

# Smart Investments to Save More Lives

## Efficiencies, Innovation, Impact from the Mozambique Experience

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# Presentation Objectives

- Describe Mozambique context and experience with costing exercises and economic evaluation
- Define lessons learned for costing process and examples of use of costing data
- Discuss challenges for implementing efficiencies and next steps for PEPFAR Mozambique



# Mozambique Context

- **Population: 20,226,296 (2007 National Census)**
- **Human Development Index Ranking 175<sup>th</sup> of 177 (UNDP, 2006)**
- **Population living on <\$1: 74.7% (int \$ PPP)**
- **< 0.5 physicians per 10,000 population**
- **>60% of health facilities lack water and electricity**
- **>50% of population lives more than 15km from a health facility**



# Health Sector in Mozambique

- Essentially all health care in national health service; negligible private or non-profit services
- Per capita total health expenditure (PPP) \$39
- Percentage of GDP to health: 4.9%
- National AIDS Spending Assessment 2008/2009 demonstrated exponential increases in funding but decrease in Mozambican government proportion
- Percentage of HIV/AIDS funding from external donors: 96%



# HIV Epidemiologic Profile

- **Prevalence: 11.5% in Adults 15-49**  
**(Government of Mozambique AIS, 2009)**
- **Estimated HIV-infected persons: 1.4 million**
- **ART coverage**
  - **ART services in all 128 districts, 220 treatment sites**
  - **170,198 on treatment (MOH 2010)**
  - **30% of persons in need currently on ART**  
**(based on CD4 threshold of 250)**



# PEPFAR Mozambique

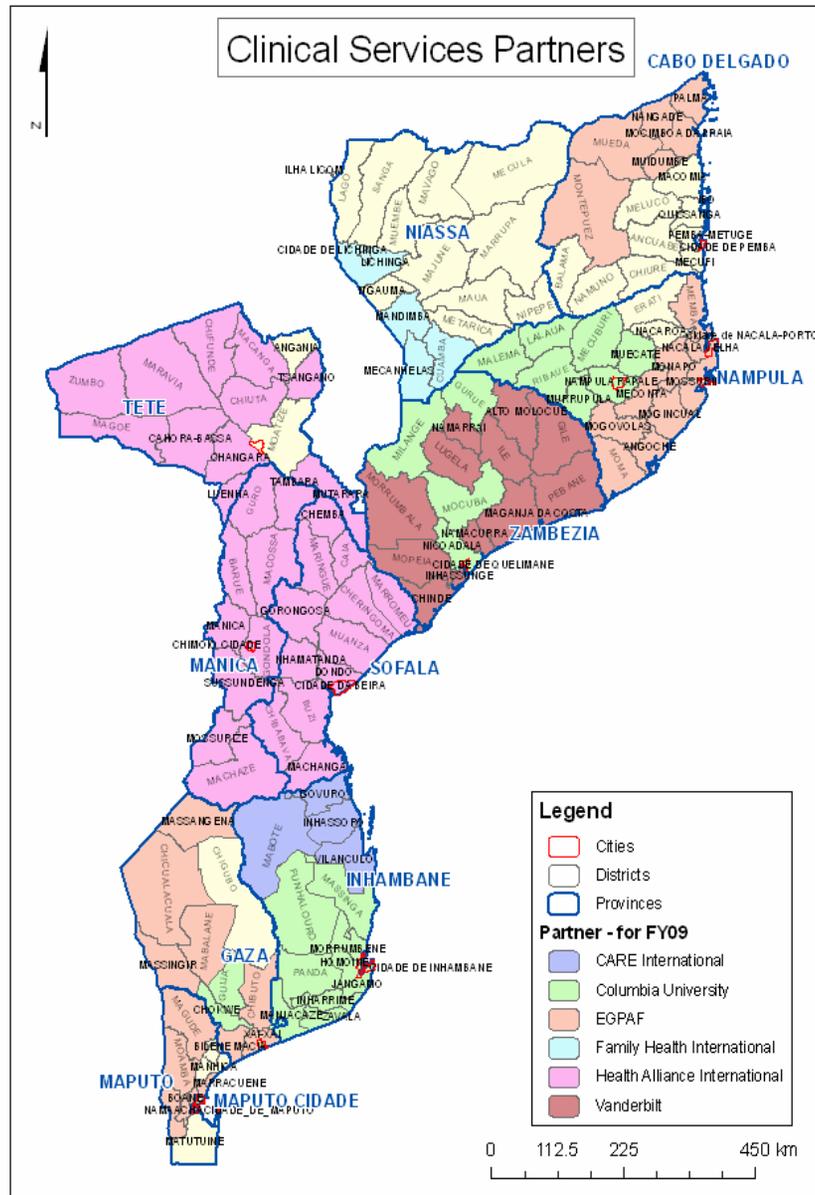
- One of original 15 focus countries; budget increased five fold from 2004 to 2008 and leveled at \$269 million per year
- Support range of care, treatment and prevention services across all 11 provinces
- Significant investments in health systems from the beginning due to severe lack of infrastructure and human resources



