

## POINT OF VIEW

### **Priorities of AIDS interventions in Africa Principles and Practice in five countries**

Anita Alban



*This Point of View is based on experience from four African countries and independent work on cost-effectiveness of HIV/AIDS interventions. The paper was first time presented at the XIV International AIDS Conference, July 2002 in Barcelona. The views expressed are solely the views of the author.*

## Priorities of AIDS interventions in Africa Principles and Practice in five countries

*By Anita Alban*

### **Summary**

This appraisal examines the ways priorities are set for HIV/AIDS in high prevalence countries and proposes strategies to improve the allocation of resources for interventions. The strategies focus on achieving greater benefits for vulnerable populations and on reaching a balance of resources between care and prevention. The appraisal assesses the HIV/AIDS strategic plans for five African countries with high prevalence and a mature epidemic resulting in large numbers of people living with AIDS. The main findings concern the goals of National Strategic Plans: targets are not attained in a systematic manner taking into account efficiency and equity; budgets are unrealistic; and mechanisms to match original priorities to the resources actually mobilised are not available. Inclusion of costing and cost-effectiveness in the priority setting process will significantly improve the national responses to the HIV epidemic.

### **Introduction**

In order to turn the tide of the HIV/AIDS epidemic in the most affected countries, attention must be given to the ways additional resources mobilised at the beginning of the 21<sup>st</sup> century are spent. The new money comes from the Global Fund for AIDS, Tuberculosis and Malaria (GFATM), The World Bank's Multi-Country AIDS Programme (MAP), and increased bi-lateral and private funding. Even when viewed optimistically, there is little prospect in the near future of a global mobilisation of extra US\$ 6.2 million per year estimated as required for an adequate global response (Commission of Macroeconomics and Health, 2001).

For the past 5-7 years countries have developed National HIV Strategic Plans. The Plans are based on a situational analysis of the HIV epidemic in the country and provide, at least in principle, the country's priorities for fundraising. The process of formulation of the National Response is often long; many stakeholders are involved at both the country level and in the international community. Since the first Plans were formulated, new issues have emerged that influence the environment of the National Response. These include the need to up-scale interventions that have proved successful and the significant price reductions for developing countries of the Highly Active Anti-Retroviral Treatment (HAART). As a consequence there is an urgent need for increased awareness and understanding on the part of decision makers of current levels of coverage and of the cost and benefits of expanding the response.

### **Materials and Methods**

To identify and assess the practice of priority setting for HIV/AIDS interventions, national HIV plans and interventions carried out on the basis of Strategic Plans and allocated budgets were identified in five countries in Sub-Saharan Africa. In connection with work in the HIV/AIDS field (donor identification reviews), four of the countries were visited and interviews held with decision makers in Government, AIDS Commissions, NGOs, UN (including the World Bank) and bi-lateral donors. A recently published literature review of cost-effectiveness studies of HIV interventions in Africa is used to illustrate how the priority setting process can be improved and greater value for

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money ensured by incorporating information on cost-effectiveness into the Plans. The countries included are Malawi (16.5%), Tanzania (12%), Uganda (8.5%), Zambia (19%) and Zimbabwe (26%). (The latest available figures for HIV prevalence rate per country are shown in brackets).

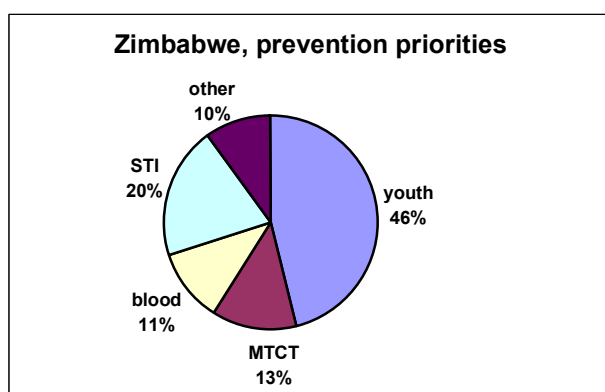
### Results

The assessments of the Strategic Plans in five African countries reveal some communality:

