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HIV EXPENDITURE ON MSM PROGRAMMING IN THE ASIA-PACIFIC REGION

Background paper produced for International Consultation on Male Sexual Health and HIV in Asia and the Pacific titled "Risks and Responsibilities" to be held in New Delhi, India, 22–26 September 2006

SEPTEMBER 2006

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EXECUTIVE SUMMARY

According to UNAIDS, at least 5–10 percent of all HIV cases worldwide are due to sexual transmission between men, though this figure varies considerably by country. In the Greater Mekong region, HIV prevalence among men who have sex with men (MSM) ranges between 3 and 17 percent, equal to 5–15 times higher than the general population. As a group, men who have sex with men (MSM) continue to be hidden and severely stigmatized, complicating the implementation of successful prevention programs. Beyond the benefit of preventing HIV transmission among MSM, HIV prevention interventions designed for MSM also benefit populations at lower risk of HIV infection. This is because the percentage of MSM reporting having sex with a woman is significant—ranging from 22 percent (in China and Vietnam) to as high as 43 and 70 percent in Cambodia.

The aim of the paper is to (1) compile information on expenditure for HIV prevention programs for MSM in the Asia-Pacific region and compare it to overall HIV prevention expenditure; (2) identify the main sources financing of MSM expenditures and the implications from a public economics perspective, raising specific issues such as predictability, sustainability, and additionality, among others, as they apply to the financing of MSM programs; and (3) estimate the resource requirements for MSM-related programming in the Asia-Pacific region and based on current expenditure quantify the resource gap.

Based on the available data, it appears that in the Asia-Pacific region expenditure on HIV prevention programs for MSM is very low relative to overall prevention expenditure, accounting for less than 4 percent of total prevention expenditure. The analysis brings to light the low coverage rates of prevention interventions for MSM, and questions the data quality where high coverage estimates have been reported.

It is estimated that between US\$550 million and US\$2.7 billion is needed annually in the countries of the Asia-Pacific region to achieve 60 percent coverage of the following MSM prevention activities: peer education and outreach, VCT, and condoms and lubricants under the assumption that between 1% and 5% of adult males are MSM. Roughly equal shares are needed for peer education/outreach and VCT, and a tenth of total resources are needed for condoms and lubricants. How big is the resource gap? In Cambodia, Thailand, and Vietnam, for example, an increase in MSM spending of 4, 8, and 25 times, respectively, is needed to achieve coverage of 60 percent for peer education and outreach programs (i.e. excluding VCT and condoms). Even more resources are needed in each country for the supply of condoms and lubricants, and VCT at the level of 60 percent coverage.

Prevention investment aimed at MSM has been demonstrated to be both effective and cost-effective in reducing risk behaviors among MSM. The challenge is to ensure that these impacts are replicated as programs are scaled up to achieve the necessary level of coverage to halt the spread of HIV seen in many parts of the Asia-Pacific region. A minimum of 60% coverage (but preferably 80% coverage) is needed to bring about the necessary behavior change. This suggests the importance of monitoring the program outputs and behavioral changes associated with interventions in order to continuously evaluate the effectiveness of the prevention programs. Equally important is the need to monitor the technical efficiency of programs to ensure optimal use to the available resources for given program outputs.

There is evidence of stigma in the patterns of resource allocation by national governments as well as donor governments. This suggests an important role for multilateral sources of funding, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and World Bank, to support evidence-driven motivations for investments in stigmatized, high-risk groups such MSM.

Finally, the results of this analysis make the case for follow-on work to better understand the level and patterns of resource allocation for specific risk groups, as done in the National AIDS Spending

Assessments. These assessments need to be expanded to a wider range of countries in the Asia-Pacific region in order to deepen the analysis of the issues raised in this paper.

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According to UNAIDS, at least 5–10 percent of all HIV cases worldwide are due to sexual transmission between men, though this figure varies considerably by country.¹ In the Greater Mekong region, HIV prevalence among MSM ranges between 3 and 17 percent, equal to 5–15 times higher than the general population.² As a group, men who have sex with men (MSM) continue to be hidden and severely stigmatized, complicating the implementation of successful prevention programs.

Beyond the benefit of preventing HIV transmission among MSM, HIV prevention interventions designed for MSM also benefit populations at lower risk of HIV infection. This is because the percentage of MSM reporting having sex with a woman is significant—ranging from 22 percent (in China and Vietnam) to as high as 43 and 70 percent in Cambodia, as noted by two studies.³

Recognizing the importance of meeting the needs of MSM for combating the HIV epidemic, this paper aims to compile information on expenditure for HIV prevention programs for MSM in the Asia-Pacific region and compare it to overall HIV prevention expenditure. Because of the paucity of disaggregated HIV expenditure data, particularly MSM expenditure data, a combination of direct and indirect methods are used in this paper to estimate the current levels of MSM expenditure. The paper also discusses the sources of financing of MSM expenditures and the implications from a public economics perspective, raising specific issues such as predictability, sustainability, and additionality, among others, as they apply to the financing of MSM programs. Principles from epidemiology and public economics are used to evaluate justifications for publicly-subsidized expenditure on HIV prevention among MSM. Finally, the paper addresses the issue of resource requirements for MSM-related programming in the Asia-Pacific region. The resource needs estimates are based on the results of an exercise to estimate the resource needs for a comprehensive package of MSM services, as was identified in a process led by the U.S.

¹ UNAIDS. 2000. *AIDS and Men who have Sex with Men*. Geneva: UNAIDS, p. 4.

² Van Greinsven F. *Epidemiology of HIV and STI in MSM in the Greater Mekong Region*. Presented at: “Strategizing Interventions among MSM in the Greater Mekong Sub-region.” Strategy Report of the CDC-GAP/USAID-RDM/FHI-APD Workshop, February 28–March 2, 2005, Bangkok, Thailand, p. 8.

³ U.S. Agency for International Development (USAID)/Centers for Disease Control and Prevention (CDC). 2005. “Strategizing Interventions among MSM in the Greater Mekong Sub-region.” Strategy Report of the CDC-GAP/USAID-RDM/FHI-APD Workshop, February 28–March 2, 2005, Bangkok, Thailand, p. 9.

Agency for International Development (USAID) and Centers for Disease Control and Prevention (CDC) in 2005. The unit cost data collection in support of the latter is described in a companion technical report⁴.

Q&A: WHY IS UNDERSTANDING THE LEVEL OF SPENDING ON HIV PREVENTION AMONG MSM IMPORTANT?

