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Cost analysis of religious based HIV/AIDS information, education and communication in Bandung, Indonesia

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Abstract

BACKGROUND AND PURPOSE:

Sexual risk behavior and preconceptions about HIV/AIDS remain a significant problem in the fight against HIV/AIDS in Indonesia. Religious based HIV/AIDS education can be used to increase the knowledge of HIV/AIDS of the general population. The Imam educates his/her visitors about HIV/AIDS, thereby reducing risk behavior and stigma. To allow policy makers to make evidence-based decisions about prioritizing between various interventions focused on HIV/AIDS, it is important to calculate the costs of this intervention.

METHODS:

The costs were calculated for the city Bandung, Indonesia over a period of a year (January 2015 - December 2015). The data were collected in April and May 2016 and obtained by interviews with experts and records from KPA Bandung (the organization coordinating the intervention). In this intervention, KPA Bandung gives annual trainings to 60 Imams on how to educate visitors about HIV/AIDS. In turn, the Imams educate their visitors during the religious gathering.

RESULTS:

The cost falling on KPA Bandung for coordinating this intervention were US\$387 per year. The largest cost components were the capital training cost (41%) and the recurrent personnel cost (35%). The total societal costs were US\$1963 per year for 60 mosques and 1200 visitor. The largest cost components of the societal costs were the building cost for the mosques (27%) and the recurrent personnel cost for the Imams (40%).

CONCLUSIONS:

The costs for KPA Bandung are low, so it is important to consider scaling up the training from one time per year to two times per year. In addition, it would be significant to determine the effectiveness of the intervention.

Key words: cost analysis, information, communication & education, religious gatherings, HIV/AIDS, Indonesia

Introduction

Currently, 690.000 people are living with HIV in Indonesia¹. In 2014, 69,000 people were infected with HIV and 34.000 people died from AIDS². The epidemic in Indonesia is concentrated among various key populations. The most important risk groups are people who inject drugs, female sex workers, men who have sex with men, transgender people and high risk men. While the dominant mode of HIV transmission was unsafe injecting behaviour in the past, now HIV mostly spreads due to homosexual and heterosexual contact. The percentage of cumulative AIDS cases due to heterosexual transmission increased from 37% in 2001-2005 to 71% in 2011, whereas the percentage of infections from injecting drug use decreased from 53% in 2001-2005 to 34% in 2011³. Especially IDU's partners and partners of sex workers' clients are at risk of getting infected through heterosexual contact⁴. High risk behaviour such as multiple partners, low condom use and access and more frequent sexual intercourse drives the HIV epidemic⁵. Another important driving factor is the stigma of people living with HIV which is considered a barrier to effective HIV prevention and treatment programs. When there is a fear of stigma, the chance that a person will not reveal their HIV status to their sexual partner increases which can lead to increased sexual risk behaviour. At the same time, people will be more reluctant towards HIV testing and treatment services due to the fear of getting stigmatized⁶.

Since 2010, new efforts have been made to contain the HIV epidemic (National AIDS Strategy and Action Plan Indonesia). The coverage of HIV services such as HIV counselling and testing, STI testing and treatment, ART delivery and prevention mother to child transmission services has expanded to all provinces in Indonesia. However coverage of services remains low, e.g. in 2014 the coverage of ART treatment was only 8%. On top of that, sexual risk behaviour and preconceptions about HIV/AIDS remain a significant problem due to a lack of knowledge in the general population⁷.

Change in behaviour and preconceptions about people living with HIV/AIDS can be accomplished by informing and educating people about HIV/AIDS. In community based HIV prevention interventions, information, education and communication (IEC) is used to increase the HIV-related knowledge and to change the risk behaviour, thereby reducing the transmission of HIV. Information about the transmission of HIV, risk factors and healthy sexual behaviour (prevention) is given. Several community based prevention interventions have proven to increase the knowledge of HIV/AIDS of the people reached. Furthermore, the self-reported sexual risk behaviour reduced as a consequence of the interventions^{8,9}. Combining community based HIV prevention with religion seems to be a favourable new intervention. The Imam will educate his/her visitors about HIV/AIDS during the religious gathering. Particular because religion is an important element in Indonesia (approximately 88% of the Indonesian population is Muslim¹⁰), changing behaviour of people by combining religion and education seems promising¹¹. Religious organizations are uniquely positioned to address HIV because they have community credibility and access to the people¹².

