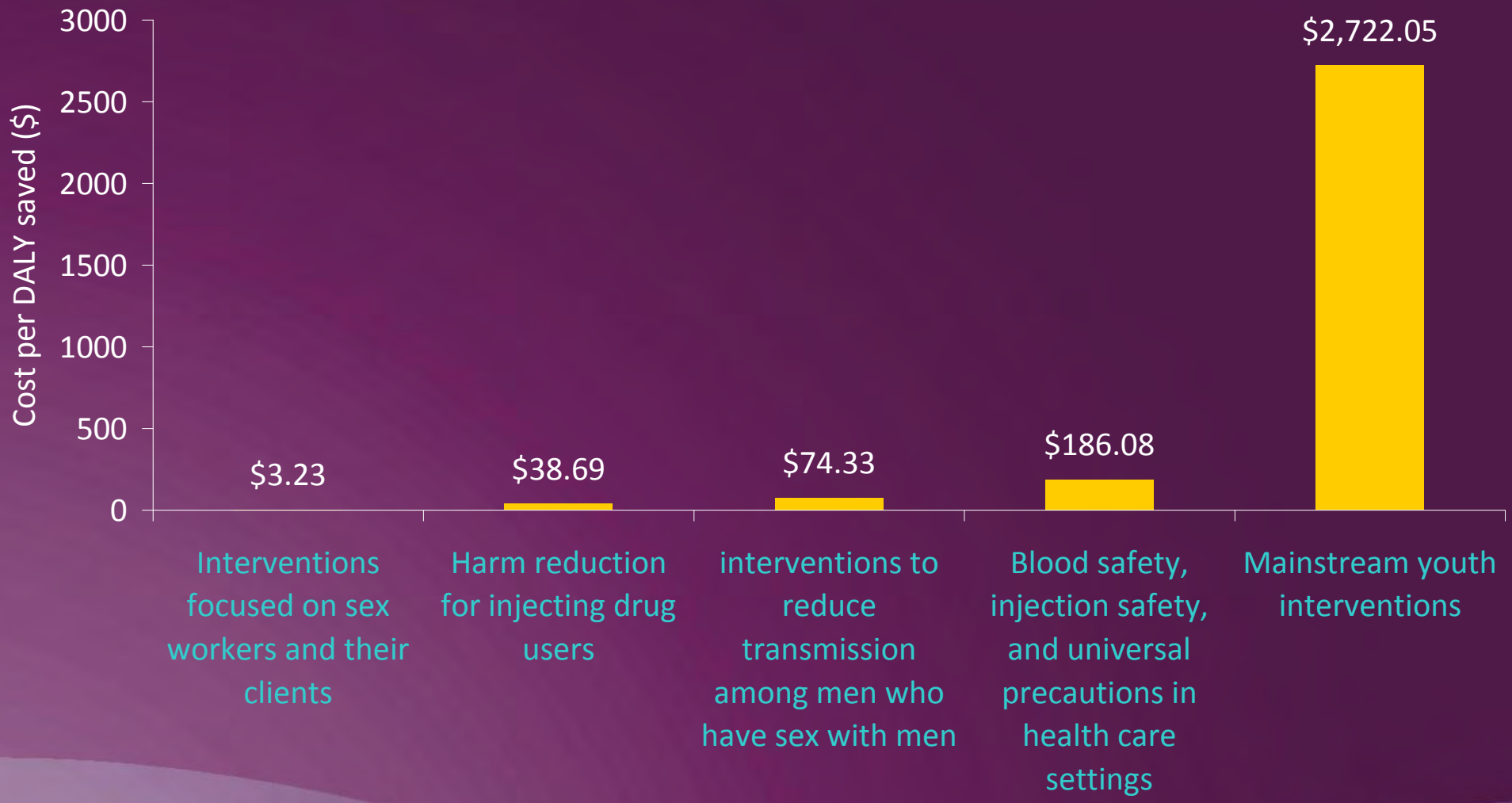
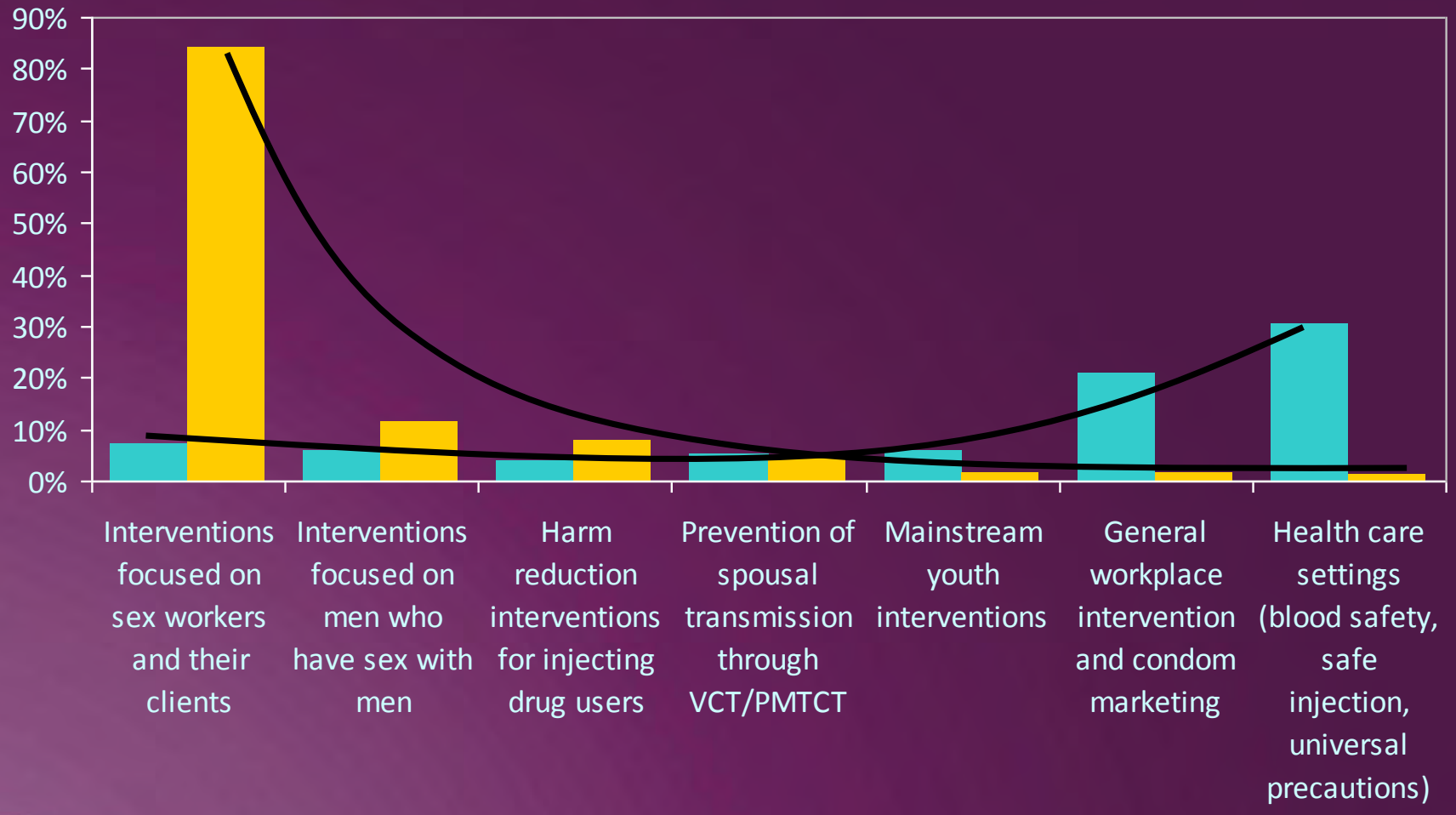
Costs per DALY saved



Resource needs versus infections averted



Cost-effectiveness using AEM

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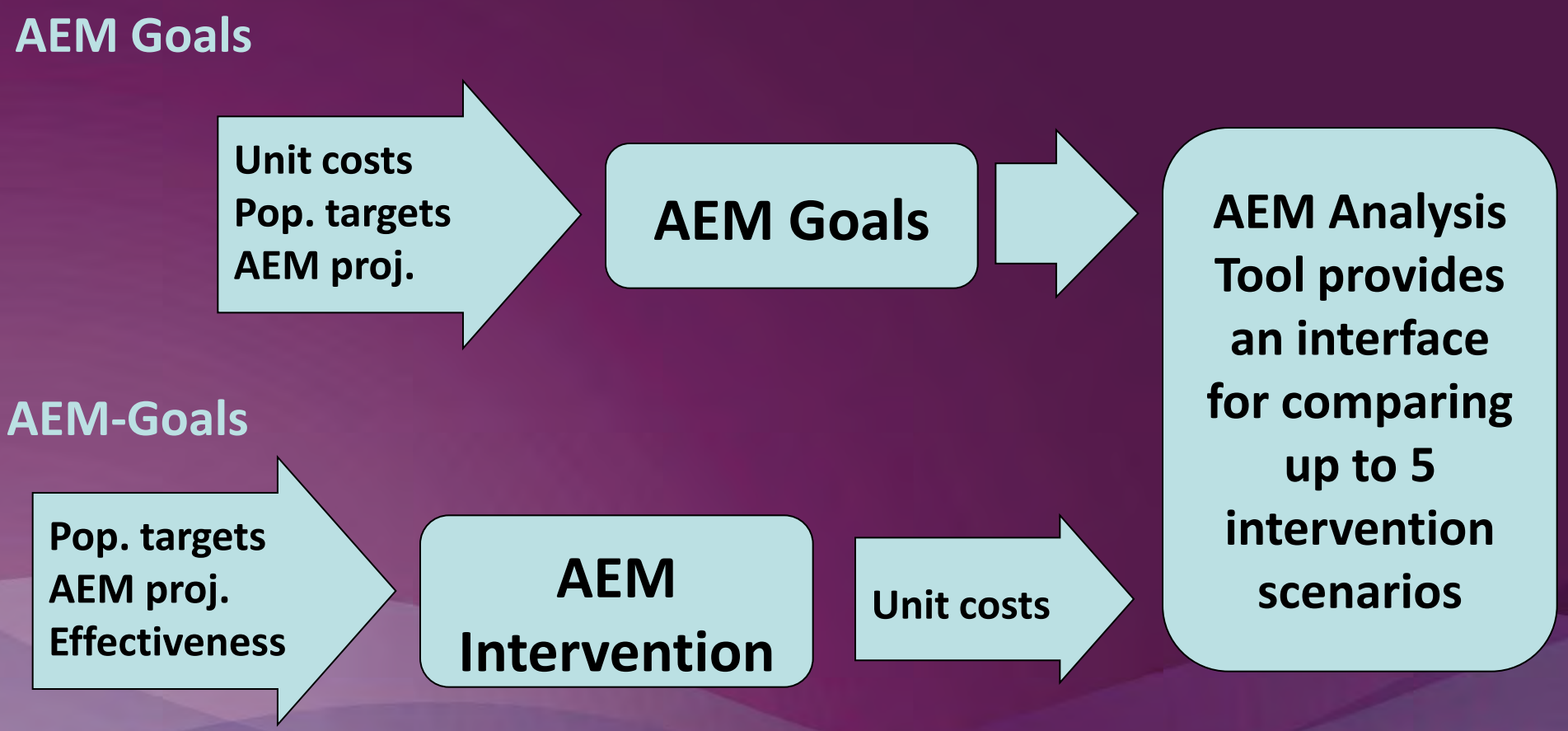
Currently Intervention Interfaces



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Required Elements-Intervention

- Start with a baseline AEM projection
- Evidence from a successful project or program:
  - Coverage of the target population
  - Behavior change and other quantitative measures of intervention effectiveness resulting from increased coverage
  - Unit cost per person reached in the target population

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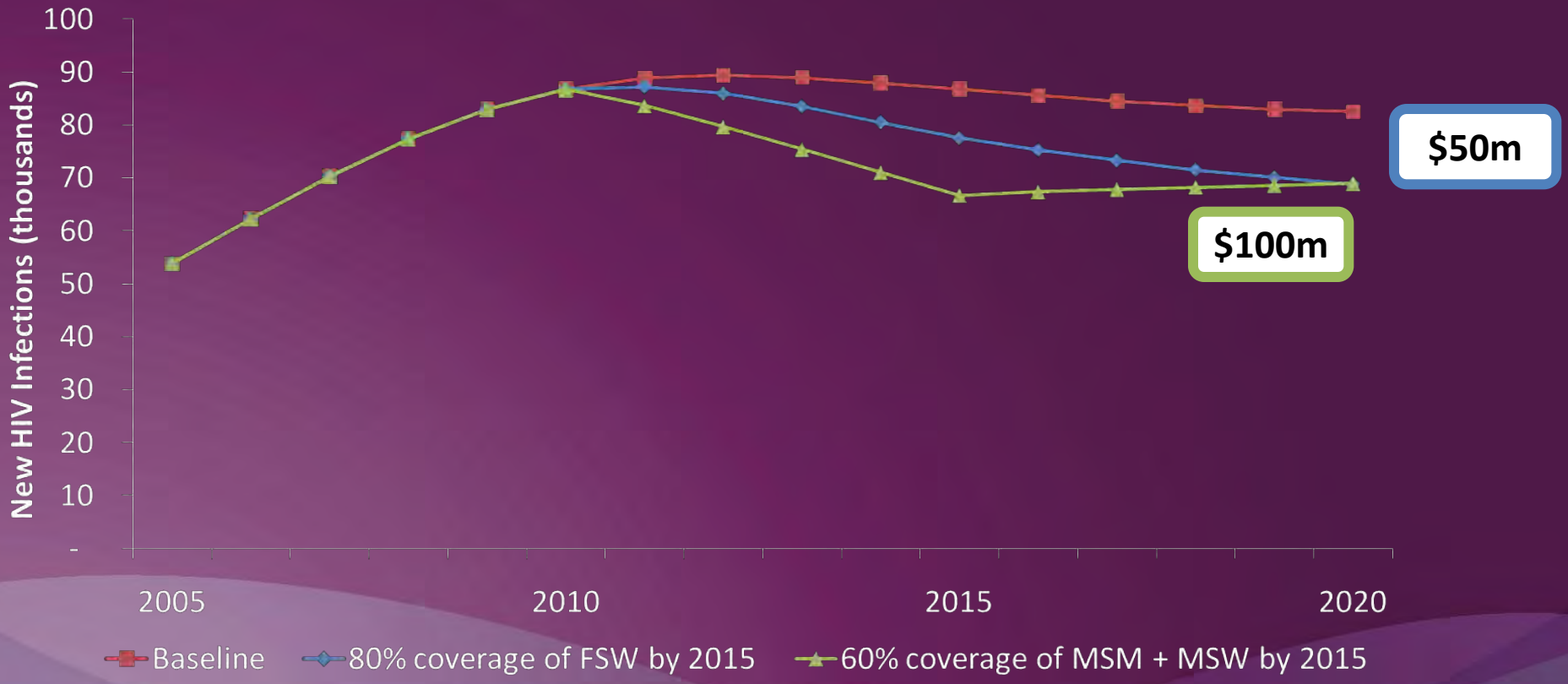
Example using the Intervention Tool

- Current baseline shows 60% condom use between FSW/clients and 30% condom use in MSM
- Two potential Scenarios for the period 2010-2015:
  - Increase coverage of FSW from 40% to 80% (condom use 60% to 78%)
  - Increase coverage of MSM from 10% to 60% (condom use rises from 30% to 61%)

Comparing Scenarios (2010-2020)



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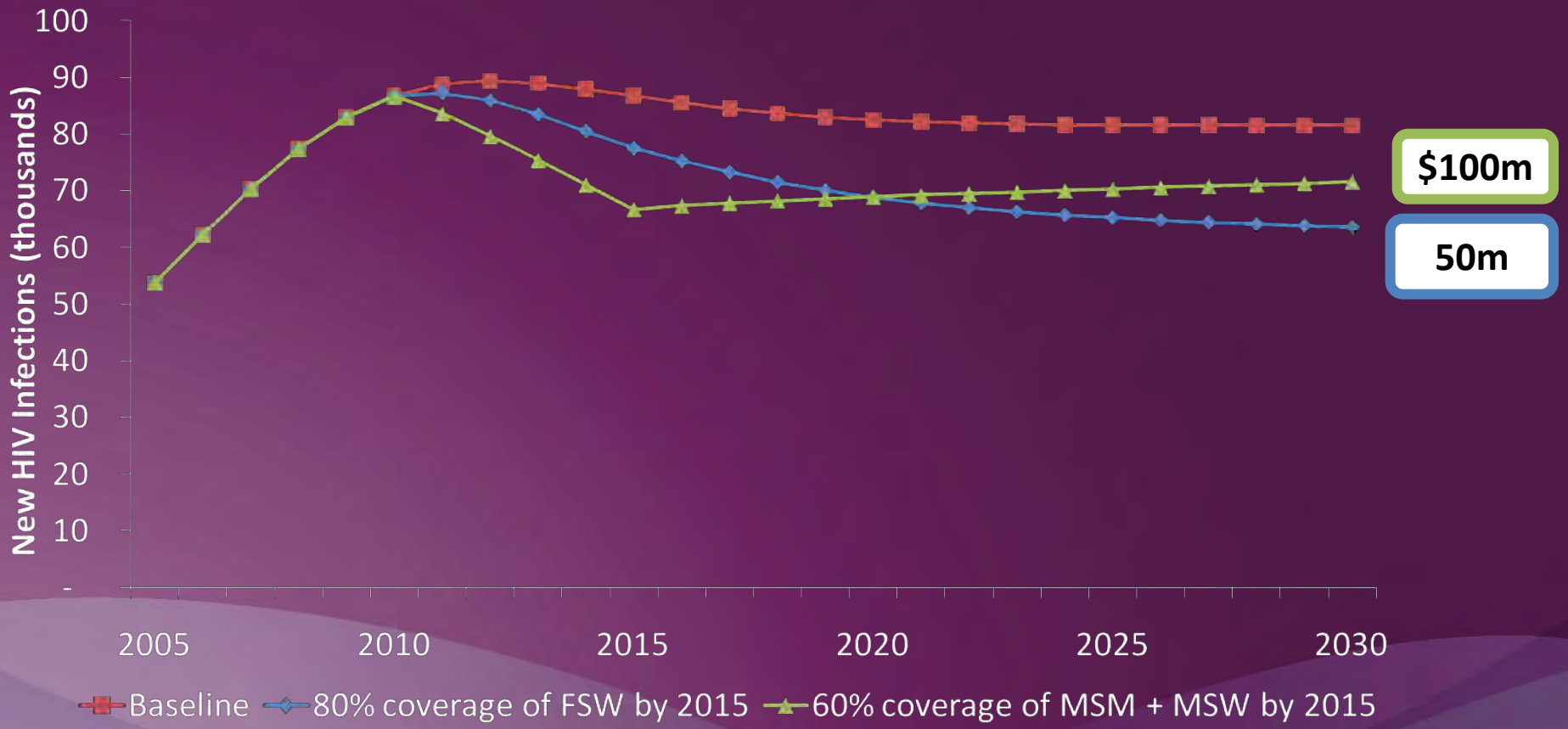
Comparing Scenarios (2010-2030)



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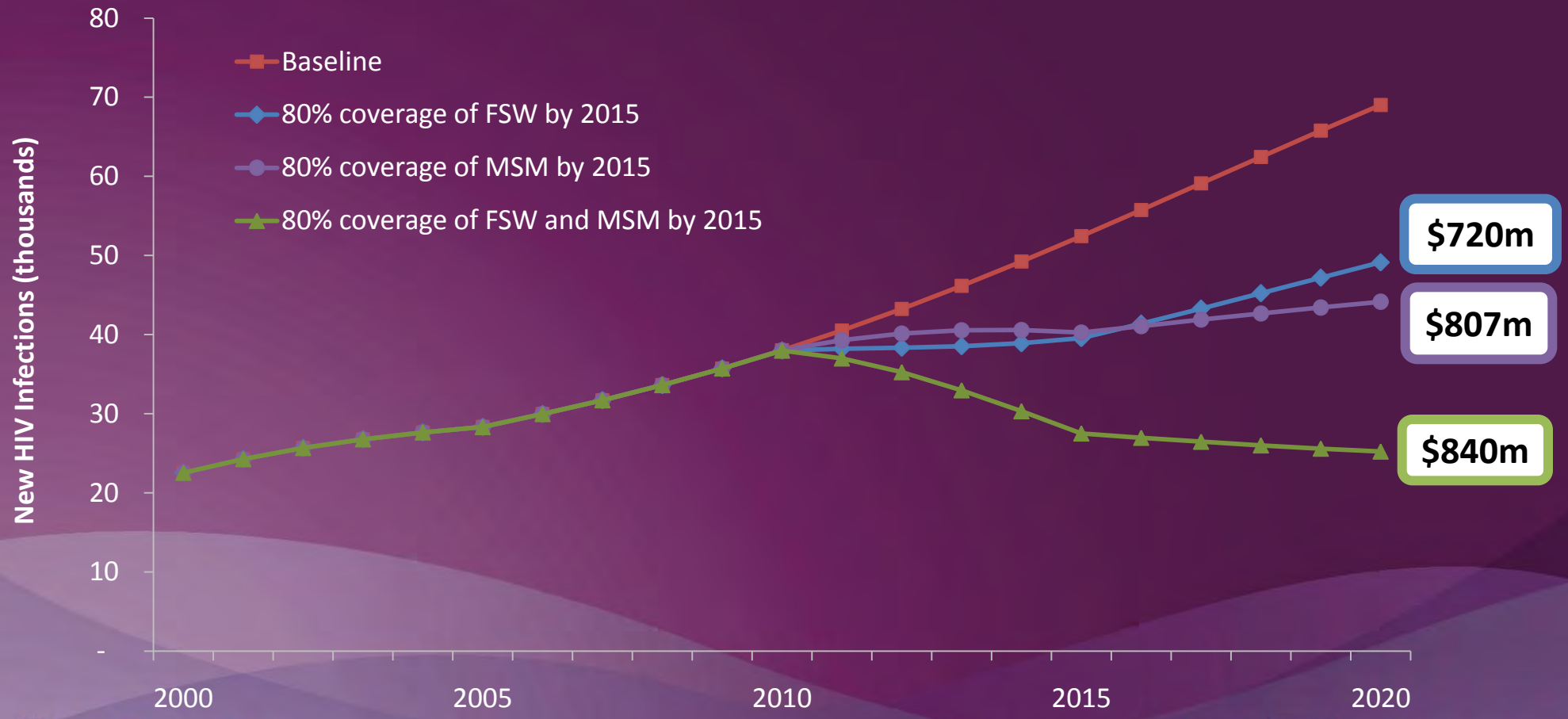
Comparing Scenarios



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Required Elements-Goals

- Start with a baseline AEM projection
- Targets and costs based National Strategic Plans:
  - Population coverage targets
  - Unit costs for various interventions

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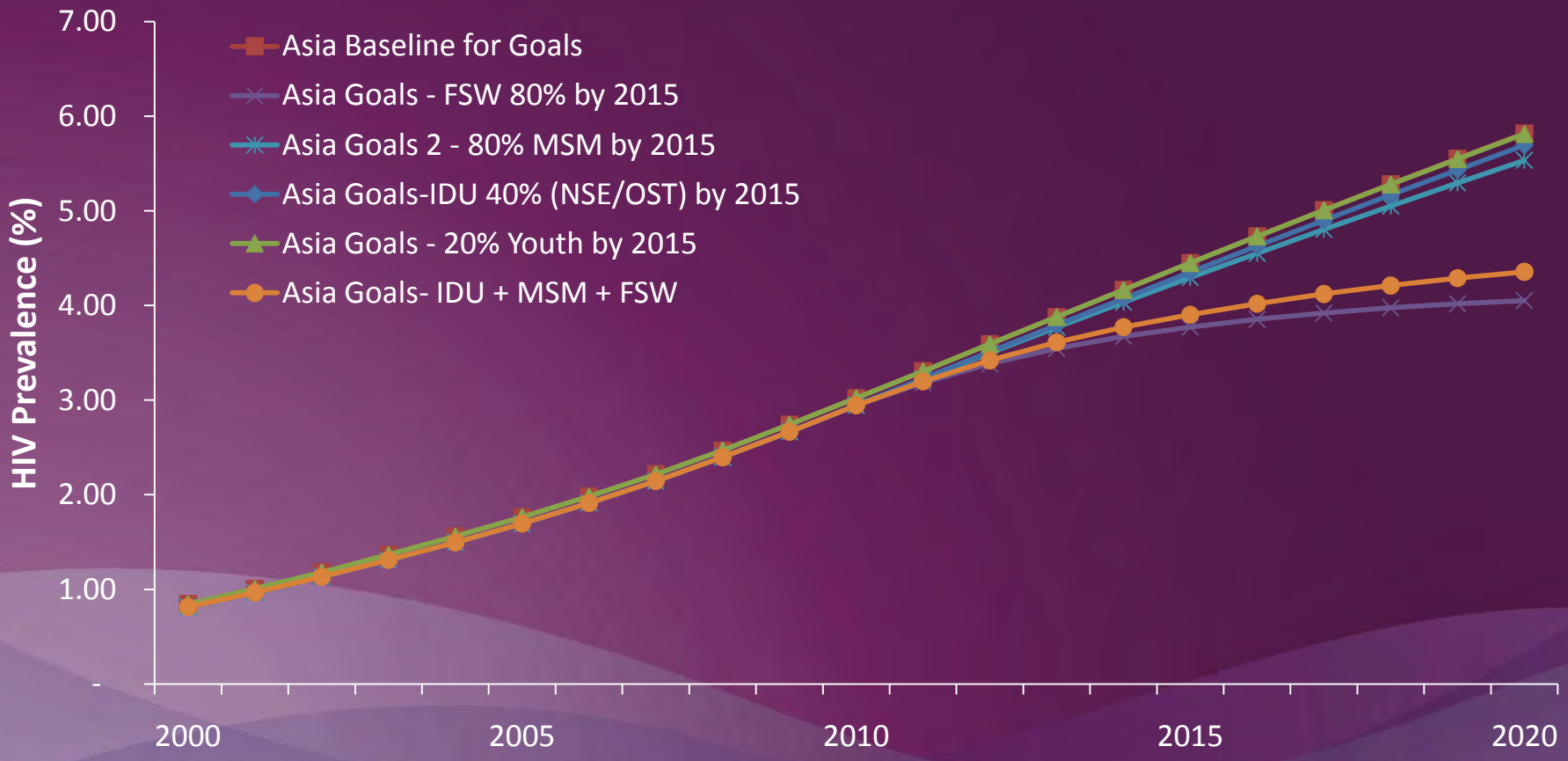
Example using Goals

- A discussion on national planning has come up with 5 proposed approaches to addressing the response:
  - FSW-focus
  - MSM-focus
  - IDU-focus
  - Young people
  - Moderate combination of FSW, MSM and IDU

Comparing Goals Scenarios



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By comparing alternatives, we can see the impact of programs and their success or their failure


STRATEGY RESULTS CYCLE
Formulate/Revise
HIV/AIDS Strategy
STRATEGIC PLAN
PRIORITIZATION
Analyze HIV/AIDS and
National Response Data
Identify Key National
Outcomes & Priorities
Select Principal
Program Strategies
Select Interventions
Resource Needs,
Funding
Implementation
& process monitoring
(indicators, resource tracking)
Evaluate
Changes in
Outcomes

Annex 8 The list of Q & A on cost effectiveness analysis

Unit cost approaches and Cost effectiveness – Anita Alban and Nalyn Siripong

(a) Anita

No	***Questions***	***Answers***
1.	*As we consider that comprehensive services should be provided for Harm Reduction program, how can we do cost-effectiveness analysis?*	***Technical efficiency*** ***Highest CER between NES/ OST as alternatives*** ***Applying to "Redefining AIDS in Asia" allocative efficiency eg. OST / NES***
2.	*Unit cost approaches – what to do to address horizontal program or carting of interventions that are part of health system strengthening ie treatment?*	***CE of health system strengthening, treatment (lab)*** ***Different coverage sophistication eg first and second line bring HR requirement, management***
3.	*Is comparing CER per country more useful than comparing each intervention for the country?*	***Yes - Cost of intervention*** ***Demands same definition different of intervention and standardizations of comparable variable (e.g. discount rate, number of year)***
4.	*What is the discount rate? Inflation or interest rate?*	1. ***Discount rate: norm = 3% - is included for both costs and effectiveness/ outcome to accommodate uncertainty over time*** 2. ***Work with alternative discount rates in sensitivity analysis***
5.	*How is the "baseline" defined in chart?*	***Different coverage, different approach***

6.	*Still unsure how CEA model works in different country context…..different country , different sets of assumptions!*	***Demands same definition different of intervention and standardizations of comparable variable (e.g. discount rate, number of year)***

(b)Nalyn

No	***Questions***	***Answers***
7.	*Cost effectiveness of a certain package of NS exchange?*	***This depends on the package of services and effectiveness of that package and the country's epidemic characteristics; we would need data on effectiveness (ie, X% coverage produces Y% reduction in the number of IDUs who share and W% difference in the frequency of injections***
8. *9.* *10.* *11.*	*What are the data needs for an effective analysis?* *How easy it is for a country to use the AEM model?* *Does it require a lot of capacity and resources?* *How many countries have enough information to run the cost effectiveness tool?* *How many done so?*	***An effective analysis using the AEM tool requires a strong, robust and validated AEM baseline projection, which means collecting all of the necessary behavioral and biological input data, including trends. Once the baseline is established, the technical details of running scenarios is easy, but we encourage countries/governments who use this tool to do so through a collaborative and inclusive process.*** ***The AEM software has been used in at least 5 countries and several provinces throughout the region. The AEM link with Goals has been utilized in several countries through the A^2 process. The cost-effectiveness tool is being piloted in several***

		of these countries as well.
12.	*Does AEM entail that DALY be established to come up with CEA? How do you go about CEA in countries / areas with no DALY data?*	***The model estimates the number of HIV infections averted; and DALYs are calculated based on a standard DALY-per-HIV infection averted ratio, which was calculated on a regional basis.***
13.	*Distinguish between CE with interventions in general (eg. SW perception, IDU harm reduction? In specific settings (related to quality of actual programme?*	***Cost-effectiveness cannot really be done "in general" per se, but must be done with reference to a specific intervention project. The AEM model allows us to estimate the cost-effectiveness if a small project is replicated at a national or larger scale.***
14.	*Are methods behinds CEAs presented by both presenters the same or compatible? (or do we need a similar meeting on CEA tools?)*	***Methods are compatible and can be compared, as long as you consider the same timeframe to consider impact (infections averted) and the same calculation for costs.***
15.	*What is the threshold level for cost effectiveness of IDU interventions ie. lowest coverage levels that being down HIV prevalence.*	***I think this would depend on a number of starting behavioral issues, including frequency of injecting, duration that people inject drugs and other factors.***

16.	*Does is it really work by using AEM for CEA?*	***As mentioned in the presentation, the success or reliability of the model depends very much on the quality of the data inputs. If you are confident that your epidemiological inputs and the effectiveness of your program are accurate, then the model will indeed give some indication of cost-effectiveness in the future.***
17.	*What are the parameter you have had in the model to predict the scenario impact?*	***Project effectiveness are usually measured according to behavioral outcomes (e.g., condom use and injecting frequency and sharing), and biological outcomes (STIs). The model will simulate the impacts of this behavior change.***

Unit cost approaches and Cost effectiveness – Anita Alban and Nalyn Siripong

(a) Anita

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1.	*As we consider that comprehensive services should be provided for Harm Reduction program, how can we do cost-effectiveness analysis?*	***Technical efficiency*** ***Highest CER between NES/ OST as alternatives*** ***Applying to "Redefining AIDS in Asia" allocative efficiency eg. OST / NES***
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Annex 9 AVAHAN: The business of prevention at scale, by James Moores

AVAHAN: THE BUSINESS OF PREVENTION AT SCALE

Perspectives, methods, and issues surrounding the cost estimates for scaling up HIV prevention

UNAIDS Expert Consultation on Costing
Bangkok
29 October 2010

BILL & MELINDA GATES foundation

Agenda

- **Avahan Overview**
- **Emerging impact results**
- **Financial cost structure and analysis**

