Introduction to global health strategy: theory and examples

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Montreal, Canada

Topics for today

What is strategy

- Ideally, it is a selection of an optimized choice based on rational assessment of evidence and weighing of trade-offs

Getting strategy right is important

- With the wrong strategic choice, businesses go bankrupt, or in public health, more people get sick or die
- With optimal strategic choices, resources and outcomes are maximized

Bad strategy vs. good strategy

- Why does bad strategy happen?
- How can good strategy be developed?

Real life examples of strategy development

- Advising South Africa on how to mobilize sufficient resources to achieve HIV epidemic control

Introduction to Pharos – using evidence to drive action

	Hepatitis C (HCV)	Nutrition	Adolescent Health	Country Transitions in global health
Strategy and program development	GILEAD	NUTRITION INTERNATIONAL KIRK HUMANITARIAN	Gavi The Vaccine Alliance	The Global Fund To Fight AIDS, Tuberculosis and Malaria
Policy dialogue	Unitaid	TATA TRUSTS		
Investment case development/ evidence-based advocacy	PLUS COALITION INTERNATIONALE SIDA	ELEANOR CROOK FOUNDATION NUTRITION INTERNATIONAL Nourish Life	JOHNS HOPKINS UNIVERSITY The Global Fund To Fight AIDS, Tuberculosis and Malaria	UNAIDS Center for Global Development

Pharos

What is strategy? A pop quiz

Which one of the statements below accurately and completely describes a strategy:

a. A world with zero preventable maternal and child deaths

b. Invest $200M dollars over the next 5 years in cost-effective maternal and child health interventions to avert 100,000 deaths

c. Reach 1 million women and children sustainably and equitably with lifesaving interventions

d. Achieve world peace

Pharos

Strategy is: a set of ***guiding principles*** that, when communicated and adopted in the organization, generates a ***desired pattern of decision making.***

A strategy is therefore about how an organization should ***make decisions and allocate resources*** in order to accomplish ***key objectives***.

A good strategy provides a ***clear roadmap***, consisting of a guiding plan, that defines the ***actions*** people in the business should take (and not take) and the things they should ***prioritize*** (and not prioritize) to achieve desired goals.

Michael Watkins

Pharos

Strategy is just one component of an overall strategic direction

1 Vision

Motivation

2 Mission

"What" will be achieved

3 Strategy

How resources should be allocated to achieve mission

4 Roadmap

Resources, partners, timelines, sequence to implement

Strategic direction

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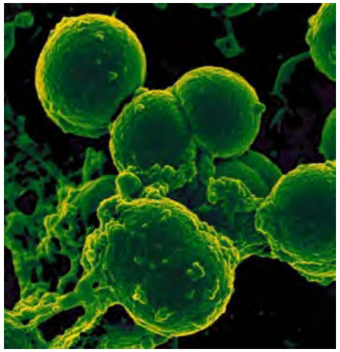
Good strategy enhances competitiveness and outcomes



Successful strategy depends upon the ability to foresee the future consequences of present initiatives

Where do we start to build a strategy?

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Good strategy vs. bad strategy

Bad	Good
Jack Welch: "reach for what appears to be the impossible"	**Wayne Gretzky: "skate to where the puck is going to be" [and be ready to shoot]**
1. Develop a **vision** to be the best or the leading or the mightiest 2. Develop a **mission** statement of the purpose of the organization, incorporating sustainability or other popular elements 3. List non-controversial **values** such as integrity, respect and excellence 4. Create some **goals** but call them strategies.	1. **Develop a diagnosis** to simplify complexity and identify the most critical obstacles 2. **Define a guiding strategic plan:** develop and test scenarios, and define an overall approach to overcome the problems identified in the diagnosis and maximize outcomes 3. **Identify and implement coherent actions:** Coordinated steps to implement the guiding strategic plan

Three basic elements of good strategy development

1 **Diagnosis and assessment**	• What are the future opportunities? • What are the looming threats/risks? • Are we ready for change?	• What are we good at? • What are our weaknesses? • What is our risk tolerance?
2 **Guiding policy (strategic plan)**	• Develop set of options based on diagnosis • Evaluate options based on objective criteria • Set strategic plan based on clear understanding of opportunities, risks, tradeoffs	
3 **Coherent actions (roadmap)**	• Define what we will need to do to be ready to implement the guiding strategy	• What we will need in terms of financial, human, & technical resources • Monitor execution and course correct

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Failures in business come from failures to get one or more of the three elements right

KODAK	FUJIFILM	Failed to diagnose and adapt to new digital marketplace
Sears	THE HOME DEPOT	Pursued wrong strategy to merge with Kmart
BLOCKBUSTER	NETFLIX	Incoherent action: reversed decision to invest in online and went back to retail

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Similarly, failures in global health come from failures to get one or more of the three elements of good strategy right

Fail		Consequence	Reason
Inadequate response to Ebola outbreak in 2014	→	>11,000 deaths, $53B cost to economies	Poor diagnosis of importance of cultural factors/obstacles, weak guiding principles, slow response
America's failure to control gun violence	→	39,000 deaths per year, $229B annual cost	Policy and political will failure, poor diagnosis
Iatrogenic HCV epidemic in Egypt	→	15% seropositive, $4B annual economic cost	Wrong action to re-use needles as part of schistosomiasis control campaign

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Good strategy development in real life

Diagnosis and analyses

- Interviews with internal and external experts
- Epidemiological analyses
- Assessment of organizational capabilities
- Competitive landscape
- Development and testing of options

Strategic plan

- Rationalization of current needs against future opportunities
- Rationalization of risks vs potential
- Development and assessment of options
- Setting of strategic direction
- Calculation of return on investment

Roadmap

- Determination of additional resources, including financial, human, and technical that will be needed to implement
- Timeline and sequence of implementation
- Milestones
- Framework for evaluation

Examples of strategic questions that we've helped our clients solve:

How to:

- Justify new investments in national scale up of programs to eliminate Hepatitis B and C in 6 countries of Asia and Africa
- Help countries plan for and achieve self-sufficiency in managing their own disease control programs after donors withdraw support
- Make the case to mobilize the resources needed to reach the World Health Assembly targets to end malnutrition
- Make the case to replenish the Global Fund's $15B target for AIDS, TB, and Malaria
- Create forward-strategies for global health organizations to be more effective in how they allocate their funding

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Revisit the pop quiz

Which one of the statements below accurately and completely describes a strategy:

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b. Invest $200M dollars over the next 5 years in cost-effective maternal and child health interventions to avert 100,000 deaths

