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
Agenda

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

Source: Tim Brown, East West Center
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)

- E Godavari: 26%
- Karimnagar: 13%
- Guntur: 7%
- Hyderabad: 8%
- Vijayawada: 33%
- Warangal: 5%
- Chittoor: 5%
- Bellary: 9.50%
- Bangalore: 9%
- Mysore: 7%
- Shimoga: 6%
- Pune: 5%
- Pune SB: 6%
- Yavatmal: 4%
- Kohlapur: 4%
- Mumbai: 38.70%
- Thane (BB): 37%
- Thane (SB): 37%
- Parbhani: 7%
- Salem: 13%
- Dharmapuri: 13%
- Prakasam: 7%
- Coimbatore: 7%
- Madurai: 26%
- Chennai: 2%

Median=14%

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

- Hyd (Teleng): 25%
- E G (coastal): 22%
- Guntur (Coastal): 13%
- Vizag (Coastal): 9%
- Bangalore: 20%
- Pune: 17%
- Madurai: 22%
- Coimbatore: 7%
- Salem: 6%
- Chennai: 5%

Median=15%

Source: Avahan IBBA MARP surveillancedata, 2006
ANC and PPTCT consistent sites; source: NACO
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

100% = USD 250 million

Focused Prevention (57%)
- High Risk Groups in 6 States
  - Female Sex Workers, HR-MSM/TG, IDUs
  - Male Clients of Sex Workers
  - Truckers on National Highways, Hotspots in 6 States

Communications for Social Norm Change (3%)

Advocacy (7%)

Best Practices Transfer (18%)

M&E, Knowledge Building, Dissemination (15%)

The Prevention Package
- Outreach, BCC
- Commodities (condoms, lubricants, needles)
- Clinical services for STIs + counseling
- Case managed approach to referral - TB, HIV testing, ART
- Local advocacy – police sensitization, crisis response, community advisory committees
- Community mobilization
AVAHAN’S MULTI-TIERED, MATRIX ORGANIZATION

- **9 LEAD PARTNERS**
  - 129 GRASSROOTS INDIAN NGOs / CBOs
  - 7,800 PEER EDUCATORS AND OUTREACH WORKERS
  - 321,000 FEMALE SEX WORKERS
  - HIGH-RISK MEN WHO HAVE SEX WITH MEN
  - INJECTING DRUG USERS
  - 5,000,000 MEN AT RISK RECEIVING SERVICES

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

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

- **State-level Strategy**
- **District-level Planning**
- **Hotspot-level Implementation**
- **Individual-level Tracking**

- **Active Management Support By Gates Foundation-Avahan Team**

*Source: Avahan monitoring data, March 2009*
AVAHAN’S SCALE UP TIMEFRAME

- **Dec 03**: 496 towns covered
- **Dec 04**: 554 towns covered
- **Dec 05**: 612 towns covered
- **Dec 06**: 632 towns covered
- **Dec 07**: 660 towns covered
- **Dec 08**: 675 towns covered

- **Peer outreach workers**
  - **Dec 03**: 2,600
  - **Dec 04**: 5,000
  - **Dec 05**: 7,000
  - **Dec 06**: 8,600
  - **Dec 07**: 8,000
  - **Dec 08**: 7,800

- **High-risk individuals contacted (thousands)**
  - **Dec 03**: 24
  - **Dec 04**: 72
  - **Dec 05**: 148
  - **Dec 06**: 217
  - **Dec 07**: 242
  - **Dec 08**: 241

- **High-risk individuals attended clinics (thousands)**
  - **Dec 03**: 2
  - **Dec 04**: 18
  - **Dec 05**: 36
  - **Dec 06**: 60
  - **Dec 07**: 67
  - **Dec 08**: 62

- **Condoms distributed per month (millions)**
  - **Dec 03**: 1
  - **Dec 04**: 4
  - **Dec 05**: 7
  - **Dec 06**: 10
  - **Dec 07**: 12
  - **Dec 08**: 9

- **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

Scale / coverage / quality / costs

- Are services adequate (~80% of population) over time?
- What were the costs?
  - If not, how to improve?
  - If adequate, then

  - Increase in condom use in HRGs?
  - Reduction in STI and new HIV in HRGs
    - If not, why not?
    - If yes, then

  - Decrease in HIV in general population?
    - If not, why not?
    - If yes, then

  - Can be attributed to HRG interventions?
    - If not, why not?
    - If yes, then

  - What was Avahan’s contribution?