AVAHAN RATIONALE AND BACKGROUND

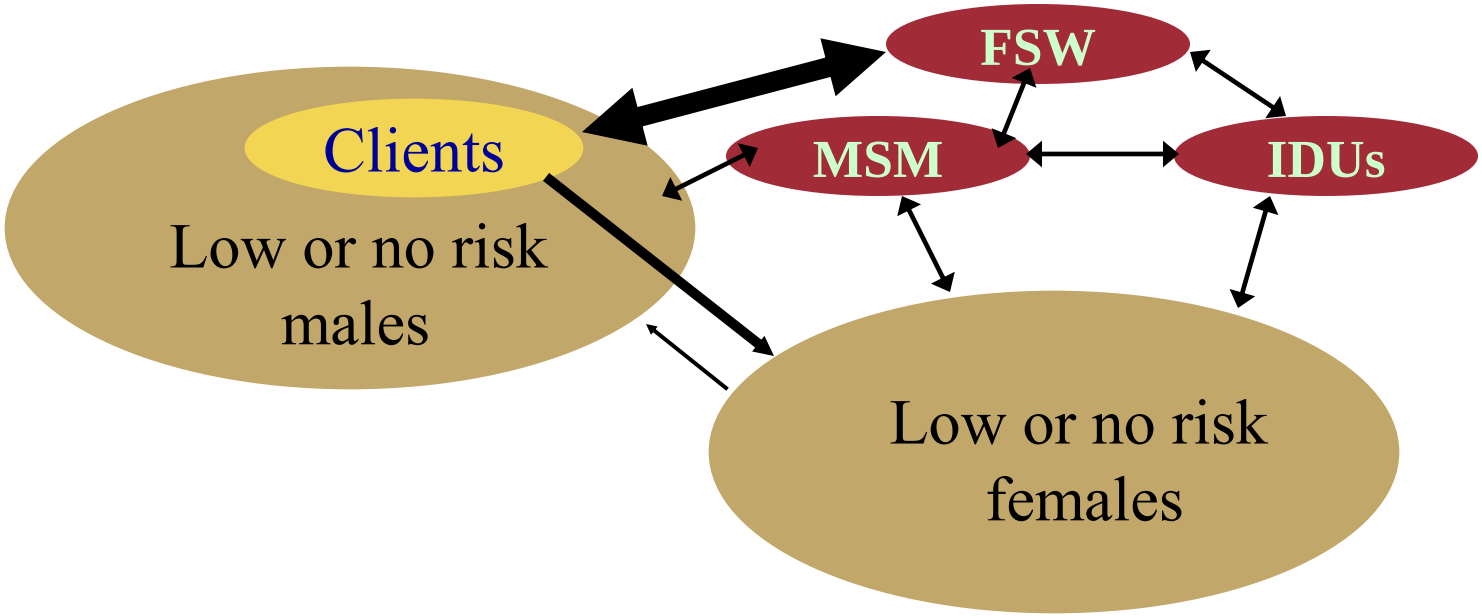
Sense of Urgency

- Projections of 25 million HIV infection by 2025
- Classified as a second-wave county (CSIS)

Foundation Rationale for Entry

- Evidence of large growing concentrated Indian sub-epidemics
- National response had low prevention coverage of high risk groups (HRG)
- Prevention for concentrated epidemics via HRG focus well known
- Few successful examples globally
- International advocacy about “prevention gap”

INDIA'S EPIDEMIC IS SIMILAR TO OTHER ASIAN HIV EPIDEMICS…



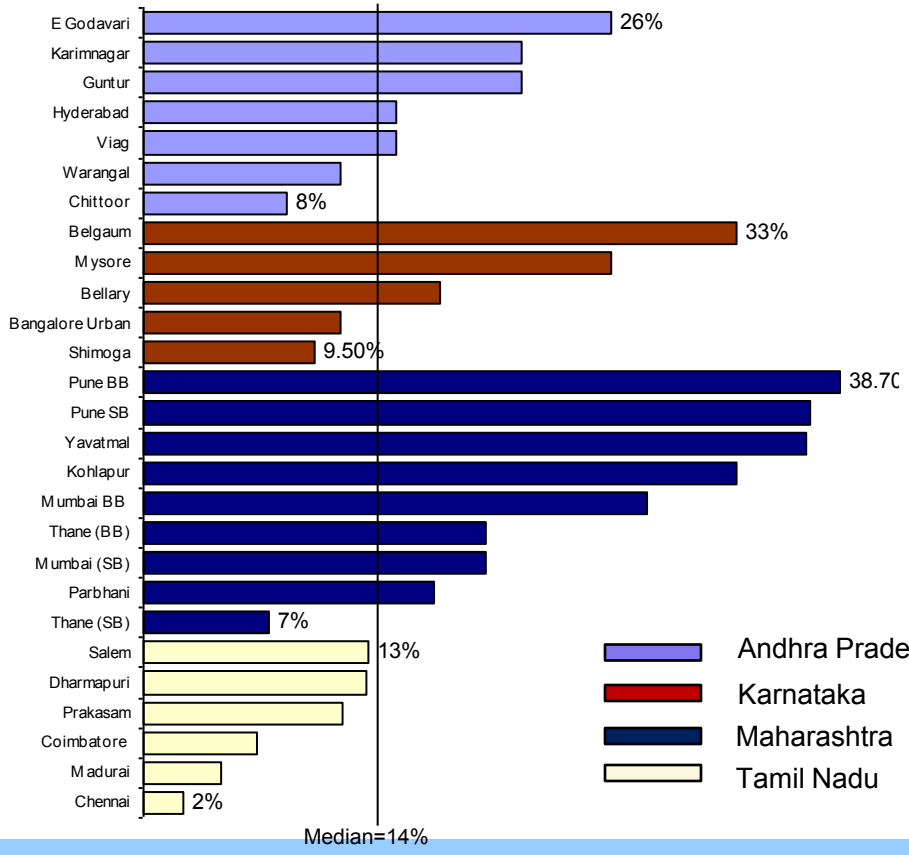
- Asian epidemics remain focused in specific populations and their partners
- There is no "generalized" spread. Rather truncated or local concentrated epidemics
- Focused prevention the effective strategy

Source: Tim Brown, East West Center

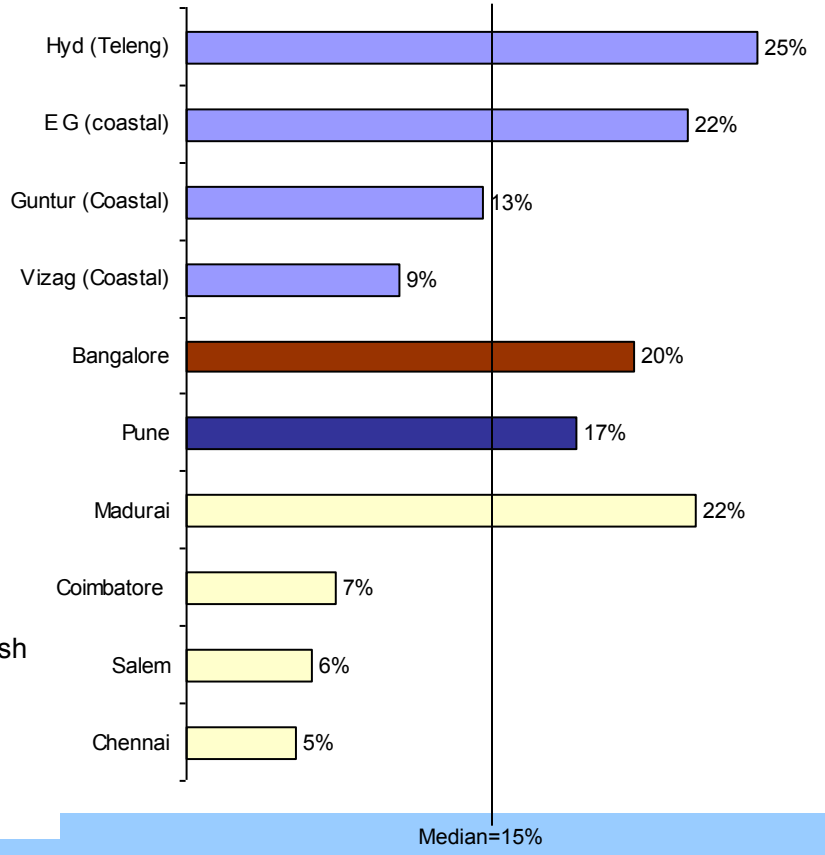
HIV PREVALENCE IN MARPs IS HIGH IN THE FOUR SOUTHERN STATES

Median district level FSW prevalence 14%, 10 of 26 districts have > 20%
Median district level MSM HIV prevalence 15%, 4 of 10 districts surveyed have > 20%

HIV prevalence among FSWs in Avahan districts (Andhra Pradesh, Karnataka, Maharashtra, Tamil Nadu)

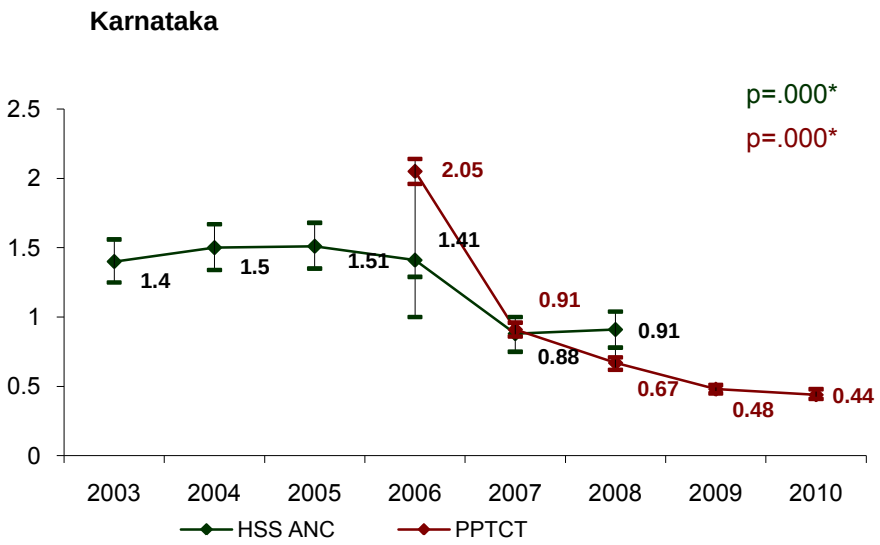


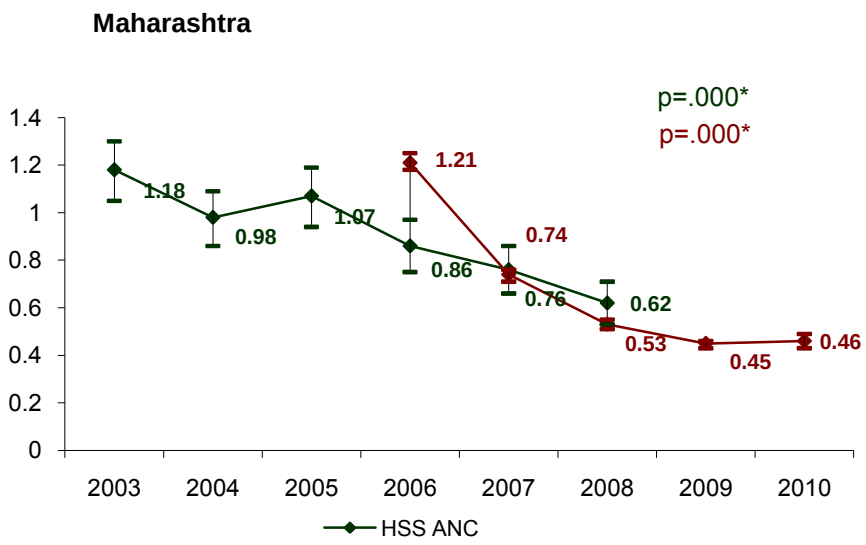
HIV prevalence among HR-MSM/TG in Avahan districts (Andhra Pradesh, Karnataka, Maharashtra, Tamil Nadu)

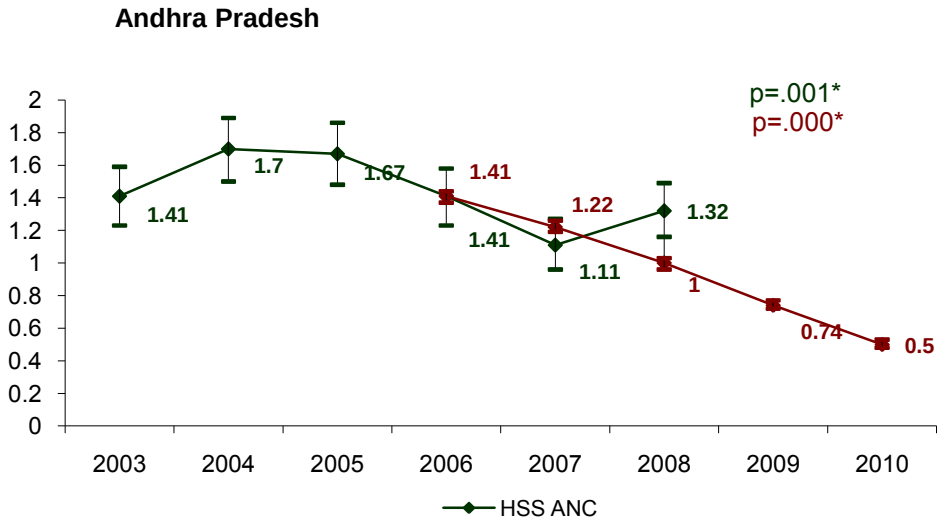


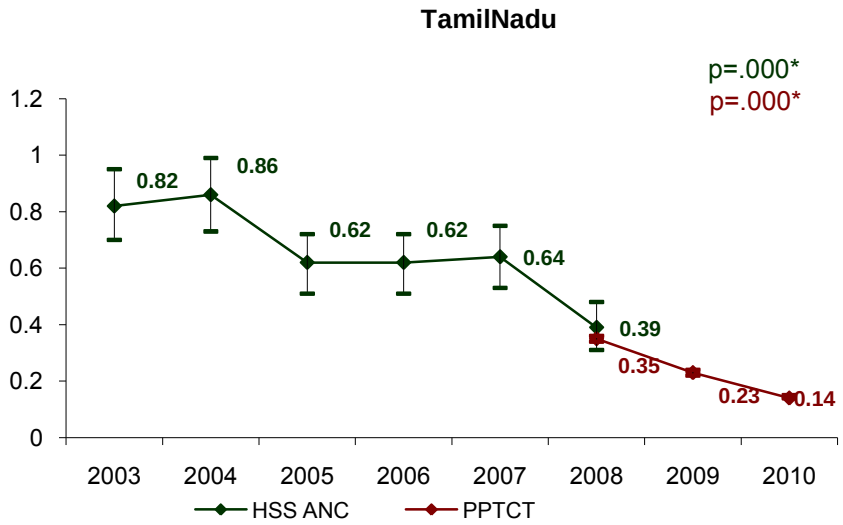
Source: Avahan IBBA MARP surveillancedata, 2006

HIV prevalence in HSS-ANC and PPTCT sites



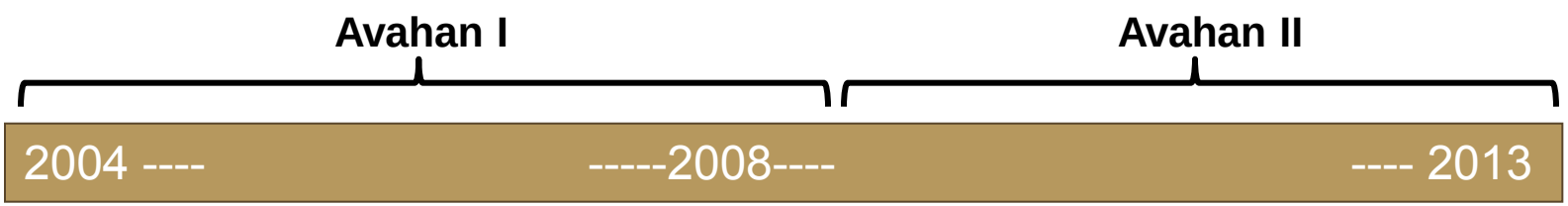






ANC and PPTCT consistent sites; source: NACO

AVAHAN'S GOALS OVER A TEN YEAR PERIOD



Build / Operate HRG prevention program at scale

- Demonstrate program at scale with coverage, quality
- Declining HIV infection trends in core, bridge, general population

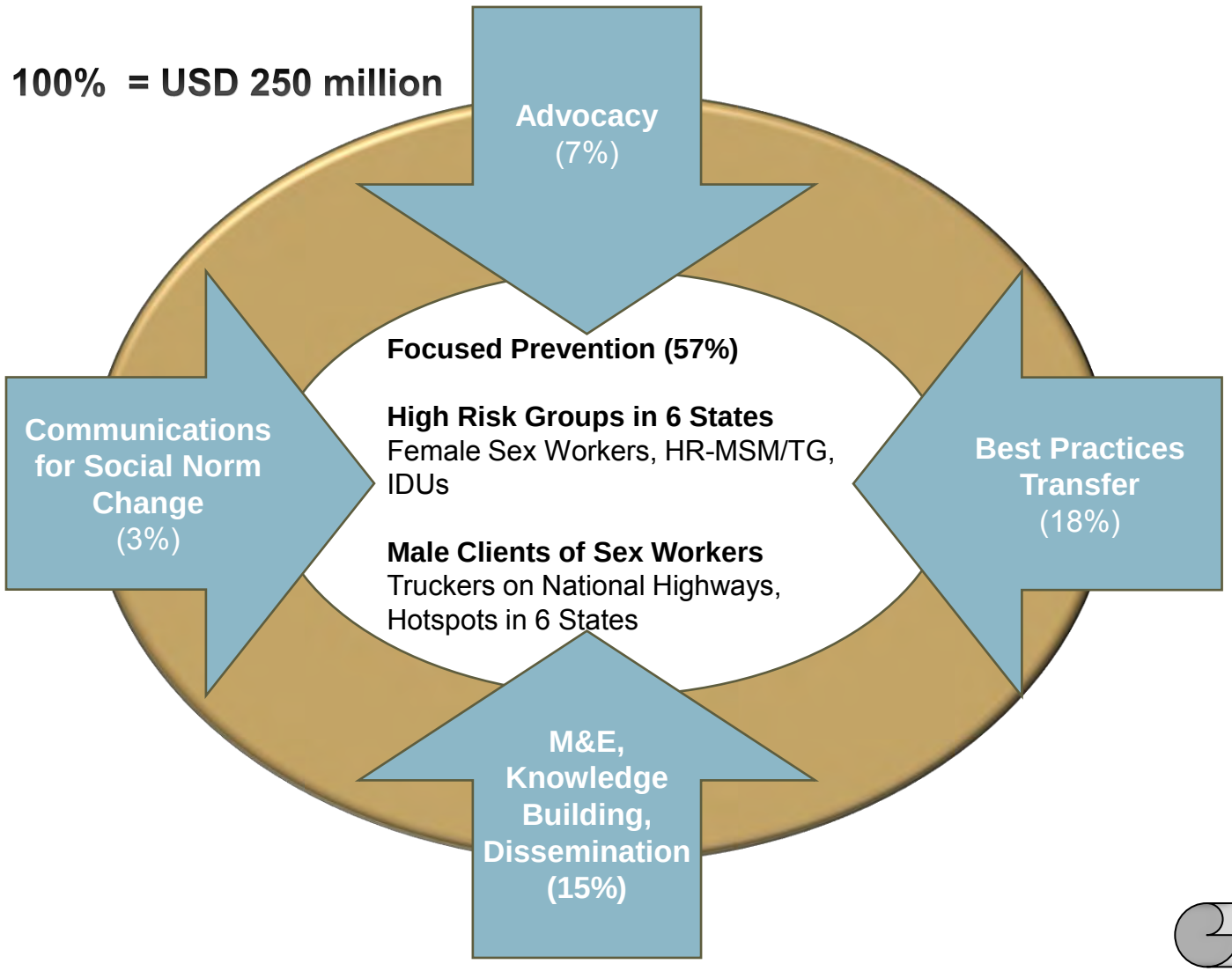
Transfer program to government, other stakeholders, communities

- Sustain funding / management without program disruption
- Strengthen communities to sustain transition post-handover

Disseminate learnings

- Actively foster opportunities for creating learnings from the Avahan live laboratory
- Disseminate learnings through a wide variety of mechanisms and fora

DESIGN OF AVAHAN'S FIRST PHASE (2003-2009) – INTEGRATED PROGRAM

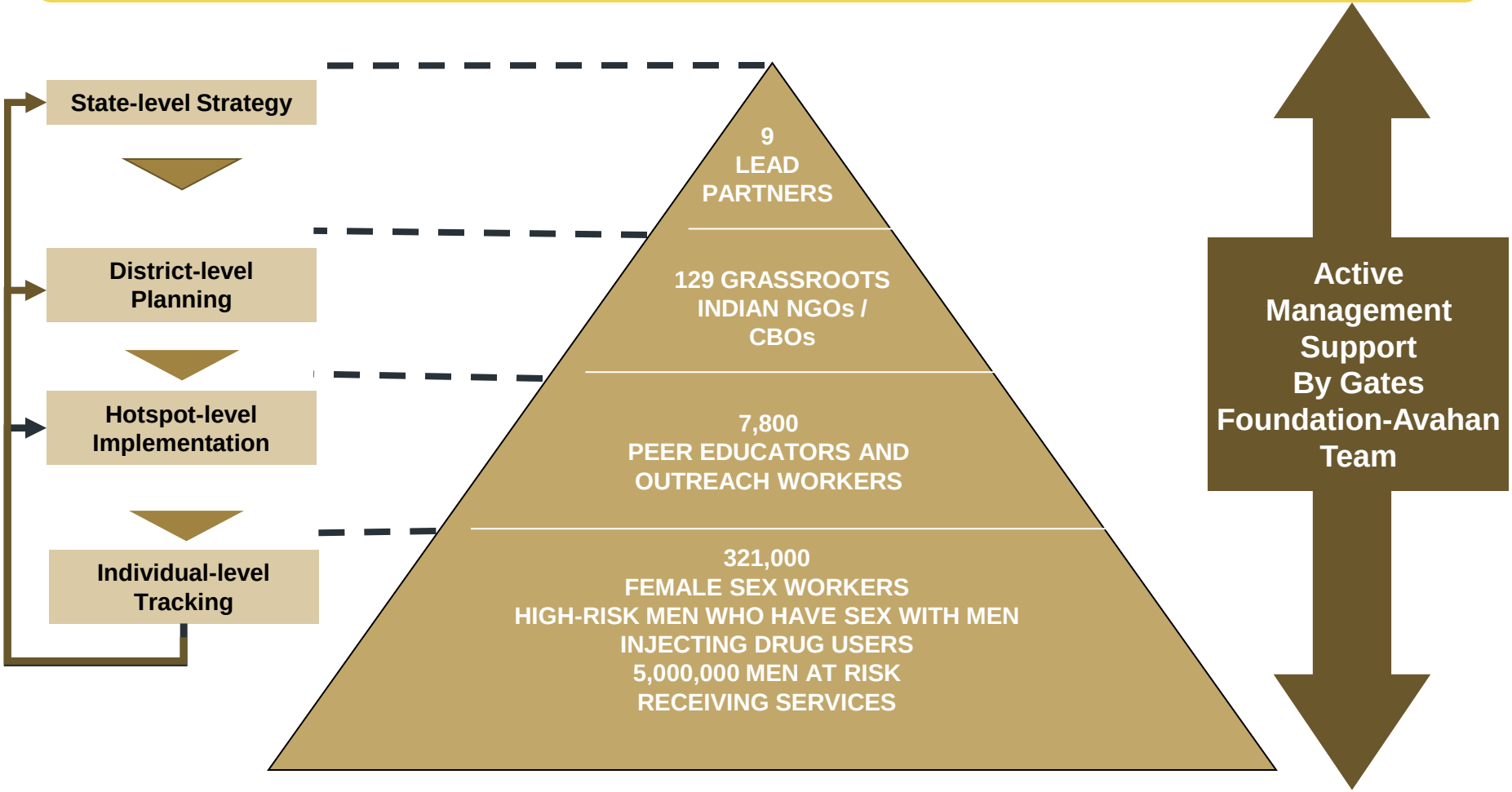


The Prevention Package

- Outreach, BCC
- Commodities (condoms, lubricants, needles)
- Clinical services for STIs + counseling
- Case managed approach to referral - TB, HIV testing, ART
- Local advocacy – police sensitization, crisis response, community advisory committees
- Community mobilization

AVAHAN'S MULTI-TIERED, MATRIX ORGANIZATION

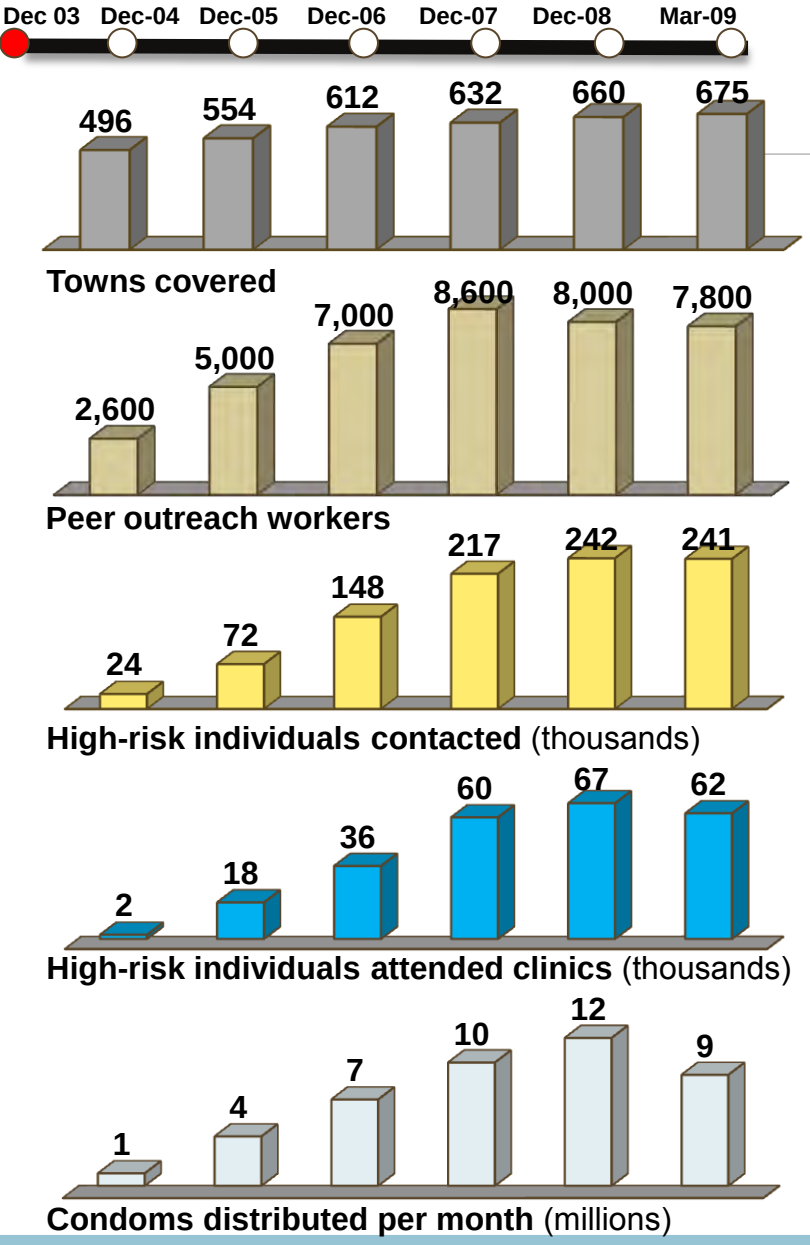
Foundation Staff In 5 Locations, 24 Grantees, 31 Grants 6 States, 82 Districts



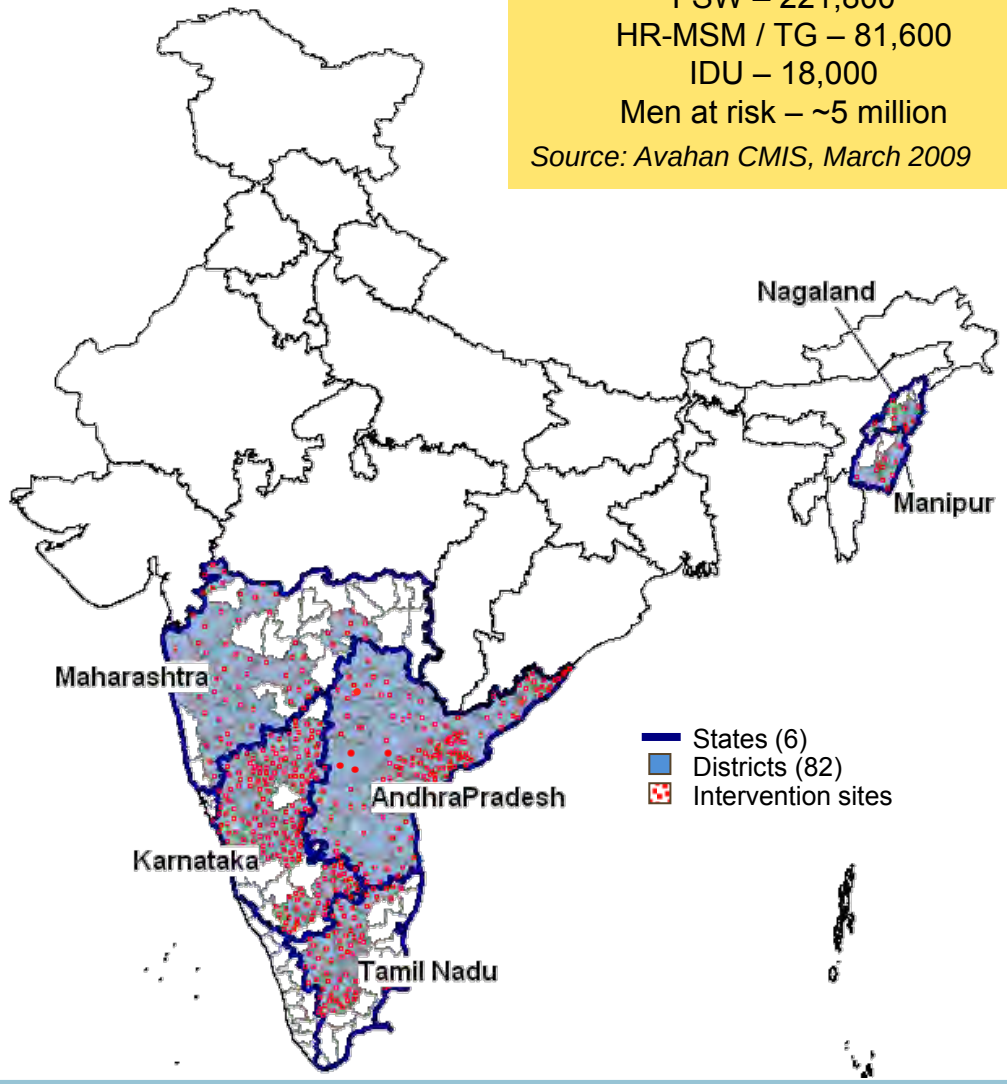
Cross Cutting Support
Capacity Building, Advocacy, Monitoring and Evaluation, Knowledge Building

Source: Avahan monitoring data, March 2009

AVAHAN'S SCALE UP TIMEFRAME



6 states, 82 districts, 600+ towns
Combined State Population
~ 300 million
High risk groups covered
FSW – 221,800
HR-MSM / TG – 81,600
IDU – 18,000
Men at risk – ~5 million
Source: Avahan CMIS, March 2009

