

AVAHAN: THE BUSINESS OF PREVENTION AT SCALE

Perspectives, methods, and issues surrounding the cost estimates for scaling up HIV prevention

**UNAIDS Expert Consultation on Costing
Bangkok
29 October 2010**

BILL & MELINDA
GATES *foundation*

Agenda

- **Avahan Overview**
- **Emerging impact results**
- **Financial cost structure and analysis**

AVAHAN RATIONALE AND BACKGROUND

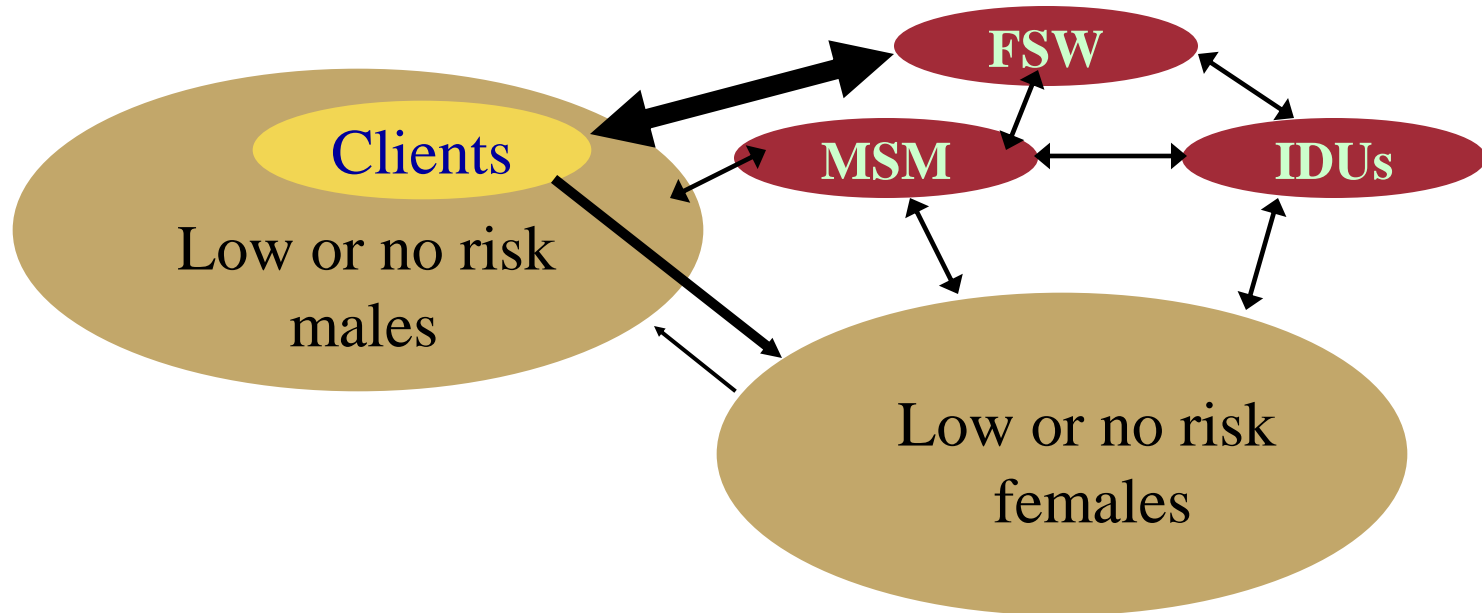
Sense of Urgency

- Projections of 25 million HIV infection by 2025
- Classified as a second-wave county (CSIS)

Foundation Rationale for Entry

- Evidence of large growing concentrated Indian sub-epidemics
- National response had low prevention coverage of high risk groups (HRG)
- Prevention for concentrated epidemics via HRG focus well known
- Few successful examples globally
- International advocacy about “prevention gap”

INDIA'S EPIDEMIC IS SIMILAR TO OTHER ASIAN HIV EPIDEMICS...

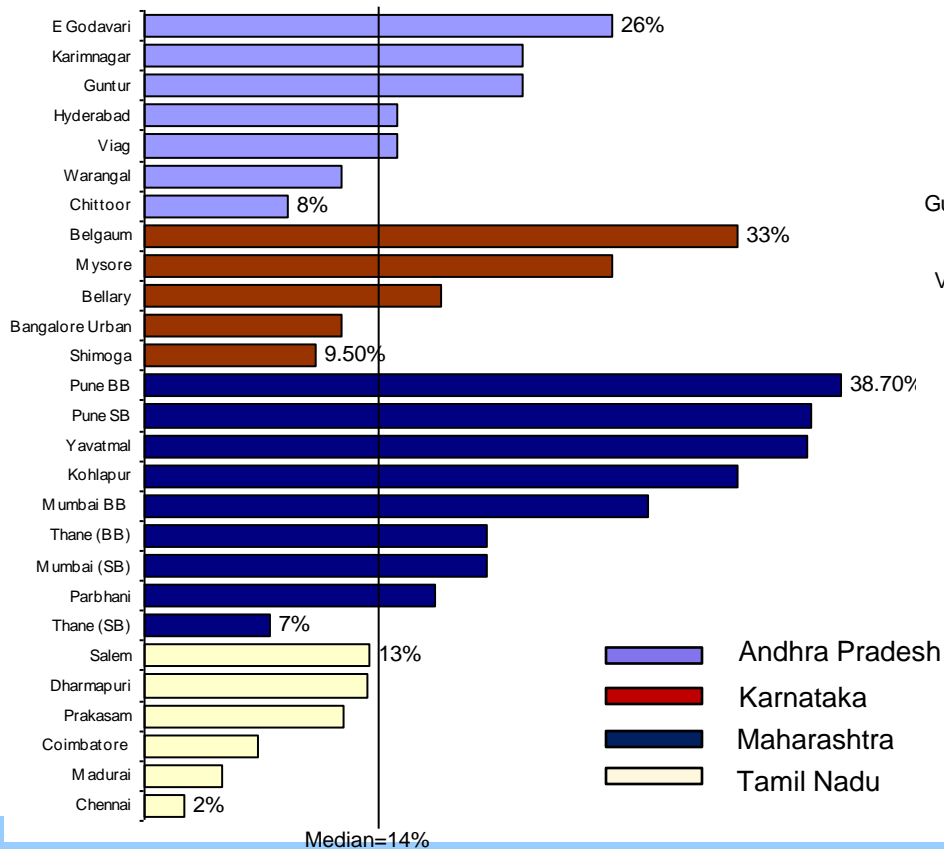


- Asian epidemics remain focused in specific populations and their partners
- There is no “generalized” spread. Rather truncated or local concentrated epidemics
- Focused prevention the effective strategy