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d. Achieve world peace

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Strategy and Analysis in Action -- South Africa

Aids2031 and the HIV/TB Investment Case feature:

- Problem Identification
- Diagnosis/Analysis
- Strategic Planning
- Development of an Action Roadmap
- Adoption and Implementation of the Roadmap
- Monitoring and Evaluation
- Mid-course Readjustment

Also combine data and tools (you learn at McGill) from: epidemiology, disease modeling, costing and financial analysis, political analysis and facilitation of consensus building

THE LONG RUN COSTS AND FINANCING OF HIV/AIDS IN SOUTH AFRICA

Prepared by the

Centre for Economic Governance and AIDS in Africa

and

Results for Development Institute

JUNE 2010

CEGAA
CENTRE FOR ECONOMIC GOVERNANCE AND AIDS IN AFRICA

RESULTS FOR DEVELOPMENT INSTITUTE

Overview of aids2031-South Africa

- South Africa project carried out during 2008-2010
- Linked to a global multi-country assessment of AIDS costs and financing options
- Sponsored and guided by SA National Steering Committee
- High level meetings with the SA Health Minister and the South Africa AIDS Council chaired by the Vice-President of SA
- Technical work by a joint South African and International team (CEGAA and Results for Development)
- Part of the larger aids2031 project led by Peter Piot, former Executive Director of UNAIDS

aids2031®

The Problem

South Africa is facing a major and mounting financial challenge as it strives to respond to the HIV/AIDS epidemic in the country. South Africa has 5.7 million people currently infected with the HIV virus, the largest number in the world, and half a million adults and children are becoming newly infected each year (UNAIDS, 2009). The funding needed to respond to HIV/AIDS on three critical fronts—for prevention, treatment, and care of orphans and others affected by AIDS—is continuing to escalate rapidly, especially as hundreds of thousands of additional South Africans enter antiretroviral treatment (ART) programmes. This situation poses huge financial dangers and risks for the country, particularly at a time when South Africa is feeling the negative effects of the global economic recession and is struggling to maintain its government budget for a wide range of pressing needs including education, housing, job creation, and other health priorities beyond HIV/AIDS.

The legacy of neglect and inaction

(from a 2015 paper by the top four SA AIDS officials)

Abstract For the past 25 years, South Africa has had to deal with the inexorable and monumental rise of HIV. From one or two isolated cases, in the late 1980s, South Africa now has an estimated 6.4 million people infected with HIV, with high rates of concomitant tuberculosis, which will profoundly affect the country for decades to come. For nearly 10 years, the South African government's response to the HIV epidemic was described as denialist, which was estimated to have resulted in the deaths of 330,000 people because lifesaving antiretroviral therapy (ART) was not provided (Chigwedere et al. J Acquir Immune Defic Syndr. 49:410–15, 2008;

(from a 2016 paper In Science on the eve of the Durban conference)

When it last hosted this international gathering in 2000, then-President **Thabo Mbeki and his health minister questioned whether HIV even causes AIDS**, triggering widespread outrage. At the time, only the wealthiest South Africans had access to ARVs, which cost about $5000 per person for an annual supply.

The Strategic Issues

- What combination of services (prevention and treatment) can turn the tide of the epidemic? What impact will they have?
- How much money will be needed for a strong and effective national HIV/AIDS program?
- How can available financial resources be used more efficiently?
- Who will pay for these critical HIV/AIDS activities in the future (government, private sector, donors)?

South Africa: Scenarios for the Future of AIDS

The Drivers:

- Political will (higher/lower)
- Pace of social norm change (fast/slow)
- Outlook (emergency/long-term)
- Financial capacity (higher/lower)
- Implementation capacity (constrained/unconstrained)

Scenario 1: National Strategic Plan (NSP)

Political will to achieve universal access is strong; short term outlook; few implementation constraints

Rapid scaling-up of prevention & treatment over short period, then maintenance of levels

- Achieving NSP targets for 2011-12 and sustain
- Treatment – old regime at 200 CD4 threshold
- PMTCT single dose till 2009, replaced by dual therapy
- Early pediatric ART from 2009
- No Male Circumcision

Scenario 2 – Expanded NSP

AIDS seen as a long-term problem: greater focus on interventions to reduce vulnerability; slower but more sustained scale up to higher levels; no long-term funding constraints

Achievement of NSP (& extra) targets by 2021

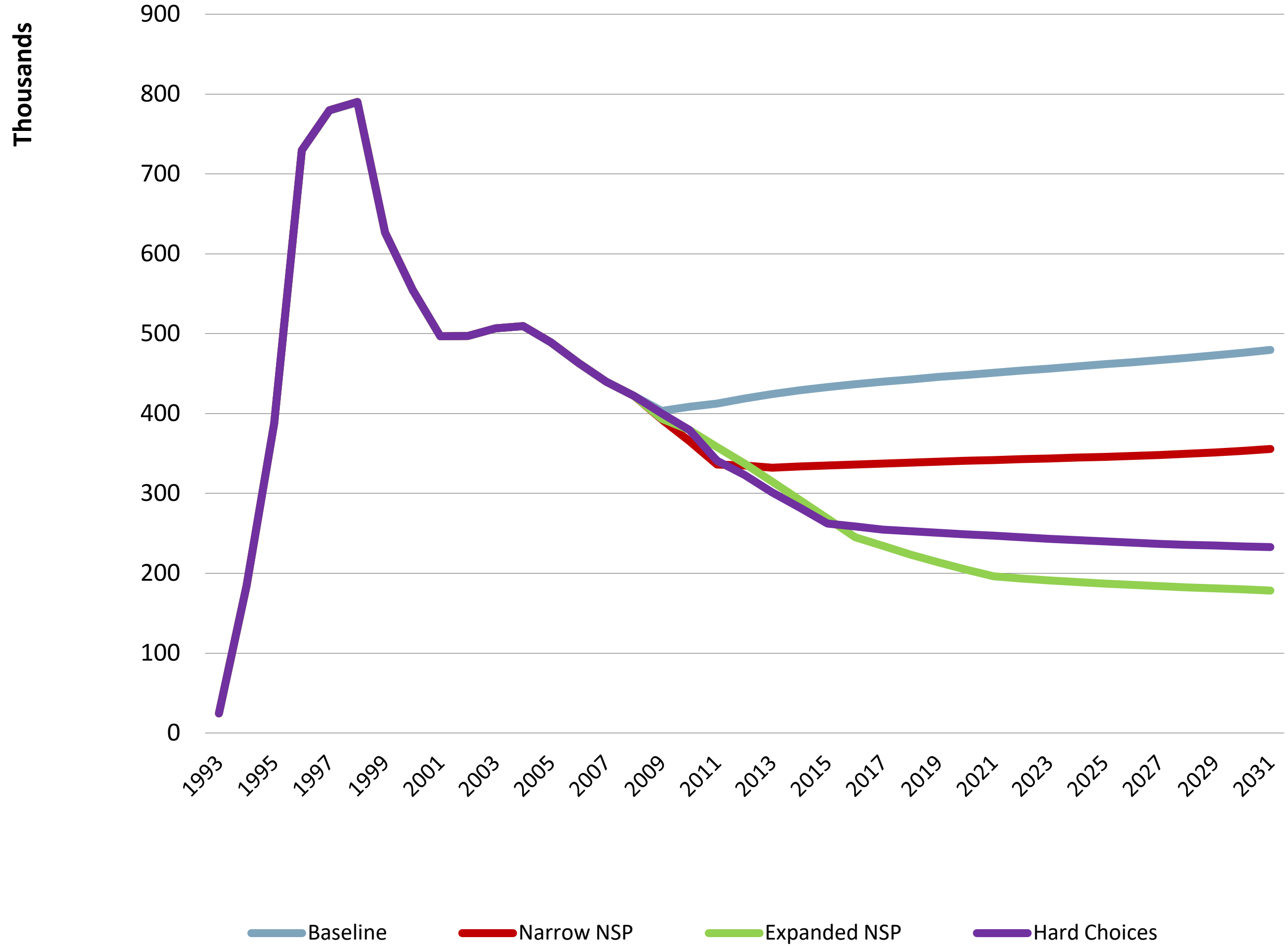
- ART - new regime & CD4 threshold = 350
- VMMC introduced 2010, reaching 60%
- Expanded workplace programmes, education, behaviour change
- Mobilization and higher coverage for Key Populations: SW, MSM
- Expanded efforts for out-of-school youths
- Programs to reduce violence against women