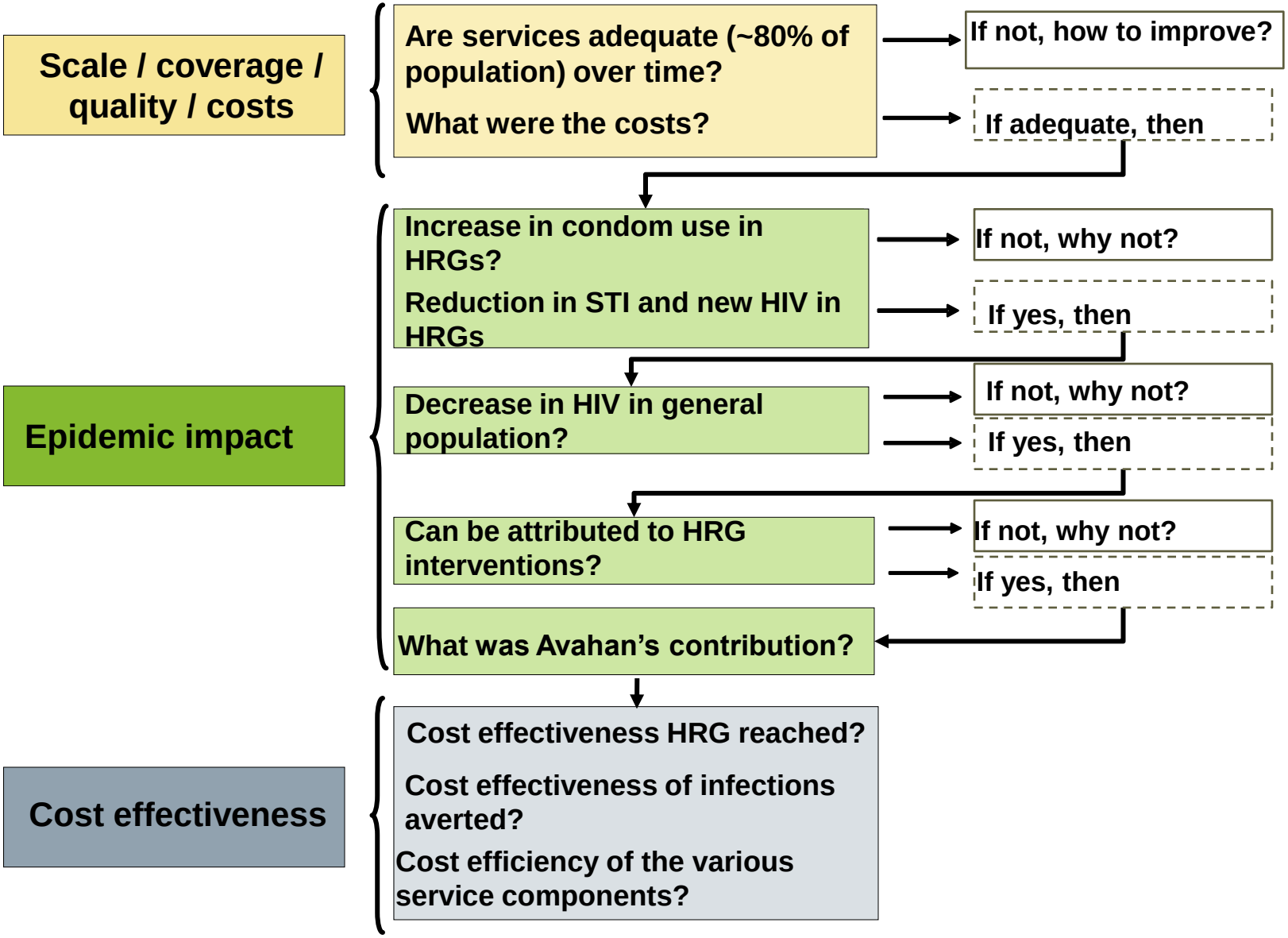


Source: Avahan routine monitoring data, all six states

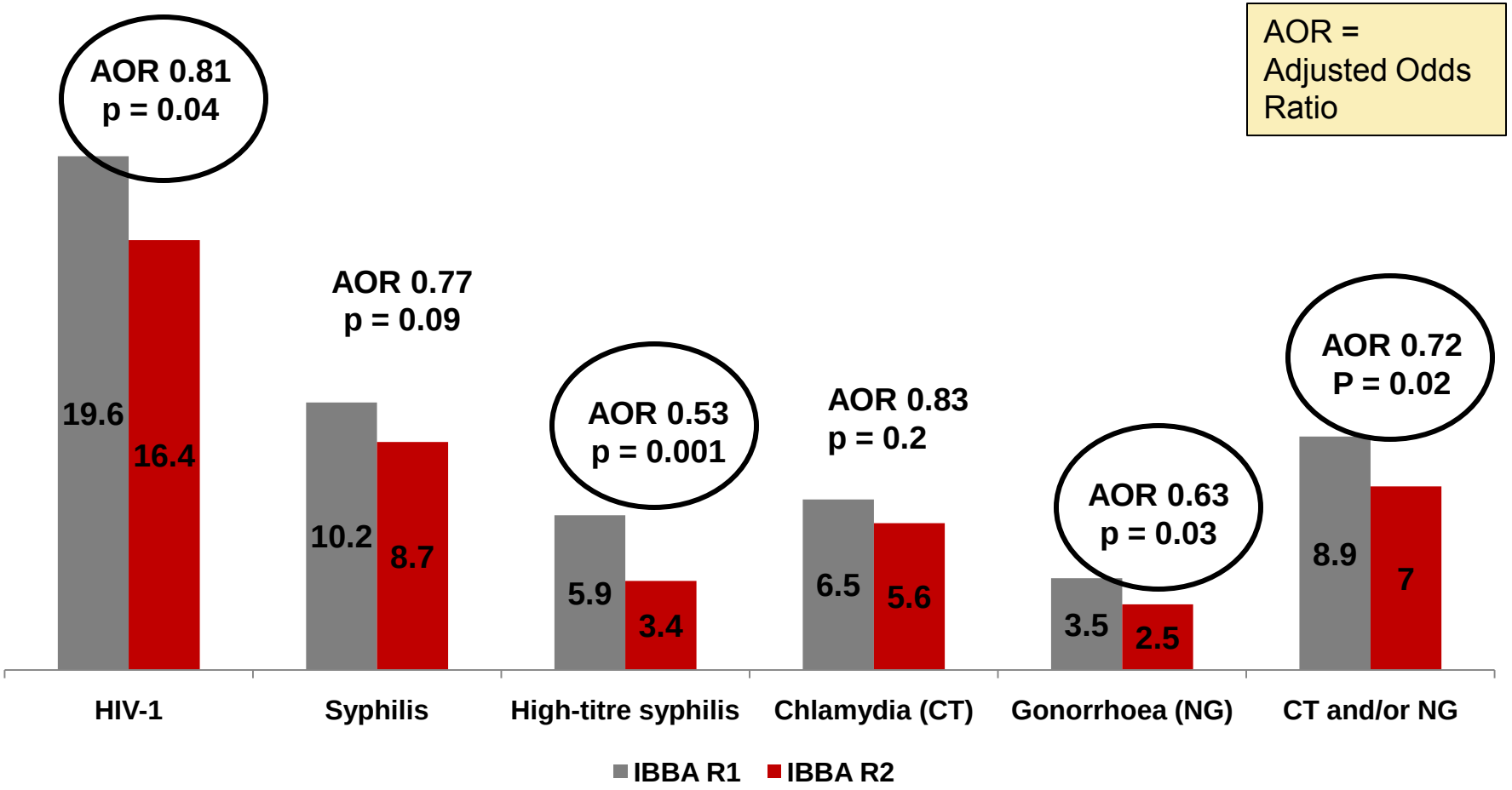
Agenda

- **Avahan Overview**
- **Emerging impact results**
- **Financial cost structure and analysis**

AVAHAN IMPACT EVALUATION QUESTIONS



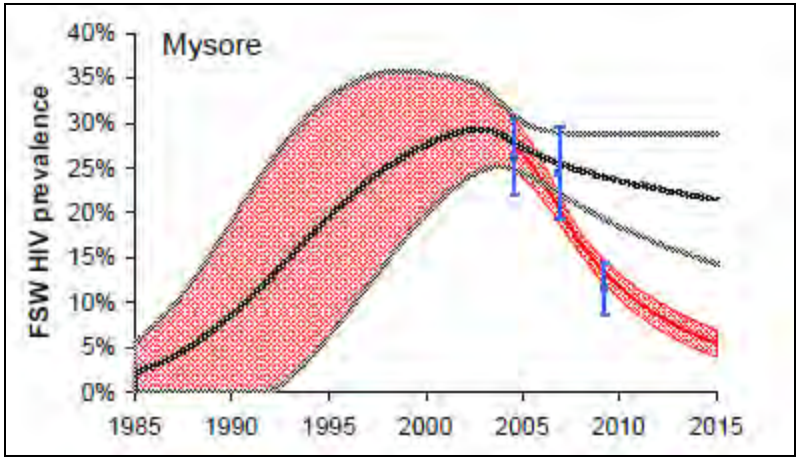
IN KARNATAKA THERE WAS A SIGNIFICANT DECLINE IN STI PREVALENCE (BASELINE AND FOLLOW-UP SURVEYS, 5 DISTRICTS)

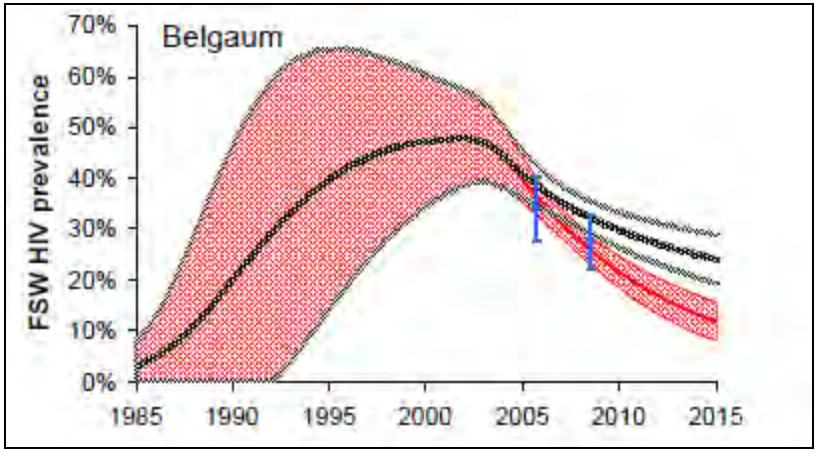


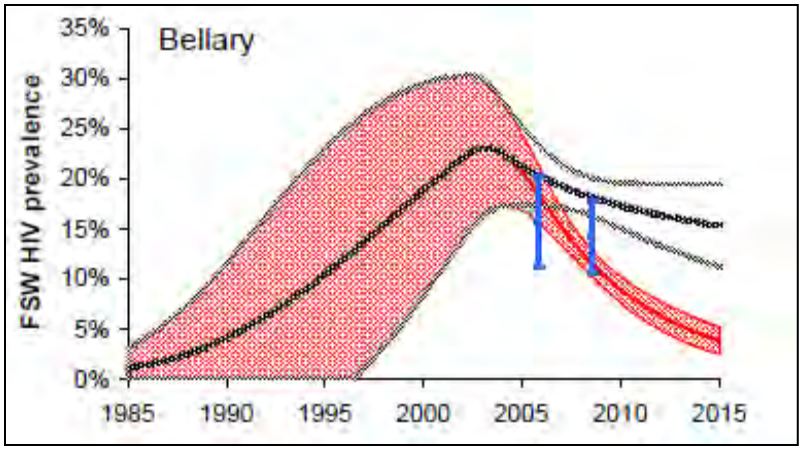
Multivariate model adjusted for the following variables: (1) district, (2) age, (3) marital status, (4) residency status, (5) usual place of solicitation, (6) age started sex work, (7) charge per sex act, (8) weekly sex work income, (9) proportion of clients who were new, (10) proportion of FSWs with regular clients.

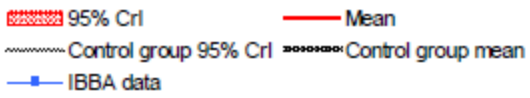
Source: Ramesh BM. IBBA two rounds analysis with FSWs in Karnataka, 5 districts. STI 2010; 86 (Suppl 1): i17.

THE ESTIMATED IMPACT of INCREASE in CONDOM USE ON HIV PREVALENCE AMONG FSWS AND CLIENTS – RESULTS OF MODELING









Predicted proportion of new HIV infections averted (2004-2014)

	FSW % (95% CI)	Clients % (95% CI)
Mysore	**59.2** (47.8-70.6)	**62.3** (51.7-72.8)
Belgaum	**43.5** (33.7-53.3)	**50.3** (39.8-60.7)
Bellary	**64.6** (59.4-69.3)	**67.6** (63.2-72.1)

Source: CHARME Team, manuscript in preparation

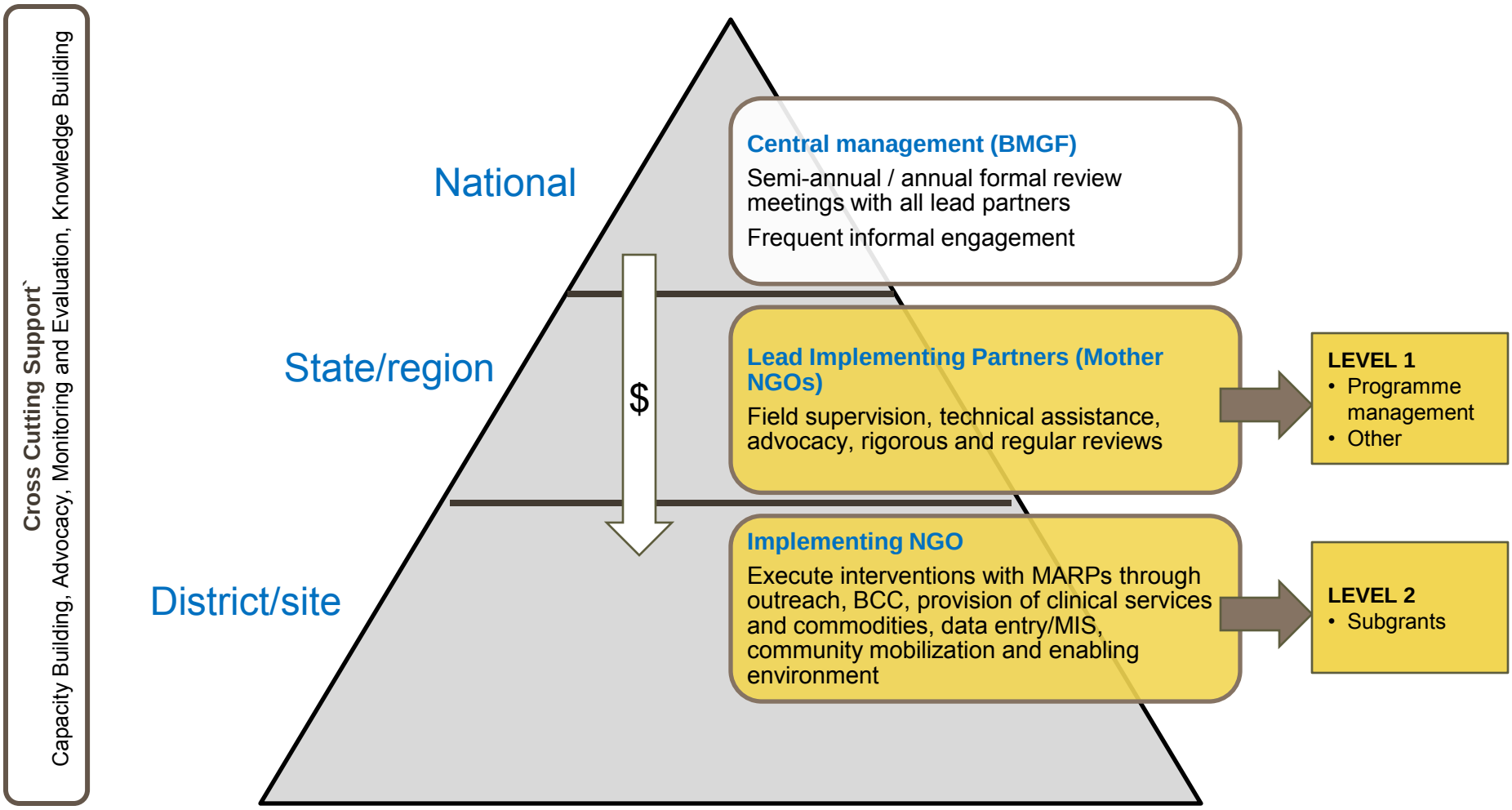
Agenda

- **Avahan Overview**
- **Emerging impact results**
- **Financial cost structure and analysis**

Key messages on Avahan budgets and investments

- **Invest in advocacy and community mobilization**
  - » Violence reduction and crises management
  - » Sustainability and empowerment
- **Flexible funding to support innovation**
  - » Tailoring to the context
- **Appropriate staffing structure and investments**
  - » Staffing ratios and numbers
- **Management, management, management**

Avahan costs are captured at two levels



Description of Avahan major cost areas

For every $100 spent on MARPs:
- At least $60 should be spent on grassroots implementation
- Programme management should be adequately funded (e.g., 50% of implementation costs)

Cost area	Pan Avahan Annual	$ per MARP per year	% of Total Costs	Description of Cost Components
Programme management	7,030,607	24	29%	• **Appropriate field and technical staff** • **Travel** for field based monitoring and handholding • **Trainings and workshops** • **Contracts** for mapping, size estimation, studies, research, tool development
Subgrants to Implementing NGOs (and medical supplies)	14,320,592	48	59%	• **Staff** (peer educators, outreach workers, managers) • **Infrastructure** • **Technical areas** such as clinical services, commodities, community mobilization, enabling environment, data collection, group meetings
Other programme costs	3,109,996	10	13%	• **Rent** and office supplies • **Indirect costs** • **Equipment**

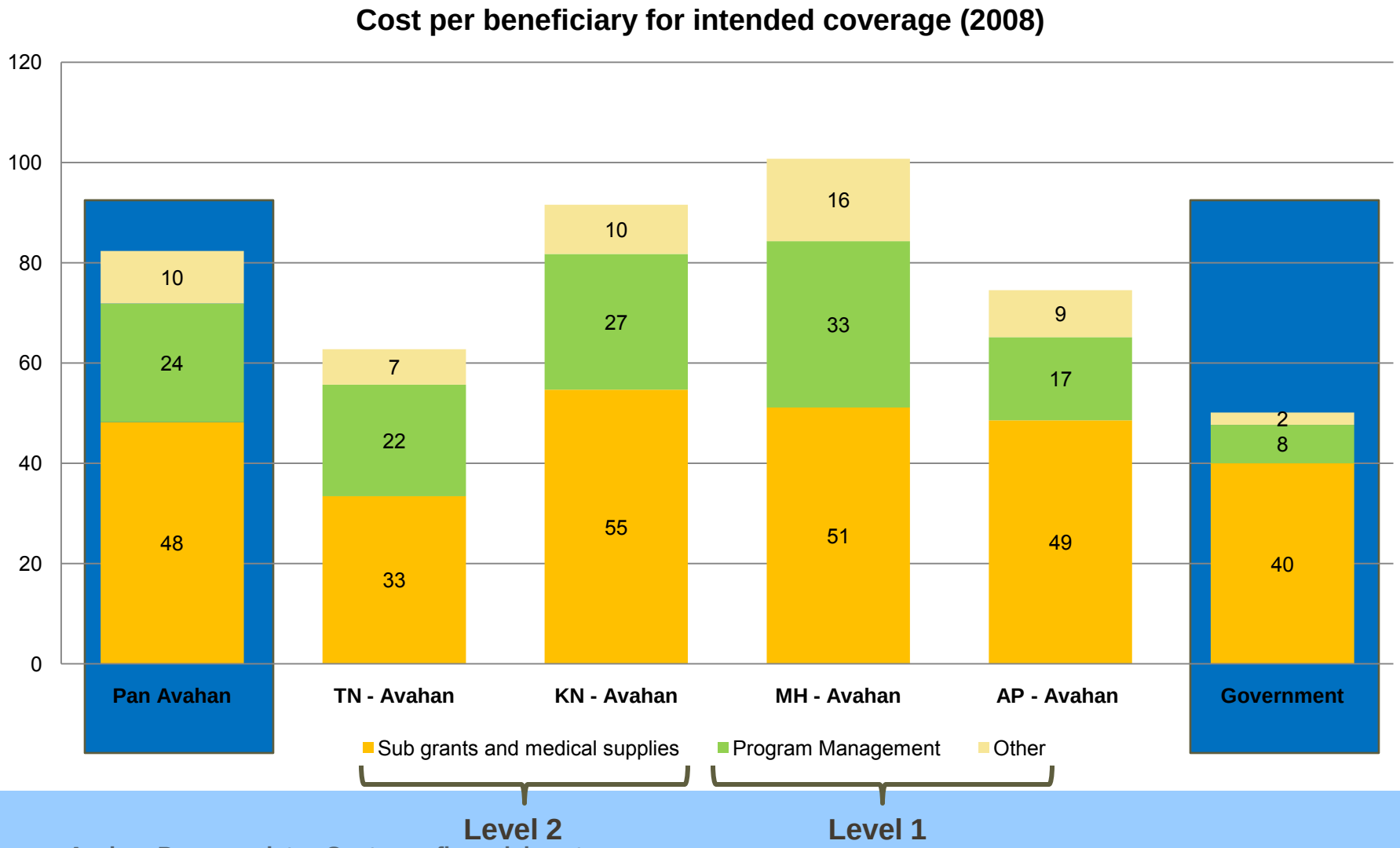
Source: Avahan 2008 budgets; Avahan Program data. Costs are financial costs.

Implementation – key components

Cost area	Per MARP	% of Total Costs
Subgrants to Implementing NGOs (and medical supplies)	**$48**	**100%**
1. Staff	$20	41%
2. Infrastructure and administration	$9	18%
3. Technical areas • Outreach and programme delivery • Clinical services and commodities • Community strengthening • Enabling environment	$20	41%

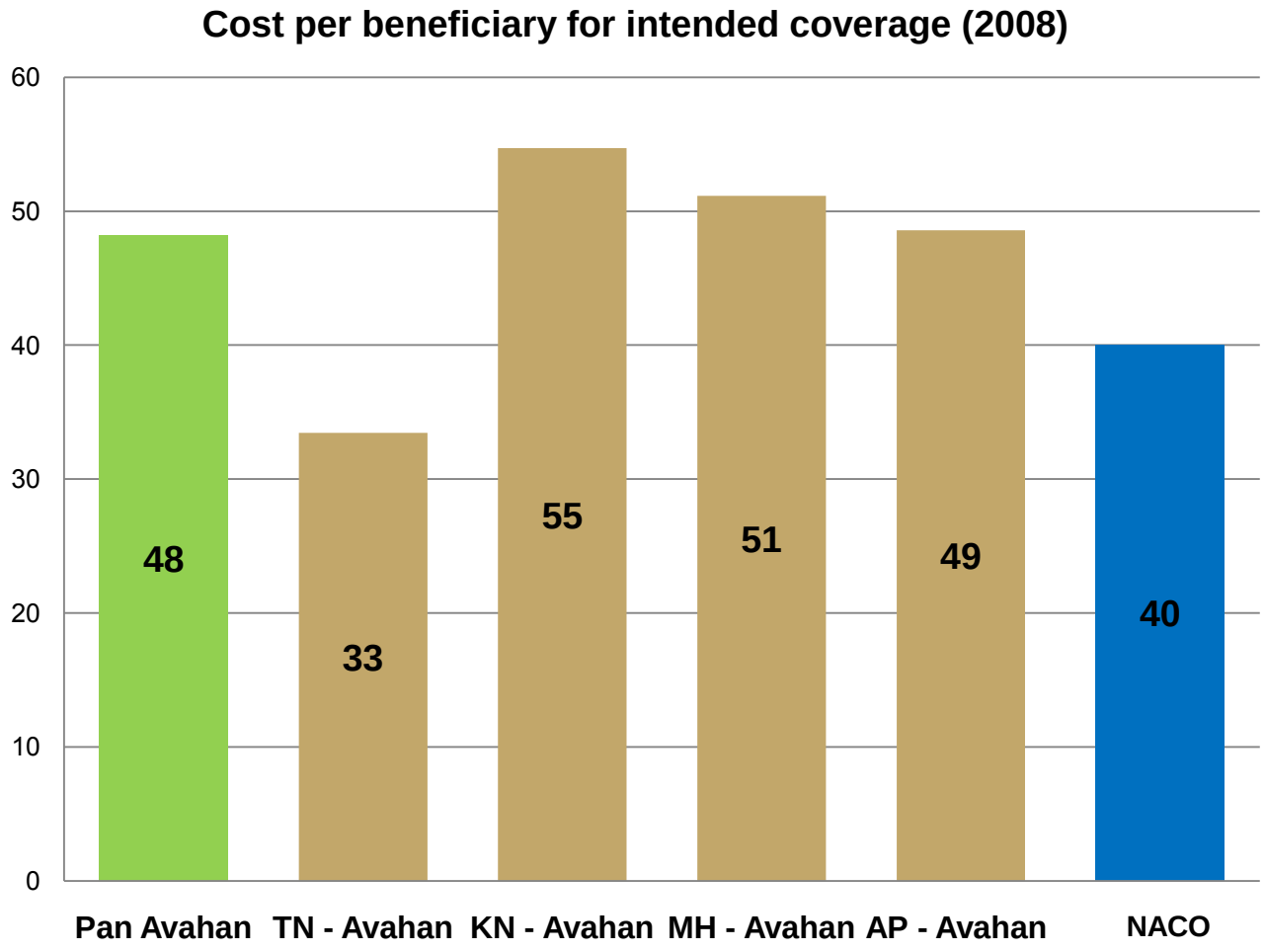
Based on typical NGO budget – 2008; Source: Avahan Program data. Costs are financial costs.

Aligned implementation costs, higher management costs



***Source**: Avahan Program data. Costs are financial costs.*

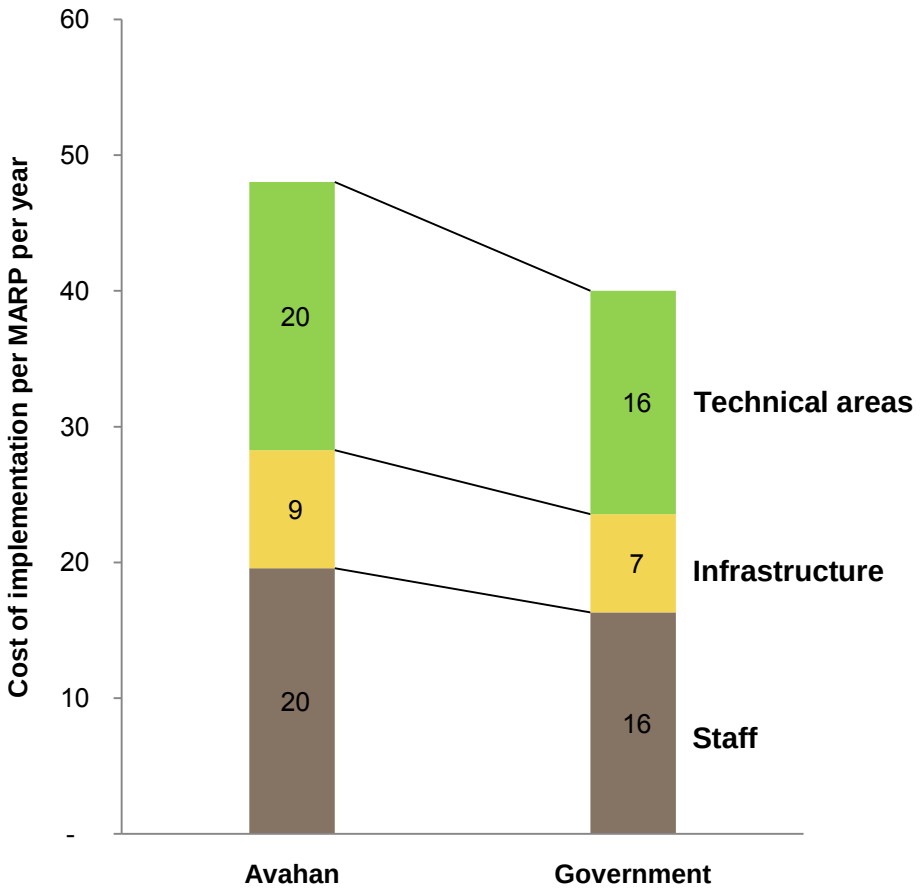
At the implementation level, Avahan's costs are roughly aligned with the government's costs



- Avahan average is **~20% higher for sub-grantee costs** (vs. NACO)

Source: Avahan Program data. Costs are financial costs.

Government costing for targeted interventions



Cost area	Variance of Avahan cost over NACO cost
Technical areas	Full time doctor cost; cost for drugs for general ailments; costing for 4 visits /MARP/year vs. 2 under government
Infrastructure and Administration	Additional DICs, more allowances for rent and DIC
Staff	More peers under Avahan (1:60 vs. more flexible 1:50 under Avahan) Additional staff positions critical for programming (e.g., additional nurses, outreach supervisors, peer counselors)

Source: http://nacoonline.org/upload/Divisions/Finance/Revised%20TI%20costing%20for%20NGO%20led%20TIs%20working%20with%20HRGs1.pdf

THANK YOU

QUESTIONS?

Annex 10 Economic analysis of Avahan Interventions in India, by Sudhashree Chandrashekar

St.John's Research Institute

Economic analysis of Avahan Interventions in India

Expert consultation on Costing HIV Responses in Asia
October 28-29th 2010, Bangkok

Sudhashree Chandrashekar
Anna Vassall

Aims of the Presentation

- To share our economic analysis of Avahan and costing methods on a technical level
- To disseminate the results of this effort (STI BMJ Published article) and also preliminary aggregated analysis for 4 years
- To discuss how our work could be shared with to inform evaluation data needs

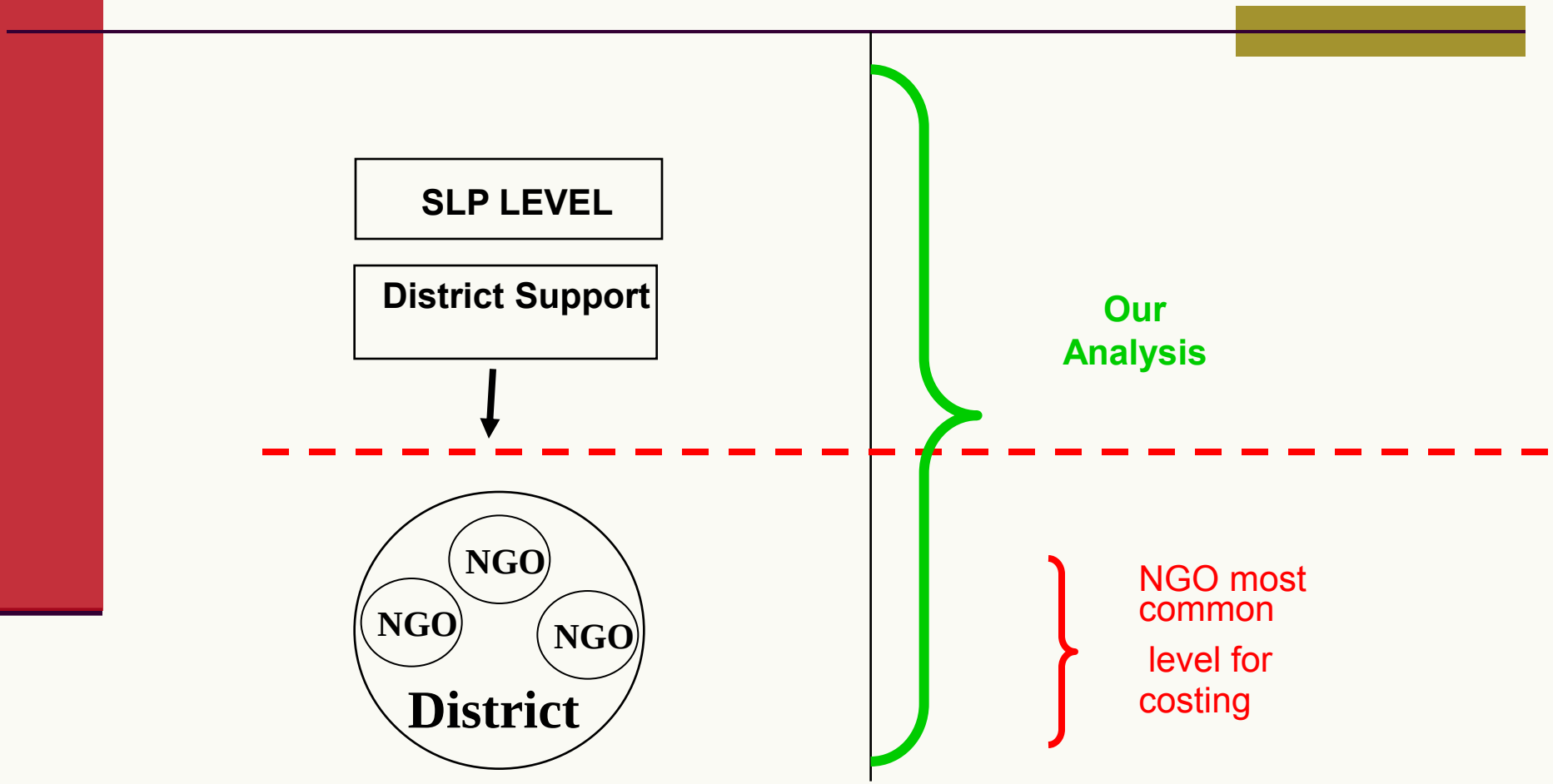
Main Areas of economic analysis for Avahan

- Cost Analysis – estimate volume of resources required to implement programme service activities
- Resource Requirements Analysis – estimate volume of resources required as projects scaled-up, increasing coverage and replicated
- Cost-effectiveness – estimate cost-effectiveness of the intervention, using modelled estimates of effectiveness

Methodological Framework of Cost Analysis

- Full economic costing based on standardised costing methods (UNAIDS guidelines)
- Prospective costing – data collected as intervention is running and built in along with monitoring and evaluation
- Multi-year Costing: over four years of the project
- Timeframe: start-up versus implementation. Start-up treated as a capital item.
- In some districts conducted repeated detailed cost. Detailed approach including staff time allocation surveys
- Reliance on routine data sources for output
- Regular feedback to implementers

Organizational levels for costing



SLP costs is an important component for rapid scale up representing Costs for expertise expansion, administration, programme monitoring and information, Special events, IEC materials and support.

