Co-financing HIV programmes improves overall development results

An investment such as paying for girls' schooling can fall through the gaps if we don't look beyond HIV and take into account broader benefits to education and health. Policy-makers need to stop taking a 'silo' approach to budgeting, where one sector's gain is another sector's loss.

Actions for Policy Makers

- Support the co-financing of structural interventions that have HIV and other health or development benefits.
- Be careful about 'silo' programming: design programmes to achieve multiple benefits.
- Take into account both the costs and benefits of delivery across sectors
- Consider co-financing particularly for programmes with multiple outcomes across different sectors, but for which no sector alone is able to finance the full costs.

Questions for Policy Makers

- What opportunities can you see for co-financing?
- What are the impediments to co-financing in your country?
- Are there opportunities to resolve these?

Why We Need Co-Financing

We know that we can make a measurable difference to HIV rates by paying cash to keep girls in school. But if we look *just* at the HIV benefits, then such an intervention doesn't prove cost-effective. The same is true if policy-makers look at the intervention just through the prism of its benefits to education, mental health, or sexual and reproductive health.

What is needed – for this investment and many others – is for policy-makers to take a broader look at all of the benefits and adopt a 'co-financing' approach.

How Structural Interventions Work

Structural factors – poverty and limited livelihood options, stigma and discrimination, gender inequality and violence, among others – contribute to drive and sustain the HIV epidemic and undermine the effectiveness of proven HIV interventions.

There is considerable interest in investments that seek to address these factors, such as enhanced microfinance, cash transfer schemes and interventions to keep girls in school.

External HIV financing is flat-lining and domestic resources are increasingly expected to sustain and scale up national responses. No longer insulated by earmarked external funding, HIV programmes in resource-limited settings increasingly need to compete with other priorities.

Structural interventions could leverage scarce resources for synergistic investments with benefits that go beyond HIV across health and development.

Sector	Outcome	Post-trial difference between the intervention and control group
HIV	6 HIV infections averted	-0.70%
Education	193 Drop-outs re-enrolled	44.3%
	24 Drop-outs averted	-3.1%
	77 additional school years gained	10.1% change in full attendance (1.5 years)
	English test score improvement	0.14 above mean
Sexual and Reproductive Health	19 HSV-2 infections averted	-2.37%
	10 Teenage pregnancies averted	-3.48%
Mental Health	46 Cases of depression averted	-5.8%

Table 1: Short-term Cross-Sectoral Outcomes from the Zomba Cash Transfer Trial

Assessing the economic benefits

There is a risk that structural interventions will not be prioritised within HIV programme resources, given the perception that they are beyond the remit of the HIV.

Conventionally, investment decisions for HIV are informed by cost-effectiveness analyses that only compare the costs of programmes with their direct HIV outcomes, such as infections averted or 'life years' saved. Budgeting arrangements rarely explicitly factor in the costs and benefits of resource allocation decisions to other sectors.

An alternative and more comprehensive approach that is very rarely used in this field is cost–benefit analysis, which examines whether the overall social benefits generated by an intervention outweigh its costs.

Proving the point with a real-world example

The 2008-2009 Zomba cash transfer trial in Malawi showed that providing an economic safety net can effectively prevent HIV. In the 18-month, US$110,250 intervention, payments were made to 1,225 girls (13–22 years) and their households, with payment conditional on school attendance for 506 of the girls. 18 months later, HIV was 64% lower among school girls who received the payment, compared to those who did not.

Other benefits included improvements in school enrolment, attendance and English test scores, as well as significant reductions in the prevalence of Herpes simplex virus type 2, school drop-out, teen pregnancy and depression.

We can compare three approaches to deciding whether to finance this intervention:

- In the first approach, HIV and non-HIV budget holders would conduct a joint, cross-sectoral cost-benefit analysis and would fund the intervention if the benefits outweigh the costs. This should lead to an efficient allocation across sectors. Using this approach, the intervention would be financed, generating a long-term net benefit of US$404,088.

- In the second, 'silo' approach, each sector considers the intervention in terms of their own objectives and funds the intervention on the basis of their own thresholds of cost-effectiveness. When sectors budget in isolation without considering other sectors' benefits, none would be willing to fund the intervention.

- In the third, 'co-financing' approach, budget holders use cost-effectiveness analysis to determine how much they would be willing to contribute towards the intervention, assuming that other sectors cover the remaining implementation costs. If the sum of each sector's maximum contributions would be greater than the full implementation cost, the intervention would be funded.

What this means for the HIV Sector

Embedding HIV responses into broader national priorities would further encourage domestic ownership and sustainability. HIV programmes should actively seek opportunities to co-finance development efforts that have been shown to produce direct HIV benefits.

This approach has implications for the design of HIV interventions. For example, removing the conditionality of the cash transfer may reduce the cost of the intervention without impacting HIV outcomes – but this may affect educational outcomes, making it less attractive for the education sector and therefore less likely to be co-financed.

How to achieve coordination

The best, most efficient approach would be for budget allocations to structural interventions to be incorporated at a centralised Ministry of Finance/Treasury level, before budgets are allocated to sectors.

This may be possible as part of joint public expenditure planning processes (e.g. Medium-Term Expenditure Frameworks), but in practice may fall through the gaps given their complexity.

A second-best scenario could involve setting up a basket-funding mechanism, whereby other sectors become donors of a programme that would be implemented by a single line ministry.

Some examples of such joint budgeting initiatives for health and social care can be found in high-income countries, generally targeting specific patient groups or broader health promotion efforts.

In countries where donor funds are important, this could also be a mechanism by which multilateral or bilateral aid earmarked for HIV is channelled towards structural approaches.

National AIDS Coordinating Authorities operating as supra-ministerial and cross-sectoral coordination bodies in several countries could play a key role in facilitating such processes and serving as an example for other cross-sectoral issues.

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RethinkHIV is a consortium of senior researchers who will evaluate new evidence related to the costs, benefits, effects, fiscal implications and developmental impacts of HIV interventions in sub-Saharan Africa, in order to maximise contributions to the fight against HIV. The aim is to find ways of creating, optimising and sustaining fiscal space for domestic HIV investment, as well as exploring long-term, sustainable national and international financing mechanisms. **RethinkHIV** is funded by RUSH Foundation.

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FUNDING DISRUPTIVE IDEAS AGAINST HIV

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