- *Sexual transmission of HIV between men accounts for 5–10 percent of all HIV cases worldwide*
- *In the Greater Mekong region, HIV prevalence among MSM ranges between 3 and 17 percent, equal to 5–15 times higher than the general population.*
- *Preventing HIV transmission among MSM benefits society as a whole because MSM often also report having sex with women, which can serve as a bridge to spread HIV to the wider population*
- *Motivations for increased expenditure on MSM programs have to be benchmarked against current level of HIV spending. Quantification of the resource needs and resource gap is critical for successful resource mobilization.*

EXPENDITURE ON PREVENTION PROGRAMS REACHING MSM

Expenditure data are incomplete, seldom disaggregated into intervention categories, and of poor quality. Box 1 highlights some of the challenges faced in extracting MSM-specific data from HIV expenditure data. Some of these are challenges associated with HIV expenditure data collection and others are specific to MSM expenditure data. Under the leadership of UNAIDS, various partners are spearheading the inclusion of financial resource tracking in the routinely collected monitoring and evaluation data. The inclusion of the necessary sub-categories in routine data collection as identified in the National AIDS Spending Assessment guidelines provides the promise of data improvement over time.⁵

Data from selected countries in the Asia-Pacific region have been collated from a variety of secondary sources. The present assessment is able to give only a snapshot of the funding picture and is incomplete (due to the challenges as outlined in Box 1). Expenditure data from selected countries in the Asia-Pacific region are shown in Table 1. The share of MSM expenditure as a proportion of total prevention expenditure ranges between a high of nearly 4 percent in Thailand to a low of zero percent in some provinces in China. Note that these expenditures are for 2004 and are higher in 2005 and 2006 although exact information is not available. These expenditures on MSM programs include peer education and outreach programs, drop-in centers, information, education, and communication (IEC) materials, and other small media for behavior change communication. Complementary activities such as voluntary

⁴ Sangruejee, N. Alkenbrack S, and Martin G.: Technical Note: Data collection and methodology for unit cost estimation of MSM Package of Services. 2005.

⁵ UNAIDS, *National AIDS Spending Assessment: A Notebook on methods, definitions and procedures for the measurement of HIV and AIDS financing flows and expenditures at country level*. UNAIDS, Geneva, May 2006.

counseling and testing (VCT) and treatment of sexually transmitted infections (STIs) among MSM are not usually reported as part of the MSM-related HIV prevention expenditure.

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

Country, City, or Province	MSM Prevention Expenditure	Total Prevention Expenditure	Share of 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%

BOX 1. MEASUREMENT CHALLENGES

Defining MSM expenditure. In this analysis, only expenditures for HIV prevention interventions were considered—excluding expenditure on care, treatment, and impact mitigation which is a departure from the definition proposed in the HIV/AIDS Survey Indicators Database.^a The types of interventions covered may include peer education and outreach programs, drop-in centers, condom social marketing, free condom distribution, and dissemination of IEC materials. It is seldom that programs targeting MSM deliver specialized services, such as VCT or STI treatment, but are more likely to offer referral to these services. It can be argued that safe sex messages aimed at the general population also benefit MSM, but these messages rarely include information about the specific dimensions of risk regarding HIV transmission between men.

MSM who are hidden. Because sex between men is highly stigmatized, a sizeable proportion of MSM cannot be identified and, hence, reached by prevention programs focusing on the specific risks related to HIV transmission between men.

Out-of-pocket expenditure and household expenditure on HIV prevention. There is generally a lack of information on individuals' out-of-pocket expenditure and is often a limitation of reporting on HIV-related expenditure. Examples are expenditure on condoms and lubricants, STI treatment at

⁶ USAID/CDC (2005), Strategy Report, p. 10. Personal Communication, Family Health International (FHI) Vietnam, August 2006. Personal Communication, FHI Cambodia, August 2006.

Personal Communication, POLICY Project/Cambodia, November 2005. Personal Communication, POLICY Project/Thailand, 2005.

Personal Communication, USAID | Health Policy Initiative, Task Order 1, Vietnam, August 2006.

BOX 1. MEASUREMENT CHALLENGES

pharmacies, and so on. In the absence of household or individual surveys, these expenditures are hard to obtain. Furthermore, unless the sampling frame is set to specifically reach special risk groups, household surveys will miss private MSM expenditure.

For the reasons listed above, the data collected on MSM expenditure may underestimate the true level of MSM prevention expenditure.

Budgeted versus actual expenditure. In expenditure reviews, actual expenditure versus budgeted allocations is preferred. The variance between budgeted and actual expenditure are quite large in some instances especially with new sources of HIV funding, usually an indication that financial resource availability has exceeded implementation capacity. Implementation of MSM programming is at such a low level that it is unlikely that data on MSM expenditure, in particular, will suffer from this problem.

Duplication of expenditure. Another data collection challenge is the double-counting of expenditures reported when implementing agencies are also financial intermediaries for donor funding that is channeled to other implementing agencies, or when donors are also implementing agencies for other donors. Examples are: (1) international NGOs who are implementing agencies, but also channel donor funding to local NGOs, or (2) United Nations agencies, generally thought of as donors, who act as implementing agencies for bilateral donors. A simple aggregation of reported expenditures will, therefore, likely suffer from some degree of double counting. This can be minimized by collecting data from implementing agencies and donors separately. However, for the collation of data for this analysis, no primary data collection was undertaken and it is impossible to assess the extent of double counting.

Currency and adjustments for purchasing power parity. The expenditures have been reported in US\$ to facilitate aggregation and comparison. Purchasing power parity (PPP) takes into account variances in domestic purchasing power of a given level of expenditure. However, it makes the assumption that prices of HIV-related goods and services purchased follow the same structure as the broader economy, which is not necessarily the case. Variance in domestic and international purchasing power is especially of concern for non-tradable inputs, for example, domestically provided labor inputs. Where goods are purchased from international markets (e.g., imported drugs, imported medical supplies, and international technical assistance), the conversion to international dollars does not make sense. The result would be internally inconsistent aggregate estimates of expenditure and, for this reason, the reporting and analysis is done in US\$ in this paper.

^a The HIV/AIDS Survey Indicators Database is a comprehensive source of information on HIV and AIDS indicators derived from sample surveys (see <http://www.measuredhs.com/hivdata>). The proposed definition for HIV/AIDS expenditure is: "The amount of money allocated in national accounts for spending on HIV/AIDS prevention and care programs, per adult aged 15–49."

Given the data limitations, an indirect method is also used to assess the level of expenditure on HIV prevention programs for MSM and, where possible, the results of the two approaches are compared. The rationale for this indirect approach is to use available coverage data from various sources to calculate the implied expenditure based on coverage data. Three pieces of information are needed: population size, coverage, and unit costs.

- ***Population size.*** It was assumed that between 1 and 5 percent of the adult male population reflected the total number of MSM in need of HIV prevention interventions. The lower bound

estimate (1% of adult males) was used to reflect MSM engaging in high-risk sex, defined as unprotected anal sex or commercial sex. This was informed by the first systematic analysis of published and unpublished surveillance and research data on the prevalence of same-sex sexual activity among male adults (including male-to-female transgenders and sex workers) in low- and middle-income countries.⁷ The upper bound estimate (5% of adult males) was based on the data from Cáceres et al. (2006) on the proportion of male-to-male sexual activity in the last year.