Scenario 3 – Hard Choices

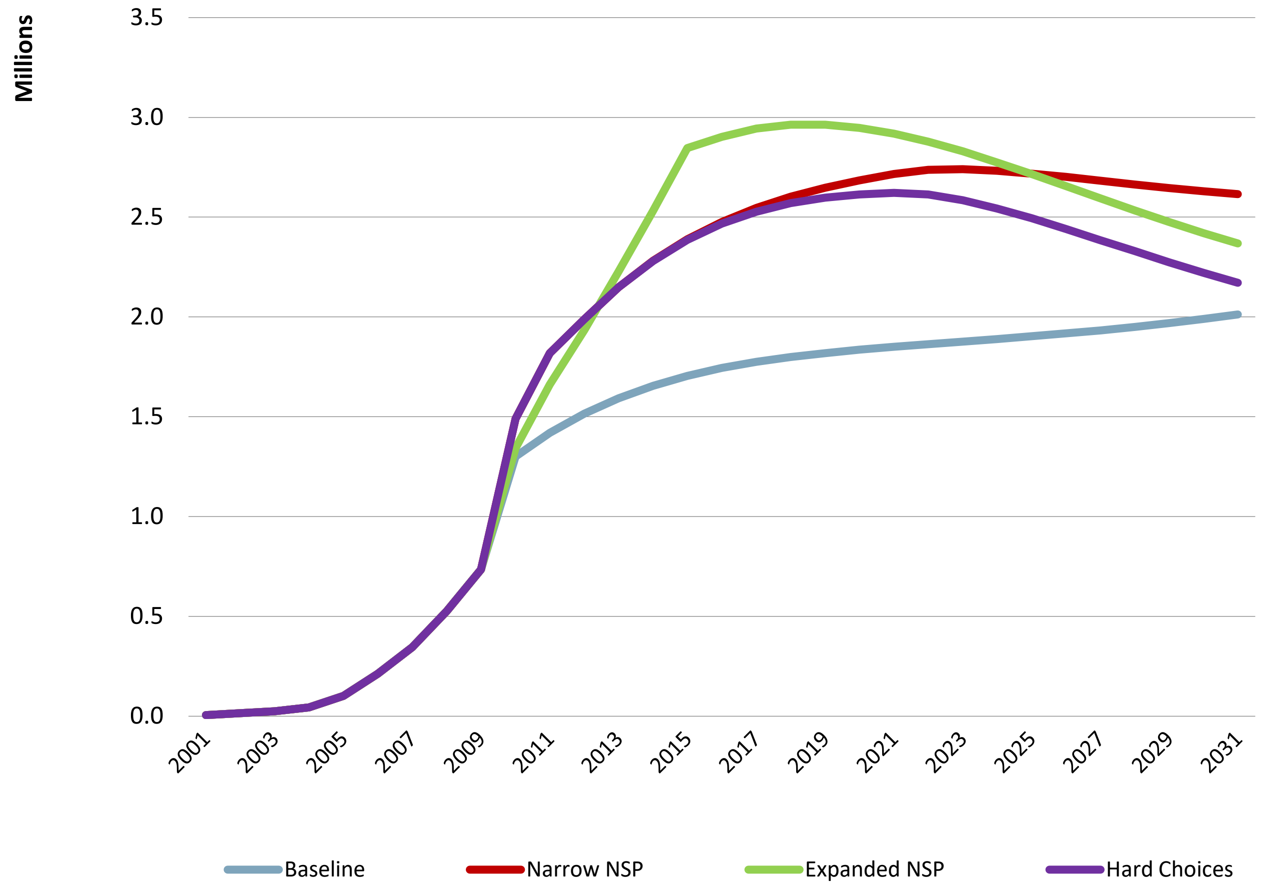
Resources are limited; focus on scaling up to the most cost-effective prevention interventions; other prevention and social programs reduced; targets achieved by 2015

- Increased coverage for youth in school, condoms, male circumcision, SW & MSMs, STI treatment
- Maintaining current coverage for HCT, child grants
- Reduction below NSP targets for mass media, youth-out of-school, workplace, HBC, palliative care, food parcels, uniforms & other mitigation
- Same ART effort as under NSP