Research question

To support policy makers to make evidence based decisions in HIV control, cost estimates of HIV interventions are needed. However, to our knowledge, no cost data is available of a similar religious based HIV/AIDS intervention in lower middle income countries, including Indonesia. Regarding IEC, cost analysis have mainly focussed on mass media campaigns, peer education and school based education but not on religious based IEC¹³. This study primarily aims to estimate the cost of

community based information, education and communication to prevent HIV/AIDS through religious gatherings in Indonesia. In addition, recommendations for potential cost reductions will be made and the effects of the community based IEC through religious gatherings will be established.

Methods

Study setting

The religious based HIV/AIDS IEC intervention is being executed by the Bandung AIDS commission (KPA Bandung). The Bandung AIDS commission is a part of the national AIDS commission in Indonesia, which focuses on the prevention and control of HIV/AIDS in Indonesia¹⁴. The Bandung AIDS commission receives funding from two donors. The Global fund provides KPA Bandung with funding for interventions targeted on the key populations in the HIV/AIDS epidemic. The other donor is the government of Indonesia, which provides funding for interventions targeted on the general population and for improvement of the KPA Bandung institute. The religious based HIV/AIDS IEC intervention was set up in 2014. Approximately one time per year KPA Bandung organizes a training about HIV/AIDS which is given to every district in Bandung (30 in total). Per district, three persons receive the training from KPA; one Imam of the religion department of the district, one Imam of the MUI (Majelis Ulama Indonesia, this is the Imam organization in Indonesia) and one person of the society. Every year KPA Bandung gives the training to the same districts, but different people attend. In turn, these three organizations give training about HIV/AIDS education to a number of Imams in their district. After this district training, the Imams pass their obtained knowledge about HIV/AIDS to the visitors of their religious gatherings. In general the education covers the definition of HIV, the transmission, process of infection and testing of HIV but the specific content of the education depends on the Imam. During one religious gathering a group of 10-20 persons attend, which consist mostly of women. KPA Bandung monitors the status of the intervention in several mosques.

Data collection and cost estimation

The costs were estimated for entire Bandung in the year 2015 and were evaluated based on the methods in the WHO training manual: 'Cost analysis in primary health care' by Andrew Creese & David Parker¹⁵. The cost data were obtained in April and May 2016. To estimate the costs as accurate as possible a micro-costing approach was used. In this method, detailed data about the quantity and cost of consumed resources are collected¹⁶. The costs have been identified from four perspectives, the patient perspective, the provider perspective, the health care system perspective and the societal perspective. A distinction was made between health-care costs and non-health-care costs. Health-care costs are the costs related to the consumption of resources in the health-care system and non-health-care costs are the costs falling on the patient for seeking and undergoing care¹⁷.

The health care costs were divided into capital costs and recurrent costs. All cost data were obtained by interviews with experts and records from KPA Bandung. The capital costs consisted of building costs, vehicle costs, equipment costs and training costs. The KPA Bandung building and mosques were rent free, for this reason the building costs have been based on the current building prices in the specific area the building is located. The vehicle and equipment costs have been based on the current market prices. The training costs were based on the expert opinion of the coordinator of the intervention in 2015. The costs of the training for the Imams by the three organizations were omitted due to lack of available data. The capital costs were annualized on the basis of the working life of the

item, using a 3% discount rate¹⁷. The recurrent costs consisted of personnel costs, supplies costs, fuel costs, maintenance/repair costs and other costs. The personnel costs were estimated on the basis of their actual wage in 2015. The fuel costs and maintenance/repair costs were based on expert opinion. The supplies costs and other costs have been based on records from KPA Bandung. The costs for electricity and water were omitted due to absence of data. All the costs have been allocated according to appropriate percentages. The non health-care costs were the costs for the visitors to be able to attend the religious gatherings. These costs and the effect of the intervention on HIV/AIDS knowledge were determined by interviews with the visitors of the mosques conducted in April and May 2016 (see appendix; questionnaire visitor mosque). Information about knowledge of HIV, opinion about the HIV/AIDS education, monthly income of the visitor, daily working hours, monthly expenditure, travel costs and travel time was collected. The number of persons attending one religious gathering was determined by interviews with the Imams (see appendix; questionnaire Imam). All costs were collected in Rupiah and converted to United States Dollar using the 2015 official exchange rate (LCU per US\$)¹⁸.

