+SECTION27 incorporating the AIDS Law Project

catalysts for social justice

Costing and budgeting for TB services in South Africa's prisons

Daygan Eagar

SECTION27 and RHAP

4 June 2013

Contents

1. What is unique about TB in Prisons
2. What do the guidelines say about managing TB in prisons
3. How should we go about costing and budgeting for TB services in prisons

“It is the overcrowded dwellings of the poor that we have to regard as the real breeding places of consumption; it is out of them that that the disease always crops up; and it is to the abolition of these conditions that we must first and foremost direct our attention if we wish to attach the evil at its root and wage war against it with effective weapons”—Dr. Koch

TB in prisons

- 100 Times higher than the general population
- High risk of transmission due to overcrowding, poor ventilation, inhumane living conditions and high turn-over of inmates (Infection control)
- High levels of reinfection (MDR and XDR)
- Inmates in facilities often come from poor and marginalized communities with high rates of infection (TB and HIV)

- Detection based on self-reporting rather than active case finding
- Understaffing at prisons, particularly qualified medical staff
- Case management is inadequate
- Poor integration with the public health system
- Implementing a comprehensive set of reforms for managing TB in prisons will require a great deal of money
- How much is enough and what are the tradeoffs?

2. TB guidelines for Prisons

- To cost any programme we need to know what is going to be implemented
- NDoH guidelines for prisons propose a number of key interventions

1. TB Screening and investigation (from entry to facility)
   - Symptom based
   - Chest x-ray
   - Microscopy and culture
   - GeneXpert
   - HIV

2. Treatment
   - Non-resistant TB, 1st line drugs, isolation for two weeks
   - MDR/XDR, referal to specialist, isolation for 6 months (hospitalization)
   - HIV (ART regardless of CD4)

3. Adherence support
   - Education
   - Counseling
   - Support, patient groups and nurses

4. Prevention
   - Education
   - IPT and ART
   - Infection control (infrastructure, patient management, behavior, N95 masks, etc.) including HIV

5. Post release continuum of care
   - Between correctional facilities
   - Reintegration into public health system

6. Monitoring and Evaluation
   + IT systems
   + Patient management and records
   + Referral

7. Human rights components
   + Rights of detainees re testing and treatment
   + Rights re isolation and segrigation
   + Stigma

3. costing and budgeting for TB services in prisons

- Costing and budgeting for TB services in public health has been extremely poor
- Some costing of community based treatment, GeneXpert (modeling of costs) but no comprehensive system wide approach
- Funded through equitable share and not conditional grant like HIV (why?). Impossible to determine with accuracy what is being spent
- We need a strategic plan with targets (intersectoral like NSP for HIV/AIDS) based on published guidelines
- Must be clarity on who is involved and where (DoH, DCS)

- Costing of such a plan would be first priority
- Must determine resource needs before we can develop budgets
- Simply put, costing is the process of placing a monetary value on the activities of an organisation. This information is then used to develop budgets and to monitor use of the organisation’s resources
- Difficulty of costing varies depending on kind of costing to be undertaken (activity based, modeling, cost-benefit, etc.)

1. Determine what will be costed.
    - Strategic implementation plan for the management of TB in prisons based on guidelines
    - All interventions in the guidelines

2. Whose health are we costing?
    - What is the population that will benefit from the programme.
        - Entire prison population?
        - A component?
        - What about post release?

3. What are the targets?

- We need to know/estimate how many people will benefit from each intervention
  - Screening, all?
  - Treatment, how many do we estimate will need PTB. MDR, XDR etc.
  - Prevention. E.g. Will all facilities be retrofitted to improve infection control

- What are our acceptable tradeoffs? Costing may actually help decide.

4. What are the unit costs?

- Price of all the ingredients of each intervention
  - Staff (full time equivalent)
  - Infrastructure
  - Equipment
  - Medicines
  - Lab costs
  - Drugs
- E.g. for treatment cost of drugs, staff and equipment)
- Many of these need to be modeled e.g. GeneXpert

5. Determining total cost

- Once we have unit cost for each intervention we could then multiply that figure by the number of people targeted for that intervention—or the number of times the intervention would be needed.
- We then tot up costs for each intervention to get a total and work it out on an annual basis
- We then know what we need to budget for
- Easy!

+ Not so fast…
+ Cost of full implementation is always much higher than available resources
+ Tradeoffs are inevitable. What is acceptable?
+ Modeling can help predict outcomes based on high, medium and low-cost programmes (accuracy?)
+ Expensive interventions, such as GeneXpert may be cheaper in the long-run. Again modeling. Again maths.
+ How do we measure indirect or intangible benefits (what is their real costs)

- There are some opportunities though
  - Prisons allow for tailored and focused interventions
  - For many patients, treatment can be closely monitored
  - Proper investment in TB management in prisons (mines are similar) can have significant public health benefits
- We have a moral and constitutional obligation to dedicate proper resources to TB in prisons

“You can judge a society by how it treats its prisoners”-Dostoyevsky