

## POINT OF VIEW

### Costing of HIV/AIDS Strategic Plans Experiences from Asia

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*This Point of View is based on work in Asia on costing and HIV/AIDS Strategic Planning Processes. The paper briefly introduces the RCA (Rapid Cost Assessment) approach that has been successfully applied in Nepal. The RCA approach is developed by EASE International in cooperation with key stakeholders in Nepal. DFID has funded the original work. The views expressed are solely the views of the author.*

## Costing of HIV/AIDS Strategic Plans Experiences from Asia

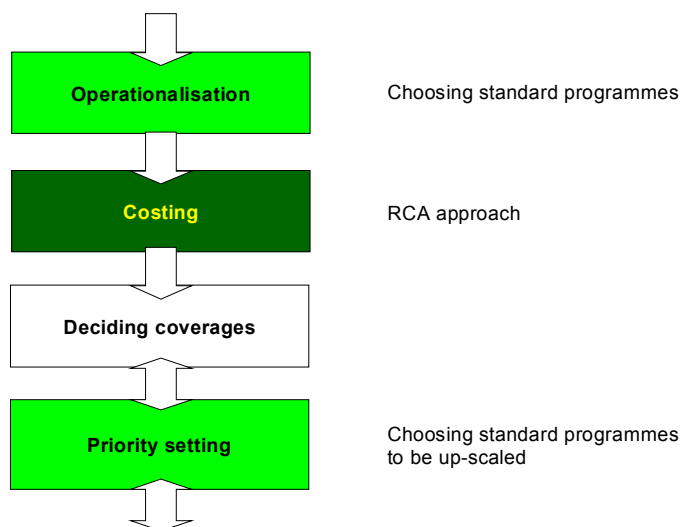
By Anita Alban

### Introduction

The HIV epidemic in the Asia region remains most places concentrated within specific populations: injecting drug users (IDU), commercial sex workers (CSW), men who have sex with men (MSM), truckers and migrant workers (MW). The HIV strategic planning process serves as the mechanism to ensure an appropriate response and prevent the concentrated epidemics or low prevalence epidemics to spread further. Put differently: Many peoples' welfare and lives depend on how intelligently the HIV Strategic Planning process is carried out and how efficient the response is implemented.

Most of the countries in the Asia region have gone through the initial stages of the strategic planning process and have developed a Strategic Plan covering five years. However, the national plans have not been costed and little attention has so far been paid to the cost-effectiveness of the planned interventions. The resource need to implement the plan is thus not yet determined for many of the countries.

### Selected steps of the Strategic Planning process



This Point of View focuses mainly on costing of the Strategic Plan. However, costing takes an operationalised plan. The inter-link between “spelling out” the plan (what components are included in a youth programme etc.) and the costing of the individual activities of the response is often not included in the formulation of the strategic plan. As a consequence the costing process will have to incorporate both steps simultaneously as lined out in the figure above. During the costing process coverage of individual activities need to be determined to arrive at the total cost. Although some strategic plans make preliminary choices of interventions the priority setting process builds on the

## POINT OF VIEW: Costing of HIV/AIDS Strategic Plans in Asia

information collected on both costing, cost effectiveness, possible coverage scenarios of interventions and potential resources mobilised. The strategic planning process is a dynamic process that needs continuous monitoring and evaluation and adaptations to implementation realities as they emerge.

### Why develop national unit costs

During the costing process it is fundamental that a discussion takes place among all stakeholders on the issues that needs to be addressed to scale up the response to HIV. Capacity and approach taken/standard set are important elements to be included in the up-scaling process. In practice scaling up means to built on boutique projects (projects of limited scope and coverage) to formulate sustainable programmes taking into account the human and institutional capacities in the country.