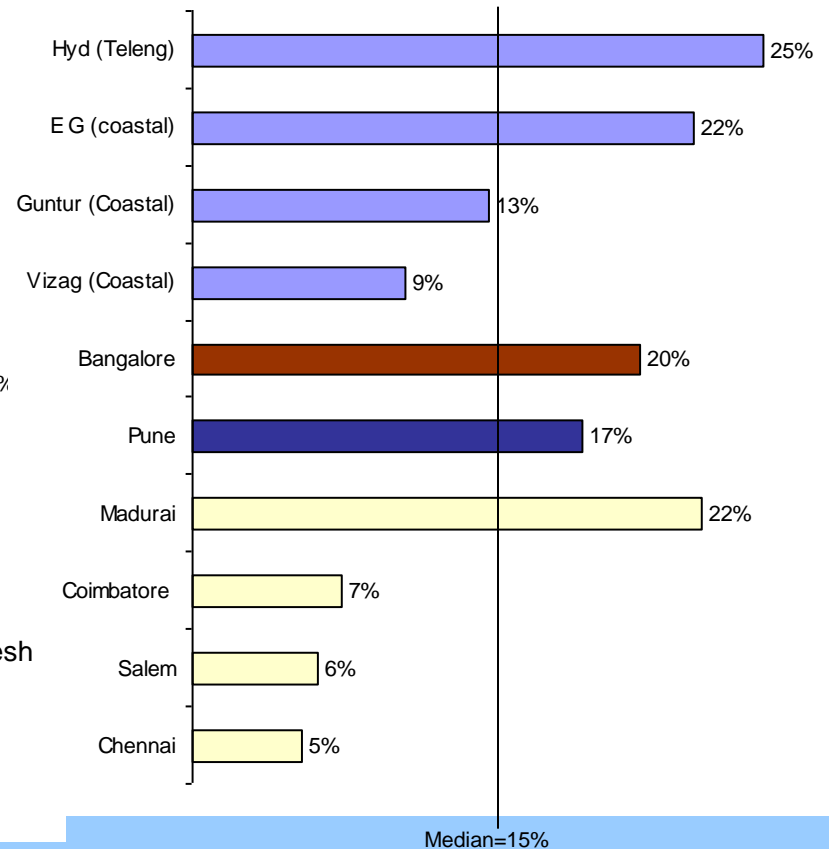
HIV PREVALENCE IN MARPs IS HIGH IN THE FOUR SOUTHERN STATES

Median district level FSW prevalence 14%, 10 of 26 districts have > 20%
Median district level MSM HIV prevalence 15%, 4 of 10 districts surveyed have > 20%

**HIV prevalence among FSWs in Avahan districts
 (Andhra Pradesh, Karnataka, Maharashtra, Tamil Nadu)**

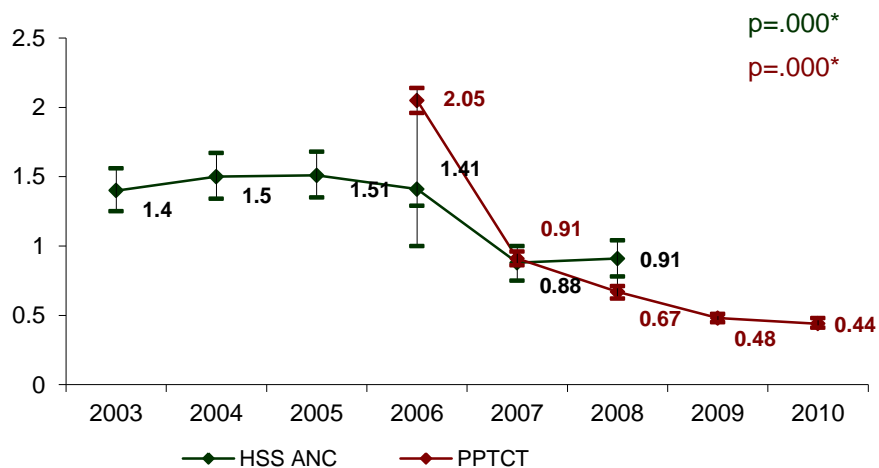


**HIV prevalence among HR-MSM/TG in Avahan districts
 (Andhra Pradesh, Karnataka, Maharashtra, Tamil Nadu)**

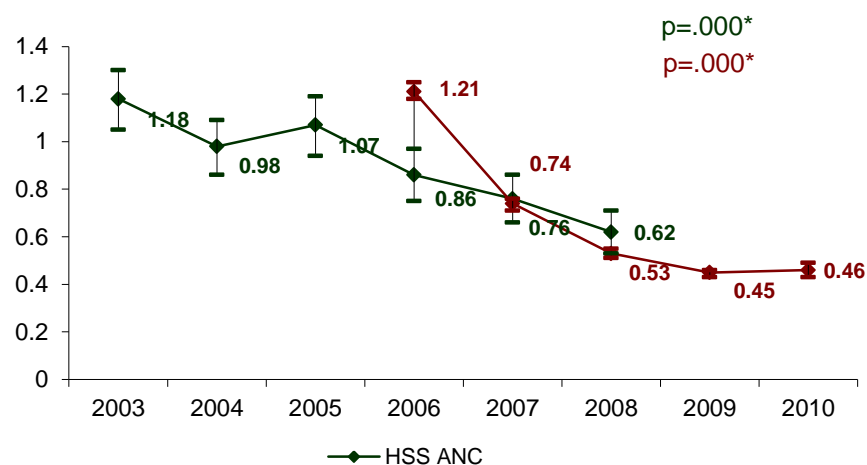


HIV prevalence in HSS-ANC and PPTCT sites

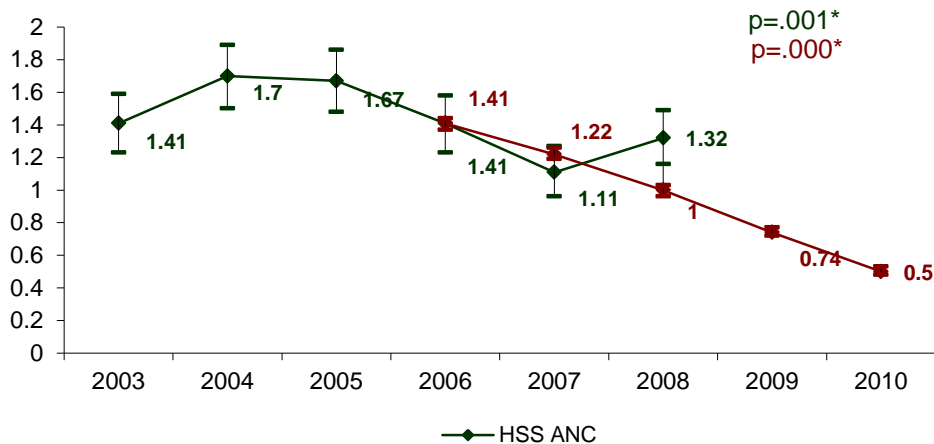
Karnataka



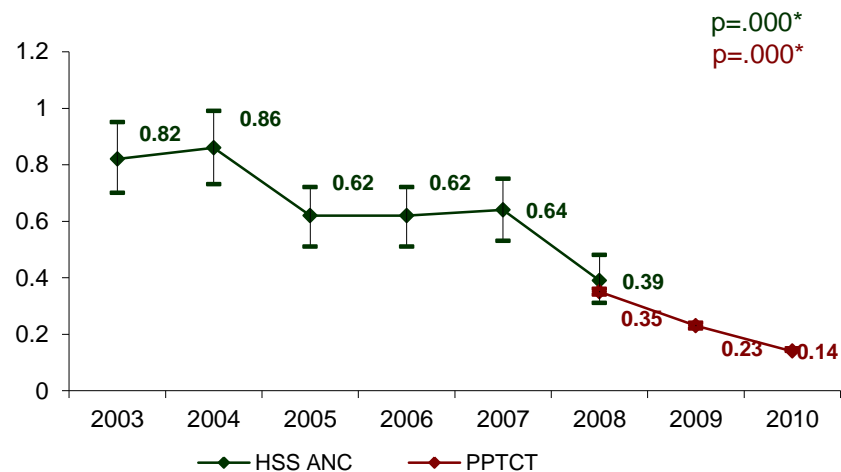
Maharashtra



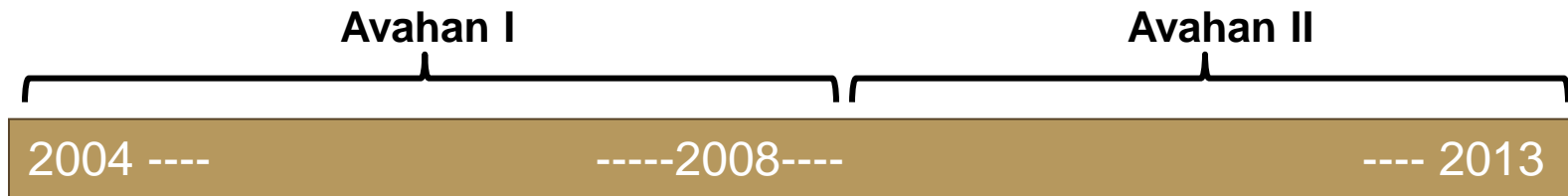
Andhra Pradesh



TamilNadu



AVAHAN'S GOALS OVER A TEN YEAR PERIOD



Build / Operate HRG prevention program at scale

- Demonstrate program at scale with coverage, quality
- Declining HIV infection trends in core, bridge, general population

