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The Value of Investing in MSM Programs in the Asia-Pacific Region

Policy Brief[1]

The Importance of HIV Prevention Programs for MSM

At least 5–10 percent of all HIV cases worldwide are attributable to sexual transmission between men. In countries in the Asia-Pacific region, HIV prevalence among men who have sex with men (MSM) ranges from 3–17 percent (5 to 15 times higher than overall HIV prevalence).[2] As many MSM also report having sex with women, preventing transmission among MSM will not only combat the epidemic within this group but also within society as a whole.

Recognizing the importance of reaching MSM with HIV prevention programs, this policy brief compares the overall expenditure on HIV prevention with the expenditure for MSM programs alone. It also discusses the sources of funds and resource requirements for MSM programs and shows the gap between current expenditures and resources needed for an effective prevention program for MSM. Determining the resource needs and resource gaps for MSM prevention programs is critical for successful resource mobilization.

Funding Sources and Implications

Donor support and influence. HIV prevention programs for MSM in the Asia-Pacific region rely on external donor support and are typically implemented by nongovernmental organizations (NGOs) and community-based organizations (CBOs).[3] The dependence on international funding for MSM programs is likely to continue and raises several issues such as donor influence in priority setting, disincentives for domestic funding, volatility and lack of predictability of donor funding, and lack of sustainability.

While these are significant concerns, note that donor investments geared toward human and institutional capacity building can often contribute to program sustainability. Moreover, donors can influence in-country approaches, thereby raising awareness of priority issues that governments might not be addressing. In some instances, donors can also use their influence to encourage expansion of innovative pilot approaches that demonstrate the feasibility and impact of MSM prevention programs.

Government commitment. Many Asian countries are experiencing economic growth rates higher than the global average and should therefore be able to afford increased spending on HIV in general and on prevention among MSM in particular. However, governments in the Asia-Pacific region have been reluctant to allocate in-country resources to MSM programs. Possible reasons include the stigma surrounding MSM and HIV or data weaknesses that prevent systematic analysis of the relative importance of various at-risk groups, including MSM. Groups such as MSM, sex workers, and injecting drug users face "double stigma" in that they are marginalized for engaging in highly stigmatized behavior as well as for their association with HIV. This stigma affects the extent to which governments champion the needs of marginalized populations and allocate resources to address their needs. Even if governments are willing to

Why should governments invest in MSM prevention programs?

- MSM is an important driver of the number of new infections, and including this group in a strategic response to HIV in Asia-Pacific countries is cost-effective in the long run.
- Targeted interventions to prevent HIV among MSM have been successful, resulting in a reduced number of sexual partners, increased condom use, and reduced unprotected sex.
- There is a disparity between the level of spending on HIV prevention programs for MSM and the disease burden borne by MSM.

allocate more resources to MSM programs, several barriers related to financing might arise. For example, interventions targeting MSM are mostly implemented by NGOs, and governments sometimes have difficulty channeling resources to these organizations—particularly in countries where NGOs are relatively new or where NGOs have limited access to government funding. Experience in the Asia-Pacific region has shown that when donor funding decreases, the support of NGOs is not replaced by host governments. Continuing to mobilize donor funding might be the reality for programs targeting MSM in some countries.

Estimating Expenditure on MSM Programs

Estimating expenditure on HIV prevention programs for MSM is challenging. Data on MSM expenditure might be incomplete or inaccurate for the following reasons:

- **Difficulty in defining MSM expenditure**, as programs targeting MSM seldom deliver specialized services. Safe sex messages aimed at the general population also benefit MSM but rarely include specific information about the risk of HIV transmission between men.
- **Difficulty in identifying MSM or reaching MSM** with specific prevention programs, as sex between men is highly stigmatized.
- **Lack of information** on private sector expenditure and on individual's out-of-pocket spending on HIV prevention.
- **Double counting of expenditures** reported when implementing agencies are financial intermediaries for donor funding or when donors are also implementing agencies for other donors.