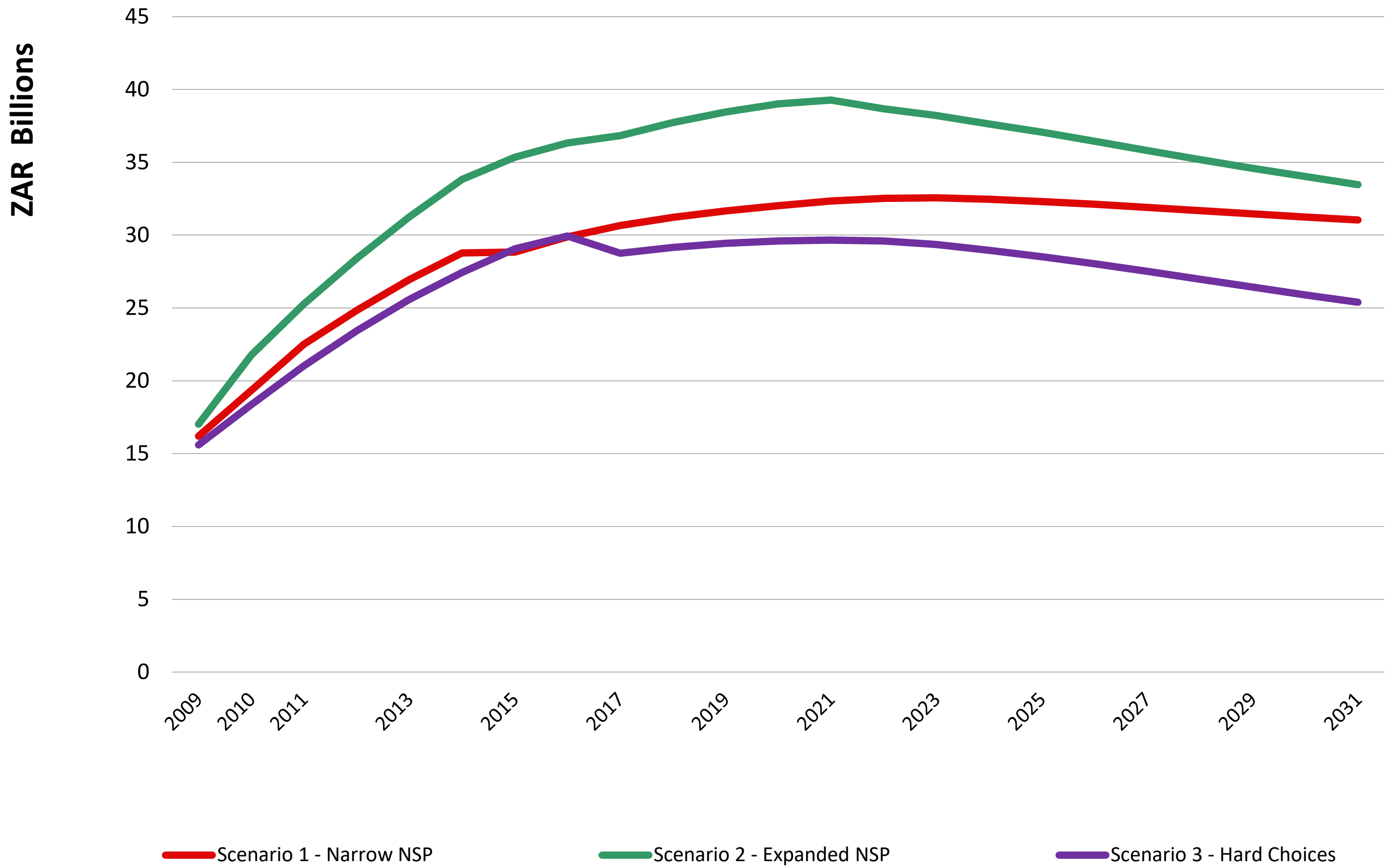
South Africa: New Adult HIV Infections, 1993-2031



South Africa: Adults Receiving ART, 2000-2031



South Africa: Total AIDS Funding Required, 2009-2031 (R billions)



Summary of Main Scenario Results

	Status Quo/ Baseline	Expanded NSP	Narrow NSP	Hard Choices
Total new infections 2009-31 (millions)	11	5	8	6
New Infections in 2031 (thousands)	500	180	360	230
Adult prevalence 2031 (percent)	17	10	15	11.5
Total AIDS deaths 2009-31 (millions)	8.1	4.4	5.9	5.8
Number of ART patients 2021 (m)	1.8	3.0	2.7	2.6
Total cost 2009-31 (R billions)	NA	765	658	598
Total annual cost in 2021 (R billions)	NA	39.3	32.3	29.7
Of which ART in 2021 (percent)	NA	65	70	74

Key Findings

- SA's epidemic is deeply entrenched: past and current dynamics make reversal extremely difficult over the next two decades
- Under scenarios studied, there will still be a substantial number of new infections and prevalence will remain high for the next two decades (>10% of adults) -- in the absence of a technology breakthrough or radical behaviour change
- Nevertheless, SA faces choices today that will have large positive (or negative) consequences for future costs and health outcomes

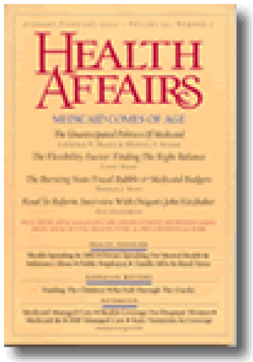
Wise Choices Matter: SA at the Crossroads

- If resources are limited, wise policy decisions on prevention can make an important difference: Hard Choices averts more infections & costs less than Narrow NSP

- With a more robust budget and willingness to tackle social issues and pursue a maximum prevention strategy, the rate of new infections can be curbed substantially
  - Under Expanded NSP approach, national incidence reduction targets can be achieved - but at a higher cost
  - Stronger prevention now will have important knock-on effects on lowering treatment costs in the long run

aids2031

www.resultsfordevelopment.org



Critical Choices In Financing The Response To The Global HIV/AIDS Pandemic

Costs could rise to $35 billion a year by 2031—unless the world takes dramatic steps to avert the worst outcomes.

by Robert Hecht, Lori Bollinger, John Stover, William McGreevey, Farzana Muhib, Callisto Emas Madavo, and David de Ferranti

