



Investing in our future

The Global Fund

To Fight AIDS, Tuberculosis and Malaria

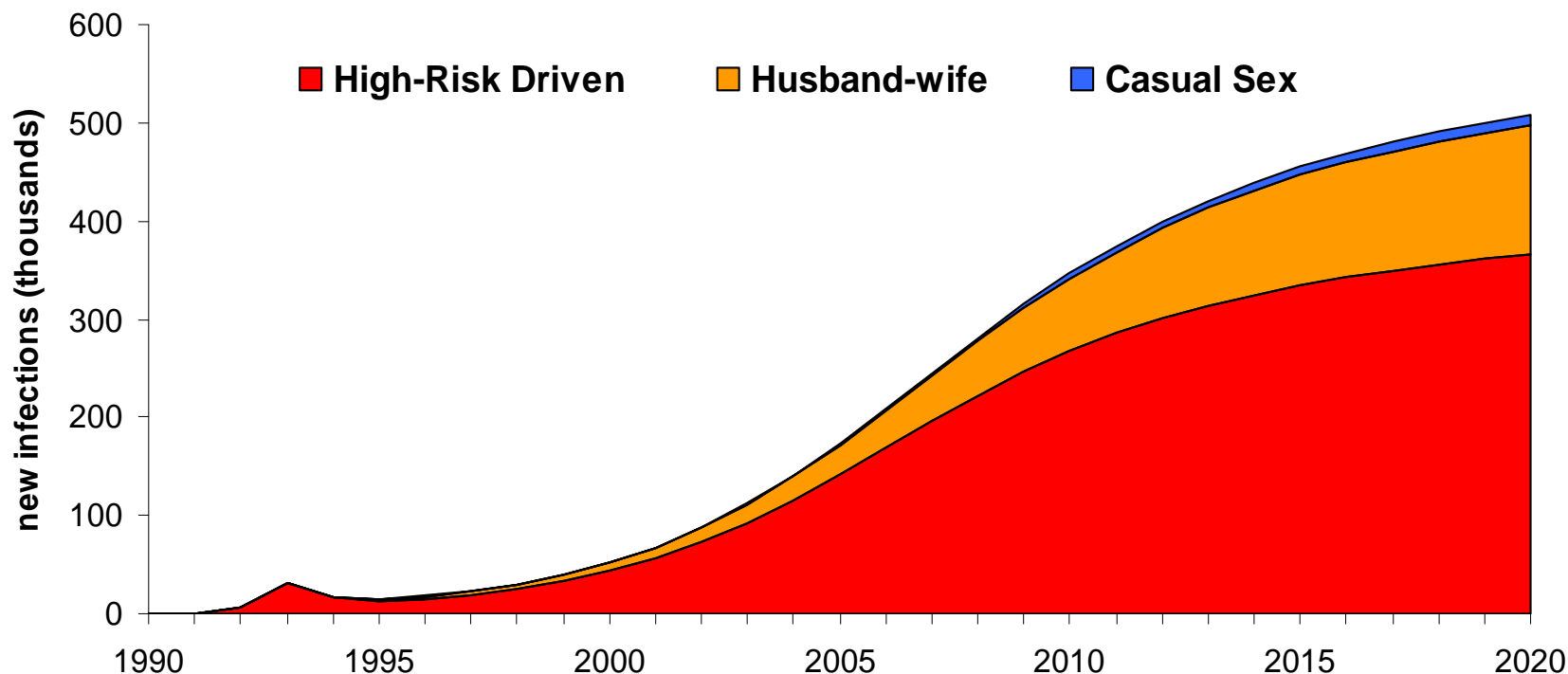
What Constitutes a Strategic Response for MARPS ?

Swarup Sarkar, Abu Abdul Quader and Nalyn Siripong

Chennai, Feb 2009

Asian epidemics are not driven by casual sex in general population...