The limited available data suggest that expenditures on MSM prevention programs range from a high of almost 4 percent of total prevention expenditure in Thailand to less than 0.1 percent in some provinces in China (see Table 1). Not only is expenditure on MSM prevention small relative to the total amount spent on prevention, but it is also not commensurate with the proportion of HIV cases attributed to HIV transmission between men.

Resource Requirements for MSM Programs

The median unit cost of a comprehensive package of services for MSM in the Asia-Pacific region—including prevention, care, and treatment—is estimated at US$47 per person reached.[4] Cost data for specific components of a comprehensive package of MSM prevention services show considerable variations in the unit costs of specific services (see Table 2).

Thus, the country-specific estimates of total resources required presented in Figure 1 are based on the following assumptions:

- Unit cost estimates: $57 per person reached by outreach; $21 per person reached by peer education; $47 per person reached by voluntary counseling and testing (VCT), and $0.10 per condom distributed.
- Number of MSM in need of the prevention intervention is 1 percent of the male population.
- The assumed coverage target is 60 percent.

Based on the resource needs estimates in Figure 1, approximately US$550 million is needed to reach 60 percent of MSM in the Asia-Pacific region with peer education/outreach, VCT, and condoms and lubricants. Forty-eight percent is needed for VCT, followed by 41 percent for peer education and outreach, and 11 percent for condom distribution. The data in Figure 2 suggest that countries need to increase their 2004 MSM expenditures by 4 to 25 times to reach at least 60 percent of MSM with prevention programs.

Table 1. Expenditure on MSM Programming, 2004 (US$)[5]

Country, City, or Province	MSM Prevention Expenditure	Total Prevention Expenditure	Share of HIV Prevention Expenditure
Thailand	$482,500	$12,516,400	3.84%
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 (Lao PDR)	$40,000	$2,694,600	1.48%

Note: HIV expenditures for prevention among MSM for 2005 and 2006 were not available when this report was completed.

Table 2. Unit Costs of Comprehensive Package of Services for MSM (US$)[6]

Service	Unit Cost
Counseling and Peer Education	
Cost per condom and lubricant distributed	$0.10
Cost per person reached	$21.12
Cost to train one new counselor/year	$18.75
Cost of refresher training for counselor/year	$25.81
Outreach	
Cost per person reached	$57.23
Training for one outreach worker per year	$16.13
Refresher training	$25.81
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 and linkages)	
Cost per meeting	$75.00
Condom Provision	
Condom distributed by public sector	$0.10
Condom distributed by social marketing	$0.30
Voluntary Counseling and Testing	
VCT per person reached	$47.00
STI Management	
STI treatment in clinic	$8.34
Mass Media	
Workshop	$1,000
Mass media campaign	$37,500
Behavior change communication campaign	$1,750
Materials (CD, brochure)	$0.15

Figure 1. Estimated Resources Required to Reach 60 Percent of MSM with Prevention

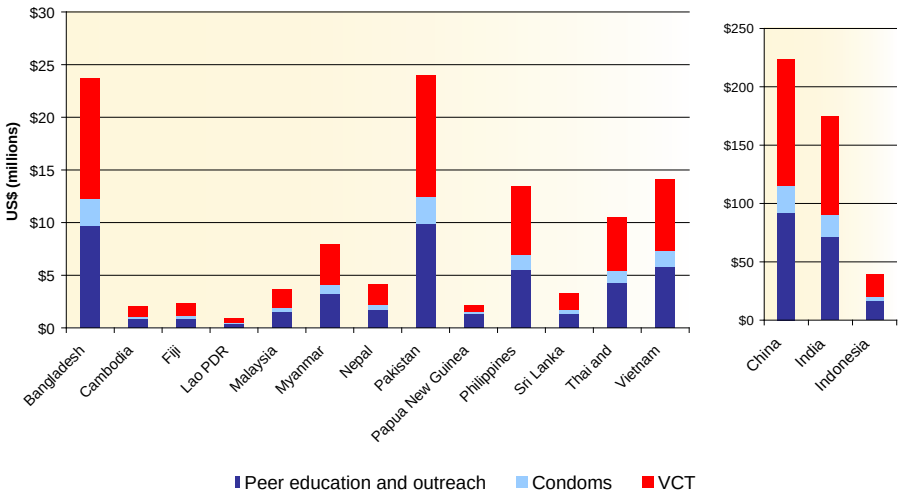
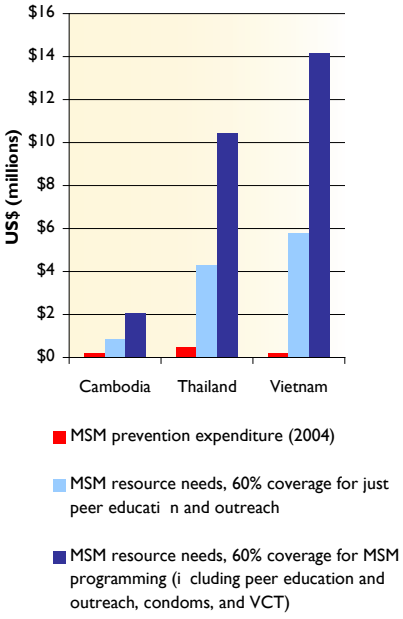