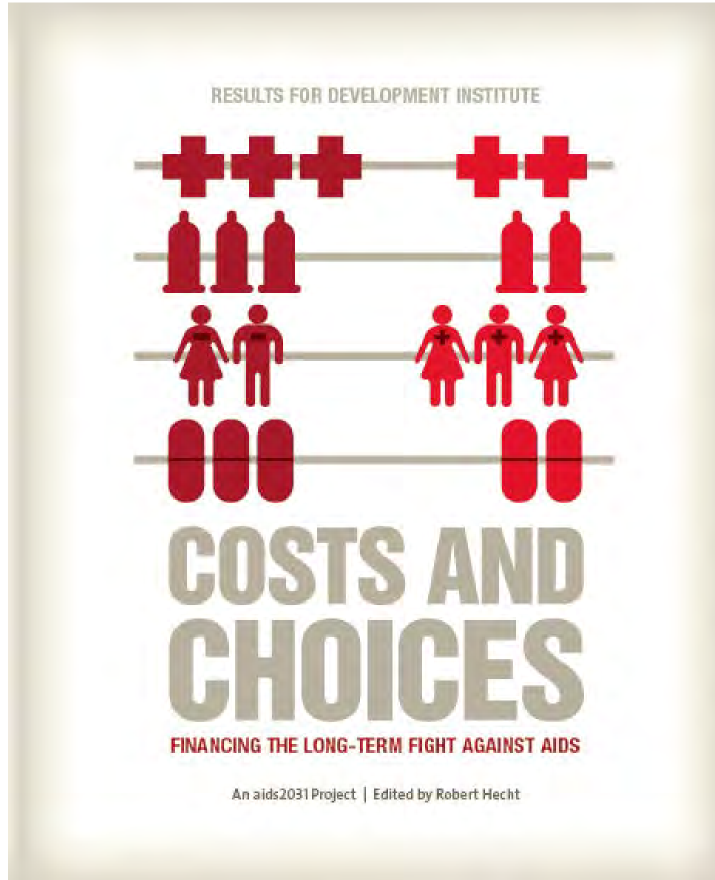
ABSTRACT: The AIDS pandemic will enter its fiftieth year in 2031. Despite much progress, there are thirty-three million infected people worldwide, and 2.3 million adults were newly infected in 2007. Without a change in approach, a major pandemic will still be with us in 2031. Modeling carried out for the AIDS 2031 project suggests that funding required for developing countries to address the pandemic could reach $35 billion annually by 2031—three times the current level. Even then, more than a million people will still be newly infected each year. However, wise policy choices focusing on high-impact prevention and efficient treatment could cut costs by half. Investments in new prevention tools and major behavior-change efforts are needed to spur more rapid advances. Existing donors, middle-income countries with contained epidemics, philanthropists, and innovative financing could help bridge the likely funding gap. [Health Aff (Millwood). 2009;28(6):1591–605]

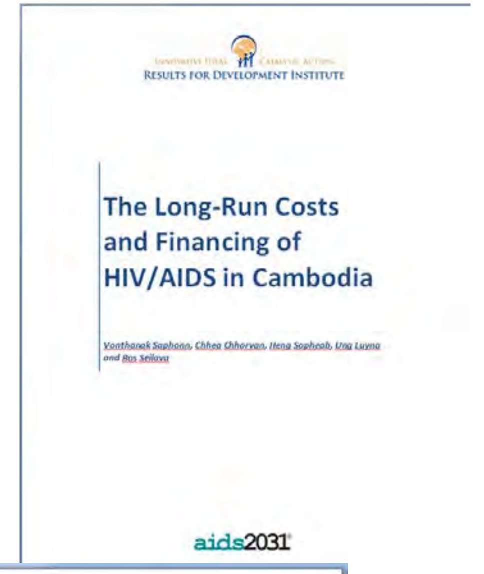
By 2031, the HIV/AIDS pandemic will enter its fiftieth year. In 1981 no one expected that the epidemic would become the formidable challenge it is today. Despite progress in responding to the pandemic over the past twenty-five years, there are still thirty-three million people living with HIV; 2.3 million adults became infected with HIV in 2007.[1] Without a change in approach, a major epidemic will still be with us in 2031.

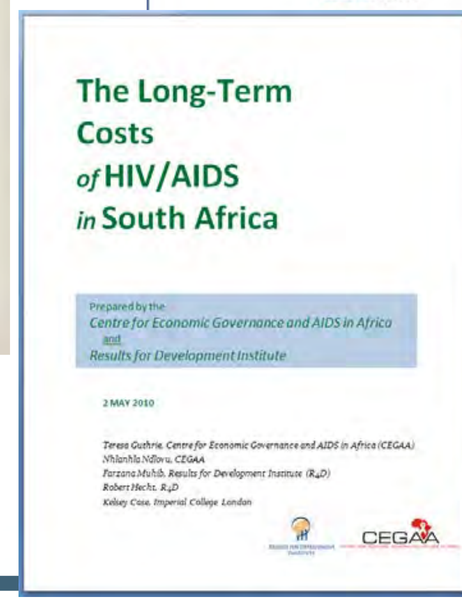
The AIDS 2031 project[2] was established to ask what might be done differently to alter the course of the AIDS pandemic significantly and positively. The goal: that by 2031 there would be few new infections, nearly all of those needing treatment would receive it, and AIDS orphans would be assisted to live normal lives.

Robert Hecht is a managing director of the Results for Development Institute in Washington, D.C. Lori Bollinger (LBollinger@futuresinstitute.org) is vice president of the Futures Institute in Glastonbury, Connecticut. John Stover is president and founder of the Futures Institute. William McGreevey is an associate professor in the Department of International Health at Georgetown University in Washington, D.C. Farzana Muhib is a program officer at the Results for Development Institute. Callisto Emas Madavo is a visiting professor at Georgetown University. David de Ferranti is president of the Results for Development Institute.

DOI 10.1377/hlthaff.28.6.1591 ©2009 Project HOPE–The People-to-People Health Foundation, Inc.







BBC WORLD SERVICE Health Check

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CEGAA CENTRE FOR ECONOMIC GOVERNANCE AND AIDS IN AFRICA

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Six years later….

Also from the article by the SA AODS leaders

Heywood 2004). However, the story of the HIV and AIDS response in South Africa over the past 5 years is one of great progress after almost a decade of complex and tragic denialism that united civil society in a way not seen since the opposition to apartheid. Today, South Africa can boast of close to 3 million people on ART, by far the largest number in the world. Prevention efforts appear to be yielding results but

trum in older age groups. As a result of the massive increase in access to ART after 2004 and particularly after 2008 as political will towards the HIV ART programme improved, there has been a marked increase in life expectancy, from 56 to 61 years in the period 2009–2012 alone; the aggressive expansion of the prevention of mother to child transmission (PMTCT) to HIV-positive pregnant women has been accompanied by dramatic decrease in HIV transmission to infants; and a 25 % decrease in child and infant mortality rates in the period 2009–2012. This progress in access is significantly due

More on the turnaround...

And from the Science paper in 2016

But by the end of 2015, the price had dropped to $100, and 3.4 million HIV-infected South Africans were receiving ARVs—more than in any other country in the world. South Africa, in fact, consumes the same amount of the life-saving drugs as Asia and the Paci c, North America, and western and central Europe combined.