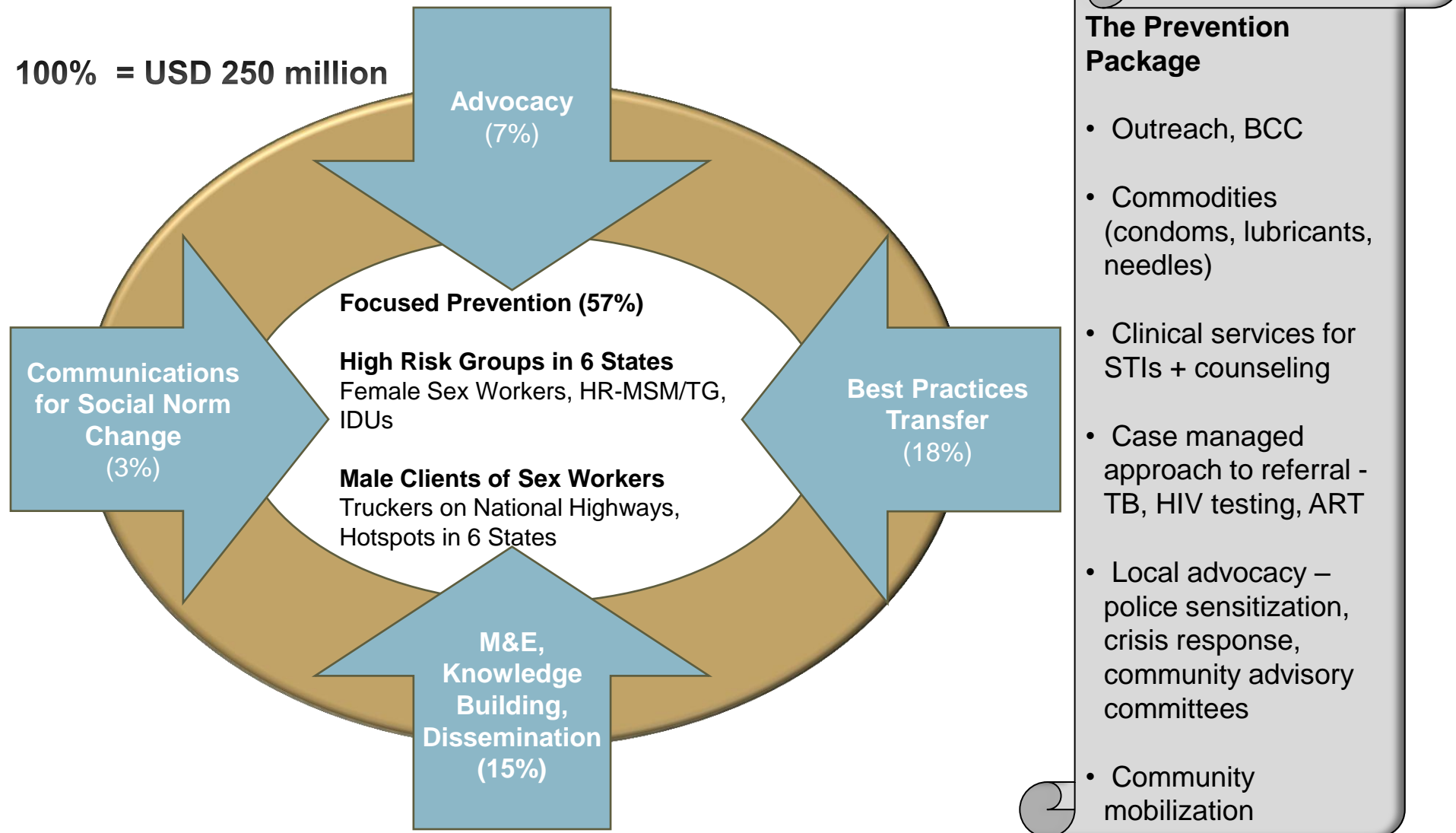
Transfer program to government, other stakeholders, communities

- Sustain funding / management without program disruption
- Strengthen communities to sustain transition post-handover

Disseminate learnings

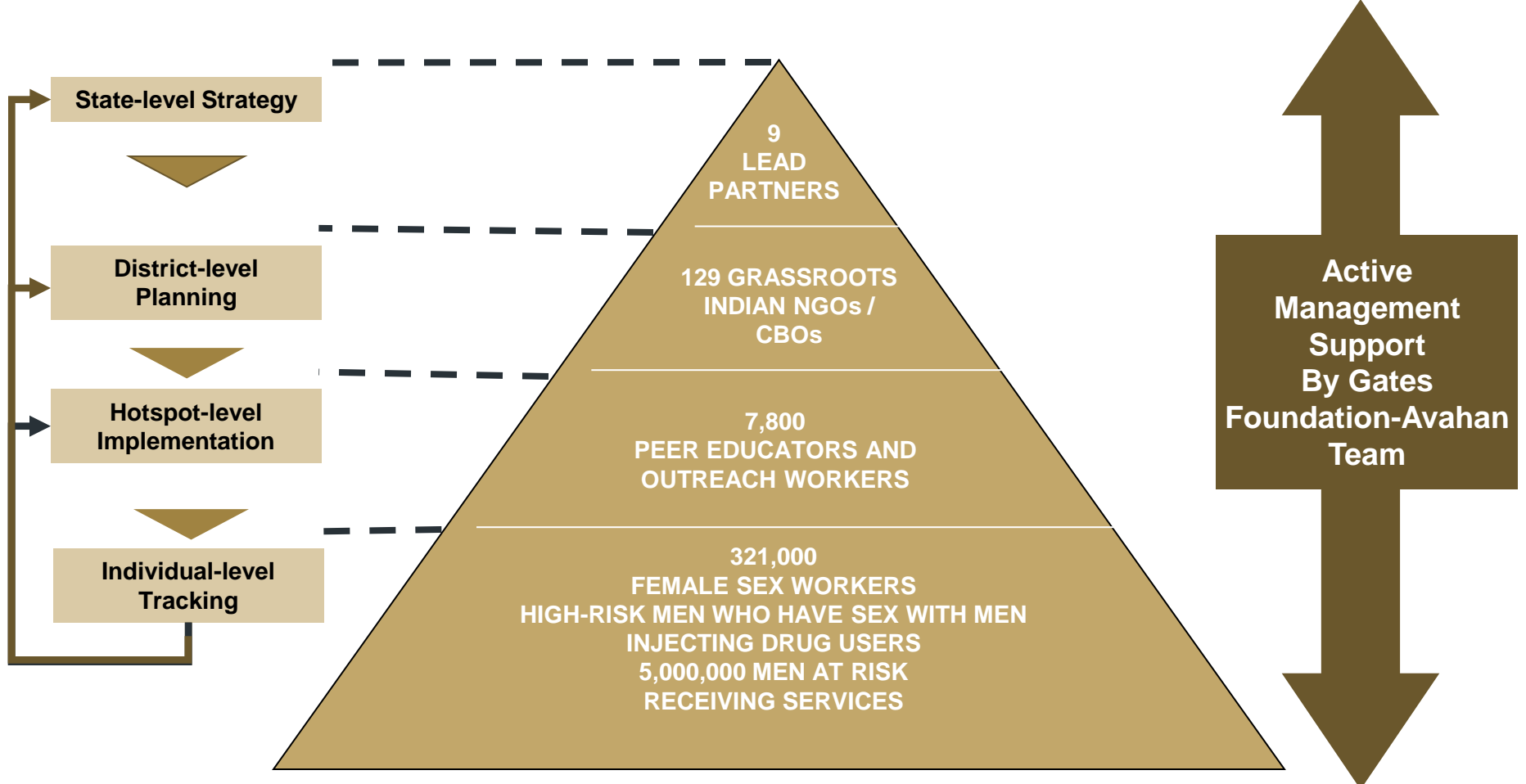
- Actively foster opportunities for creating learnings from the Avahan live laboratory
- Disseminate learnings through a wide variety of mechanisms and fora

