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HIV EXPENDITURE ON MSM PROGRAMMING IN THE ASIA-PACIFIC REGION

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OBJECTIVES OF THE ANALYSIS

1. Assess the current level of HIV prevention expenditure dedicated to MSM interventions
2. Explore the impact of sources of funding on MSM programs
3. Provide a rationale for public funding of MSM HIV prevention interventions
4. Estimate the level of resources required to reach MSM with HIV prevention programs

WHY ESTIMATE HIV EXPENDITURE ON MSM?

- To determine if current resources allocated match the estimated level of need
 - MSM account for 5–10% of HIV transmission globally (UNAIDS)
 - In the Greater Mekong Region, HIV prevalence among MSM ranges from 3–28%
- To mobilize additional resources for MSM HIV prevention programs
 - Beneficial for MSM and for society as a whole, because MSM often report having sex with women and therefore can serve as a bridge population for spreading HIV to the general population
 - Expenditure on MSM programs should be assessed against the current level of HIV spending. Quantification of resource needs and the resource gap are critical for successful resource mobilization

THE CURRENT SITUATION



LIMITATIONS: MEASUREMENT CHALLENGES

- Incomplete data, poor quality data
- Lack of data disaggregated by target group
- Defining what constitutes MSM HIV prevention expenditure
- Lack of data on out-of-pocket and household expenditure
- Due to stigma, MSM are a hidden group and it is difficult to track how many are reached with services
- Budgeted vs. actual expenditure
- Duplication / double-counting of expenditure
- Currency and adjustments for purchasing power parity

***For these reasons, expenditure estimates could underestimate or over-estimate the true level of MSM expenditure**

ESTIMATING RESOURCE LEVELS: METHOD 1—Secondary Sources

TABLE 1: EXPENDITURE ON MSM PROGRAMMING, 2004 (US\$)⁶

Country, City, or Province	MSM Prevention Expenditure	Total Prevention Expenditure	Share of HIV Prevention Expenditure
Thailand	\$482,500	\$12,516,400	3.85%
Myanmar	\$375,000	n/a	n/a
Vietnam	\$220,000	\$20,670,673	2.59%
Ho Chi Minh City	\$4,232	\$430,376	0.05%
Cambodia	\$190,000	\$8,506,560	2.23%
	\$184,676		2.17%
China	\$140,000	n/a	n/a
China Province 1	\$28,000	\$21,000,000	0.13%
China Province 2	\$0	\$3,000,000	0%
Lao People's Democratic Republic (PDR)	\$40,000	\$2,694,600	1.48%

Expenditure ranges from a high of 4% in Thailand to a low of 0% in a province in China

- Includes peer education and outreach, IEC materials, media messages on behavior change
- Complementary activities (VCT, STIs) among MSM are not generally reported as MSM expenditure

ESTIMATING RESOURCE LEVELS: METHOD 2—Indirect Approach

TABLE 2. INDIRECT ESTIMATION OF EXPENDITURE ON MSM-RELATED HIV PREVENTION PROGRAMMING, 2005 (NOMINAL US\$)

Country	% MSM reached by prevention services		Male population 2005 15–49 years ¹³	Range of estimated expenditure ^{14,15}	
	UNAIDS ¹⁶	Coverage survey ¹⁷		Using 1% adult male population to estimate number of MSM	Using 5% adult male population to estimate number of MSM
Bangladesh	77%	--	40,516,000	\$14,662,740	\$73,313,702
Cambodia	17%	17%	3,554,000	\$283,965	\$1,419,823
China	8%	8%	382,852,000	\$14,395,235	\$71,976,176
Fiji	--	--	4,269,220	--	--
India	45%	4%	299,051,000	\$5,622,159	\$28,110,794
Indonesia	1%	10%	67,210,000	\$410,653	\$2,053,265
Lao PDR	--	1%	1,501,000	\$7,055	\$35,273
Malaysia	--	10%	6,315,000	\$296,805	\$1,484,025
Mongolia	68%	--	843,000	\$269,819	\$1,349,095
Myanmar	-	30%	13,488,000	\$1,901,808	\$9,509,040
Nepal	5%	36%	7,061,000	\$179,208	\$896,041
Pakistan	22%	15%	41,017,000	\$2,891,699	\$14,458,493
Papua New Guinea			1,437,221	--	--
Philippines	2%	2%	22,959,000	\$215,815	\$1,079,073
Sri Lanka	--	10%	5,556,000	\$261,132	\$1,305,660
Thailand	--	1%	17,908,000	\$84,168	\$420,838
Vietnam	--	--	24,220,000	--	--
TOTAL				\$41,482,260	\$207,411,298