- **Coverage.** UNAIDS reported coverage data for specific risk groups, including MSM, in the country profiles of the *2006 Report on the Global AIDS Epidemic*.⁸ Another source of coverage data is the 2005 survey of coverage of selected HIV, prevention, treatment, and care services.⁹
- **Unit costs.** The unit cost assumptions (needed to convert the coverage data into estimated expenditure required to achieve a given level of coverage) were informed by the unit costs used in the global resource needs estimation by UNAIDS.¹⁰ Based on the country-specific unit costs from the regional Resource Needs Modeling workshops, the median cost for the region is US\$47.¹¹

The results of this analysis are presented in Table 2. For some countries (e.g., Cambodia, , Lao PDR, Thailand), the implied level of expenditure calculated using the indirect approach was relatively consistent with the country data reported in Table 1. However, there were examples where the indirectly derived estimates of MSM expenditure provide non-credible estimates. For example, according to the Coverage Survey¹², the percentage of MSM in Bangladesh being reached with prevention programs is 77 percent.¹³ The implied number of MSM being reached is between 0.3 million and 1.6 million (assuming between 1% and 5% of adult men are MSM). Assuming a cost per MSM reached of \$47, the implied level of MSM expenditure is between US\$14.7 million and US\$73.3 million. This figure is not credible in view of an estimated total HIV spending for Bangladesh of US\$4.4 million. It is, therefore, difficult to determine which approach provides the preferred estimate of MSM expenditure—both data sources are flawed by incomplete data and data quality limitations.

⁷ Cáceres C., K. Konda, M. Pecheny, A. Chatterjee, and R. Lyerla. 2006. “Estimating the Number of Men who Have Sex with Men in Low- and Middle-income Countries.” *Sexually Transmitted Infections* 82: 3–9.

⁸ UNAIDS. 2006. *2006 Report on the Global AIDS Epidemic*. Geneva: UNAIDS, pp. 296–500.

⁹ Stover, J., and M. Fahnestock. 2006. *Coverage of Selected Services for HIV/AIDS Prevention, Care, and Treatment in Low- and Middle-income Countries in 2005*. Washington, DC: Constella Futures, POLICY Project.

¹⁰ UNAIDS. 2005. “Resource Needs for an Expanded Response to AIDS in Low- and Middle-income Countries.” Geneva: UNAIDS.

¹¹ Regional median is US\$47.0 and the interquartile range is US\$40.3–US\$57.5 (Personal Communication, John Stover, Futures Institute, August 2006).

¹² UNAIDS. 2005. “Resource Needs for an Expanded Response to AIDS in Low- and Middle-income Countries.” Geneva: UNAIDS.

¹³ Stover, J., and M. Fahnestock. 2006. *Coverage of Selected Services for HIV/AIDS Prevention, Care, and Treatment in Low- and Middle-income Countries in 2005*. Washington, DC: Constella Futures, POLICY Project.

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 ¹⁴	Range of estimated expenditure ^{15,16}	
	UNAIDS ¹⁷	Coverage survey ¹⁸		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

Based on the available data, it appears that expenditure on MSM prevention programs is very low relative to overall prevention expenditure (shown in Table 1), accounting for less than 4 percent of total prevention expenditure.

In comparison, data from Latin America and the Caribbean estimate that MSM-related HIV expenditures range from 0.01 to 6.5 percent (median=0.3%) of the countries' total prevention expenditures (see Appendix A).

¹⁴ US Census Bureau website. Accessed on August 26, 2006. <http://www.census.gov/ipc/www/idbprint.html>

¹⁵ Regional median is US\$47.0 and the interquartile range is US\$40.3–US\$57.5 (not including cost of condoms, STI treatment, and VCT). (Personal Communication, John Stover, Futures Institute, August 2006).

¹⁶ The minimum value of the coverage data obtained from UNAIDS (2006) and the coverage survey (Stover and Fahnestock, 2006) was used in the calculations.

¹⁷ UNAIDS. 2006. *2006 Report on the Global AIDS Epidemic*. Geneva: UNAIDS.

The definition used in this publication is: “the percentage of MSM receiving one of the following services: community outreach programs that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment.”

¹⁸ Stover, J., and M. Fahnestock. 2006. *Coverage of Selected Services for HIV/AIDS Prevention, Care, and Treatment in Low- and Middle-income Countries in 2005*. Washington, DC: Constella Futures, POLICY Project. The definition used in this publication is: “percentage of MSM receiving outreach.”

Q&A: WHAT LEVEL OF EXPENDITURE IS DEVOTED TO MSM PROGRAMS?

- *For various reasons—including that expenditure data are rarely disaggregated by sub-group and that MSM are often a hidden population that is difficult to track—accurately estimating the level of spending on MSM programs remains a challenge*
- *Best available data suggest that HIV prevention efforts targeted to MSM constitute a very small proportion of overall prevention expenditure*
- *These spending levels are not commensurate with the proportion of HIV cases attributed to HIV transmission via sex between men*
- *Secondary data estimates suggest that MSM-related HIV prevention expenditure ranges from a high of nearly 4 percent in Thailand to a low of zero percent in some provinces in China*

SOURCES OF FINANCING

Data limitations prevented a systematic analysis of the sources of financing for MSM prevention programs. However, anecdotal evidence from many countries in the region and communications with key informants suggest that expenditure on MSM interventions are mainly funded by donors (including bilateral donors, multilateral donors, and private foundations) and implemented by NGOs and CBOs.¹⁹

When implementing prevention programs and campaigns, governments usually focus on interventions aimed at the general public or more easily identifiable groups, such as female sex workers.²⁰ Why do we see such low government commitment for MSM programs? Legal prohibitions against sex between men are reported to exist in 11 out of 23 countries surveyed in the Asia-Pacific region,²¹ and may be offered as a possible explanation for present and future lack of funding by governments. However, this provides only a partial explanation because sex work is similarly illegal in many countries and governments do, in fact, provide funding for programs targeting sex workers. Another explanation that is offered is that data weaknesses preclude systematic analysis of the relative importance of various risk groups, including MSM. Despite these data weaknesses (which also apply to many other risk groups), governments and donors year after year make resource allocation decisions.

The failure of the declaration from the United Nations High-level Meeting on HIV/AIDS²² in July 2006 to address some of the root causes of HIV transmission in Asia, including sex between men, suggests a continuing struggle within countries, governments, and some donor organizations to recognize that the HIV response cannot be effective without supporting prevention interventions for marginalized, high-risk groups. This is especially important for the Asia-Pacific region. In contrast to regions such as sub-Saharan

¹⁹ AMFAR – Treat Asia 2006. *MSM and HIV/AIDS Risk in Asia: What is fueling the epidemic among MSM and how can it be stopped?* Special Report, Treat Asia, New York, NY.

²⁰ Ibid. p. 19.

²¹ Ibid. p. 17

²² United Nations General Assembly: *Political Declaration on HIV/AIDS*. Resolution adopted by the General Assembly Sixtieth session 15 June 2006. <http://www.un.org/ga/aidsmeeting2006/documents.html>

Africa—that are experiencing generalized epidemics spread primarily through heterosexual sex—the spread of HIV in the Asia-Pacific region is fueled by concentrated epidemics among groups such as MSM, sex workers, and injection drug users. These are groups that face “double stigma”—they are marginalized for engaging in highly stigmatized behavior and they are stigmatized for their association with HIV. This stigma affects the entire range of policies and services for high-risk groups, including the extent to which governments will step forward and champion the needs of marginalized populations and allocate resources to address their needs.