DESIGN OF AVAHAN'S FIRST PHASE (2003-2009) – INTEGRATED PROGRAM



AVAHAN'S MULTI-TIERED, MATRIX ORGANIZATION

Foundation Staff In 5 Locations, 24 Grantees, 31 Grants 6 States, 82 Districts

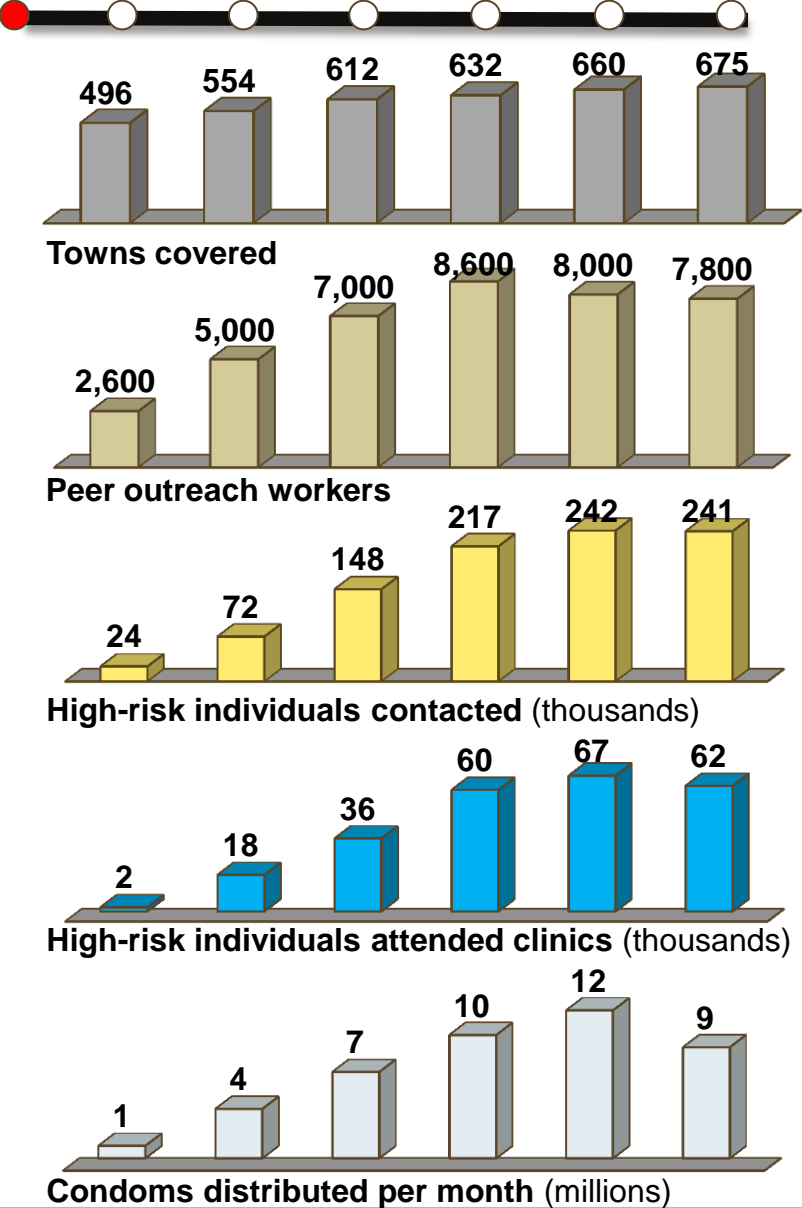


Cross Cutting Support
Capacity Building, Advocacy, Monitoring and Evaluation, Knowledge Building

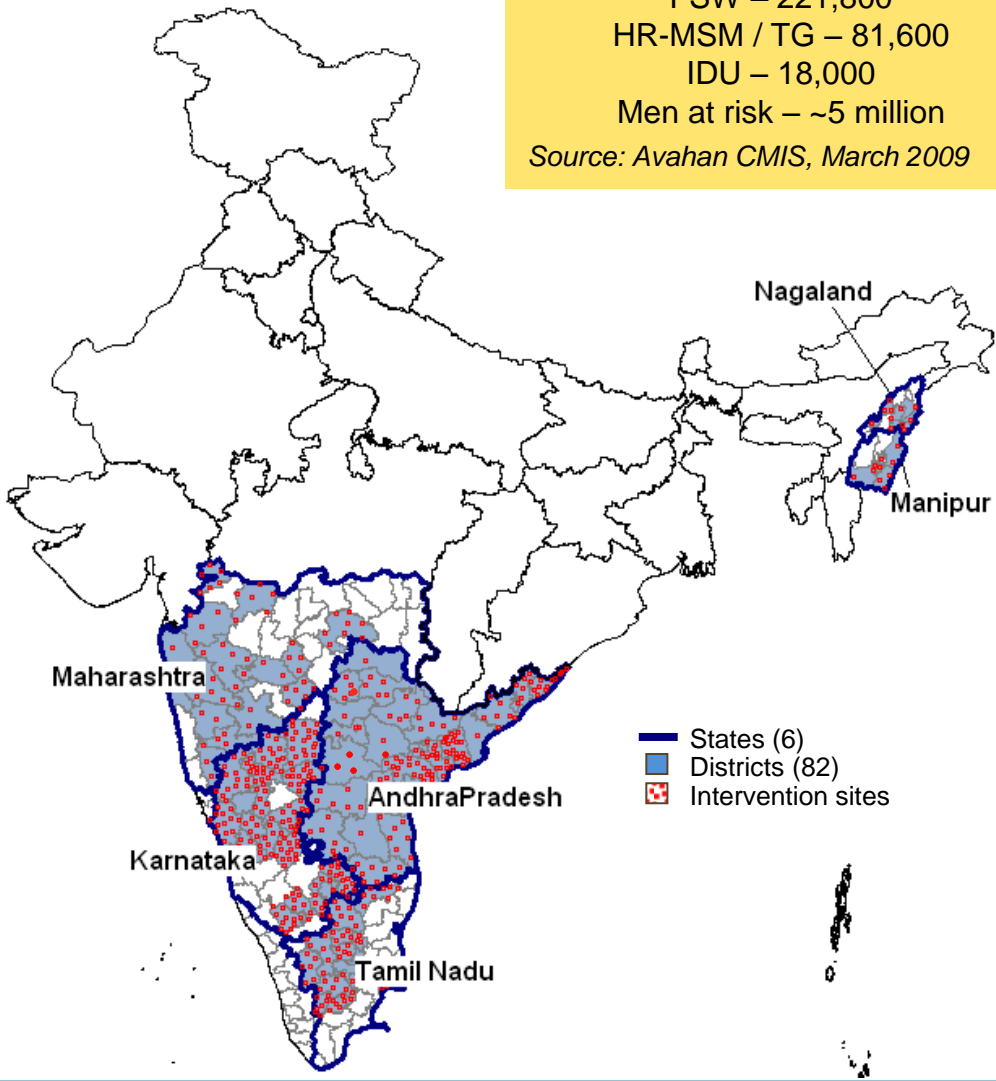
Source: Avahan monitoring data, March 2009