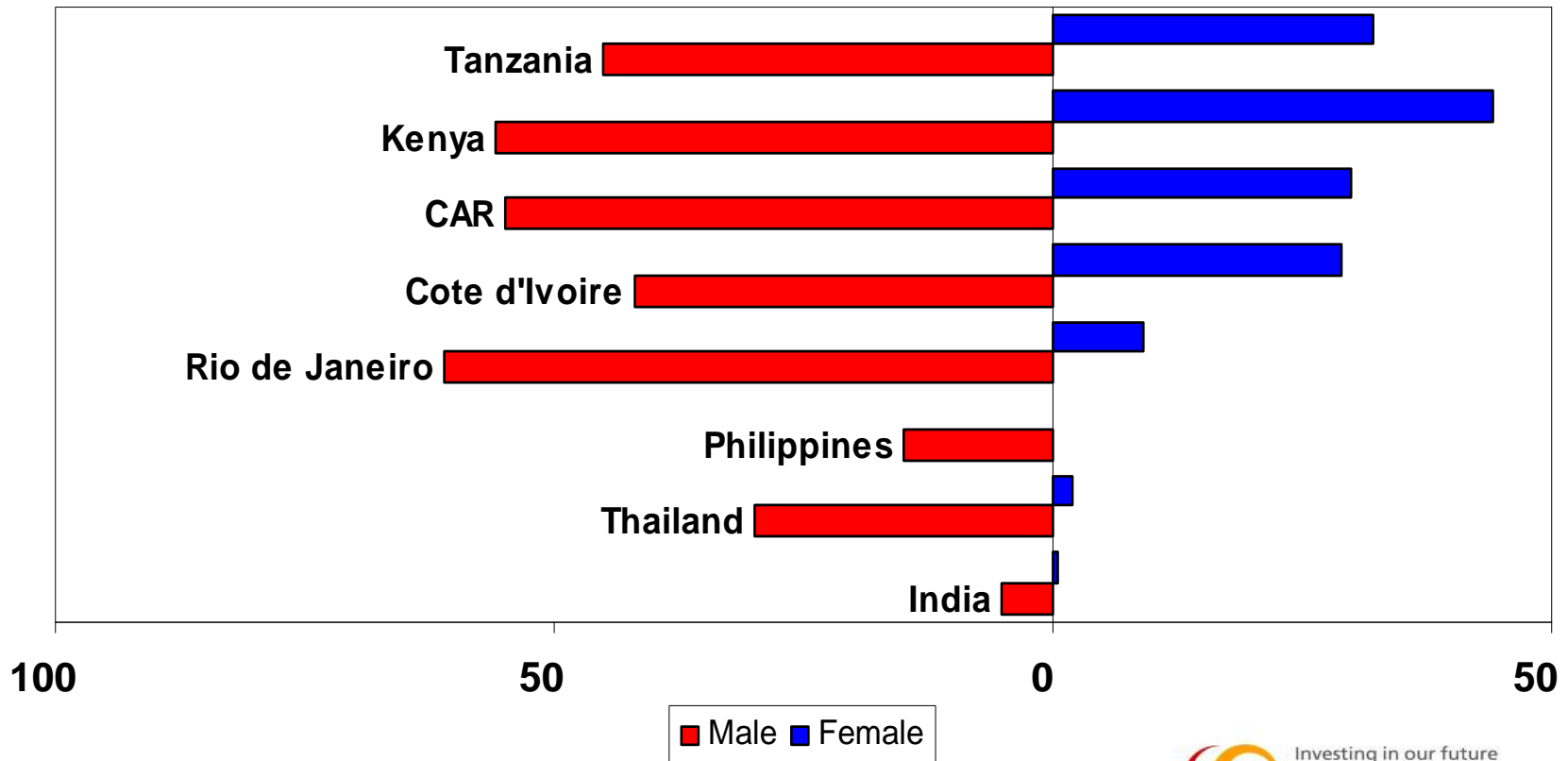
Estimated number of annual new infections and proportion of casual sex in a typical 100-million population setting in Asia