- The priorities as stated prove unrealistic in terms of resource allocation;
- The budgets are designed for purposes of resource mobilisation;
- To a large extent the real priorities are decided by the donors, including the World Bank, NGOs and the Global Fund;
- If the costing of the Strategic Plan enters at all into the process of its development, it enters too late to make a significant difference to priority setting;
- Consideration to cost-effectiveness is given in only one of the five sample countries;
- The balance between care and prevention is often arrived at arbitrarily, if at all.

A National Strategic HIV Plan might for example have a five year budget of US\$ 500 million in spite of the fact that only US\$ 20 million per year is allocated. None of the five sample countries had made contingency plans for the eventuality of a 'less than estimated resource need'. The fact of being two years into the Plan with a noticeably deficient budget did not provoke any changes in priorities. Thus all interventions are presented as equally important and priority setting is left to the discretion of donors and NGOs. This resource mobilisation approach of the National HIV Plan can have great impact on the effectiveness of the response. One of the countries in the sample provides an interesting illustration: according to the National HIV/AIDS Plan in Malawi, 52% of the resources should be spent on prevention, 13% on care and mitigation, and 28% on management and administration; almost two years into the plan the majority of resources have been allocated to the management component. This happened because it was considered necessary by the government and the donors to establish an administrative system adequate to managing more substantial investments. However, the resources allocated for care and prevention interventions have been too insufficient to make a significant impact on the epidemic. If funds for the activity priorities are not identified soon, then very little will have been achieved to control the epidemic.

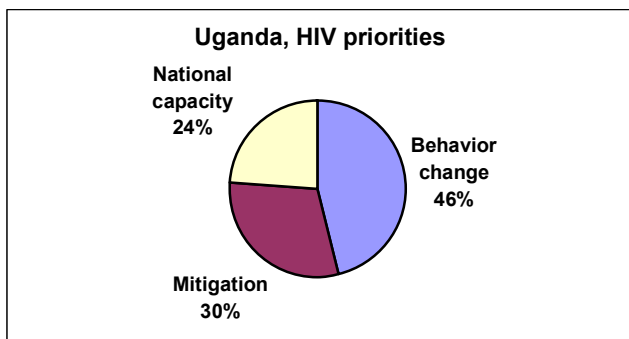
Below is shown a number of country cases of HIV priorities for prevention and/or care as they appear in the National Strategic Plans. The priorities in the examples are based on budget allocation in the plans – not resources spent.



The example from Zimbabwe shows the prevention priorities according to the National Strategic Framework (Zimbabwe Strategic Framework for a National Response to HIV/AIDS: 2001-2005. Volume 2: Operationalisation Parameters and Indicative Costs, 2000). Prevention constitutes 49% of the total budget while care only constitutes 30%. Of the preventions budget the Government wants to spend 46% at youth prevention, 20% at STI prevention and 13% at PMTCT – that is if the resource target is met. Half of the care budget is

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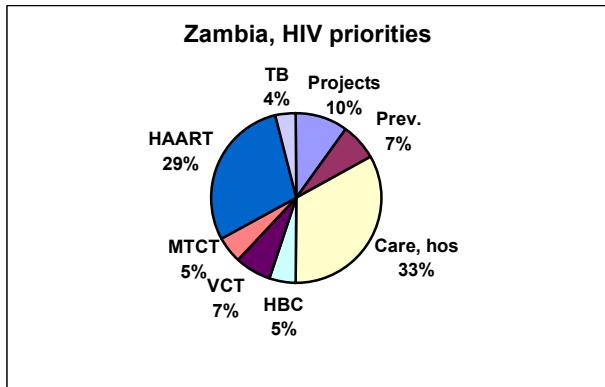
allocated for home based care support and 33% is allocated for opportunistic infections. No budget is allocated for HAART.