AVAHAN'S SCALE UP TIMEFRAME

Dec 03 Dec-04 Dec-05 Dec-06 Dec-07 Dec-08 Mar-09



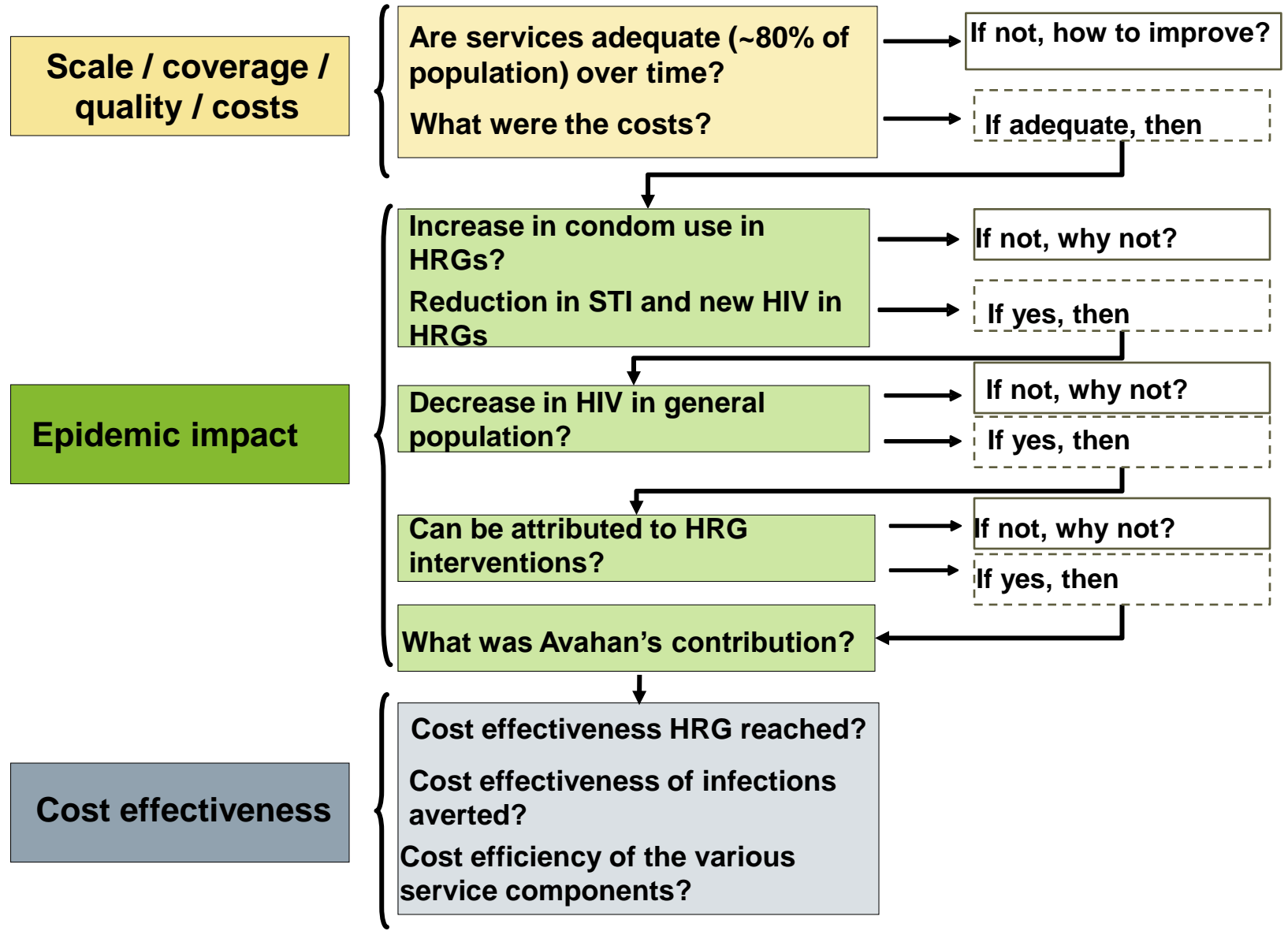
6 states, 82 districts,
600+ towns
Combined State Population
~ 300 million
High risk groups covered
FSW – 221,800
HR-MSM / TG – 81,600
IDU – 18,000
Men at risk – ~5 million
Source: Avahan CMIS, March 2009



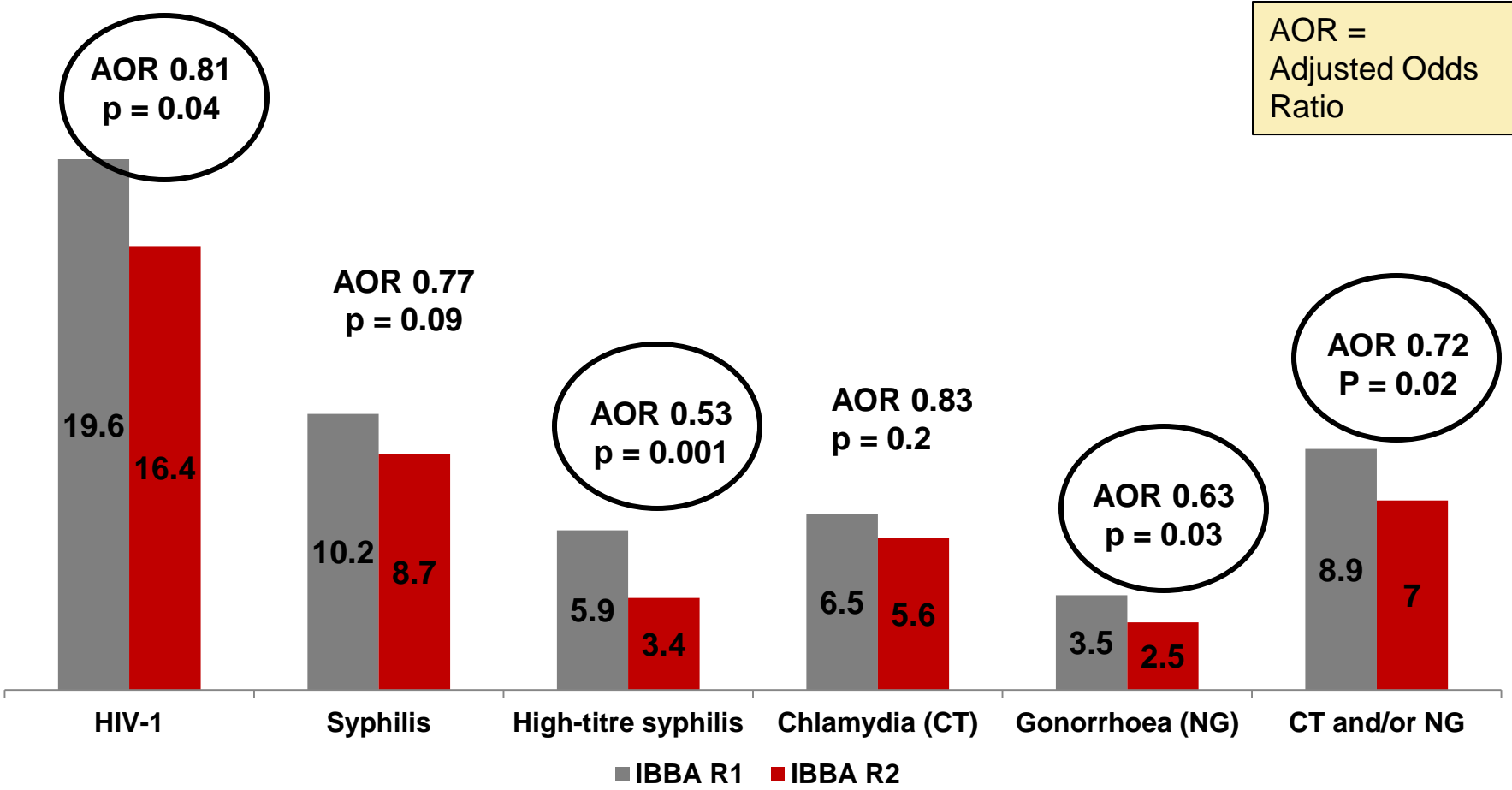
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AVAHAN IMPACT EVALUATION QUESTIONS



