Campaign briefing 2 (July 2010)

The cost efficiency of HIV Prevention for vulnerable and most-at-risk populations[1] and the reality of funding

This briefing describes the cost efficiency of HIV prevention for vulnerable and most-at-risk populations and the reality of how funding helps, or does not help, those groups. This is one of a number of briefings which have been produced in support of an Alliance campaign which is asking **'what's preventing prevention?'**. These briefings are available to download from the Alliance website www.aidsalliance.org

1. The unavoidable need for HIV prevention programmes and services

The HIV/AIDs epidemic is a tragedy for millions of people and a costly time-bomb for governments and donors. For every 2 people who get treatment, 5 others get infected. At this rate, spending for HIV will raise from $13 billion now to between $19 and $35 billion in just 20 years' time.[2]

To reduce and contain long-term AIDS spending, the number of new infections over the next two decades must reduced to well below 1.2 million a year as opposed to the 2.3 million people who were infected globally in 2009.[3]

Globally, the estimated cost of preventing an infection is US $3,923, whereas the estimated cost of lifetime treatment is US $ 4,707. This gives a net saving of US $ 784 for each infection averted.[4]

For as long as treatment for HIV-AIDS is for life and based on the current costs of HIV treatment, there is no doubt that HIV prevention programmes and services are essential to stop the epidemics in the medium term.

Halving new infections in eastern and southern Africa by 2015 would avert 2.3 million new HIV infections and save US$ 12.5 billion in treatment costs.[5]

Notes:

[1] Vulnerable and most-at-risk populations are part of key populations, who are groups at higher risk of being infected or affected by HIV, who play a key role in how HIV spreads, and whose involvement is vital for an effective and sustainable response to HIV. Key populations vary according to the local context and may include people living with HIV, their partners and families, people who sell or buy sex, men who have sex with men (MSM), people who use drugs, orphans and other vulnerable children, certain categories of migrants and displaced people, and prisoners.
[2] Results for Development Institute. Cost and Choices, financing the long term fight against aids, 2010.
[3] Results for Development Institute. Cost and Choices, financing the long term fight against aids, 2010.
[4] Stover and others, 2006.
[5] UNAIDS, *Mobilizing prevention as a movement for universal access*, December 2009.

2. The case for focusing HIV prevention on vulnerable and most-at-risk populations

Most-at-risk populations account for a large proportion of new infections in countries with concentrated AIDS epidemics, especially in Latin America, East Asia, and Eastern Europe, and Central Asia. Most-at-risk populations are also important in the high prevalence countries of Africa, though they account for a smaller share of new infections.

Eliminating legal, social and political barriers to HIV prevention for vulnerable and most-at-risk populations is not only a moral imperative, but a strong economic argument. These measures reduce levels of vulnerability and risk and allow HIV prevention interventions to optimise coverage while reducing costs and lowering the number of new infections.

By addressing the underlying social drivers of AIDS –such as stigma and discrimination, criminalisation of behaviours such as men having sex with men and intravenous drug injection, and women's low social and economic status–countries can reduce the number of expected new infections by an extra 10% or more.[6]

If national AIDS Programmes made the difficult decisions, addressed the barriers that are preventing marginalised groups from accessing services and targeted resources to those that are most affected they could cut more new infections and still have savings to put into scaling up treatment.

The Asia case[7]

Asian countries with a concentrated epidemic should allocate 42 percent of all AIDS intervention to programs for MSM, sex workers and their clients, and drug users. At present, Asian countries spend less than 10 percent of the total HIV prevention funding on services for these groups.

A strong, global commitment to expanded HIV prevention programmes targeted at sexual transmission and transmission among drug users, started now, could avert 28 million new infections between 2005 and 2015.

In Asia, the cost per life year gained may be as low as US$3 for interventions focused on sex workers and their clients, US$40 for harm reduction among IDUs, and US$75 to reduce transmission among MSM.

Interventions for most-at-risk populations cost US$100 per person per annum. Applied to the total number of persons in these groups in Asia, HIV prevention programs with extensive coverage of IDUs, CSW, and MSM in the region would cost about $1 billion a year over the next few years, less than 15 percent of the total estimated annual requirement for a strong response to the epidemic. The cost per infection averted would be US$1,800.[8]

3. The reality of funding for HIV prevention programmes and services

There is a common failure to prioritise HIV prevention programmes for vulnerable and most-at-risk populations among donor governments.

Notes:

[6] Results for Development Institute. Cost and Choices, financing the long term fight against aids, 2010.

[7] Results for Development Institute. Cost and Choices, financing the long term fight against aids, 2010.

[8] The Independent Commission on AIDS in Asia (ICAA), Redefining AIDS in Asia, 2008.

According to UNAIDS: “Even though injecting drug users, men who have sex with men, sex workers, prisoners and mobile workers are at higher risk of HIV infection, the level of resources directed towards focused HIV prevention programmes for these groups is typically quite low, even in concentrated epidemics”.[9]

HIV prevention programmes in support of vulnerable and most-at-risk populations receive less than a fifth of the total funding support for HIV prevention globally.[10]

Worldwide, only 61% of the estimated number of sex workers targeted is actually reached by HIV prevention programmes; while for drug users, only 37% of the target is reached.[11]

- In China, 90 per cent of HIV transmission is attributable to MSM or drug users, yet 54% of donors’ HIV prevention funding is allocated to the general population.[12]

- In Russia, specific interventions for drug users are around 25% of the total HIV prevention coverage, whereas this group represents over 65% of all infections.[13]

- In Costa Rica, the prevalence of AIDS among MSM is 60%, while the preventive expenditure on MSM is less than 1%. In Panama, prevalence among MSM is close to 40% but there are no HIV prevention programmes that target MSM. Prevalence among MSM in Uruguay is 30% but preventive expenditure is just 2%. Similarly, in Guatemala prevalence among MSM is close to 35% but preventive expenditure is 4%.[14]

Most HIV/AIDS accounts frameworks used by donors fail to capture the extent to which beneficiaries receive intended goods and services, which makes it difficult to ascertain the resources for HIV Prevention that reach vulnerable and most-at-risk populations.[15]

In 2008, out of 107 countries that reported data on expenditure to combat HIV/AIDS, 24 (22%) did not report expenditure on HIV Prevention services and programmes. Only 28 (26%) countries reported disaggregated data on HIV prevention and 56 (52%) did not report data for programmes for sex workers and they clients, drug users or men having sex with men.[16]

For more information, contact: mail@aidsalliance.org

Notes:

[9] UNAIDS, *Report on the global AIDS epidemic*, Geneva, 2008.

[10] OPM for HIV/AIDS Alliance interim report, July 2010

[11] 2006 progress report, UNAIDS

[12] Results for Development Institute, Cost and Choices, financing the long-term fight against Aids. 2010.

[13] UNAIDS, 2006 Report on the Global AIDS Epidemic.

[14] UNESCO, SIDALAC, PAHO Report of AIDS cases. www.sidalac.org.mx Accessed on 21 June 2010.

[15] OPM for HIV/AIDS Alliance interim report, July 2010.

[16] OPM for HIV/AIDS Alliance interim report, July 2010.