*Local costs bring ownership, transparency and cost consciousness into the strategic planning process and it strengthens partnership and commitment.*

There is a number of reasons for developing national unit costs and not only applying global figures from sources such as The World Bank, 2000, Schwartlander et al., 2001 and Creese et al., 2002. At country level global figures serve as reference for unit costs – they do not replace them. The costing of the national HIV Strategic Plan is an integrated part of the Strategic Planning process. It will inevitable provoke a debate on the up-scaling procedure to be

undertaken (the standards for up-scaling: what is the government/donors prepared to fund as a minimum intervention). Local costs bring ownership, transparency and cost-consciousness into the strategic planning process and it strengthens partnership and commitment between the country and the donors. These features are necessary to ensure joint commitment from all stakeholders (government, NGOs, UN, bilateral donors, PLWHA). National unit costs are superior to global figures because they are country specific, in line with the national strategic plan, and assist significantly to create awareness of cost implications and perhaps most importantly they fertilise the ground for priority setting. If global cost figures are used they need to be adjusted to capacity differences, price differences, and institutional differences and even programme differences.

### Costing of HIV/AIDS Strategic Plans

The optimal scheme for costing of a national plan is local cost studies of implemented programmes or standard interventions for a scaled up programme. However, very few countries in the Asia region have available cost studies for the various interventions included in the National Strategic HIV/AIDS Plans. If studies are available, e.g. a study on VCT and CSW, that utilises the economic principles as outlined in the UNAIDS Costing Guidelines (2000) they should be included. Another hindrance for using national cost studies of HIV programmes is that the programme standards are not developed and only a limited number of projects are implemented. Costing of the National Strategic Plans is now urgent since resources are increasingly being mobilised in the region. This calls for alternative costing strategies for operationalisation of the plans that meet the need for urgency. The increased global attention and willingness to deal appropriately with the global HIV/AIDS epidemic is putting pressure on countries to cost their national plans. The time constraints imposed, e.g. for applications to the GFATM further adds to this. The Rapid Cost Assessment (RCA) approach accommodates the time constraint.

### The RCA approach

The RCA framework including an accompanying spreadsheet tool has been developed for and tested in Nepal in August 2002. The tool is flexible to fit other settings in the region. However, the process of costing: discussing what is involved in transforming boutique projects to up-scaled programmes, and the debate with government and NGOs of sustainable programme standards are beneficial in its own right. In many countries in the region the hard issue facing the planners and decision makers at present time is to decide the programme standards and cost their elements/components.

The RCA approach includes the following steps:

1. Selection of HIV/AIDS interventions included in the National Strategic Plan
2. Definition of “standard” HIV programmes for up-scaling
3. Collection of available cost data from projects already being implemented or being planned
4. Organisation of panels of implementers/programme managers of ongoing or planned projects to discuss the cost data available for an up-scaled programme
5. Validation of approach/standard (content of programme) comparative to Best Practice
6. Collection of default cost data, preferably from the region to act as reference data
7. If all this fail the application of “global” unit cost data can be used, e.g. from the Goals model<sup>1</sup>, from the Schwartzlander et al, 2001<sup>2</sup>, the World Bank Report, 2000<sup>3</sup> or Creese et al, Lancet, 2002<sup>4</sup>
8. Collection of data on cost-effectiveness of the various programmes to assist in facilitating the continuing Strategic Plan process on priority setting.

The RCA approach assists in developing *unit costs* for HIV interventions relevant for individual countries. Unit costs are optimal for planning purposes (including scaling up) but cannot be used for assessing cost-effectiveness. For this the total costs for all parties need to be included. Examples of unit costs are:

- Costs per CSW per year
- Cost per person trained, peer educator (PE)/year
- Cost per migrant worker (MW) trained/year
- Cost per client receiving HAART/year or lifetime
- Cost per client receiving care package/year or lifetime

Once the national unit costs have been developed the process starts of bringing the interventions to scale and/or decide on the coverage of interventions in the short (work plan) and longer run (goal).

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<sup>1</sup> [http://www.futuresgroup.com/Goals\\_model](http://www.futuresgroup.com/Goals_model)

<sup>2</sup> Schwartzlander et al, Science, 2001, Vol. 292: 2434-2436

<sup>3</sup> World Bank. Costs of scaling HIV program activities to a national level in Sub-Saharan Africa. November 2000