In some cases, the implied expenditure level was consistent with Method 1

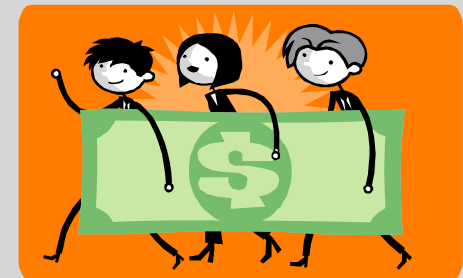
In other cases, the estimated expenditures using the indirect approach were not credible

- Considers population size, coverage, and unit costs

WHAT DO THE DATA SUGGEST ABOUT FUNDING OF HIV PREVENTION PROGRAMS FOR MSM?

- Accurately estimating the level of MSM spending remains a challenge
- HIV prevention efforts targeted to MSM constitute a very small proportion of overall prevention expenditure
- Best available data suggest that MSM-related HIV prevention expenditure in the region ranges from 0% (Chinese province) to 4% (Thailand)
- Spending levels are not commensurate with the proportion of HIV cases attributed to transmission via sex between men

SOURCES OF FUNDING



WHERE DOES MSM FUNDING COME FROM?

- Anecdotal evidence suggests MSM interventions are mainly funded by donors and implemented by NGOs
- Why?
 - MSM activities prohibited in 11 out of 23 countries in the region (however, sex work is also prohibited yet many governments fund programs targeting sex workers)
 - Data weaknesses preclude analysis of the disease burden borne by MSM (but lack of data is an issue with all at-risk groups)
 - Continuing struggle in the region (among donors and governments) to address the driving factors of HIV in Asia, particularly concentrated epidemics among marginalized groups such as MSM, injecting drugs users, and sex workers
 - The “double stigma” faced by these groups influences a range of policy, financing, and service delivery decisions

WHY IS DONOR FUNDING A CONCERN?

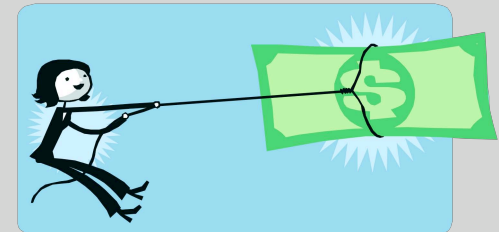
- **Priority Setting, disincentives, and additionality**
 - Concern over donors influencing national priorities and creating disincentives for internal funding sources
- **Volatility and lack of predictability**
 - Volatility of donor funding is 40 times higher than that of tax revenues
 - Predictability, consistency of funding improves planning, implementation, and scale-up
- **Sustainability**
 - Generally thought of as self-sufficiency after the end of donor assistance

HOW CAN DONOR FUNDING BENEFIT MSM PROGRAMS?

- Governments in the Asia-Pacific region have been reluctant to allocate in-country resources to MSM programs
- With highly-stigmatized populations, withdrawal of donor funding will not necessarily lead to governments investing their own resources
- Donors can raise awareness of priority issues that governments may not address
- Donor investments geared toward human and institutional capacity building of MSM programs and the implementing NGOs can help enhance future sustainability of programs

***Due to stigma, traditional concerns about donor funding for MSM interventions may need to be viewed in a different light**