Epidemic impact

Cost effectiveness

- Cost effectiveness HRG reached?
- Cost effectiveness of infections averted?
- Cost efficiency of the various service components?
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.

<table>
<thead>
<tr>
<th>Condition</th>
<th>IBBA R1</th>
<th>IBBA R2</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV-1</td>
<td>19.6</td>
<td>16.4</td>
</tr>
<tr>
<td>Syphilis</td>
<td>10.2</td>
<td>8.7</td>
</tr>
<tr>
<td>High-titre syphilis</td>
<td>5.9</td>
<td>3.4</td>
</tr>
<tr>
<td>Chlamydia (CT)</td>
<td>6.5</td>
<td>5.6</td>
</tr>
<tr>
<td>Gonorrhoea (NG)</td>
<td>3.5</td>
<td>2.5</td>
</tr>
<tr>
<td>CT and/or NG</td>
<td>8.9</td>
<td>7.0</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Location</th>
<th>FSW % (95% CI)</th>
<th>Clients % (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mysore</td>
<td>59.2 (47.8-70.6)</td>
<td>62.3 (51.7-72.8)</td>
</tr>
<tr>
<td>Belgaum</td>
<td>43.5 (33.7-53.3)</td>
<td>50.3 (39.8-60.7)</td>
</tr>
<tr>
<td>Bellary</td>
<td>64.6 (59.4-69.3)</td>
<td>67.6 (63.2-72.1)</td>
</tr>
</tbody>
</table>

Source: CHARME Team, manuscript in preparation
Agenda

- Avahan Overview
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- Financial cost structure and analysis
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

Central management (BMGF)
Semi-annual / annual formal review meetings with all lead partners
Frequent informal engagement

Lead Implementing Partners (Mother NGOs)
Field supervision, technical assistance, advocacy, rigorous and regular reviews

Implementing NGO
Execute interventions with MARPs through outreach, BCC, provision of clinical services and commodities, data entry/MIS, community mobilization and enabling environment

LEVEL 1
- Programme management
- Other

LEVEL 2
- Subgrants
### 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)

<table>
<thead>
<tr>
<th>Cost area</th>
<th>Pan Avahan Annual</th>
<th>$ per MARP per year</th>
<th>% of Total Costs</th>
<th>Description of Cost Components</th>
</tr>
</thead>
</table>
| Programme management                          | 7,030,607         | 24                  | 29%              | • **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%              | • **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%              | • **Rent** and office supplies  
  • **Indirect costs**  
  • **Equipment**                                               |

**Source:** Avahan 2008 budgets; Avahan Program data. Costs are financial costs.
## Implementation – key components

<table>
<thead>
<tr>
<th>Cost area</th>
<th>Per MARP</th>
<th>% of Total Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Subgrants to Implementing NGOs (and medical supplies)</strong></td>
<td>$48</td>
<td>100%</td>
</tr>
<tr>
<td><strong>1. Staff</strong></td>
<td>$20</td>
<td>41%</td>
</tr>
<tr>
<td><strong>2. Infrastructure and administration</strong></td>
<td>$9</td>
<td>18%</td>
</tr>
<tr>
<td><strong>3. Technical areas</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Outreach and programme delivery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Clinical services and commodities</td>
<td>$20</td>
<td>41%</td>
</tr>
<tr>
<td>• Community strengthening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Enabling environment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Based on typical NGO budget – 2008; Source: Avahan Program data. Costs are financial costs.*
Aligned implementation costs, higher management costs

Cost per beneficiary for intended coverage (2008)

- **Pan Avahan**: 10 (Sub grants and medical supplies), 24 (Program Management), 48 (Other)
- **TN - Avahan**: 7 (Sub grants and medical supplies), 22 (Program Management), 33 (Other)
- **KN - Avahan**: 10 (Sub grants and medical supplies), 27 (Program Management), 55 (Other)
- **MH - Avahan**: 16 (Sub grants and medical supplies), 33 (Program Management), 51 (Other)
- **AP - Avahan**: 9 (Sub grants and medical supplies), 17 (Program Management), 49 (Other)
- **Government**: 2 (Sub grants and medical supplies), 8 (Program Management), 40 (Other)

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)

Source: Avahan Program data. Costs are financial costs.
Government costing for targeted interventions

![Cost comparison chart showing differences in cost per MARP per year between Avahan and Government.]

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

Source: http://nacoonline.org/upload/Divisions/Finance/Revised%20TI%20costing%20for%20NGO%20led%20TIs%20working%20with%20HRGs1.pdf
THANK YOU

QUESTIONS?