<sup>4</sup> Creese, Floyd, Alban, Guinness. Lancet, 2002, Vol. 359: 1635–42

## POINT OF VIEW: Costing of HIV/AIDS Strategic Plans in Asia

**Table 1. Examples of unit costs from Asia and outside**

Unit per Intervention	US\$	US\$	US\$	US\$	US\$	US\$
	Nepal	India	Bangladesh	Cameroon	Belarus	Global <sup>5</sup>
Cost per IDU/year	60		60		41 <sup>2</sup>	12.6
Cost per CSW/year	41	28 <sup>3</sup>	60	60-84 <sup>1</sup>		
Cost of VCT/client	19					10.6
Care package/lifetime	500	200 <sup>4</sup>				375

The overall *costing principle* in the RCA approach is incremental or full economic cost. Full economic cost is used when it is relevant (no available infrastructure). Incremental cost does not include infrastructure/capital costs and general overhead. It is recommended to focus on extra staff, extra training, extra drugs, extra test kits, extra condoms, extra furniture etc. Economic costs will include expenditures of staffing (whether volunteers or paid personnel) and commodities (condoms, test kits) whether provided by a donor or bought by the supplier. The perspective of the costing is the provider. Only the costs for providers such as government, NGOs are considered but the costs incurred to the clients such as transport, user fees and time spent, e.g. on VCT and treatment are excluded. However, the consumer perspective is essential for explaining the success/failure of the programme.

An example of information included is presented below:

### Example: Voluntary Counselling and Testing (N= 750)

<u>Selected HIV interventions</u>	NRs		US \$		
	<u>Cost</u>	<u>Cost</u>	<u>Reference</u>	<u>Year</u>	<u>Origin</u>
<b>VCT activities</b>					
Training	12.860	165			
Couns. remuneration	364.000	4.667			
Supervision	22.560	289			
Investments	70.000	897			
Running costs/unit	100.000	1.282			
Testing	292.500	3.750			
Condoms	3.510	45			
Programme managemnt.	129.815	1.664			
M+E (10%)	99.524	1.276			
<b>TOTAL</b>	<b>1.094.769</b>	<b>14.035</b>		2002	Nepal

<sup>1</sup> Creese, Floyd, Alban, Guinness. Lancet, 2002, Vol. 359: 1635-42

<sup>2</sup> Kumaranayake et al. UNAIDS, Geneva, DRAFT, May 2000

<sup>3</sup> UNAIDS, South Asia and NACO, 2001

<sup>4</sup> NACO, 2001

<sup>5</sup> Schwartlander et al, Science, 2001, Vol. 292: 2434-2436

## POINT OF VIEW: Costing of HIV/AIDS Strategic Plans in Asia

*No of clients 750/year, 75% capacity*

<b>Cost per VCT client</b>	<b>1.460</b>	<b>19</b>	2002	Nepal
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### **Reference cases**

<b>Cost per client</b>		29-31	2000	Ken.&Tanz
<b>Cost per person CT, clinic</b>		14	1999	Uganda*

### **Cost-effectiveness**

VCT costs US\$ 18-22/DALY(Sweat et al, 2000 prices)

The cost per HIV averted was \$393 in Kenya and \$ 482 in Tanzania (Sweat et al, 2000 prices).

## **The use of costs in the Strategic Planning Process**

The unit cost is not only a figure, it provides the basis for serious monitoring and evaluation of costs as the National Strategic Plan is being implemented. A number of potential areas are:

- Monitoring of the unit cost over time
- Comparison with cost studies as they become available
- Monitoring of cost components across programmes, e.g. STI services provided in outreach CSW and IDU programmes, unit costs in rural and urban settings.

### ***Working with unit costs***

*Low unit cost does not necessarily mean that the implementation is successful. Low spending could mean that few people are using the services.*

It is highly recommended that cost and impact of programmes become part of the monitoring and evaluation system. Outcome measures such as CSW/IDU/MW reached are preferable to measures such as CSW/IDU/MW intended to be covered within the scheme.

The costs arrived at in the RCA approach are economic costs from the provider perspective. These are not necessarily the cost needed for other purposes such as programme budgeting or an application for the GFATM.

### **Priority setting**

***“Being strategic is about being responsive to change and about being able to set priorities”<sup>1</sup>***

It is the responsibility of strategic planners to advise decision-makers on making best use of scarce resources. In this regard, cost-effectiveness analysis is the tool of choice that enables programme managers and planners to make informed choices about resource allocation. It identifies the relative efficiency of alternative activities by comparing costs and results or outputs.