Figure 2. Current Expenditure Versus Resources Required for MSM Prevention



Recommended Steps

Increase resource allocation for MSM programming. The analysis reveals the low coverage rates of prevention interventions for MSM. Available data show that expenditure on HIV prevention programs for MSM is extremely low compared with the overall prevention expenditure—despite the proportion of HIV transmission attributed to sex between men. MSM expenditure accounts for less than 4 percent of total prevention expenditure, despite evidence that sex between men contributes to 5–10 percent of new infections worldwide. On a country-by-country basis, the *level of prevention expenditure should be consistent with the level of HIV risk and disease determinants.* The magnitude of the HIV epidemic among MSM and the effectiveness of interventions demand that countries increase resource allocations for MSM programming.

Scale up successful pilot interventions for MSM. Prevention investment targeting MSM has been effective in reducing risk behaviors among MSM.[7] The challenge is to replicate the impact as programs are scaled up to achieve the necessary coverage to halt the spread of HIV in the Asia-Pacific region. *Pilot interventions for MSM must be carefully monitored* and adapted to ensure that efforts achieve the desired behavior change to reduce the spread of HIV and maximize the available resources for given program outputs.

Demonstrate cost-effectiveness and increase the evidence base. Policymakers are more motivated by demonstrations of the successful impact of current investment in MSM programs than by the potential impact from future investment. Government policymakers and program planners will require more evidence of the cost-effectiveness of MSM interventions *to understand the value of investing in programs for most-at-risk groups.*

Draw on multilateral funding sources. Because of stigma related to MSM programming, national governments and donors will continue to face difficulty in allocating the necessary resources for MSM prevention interventions. This suggests an *important role for multilateral donors*—such as the World Bank and the Global Fund to Fight AIDS, Tuberculosis and Malaria—*to support evidence-driven MSM programming.* A strong evidence base is essential for overcoming the stigma that influences resource allocation decisions pertaining to MSM.

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[1] This brief is based on a background paper that staff of the USAID | Health Policy Initiative prepared for the International Consultation on Male Sexual Health and HIV in Asia and the Pacific, held in New Delhi, India, in September 2006. The paper, "HIV Expenditure on MSM Programming in the Asia-Pacific Region," is available at www.healthpolicyinitiative.com.

[2] Van Greinsven, F. 2005. 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, Februray 28–March 2, 2005, Bangkok, Thailand, p.8.

[3] 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. New York: Treat Asia.

[4] Range is from US$40.30–57.50; personal communication, John Stover, Futures Institute, August 2006.

[5] 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.

[6] Sangrujee, N., S. Alkenbrack, and G. Martin. 2005. "Technical Note: Data Collection and Methodology for Unit Cost Estimation." Washington, DC: Futures Group, POLICY Project.

[7] 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)." *Journal of Acquired Immune Deficiency Syndrome* 39(2): 228–241.

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