The reliance on international funding for MSM programs is likely to continue. Heavy donor reliance is usually viewed with great concern, raising public finance issues such as donor influence in priority setting, disincentives for domestic funding, the crowding out of government financing, and questions about additionality of donor resources, volatility and lack of predictability of donor funding, and lack of sustainability. It can be argued that these public finance issues may need to be viewed in a slightly different light in view of the high level of stigmatization associated with MSM programming within the Asia-Pacific region. These issues are briefly discussed below.

Priority Setting, Disincentives, and Additionality

Donor influence over countries’ priorities—in particular, government priorities—is usually viewed as a negative consequence of large aid inflows.^{23,24} However, where MSM are highly stigmatized and marginalized, the emphasis on an issue by international partners may be a welcome consequence of donor funding.

In some instances, donor influence serves to highlight the feasibility of an intervention (e.g., financial and operational feasibility) and make up-stream investments that governments may take up as the issue of feasibility is addressed. The case of antiretroviral treatment (ART) may be an example. However, this is not necessarily the case for funding for MSM programming. Some governments may continue to be reluctant to support MSM programming and, therefore, the continuing importance of donor funding may be a reality for programs aimed at MSM in some countries.

A recent evaluation of World Bank HIV projects²⁵ highlighted the failure of many of the projects to implement priority interventions targeting high-risk groups, including MSM. A further weakness was the failure to implement planned activities targeting high-risk groups even when such interventions would be deemed highly efficient in terms of infections averted and have been included in implementation plans.²⁶

The low priority placed on MSM programs by national governments may be a particularly pertinent issue for countries that are no longer eligible for donor funding because of economic growth and graduation from donor-eligible to donor-ineligible status (e.g. South Korea, Singapore, Taiwan and Malaysia). The

²³ Lewis. 2005. Addressing the Challenge of HIV/AIDS: Macroeconomic, Fiscal and Institutional Issues. Center for Global Development, Working Paper Number 58 April 2005, Washington DC.

²⁴ UNDP 2006. Macroeconomic issues of aid flows for HIV/AIDS, New York NY.

²⁵ Ainsworth M, D Vaillancourt, J H Gaubatz. 2005. *Committing to Results: Improving the Effectiveness of HIV/AIDS Assistance. An OED Evaluation of the World Bank’s Assistance for HIV/AIDS Control*. World Bank. Washington, DC.

²⁶ *Ibid.*, p. 33. “An important lesson is that including these interventions in implementation plans or on a list of interventions to be supported does not ensure that they will be implemented to the extent necessary to reduce HIV transmission. Strong incentives and supervision by the Bank are critical to ensure that they are implemented.”

cut-off point varies by donor, but this is a very real discussion for countries in the Asia-Pacific region, where economic growth rates are the highest globally.

Can donor support for HIV programming be a disincentive for increasing government commitment? If this were true, removal of donor funding would be followed by an increase in government funding. The experience in the region has shown that when donor funding decreases, the support of NGOs is not replaced by host governments. In fact, in the absence of donor support, many NGOs would not even be in existence.

Even if governments were to be able to increase resource allocation for MSM, there are some challenges of financial flows between financing agencies (e.g. the Ministries of Finance or National AIDS Authorities) and implementing agencies (e.g. NGOs) that may arise. Interventions aimed at MSM are mostly implemented by NGOs, yet governments sometimes have difficulty channeling resources to NGOs. In some countries, the existence of NGOs is a relatively new phenomenon or NGOs have limited access to government funding. This situation will have to be addressed to ensure that increase resource allocation for MSM programs are successfully channeled to implementing agencies.

Volatility and Lack of Predictability

Predictability improves technical and allocation efficiency because when constrained to single-year planning, implementing agencies are not able to plan over a sufficiently long time horizon to make the necessary investments in infrastructure and human capacity and the types of activities that would make programmatic sense. Uncertainty also compromises plans for scaling up programs. It is, therefore, not surprising that MSM program coverage is very low even in countries at the forefront of the response in the region, such as Thailand.

Development finance research suggests that volatility of external financing is about 40 times higher than that of tax revenue as a source of funding.²⁷ The likely continued reliance of MSM programming on donor funding suggests that volatility is inevitable. However, where possible, this volatility should be minimized. One example is if donors were to move from a one-year planning horizon to at least a two-year planning framework. Donors seldom are able to make legal commitments to the second year of funding, but extending at least the planning time-frame would be one step toward mitigating the negative effects of volatility.

Sustainability

Sustainability has largely been thought of in financial terms as self-sufficiency. The concern arises from the availability of recurrent expenditure to sustain the past investments that have been made in a project. Optimists about sustainability of donor-funded projects often argue that after the successful implementation of the project, there will be sufficient commitment from national decisionmakers to take over financing of the project. Alternately, it is argued that the economy will grow at a sufficient pace so that by the end of the donor funding, there will be sufficient fiscal space for government to take on the financing of the project.

Many economies in the Asia-Pacific region are growing at rates that are well in excess of the global average—e.g., China, India, and Vietnam have, on average, outpaced growth in other countries for the past seven years. In countries in the region, the tax revenue base from which public expenditure is

²⁷ Bulir A. and Hamman A.J. 2005. Volatility of development aid: From the frying pan into the fire? International Monetary Fund Working Paper (Draft). IMF, Washington, DC.

financed is growing and, thereby, reducing the fiscal constraints that may be said to hamper domestically-funded HIV spending. The UNAIDS 2006 annual report commented on the fact that Asian governments “should be spending more on HIV and could afford to do so but have yet to recognize HIV as an urgent problem requiring more attention.”²⁸ That being said, the increased fiscal space does not necessarily bring the promise of increased funding for MSM programming given the highly stigmatized nature of MSM in some countries. Translating any increases in domestically-financed HIV spending into increased resources for MSM programming will be a challenge.

The evidence above suggests a high likelihood of continued strong reliance on donor funding for MSM programming and ongoing challenges of financial sustainability. One can also think of alternate ways that non-financial forms of sustainability may be advanced. If donor-funded expenditures are used to invest in local capacity and institutional strengthening, the prospects for continued existence of a program may be more likely even despite the break of funding in a particular year. If the human and institutional capacity investments have been made, there will be greater likelihood that local (including private) sources of financing could be mobilized.

Q&A: WHERE DOES FUNDING FOR HIV PREVENTION PROGRAMS FOR MSM COME FROM AND WHY DOES IT MATTER?