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Specific Data Collection Instruments for Detailed Costing

- **Records review**
  - designed to review all data that is being routinely reported (financial and programming).
- **Key informant interviews** with project staff
  - questionnaires for the field officers and project/district coordinators
- **Discussions with peer educators/community members**
- **Time-sheets**
  - to collect data regarding allocation between activities undertaken by field officers and STI doctors

Districts summary

Summary of districts included in the cost analysis of Avahan for first 2 years of activity

State Lead Partner	Number of districts (number of NGOs) costed in Year 1		Number of districts (number of NGOs) costed in Year 2	
	Non-Detailed districts	Detailed costing districts	Non-Detailed districts	Detailed costing districts
Tamil Nadu	12(24)	-	12(25)	2(7)
Karnataka	15(15)	15(15)	16(17)	3(4)
Maharashtra 1	-	-	11(12)	2(2)
Maharashtra 2	-	-	2(14)	1(5)
Andhra Pradesh 1	8(10)	-	8(10)	1(1)
Andhra Pradesh 2	9(21)	-	13(29)	2(4)
All Avahan	44(70)	15(15)	62(107)	11(23)

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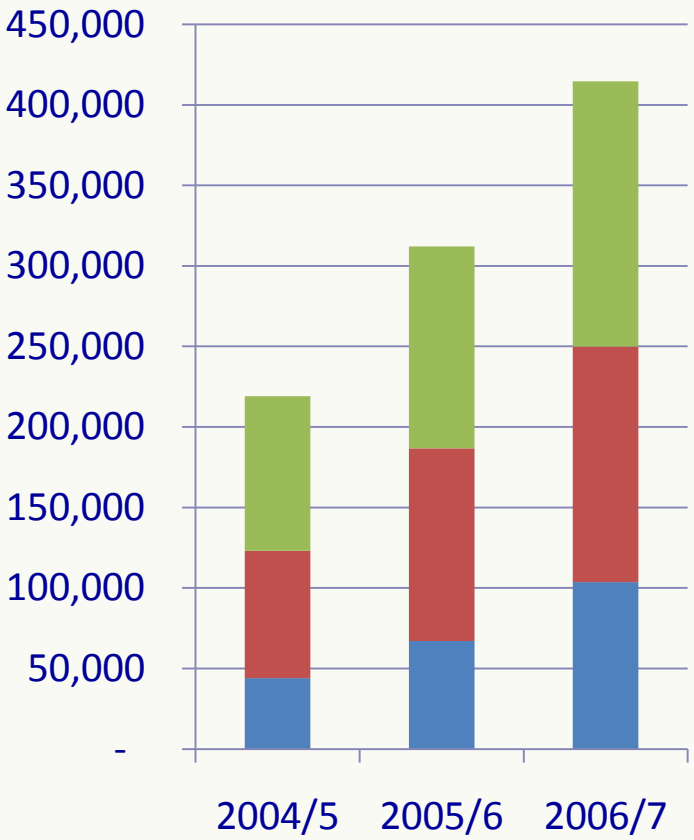
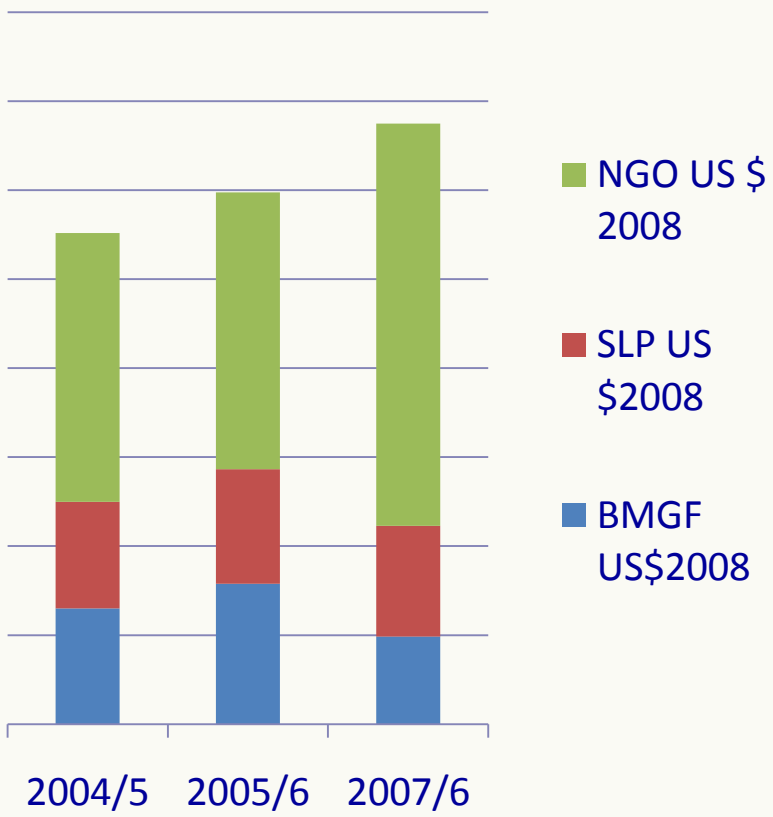
Avahan scale up from Y1-Y2 resulted in the addition of 18 districts and 37 NGOs in the 4 implementing states.

Total cost - different institutions - Example 2 districts



District A



District B

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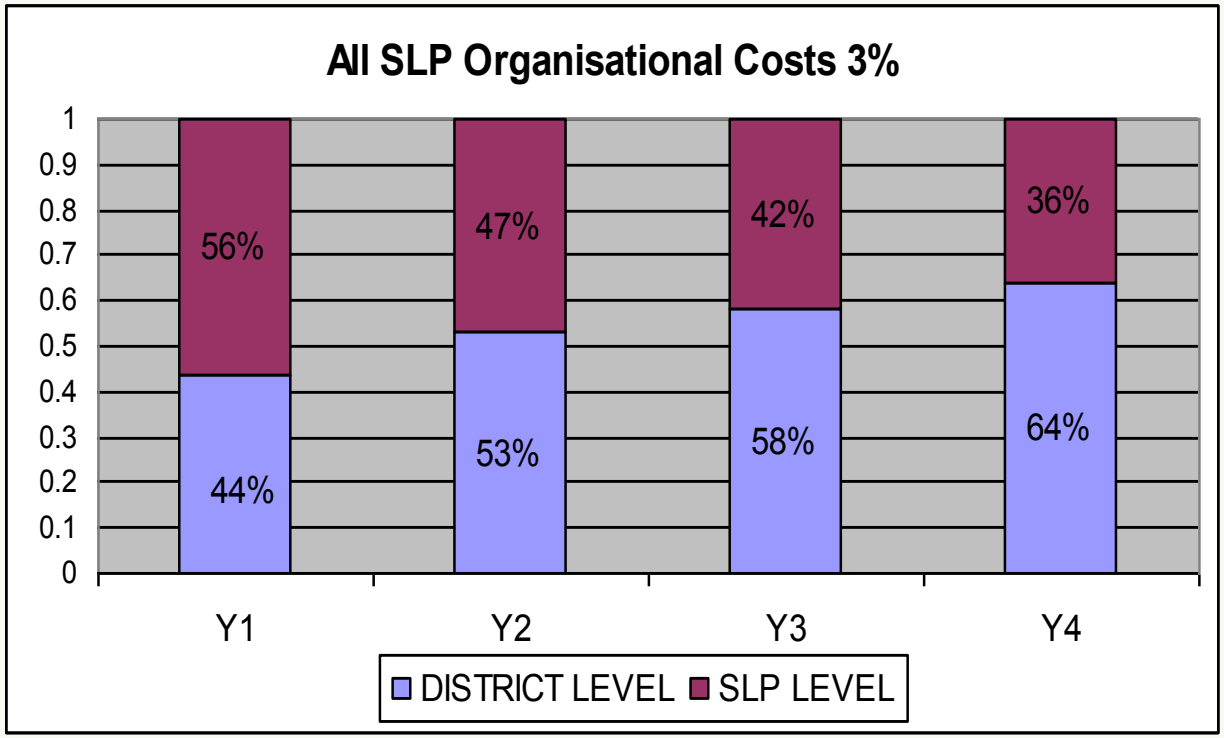
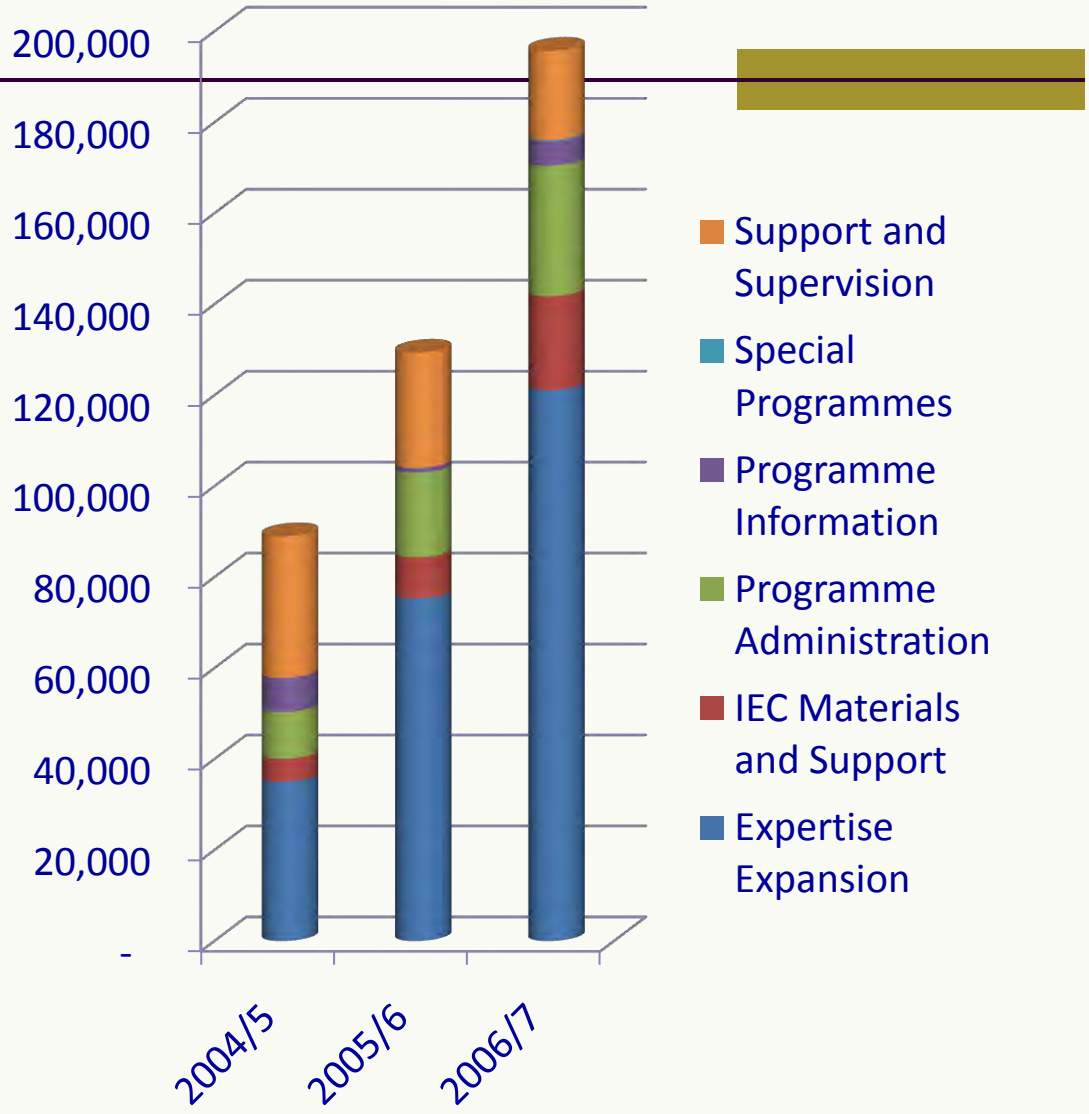
Costs by organisational level



SLP cost (example 1 state)

- Expertise expansion costs substantial component of support
- Increase in later years reflecting support for expansion to of services throughout project
- Administration costs around 13%



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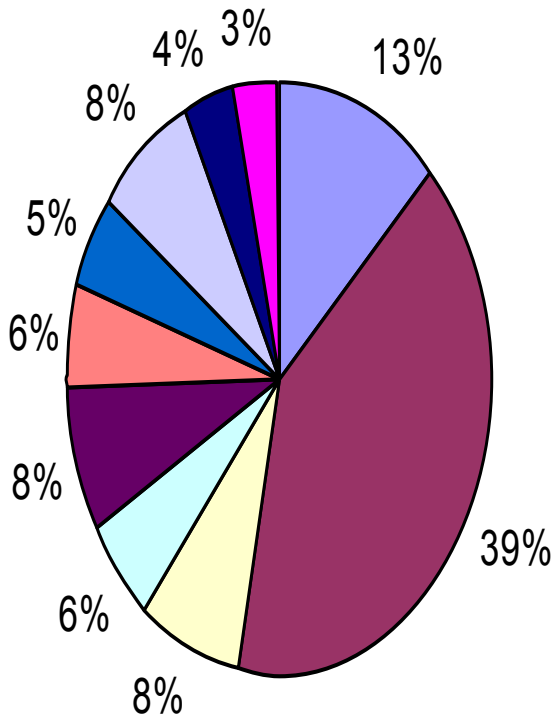
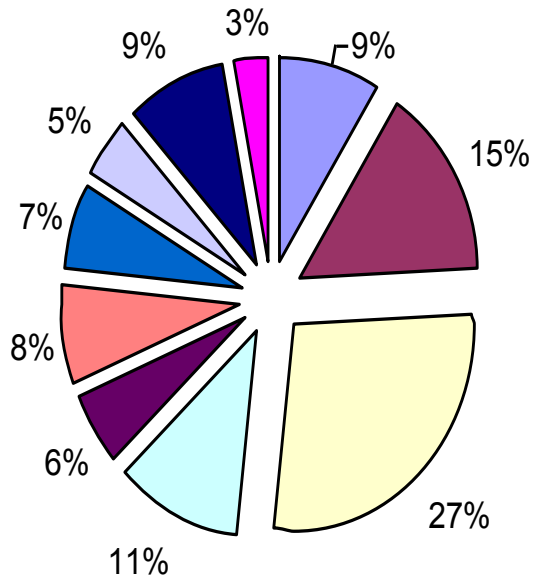
Total costs by input, for the first two years (US$ 2006 Prices)

Financial years 2004/2005 and 2005/2006



- Capital costs
- Personnel
- Travel
- Building operating & maintenance
- STI Supplies
- Monitoring
- Information Education Communication
- Training recurrent
- Condom Supplies
- Indirect Expenses

Total cost by activity at the state level (US $ 2006)



- Capacity Building
- Behaviour change communication
- STI Services
- Condom promotion
- Community Mobilization
- Monitoring
- Planning and co-ordination
- Start-Up Activities
- Enabling Environment
- Others

Percentage of total cost by input
(4 years aggregated analysis of LP-Tamil Nadu

Inputs	Y1	Y2	Y3	Y4	Total
Rent	7.1	4.0	3.4	3.8	4.0
Equipment	4.0	2.1	2.0	2.1	2.3
Trainings	0.2	0.1	0.1	0.1	0.1
Vehicle	0.7	0.3	0.3	0.3	0.3
Insurance And Repairs	0.1	0.1	0.1	0.2	0.1
start up	4.9	1.9	1.5	1.6	2.0
Capital total	**16.9**	**8.5**	**7.3**	**8.1**	**8.8**
Personnel	32.3	35.8	32.0	37.4	34.7
Travel	5.6	5.8	5.1	6.1	5.6
Building operating & maintenance	3.6	3.7	2.5	3.0	3.1
STI Services	18.3	14.6	16.2	15.6	15.8
Monitoring & Evaluation	10.0	3.7	5.2	3.1	4.6
Information Education Communication	5.7	11.5	10.6	7.1	9.3
Trainings	6.0	10.9	12.3	10.7	10.9
Condom Promotion	1.6	5.5	8.7	9.0	7.3
Recurrent Total	**83.1**	**91.5**	**92.7**	**91.9**	**91.2**
Grand Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Aggregated Analysis Average Costs Economic 3% Lead Partner-Tamil Nadu

		Year 1	Year 2	Year 3	Year 4
1 Estimated Number of KP's	Rs	1148	3144	3834	2697
	$	$ 29	$ 80	$ 97	$ 68
Ever Contacted	Rs	2245	2981	3038	2509
	$	$ 57	$ 76	$ 77	$ 64
Ever Clinic Visit	Rs	7056	4280	3693	2933
	$	$ 179	$ 109	$ 94	$ 74
Registration	Rs	1332	3021	3405	2961
	$	$ 34	$ 77	$ 86	$ 75

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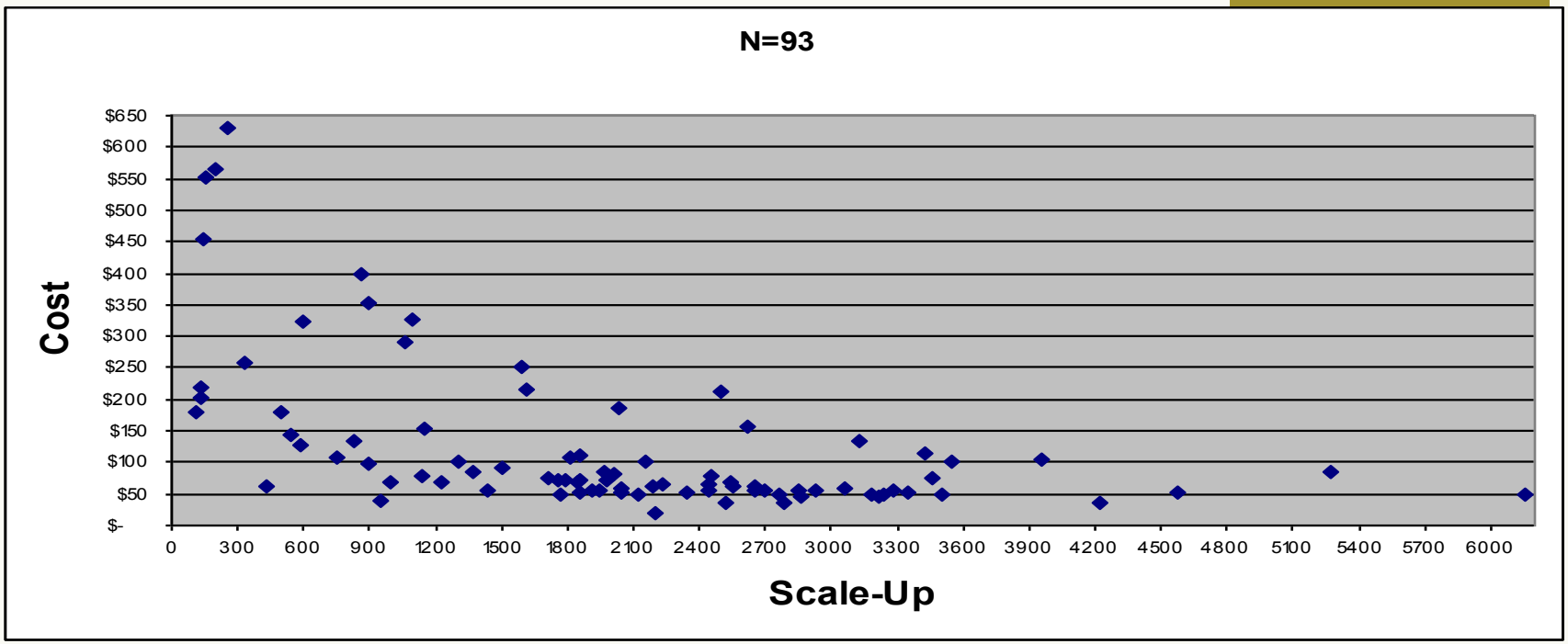
Average Costs By Scale – Year 1+ Year 2 (Contact per Person registered)



Scale was significantly associated with decreasing average costs (Adjusted R2 =0 .248, p<0.0001). Sixty-one per cent of the cost variation could be explained by scale (positive association), number of NGOs per district (negative),number of LPs in the state (negative) and project maturity (positive) (p<0.0001).

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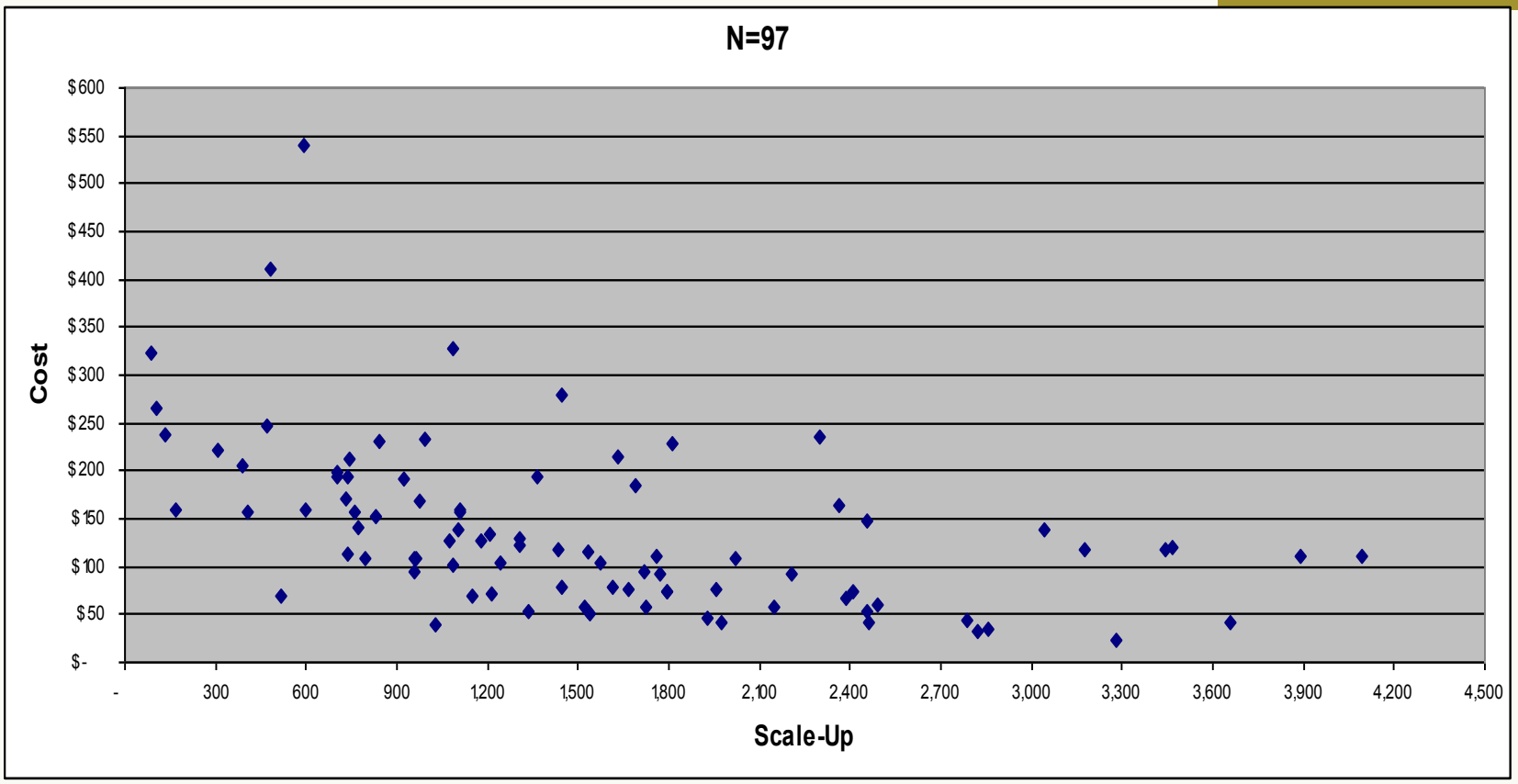
Average Costs By Scale – Year 1 +Year 2 by clinic visits



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Unit costs year wise

Unit costs - all programme(US $ 2008)	Y1	Y2	Y3
	2005-06	2006-07	2007-08
Estimated number of sex workers	6226	6226	6226
NGO cost per MSM (for NACO comp)	12	53	68
Total cost per estimated	27	67	76
Ever Contacted	3591	9483	11496
NGO cost per Ever Contacted	21	35	35
Tota cost per Ever Contacted	46	44	41
Number of MSM registered: CUMULATIVE	1368	4532	6984
NGO cost per MSM registered: CUMULATIVE	55	73	58
Total cost per MSM registered: CUMULATIVE	121	92	68
Number of MSM reached every month(yearly mean)	2200	3225	5146
NGO cost per MSM reached every month (yearly mean)	34	102	85
Total cost per MSM reached every month (yearly mean)	75	130	100
Number of Clinic visits (Ever clinic visit)	1248	3088	5381
NGO cost per Clinic visit (Ever clinic visit)	60	107	75
Total cost per Clinic visit(Ever clinic visit)	133	135	88

Key messages

- Unique costing of a large-scale HIV prevention programme for vulnerable groups with multiple national and international implementing partners in South Asia.

- Costs incurred at central level during early years to provide high level technical and management inputs to ensure quality and consistency of services and supplies and to develop management systems while scaling up were quantified which are rarely reported in many studies.

- The average cost variation was largely explained by scale, number of NGOs per district, number of LPs in the state and project age.

Special analyses conducted by our team

- Learning effects on the costs of phased scale-up implementation of targeted HIV prevention among high risk populations in Karnataka, India (AIDS conference 2006)
- The economics of STI provision in scaling-up HIV prevention among high risk populations in Karnataka, India (AIDS conference 2006)
- Is it worth it? Opportunity costs of working as peer educators among sex workers (KACH 2007)
- Roll out of focused HIV/AIDS prevention intervention with HKDHBM (Hijras, Kothis, Double Decker and other Homosexual/Bisexual men) by a Community Based organization. What are the costs? Experience from Karnataka, Southern India (ICAAP 2007)
- Comparison of payment mechanisms for peer educators: A study from Kolar and Chitradurga, India (ICAAP 2007) -article submitted to Health Policy and Planning under review.

continued

- Econometric Analysis of Cost Drivers of Targeted HIV Prevention Interventions in India (AIDS conference 2008)
- The Effects of Scale on Costs of Targeted HIV Prevention Interventions Among Female and Male Sex Workers, MSM, and Transgenders in India(AIDS conference 2008)
- Typology Matters: Costs of large scale HIV prevention intervention among sex workers in two districts of Maharashtra state, India.(ICAAP 2009)
- Costs of scaling-up programme for Men who have sex with Men (MSM) in Bangalore over three years, Karnataka, India (AIDS 2010)
- Costing analysis of delivery structures treating Sexually Transmitted Infections to high-risk groups in Karnataka, India over three years(AIDS 2010)
- The cost-effectiveness of large scale HIV prevention activities. The case of Avahan (IAEN 2010)

Future analysis

- CEA for other IBBA sites
- Overall CEA
- Also
  - Explore costs from different settings
  - Explore contributions of different activities/ institutional structures/ population groups
  - Examine changes over time as well as scale, what happens to costs as the programme evolves
  - Look at longer term cost implications (ie. removing start-up, expertise enhancement etc).
  - Future cost savings

Thank you

Process Output Measures

	Year 1	Year 2	Year 3	Year 4
1 Estimated Number of KP's	4338	18078	35444	37041
16.1 Contact once New during the period	2918	18349	27288	8397
16.1 + 16.2 Total Contact (New + Repeat)	7173	97316	276837	402380
20.11 + 20.12 Clinic visits	519	13396	21685	36653

Process Output Measures

	Year 1	Year 2	Year 3	Year 4
Estimated Number of KP's	34400	34400	36300	50050
Ever Contacted	17600	36277	45814	53800
Ever Clinic Visit	5599	25266	37688	46020
Registration	29651	35798	40874	45590

- The median start up time for the programme was 3 months (range 0-6 months). The programme had 134 391people registered, and utilisation at the NGO level varied from 37 to 6315 people registered (n=93). The total cost of the programme was US$16 759 189

- The economic costs were 6% higher than the financial costs.

- Costs were incurred beyond the NGOs and LP organisational levels at the foundation office 70% of which was spent through pan-Avahan capacity development partners. Approximately 14% of total financial costs are foundation staff costs.

- With a 3% discount rate, the median costs per person registered and STI costs/person were US$75 and US$112

Specific Aims of Cost Analysis

1. Document the specific activities of the intervention, including the nature, range and method of delivery of activities.

2. In each of these sites, undertake a cost analysis of intervention activities.
   - How do costs change by coverage, scale and intensity of activity?
   - How do costs vary by context and design of intervention?

3. Estimate the average cost of different activities at each study site, using process and outcome indicators.

Methods – Cost analysis

- **Costs from all levels, BMGF (India office), Lead Partner(LP) and NGO**
- **NGO costs**: totals; averages; and activity breakdown based on staff time spent
- **SLP costs**: totals; activity breakdowns based on staff time; district allocations based on equal division of fixed costs, and activity/ estimated population for variable costs.
- **BGMF costs**: totals; state allocations based on grants; district allocation based on population in need

Measurement of outputs and outcome

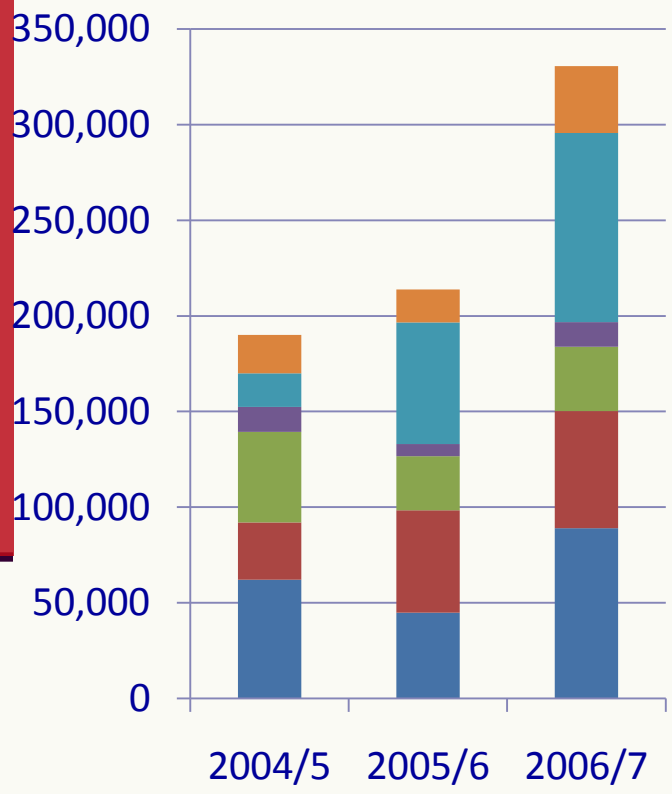
- Outputs
  - Average cost per estimated population
  - Average cost per person reached per year
  - Average cost per person reached per month
  - Average cost per STI visit
- Outcomes
  - HIV infections averted calculated through mathematical model fitted to survey data
  - DALYs (HIV averted) calculated using standard methods

Data Sources

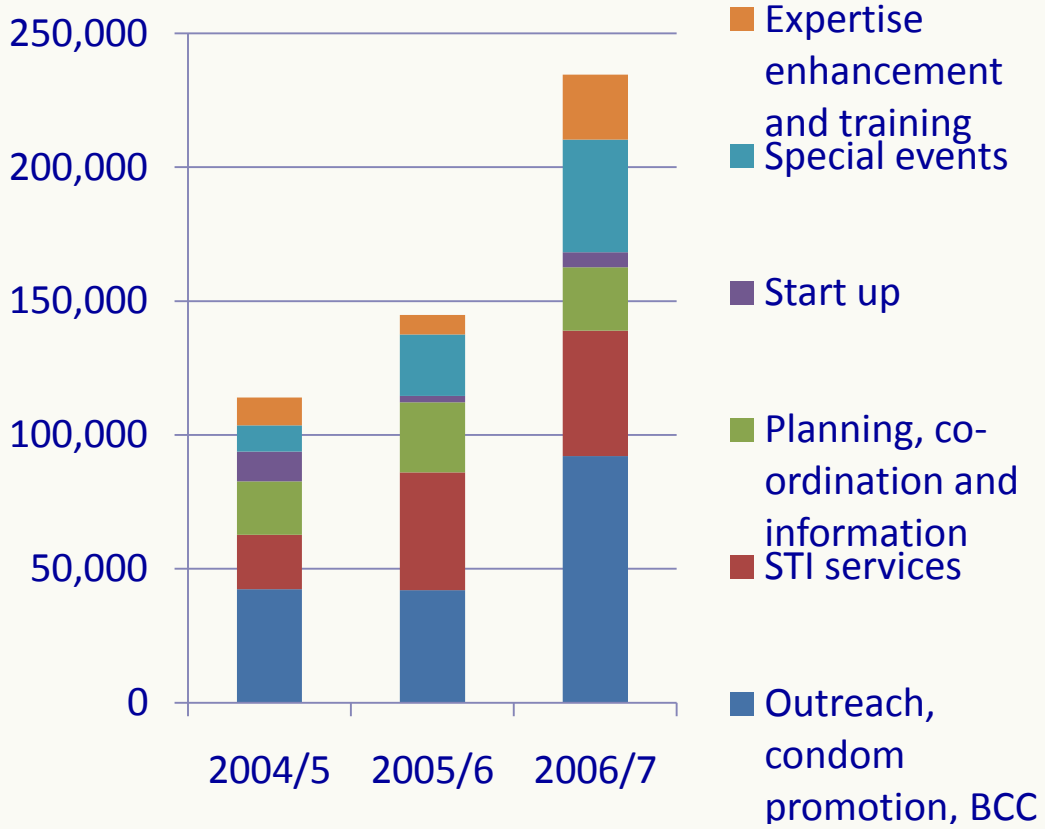
- Retrospective and prospective
- Financial records from NGOs and SLPs
  - Using routine financial and management reporting
- Process and outcome data from routine reporting
- Interviews with SLP staff related to district programming

NGO Cost by Activity
(including MSM and rural)

District A



District B



same
social and mathematical epidemiology

Comparison of unit costs (cost per sex worker reached) in India

Cost study	Unit cost (US$2008)	Min	Max	Sites	Scale (FSWs)
Mysore (2005/06)	121	-	-	1	1036-1280
Belgaum (2005/06)	45	-	-	1	867-1090
Chandrashekar 2010	59.5	11.2	139.2	107	37-6315
Guinness 2005	25.7	13.38	68.24	17	250-2008
Dandona 2005a	14.3	6.13	37.85	14	803-6379
Fung 2007	69.3	-	-	1	2342
Dandona 2008	37.3	25.31	67.35	14	1109-5721
Dandona 2009	37.8	-	-	16	

Percentage of total cost by input
(3% Economic costs Lead Partner-Andhra Pradesh)

Inputs	Y1	Y2	Y3	Y4	Total
Rent	2.7	3.4	4.2	3.6	3.6
Equipment	0.6	1.2	0.7	0.4	0.7
Trainings	0.8	0.4	0.2	0.1	0.2
start up	13.8	7.0	4.5	2.0	4.3
Capital total	**18.0**	**12.0**	**9.7**	**6.2**	**8.9**
Personnel	28.0	35.2	33.8	33.6	33.5
Travel	3.2	8.2	7.7	8.4	7.8
Building operating & maintenance	7.2	5.5	4.8	4.4	4.9
STI Services	13.5	16.4	18.1	13.8	15.4
Monitoring & Evaluation	18.8	0.5	0.2	1.0	1.9
Information Education Communication	0.9	3.6	1.7	3.0	2.6
Trainings	9.4	6.3	11.3	6.0	7.8
Condom Promotion	0.6	2.3	6.0	8.7	6.4
Indirect Expenses	0.5	10.1	6.7	14.9	11.0
Recurrent Total	**82.0**	**88.0**	**90.3**	**93.8**	**91.1**
Grand Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Average Costs Economic 3%
(Lead Partner Andhra Pradesh

		Year 1	Year 2	Year 3	Year 4
1 Estimated Number of KP's	Rs	5395	2732	2627	4997
	$	$137	$69	$67	$127
16.1 + 16.2 Total Contact (New + Repeat)	Rs	3263	508	119	236
	$	$83	$13	$9	$12

NACO(2009) $ 34.2 to 50.88, Scale 400 to 1000 (Annual financial cost)
UNAIDS(2000) $31.02, Scale 1000 (Annual financial cost)
UNAIDS-ADB (2004), Scale 1000 $40

same
social and mathematical epidemiology

Annex 11 The list of Q & A on Avahan project

The Avahan approach to costing HIV interventions and scaling up

(a) James Moore

No	***Questions***	***Answers***
1.	*When you say you believe in management, what does that entail/ what does that mean?*	We believe high quality management is critical to the success of any program. Management in the Avahan program entails staff and adequate funding to support evidence and data driven decision making – intensive field engagement by decision makers, technical mentoring in the field, and continuous data collection consistent with the program phase.
2.	*Why is it needed (compared to government)?*	Strong management/leadership is needed for any program to create value, drive innovation, enable decision making at the appropriate levels, and strategically guide programs for impact and sustainability.
3.	*How much do you invest in M&E and how do you ensure you are getting the desired outcomes?*	We dedicate approximately 15% of our program budget for monitoring and evaluation. We have a robust evaluation framework with oversight provided by a WHO-lead expert evaluation group. For an early preview of Avahan's early evaluation results, pls view the open access BMJ STI supplementation online at http://sti.bmj.com/content/86/Suppl_1

4.	*Is there any comparison of the outcomes relative to costs in different NGOs/ districts?*	Yes. We have interim cost effectiveness analysis for three districts. These results are expected to published in the first half of 2011.
5.	*How do you estimate / measure "effectiveness"?*	Effectiveness is HIV infections averted. This is estimated by mathematical modeling supplemented with behavioral and biological surveys.
6.	*How might you do this for MSM (where turnover is lower and the population is much larger / difficult to capture?*	MSMs populations in India are diverse and highly context specific, making a single estimation of impact difficult. We are cognizant of these constraints and will be working with our evaluation experts and subject experts to inform the research and evaluation agenda.
7.	*How did you establish unit costs for your program? Per services unit or per target reached?*	Unit costs were constructed by coupling line items in our program budgets per target beneficiary.
8.	*How will you resolve differences in resource availability in handling over to NACO if costs go different?*	Cost alignment has been a top priority and a prerequisite for handing programs over to NACO. We have supported our transition with a strong advocacy strategy.
9.	*How will you ensure of spent on program management and M&E?*	Avahan was a critical planning partner for NACO's current program management, budgeting, and implementation guidelines. NACO's guidelines are informed by and complement Avahan's guidelines.
10.	*How do you used such analysis –*	Financial analyses can be used to drive planning and

	some example?	create more budget efficiencies. E.g. aligning (and reducing) overhead costs for Avahan's supervising NGOs allowed us to commit more funds to program implementation.
11.	*How will information be use by government?*	We expect this information to positively inform and support Avahan's transition of programs to government.
12.	*How has Avahan "efficiency" monitoring (a) influenced program decisions (b) informed NACO decisions at national level*	Early in the program, rigorous financial analysis allowed Avahan to driving key decisions in terms of adequate resource allocations for implementation, staff, and management/supervision. Our costing has informed and influenced NACO's costing guidelines.