# Geographic Partner Rationalization

- Reorganized implementing partners for the 11 provinces
  - Strategy for improved efficiency of services/support
  - Response to Government of Mozambique desire for improved donor coordination and streamlined communications
- 1 PEPFAR clinical service provider per site/facility
- No more than 2 PEPFAR clinical partners per province (1 lead)
- Clinical partners funded for Counseling & Testing at facilities
- First step in reducing duplication and orienting program planning to emphasize efficiencies





Source: COP09. Prepared October 9, 2008 by CDC Mozambique.

# History of Costing in Mozambique

- **2008: Public Health Evaluation by USG, MACRO, and GOM on costing of National ART Program**
- **2009 country operational plan preparation we needed data on costs for treatment services to ensure we could support proposed scale up on proposed budget**
- **Identified funds allocated to treatment partners for health systems strengthening and recoded them for budget clarity**
- **Opportunity to look at budgets relative to targets and start to emphasize strategies to get more for our treatment dollars**



# Taking Costing to the Next Level

- **2009 program planning: formal costing exercise PEPFAR/MACRO**
  - expenditure data reported by partners using standardized tool
  - costing for multiple program areas in addition to treatment
  - started identifying ways to improve costing data
- **Costing workshop conducted in Mozambique for representatives from multiple ministries and academia**
- **Real Life example: costing data for counseling and testing services**



# Real Life Example

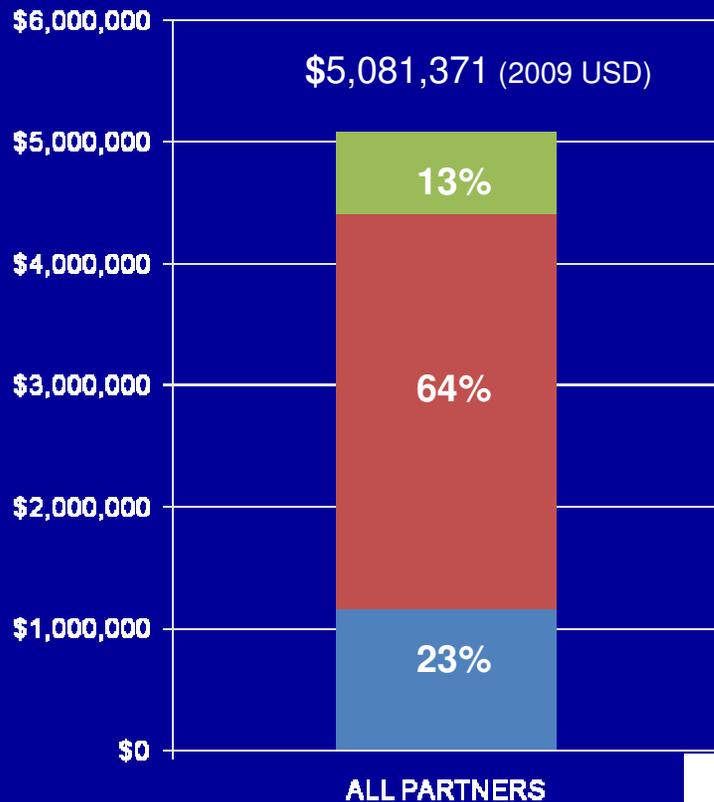
## Counseling and Testing (C&T)

- Will illustrate some key points with the example of C&T data
- 8 partners reported data
- Partners provide a mixture of C&T modalities: provider-initiated, facility-based VCT (ATS), community VCT



# Counseling and Testing Total USG Expenditures

■ Site Development Costs   ■ Site Running Costs  
■ Central Support Costs



## Distribution of USG Costs by Category

Category	ALL Partners	Range
Central Support	13 %	5 %-57 %
Operating	64 %	30 %-84 %
Investment	23 %	2 %-37 %

Variation in proportion of total program resources devoted to each cost category across IPs

Potential explanations

Implementation phase

Additional sources of funding (not included)