As a result, life expectancy jumped 9 years between 2005, when ARVs started to become widely available, and 2014. The country has pioneered innovative ways to deliver the drugs and help people stay on them. And South Africa's strong cadre of HIV/AIDS investigators has made the country a hub of cutting-edge basic research and clinical trials.

Financing South Africa's HIV Response

Aaron Motsoaledi
Minister of Health, South Africa

Mcebisi Hubert Jonas
Deputy Minister of Finance, South Africa

Michel Sidibé
Executive Director, UNAIDS

Deborah Birx
Global AIDS Coordinator, United States

Mark Dybul
Executive Director, The Global Fund

Moderated by
Mia Malan
Director and Editor
Bhekisisa: M&G Centre for Health Journalism
South Africa

With technical introduction from
Robert Hecht
Results for Development Institute

Organized by
National Department of Health
South Africa
In partnership with
UNAIDS
Results for Development Institute

UNAIDS

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Financing South Africa's HIV Response: Much to Celebrate, Much Left to Do

Robert Hecht

Results for Development Institute

Durban, South Africa

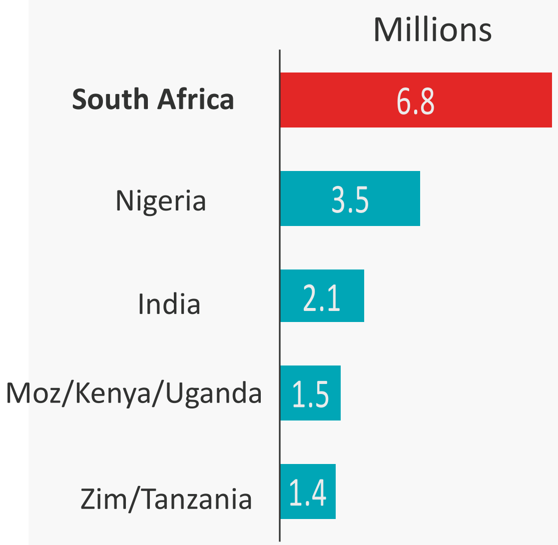
19 July 2016

Satellite Symposium at the 21st International AIDS Conference