(b) Sudhashree

No	***Questions***	***Answers***
13.	*Are there any "significant" between – State (SLP) cost (incl. effectiveness) differences that would be instructive?*	***There are differences when we look at different state (SLP) cost(Effectiveness analysis is ongoing so will not be able to comment now). Two main differences would be due to the scale of the programme in the state ,context of intervention and the SLP strategy of delivery of services.***
14.	*Do you understand that it is not*	***Unit costs do change with the context of the***

	possible to have standard unit cost for the interventions? And that it may change by implementing agent, district and state?	***intervention and the target groups reached. But it is possible to get a range of unit costs by scale of intervention and target groups,implementing agency like NGO /community based organization,district,state.***
15.	*Where is the perspective of number of beneficiaries in SLP costing and budgeting?*	***Provider perspective and beneficiaries determined by mapping and the service uptake by MIS and CMIS***
16.	*What explains the differences in costs in different states?*	***See above A 13***
17.	*Based on the implementation of the activities, can a range of unit costs for each MARP intervention already be determined?*	***See above A 14***
18.	*What are the data capture structures that have been put in place?*	***Data is captured at the NGO level through peer cards,clinic forms, registration forms and entered into computerized management information system and individual tracking of beneficiaries is also in place.***
19.	*Is the economic model can aggregate of a base unit?*	***Question not clear***
20.	*What is the base unit?*	***Question not clear***
21.	*I'm interested in your finding that 14% of overall costs were dedicated*	***This component of costs rose in the 2nd year born out of a need to address the felt needs of the community***

	to enabling environment and community mobilization. Was there higher expenditure on these in early years with tapering off, ar was expenditure relatively constant (as proportion of program costs) over the life of the project?	***and increases over the years***
22.	*Interested in prospective costing.*	***Helps to fill lot of data limitation issues.***
23.	*System with importance of regular feedback to implementers for improvement and decision making facilitation*	***Helps to keep the rapport with the SLP and also results of the analysis are discussed so they are understood by the implementing agencies and can feedback into their planning***
24.	*What is the tool to gather data?*	***Excel tool and cost categories based on UNAIDS costing guidelines***

Annex 12 Resource Needs Model / Goals Model, by Rachel Sanders

Resource Needs Model

Rachel Sanders

October 28th, 2010

Purpose

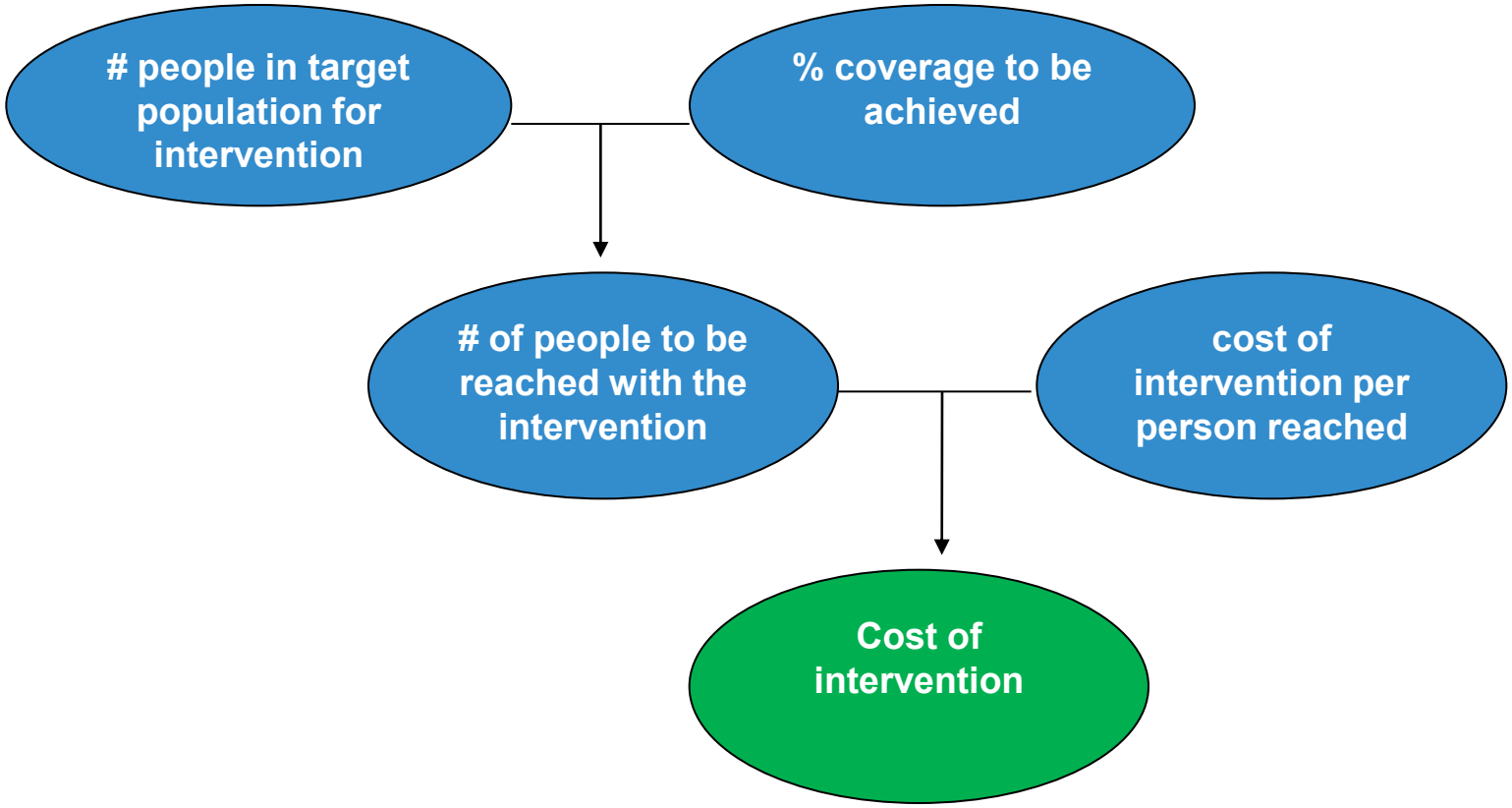
- Estimate costs of a comprehensive national response to HIV & AIDS
- Typically used to cost national strategic plans or national programs
- Time horizon: 5-6 years, although has been used for longer

Key features

- Used by UNAIDS for Global Resource Needs Estimates since 2001
  - Country validation workshops held in 2009-2010 for most recent update
- Flexible excel based model – can be used across a range of contexts and is easily adaptable
- Can be linked with the Goals model to estimate impact of a program
- Built in capacity to estimate scale impacts on unit costs for some services

Data requirements/calculations

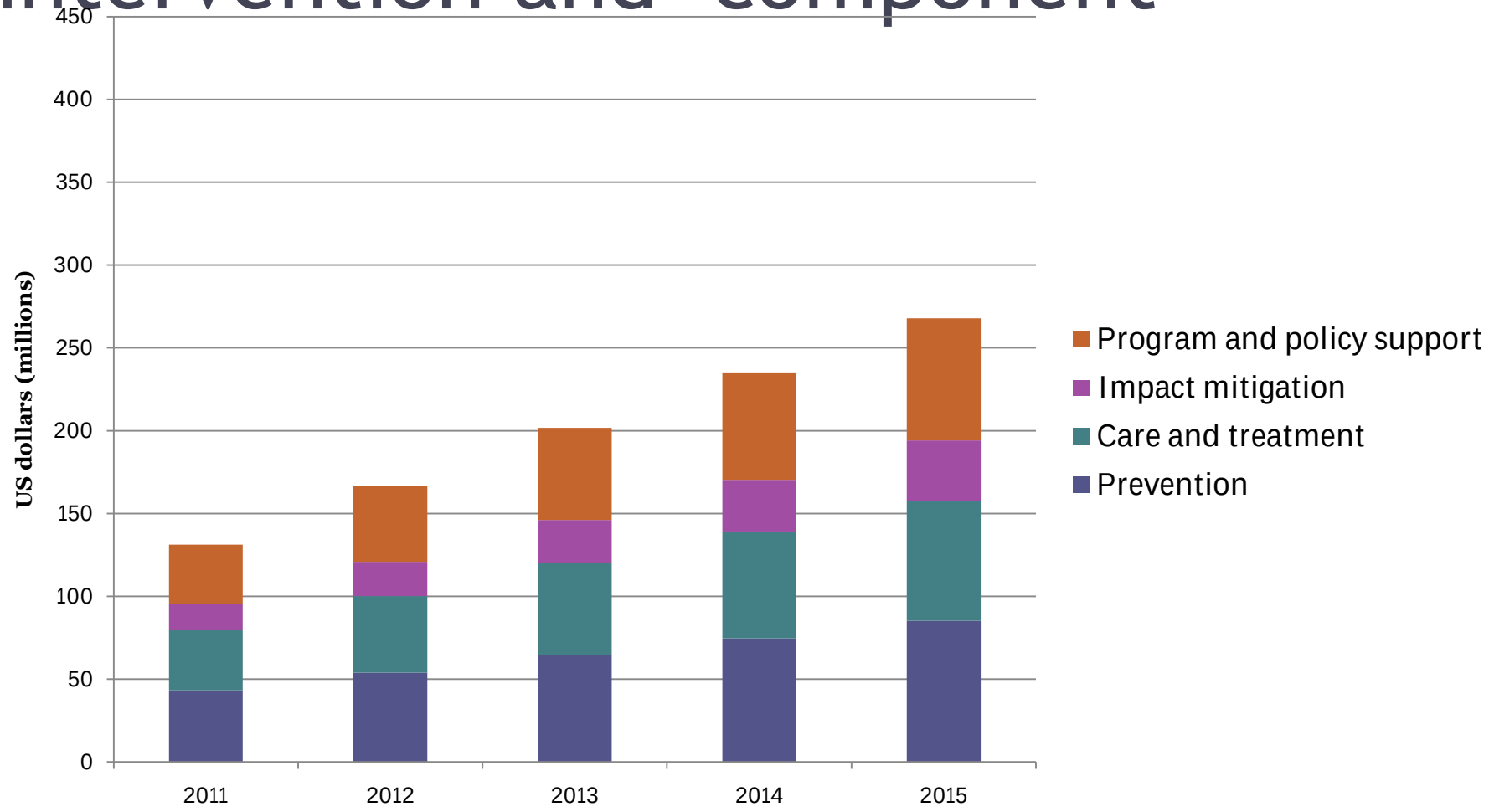
For each intervention:



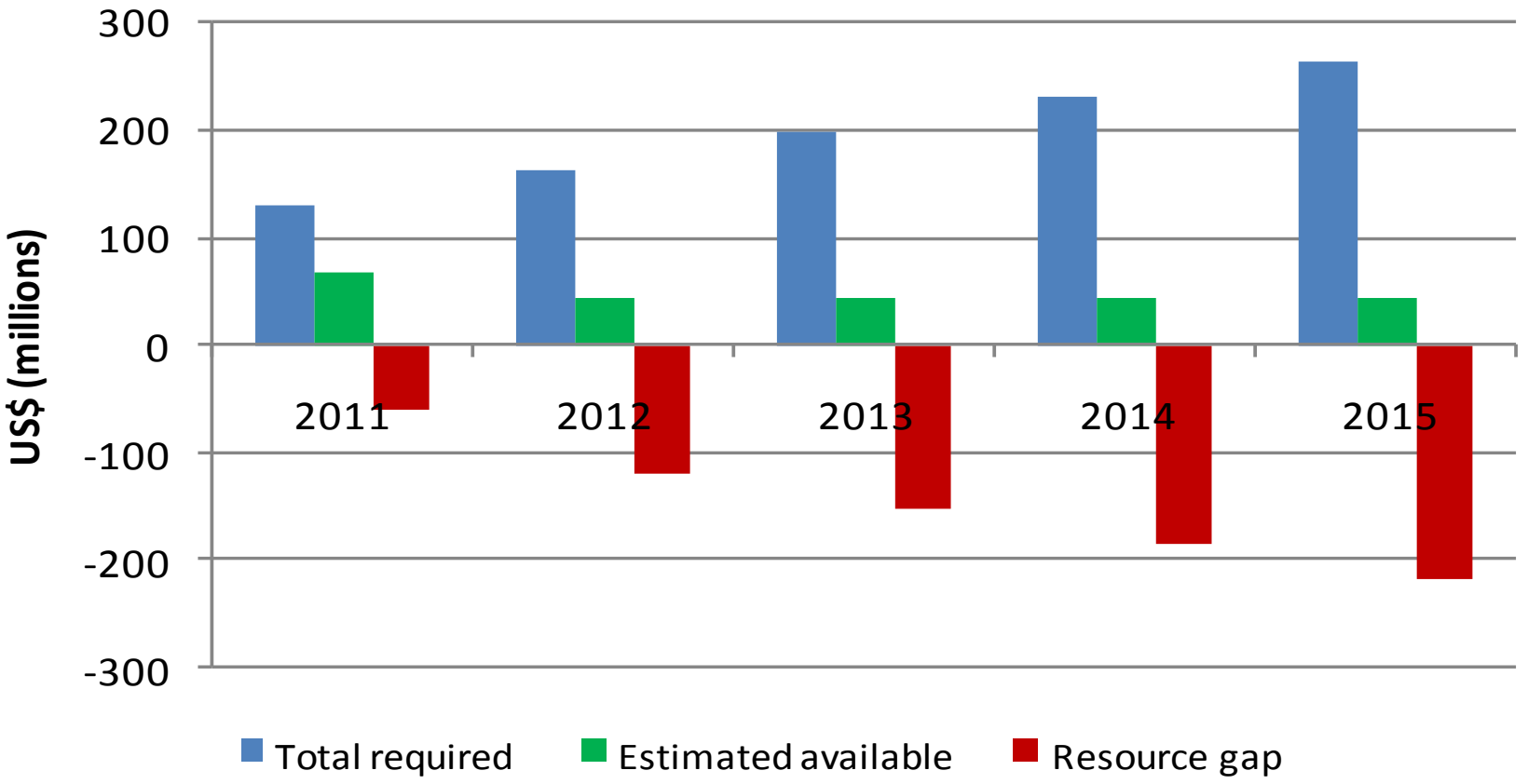
Comprehensive program

- Prevention services
  - Priority populations
  - General population
  - Health care and service delivery
- Care and treatment
- Mitigation
- Policy and program support

Outputs: Resources required by intervention and component



Resource Gap

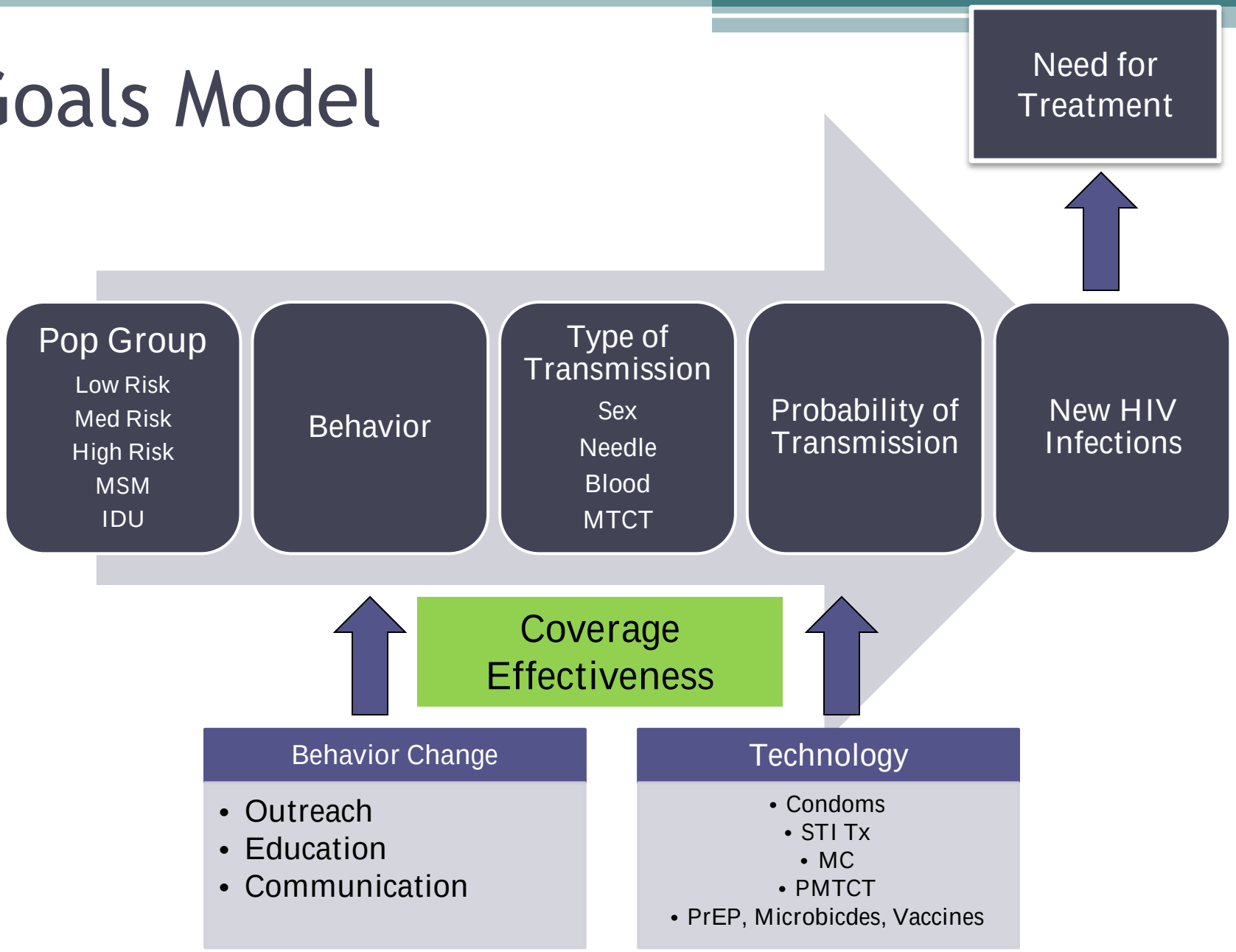


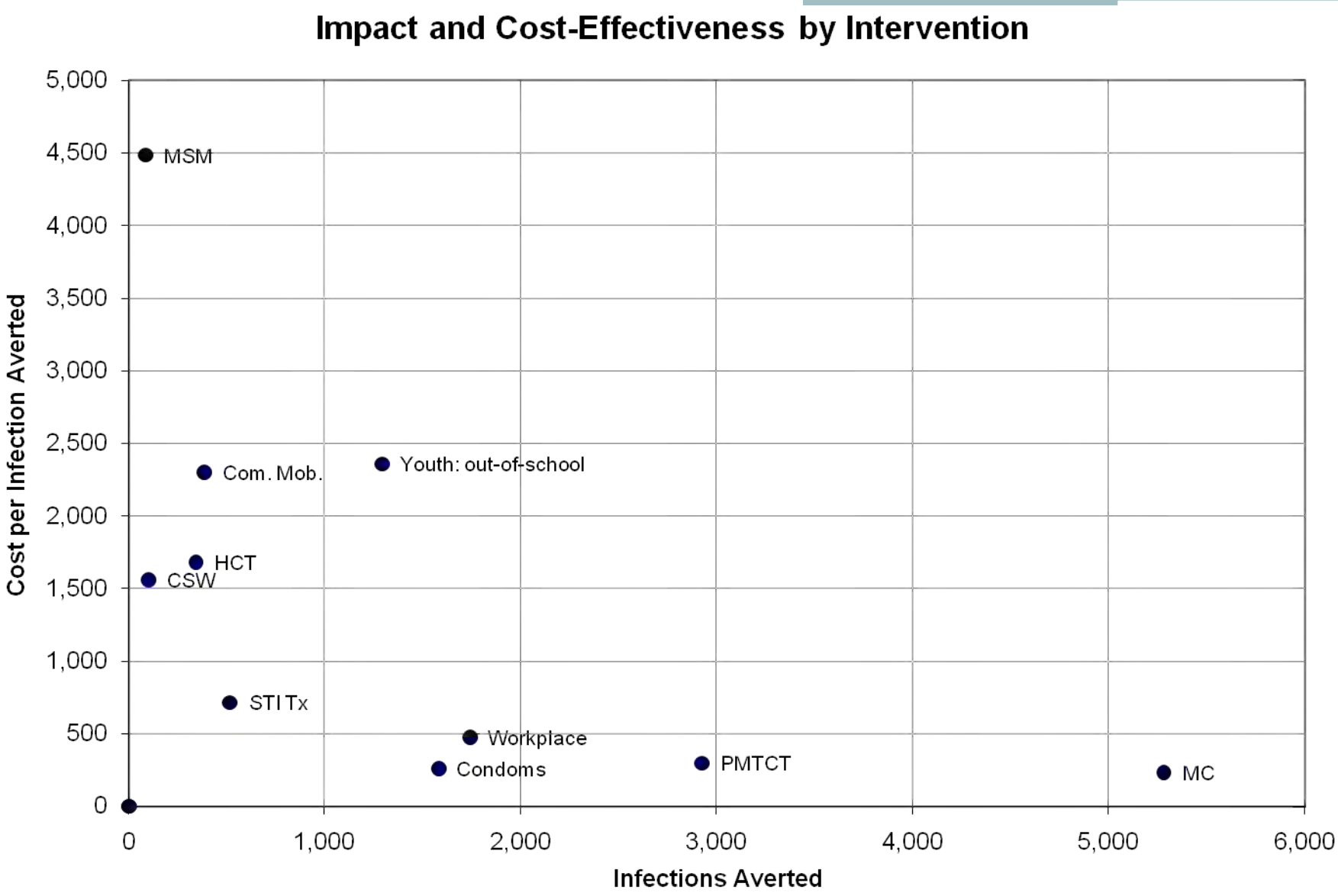
GOALS Model

Goals Purpose

- Estimate the cost and impact of a package of interventions on new infections, treatment and mitigation coverage
- Can be used to examine different resource allocation scenarios
- Align activities and targets with national goals

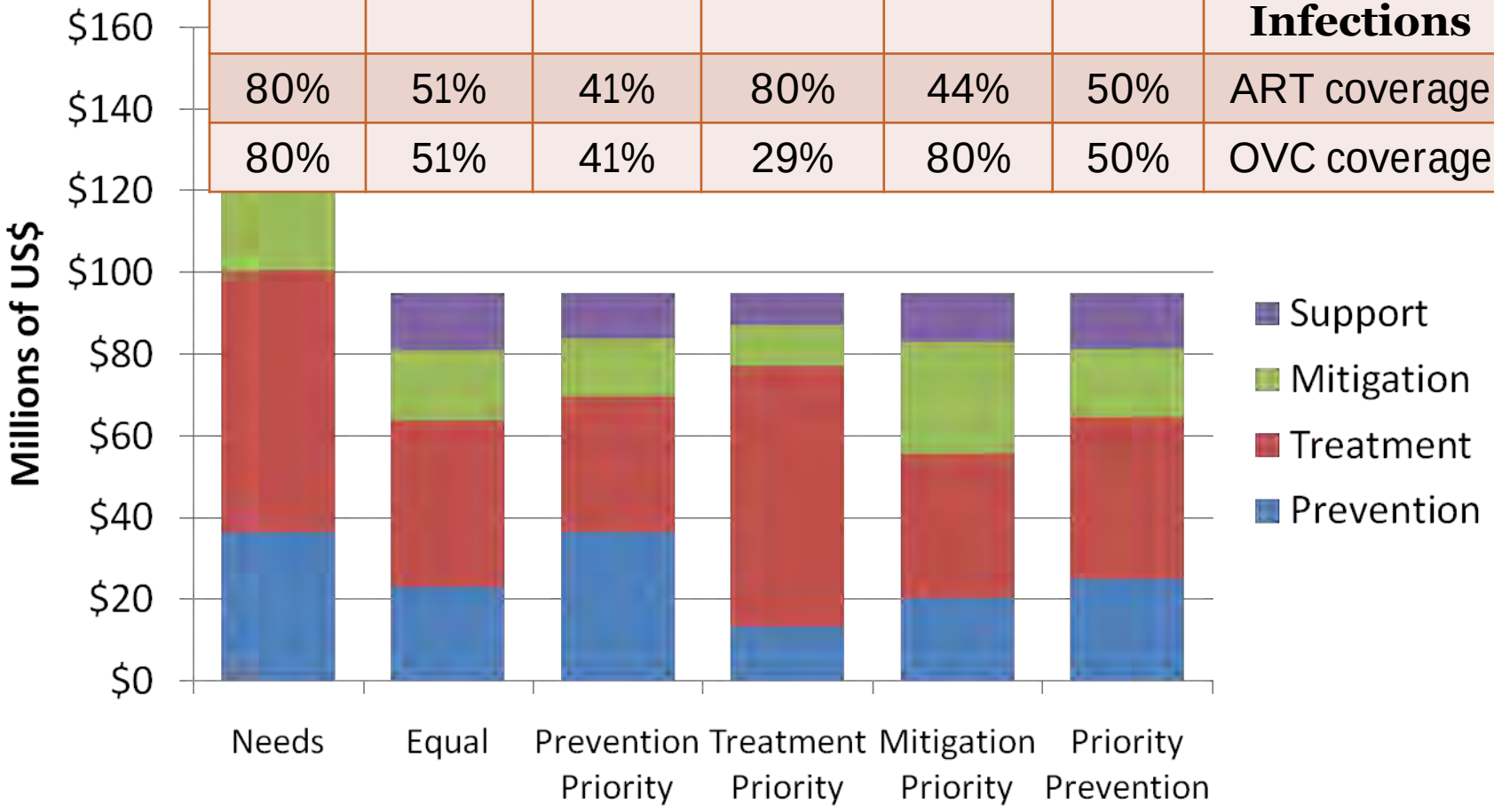
Goals Model


Need for Treatment
Pop Group
Low Risk
Med Risk
High Risk
MSM
IDU
Behavior
Type of Transmission
Sex
Needle
Blood
MTCT
Probability of Transmission
New HIV Infections
Coverage
Effectiveness
Behavior Change
• Outreach
• Education
• Communication
Technology
• Condoms
• STI Tx
• MC
• PMTCT
• PrEP, Microbicdes, Vaccines


Impact and Cost-Effectiveness by Intervention
Cost per Infection Averted
5,000
4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
MSM
Com. Mob.
Youth: out-of-school
HCT
CSW
STI Tx
Workplace
Condoms
PMTCT
MC
0
1,000
2,000
3,000
4,000
5,000
6,000
Infections Averted

GOALS: Scenario Analysis

-45%	-18%	-45%	+5%	10%	-45%	New Infections
80%	51%	41%	80%	44%	50%	ART coverage
80%	51%	41%	29%	80%	50%	OVC coverage



Thank you for your attention.

Questions or comments?