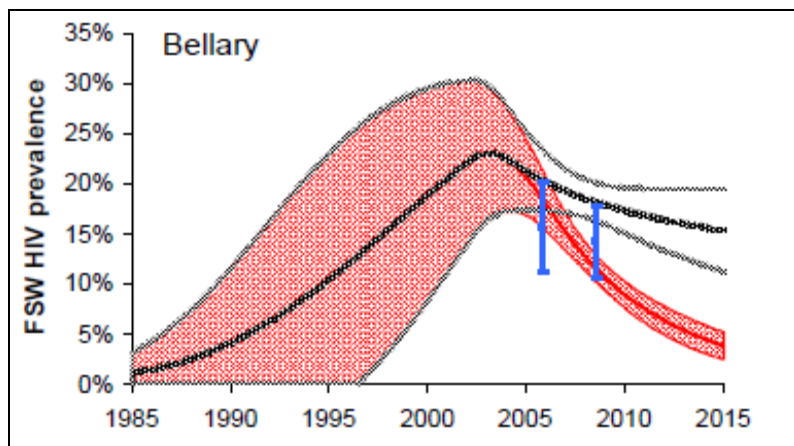
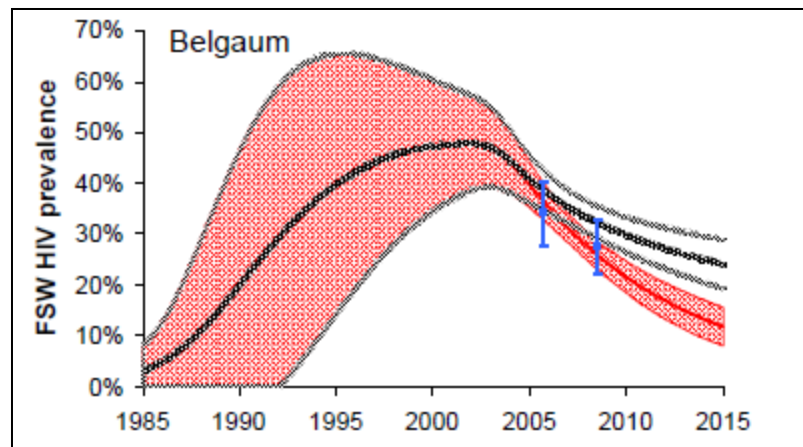
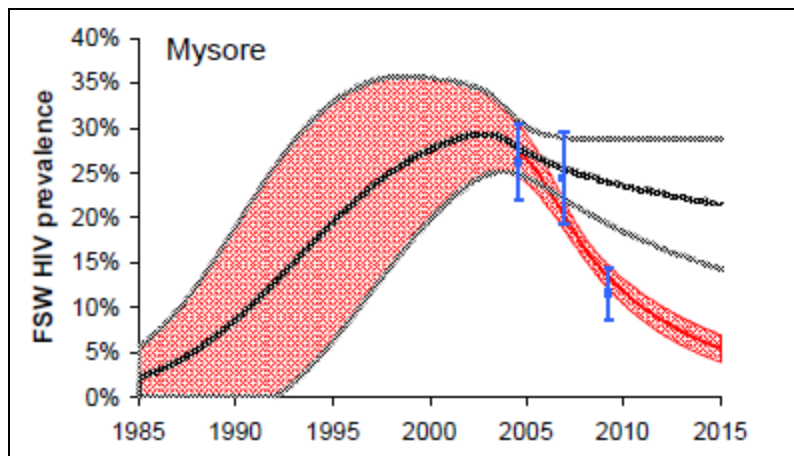
IN KARNATAKA THERE WAS A SIGNIFICANT DECLINE IN STI PREVALENCE (BASELINE AND FOLLOW-UP SURVEYS, 5 DISTRICTS)



Multivariate model adjusted for the following variables: (1) district, (2) age, (3) marital status, (4) residency status, (5) usual place of solicitation, (6) age started sex work, (7) charge per sex act, (8) weekly sex work income, (9) proportion of clients who were new, (10) proportion of FSWs with regular clients.

Source: Ramesh BM. IBBA two rounds analysis with FSWs in Karnataka, 5 districts. STI 2010; 86 (Suppl 1): i17.

THE ESTIMATED IMPACT of INCREASE in CONDOM USE ON HIV PREVALENCE AMONG FSWS AND CLIENTS – RESULTS OF MODELING



▨ 95% CrI — Mean
▨ Control group 95% CrI — Control group mean
—■— IBBA data

Predicted proportion of new HIV infections averted (2004-2014)

	FSW % (95% CI)	Clients % (95% CI)
Mysore	59.2 (47.8-70.6)	62.3 (51.7-72.8)
Belgaum	43.5 (33.7-53.3)	50.3 (39.8-60.7)
Bellary	64.6 (59.4-69.3)	67.6 (63.2-72.1)