Focusing on the cost-effectiveness or efficiency of the response involves continuously asking questions such as what are the costs involved in a specific activity or group of activities in the programme and what do we achieve with the money? To reach this strategic point takes an

<sup>1</sup> UNAIDS Best Practice Collection, Module 4. Guide to the strategic planning process for a national response to HIV/AIDS. August 2000.

<http://www.unaids.org/publications/documents/responses/national/una0021e.pdf>

## POINT OF VIEW: Costing of HIV/AIDS Strategic Plans in Asia

operationalised and costed plan. Further, given the need to intervene urgently priority setting also has to consider which activities can be rapidly scaled-up. In the short term, effective activities that can be scaled up quickly need to be identified. For rapid scaling-up, the potential to use the existing infrastructure to achieve widespread coverage must be maximised (The World Bank, 2000).

The use of cost-effectiveness information in the Strategic Planning process is useful as an aid for setting priorities given a budget constraint, but also for decisions on coverage of individual interventions.

### Procedure of RCA

The RCA approach operates at three levels of information exemplified below with information from Nepal:

#### Example, VCT

*Level 1* data is basically the assumptions spelled out. The unit is: *cost per client* (the choice of client is important since it is assumed that each client makes two visits/sessions – some studies use cost per session and will need adaptation). Since counsellors will have to be trained, training is part of the cost of the services. In the case of Nepal it was assumed that on average the counsellors are trained one week/year. The next step includes the cost of a counsellor per year incorporating local salaries and % capacity (as a start it is assumed that each counsellor trained will use 75% of her capacity which is optimistic at the start of a new programme). It is further assumed that each counsellor is being supervised 10 days per year. Next it is decided if investments are necessary (office furniture, paint) to get started, and how many condoms per visit each client will receive. Finally, the cost of testing is added. The most expensive part of the VCT programme is remuneration of counsellors and rent. It obviously matters a lot if the salary of counsellors is changed. If for example the monthly salary of a counsellor in Nepal is changed from NRs 12 000 to 14 000, the unit cost will change from US\$ 18 to US\$ 19 – see example page 5-6.