Annex 13 ASAP HIV/AIDS Costing Model, by John Cameron

ASAP HIV/AIDS Costing Model

Developed by Dominic S. Haazen
Lead Health Policy Specialist
ASAP – A Service of UNAIDS
Presented by John Cameron- ASAP
Bangkok- October 2010

Key Features of the Model

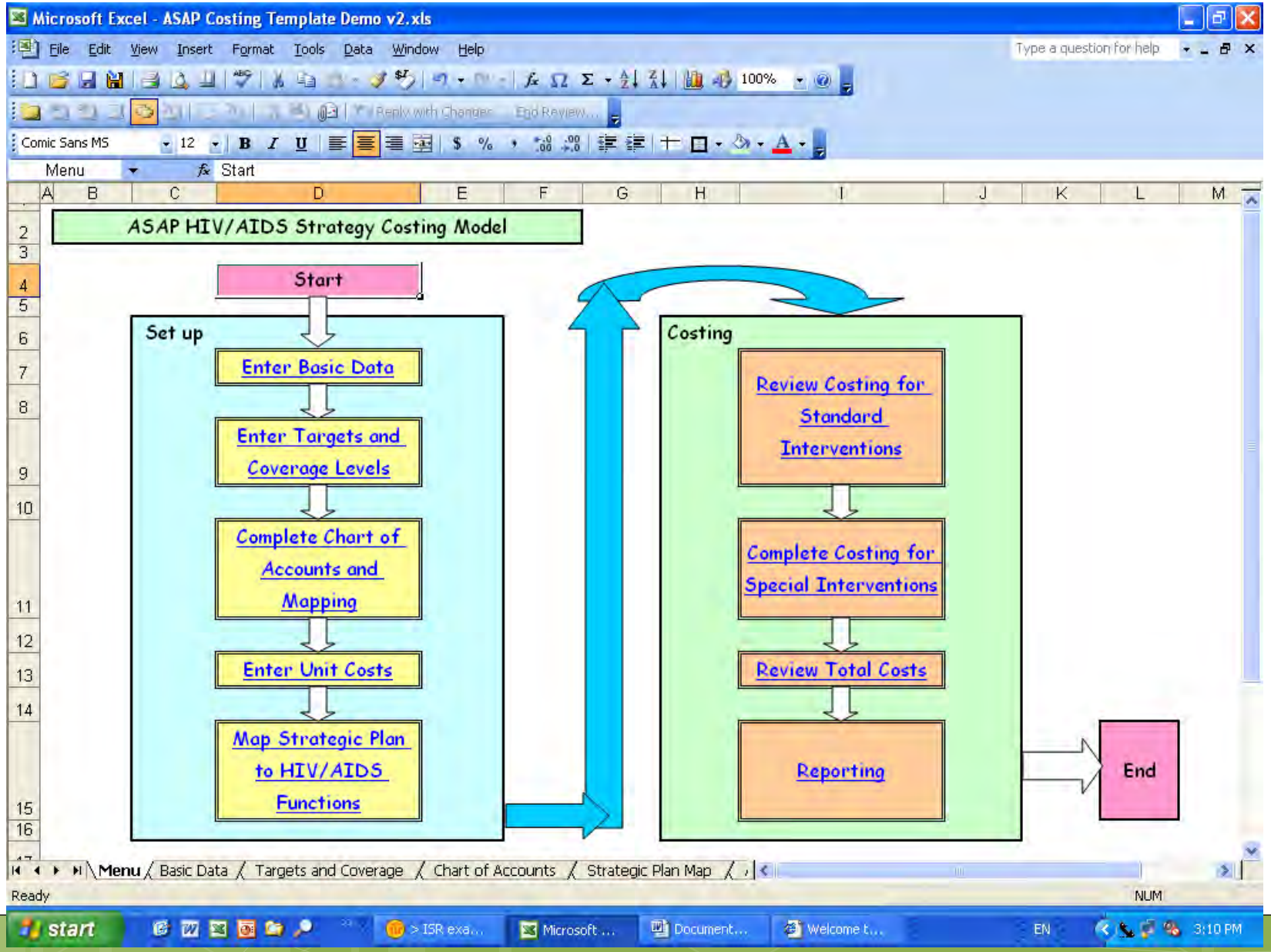
- Designed specifically to support the Activity Based Costing Approach
- Logical menu-driven sequence of steps
- Level of detail up to the user:
  - e.g., major drugs, laboratory supplies, other key cost items
  - selected activities
  - or comprehensive; all costs/activities

Key Features of the Model (cont'd)

- User can easily do variance simulations- eg
  - different coverage levels,
  - unit cost reductions
- Allows mapping of expenditure types to government accounting framework
- Supports complete cycle of planning, budgeting, operations and evaluation
- Inflation capability at users discretion
- Financing gap analysis

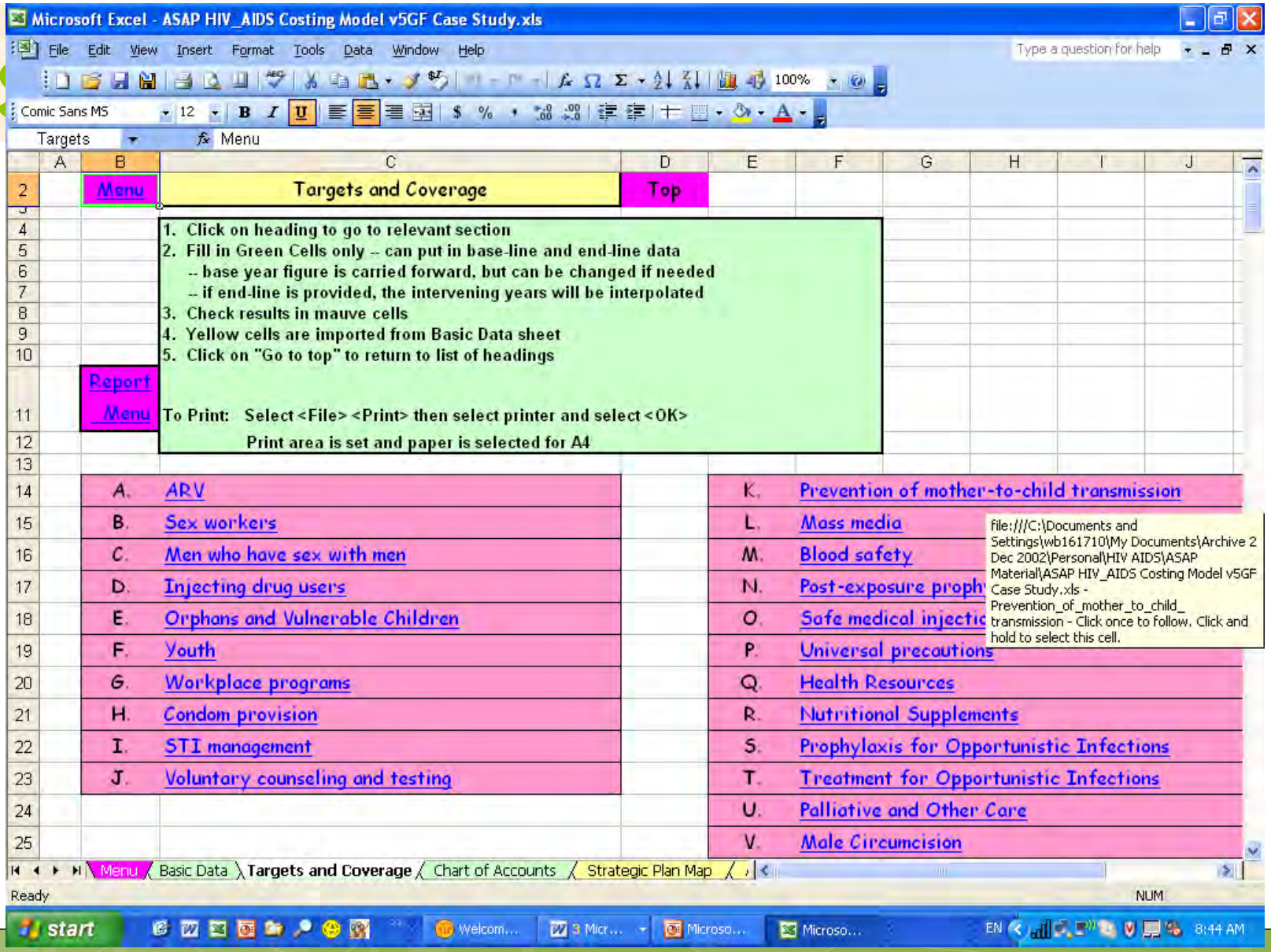
More features!

- Unit cost report
- Templates for M&E & training
- Coverts results to format suitable for Global Fund Proposals


Microsoft Excel - ASAP Costing Template Demo v2.xls
File Edit View Insert Format Tools Data Window Help
Type a question for help
Comic Sans MS 12
Menu
Start
ASAP HIV/AIDS Strategy Costing Model
Start
Set up
Enter Basic Data
Enter Targets and Coverage Levels
Complete Chart of Accounts and Mapping
Enter Unit Costs
Map Strategic Plan to HIV/AIDS Functions
Costing
Review Costing for Standard Interventions
Complete Costing for Special Interventions
Review Total Costs
Reporting
End
Menu
Basic Data
Targets and Coverage
Chart of Accounts
Strategic Plan Map
Ready
NUM
start
Microsoft ...
Document...
Welcome t...
EN
3:10 PM

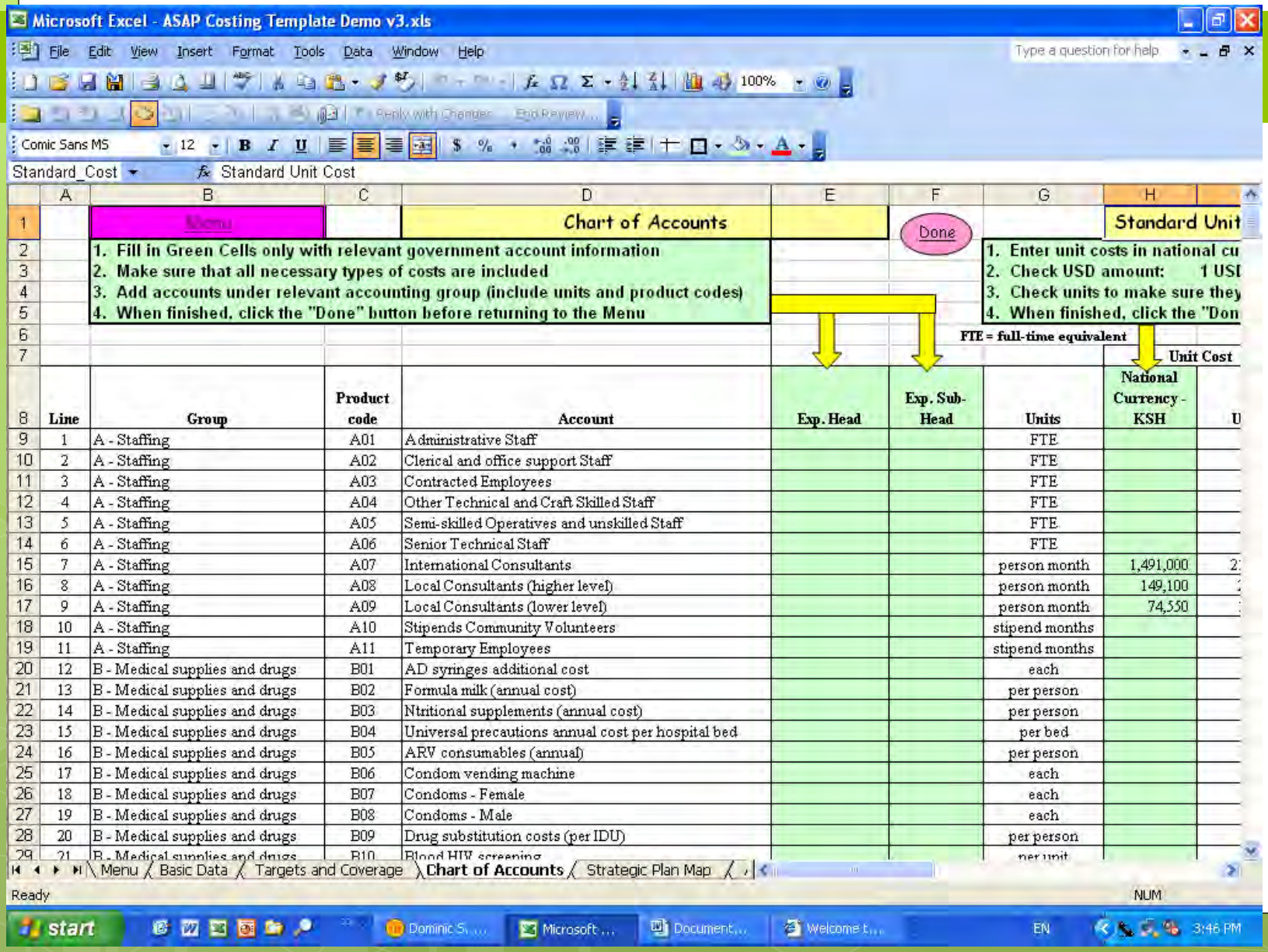
Step 1 – Enter Basic Data

- Can largely be drawn from RNM or similar sources.
- Base data entered, model projects following years.
- Shading of cells is used to guide user:
- The system makes extensive use of drop down menus: reduces errors and speeds up the use of the model.


Microsoft Excel - ASAP HIV_AIDS Costing Model v5GF Case Study.xls
File Edit View Insert Format Tools Data Window Help
Type a question for help
Comic Sans MS 12
Targets
Menu
Menu
Targets and Coverage
Top
1. Click on heading to go to relevant section
2. Fill in Green Cells only -- can put in base-line and end-line data
-- base year figure is carried forward, but can be changed if needed
-- if end-line is provided, the intervening years will be interpolated
3. Check results in mauve cells
4. Yellow cells are imported from Basic Data sheet
5. Click on "Go to top" to return to list of headings
Report Menu
To Print: Select <File> <Print> then select printer and select <OK>
Print area is set and paper is selected for A4
A. ARV
B. Sex workers
C. Men who have sex with men
D. Injecting drug users
E. Orphans and Vulnerable Children
F. Youth
G. Workplace programs
H. Condom provision
I. STI management
J. Voluntary counseling and testing
K. Prevention of mother-to-child transmission
L. Mass media
M. Blood safety
N. Post-exposure proph
O. Safe medical injectio
P. Universal precautions
Q. Health Resources
R. Nutritional Supplements
S. Prophylaxis for Opportunistic Infections
T. Treatment for Opportunistic Infections
U. Palliative and Other Care
V. Male Circumcision
file:///C:\Documents and Settings\wb161710\My Documents\Archive 2 Dec 2002\Personal\HIV AIDS\ASAP Material\ASAP HIV_AIDS Costing Model v5GF Case Study.xls - Prevention_of_mother_to_child_ transmission - Click once to follow. Click and hold to select this cell.
Menu Basic Data Targets and Coverage Chart of Accounts Strategic Plan Map
Ready
NUM
start
8:44 AM

Step 2- enter targets and coverage

- **Objectives from NSP are entered as specific targets and coverage areas**
- **Data also taken from base data sheet**
- **Feeds targets into subsequent sheets**



Microsoft Excel - ASAP Costing Template Demo v3.xls

File Edit View Insert Format Tools Data Window Help

Type a question for help

Comic Sans MS 12

Standard_Cost — Standard Unit Cost

Menu

Chart of Accounts

Done

1. Fill in Green Cells only with relevant government account information
2. Make sure that all necessary types of costs are included
3. Add accounts under relevant accounting group (include units and product codes)
4. When finished, click the "Done" button before returning to the Menu

Standard Unit

1. Enter unit costs in national cu
2. Check USD amount: 1 USI
3. Check units to make sure they
4. When finished, click the "Don

FTE = full-time equivalent

Unit Cost

Line	Group	Product code	Account	Exp. Head	Exp. Sub-Head	Units	National Currency - KSH	U
1	A - Staffing	A01	Administrative Staff			FTE		
2	A - Staffing	A02	Clerical and office support Staff			FTE		
3	A - Staffing	A03	Contracted Employees			FTE		
4	A - Staffing	A04	Other Technical and Craft Skilled Staff			FTE		
5	A - Staffing	A05	Semi-skilled Operatives and unskilled Staff			FTE		
6	A - Staffing	A06	Senior Technical Staff			FTE		
7	A - Staffing	A07	International Consultants			person month	1,491,000	2
8	A - Staffing	A08	Local Consultants (higher level)			person month	149,100	
9	A - Staffing	A09	Local Consultants (lower level)			person month	74,550	
10	A - Staffing	A10	Stipends Community Volunteers			stipend months		
11	A - Staffing	A11	Temporary Employees			stipend months		
12	B - Medical supplies and drugs	B01	AD syringes additional cost			each		
13	B - Medical supplies and drugs	B02	Formula milk (annual cost)			per person		
14	B - Medical supplies and drugs	B03	Ntritional supplements (annual cost)			per person		
15	B - Medical supplies and drugs	B04	Universal precautions annual cost per hospital bed			per bed		
16	B - Medical supplies and drugs	B05	ARV consumables (annual)			per person		
17	B - Medical supplies and drugs	B06	Condom vending machine			each		
18	B - Medical supplies and drugs	B07	Condoms - Female			each		
19	B - Medical supplies and drugs	B08	Condoms - Male			each		
20	B - Medical supplies and drugs	B09	Drug substitution costs (per IDU)			per person		
21	B - Medical supplies and drugs	B10	Blood HIV screening			per unit		

Menu | Basic Data | Targets and Coverage | Chart of Accounts | Strategic Plan Map

Ready NUM

start Dominic S... Microsoft ... Document... Welcome t... EN 3:46 PM

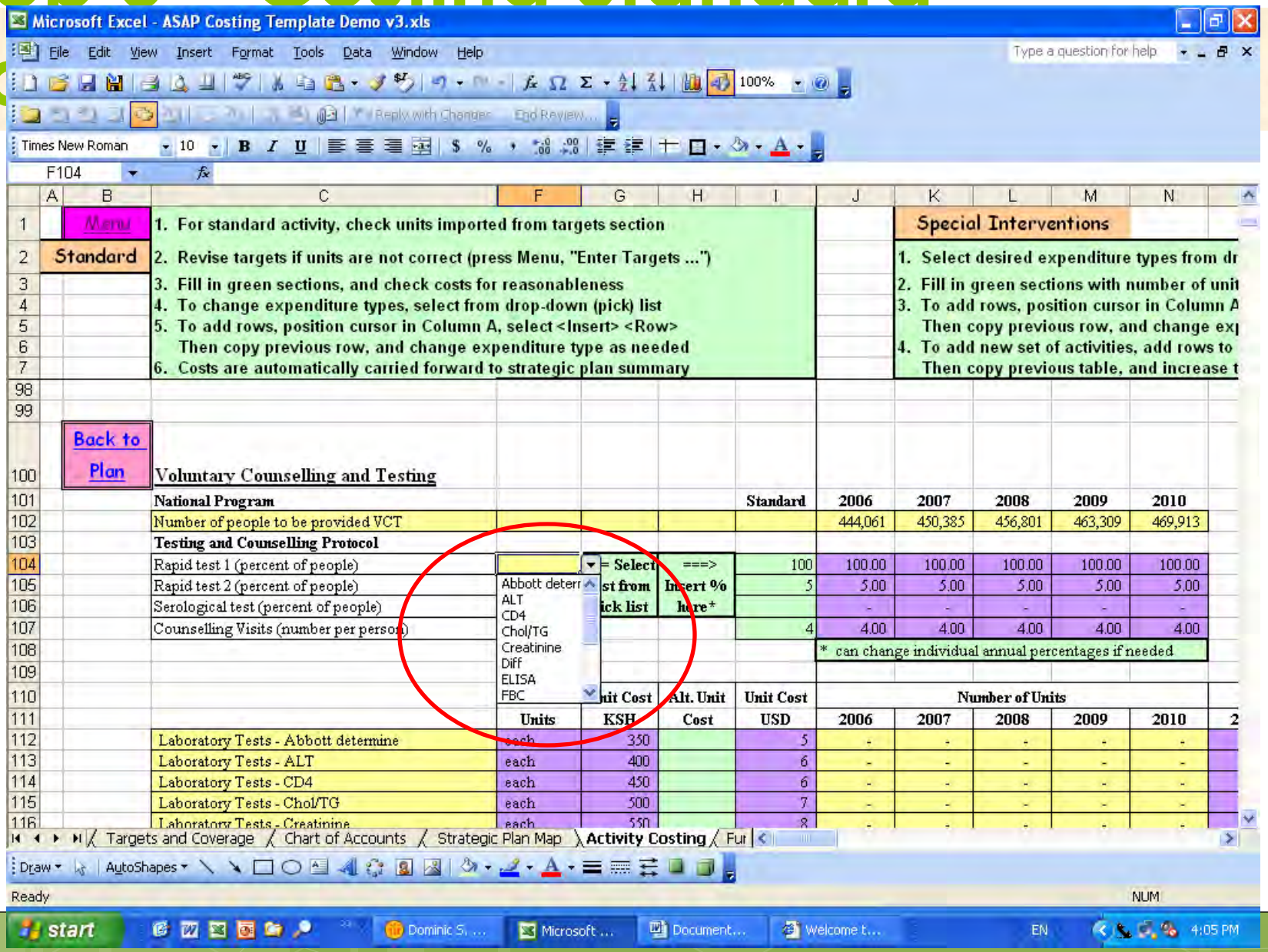
Step 3- complete chart of accounts & unit costs

- **Single chart of account used with standard unit costs**
- **Unit costs may also be mapped to government chart of account**
- **Standard unit costs entered for each expenditure account**

Step 4 – Mapping of Strategy to Standard Functions

- Where strategies and related activities are introduced
- Each activity is mapped to a standard functional classification according to priority, priority strategy, and activity
- A classification can have more than one activity
- Costs for activities derived from activity costing sheet

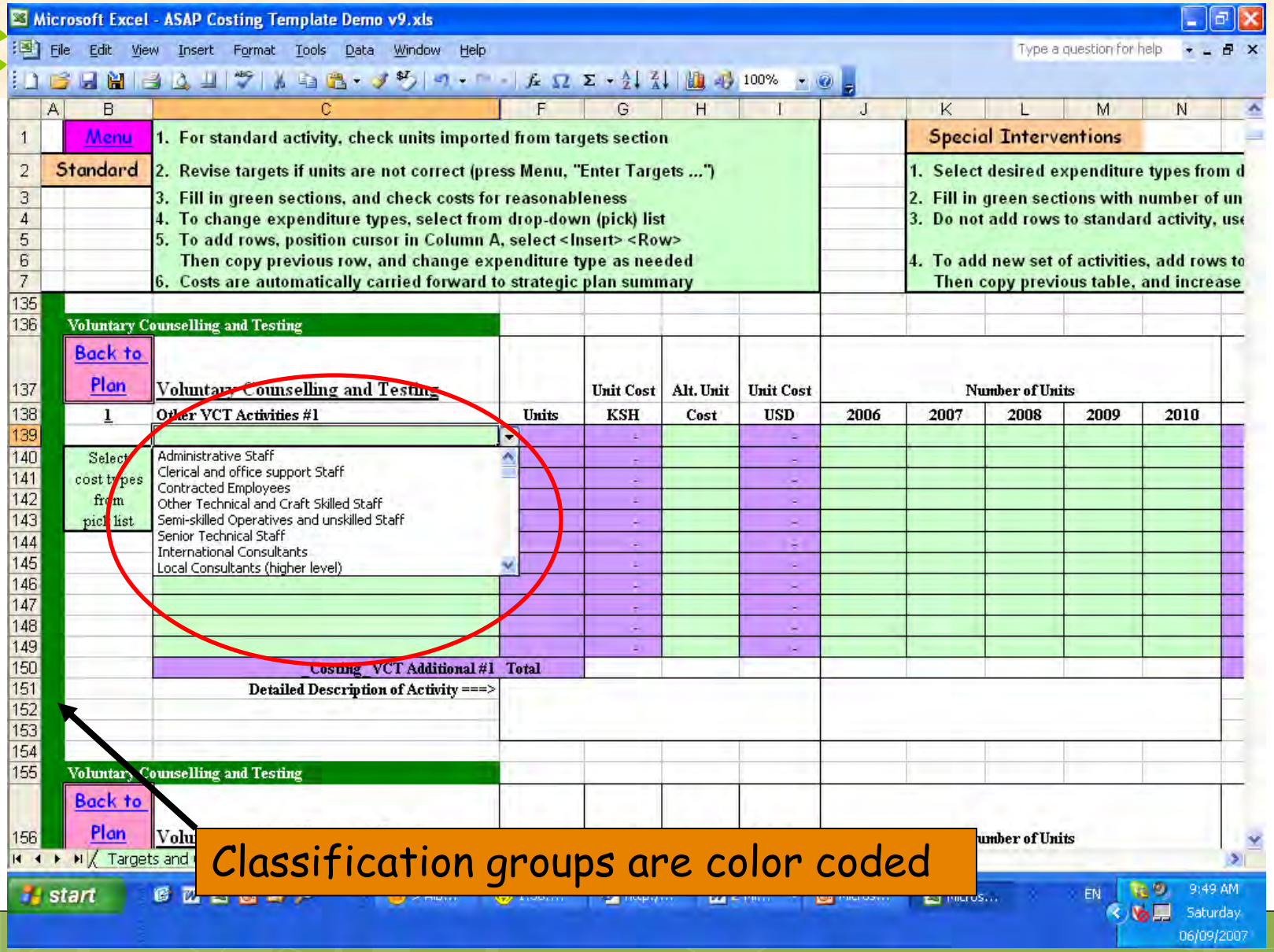
Step 5 – Costing Standard Ac



Step 5- Complete costing for standard interventions

- **Ensure that all appropriate costs are included and that they make sense**
- **Inputs derived from drop down menus and & unit costs from chart of accounts**
- **Determine # units for each activity**

Step 6 – Costing "Additional Ac



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Microsoft Excel - ASAP HIV_AIDS Costing Model v5GF.xls

File Edit View Insert Format Tools Data Window Help

Type a question for help

Report_Menu | Reporting

	A	B	C	D	E	F	G	H	I	J	K
1		Menu		1. Select type of report required							
2		Reporting		2. Return to Menu when finished							
3											
4		Reporting Menu:		By Priority		Graph					
5											
6				By Activity							
7											
8				By Function		Graph					
9											
10				By Expenditure Type		Graph					
11											
12				By Government Classification							
13											
14				By Physical Quantities							
15											
16		Assumptions:		Print Basic Data							
17											
18				Print Targets and Coverage Levels							
19											
20				Print Unit Costs							
21											
22											

Strategic Plan Map | Activity Costing | Total Cost Summary | Reporting | Graphs | Cos

Ready NUM

start Welcom... 3 Micr... Microso... Microso... EN 9:19 AM

Global Fund Module

- **Model converts ABC results to Global Fund format**
- **Check mapping of expenditure**

MODEL STRENGTHS

- SINGLE COST SOURCE
- MAPPING OF STRATEGIES AND PULLING IN ACTIVITIES TO MEET STRATEGY NEEDS
- ACTIVITIES COSTED USING UNIT COSTS FROM CHART OF ACCOUNTS
- CONVERSION TO GLOBAL FUND FORMATS AND COST CATEGORIES
- GAP ANALYSIS
- FULLY INTEGRATED

DISADVANTAGES

- **TOO BIG FOR EXCEL- MAYBE A DIFFERENT PLATFORM?**
- **THOROUGH UNDERSTANDING AND TRAINING NEEDED TO BE ABLE TO USE EFFECTIVELY**

Annex 14 Costab Model, by John Cameron

Costab presentation

Bangkok- October 28, 2010

WHAT IS COSTAB

- **DATA BASE COSTING TOOL**
- **USED TO ANALYSE, SUMMARISE AND PRESENT PROJECT FINANCIAL AND ECONOMIC COSTS**
- **A ROBUST MODEL WHICH CAN BE READILY ALTERED TO SUIT OPERATORS NEEDS**

WHAT DOES COSTAB DO?

- **INTRODUCES A NEW LEVEL OF SOPHISTICATION INTO HIV COSTING AND ANALYSIS**

HOW DOES IT DO THIS?

- **ACCUMULATES DATA ACCORDING TO**
  - **INVESTMENT & OPERATIONAL COSTS**
  - **COMPONENTS- EG *PREVENTION***
  - **SUB COMPONENTS- EG *MSM***
  - **UNITS- EG- *CONDOMS, PEER EDUCATORS***
- **EXPENDITURE ACCOUNTS- EG *DRUGS*, TRAINING, ADMINISTRATION**
- **FINANCIERS- EG GLOBAL FUND, GOVT**
- **PROCUREMENT METHODS- EG UN**

- ALL THESE GROUPINGS ARE DETERMINED BY THE OPERATOR AT FILE OR PROJECT SET UP
- DEFAULTS ARE ESTABLISHED BUT THESE MAY BE ALTERED FOR ANY ITEM

IT ALSO INTRODUCES ANALYSIS OF

- **PHYSICAL CONTINGENCIES**
- **PRICE CONTINGENCIES**
  - **LOCAL INFLATION**
  - **INTERNATIONAL INFLATION**
- **IDENTIFICATION OF LOCAL CURRENCY REQUIREMENTS AND FX**
- **IDENTIFICATION OF TAXES ON ALL INPUTS**
- **ECONOMIC COSTS V FINANCIAL COSTS**

WHAT IS REQUIRED

- **DEVELOP MODEL STRUCTURE- COMPONENTS, SUB-COMPONENTS, EXPENDITURE AND PROCUREMENT ACCOUNTS**
- **UNIT COSTS AND PROGRAM TARGETS**
- **OPERATOR TRAINING**

WHAT ARE ITS WEAKNESSES

- **DIFFICULT TO SET UP**
- **NOT PARTICULARLY USER FRIENDLY- BUT OK**
- **NOT SUPPORTED- DIFFICULTIES WITH LATEST SOFTWARE**
- **WEAK MANUAL**

STRENGTHS

- **NOT EXCEL BASED**
- **WHEN YOU KNOW HOW TO USE IT- IS EASY**
- **VERY ADAPTABLE- STRUCTURE EASY TO ALTER**
- **FAST**
- **SIGNIFICANT RANGE OF REPORTS WHICH ADD A NEW DIMENSION TO HIV COSTING**
- **DEFAULT INPUTS**
- **PRINTS TO EXCEL**

WHAT TO DO TO MAKE EASIER

- **DEVELOP AN HIV/AIDS TEMPLATE STRUCTURE WHICH CAN BE READILY ADAPTED BY OPERATOR**
- **INSTITUTION TO MAINTAIN SOFTWARE**
- **PREPARE A USER FRIENDLY MANUAL**
- **TRAIN PEOPLE HOW TO USE**

Annex 15 HIV Unit Cost Calculation, by John Cameron

HIV UNIT COST CALCULATOR

WORLD HEALTH ORGANISATION DEVELOPED MODEL

BANGKOK- OCTOBER 2010

BASE INFORMATION

- 10 SHEET EXCEL MODEL- BUT JUST 4 MAIN SECTIONS
- USES WHO COST CATEGORIES- NOT FLEXIBLE
- SIMPLE UNIT COST CALCULATOR- BUT BIG
- MODEL READILY EXTENDABLE AND COULD BE USED, EG TO CALCULATE THE QUANTITY OF DRUG TYPES
- ALL PAGES ROLLED UP FOR EASY DATA CONTROL
- DONT HAVE TO USE ALL MODEL
- COMPANION MODEL FOR COSTAB
- MAJOR BENEFIT- CALCULATION OF REGIMENS

1. BASE DATA INPUT

- **DRUG LIST- SPACE FOR 49**
- **TEST LIST- SPACE FOR 20 TESTS**
- **CONSUMABLES- SPACE FOR 49 ITEMS**
- **NUTRITIONAL SUPPORT- 8 TYPES**
- **DATA USED THROUGHOUT MODEL**
- **SHOWS COST PER DOSE/COST PER TEST**
- **4 LISTS AS OPPOSED TO ONE- EASY TO FIND WAY AROUND**

2. Interim sheets- data from base data and other inputs

- **Data form base data and additional inputs used to calculate "sub activities" which are used further on. Examples include**
- **Training unit costs**
- **Workshop/meeting unit cost**
- **Building and office costs**
- **Media campaigns**
- **Condoms & lubricants**
- **Hospital costs**
- **Personnel costs- health facilities**
- **Personnel costs- outreach, peer support**

3- Activities
data from previous 2 sections + inputs- output is unit cost- WHO categories

- Enabling people to know their HIV status
- Preventing sexual transmission
- HIV prevention in youth groups
- Non occupational PEP
- Interventions for idu
- Preventing hiv in infants and children
- Preventing HIV in health settings
- Treatment & care- adults & children
- OI, palliative care, TB

4- summary and overheads

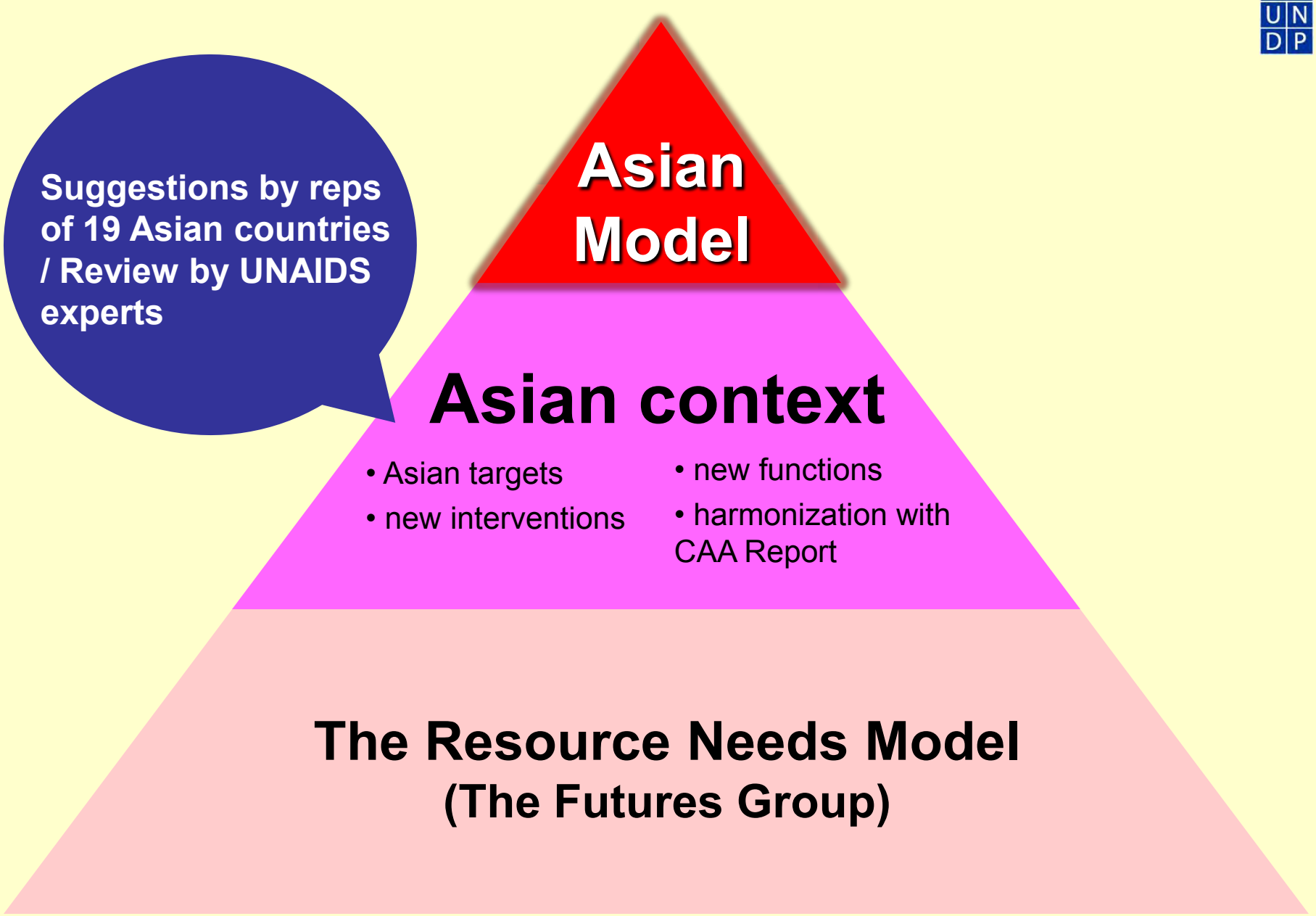
- **Provides a summary of unit costs- before and after apply overheads**
- **Distributes overheads according share of total variable cost**
- **Determines total cost if user enters all physical targets**