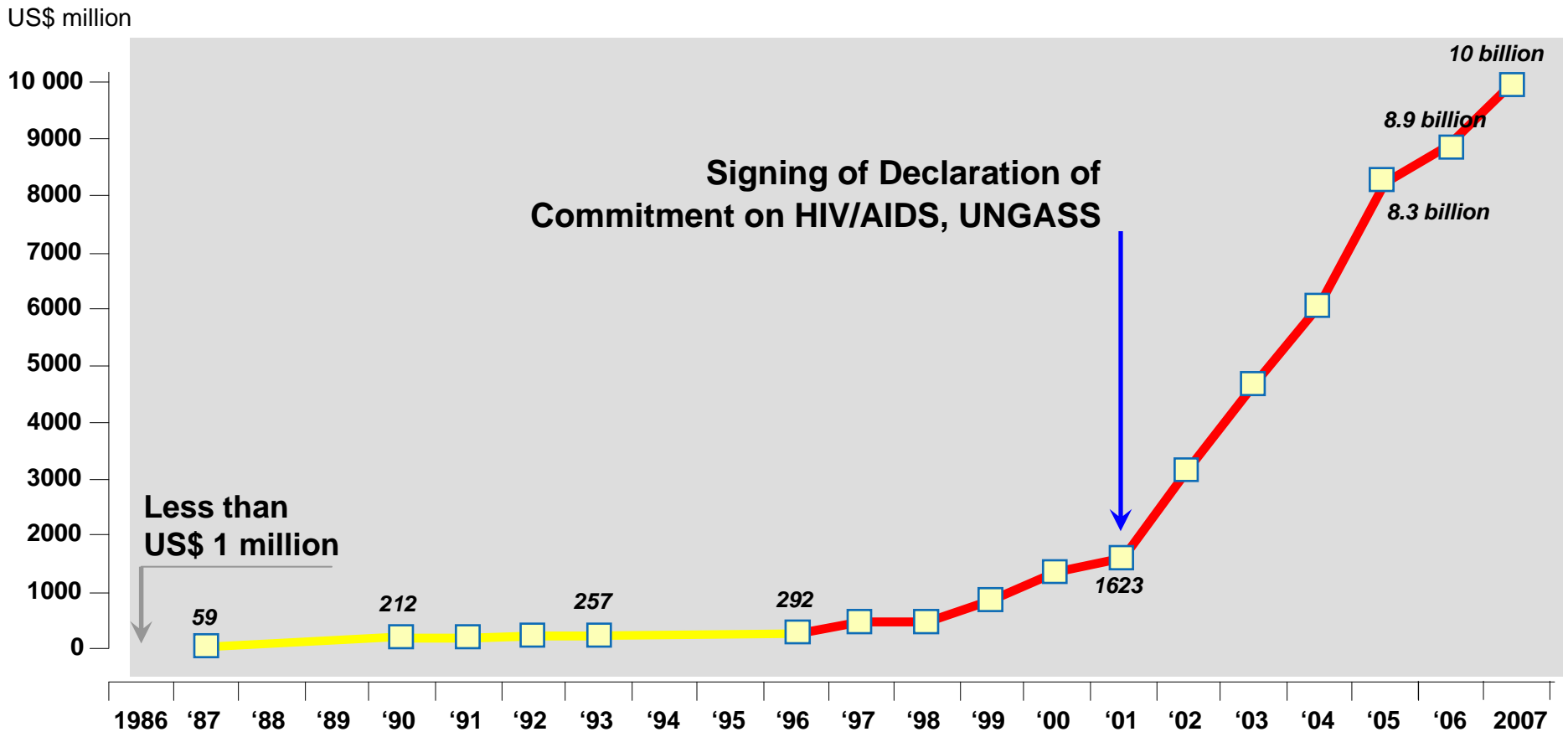
...but by percentage of adult men visiting sex