Intervention model

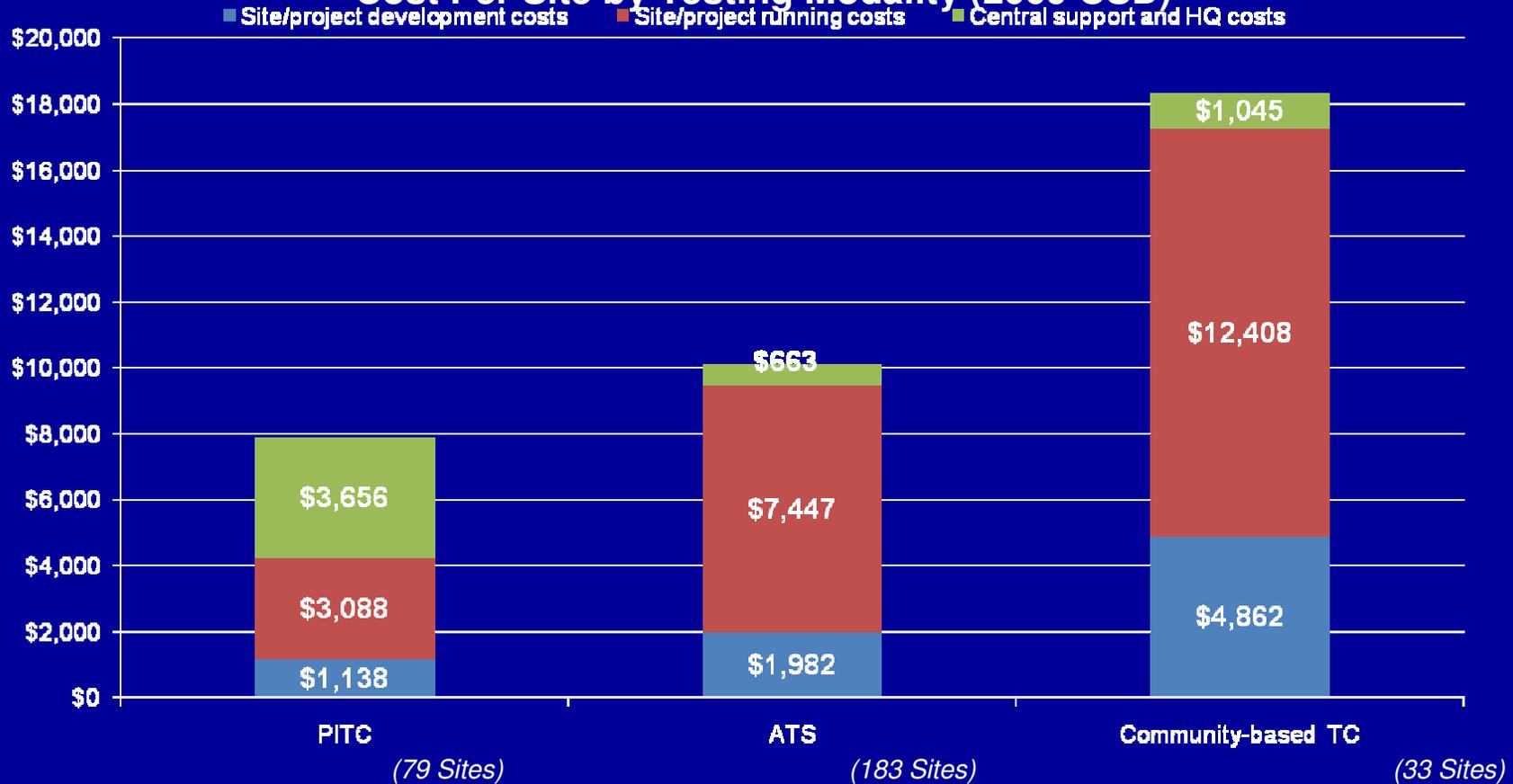
Other?



*\*\*Do not cite\*\**

# Counseling and Testing USG Costs Per Site\*

Cost Per Site by Testing Modality (2009 USD)