JUSTIFICATIONS FOR FUNDING MSM PROGRAMS



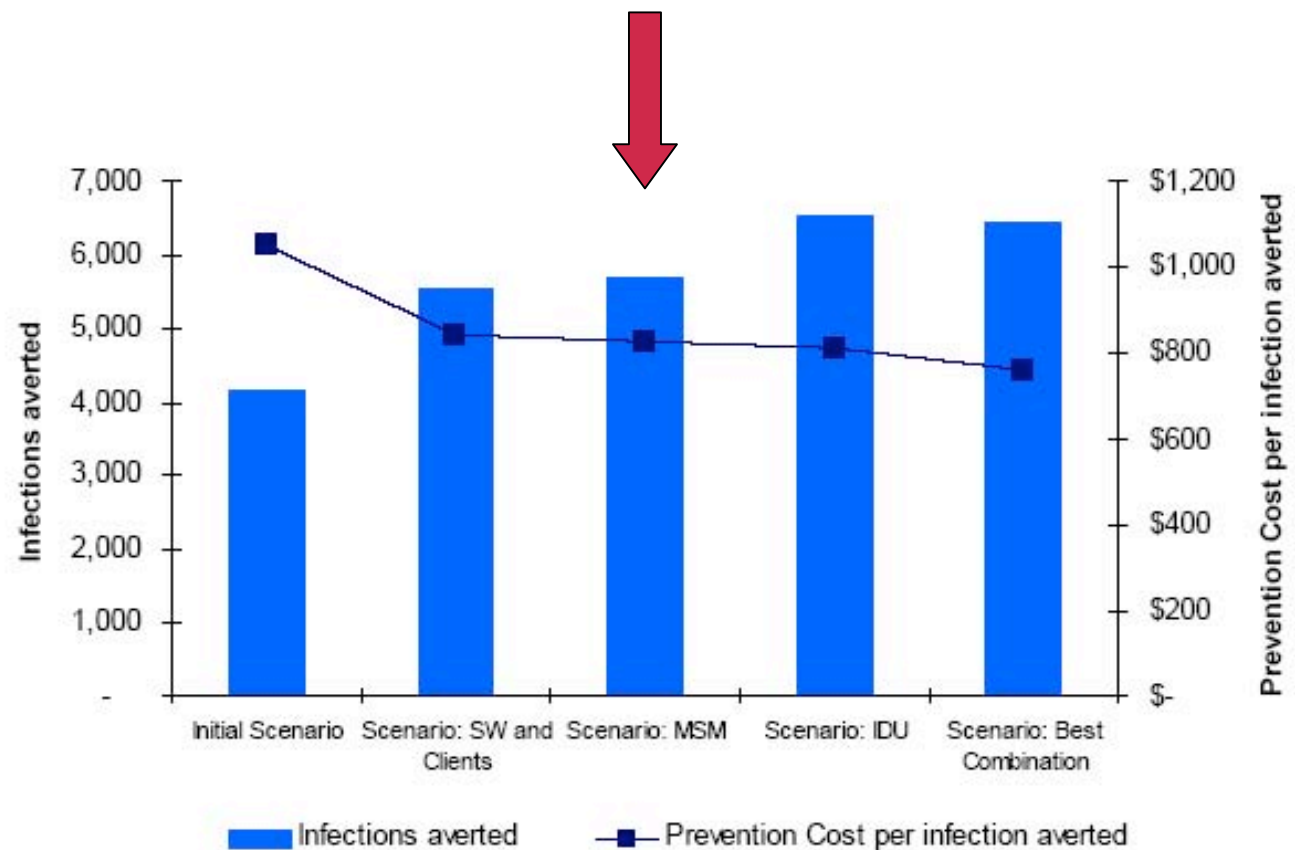
WHY SHOULD THE PUBLIC SECTOR INVEST MORE RESOURCES IN HIV PREVENTION AMONG MSM?

1. Disparity between disease burden/risk and current level of expenditure
 - E.g., In Ho Chi Minh City, MSM accounted for 6.1% of current adult HIV infections and 8.5% of new infections in 2004, yet accounted for less than 1% of HIV prevention expenditure
2. Effectiveness of MSM interventions
 - A 2005 meta-analysis using data from 33 studies found that MSM interventions were associated with a significant decrease in unprotected anal sex and number of sexual partners, as well as a significant increase in condom use during anal intercourse

WHY SHOULD THE PUBLIC SECTOR INVEST MORE RESOURCES IN HIV PREVENTION AMONG MSM?