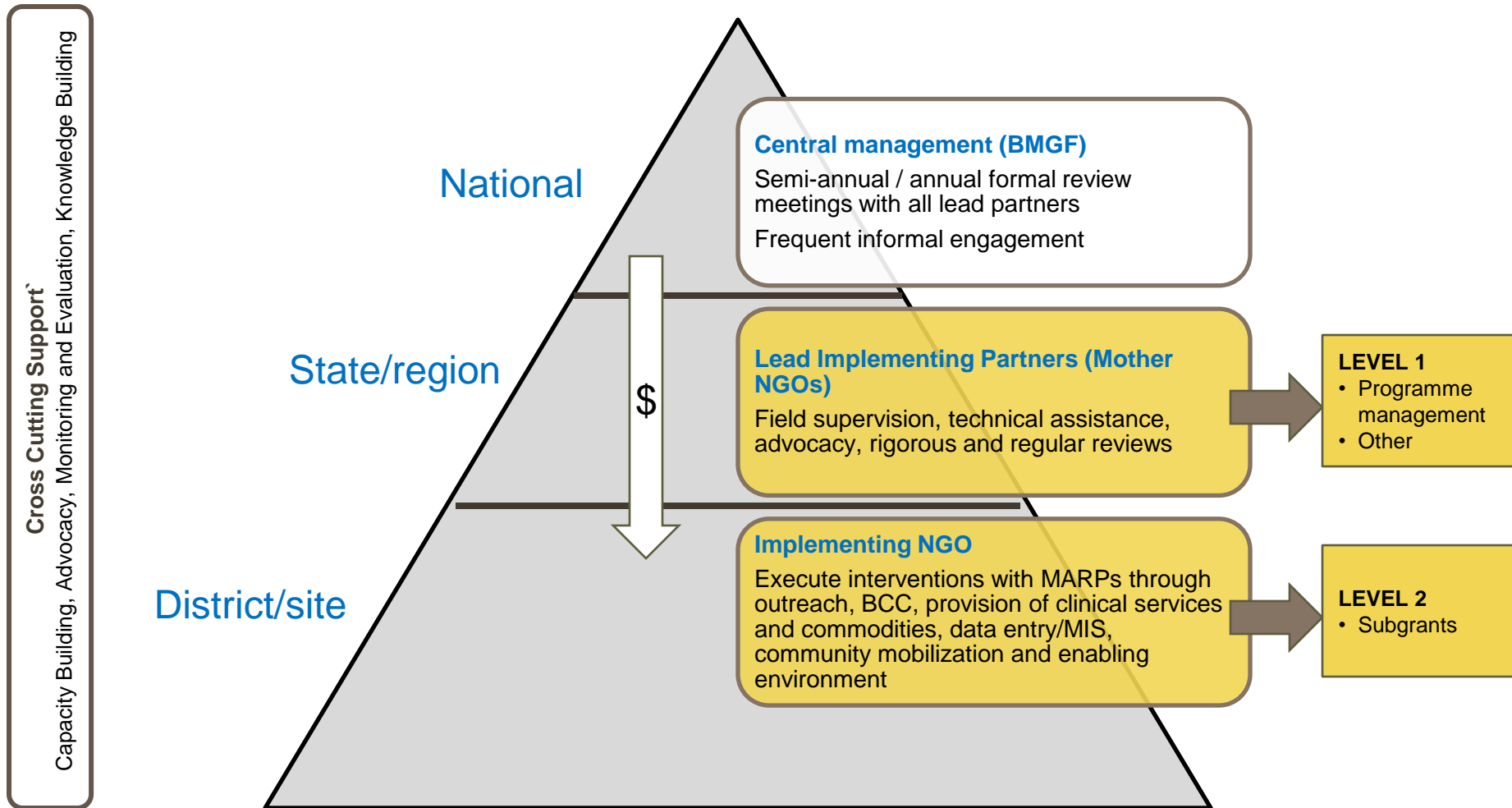
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Key messages on Avahan budgets and investments

- **Invest in advocacy and community mobilization**
 - » Violence reduction and crises management
 - » Sustainability and empowerment
- **Flexible funding to support innovation**
 - » Tailoring to the context
- **Appropriate staffing structure and investments**
 - » Staffing ratios and numbers
- **Management, management, management**

Avahan costs are captured at two levels



Description of Avahan major cost areas

For every \$100 spent on MARPs:

- At least \$60 should be spent on grassroots implementation
- Programme management should be adequately funded (e.g., 50% of implementation costs)

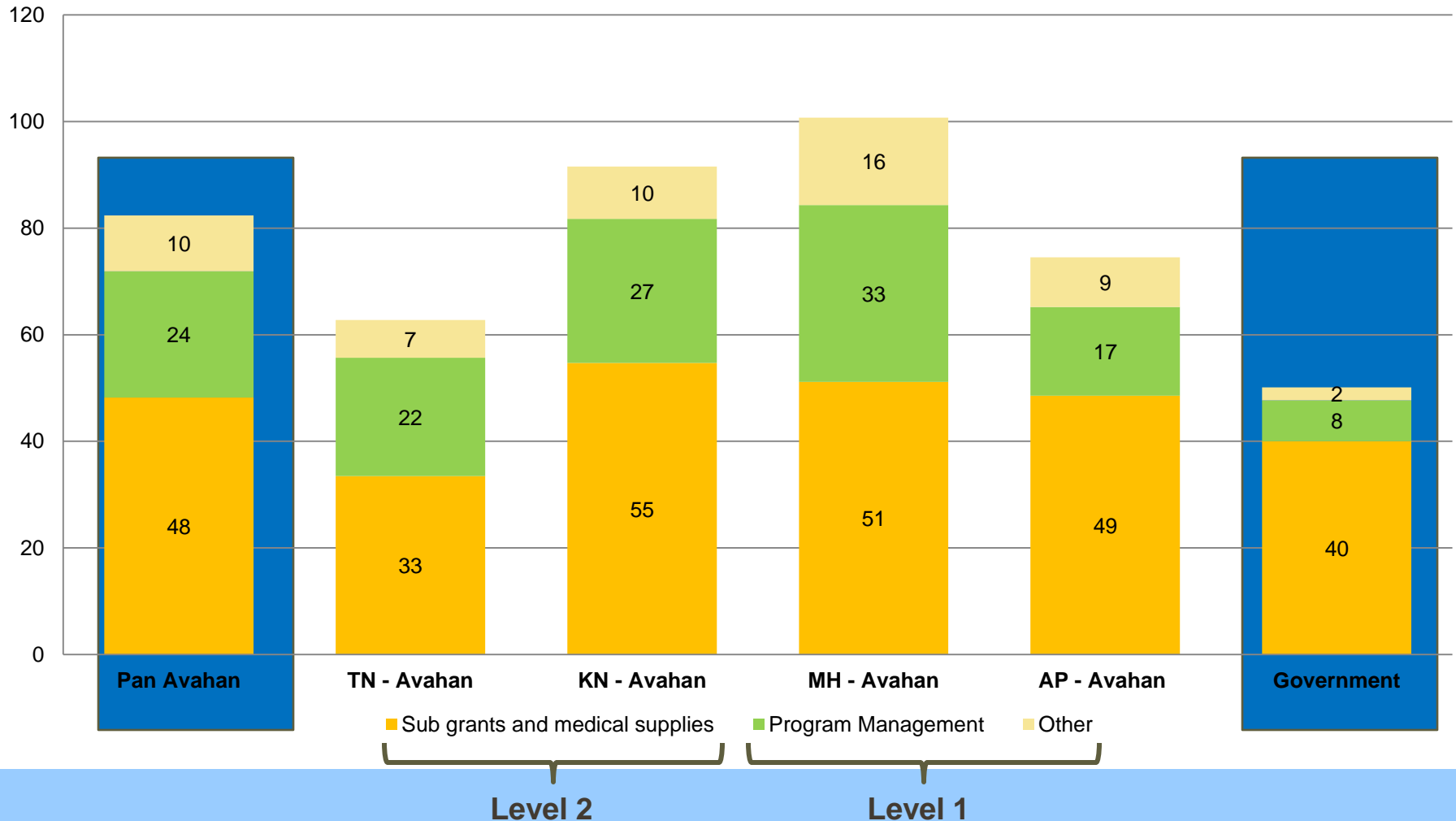
Cost area	Pan Avahan Annual	\$ per MARP per year	% of Total Costs	Description of Cost Components
Programme management	7,030,607	24	29%	<ul style="list-style-type: none"> • Appropriate field and technical staff • Travel for field based monitoring and handholding • Trainings and workshops • Contracts for mapping, size estimation, studies, research, tool development
Subgrants to Implementing NGOs (and medical supplies)	14,320,592	48	59%	<ul style="list-style-type: none"> • Staff (peer educators, outreach workers, managers) • Infrastructure • Technical areas such as clinical services, commodities, community mobilization, enabling environment, data collection, group meetings
Other programme costs	3,109,996	10	13%	<ul style="list-style-type: none"> • Rent and office supplies • Indirect costs • Equipment

Implementation – key components

Cost area	Per MARP	% of Total Costs
Subgrants to Implementing NGOs (and medical supplies)	\$48	100%
1. Staff	\$20	41%
2. Infrastructure and administration	\$9	18%
3. Technical areas <ul style="list-style-type: none">• Outreach and programme delivery• Clinical services and commodities• Community strengthening• Enabling environment	\$20	41%