- *HIV prevention programs for MSM in the Asia-Pacific region rely heavily on external donor support and are typically implemented by NGOs*
- *Donors can have an influence on in-country approaches, thereby raising awareness of priority issues that governments may not address*
- *Governments in the Asia-Pacific region have been reluctant to allocate in-country resources to MSM programs; the heavy stigma surrounding MSM and HIV may be a possible reason for this reluctance*
- *However, heavy reliance on donors for MSM interventions will likely lead to volatility in funding levels and make it more difficult for countries to plan and implement appropriate, sustainable programs*
- *Some countries in Asia are experiencing economic growth rates that are higher than the global average and should, therefore, be able to afford increased spending on HIV, in general, and for prevention among MSM, in particular*
- *Donor investments geared toward human and institutional capacity building of MSM programs can help enhance future sustainability of programs*

JUSTIFICATIONS FOR MSM EXPENDITURE

Various motivations exist for government subsidization of HIV prevention activities and services for HIV-related care and treatment. Traditional market failure motivations, such as pure and quasi-public

²⁸ UNAIDS. 2006. *2006 Report on the Global AIDS Epidemic*. Geneva: UNAIDS, p. 234.

goods,²⁹ and externalities are key justifications for subsidization.³⁰ If the benefits of an activity are primarily private and few externalities accrue, the justification for publicly-funded expenditure is weak. An example is treatment of STIs³¹. However, if the externalities are large, whether positive or negative, the justification for public subsidies is stronger, e.g. peer education and outreach programs aimed at bringing about behavior change. Another key set of justifications for subsidization focuses on equity arguments and is particularly pertinent for access to care and treatment—however, the focus of this paper is mainly on prevention expenditures so this argument will not be addressed here. The aforementioned public economics principles provide a framework for making resource allocation decisions.

Disease Burden and Share of Risk

The mismatch between disease risk and disease burden, on the one hand, and funding for programs targeting most at-risk populations, on the other hand, have been raised in several publications.³² A well known comparison using SIDALAC data is shown in Figure 1. In most countries, the percentage of HIV prevention expenditure allocated to MSM is disproportionately lower than the number of the population's HIV infections that are attributed to transmission via sex between men. Further evidence of this mismatch can be gleaned from the evaluation conducted by the World Bank. One of the key criticisms was the failure to design programs for high-risk groups, such as female sex workers, injection drug users, and MSM, even where the epidemiology suggested this priority³³.

Data from Ho Chi Minh City provide some evidence from the Asia-Pacific region of the similar mismatch between level of risk and prevention expenditure illustrated above. In 2004, MSM as a risk group (including male sex workers) accounted for an estimated 6.1 percent of current adult infections and 8.5 percent of new infections. In the same year, interventions targeting MSM accounted for less than 1 percent of HIV prevention expenditure in Ho Chi Minh City.³⁴

²⁹ Pure public goods have the following characteristics: non-rival and non-excludability, i.e., goods where the marginal cost of an additional person consuming the good is zero and where the cost of excluding an individual from its benefits is infinite or prohibitive. There are intermediate cases where the consumption of a good affects, to some degree, its availability to others—these are called quasi-public goods (Mas-Colell A, Whinston MD, Green JR, *Microeconomic Theory*, Oxford and New York, Oxford University Press, 1995: p. 360).

³⁰ It is worth noting that, in recent decades, additional sources of market failure—such as imperfect information, imperfect and incomplete markets, multiple equilibriums, path dependence, and increasing returns to scale—have been stressed as further motivations for government intervention.

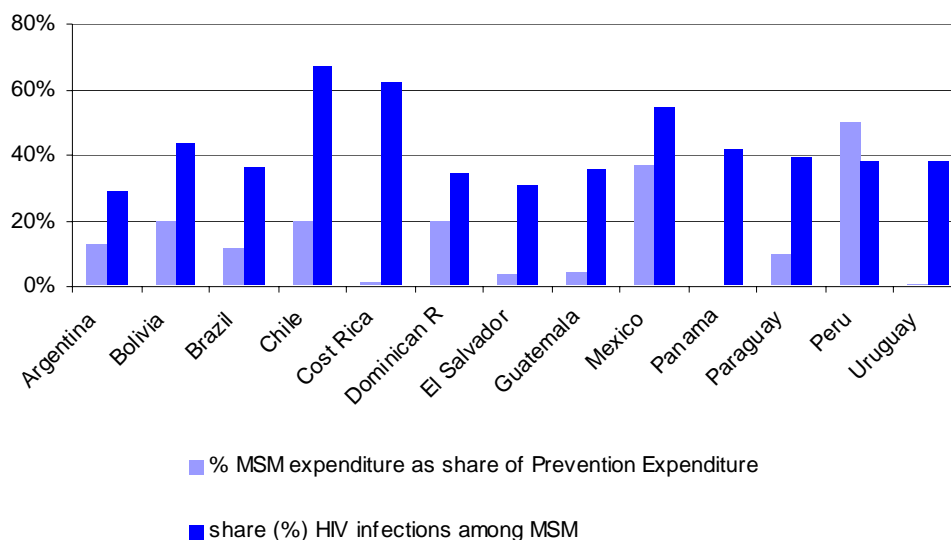
³¹ If one considers the role of treated STIs in reducing the probability of HIV transmission it can be argued that there are in fact some positive externalities associated with STI treatment.

³² United Nations Program on HIV/AIDS (UNAIDS). 2006. *Report on the Global AIDS Epidemic*. Geneva, Switzerland: UNAIDS; Ainsworth M, D Vaillancourt, J H Gaubatz. 2005. *Committing to Results: Improving the Effectiveness of HIV/AIDS Assistance*. An OED Evaluation of the World Bank's Assistance for HIV/AIDS Control. World Bank. Washington, DC.

³³ Ainsworth M, D Vaillancourt, J H Gaubatz. 2005. *Committing to Results: Improving the Effectiveness of HIV/AIDS Assistance*. An OED Evaluation of the World Bank's Assistance for HIV/AIDS Control. World Bank. Washington, DC.

³⁴ A² Project Vietnam.

FIGURE 1. BENEFICIARY ANALYSIS IN CONCENTRATED EPIDEMICS IN LATIN AMERICA: COMPARING MSM EXPENDITURE TO DISEASE BURDEN³⁵



Effectiveness of MSM Interventions

In 2005, a meta-analysis was conducted using data from 33 studies described in 65 reports. Interventions³⁶ were associated with a significant decrease in unprotected anal sex (odds ratio [OR] = 0.77, 95% confidence interval [CI]: 0.65–0.92) and number of sexual partners (OR = 0.85, 95% CI: 0.61–0.94) and with a significant increase in condom use during anal intercourse (OR = 1.61, 95% CI: 1.16–2.22).³⁷

Cost-effectiveness Analysis

Cost effectiveness analysis allows for the comparison of various prevention scenarios using the same metric, namely prevention cost per infection averted. An example from a large sub-national location in the region illustrates that MSM is not only an important source of the number of new infections, but also is a cost-effective option to include in a strategic response to HIV in Asian countries³⁸.