Annex 16　Introduction to the Asian HIV/AIDS Resource Needs Estimation and Costing Model (The Asian Model), by Kazuyuki Uji

Introduction to the Asian HIV/AIDS Resource Needs Estimation and Costing Model (The Asian Model)

Amala Reddy
Kazuyuki Uji

An Overview of the Asian Model



(1) Strong alignment with the Commission on AIDS in Asia Report

- **Key recommended interventions and targets are included by default**
  - *Onsite reference to evidence & recommendations of CAA*
  - *Provides justification and credibility*

CAA

- **Recommended strategic directions are reflected in costing methodology** (e.g. community/peer-based interventions for MARPs)

(2) Enabling Environment

- **Considered critical but not included/disaggregated**
  - *Legal, gender, governance and human rights aspects of HIV responses*
  - *E.g. Laws related to the use of TRIPS flexibilities, decriminalisation of MSM, IDU harm-reduction activities etc.*

(3) Results-based costing

Intervention	Targets/indicators
Review/develop/amend intellectual property laws to allow the application of TRIPS safeguards and flexibilities	Presence of IP laws that will enable access to affordable generic HIV medicines by 20XX (target year defined by each country)
Review/amend/remove policies and laws that discriminate against vulnerable populations, including women, sex workers, IDUs and MSM	Presence of legislations/policies that de-criminalise sex workers, MSM and harm-reduction activities and that promote and protect the rights of women including their right to property and inheritance by 20XX
Provide affordable legal support for PLHIV and vulnerable groups	% of vulnerable population having access to affordable legal support
Conduct research and/or strengthen surveillance system to collect epidemiological data related to HIV and provide evidence for optimal decision-making and resource prioritisation	Presenc… d to the epidemi… g, monitori…
Monitor human rights violations against people living with HIV and their family members	Presenc… rights violation…
Implement programmes to reduce stigma and discrimination	Reductio… eline
Support the empowerment and capacity building of HIV positive people's networks for their meaningful participation in the response	Presence of positive people's networks organisationally and financially empowered to advocate for their rights and provide services by 20XX
HIV/AIDS training for law enforcement officials and judges	Y% of law enforcement officials and judges trained on HIV by 20XX
Other programmes/interventions defined by the user	Defined by the user

Accountability

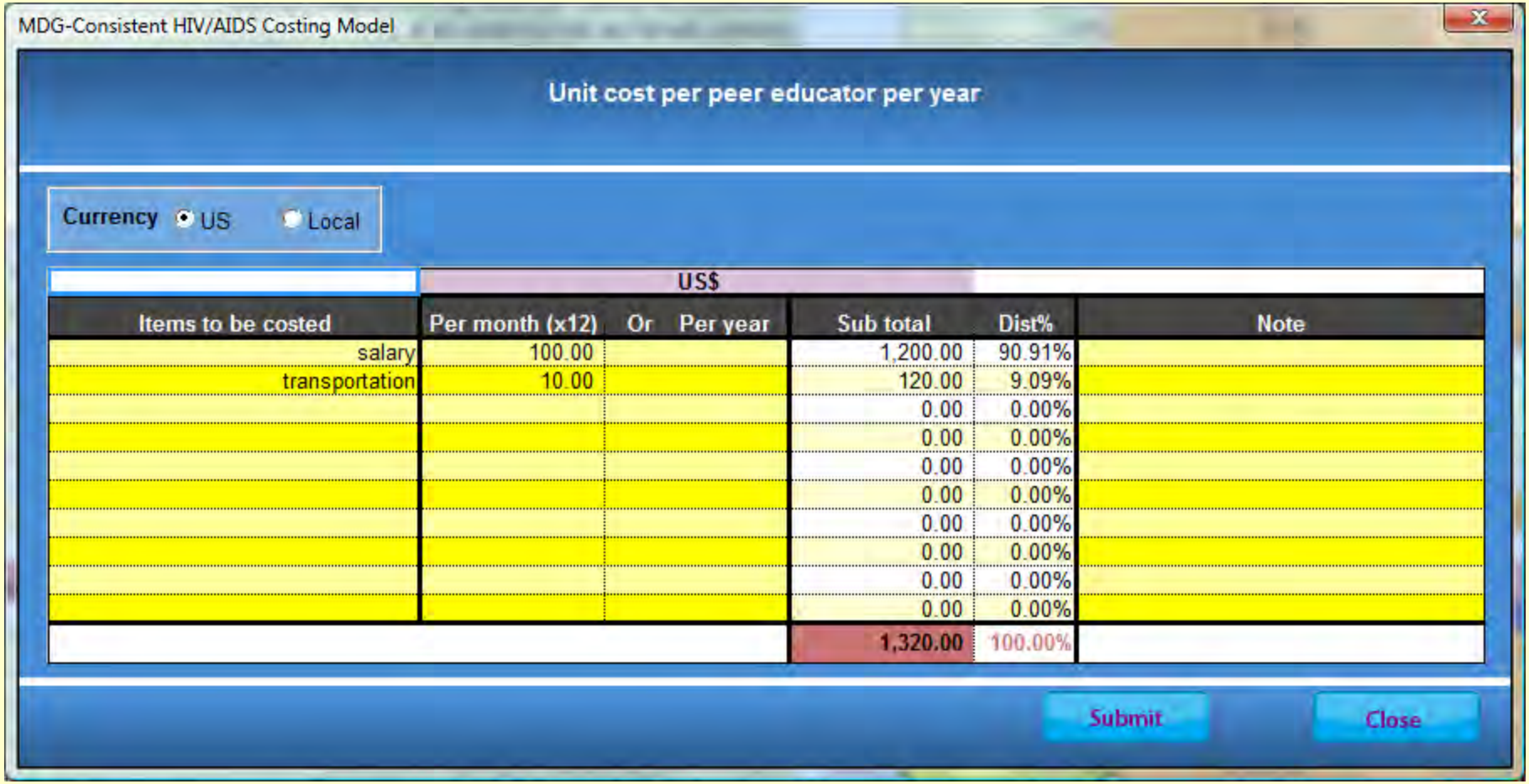
Benchmarks

(4) Onsite unit cost calculation function

- **Unit cost calculations can be done onsite**
  - *No longer required to use a different tool (e.g. INPUT) for unit cost calculations*
  - *Retains records of how the unit cost was calculated*
  - *Highly flexible unit cost calculations*

Calc

Unit cost calculation grid



(5) Priority intervention summary

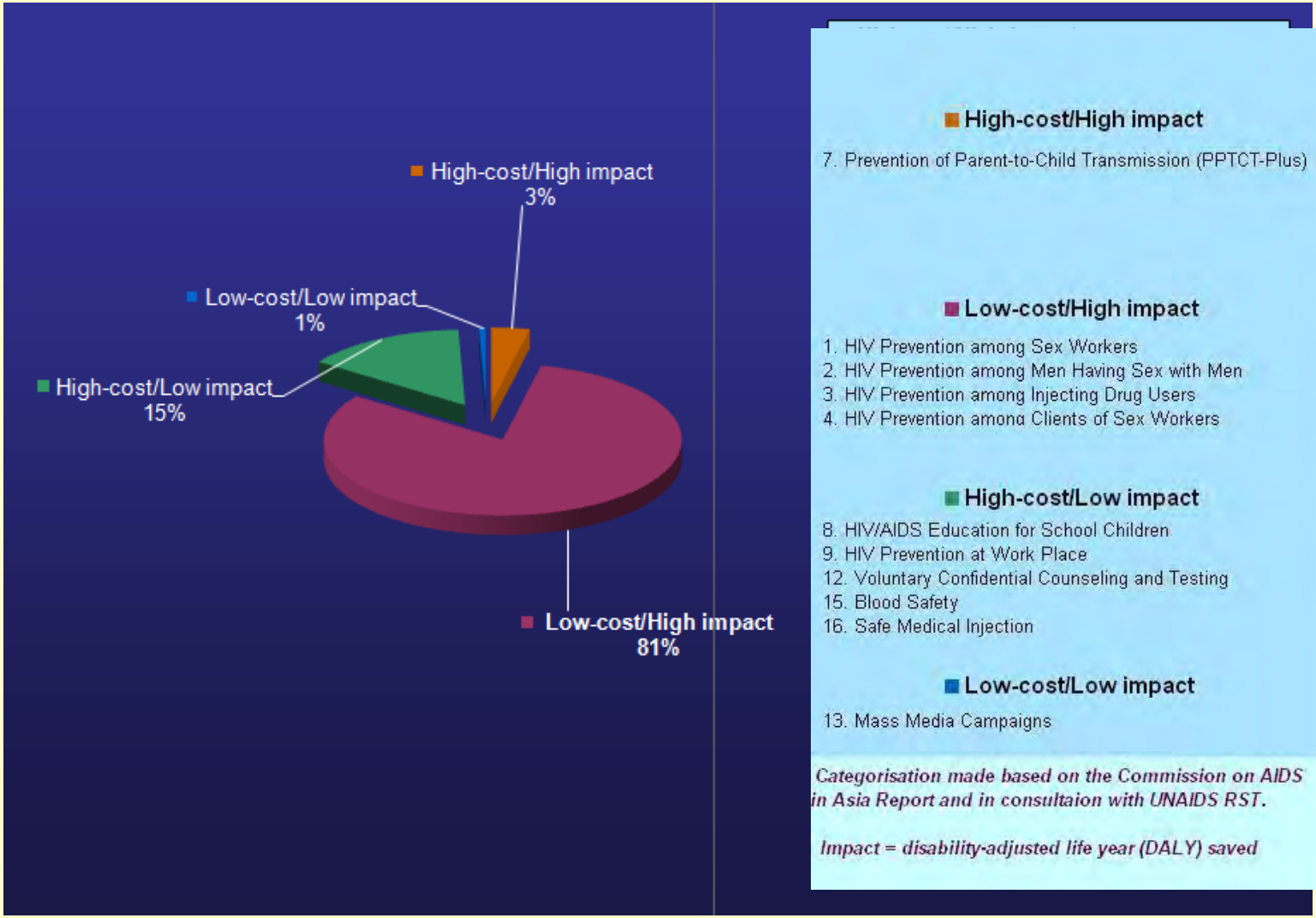
- *Separate chart/graphs only for key priority interventions as per CAA*

Priority Interventions			
		2008	2009
Prevention		**US$**	**US$**
1. HIV prevention among sex workers		1,798,680.00	2,225,600
2. HIV prevention among men having sex with men		834,200.00	799,640
3. HIV prevention among injecting drug users		2,660,000.00	2,825,000
4. HIV prevention among clients of sex workers		-	
7. Prevention of parent-to-child transmission (PPTCT-Plus)		250,000.00	271,428
Total: Priority Interventions		**5,542,880.00**	**6,121,669**
Total: Resource Required		**5,542,880.00**	**6,121,669**
Total: Resource Available		**1,250,000.00**	

(6) Impact analysis

- **Impact analysis graph**
  - *Visualisation of interventions according to cost-impact categorisation*
  - *Impact in terms of DALY saved (DALY=disability-adjusted life years)*

Impact analysis based upon the cost per DALY saved (disability-adjusted life year)



*Only for Prevention / Impact category based upon CAA Report (p91) and inputs from UNAIDS

(7) Funding analysis

Funding

- *Who is paying how much for what?*
- *What is the resource gap?*
- *How to fill the resource gap?*

Funding

Funding/resource situation analysis

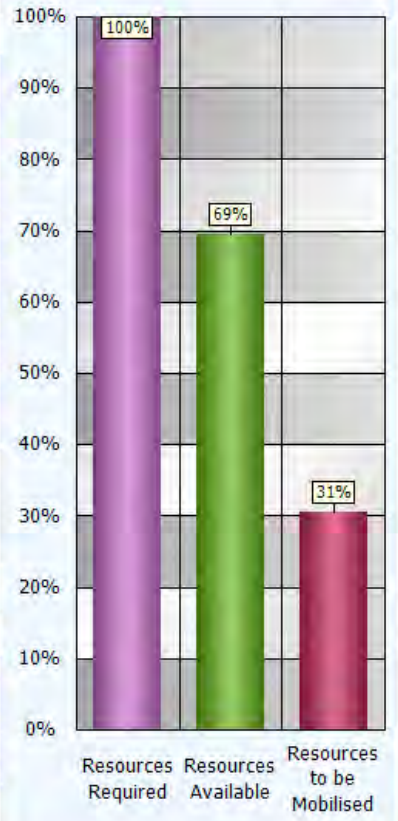
MDG-Consistent HIV/AIDS Costing Model

Funding Analysis for - 1. HIV prevention among sex workers - 2008

Currency ◉ US ○ Local

	US$		
Agency/Funding Source	Contribution amount	%	Note
Ministry of Health	200,000.00	11.12%	
GFATM	500,000.00	27.80%	
UNAIDS	300,000.00	16.68%	
Clinton Foundation	150,000.00	8.34%	
Oxfam	100,000.00	5.56%	
		0.00%	
		0.00%	
		0.00%	
		0.00%	
		0.00%	
		0.00%	
		0.00%	
		0.00%	
		0.00%	
		0.00%	
		0.00%	
Toal amount required	1,798,680.00		
Total amount available	1,250,000.00		
Funds to be mobilised	548,680.00	30.50%	
		100.00%	

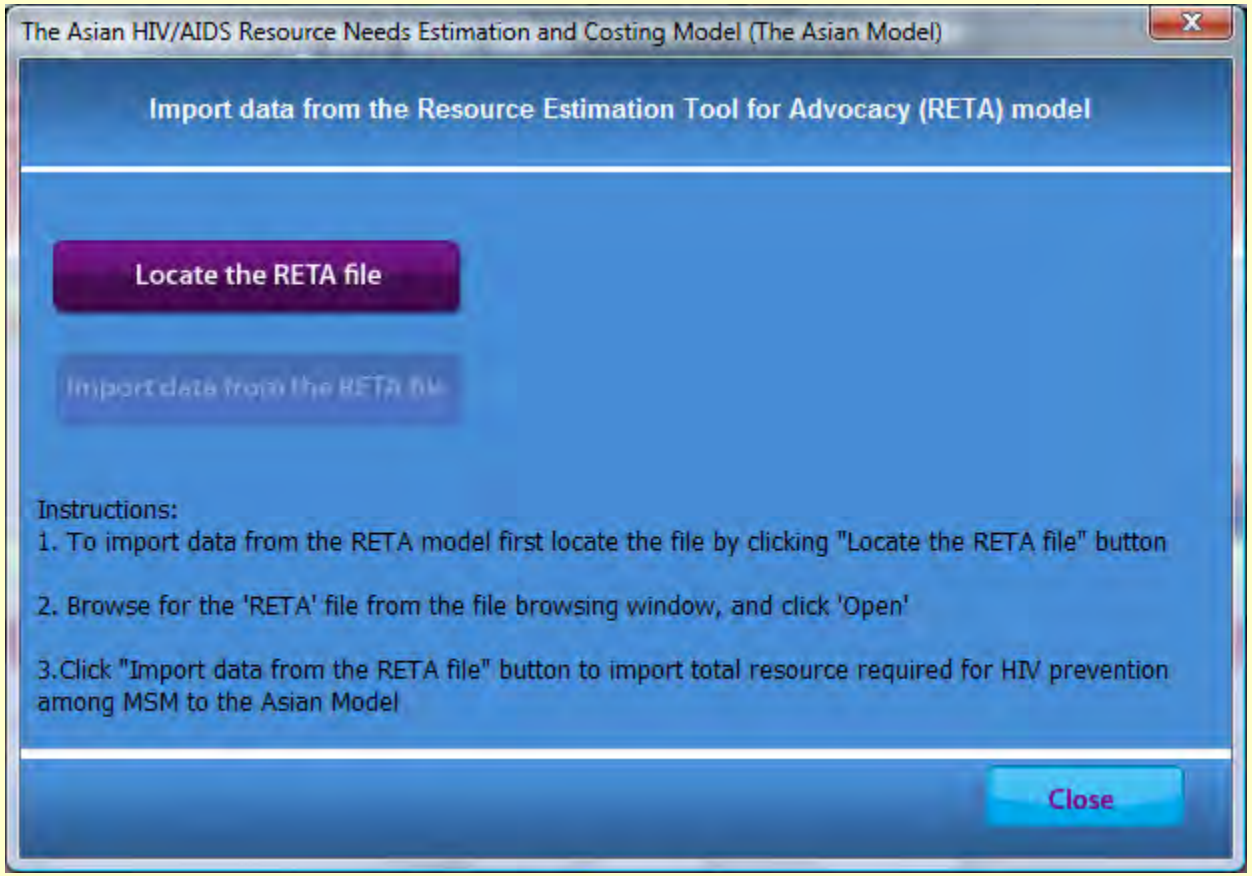
Potential Funding Sources	Amount	Note
UNFPA	100,000.00	
UNAIDS	50,000.00	PAF
WHO	100,000.00	
HIV/AIDS Alliance	150,000.00	
Oxfam		
Total resource mobilasation	400,000.00	
Funding gap	148,680.00	



Submit Close

(8) Integration of community voice

- Direct importation of data from the RETA model (by USAID)



Summary

- ***Can be a powerful guiding tool in alignment with the Commission Report***
- ***Enhanced analytic functions to appreciate realistic needs and gaps***
- ***Single tool both for the unit cost and resource needs estimation***
- ***Designed specifically for Asia***

1. HIV prevention among sex workers

From the Report of the Commission on AIDS in Asia

- 'The Commission receommends that prevention programmes for most-at-risk populations should be implemented through community-based and other civil society organizations' (p. 216)
- 'In every setting with a flourishing sex trade, achieving and maintaining high levels of condom use in commercial sex will, more than any other intervention, prevent the greatest number of HIV infections in the society as a whole' (p. 42)
- 'Avoiding HIV infection is seldom the main concern of sex workers or drug injectors, mainly because of the need to deal with daily hardships like police harassment, the threat of violence, and the need for safe shelter and income. ▪ Fostering a sense of respect and trust, or providing safe spaces in otherwise unsafe settings, can make a difference. Drop-in centres, for example, provide temporary havens where people can gather, share their experiences and ideas, gain information and link up to relevant services (whether HIV testing and counseling, treatment for sexually transmitted infections or finding a room to rent)' (p. 116)
- '▪ [A]bout 60 per cent of most-at-risk populations need to adopt safer behaviours if HIV epidemics are to be reversed. Importantly, to achieve that level of behavior change, service coverage has to reach at least 80 per cent.' (p. 4)

Close

Annex 17 RETA - A Tool to Estimate Resource Gaps for Preventing HIV Among Men Who Have Sex with Men, by Brad Otto

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RETA

A Tool to Estimate Resource Gaps for Preventing HIV Among Men Who Have Sex with Men

Expert Consultation on Costing HIV Responses in Asia

Bangkok - 28 October 2010

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Advocacy and Men Who Have Sex With Men

- Evidence from as early as 2000 has shown that HIV is disproportionately affecting men who have sex with men in Asia, yet until very recently there has been minimal financial investment in interventions to address HIV risk among men who have sex with men
- Coverage of prevention services for men who have sex with men in the region is estimated at a mere 5%
- The CAA report is galvanizing attention and the imperative to scale up coverage among at-risk populations, particularly men who have sex with men
- Key advocacy issues are emerging, but the most critical is for community advocates to become “resources literate”

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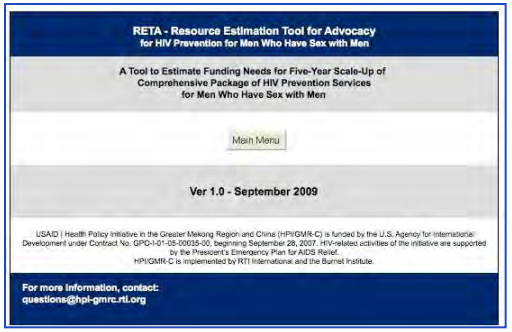
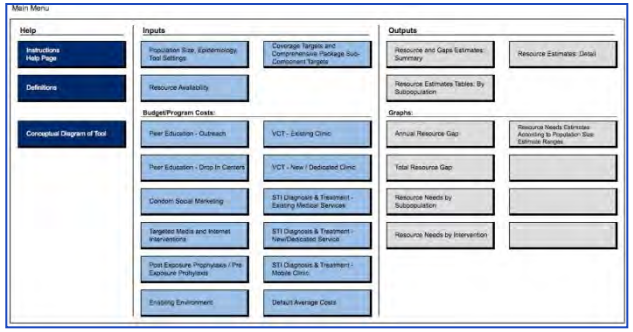
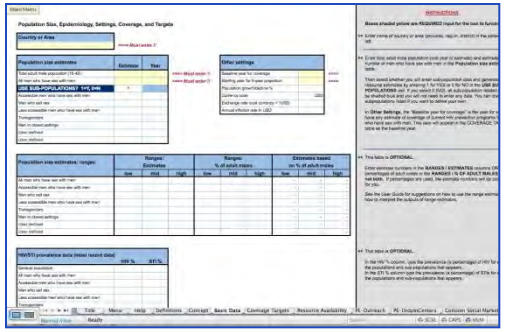
FROM THE AMERICAN PEOPLE

Why did we build RETA?

- To increase funding and assure that funds are allocated appropriately to programming for men who have sex with men
- To improve our evidence base for advocacy
- To ensure that community advocates understand money flows
- To facilitate community engagement with governments and donors to advocate for increased resources for HIV prevention programs for men who have sex with men







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Data needed to feed into RETA

1. **Current / recent population size estimates**
   - All men who have sex with men and/or ***sub-populations***

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Population Size, Epidemiology, Settings, Coverage, and Targets

Country or Area
Khayalistan

Population size estimates	Estimate	Year
Total adult male population (≈15-49)	6,960,109	2010
All men who have sex with men	139,202	2010
USE SUB-POPULATIONS? 1=Y, 0=N	1	
Accessible men who have sex with men	41,761	
Men who sell sex	4,000	
Less accessible men who have sex with men	97,442	
Transgenders		
Men in closed settings		
User defined		
User defined		

Other settings	
Baseline year for coverage	2005
Starting year for 5-year projection	2011
Population growth/decline %	1.71%
Currency code	KXP
Exchange rate local currency = 1USD	3.30
Annual inflation rate in KXP	1.50%

Population size estimates: ranges	Ranges: Estimates			Ranges: % of adult males			Estimates based on % of adult males		
	low	mid	high	low	mid	high	low	mid	high
All men who have sex with men	139,202	173,000				12.0%	-	-	835,213
				% of "All men who have sex with men"					
Accessible men who have sex with men							-	-	-
Men who sell sex							-	-	-
Less accessible men who have sex with men							-	-	-
Transgenders							-	-	-
Men in closed settings							-	-	-
User defined							-	-	-

USAID FROM THE AMERICAN PEOPLE | HEALTH POLICY INITIATIVE

Data needed to feed into RETA

1. **Current / recent population size estimates**
   - All men who have sex with men and/or ***sub-populations***
2. **Population coverage scale up targets**
   - Targeting delivery of services to sub-populations

Annual prevention program coverage targets	Baseline Coverage 2005	Annual targets 2011	2012	2013	2014	2015
All men who have sex with men	3.0%	24.6%	33.1%	41.7%	50.2%	58.7%
Accessible men who have sex with men	11.0%	60.0%	65.0%	70.0%	75.0%	80.0%
Men who sell sex	0.0%	10.0%	20.0%	30.0%	40.0%	50.0%
Less accessible men who have sex with men	0.0%	10.0%	20.0%	30.0%	40.0%	50.0%
Transgenders						
Men in closed settings						
User defined						
User defined						

Coverage of Sub-Components for Each Sub-Population by Year 5

Comprehensive Package of Prevention Services	All men who have sex with men	Accessible men who have sex with men	Men who sell sex	Less accessible men who have sex with men	Transgenders	Men in closed settings
Strategic behaviour change communication						
Repeat Contact Peer Education Through Outreach						
Repeat Contact Peer Education - Drop In Centers						
Social Marketing of Condoms and Lubricant						
Targeted Mass Media						
Social Networking Web Sites - Internet Interventions	60%	50%	50%	65%		
STI diagnosis and treatment						
STI Treatment and Diagnosis - Existing Clinical Services	16%	5%	40%	20%		
STI Diagnosis & Treatment - New/Dedicated Clinical Service	14%	20%	40%	10%		
STI Diagnosis & Treatment - Mobile Clinic						
VCT						
Voluntary Counseling and Testing Services - Existing Services	20%	55%	30%	5%		
Voluntary Counseling and Testing Services - New / Dedicated Serv	20%	60%	50%	2%		
PEP and PrEP						
Post Exposure Prophylaxis						
Pre-Exposure Prophylaxis						

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Data needed to feed into RETA

1. **Current / recent population size estimates**
   - All men who have sex with men and/or ***sub-populations***
2. **Population coverage scale up targets**
   - Targeting delivery of services to sub-populations
3. **Services costing information**
   - Comprehensive Package of Services

Repeat Contact Peer Education Through Outreach

Khayalistan

Source of data : PHU
Year : 2010

Total budget (KXP): 155,349
Beneficiaries : 6,768
Percent of current capacity : 100%
Average cost at capacity (KXP) : 22.95

Cost categories	Resource/activity description	Calculation base	Cost	Total cost	Assumptions
Personnel / Human Resources			KXP	105,060	
	outreach manager		36,900.00		
	outreach coordinator		36,000.00		
	peer educator and volunteer		20,160.00		
	admin officer	50%	12,000.00		
Consultants			KXP	-	
Travel and transport			KXP	13,440	
	peer educator travel allowances		13,440.00		
Equipment and supplies			KXP	2,400	
	rental of office equipment		2,400.00		

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Data needed to feed into RETA

1. **Current / recent population size estimates**
   - All men who have sex with men and/or ***sub-populations***
2. **Population coverage scale up targets**
   - Targeting delivery of services to sub-populations
3. **Services costing information**
   - Comprehensive Package of Services
4. **Current or anticipated program funding**

# of people targeted per year x **average cost of comprehensive package of services** = **estimated annual cost of comprehensive package of services**

estimated annual cost of comprehensive package of services - **total anticipated annual funding** = **estimated annual funding gap**

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What advocacy information is generated by the tool?

- RETA is specific to men who have sex with men and breaks down into sub-populations, addressing prevention and enabling environment
- Includes process for determining costs of services, based on EXISTING services (with consideration of good practice)
- Comprehensive Package of Services
- Estimates
  - Resource needs and gaps:
    - Annual,
    - 5 year total
    - Scenarios by population estimate
  - Resources needed by sub-population
  - Resources needed by component for the comprehensive package of services
  - It will tell us how much funding is currently available, and how much is going to be needed ***in addition*** to scale up coverage of the comprehensive package of services

Resource and Gaps Estimates: Summary

All men who have sex with men		Baseline	End of year targets			
		2010	2011	2012	2013	2014
Size of target group						
Size of target group per year: point estimate		139,202	141,583	144,004	146,466	148,971
Low population size estimate		139,202	141,582	144,003	146,466	148,970
Mid population size estimate		173,000	175,958	178,967	182,028	185,140
High population size estimate		835,213	849,495	864,022	878,796	893,824
Coverage:						
% men covered with comprehensive package	%	3%	25%	33%	42%	50%
Number of men covered - point estimate			34,802	47,698	61,025	74,793
Low population size estimate			34,802	47,698	61,025	74,793
Mid population size estimate			43,252	59,279	75,841	92,953
High population size estimate			208,815	286,189	366,149	448,759
Total resources required - point estimate		KXP	**4,409,775**	**5,415,660**	**6,510,097**	**7,696,152**
Low population size estimate			4,409,769	5,415,653	6,510,088	7,696,142
Mid population size estimate			5,480,453	6,730,565	8,090,726	9,564,751
High population size estimate			26,458,649	32,493,963	39,060,580	46,176,910
Resources available		KXP	**600,000**	**600,000**	**600,000**	**600,000**
Resource gap - point estimate		KXP	**3,809,775**	**4,815,660**	**5,910,097**	**7,096,152**
Low population size estimate			3,809,769	4,815,653	5,910,088	7,096,142
Mid population size estimate			4,880,453	6,130,565	7,490,726	8,964,751

Resource Estimates: Detail

Khayalistan

All men who have sex with men		Baseline	End of year targets					
Population point estimate		2010	2011	2012	2013	2014	2015	Total
Size of target group								
Size of target group per year: point estimate		139,202	141,583	144,004	146,466	148,971	151,518	
Coverage:								
% men covered with comprehensive package		**3%**	**25%**	**33%**	**42%**	**50%**	**59%**	
Number of men covered - point estimate			34,802	47,698	61,025	74,793	89,015	
Resources required								
Strategic behaviour change communication		KXP	2,292	3,188	4,140	5,150	6,221	20,991
STI diagnosis and treatment		KXP	724,696	1,008,124	1,309,136	1,628,571	1,967,308	6,637,835
VCT		KXP	2,201,725	3,062,821	3,977,335	4,947,824	5,976,952	20,166,657
PEP and PrEP		KXP	-	-	-	-	-	-
Enabling Environment		KXP	795,048	658,155	529,061	407,413	292,871	2,682,548
Research		KXP	397,524	329,077	264,531	203,707	146,436	1,341,274
Monitoring and Evaluation		KXP	288,490	354,296	425,894	503,487	587,285	2,159,451
Total: Resources required		**KXP**	**4,409,775**	**5,415,660**	**6,510,097**	**7,696,152**	**8,977,073**	**33,008,757**
Cost per client covered with comprehensive services (KXP)								**107.40**

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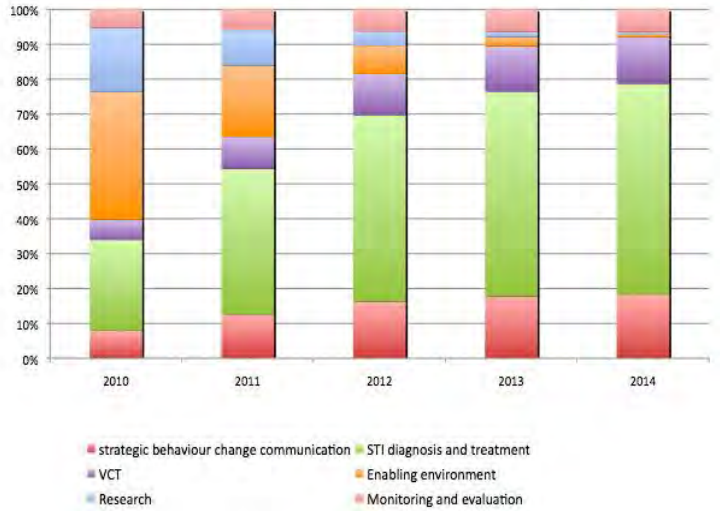
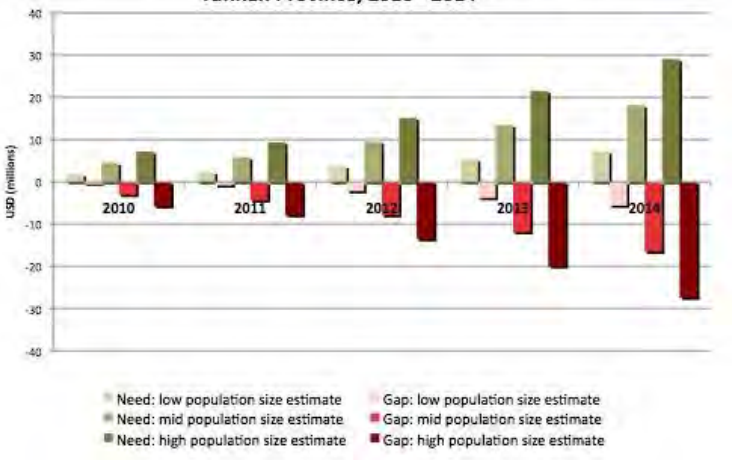
Annual Resource Gap for HIV Prevention Programs for Men Who Have Sex With Men, China - Yunnan Province, 2010 - 2014

Annual Resource Requirements, by Component of Comprehensive Package of Services, China - Yunnan Province, 2010 - 2014



Resource Gap for HIV Prevention Programs for Men Who Have Sex With Men, China - Yunnan Province, 2010 - 2014

Resource Needs and Gaps by Population Size Estimate, China - Yunnan Province, 2010 - 2014



Annex 18 Marginal Budgeting for Bottlenecks, by Kyaw Myint Aung

Marginal Budgeting for Bottlenecks (Sri Lanka example)

Amari Watergate Hotel

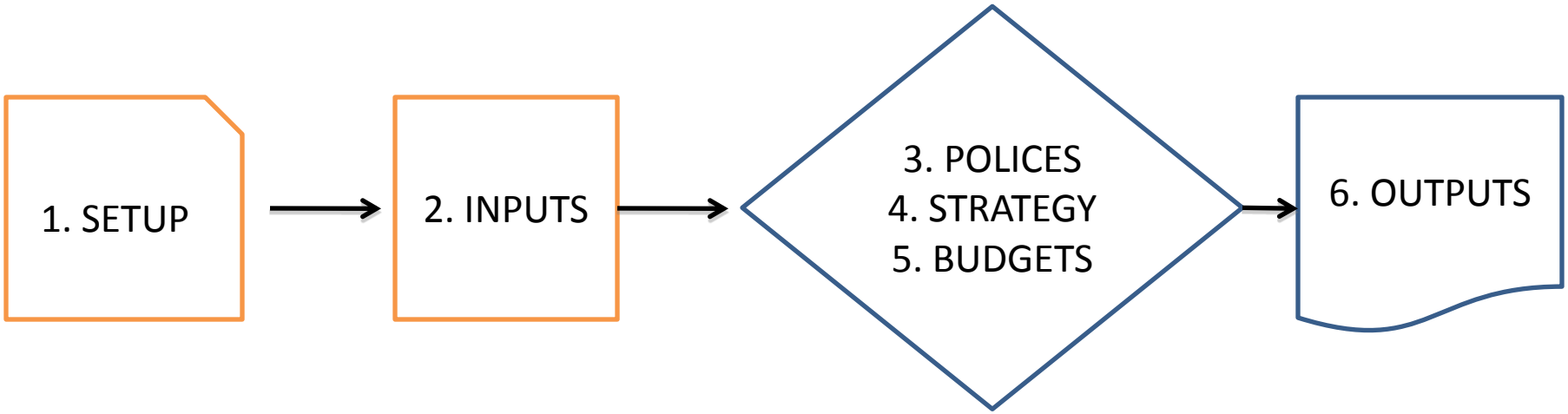
Dr. Kyaw Myint Aung

27th -29th October

Introduction

- an analytical tool for evidence based policy, planning, costing and budgeting at country and district level.
- The tool helps to:
  - plan and forecast the potential cost and impact of scaling up of high impact health, nutrition, malaria and HIV/Aids interventions , to remove health system constraints towards increasing the intake, coverage and quality
  - prepare results-oriented national health strategic plans, expenditure programs and health budgets, and
- results are very context dependent: uses local costs and constraints, plus locally chosen interventions, and applies best available evidence to estimate impacts
- Does not tell users what to do: its strength is in helping stimulate discussions to maximize the impact of new funding.