Limiting factor in Asian epidemics: women's behaviors

Men have a greater tendency to engage in multiple concurrent partnerships

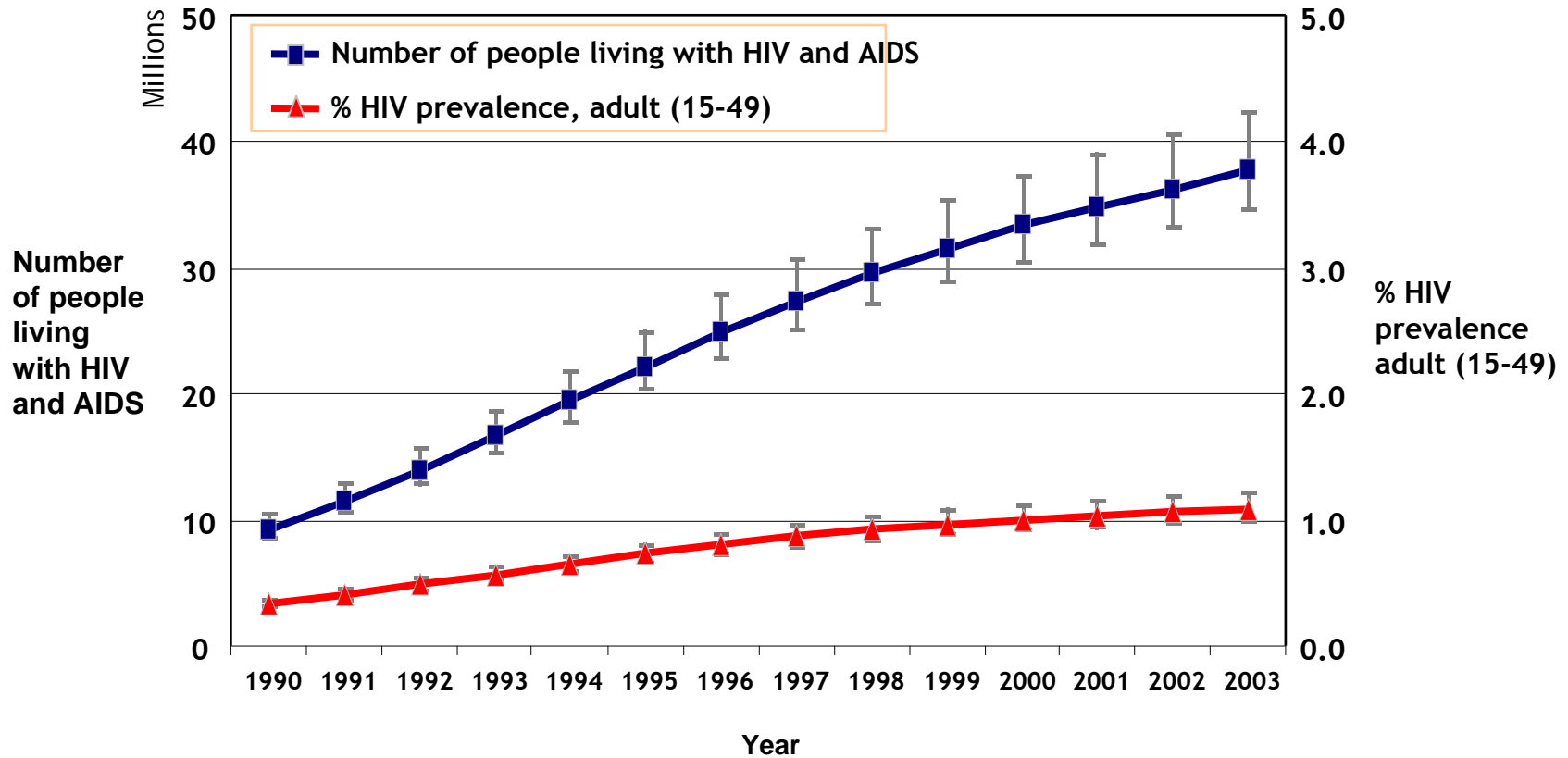


Dramatic Increase in Resources for AIDS 1986 – 2007



Notes: [1] 1986-2000 figures are for international funds only
 [2] Domestic funds are included from 2001 onwards

Not Enough impact on Global AIDS epidemic 1990–2003



Source: UNAIDS/WHO, 2004

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2004 Report on the Global AIDS Epidemic (Fig 1)

We need both Scale (coverage) and quality of intervention

Effectiveness in Projects (qlty) × **Coverage of Projects** = **Overall Effectiveness**