Assumptions

Various assumptions were made to complete the data for the analysis. First, the cost data were obtained by interviews with experts. It was assumed that the experts' knowledge was up to date enough to give accurate estimations. Second, for the allocation of the capital and recurrent building costs of the mosques, it was assumed that the opening hours for the mosques were from 4.30 am to 8.00 pm, seven days a week. Praying started at 4.30am until 18.55pm, plus one hour for praying and closing the mosque. These hours were based on information collected at the mosques. Third, to obtain the allocation percentage for the equipment, supplies and other recurrent costs, the funding for this specific intervention was divided by the total funding of KPA. It was assumed that this percentage (0.0019%) gave an accurate reflection of the allocation of the equipment and supplies for this intervention. Fourth, the group of visitors predominantly consisted of housewives. To estimate the economic costs for the visits, the salary missed for the housewives was set on the salary of a housekeeper of 2,500,000 rupiah per month (US\$187)¹⁹. The average weekly working hours was set on 50.9 hours²⁰. Fifth, the KPA building and mosques were rent free. Nevertheless, these building costs were part of the economic costs. To calculate the annual building costs for the mosques and KPA building, the costs for a building in the same street as that of the building of interest (KPA building/mosque) were collected and used. The selling price of the building was divided by the total square metres to obtain the price per square metre in that specific area. The total square metres of the KPA building and the mosques were multiplied by the price per square metre to obtain the construction price of the KPA building and mosques. With this assumption, the difference in construction year of the building has not been taken into account. The price per square metres was estimated for another year and another building, so these estimates will not be exactly accurate for the KPA building and the mosques. Sixth, based on information gained from the interviews with the visitors and Imams, the number of educations was set on one education per month. Seventh, in total 60 Imams were trained thus 60 mosques were involved in this intervention in 2015. It was assumed that per mosque, 20 visitors were attending the religious gatherings and receiving the education. In total 1200 visitors were educated in 2015 in 60 different mosques in Bandung. Bandung consists of 30 districts and each district has approximately 60 mosques. In total, it was assumed that there were 1800 mosques in the whole city of Bandung.

Sensitivity analysis

The societal costs were highly dependent on various assumptions, therefore it was important to do a sensitivity analysis to determine the influence of these assumptions. The assumptions of interest were the number of annual educations, the time for one education, the number of mosques included and the number of visitors reached.

Results

		Visitor	Health care system	Societal
<i>Capital</i>	Building	KPA	244.02	244.02
		Mosque		462.24
	Vehicles		24.46	24.46
	Equipment		3.33	3.33
	Training		157.60	157.60
<i>Recurrent</i>	Personnel	KPA	134.43	134.43
		Imam	11.20	786.38
	Supplies		1.91	1.91
	Vehicles		4.48	4.48
	Building	KPA	75.15	75.15
		Mosque		67.96
	Other		1.51	1.51
	Non-health care costs	58,188.62		58,188.62
	Total annual cost (\$)	58,188.62	658.09	60,127.64

Table 1. Total annual costs of 2015 for 60 mosques and 1200 visitors in dollar categorized by perspective

In table 1, the total costs for 60 mosques and 1200 visitors are categorized by visitor, health care system and societal perspective. The annual health care system costs were US\$658 and consisted of costs incurred by KPA Bandung, the government, the department for religion and donors. The total annual cost falling on KPA Bandung for coordinating this intervention were US\$387, the unit costs per reached visitor for KPA Bandung were US\$0.3 and the costs per reached mosque were US\$6. For KPA Bandung (see figure 1), the largest cost components were the capital training costs (41%) and the recurrent personnel costs (35%). The societal costs are a summation of the visitor and health care system cost plus the costs for the mosque and Imam (these are falling on the society). The visitor costs make up 97% of the total societal costs. If these visitors cost would not be included, the total societal costs were US\$1963 from which the distribution are represented in figure 2. The largest cost components were the personnel cost for the Imam and the building cost for the mosques.