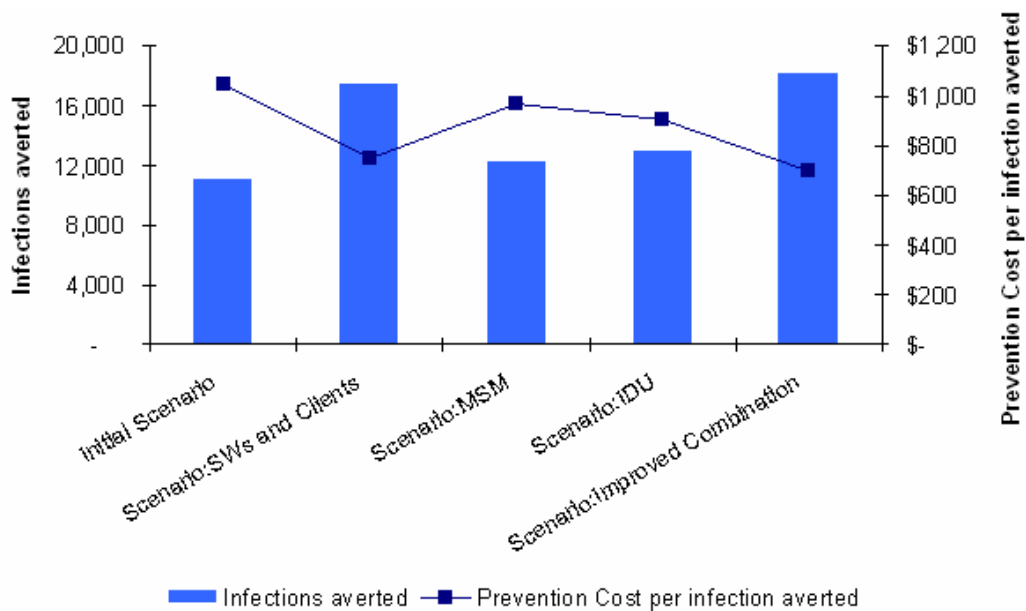
³⁵ SIDALAC. 2001. National HIV/AIDS Accounts: National estimation of financial flows and expenditures on HIV/AIDS. Mexico, DF: FUNSAUD; 2001.

³⁶ These interventions included: small group or community-level outreach- or peer-based education, individual and group counseling, skills training, and motivational campaigns to maintain behavior change.

³⁷ Herbst, J.H., T.R. Sherba, N. Crepaz, J.B. DeLuca, L. Zohrabyan, R.D. Stall, C.M. Lyles, and the HIV/AIDS Prevention Research Synthesis Team. 2005. A Meta-Analytic Review of HIV behavioral interventions for reducing sexual risk behavior of men who have sex with men (MSM). *J Acquir Immune Defic Syndr* 39 (2): 228–241.

³⁸ This modeling of alternate resource allocation scenarios was used in the process of deciding on the most cost effective resource allocation scenario to guide the implementation plan. The various scenarios compared are:
Scenario: Initial allocation: This scenario reflects the starting point of the scenario modeling process where the priorities were not necessarily informed by epidemiologic and effectiveness data;
Scenario SW and clients: Similar to the initial scenario, but emphasizing SW and their clients because this groups showed to be the largest contributor to the number of new infections.
Scenario MSM: Similar to the initial scenario, but emphasizing MSM and male SWs because these groups showed to be a key contributor to the number of new infections.

FIGURE 2. CUMULATIVE INFECTIONS AVERTED AND PREVENTION COSTS PER INFECTION AVERTED UNDER DIFFERENT RESOURCE ALLOCATION SCENARIOS (2006-2010)³⁹



Q&A: WHY SHOULD GOVERNMENTS INVEST IN MSM PROGRAMS?

- *There is a disparity between the disease risk and disease burden borne by MSM and the current level of spending on HIV prevention programs for MSM*
- *Targeted interventions to prevent HIV among MSM have been proven to be effective, resulting in a reduced number of sexual partners, increased condom use, and less unprotected sex*
- *An example from a large sub-national location in the region illustrates that MSM is not only an important source of the number of new infections, but also is a cost-effective option to include in a strategic response to HIV in Asian countries.*

Scenario IDU: Similar to the initial scenario, but emphasizing intervention targeting IDUs (counseling and testing for IDUs, methadone programs, needle and syringe programs) because this group was found to be a key contributor to the number of new infections.

Scenario Improved allocation: This scenario combines the information from the scenarios targeting key risk groups into a more cost effective and preferred resource allocation pattern.

³⁹ Own Calculations. Contact Author for details.

RESOURCE NEEDS ESTIMATES

The current level of funding for MSM programming can only be fully evaluated when compared to the resource requirements for addressing HIV and AIDS as a whole. Before doing so, it is worth revisiting the motivations for public⁴⁰ subsidization of MSM prevention programs.

In 2005, USAID and CDC/Thailand led a process of developing a package of prevention, care, and treatment services aimed at MSM. Table 3 lists the prevention interventions identified in the package of services. As described in Sangrujee et al. (2005)⁴¹ cost data were collected from existing MSM programs in Thailand and the unit costs of each of these elements of the package of services were estimated.

TABLE 3. INTERVENTIONS INCLUDED IN THE MSM PACKAGE OF SERVICES

Prevention

- Counseling and peer education
- Outreach
- Condom provision
- Voluntary counseling and testing
- STI management
- Mass media
- Vulnerable population 1: Male sex workers
- Vulnerable population 2: Transgenders
- Vulnerable population 3: MSM Youth
- Advocacy and network development

Care and Treatment

- Palliative care
- Home/community-based care
- Opportunistic infection treatment
- Opportunistic infection prophylaxis
- Treatment advocacy
- Laboratory tests for ART
- ART
- Training
- Nutritional support
- Support groups and drop-in centers

Policy, Administration, Management, and Monitoring and Evaluation

⁴⁰ The sources of publicly subsidized expenditure comes from tax revenue, whether from the country in question (in the form of government expenditure) or from a donor country (in the form of bilateral and multilateral donor assistance). The World Bank funded expenditure is a combination of national and donor country funding because a share of World Bank assistance is repaid by the national government, presumably from tax revenues. The share of repayment will vary by the income level of the country.

⁴¹ Sangrujee, N. Alkenbrack S, and Martin G.: Technical Note: Data collection and methodology for unit cost estimation. 2005.

TABLE 4. UNIT COSTS OF COMPREHENSIVE PACKAGE OF SERVICES FOR MSM (US\$)⁴²

Counseling and Peer Education	
Cost per condom and lubricant distributed	\$0.10
Cost per MSM reached	\$21.12
Cost to train one new counselor per year	\$18.75
Cost of refresher training for counselor per year	\$25.81
Outreach	
Cost per MSM reached	\$57.23
Training for one outreach worker per year	\$16.13
Refresher training	\$25.81
Mass Media	
Workshop	\$1,000
Mass media campaign	\$37,500
Behavior change communication campaign	\$1,750
Materials (CD, brochure)	\$0.15
Outreach and Skills Development for Male Sex Workers	\$42.24
Cost per Transgender Reached	\$21.12
Cost per MSM Youth Reached	\$21.12
Advocacy (including network development/linkages)	
Cost per meeting	\$75.00
Condom Provision	
Condom distributed by the public sector	\$0.10
Condom distributed by social marketing	\$0.30
Voluntary Counseling and Testing	
VCT per MSM reached	\$47.00
STI Management	
STI treated in clinic	\$8.34

As mentioned earlier in the paper, the median unit cost of prevention programs for MSM in Asia was US\$47⁴³ per MSM reached, as used in the global resource needs estimation process. The cost data presented for the comprehensive package of services suggests a unit cost per well in excess of the \$47 per person currently used in the global calculations.