MBB Structure



Setup

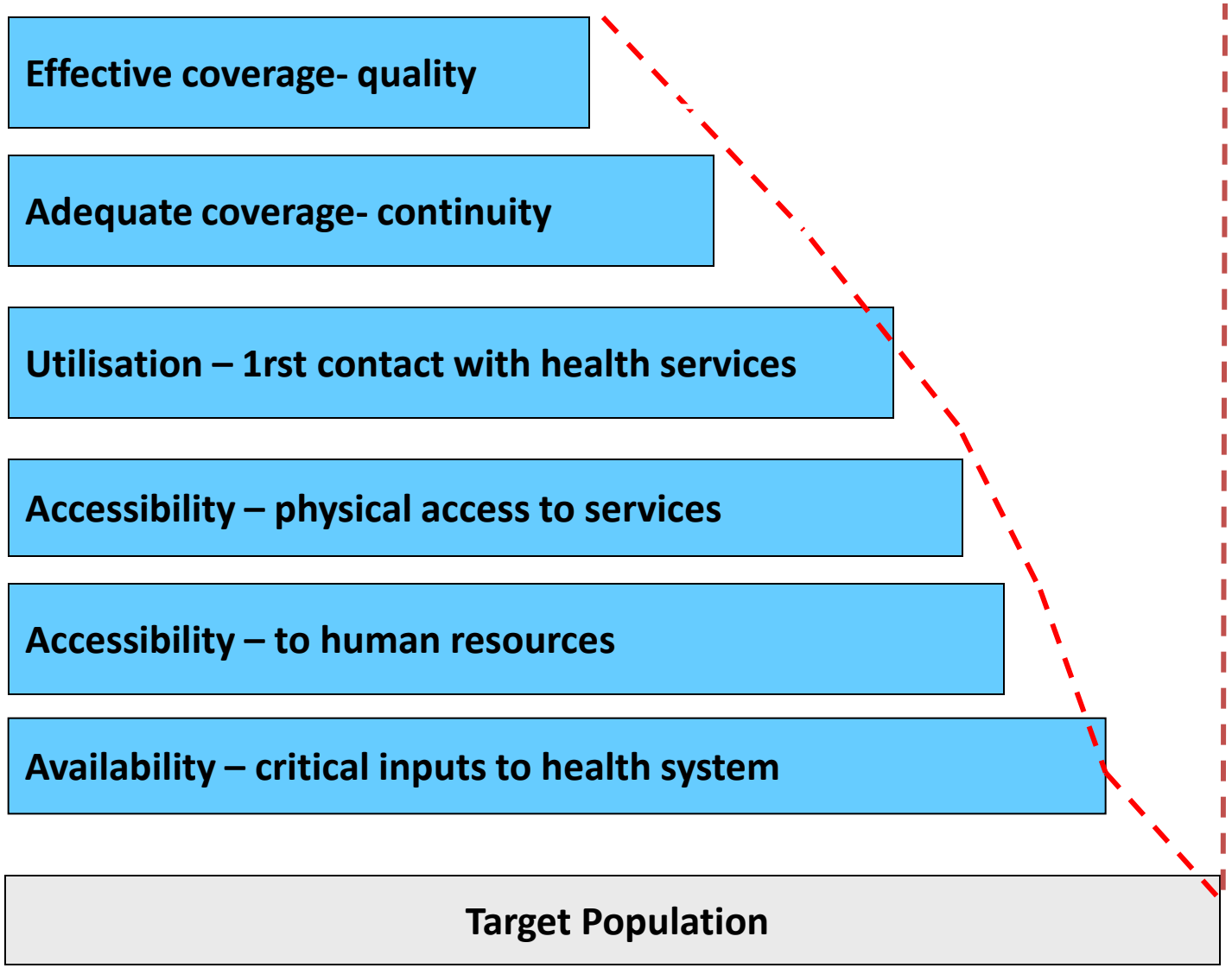
- Selection of **Languages**
- Selection of years and time period
- **Comparing Scenarios**
- **Compare Groups**
- **Phasing over**
- Default database is used in the absence of local data

Inputs (types of data)

- Demographics data such as population disaggregated by age groups
- Epidemiology data such as morbidity, mortality, etc.
- Health systems such as infrastructure, man power, time and distance to travel
- Health Interventions such as child and new born care
- Coverage such as immunization, AN care coverage
- Macro economics such as GDP, inflation rate

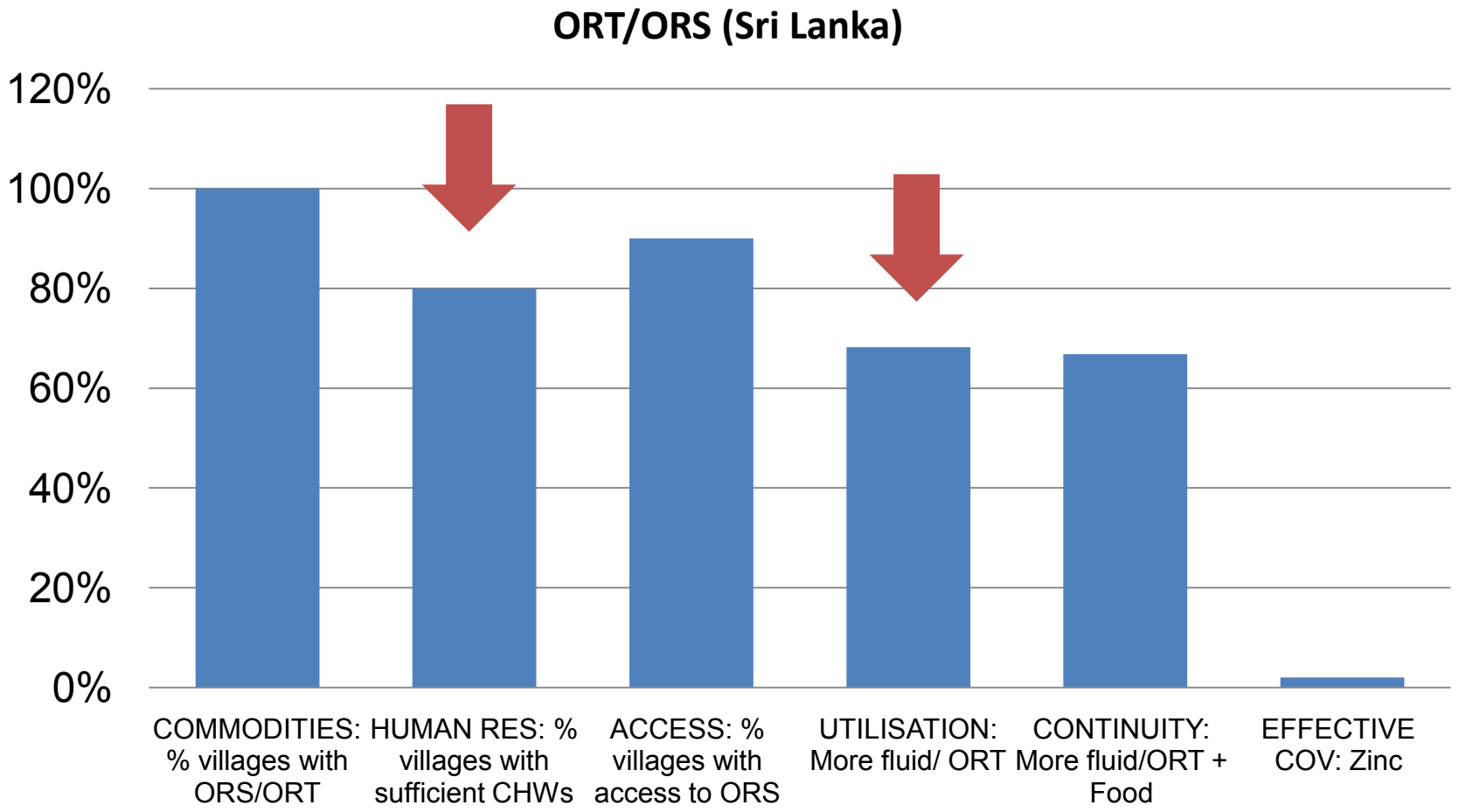
3 Service Deli Modes	12 Sub Packages	12 Tracers
Family-oriented, community-based services (Health services that families and communities can provide/ practice by themselves or with limited inputs)	Family preventive/WASH services	Insecticide Treated bed nets
	Family neonatal care	Clean Delivery and Cord care
	Infant and child feeding	Breast feeding for 0-5 months
	Community management of common illnesses	ORS/ORT
Population oriented schedulable services (Mainly preventive care services delivered to a target group with schedule, and/or providing through outreach facilities)	Preventive care for adolescent girls & women	Family Planning
	Preventive pregnancy care	Antenatal Care
	HIV/AIDS prevention & care	PMTCT
	Preventive infant & child care	Measles Immunization
Individual oriented clinical services (Services provided by trained healthcare professionals in a healthcare facility)	Clinical primary level skilled maternal & neonatal care	Normal Delivery for skilled Attendant
	Clinical management of illnesses at primary level	Antibiotics for Pneumonia
	Clinical first referral illness management	Basic Emergency Obstetric Care
	Clinical second referral illness management	Comprehensive Emergency Obstetric Care

Identification of Bottlenecks (Tanahashi's Model)

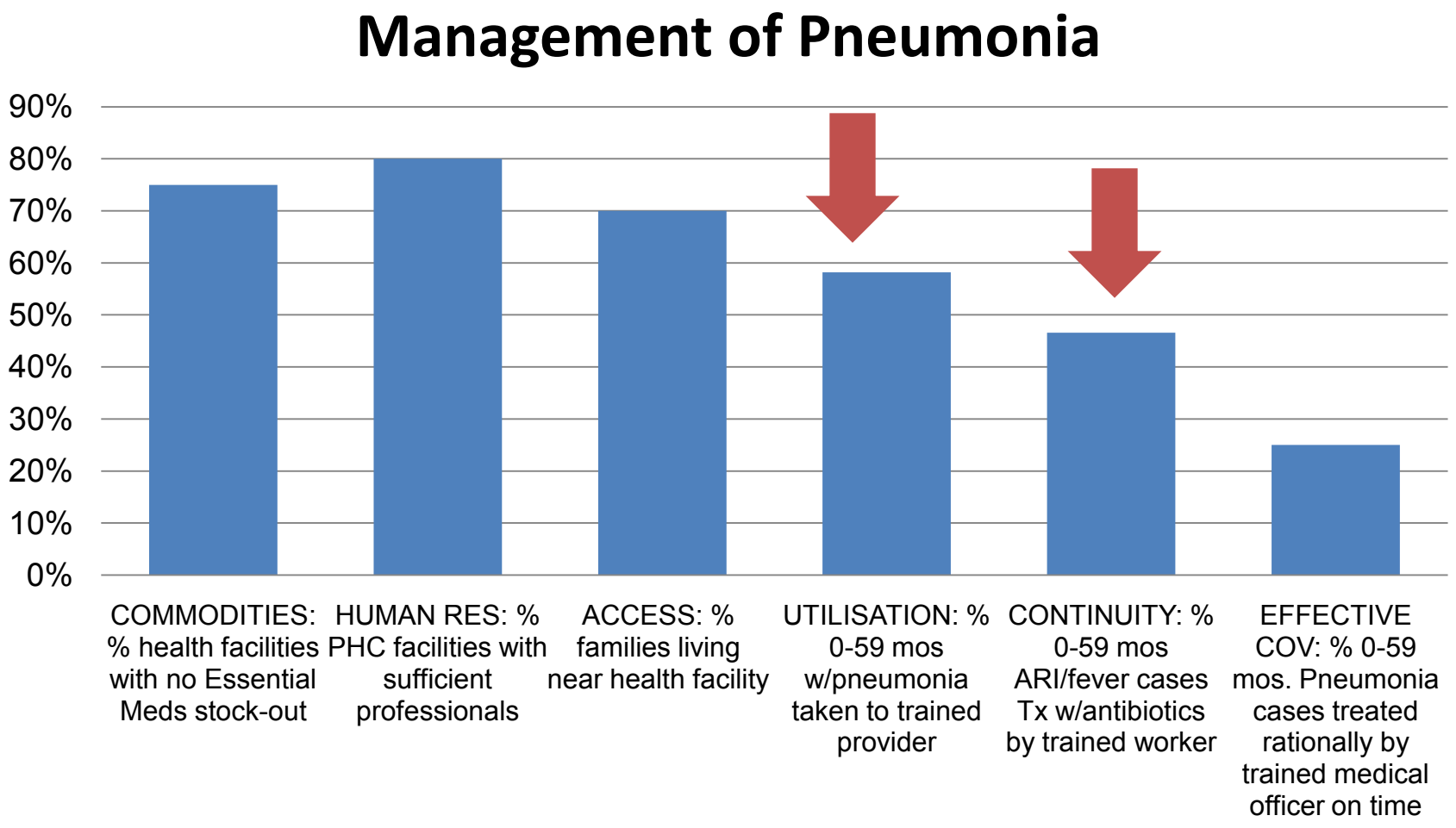


From *Tanahashi T. Bulletin of the World Health Organization, 1978, 56 (2)*
http://whqlibdoc.who.int/bulletin/1978/Vol56-No2/bulletin_1978_56(2)_295-303.pdf

Sub package 1.4; Community Management of common illness



3.2. Mana: of illness at Primary Level



Policies

- Policies sheet built the same way as inputs sheet
- Policies for interventions, health coverage and economic can be amended between scenarios or groups

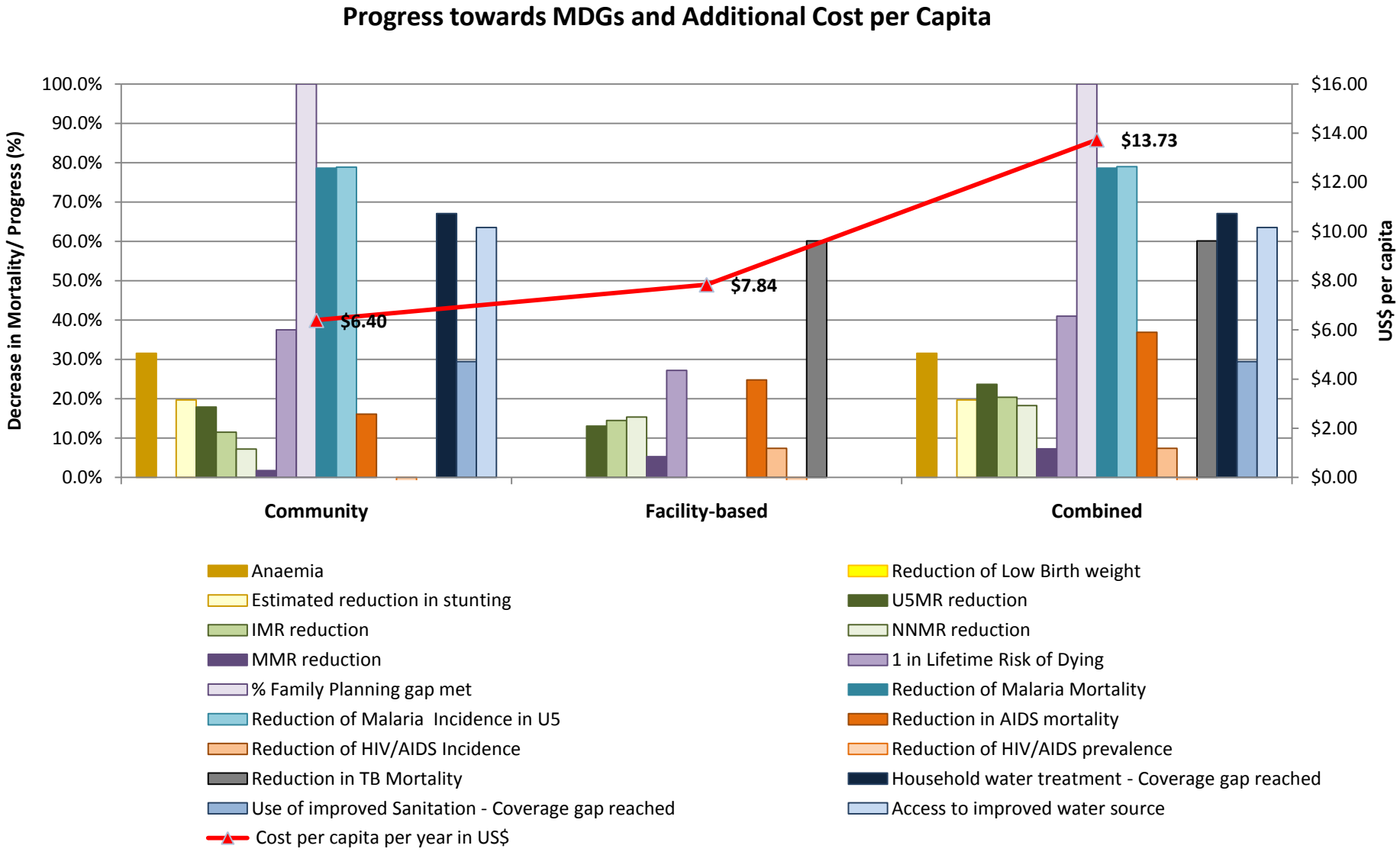
Strategies

- Analysis of bottlenecks as well as strategies identification is a participatory process which **pinpointing possible causes and proposing operational strategies/solutions** to overcome the identified bottlenecks.
- These strategies may focus on **existing plans** or may go further to consider **new strategic interventions** whose costs and impact may be simulated and compared to an existing strategies.

Budget

- Strategies which come up from the discussion will require to open budget items for those activities
- It also required to classify into national strategic plan, MTEF and national chartered of accounts

Output (Costs and Impacts)



Other Outputs

- Additional cost gap
- Cost breakdown
  - Programs
  - Funding sources (govt, UNs, Bilateral, OOP)
  - National strategic plan and etc.
- Human resources needs
- Impact

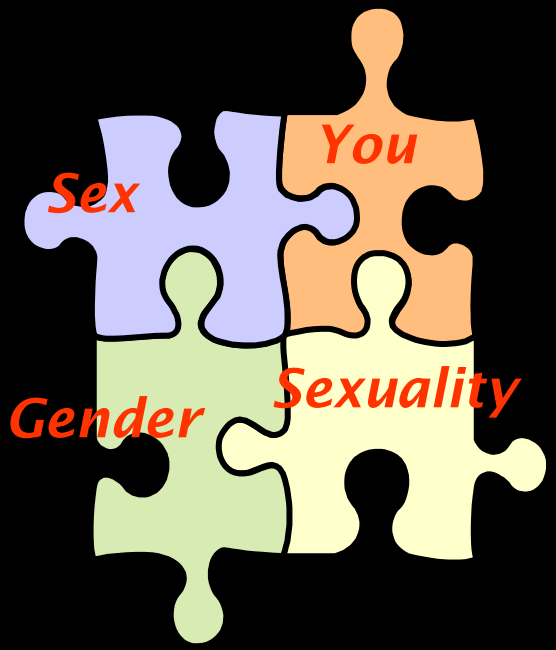
Annex 19 Integrating gender perspectives and programmes into costing of HIV responses, by Jane Wilson

Integrating gender perspectives and programs into costing of HIV responses

Expert Consultation on Costing HIV Responses in Asia – Pacific, 29 October 2010

Jane Wilson – UNAIDS Bangkok (wilsonj@unaids.org)

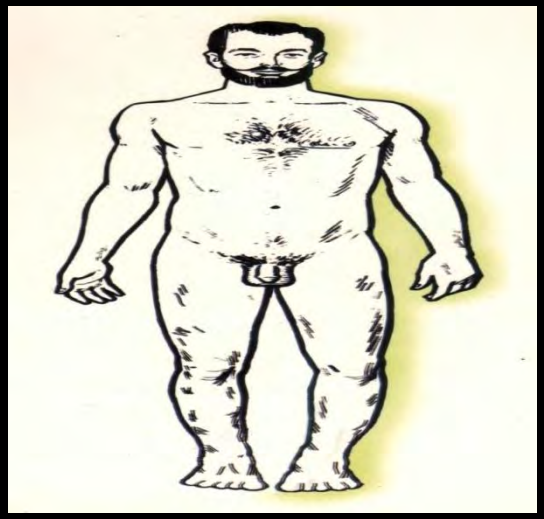
Start with definitions ……..



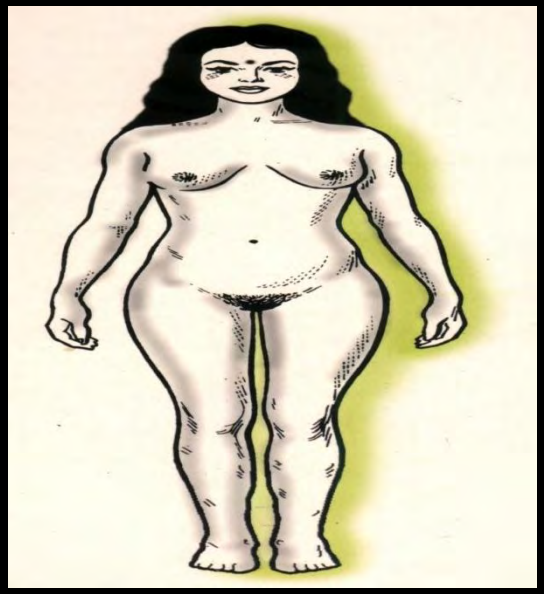
Sex ~ is what you are born with

Sexuality ~ is how you perceive sex and your preferences

Gender ~ is how you socially exhibit your sexuality/ social construction

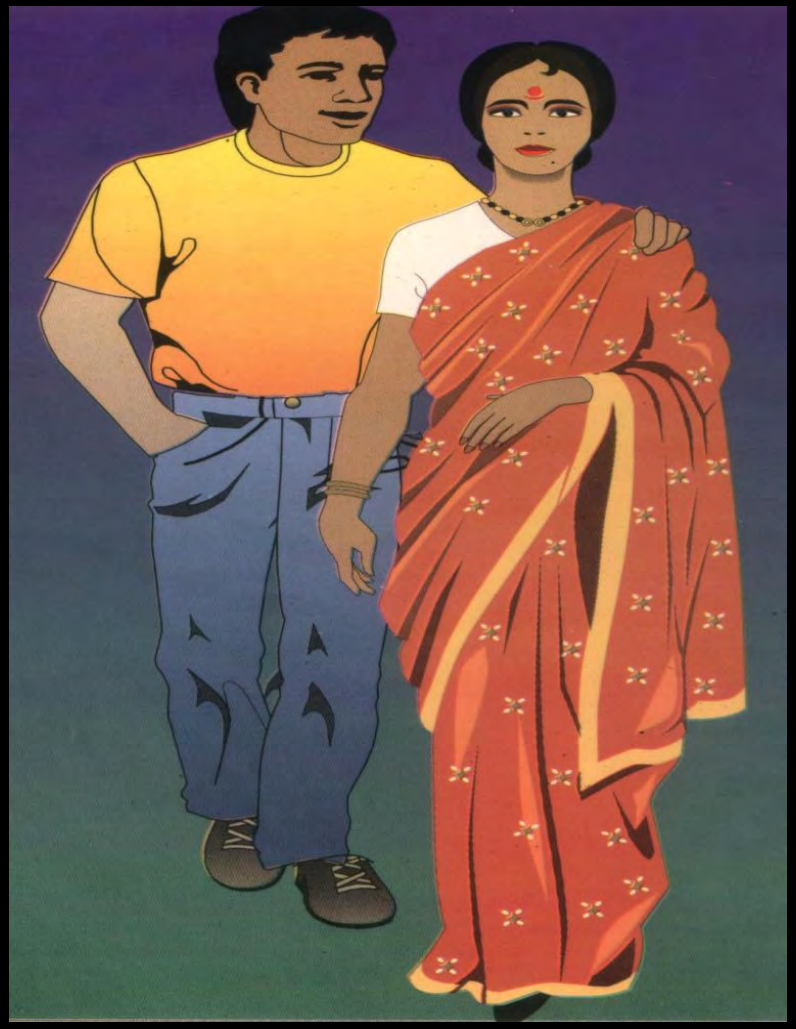


Born as a male



Or as a female

Gender is how you are socially constructed as a man or as a woman



How gender identities affect vulnerabilities of community?

- *Inappropriate and insensitive services*
- *Inadequate reach of services*
- *Isolation and marginalization*
- *Violence: Physical and mental abuse*
- *Violation of human rights*
- *Psychological distress*

2008 analysis

- UNGASS indicators bio-medical and don't address women's/ gender issues (new gender indicator in 2010 as part of UNGASS review?)
- Need for synergy between work on violence and HIV work to address unequal gender relations and cultural norms of power & decision making
- Programmes must address links between GBV, HIV and access to sexual and reproductive health care and rights - risk behaviour happens in a context!

We have now have strong policies but what about progress to date in 2010?

Gender is integral to priority areas of UNAIDS Outcome Framework

" we can reduce sexual transmission"

" we can prevent mothers from dying and babies from becoming infected"

" we can empower MSM, SWs and TG people to protect themselves from HIV and to fully access ART"

"we can meet the HIV needs of women & girls & can stop sexual & gender based violence"

UNAIDS Agenda for Women & Girls 2010 - 2015

- *26 strategic actions to catalyze action at country level*
- *Building synergies between women's rights movement & AIDS response*
  - *reproductive health networks, women's rights advocates*
  - *Using existing initiatives: SG's UNiTE campaign 25/11/10*
  - *Strengthening and broaden partnerships*
- *Time-bound and results oriented*
- *Accountability built in: progress report to PCB twice a year*

Key Recommendations

1. Jointly generate better evidence and increased understanding of the specific needs of women and girls in the context of HIV and ensure tailored national AIDS responses (*"knowing your epidemic and response"*)

2. Translate political commitments into scaled-up action and resources that address the rights and needs of women and girls in the context of HIV

3. Champion leadership for an enabling environment that promotes and protects women's and girls' human rights and their empowerment, in the context of HIV

Really know your epidemic….

- Countries collect & analyze epidemiological & qualitative data - disaggregated by sex, age & setting, on how the epidemic affects target groups ex women and girls and KAPs
- Support women's groups & networks to contribute to national data collection (UNGASS & qualitative data)
- Countries include equality analysis in assessments of national AIDS spending ex services for KAPs and sexual partners
- 2010 for one indicator on HIV/gender in 25 UNGASS HIV core indicators

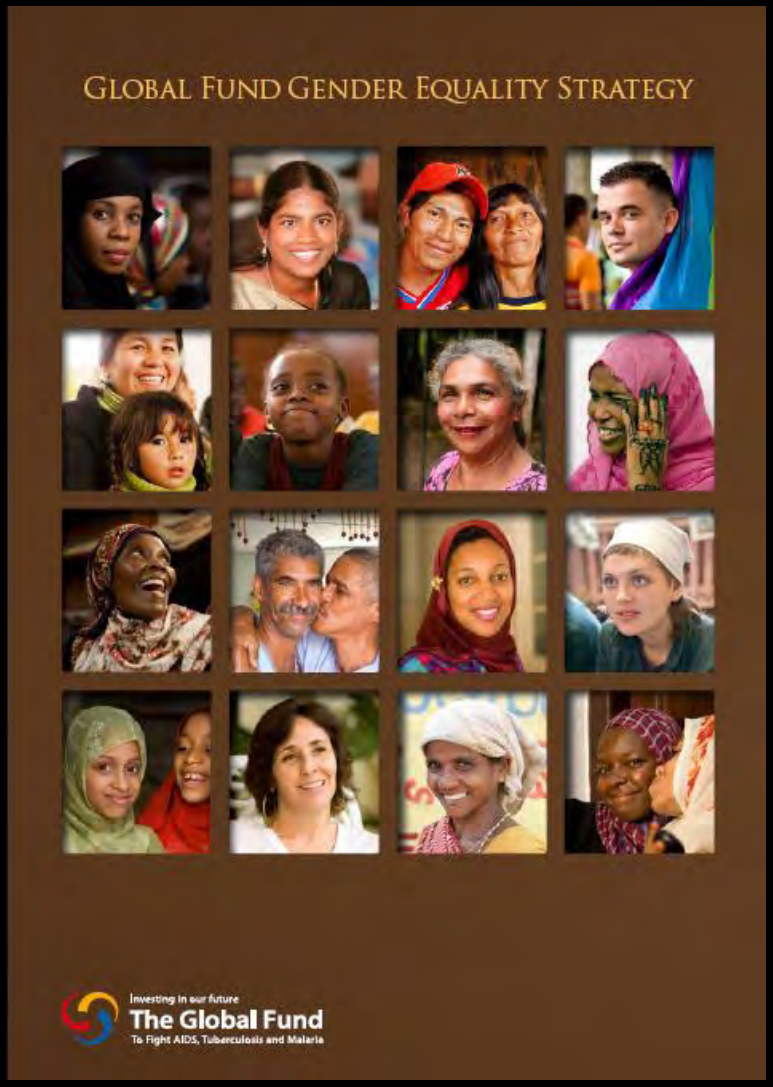
Scaled up action and resources

- Incorporate action on gender in new National Strategic AIDS Plans (AP region all countries 2010 - 11)
- Include HIV into national UNiTE to End Violence against Women campaign in the region (25 November launch)
- Ensure a national minimum package of services for HIV, tuberculosis, sexual and reproductive health services and MCH (one stop shop = increase access)
- Ensure HIV policies are engendered and scaled up

The time for bold leadership and advocacy

- Rapidly strengthen capacity and coalition building among women's groups, networks of women PLHIV, organizations of men working (ex APN+ Regional Proposal)
- Engage men & boys to address and redefine masculinity
- Regional technical support hubs to dedicate resources
- Advocate for **40% of positions in CCM** to be allocated to women (experts)

Gender and SO/GI Strategies



Key messages

The gender equality and the SOGI strategies were approved by GFATM Board to:

- To ensure positive bias in Global Fund proposals and programming and
- To be more proactive in addressing equity in proposals and grants supported by the global fund and
- To address ***the vulnerabilities and needs of women and girls, men and boys, MSM, transgender people, and sex workers*** in the fight against the three diseases

What about progress to date in 2010?

General Gender-related weaknesses in previous proposal – review 2010

- *Most gender neutral, some gender sensitive and none gender transformative*
- *Gender still treated as an add-on, not a key aspect to be integrated in all phases of proposal development*
- *Little gender analysis underlying the GFATM proposals*
- *Limited or no gap analysis*
- *Findings from the gender analysis are not translated into targeted programmatic actions*
- *Intervention or actions planned have no budget and indicators*
  - *Budgeting is a big issue (proposed activities have no clear budget)*
  - *Lack of gender sensitive indicators*
  - *Performance framework with no disaggregated input and outcome data*

Examples PCB progress report 12/2010

- *9 countries developing new NSPs have undertaken gender analyses of their NSPs*

- *9 countries are developing programmes for men and boys to address social norms around gender and sexual relationships related to gender equality*

- *9 countries developing new NSPs have provided leadership development programmes for women, young women and girls living with HIV*

Country Initiatives

- Strong engagement UNJTAs in China, India, Nepal, Cambodia, Thailand, Viet Nam, PNG (priority countries)
- ➢ India in gap areas – best model to reach intimate partners of HR men, female IDUs and clients of sex workers
- ➢ China – through support $500 million RCC (5 priorities) 6 priority provinces
- ➢ Nepal – building on amendment of property rights and land ownership bills + many female MPs
- ➢ All countries revising NSPs this biennium

We know what interventions work - ex responses to gender based violence

- Address gender inequality ex empower women (income generation)
- Work with community, men and boys to challenge gender norms
- Provide comprehensive post rape care
- Address violence in context of HIV testing
- Focus on violence against SWs

What can costers do?

Know about the gender tools ….

- Gender sensitive measuring and assessment mechanisms
- Gender planning including monitoring and evaluation
- Gender impact assessments
- Gender audits
- Gender responsive budgeting

Use gender and HIV check lists

1 Gender in the National AIDS Action Framework (core packages etc)

2 Gender in one national AIDS coordinating authority (capacity)

3 One gender sensitive monitoring an evaluation system (integration)

And finally ….

This is work in progress and we need your support so that programmes are engendered and effective ...