

Costs of scaling-up programme for Men who have sex with Men (MSM) in Bangalore over three years, Karnataka, India

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Background

- MSM account for 5-10% of HIV transmission globally (UNAIDS) yet HIV prevention efforts targeted at MSM constitute a very small proportion of overall prevention expenditure (<4%), and there is scarce evidence on their costs.
- In India a high HIV prevalence of over 5% is seen among the MSMs in 21 districts (HIV sentinel Surveillance 2007)
- A study of MSM in Bangalore (2008), capital city of Karnataka district showed a HIV prevalence of 18.9%.
- There is a critical need to reach MSM populations with effective HIV prevention interventions.
- Studies to estimate costs of MSM programmes are plagued by challenges of incomplete and poor quality data not segregated by the target group and also basically the difficulty in defining what constitutes a MSM HIV prevention expenditure.
- 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***

Background

- This could lead to either under estimate or over estimate the MSM expenditure. MSM are a hidden group and it is difficult to track how many are reached by the services.
- The programme under study overcomes these shortcomings with good quality data and being a large scale exclusive MSM programme.
- Prevention investment targeting MSM has been effective in reducing risk behaviors among MSM.(Herbts JH et.al (2005),Valdiserri et.al (1989), Kegeles et.al(1996),Johnson et.al(2005). The challenge is to replicate the impact as programs are scaled up to achieve the necessary coverage to halt the spread of HIV.
- Avahan, The India AIDS Initiative of the Bill & Melinda Gates Foundation is involved in rapid scale up of HIV prevention targeted at high risk populations in India. In Karnataka, implementation is undertaken by the **Karnataka Health Promotion Trust (KHPT)**, a joint trust between the University of Manitoba (Canada) and the Karnataka State AIDS Prevention society

Methods

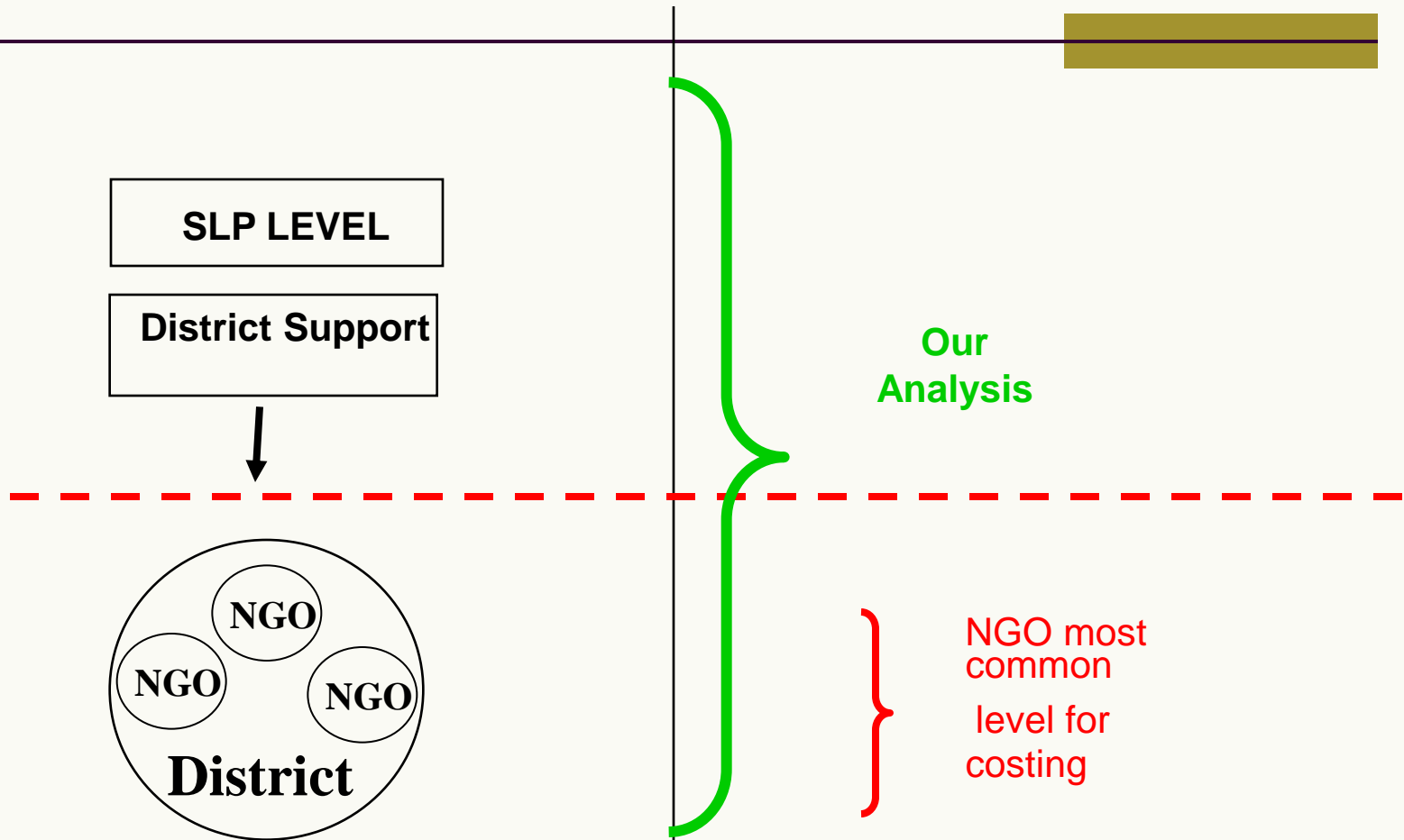
- This study looks at the first three year of scale-up activities for MSMs in urban district in Karnataka state which is implemented by community based organisation.
- The programme components costed were the needs assessment conducted among MSMs (sites validation and risk assessment), outreach activities like BCC to reinforce knowledge of HIV/AIDS and STI.
- Activities to promote safe sex practices, creating enabling environment by providing crisis intervention services, Drop-in-centre facilities, psychosocial support and clinical services to address STI and Opportunistic infections were also costed.