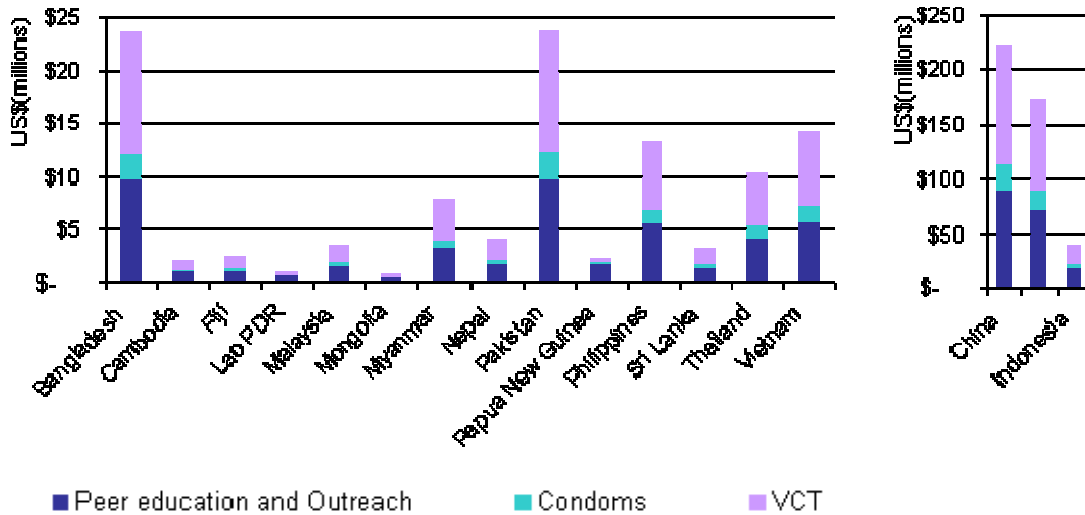
The total resource requirements per country in the Asia-Pacific region were calculated using the following estimates: US\$57 per person reached by outreach, US\$21 per person reached by peer education, US\$47 per person receiving VCT, and US\$0.10 per condom distributed. In this calculation, the lower bound estimate of 1% of the male population was used to estimate the number of MSM in need of the prevention

⁴² Sangrujee, N. Alkenbrack S, and Martin G.: Technical Note: Data collection and methodology for unit cost estimation. 2005.

⁴³ Personal Communication, John Stover, Futures Institute, August 2006.

intervention. The assumed coverage target is 60 percent.⁴⁴ The analysis excluded costs of STI treatment, mass media, and advocacy because more country-specific data are needed than the present analysis allows. The intention is to get a conservative estimate of the order of magnitude of resource requirements compared with what is currently available. The results of the resource needs estimation are shown in Figure 3 and Figure 4.

FIGURE 3. ESTIMATED RESOURCES REQUIRED FOR MSM PREVENTION (US\$ MILLIONS)⁴⁵



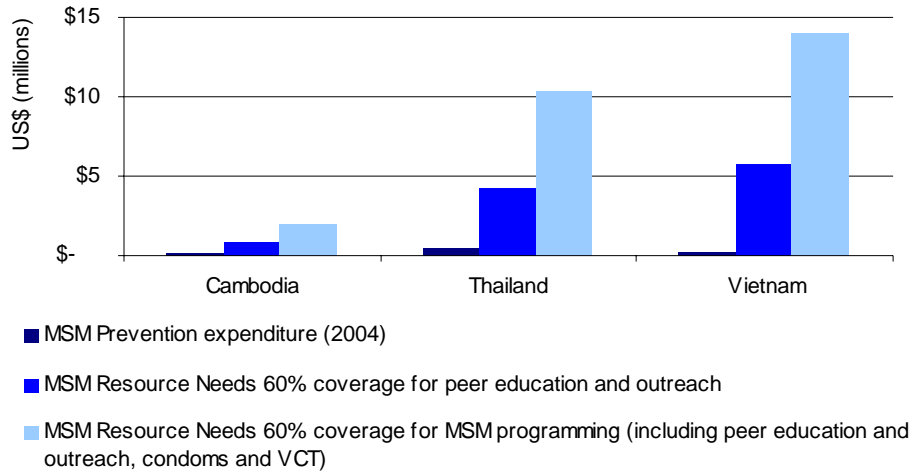
In order to give meaning to these estimates, they should be compared to what is currently being spent on MSM prevention programs, as shown for selected countries in Figure 3. In Cambodia, Thailand, and Vietnam, for example, an increase in MSM spending of 4, 8, and 25 times, respectively, is needed to achieve coverage of 60 percent for peer education and outreach programs.⁴⁶ Even more resources are needed in each country for supply of condoms and lubricants, and VCT at the level of 60 percent coverage. (A direct comparison of this higher level of resource needs is not made with current MSM spending because the latter does not include VCT and is unlikely to include condoms and lubricants distributed for use by MSM.)

⁴⁴ In the UNAIDS resource needs estimation (UNAIDS, 2005), reported in UNAIDS (2006), a coverage target of 80 percent is used. The estimates derived here can, thus, be thought of as conservative or lower bound estimates.

⁴⁵ Note the condom requirement is an average of two sex acts per week. This is a very conservative estimate and can easily be changed.

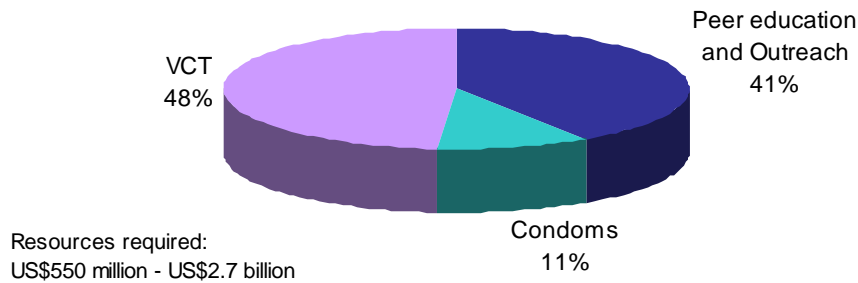
⁴⁶ To achieve a coverage target of 80 percent in Cambodia, Thailand, and Vietnam, an increase in MSM spending of 5, 11, and 34 times, respectively, is needed to achieve coverage of 60 percent for peer education and outreach programs.