The overall HIV priorities of Uganda (National Strategic Framework for HIV/AIDS Activities in Uganda 2000/01-2005/06, March 2000) emphasises behaviour change. The most prominent component in the behaviour change package is VCT with a quarter of the resources allocated – more than 11% of all resources in the budget. A relatively large part of the mitigation component is allocated for orphans as social support. A quarter of the budget is allocated for strengthening of the national

capacity and most of the money is for mobilisation of the government, civil society and private sector.

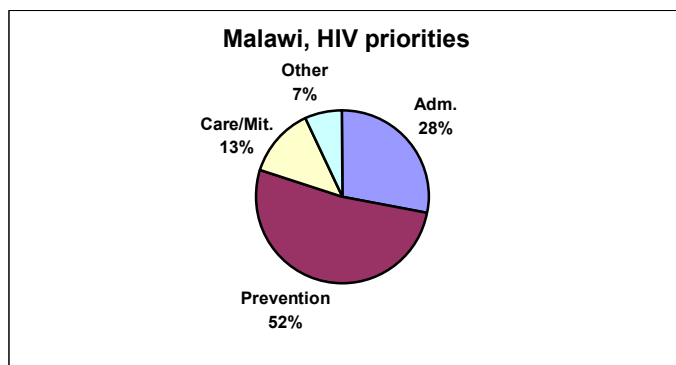
In Tanzania ten priorities are listed but not costed and no serious budget allocation has been carried out (The Third Medium Term HIV/AIDS Plan, MTPIII, 1998-2002). The budget allocation from Government has until 2001 been meagre but in 2001/2002 US\$ 8 million have been allocated and Tanzania is at present (June 2002) developing a new costed Strategic Framework.



In the case of Zambia the relative balance between prevention and care is very different from Zimbabwe and Uganda. The budget allocation includes a significant part of the budget for hospital care (33%) and HAART (29%) while prevention strategies feature less prominent (Bail and Mwikisa. Costing the Zambia National HIV/AIDS Strategic Framework, 2001-2003, October 2000). The priority setting process in Zambia includes cost-effectiveness information for PMTCT, VCT, STI and condom social marketing. The total budget

was estimated to US\$ 558 million when the Plan was published, US\$ 126 million to be provided by the Government and US\$ 414 million by donors (including all costs to HAART). No specific information is provided on how the balance between care and prevention was reached: “Planners felt that 50% of HIV patients should have access to HAART by 2003” (op. cit. page 52). The assumptions for HAART are: 30% of all HIV positive persons are appropriate for HAART, 50% of these would have access by 2003; 30% in 2002, and 10% in 2001. The HAART price used (including monitoring) is US\$ 8 000. [This price has since been reduced to approx. US\$ 800].

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In Malawi the National Strategic Framework focus on prevention interventions including Youth and Social Change (17%), VCT (12%) (Malawi National HIV/AIDS Strategic Framework 2000-2004. The Agenda for Action, October 1999). The total cost of a five- year programme was in 1999 estimated at US\$ 212 million.

A 'Review of Cost-effectiveness of HIV/AIDS Interventions' by Creese et al shows that the most cost-effective strategies are targeted interventions such as those intended for commercial sex workers (US\$ 1-10 per DALY, Disability Addjusted Life Years). Blood screening, STI interventions, some MTCT regimes and VCT are all interventions in medium and high prevalence countries with a cost-effectiveness below US\$ 50 per DALY and thus recommendable for developing countries. Most care interventions, including drugs, have a low cost-effectiveness although TB care interventions are reasonably cost-effective within a developing country context (US\$ 200 per DALY). Provision of HAART, even at very low prices, does not compare in terms of cost-effectiveness to HIV prevention interventions; TB care and prophylaxis are more cost-effective than the use of HAART. Thus, the opportunity cost (benefits forgone) of introducing HAART in an environment with an incomplete HIV prevention agenda is high.