Figure 1. Distribution (%) of the costs for KPA Bandung

Figure 2. Distribution (%) of the total societal costs

Knowledge of the visitors

Data about knowledge of HIV/AIDS after receiving the education were collected from eight visitors. All the visitors knew the information they received from the Imam already from television or radio. Nevertheless, every participant found the education from the Imam useful. All the participants were willing to learn more about HIV/AIDS and thought it would be valuable to hear more about HIV/AIDS from a person from an HIV-organisation. The visitors did not think people are more willing to learn about HIV/AIDS because of the fact that the Imam is giving the education.

Scenarios

To estimate the costs for this intervention when the number of Imams trained or the frequency of education would be scaled-up, different scenarios were constructed.

1. Present scenario: One annual training, coverage of 60 mosques per year + one education per month.
2. Two annual trainings, coverage of 120 mosques per year + one education per month.
3. Four annual trainings, coverage of 240 mosques per year + two educations per month.
4. Six annual trainings, coverage of 360 mosques per year + one education per month.

Table 2. Costs of various upscale scenarios for the health care system and KPA Bandung

Scenario	Imams trained	Fixed costs (\$)	Variable costs (\$)	Costs for health care system (\$)	Costs for KPA (\$)	Years until every mosque is trained
# 1	60	322.5	335.6	658.1	386.5	28
# 2	120	322.5	671.2	993.7	773.1	14
# 3	240	322.5	1,342.4	1,664.8	1,546.2	7
# 4	360	322.5	2,013.6	2,335.1	2,319.2	4.7

Table 2 represents the costs of the different up-scaling scenarios. The years until every mosque is trained was based on the fact that in 2014 and 2015 KPA Bandung already trained 120 Imams, this means that the number of Imams left to train was approximately $1800 - 120 = 1680$. This number (1680) was divided by the annual number of Imams trained.

Sensitivity analysis

Table 3. Societal cost of varied assumptions

	Number of annual educations	Time of education (min)	Number of mosques included	Number of visitors reached	Total societal cost (\$)	Cost per reached visitor (\$)	Costs per mosque (\$)
Base case	12	10	60	1200	2076	1.7	34.6
2	12	5	60	1200	1418	1.2	23.6
3	24	10	60	1200	3393	2.8	56.6
4	12	10	80	1600	2515	1.6	31.4

The results of the sensitivity analysis are represented in table 3. In this table, the visitor costs were omitted assuming the visitors will come to the religious gathering regardless of the presence of education. The total societal costs for the base case were US\$1963. When the time of the education is decreased to five minutes (2), the total societal costs will decrease with approximately 32%. When the number of annual educations would be 24 instead of 12 (3), the costs will increase with 39% of the base case costs. When the number of mosques and visitors would be 80 (4), the total societal costs would increase with 21%.

Discussion

This costing analysis has provided the annual costs of 2015 from four perspectives, i.e. visitors, provider (KPA Bandung), health care system and societal perspective and the costs when the training from KPA Bandung would be scaled-up to two trainings per year. 97% of the total societal costs consist of the non-health care costs. Without these visitors cost, the total societal costs are US\$1963. It is questionable whether these visitor costs should be included in the total societal costs. The visitors might come to the religious gatherings regardless of the presence of HIV/AIDS educations since the education is included in the time for the religious gathering. If this is true, the visitor costs should not be included but this is not clear. The capital and recurrent building costs for the mosques such as rent, maintenance and repair, electricity and water and the salaries of the Imams are included in the total societal costs. This is important since the Imams are spending their time on the education and the mosques are used. These costs are allocated based on one education of ten minutes per month. Unfortunately, no cost analysis has been done of a similar religious based IEC intervention therefore it is not possible to compare the cost of this intervention with a similar intervention. The total annual costs for KPA Bandung to coordinate this intervention are US\$387. The largest components of the costs for KPA are the training costs, this is logical because the intervention mainly consist of providing the annual training. Currently, the costs for the training consists of salaries of the trainers and KPA staff, rent and attendants costs such as meals, transport and seminar kit. It would be difficult to lower the costs for the annual training since all current cost components are important for an effective training and turn-out. Nevertheless, KPA can improve their intervention by developing guidelines about the HIV/AIDS education. Currently, the educations are not optimal due to a low frequency of educations and a questionable content. Generally, the interviewed visitors only had knowledge about the definition of HIV/AIDS and the transmission, on top of that they already received most of the information from television or radio. Evidently there is still much work to do regarding to the knowledge of the visitors and the mode of education by the

Imams. By creating educational guidelines for the Imams, the education will be consistent over all mosques and the Imams will have a clear image on how to educate their visitors.