Aligned implementation costs, higher management costs

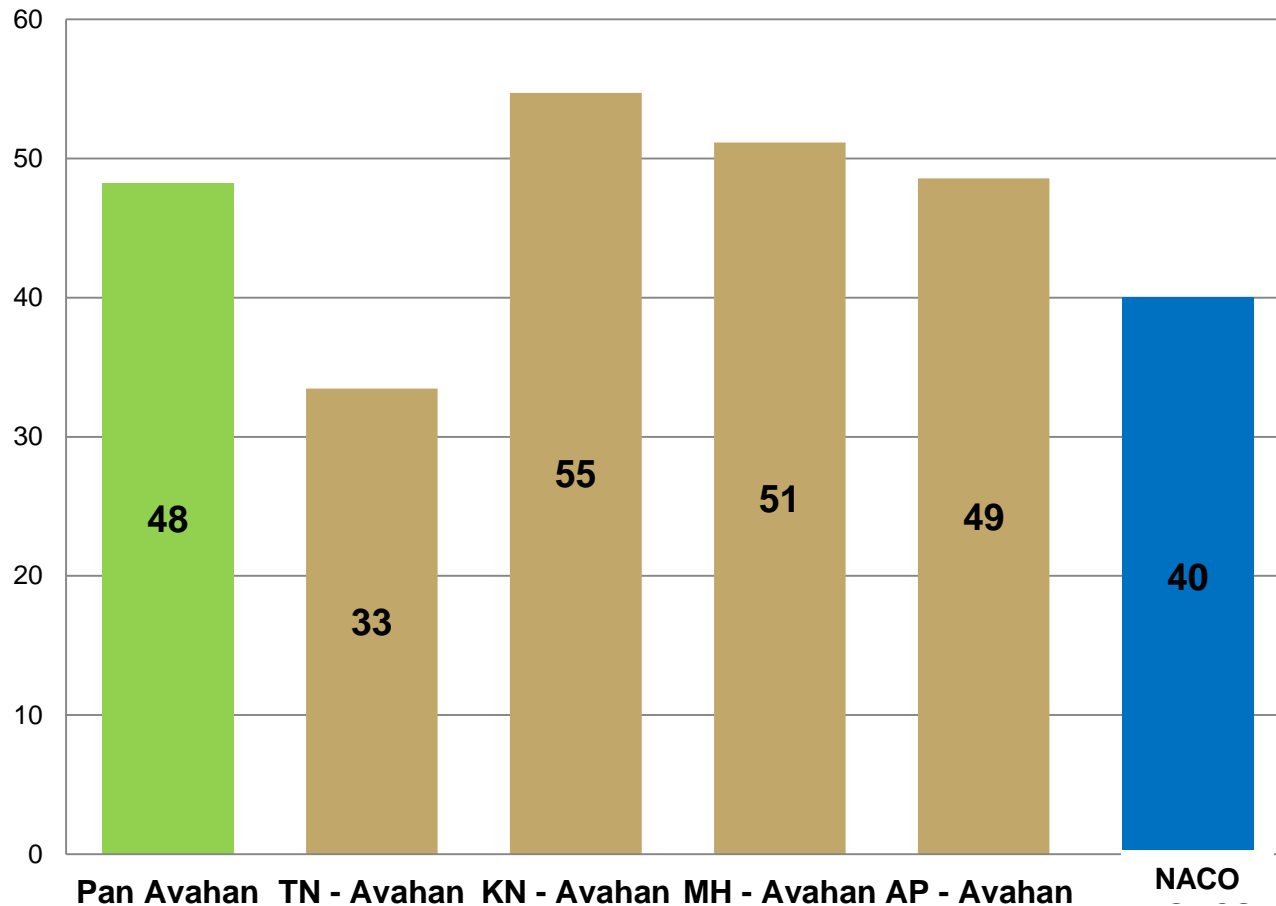
Cost per beneficiary for intended coverage (2008)



Source: Avahan Program data. Costs are financial costs.

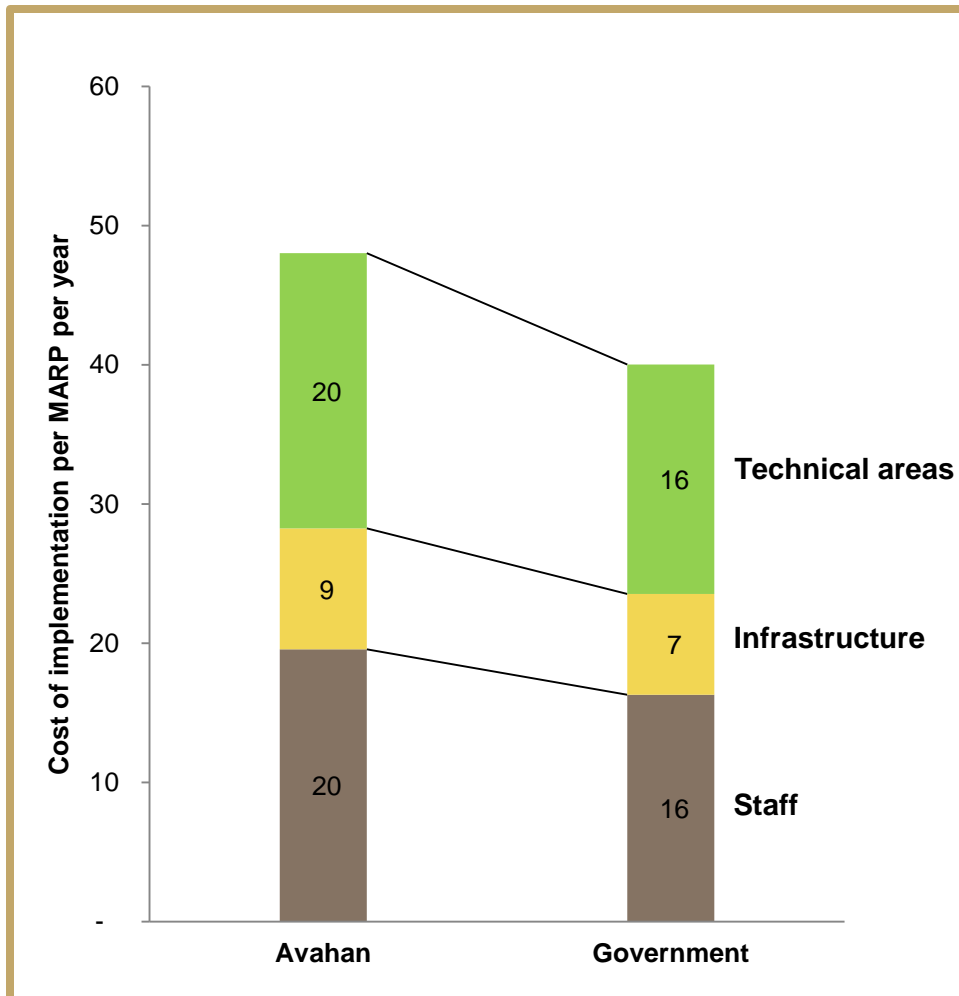
At the implementation level, Avahan's costs are roughly aligned with the government's costs

Cost per beneficiary for intended coverage (2008)



• Avahan average is ~20% higher for sub-grantee costs (vs. NACO)

Government costing for targeted interventions



Cost area	Variance of Avahan cost over NACO cost
Technical areas	Full time doctor cost; cost for drugs for general ailments; costing for 4 visits /MARP/year vs. 2 under government
Infrastructure and Administration	Additional DICs, more allowances for rent and DIC
Staff	More peers under Avahan (1:60 vs. more flexible 1:50 under Avahan) Additional staff positions critical for programming (e.g., additional nurses, outreach supervisors, peer counselors)

THANK YOU

QUESTIONS?