FIGURE 4. RESOURCES REQUIRED FOR MSM PREVENTION



Using the resource needs estimates in Figure 3, it is estimated that between US\$550 million and US\$2.7 billion is needed to achieve 60 percent coverage of the following MSM prevention activities: peer education and outreach, VCT, and condoms and lubricants under the assumption that between 1% and 5% of adult males are MSM. Roughly equal shares are needed for peer education/outreach and VCT, and a tenth of total resources are needed for condoms and lubricants (Figure 4).

FIGURE 5. SHARE OF RESOURCES REQUIRED FOR MSM PREVENTION (%)



Q&A: WHAT LEVEL OF RESOURCES IS NEEDED?

- *Overall, an estimated \$550 million is needed to reach 60 percent of MSM in the region with peer education/outreach, VCT, and condoms and lubricants*
- *About half of this spending would be needed for VCT, with another 40 percent allocated to peer education and outreach, and 10 percent devoted to condom distribution*
- *Best available data suggest that countries need to increase their MSM expenditures by anywhere from 4 to 25 times in order to reach at least 6 out of 10 MSM with peer education and outreach programs*

CONCLUSION

Large data gaps preclude a systematic analysis of expenditure on MSM. However, some of the resource gaps are so obvious that some broad conclusions can be drawn with a reasonable level of confidence.

The analysis brings to light the low coverage rates of prevention interventions for MSM. For example, MSM are one of the key risk populations that are driving the epidemic in Thailand, a country at the forefront of the HIV response in the region, yet service providers have only been able to reach approximately 1 percent of MSM through prevention activities.

Based on the available data, it appears that expenditure on HIV prevention programs for MSM is very low relative to overall prevention expenditure, accounting for less than 4 percent of total prevention expenditure, despite evidence that sex between men contributes to 5–10 percent of new infections worldwide. There is considerable variation between countries in the contribution of sex between men to incidence of HIV infections as well as in the share of prevention expenditure devoted to prevention among MSM. On a country-by-country basis, the level of prevention expenditure needs to be consistent with the level of HIV risk and disease determinants.

There is evidence of stigma in the patterns of resource allocation by national governments as well as donor governments. This suggests an important role for multilateral sources of funding, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and World Bank, to support evidence-driven motivations for investments in stigmatized, high-risk groups such MSM.

Prevention investment aimed at MSM has been demonstrated to be effective in reducing risk behaviors among MSM.⁴⁷ The challenge is to ensure that these impacts are replicated as programs are scaled up to achieve the necessary level of coverage to halt the spread of HIV seen in many parts of the Asia-Pacific region. This suggests the importance of monitoring the program outputs and behavioral changes associated with interventions in order to continuously evaluate the effectiveness of the prevention programs. Equally important is the need to monitor the technical efficiency of programs to ensure optimal use to the available resources for given program outputs.

⁴⁷ Herbst, J.H., T.R. Sherba, N. Crepaz, J.B. DeLuca, L. Zohrabyan, R.D. Stall, C.M. Lyles, and the HIV/AIDS Prevention Research Synthesis Team. 2005. A Meta-Analytic Review of HIV behavioral interventions for reducing sexual risk behavior of men who have sex with men (MSM). *J Acquir Immune Defic Syndr* 39 (2): 228–241.

The resource needs assessment suggests a large resource gap. Demonstration of the resource gap is but one part of the information that needs to be presented to encourage adequate resource mobilization. Policymakers are more motivated by demonstrations of their returns to current, albeit insufficient investments, rather than elaborate demonstrations of the magnitude of the potential future socio-economic impacts. Another very important piece of information, one that has been totally neglected in the past, is to demonstrate the successful impact of the resources that are currently being spent. The effectiveness evaluation and cost analysis are the two drivers of the overall cost-effectiveness of prevention investments and are, therefore, needed to demonstrate to policymakers that they are getting value for the money invested in the prevention package of services.

Finally, the results of this analysis make the case for follow-on work to better understand the level and patterns of resource allocation for specific risk groups, as done in the National AIDS Spending Assessments. These assessments need to be expanded to a wider range of countries in the Asia-Pacific region in order to deepen the analysis of the issues raised in this paper.

Q&A: WHAT NEXT?

- *Expenditure on HIV prevention programs for MSM is very low relative to overall prevention expenditure—despite the proportion of HIV transmission attributed to sex between men*
- *The evidence, both on the magnitude of the issue and the effectiveness of MSM interventions, demands that countries increase resource allocations for MSM programming*
- *Government policymakers and program planners will require more evidence of the cost-effectiveness of MSM interventions so that they understand the value of investing in programs for high-risk groups—this needs to be part of future research agendas*
- *Scale up of successful pilot interventions for MSM must also be carefully monitored and adapted to ensure that they achieve the desired impacts in terms of behavior change to reduce the spread of HIV*
- *A strong evidence base is also essential for overcoming the stigma that influences resource allocation decisions of governments and donor organizations*
- *The highly stigmatized nature of MSM programming implies that national and donor governments will continue to have difficulty allocating the necessary resources for MSM prevention interventions. This suggests an important role for multilateral sources of funding, such as the World Bank and the Global Fund to Fight AIDS, Tuberculosis and Malaria, to support evidence-driven motivations for MSM programming.*

APPENDIX A. DATA ON MSM-RELATED HIV PREVENTION EXPENDITURE FROM OTHER LAC REGION

Country (Year)	MSM-related HIV prevention expenditure	Total HIV prevention expenditure	Share of prevention expenditure*	Sources of MSM expenditure		
				Public	Private	Donors
Argentina (2000)	\$36,068	\$87,521,099	0.04%	33%	22%	45%
Bolivia (2002)	\$37,500	\$837,450	4.48%	0%	67%	33%
Brazil (2000)	\$900,807	\$332,153,471	0.27%	100%	0%	0%
Colombia (2002)	\$85,635	\$24,951,047	0.34%	79%	21%	0%
Costa Rica (1999)	\$1,725	\$5,382,521	0.03%	95%	5%	0%
El Salvador (2002)	\$9,072	\$9,067,037	0.10%	6%	0%	94%
Guatemala (2000)	\$4,126	\$7,734,067	0.05%	0%	0%	100%
Honduras (2001)	\$594,823	\$9,155,528	6.50%	27%	73%	0%
Mexico (2002)	\$843,567	\$103,420,990	0.82%	53%	47%	0%
Nicaragua (2003)	\$177,165	\$2,688,482	6.59%	11%	55%	34%
Peru (2000)	\$215,288	\$3,253,243	6.62%	100%	0%	0%
Uruguay (2002)	\$683	\$4,882,745	0.01%	100%	0%	0%
Venezuela (2002)	\$5,794	\$39,658,740	0.01%	100%	0%	0%
<i>Average</i>			2%	54%	22%	24%
<i>Median</i>			0.3%	53.0%	5.0%	0.0%

* Prevention funding from all sources, including household expenditures, SIDALAC, 2006. Public sector includes central government, subnational governments and social security; private sources includes social insurance, private insurance, NGOs, households and corporations; donors include multilateral, bilateral and private external agencies.

Source: SIDALAC/UNAIDS, National HIV/AIDS Accounts for Latin America, the Caribbean, and West Africa, 1997-2003, Database.