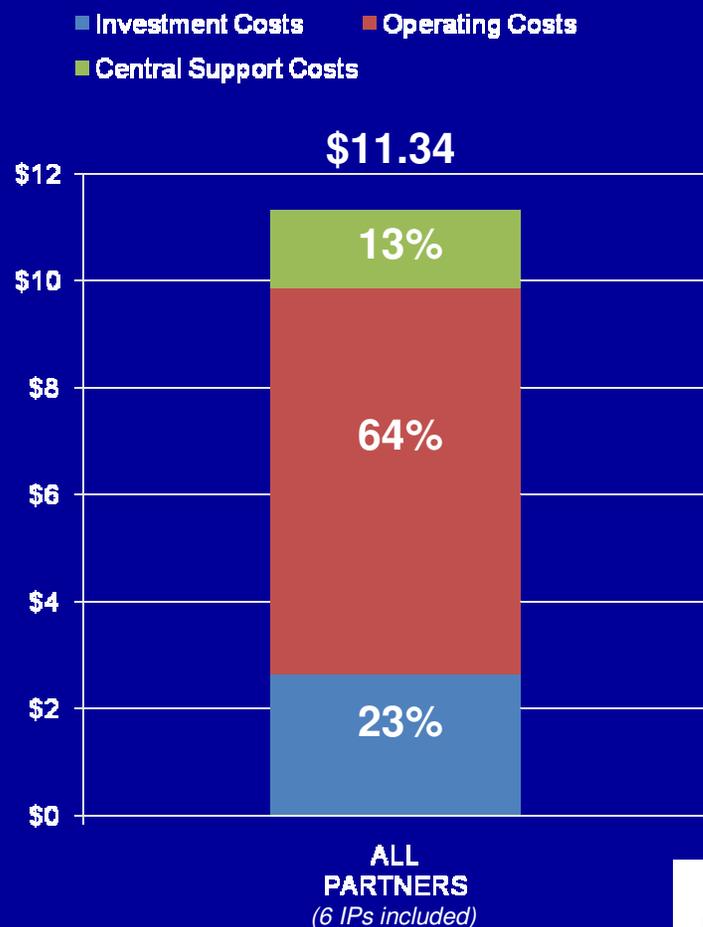


*\*Insufficient data to calculate cost per client by testing modality; however, cost per site serves as a proxy for examining variances in cost due to intervention model*

**\*\*Do not cite\*\***



# Counseling and Testing Mean USG Cost Per Client\*



Cost Per Client by Cost Category (2009 USD)

Category	Mean	Range
Central Support	1.48	0.38-12.41
Operating	7.24	1.66-21.43
Investment	2.62	0.27-5.88
<b>Total</b>	<b>11.34</b>	<b>2.63-32.82</b>

Distribution of Costs by Category

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\*\*Do not cite\*\*



\*USG funding only; based on self-reported financial data requested from PEPFAR IPs

# Costing Data for Budget and Program Planning

- 2010–11 program planning: institutionalizing processes
  - Standardized methods for attributing/reporting
  - Trend analysis to compare partners
- Facility level data on relative costs used to inform partner budget allocations based on their site profiles
  - urban versus rural; new versus established
- Data indicate higher costs per patient treated at health center/district versus provincial/general hospital
  - Implications for costs under planned decentralization by MOH
  - Can use this data with prevalence data to determine areas where treatment expansion will be most cost-effective



# Challenges from Partner and USG Perspectives

- Self-reported financial data allows for misclassification
- Partners can perceive costing evaluations as audits or punitive actions by the donor
- Routine indicators often do not provide clear accomplishments to link to cost-effectiveness analysis
- Indicators for prevention and systems strengthening do not lend themselves to cost analysis under this model



## What Will it Take to Get More from Our Costing Activities?

- Standard forms, standard criteria, TA to partners, standard definitions of terms like “overheads”
- More rigorous M&E on part of USG program staff
- Linkages between outcomes and costs
- Transparent accounting systems within implementing partners designed to capture program expenditure data in manner consistent with standards
- Improved comfort level with economic analysis for both donors and implementing partners



# New Paradigms for Implementing Partners

- **Efficiency is everybody's responsibility**
  - Greater efficiency must translate into more services provided to more people
  - What is a partner's incentive for increased efficiency?
- **Costs must be matched with quality metrics to demonstrate high-quality and efficient service provision**
- **Partner budget allocations need to align with high-quality but efficient performance**



# What Happens in 2011 and Beyond?

- **New contracts and cooperative agreements will contain language mandating routine reporting of key expenditure data**
- **Next iteration of expenditure analysis in 2011 will emphasize partner level outputs relative to expenditures**
  - **Comparisons across partners to increase efficiency through healthy competition**
  - **Analysis of trend data for overall costs to inform portfolio planning**
- **Comparing costing data across implementing partners**
  - **Sharing best practices between partners**
  - **Addressing outliers and identifying extreme variances**
- **Identifying key areas for focused evaluations**



# The E in PEPFAR Isn't Emergency Anymore

- It's EVALUATION
- We need to evaluate programs and cost saving measures to know whether they truly are cost saving and still maintaining quality standards
- Know your epidemic or you will direct funds inefficiently
  - First AIDS Indicator Survey completed/disseminated 2009
  - First behavioral surveillance survey for MARPs (4 groups) in 2011
  - Piloting systems to encourage data use by programs



## A Larger Perspective

- **Costing treatment service provision can't happen in a vacuum: need to look at the rest of the portfolio**
  - What are the most cost-effective prevention interventions and are we using them strategically?
  - What metrics can we apply to assure efficient use of increasing Health System Strengthening investments?
- **Efficiencies begin at home**
  - Further rationalization of partners
  - More rigorous evaluations
  - Find ways to decrease internal USG operating budget



# Thank You

- **PEPFAR Mozambique Program Staff**
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