Scenarios

The fixed costs in the scenarios consisted of the capital building costs for the KPA building, equipment costs and the recurrent building costs for the KPA building. The variable costs consisted of vehicle costs, training costs, personnel costs for KPA, supplies costs and other recurrent costs. With regards to the capacity of KPA Bandung, it would be more feasible to organise two or four annual trainings instead of six. When comparing scenario 2 with scenario 3, it would take seven years to include all mosques in Bandung. However, the impact on the budget of KPA would be greater with two extra trainings per year. Besides in scenario 3, the Imams would give two educations per month instead of one. Two educations per month could be too frequent, with regard to the variety of HIV/AIDS topics. Concluding, scenario 2 seems to be the best option when scaling up this intervention. The annual training would be scaled up to two trainings per year, and the frequency of educations would remain to be ones per month. In every scenario, the years until every mosque is trained were an overestimation. This is due to the fact that there were more Imams trained (district training) than only the 60 Imams trained by KPA Bandung. However, it is not clear how many years this would save. Also, when calculating the years until every mosque in Bandung is trained, it was assumed that every mosque is interested in giving the HIV/AIDS education to their visitors.

Sensitivity analysis

In the analysis, the visitor costs were omitted assuming the visitors would come to the religious gathering regardless of the presence of education. All the investigated variables had a substantial impact on the total societal costs. The sensitivity analysis showed that the frequency of education had the highest impact on the total societal costs of all investigated variables. This means, when in reality the frequency of education differs from one education per month, the non-health care cost, the personnel cost for the Imams and the building cost for the mosques will be altered. When the number of Imams and mosques is higher, the total societal costs would also be higher (more building costs and salaries). However, the sensitivity analysis showed that the cost per reached visitors and per mosque will roughly stay unaltered when including 80 mosques.

This costing analysis has a number of limitations. First, some of the data were collected for one month in 2016, whereas the total costs were estimated for the whole year of 2015. This data had to be extrapolated from one month to twelve months. Besides, people have to think in hindsight about their time distribution. This could result in wrong estimates of the allocation. Second, the excursions to the mosques were done during working hours so only housewives were interviewed. The data from the housewives was used for the analysis, but in reality also men and children attend the religious gatherings. However, the Imams confirmed that in general the majority of the visitors are housewives. Third, not all Imams who are giving the HIV/AIDS education were included in the cost data. In reality, the number of mosques giving the education about HIV/AIDS was higher than 60. This was due to the fact that the three organisations that receive the training from KPA, also provides training to Imams in their district. This number of mosques was not included in this analysis because the data of these district trainings were not available. The costs of these particular trainings given by the three organisations were also not included in the analysis. Fourth, several assumptions have been made to make the data as complete as possible. These have been described under *Methods*;

assumptions. Some of these assumptions could alter the real cost data, but had to be made in order to make the analysis complete. Fifth, the costs for electricity and water were omitted. These costs are presumably small, so this will not alter the total cost. Sixth, the frequency of the education given by the Imams was inconclusive. The frequency of education according to the Imams varied from one time per week up until two times a day for seven days a week, whereas the frequency of education according to the visitors range from once a month, to five times in six years, to never received any training at all. In this analysis a frequency of one education per month was adopted.

Conclusion

To our knowledge, this paper is the first to analyse the costs of a religious based HIV/AIDS IEC intervention in a lower middle income country such as Indonesia. With this information policy makers, e.g. the religion department in Bandung, can make evidence based decisions about their role in HIV/AIDS control in Indonesia. Since there is no information available on the effectiveness of this intervention, it would be meaningful to analyse the cost-effectiveness to improve the decision making process. With the information in this analysis and related recommendations, KPA Bandung can improve their intervention.