RESULTS FOR DEVELOPMENT

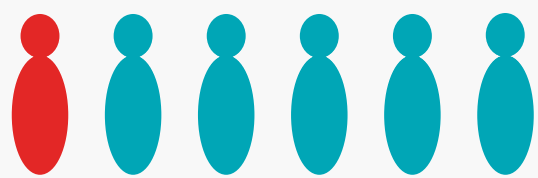
Why South Africa matters so much…

6.8M HIV-infected people live in **South Africa**, more than any other country



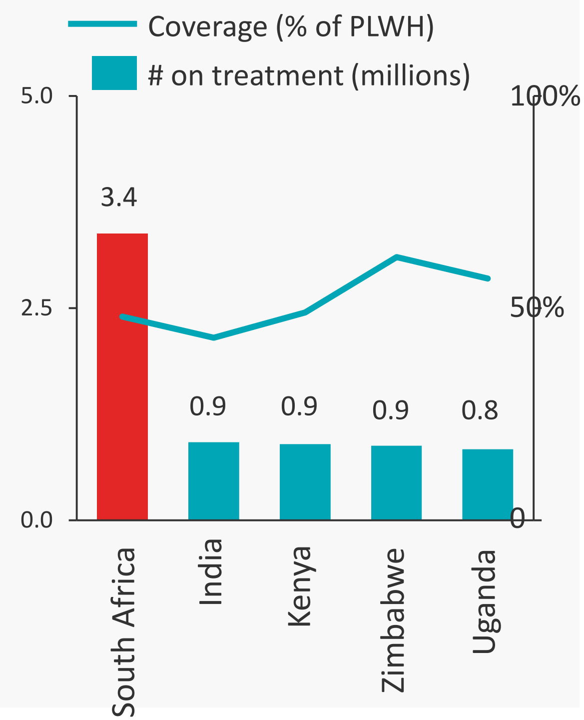
Most number of PLHIV

1/6 of all new infections occur in **South Africa…**



…about **340,000** new infections per year

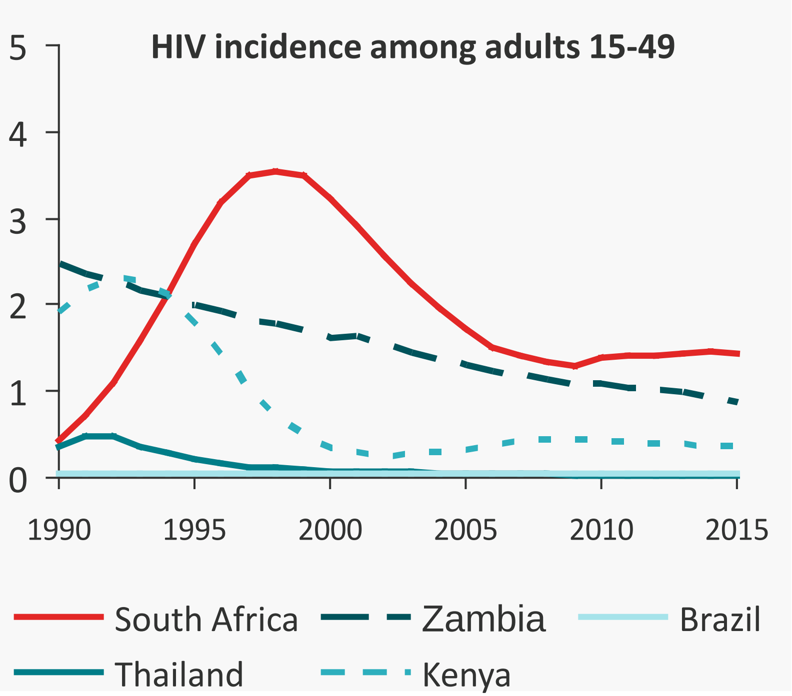
Most new infections



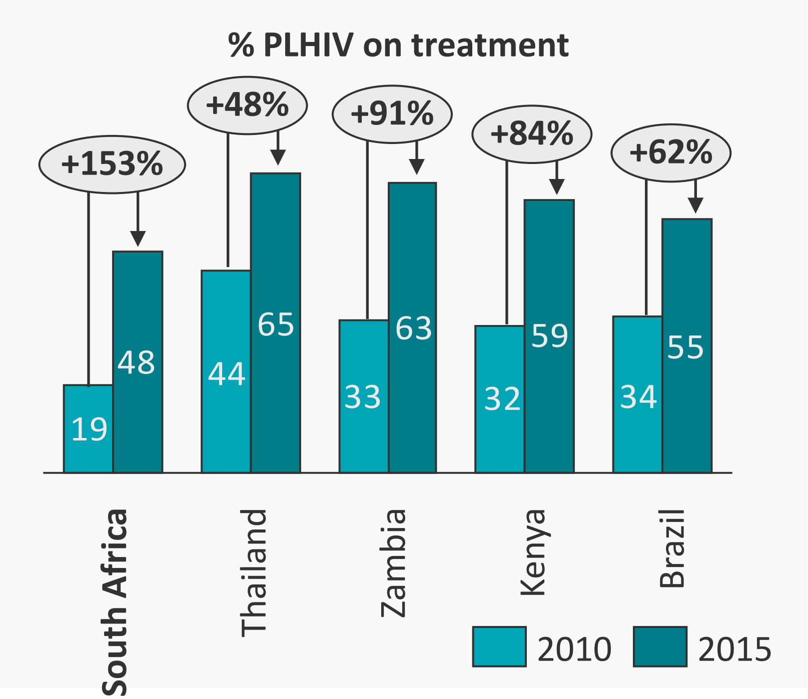
Most patients on treatment

Data notes: all data in the left and right panels are reported for 2015 at aidsinfo.unaids.org. South Africa's new infections in the center panel is reported in the HIV and TB Investment Case for 2013. The total number of new infections globally for that year (2.1 million) comes from aidsinfo.unaids.org.

South Africa started late but has since made dramatic progress



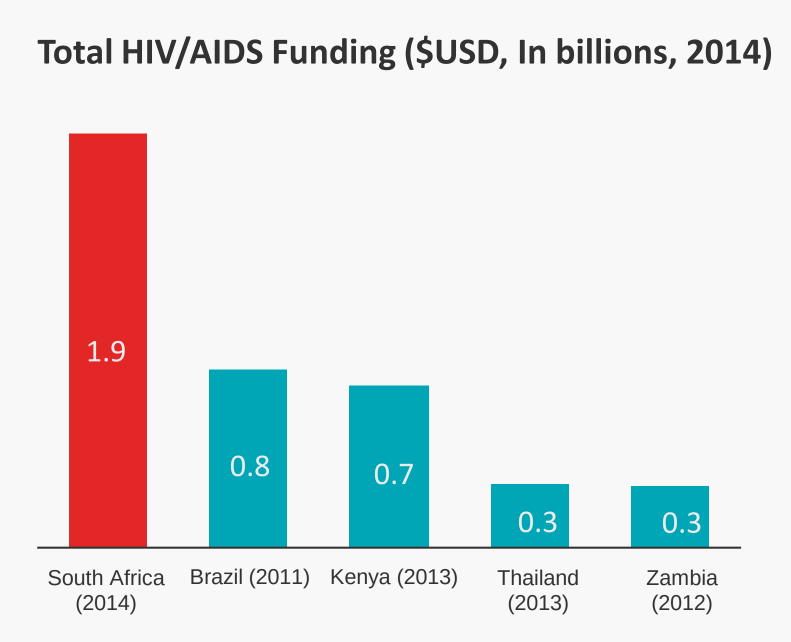
The decline in new infections came later in South Africa…

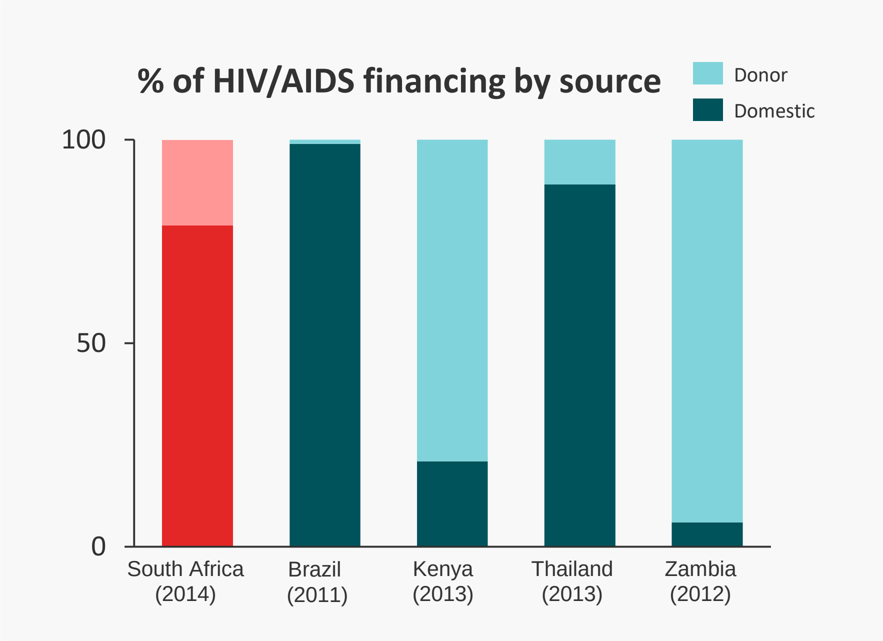


…but coverage has accelerated rapidly

Data notes: these data come from aidsinfo.unaids.org.

Increased financing has propelled and underpinned the growth in coverage





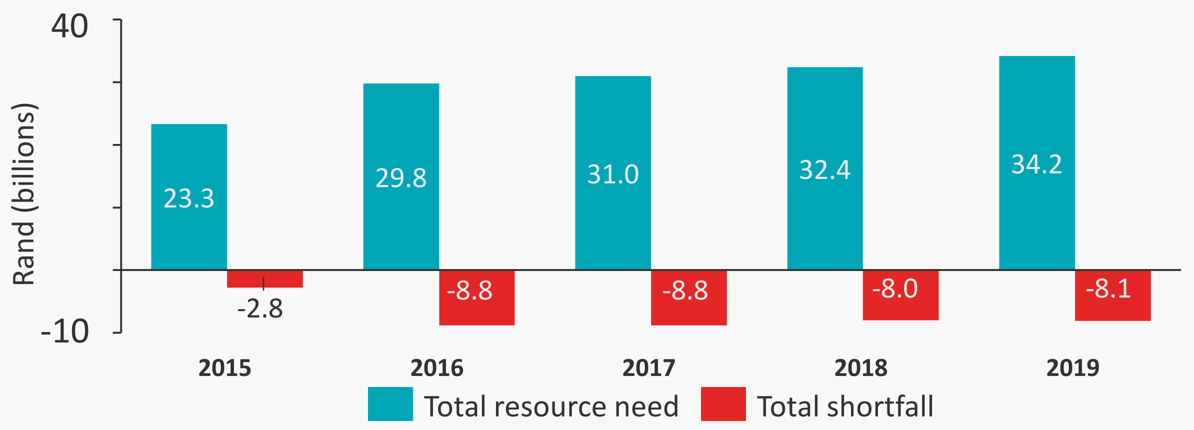
South Africa is the largest spender among LMICs…