Specific Considerations in Costing



- By Input: capital versus recurrent items
- By Activity: training, STI services etc
- By organisational level –NGO and State lead partner (SLP)
- Annualizing capital costs so that costs are spread over period of project, not just one year
- Allocating shared resources
- Donated goods and services(Full economic costing)
- Timeframe: start-up versus implementation. Start-up treated as a capital item.
- Multi-year Costing: establish base year (2008) and adjust by inflation

Organizational levels for costing



SLP costs is an important component for rapid scale up representing Costs for expertise expansion, administration, programme monitoring and information, Special events, IEC materials and support.

Data Sources

- Retrospective and prospective
- Financial records from NGOs and SLPs
 - Using routine financial and management reporting
- Process and outcome data from routine reporting
- Interviews with SLP staff related to district programming
- detailed costing – additional data collection instruments

Specific Data Collection Instruments for Detailed Costing

- **Records review**
 - designed to review all data that is being routinely reported (financial and programming).
- **Key informant interviews** with project staff
 - questionnaires for the field officers and project/district coordinators
- **Focus group discussion** guidelines –
 - discussions with peer educators/community members
- **Time-sheets**
 - to collect data regarding allocation between activities undertaken by field officers and STI doctors

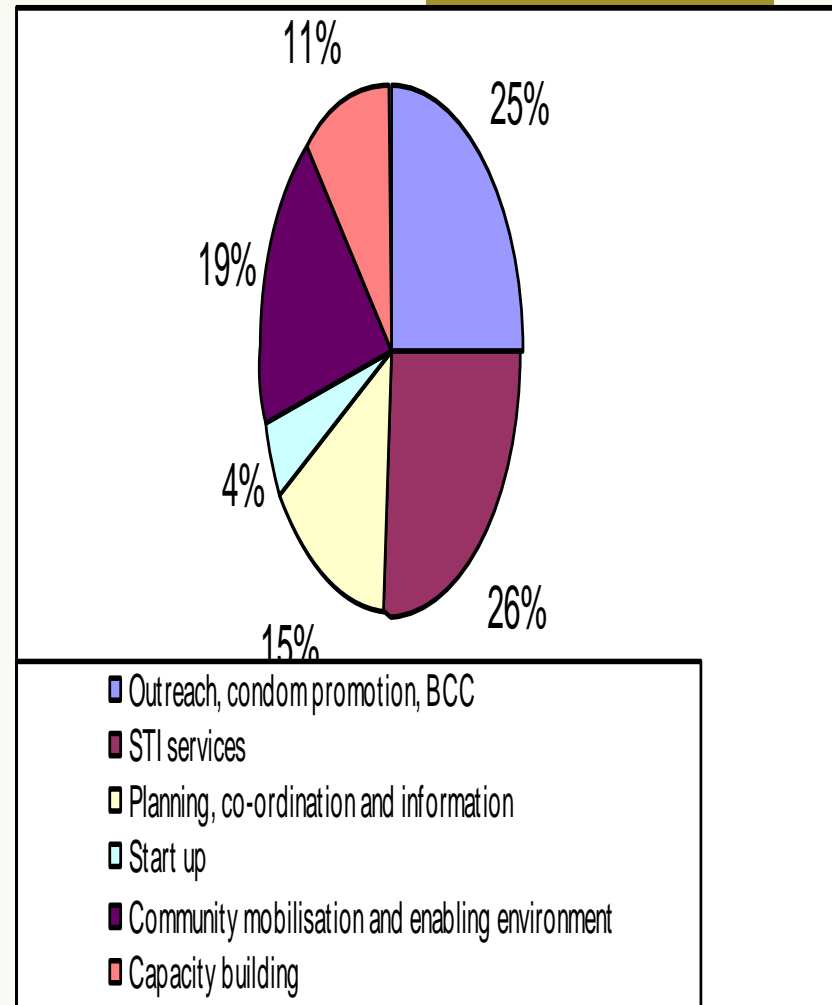
Costs by input category

Input Category	*US \$ 2008	Financial*	Economic 3%*	%
Total Capital		143,835	149,511,	14.1
Recurrent				
Personnel		466,297	466,297	44.1
Travel		79,498	79,498	7.5
Office operating & maintenance		77,771	77,181	7.3
STI supplies, including condoms		57,678	101,825	9.6
Monitoring & Evaluation		13,283	13,283	1.3
Information Education Communication		28,526	28,526	2.7
Training (recurrent)		60,768	60,840	5.8
Community mobilisation/ enabling environment		49,758	49,972	4.7
Indirect expenses		31,140	31,140	2.9
Recurrent Total		864,719,	9,08,561	85.9
Grand Total		10,08,554	10,58,072	100

The economic cost of the programme over three years was \$ 10,58,072, 4.7% higher than the financial costs. NGO level costs varied between 45-85% of the total costs during the 3 year period

Total costs by activity

- The start-up period in the district for the programme for MSMs was 4 months. The average start up time for similar programmes implemented by Non-Governmental organization for the Female sex workers in the state was 5.2 months
- Community mobilisation including enabling environment is an important component contributing 19% when compared to 12% in FSW programme in the same district.