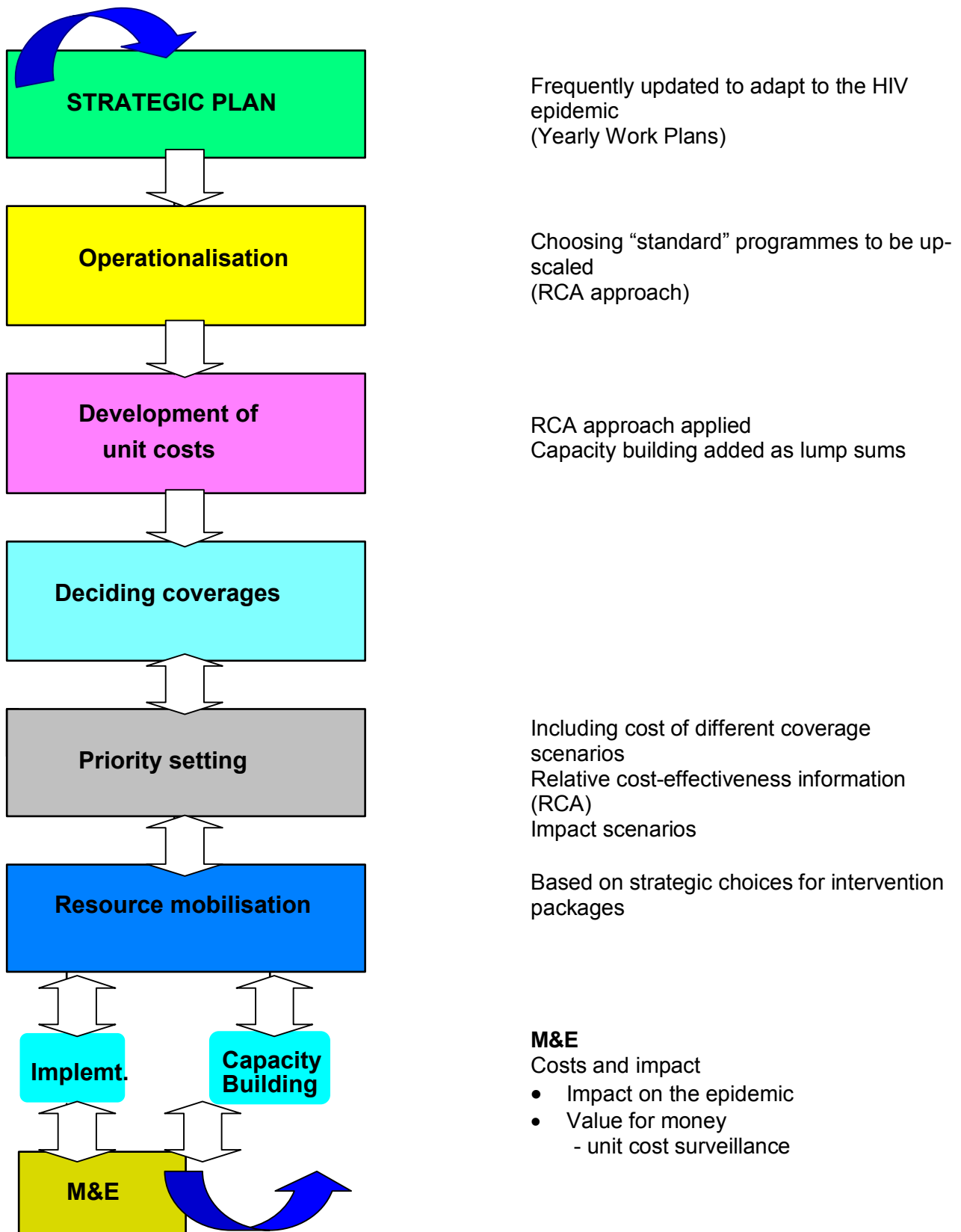
*Level 2* data provides an overview of the main cost components including a calculated unit cost, but it adds reference studies of unit costs as well as cost-effectiveness figures to guide the priority setting process. The most important information for planning is perhaps the list of assumptions that needs careful consideration before adaptation of the RCA approach in alternative settings. The quoted reference cases of VCT services from Kenya and Tanzania have calculated a unit cost of US\$ 29-31 (independent clinics, full costs) and the reference case from Uganda (excluding overhead) has calculated a unit cost of only US\$ 14. The cost-effectiveness of VCT is US\$ 18-22 per DALY (Disability Adjusted Life Years) and US\$ 393 and US\$ 482 per HIV averted in Kenya and Tanzania respectively. This makes VCT a relatively good investment as both a care and prevention intervention and something worth pursuing.

*Level 3* data includes the total need of resources to carry out the National Strategic Plan and shows the proposed allocation of resources in main programmes (vulnerable groups, youth, care).

All the three levels of data are *interlinked* in the RCA spreadsheet tool. The cost components calculated at level 1 *automatically* feeds into level 2 with added information on reference studies and cost effectiveness. At level 3 the unit cost is *automatically* imputed from level 2 and multiplied with the proposed coverage figures to show the total resource need in the planning period. If one main assumption is changed in an important activity the resource need is automatically re-calculated.

# POINT OF VIEW: Costing of HIV/AIDS Strategic Plans in Asia

## The Strategic Planning Process, simplified



## POINT OF VIEW: Costing of HIV/AIDS Strategic Plans in Asia

### Important links and key references:

Creese, Floyd, Alban, Guinness. Cost-effectiveness of HIV/AIDS interventions in Africa: a systematic review of the evidence. Lancet. 2002. Vol. 359: 1635-1642

Goals model: [http://www.futuresgroup.com/ Goals model](http://www.futuresgroup.com/Goals_model)

Schwartzlander et al, Science, 2001, Vol. 292: 2434-2436

World Bank. Costs of scaling HIV program activities to a national level in Sub-Saharan Africa. November, 2000

UNAIDS. Costing Guidelines for HIV Prevention Strategies. Key Material. UNAIDS, Geneva, 2000

UNAIDS. Guide to the strategic planning process for a national response to HIV/AIDS. Resource mobilisation. Module 4. Key Material. UNAIDS, Geneva, 2000

**For further information on the RCA tools, please contact: [ease@easeint.com](mailto:ease@easeint.com)**