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Appendix

Questionnaire Imam

Name Imam:

Name of mosque:

Address of mosque:

Date:

Training; use form Training

1. Did you follow any training about the HIV education?
2. When did you follow this training? (in what year)
3. Was this a one time training, or did you follow several trainings? If so how many did you follow?
4. From whom did you receive this training?
5. Where did the training took place?
6. Did you pay for any travel cost to receive this training?
Any other cost than travel cost?
7. How long did the training take, 1 hour/2hours etc.? And how many days?
8. Did you miss a religious gathering because of the training?
9. Do you give any training about HIV/AIDS to other imams?

Intervention; use form Recurrent cost: personnel and form during educational gathering

10. How many hours do you work at the mosque per week?
11. What is approximately your gross salary per month?
12. Do you receive any monthly allowances? If yes how much do you receive?
13. How many hours do you spent on the intervention per week + preparations?
14. How long does one religious gathering take (without education on HIV/AIDS), 1hour/2hours etc.?
15. How long does one religious gathering take with the education on HIV/AIDS, 1hour/2hours etc.?
16. Are there any other people at the mosque helping with this intervention? E.g. volunteers to help set up the education/lunch.
17. Do you do some individual follow-up on people? E.g. if someone asks you some questions about HIV/AIDS after the gatherings, do you explain this? If so how much time does this approximately take after the religious gatherings?
18. What kind of information on HIV/AIDS is given?

Building; use form Capital cost: building and Recurrent cost: building.

19. How many times per week does a religious gathering take place?
20. Where does the religious gathering take place in the mosque?
21. How many square meters is the room for the religious gathering?
22. How many square meters is the whole mosque?
23. What is the monthly/annual rent of the mosque? Funded by?
24. For how long has the mosque existed (working life of building)?
25. Are there any costs for furnishing? Funded by?
26. Do you have an idea about the utility costs of the mosque; funded by?
 - a. Insurance;
 - b. Cleaning;
 - c. Maintenance and repair;

- d. Elektricity + water;
- e. Other costs?;

Questionnaire visitor mosque

1.What is your name?

2.What did you learn about HIV during the education?

Prevention:

Diagnostics:

Prognosis:

Testing and treatment:

3.Did you know already know this information before you attended the religious gathering + education? Or was this new information?

4.If yes → which part of the education was new for you?

5.Did you find the information about HIV/AIDS useful?

6.Is there any other way you are being educated about HIV/AIDS? E.g. radio/television?

7.What did you think of the way the Imam told the info? Would it be more useful if the imam used a powerpoint / beamer/ whiteboard ?

8.Do you think people are more willing to take up the information and listen to it because the Imam is telling the info? Rather than someone from an HIV-organisation?

9.Is there something you really wanted to know about HIV/AIDS which the Imam didn't tell you about?

Income:

1. What is your average monthly income?
(if you have more than one occupation, please state the total income)

2. How many hours do you work per day?

3. How many days do you work per week?

4. Please state and detail your monthly expenses

No	Expenses	Monthly amount
1	House rent/mortgage	Rp
2	Electricity, water, telephone	Rp

3	Transport to work place	Rp
4	Cellphone credit	
5	Food	Rp
6	Entertainment (i.e. snacks, smoke, cinema)	Rp
7	Health/doctor fee	Rp
8	Savings	Rp
9	Others, please state.....	Rp.....

5. How do you reach the mosque?

☐ 1. On foot	☐ 6. Public transport (car)
☐ 2. Bicycle	☐ 7. Taxi
☐ 3. Motorcycle	☐ 8. Public transport (bus)
☐ 4. Motorcycle taxi	☐ 9. Others, please state.....
☐ 5. Car	

6. How long is your travel time to reach the mosque?

7. On your visit to the mosque, how much do you spent in average for:

a. Two way transport for yourself	Rp.....
b. Two way transport for person(s) accompanying you	Rp.....
c. Lunch/snack	Rp.....

8. How much time do you spent in the mosque? (including waiting time) minutes/hours.

9. How many times per week do you visit the mosque?

10. How many times do you receive HIV/AIDS education during a religious gathering per week?