3. Cost-effectiveness analysis

FIGURE 1.
Cumulative
Infections Averted
and Prevention
Costs per Infection
Averted Under
Different Resource
Allocation Scenarios
(2006 – 2010)



ESTIMATING RESOURCE NEEDS

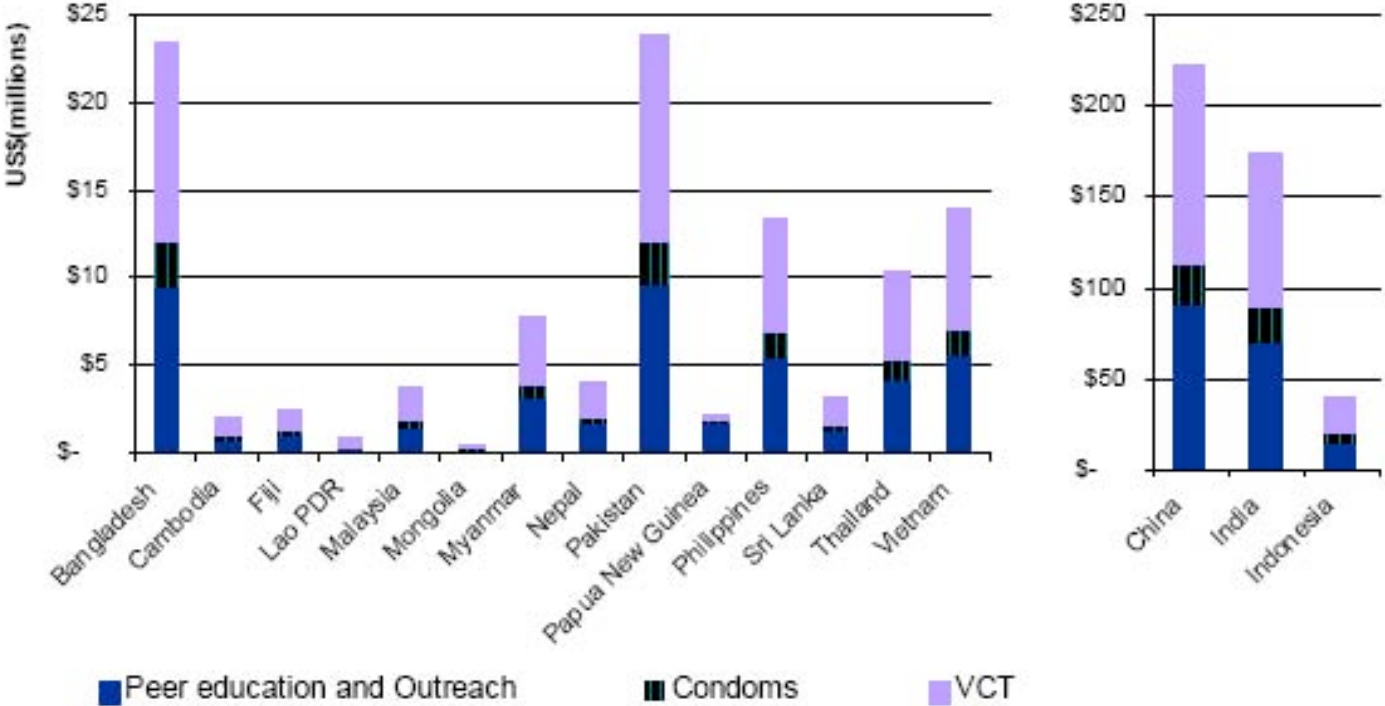


RESOURCE NEEDS ESTIMATE: METHODOLOGY

- **Interventions:** Based on the prevention components of the minimum package of services for MSM developed by USAID and CDC/Thailand in 2005
- **Unit costs:** \$57 – outreach per person reached; \$21 – peer education per person reached; \$47 per person receiving VCT; \$0.10 per condom distributed
- **Population:** Lower bound calculation assumes 1% of male population is in the MSM target group (conservative estimate)
- **Coverage:** Estimates 60% coverage of MSM with HIV prevention programs
- **Limitations:** More country-specific data needed to estimate costs for STI treatment, mass media, and advocacy (therefore, not included in the study)