- Crisis intervention and legal aid strategy had helped the programme mobilise the key population



Unit costs year wise

Unit costs - all programme(US \$ 2008)	Y1	Y2	Y3
	2005-06	2006-07	2007-08
Estimated number of sex workers	6226	6226	6226
NGO cost per MSM (for NACO comp)	12	53	68
Total cost per estimated	27	67	76
Ever Contacted	3591	9483	11496
NGO cost per Ever Contacted	21	35	35
Total cost per Ever Contacted	46	44	41
Number of MSM registered: CUMULATIVE	1368	4532	6984
NGO cost per MSM registered: CUMULATIVE	55	73	58
Total cost per MSM registered: CUMULATIVE	121	92	68
Number of MSM reached every month(yearly mean)	2200	3225	5146
NGO cost per MSM reached every month (yearly mean)	34	102	85
Total cost per MSM reached every month (yearly mean)	75	130	100
Number of Clinic visits (Ever clinic visit)	1248	3088	5381
NGO cost per Clinic visit (Ever clinic visit)	60	107	75
Total cost per Clinic visit(Ever clinic visit)	133	135	88

Results

- The cost per person registered decreased from \$ 121 in the first year to \$ 68 in the third year while the scale increased from 1368 to 6984 registered persons (saturation).
- Costs per member availing STI services, fell from \$133 to \$ 88 for the MSM programme while costs for STI services of a programme for Female sex workers in the same district fell from \$ 188 to \$ 71.
- Average of total individuals contacted monthly varied from 2200 in the first year to 5146 by third year and correspondingly cost ranged between \$ 75-130
- There were issues as we could not get the total contacts per month as it was not recorded in the management information system. Even if the key population was contacted twice in the month it would be entered only once. Hence the actual contacts per month would be slightly underestimated.

Cost Comparison with guidelines

Study/Guidelines	Target Population (MSM)	Unit costs (Range) US \$ 2008
NACO Guidelines 2009, India	400-1000+	43(32-57)
USAID estimates for MSM programming in Asia-Pacific region (2006)		49(41-59)
UNAIDS –ADB costing guidelines (2004)	1000	30
This study(2010)*	6226	57(27-76)

*Full costing SLP and NGO, 3% discount rate

Conclusions

- Involvement of Community Based Organisations as key implementing partner for interventions with hidden populations helped in decreasing the start up time. It lead to rapid coverage of majority of the estimated Key population
- As costs vary considerably by scale, it is important to measure costs when service utilization increases to provide policy makers and planners with accurate estimates of long-run programme costs and also variation in the costs compared to Female sex worker programmes
- There is very limited cost data from programmes targeting MSM population. This study aims to add to such evidence. Further a cost-effectiveness analysis is also planned

Acknowledgements

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Thank you