**Table 1. Costs per DALY gained for different programmes**

Intervention	US\$ per DALY
Male Condom distribution	1-99
Blood safety	1-43
CSW, peer education	4-7
STI treatment	12
VCT services	18-22
PMTCT	1-731
TB prevention	169-288
TB short course	18-22
Home Based Care	77-1230
HAART	1100-1800

The figures in table 1 are derived from Creese, Floyd, Alban and Guinness, The Lancet, May 11, 2002, Table 6. The variation per intervention is due to different studies, sensitivity analysis of results or different HIV epidemics. The care interventions included, HBC and HAART are both relatively expensive while TB short course is highly competitive. Targeted prevention is among the most cost-effective buys, e.g. peer education among commercial sex workers. Prevention of MTCT has great variations caused by different studies including/excluding different drugs and formula provision for different numbers of months. The costs of HAART has come down since the latest available study was published and the cost per DALY would today (June 2002) probably be half – however studies to prove effectiveness in big cohorts in Africa still needs to be seen.

To demonstrate the importance of cost-effectiveness considerations into the National Strategic Plans, two different choice scenarios to allocate an additional US\$ 10 million is developed. One with a split of 50/50, the other with a split of 30/70 on care and prevention:

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1. **50% care/50% prevention gains 212 800 DALYs**
2. **30% care/70% prevention gains 344 310 DALYs**

*[The care package includes home based care support (10%) and HAART (40/20%) and the prevention package includes Voluntary Counselling and Testing (10/20%); STI treatment (10/20%); other prevention (20%); and prevention of Mother To Child Transmission (10%)].*

From a strict efficiency point of view, all resources will go to a prevention package until sufficient resources have been fundraised. However, this is neither practicable (the health service provides for all sick people) nor possible (only a small proportion of people are HIV tested). The ongoing political pressure in the African countries, the UN system and some African and International NGOs for introducing HAART into developing countries emphasizes the role of the care agenda, albeit in an unbalanced way. The priority setting issues in the National Strategic Plans should in principle reflect not only efficiency concerns but also equity concerns. The hardest choices facing decision makers in Africa at present are not whether HAART will be part of the care package, but rather determining the balance between the care interventions and defining the crucial balance of resource allocation between care and prevention interventions. At present the resource split care/prevention is arrived at arbitrarily, or on what is possible in the near future (arguments used in the article by Schwartlander et al. AIDS, Science. 2001. Vol. 292, Issue 5526: 2434-2436).

### Conclusion

The overwhelming concern at the present time is the need to ensure appropriate costing and to develop priority setting processes in the National HIV planning that also include scenarios for expected benefits (contribution to halt and/or decrease the epidemic). Most plans today are developed for fundraising purposes with unclear definition of the need and little if any information on what impact would be made by implementation of the plan; therefore they contain little information on the implications of only part implementation of the plan. Furthermore, the budget for the plans are not met, sometimes not even half met. It is hardly likely that the newly operating GFATM will be able to fill the resource gap in the foreseeable future. In order to decrease the gap between expectation and reality, priorities should be formulated to indicate how the first US\$ 10 million should be allocated, and so on for each US\$ 10 million portion of the budget.

The National Strategic Plans need to incorporate a mechanism to ensure that resources fundraised over the planning period are allocated to achieve the goals of the Plan whilst simultaneously maintaining the balance between care and prevention. The current overwhelming focus on HAART at country level distracts attention from the important question of the balance between investing in damage control or infection control.

The incorporation of cost-effectiveness information early in the planning process could improve investments in HIV activities and should be considered as best practice as proposed by UNAIDS Guide to the strategic planning process for a national response to HIV/AIDS.

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*Important links and key references:*

Kumaranayake, Kurowski, Conteh. Analysis of the Costs of Scaling Up Priority Health Interventions. Commission of Macroeconomics and Health. 2001

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

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

The Global Fund to fight AIDS, Tuberculosis and Malaria: <http://www.globalfundatm.org>

UNAIDS: <http://www.unaids.org>