RESOURCE NEEDS ESTIMATE: FINDINGS

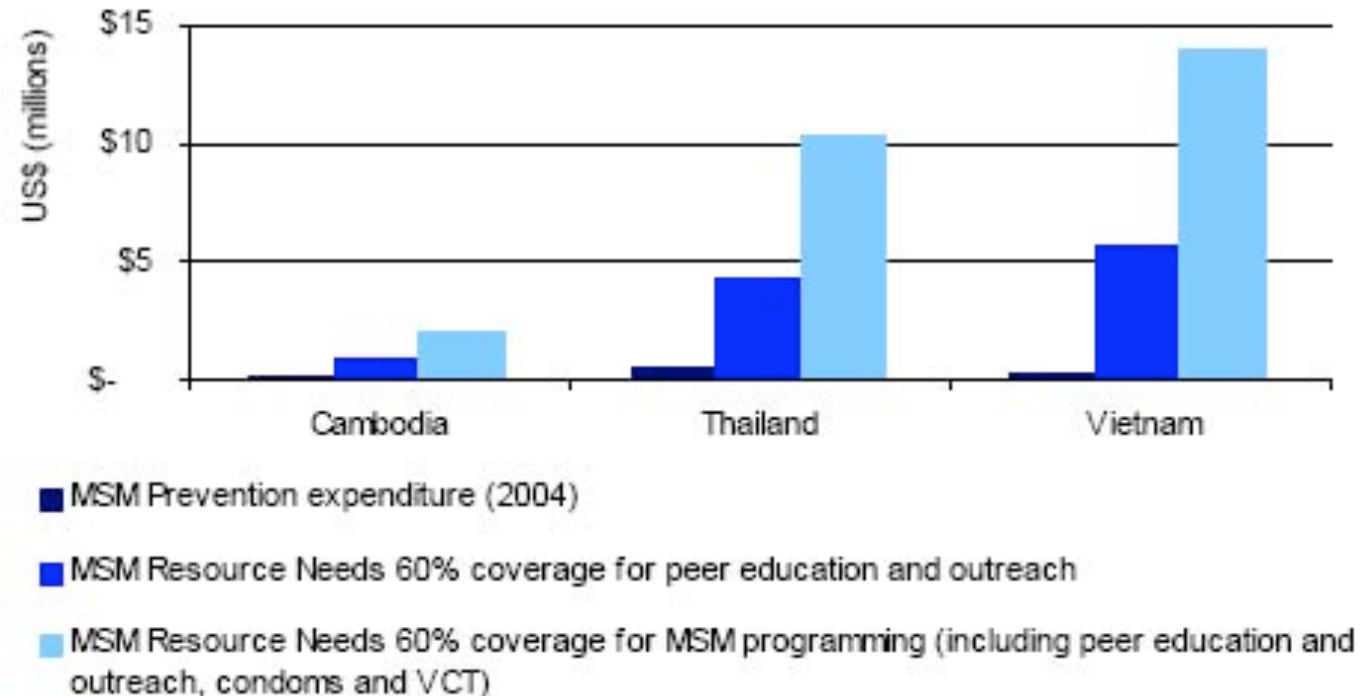
FIGURE 2.
Estimated Resources Required for HIV Prevention Among MSM



***An estimated \$550 million - \$2.7 billion is needed to achieve 60% coverage of MSM with peer education and outreach, VCT, and condoms and lubricants (assuming 1- 5% of males are MSM)**

RESOURCE NEEDS ESTIMATE: ANALYSIS

FIGURE 3.
Comparison of
2004 Prevention
Expenditures vs.
Resources
Required in
Selected
Countries



***Countries in the region need to increase MSM expenditures by anywhere from 4 to 25 times in order to reach at least 6 out of 10 MSM with HIV peer education and outreach programs. The number is even higher for VCT and condoms.**

CONCLUSION



MAJOR FINDINGS

- ✓ Large data gaps preclude systematic analysis of MSM expenditure
- ✓ Low coverage rates of HIV prevention interventions for MSM
- ✓ HIV expenditure for MSM low relative to overall expenditure and relative to need among MSM
- ✓ Large resource gap between current level of expenditure and level of resources needed
- ✓ Evidence that stigma affects resource allocation for MSM programs

THE WAY FORWARD

- Strong evidence base is needed to promote strategic planning and to overcome the stigma that influences resource allocation decisions
 - Evidence suggests a need for increased resource allocations for MSM programming
 - Research agenda should continue to assess cost-effectiveness of MSM interventions—essential for helping policymakers understand their value
 - Monitor scale-up of successful interventions
- Role of governments and donor organizations

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