…and finances the majority of HIV services with domestic resources

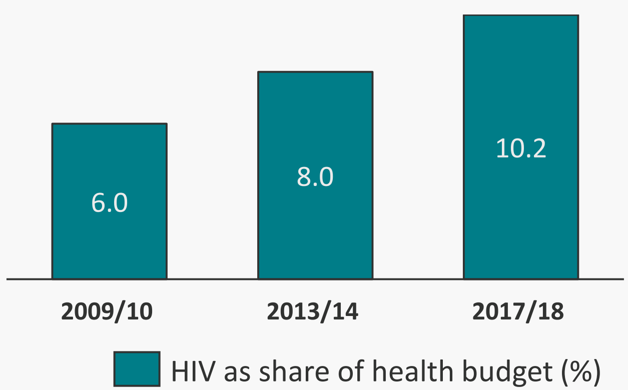
Data notes: these data come from aidsinfo.unaids.org.

The work is not done: despite successes, there are still major challenges to be addressed

Significant financial gaps remain before epidemic control can be achieved



Increased HIV spending risks crowding out other health priorities

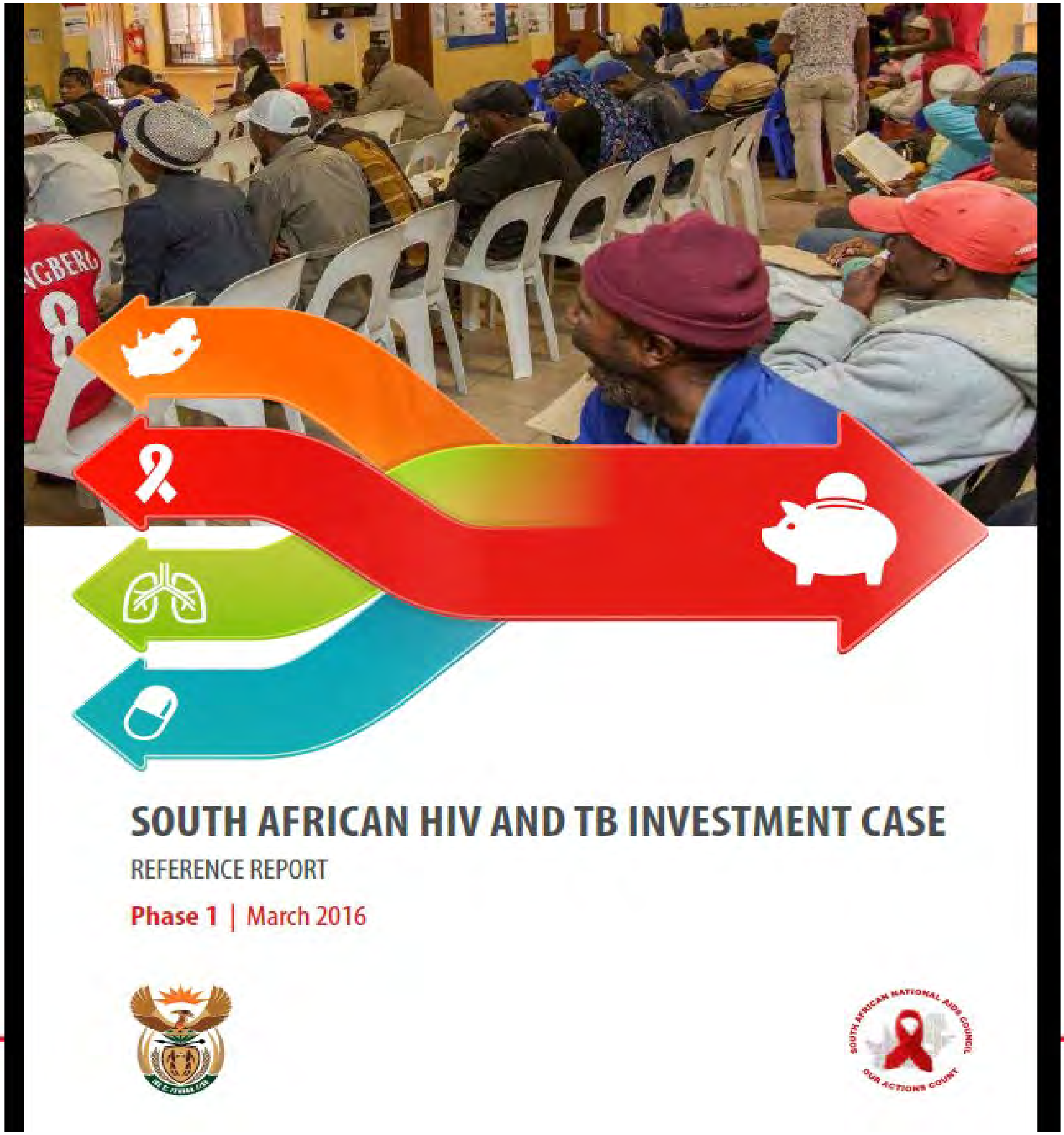


Data notes: the top panel is a recreation of Figure 1 in the South African HIV and TB Investment Case. Data in the bottom panel come from R4D's analysis of South Africa's Estimates of National and Provincial Expenditure.

How will South Africa keep funding its HIV scale-up? Strategies to get the most out of every Rand

Lower drug and procurement costs	Enhance workforce efficiency	Maximize program effectiveness & efficiency	Increase sustainability	Improve coordination
Procurement and market shaping, especially for diagnostics and $2^{nd}/3^{rd}$ line drugs	Downward task shifting Better supervision of HCWs and other inputs	Adherence counseling, community and family support Get the money to where the problem is most acute -- target high prevalence districts	Sustain the effort financially with stable long-term domestic sources – integration with PHC, incorporation in NHI	Avoid waste and unplanned gaps – better coordination and carefully designed transitions among Government and Partners

The Strategy Cycle Continues



“When people are **determined** they can **overcome** anything”

“It always seems **impossible** until it’s **done**”

-Nelson Mandela