90% × **10%** =

9%

30% ×

80% =

24%

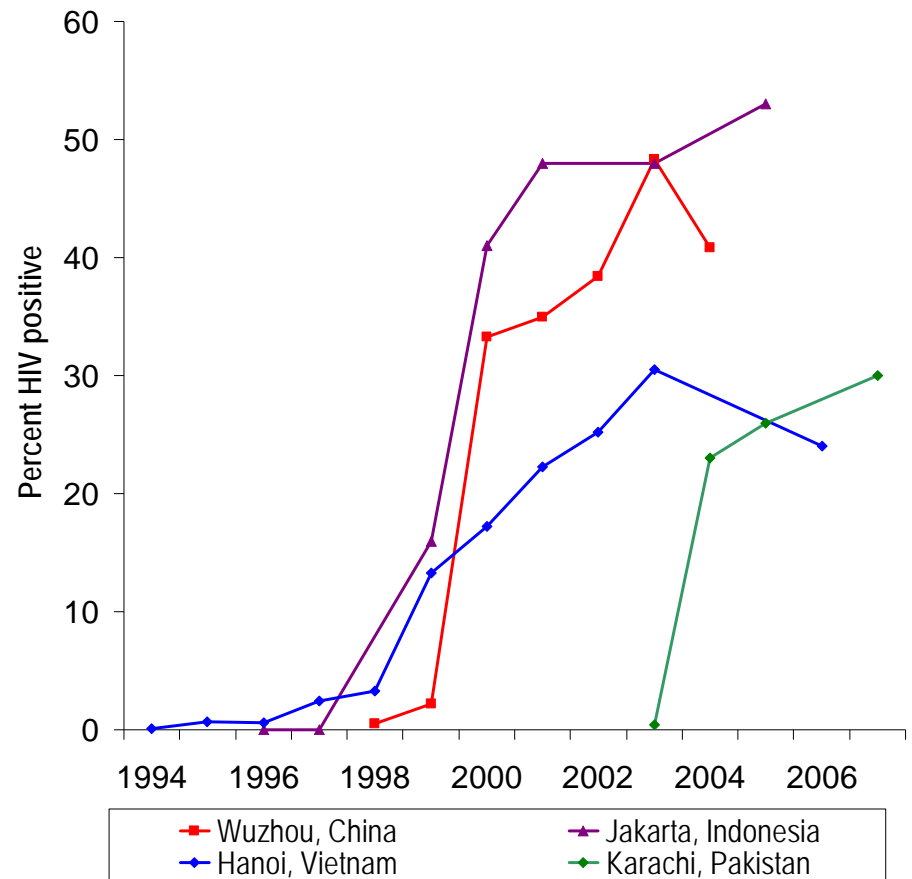
90% ×

80% =

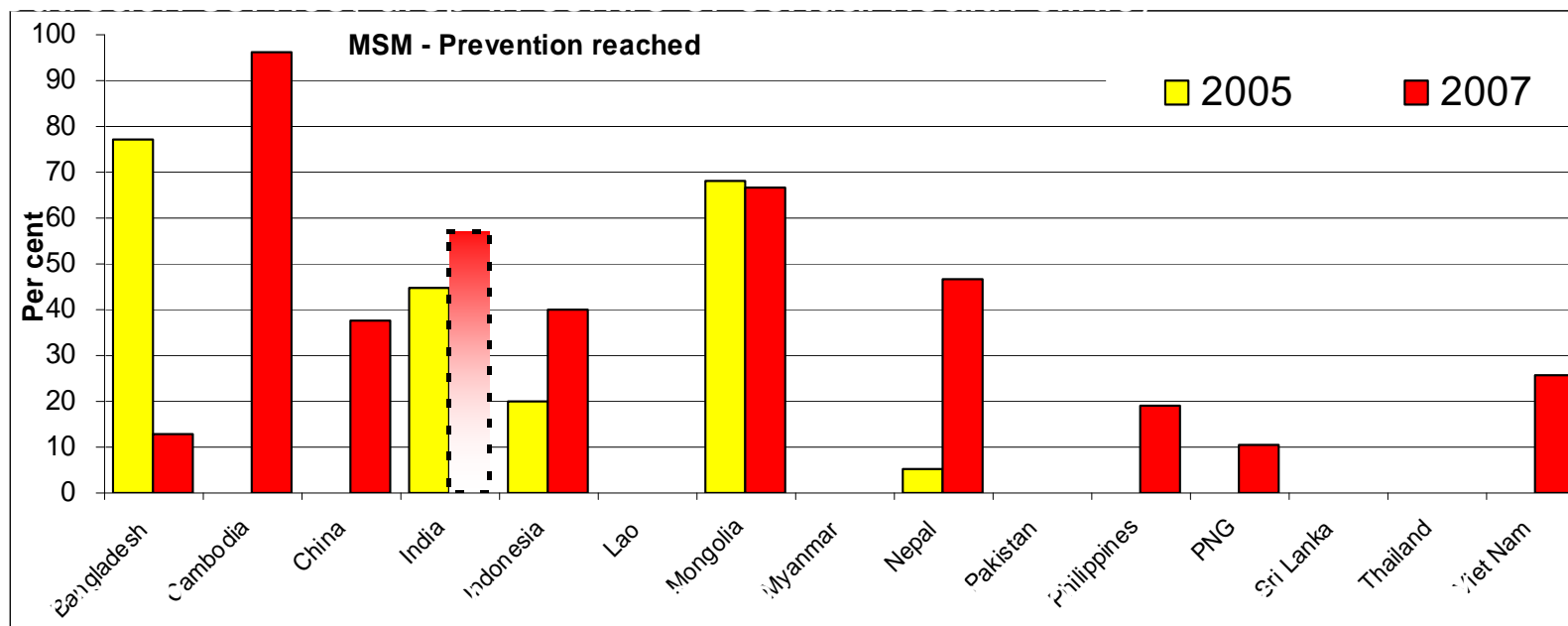
72%

After 25 years of epidemic do we know what are the right interventions ?

- IDU epidemics continue to expand in Asia
- Secretary-General's (UNGASS 2008) report highlighted South and South East Asia for 62% coverage of injecting drug users

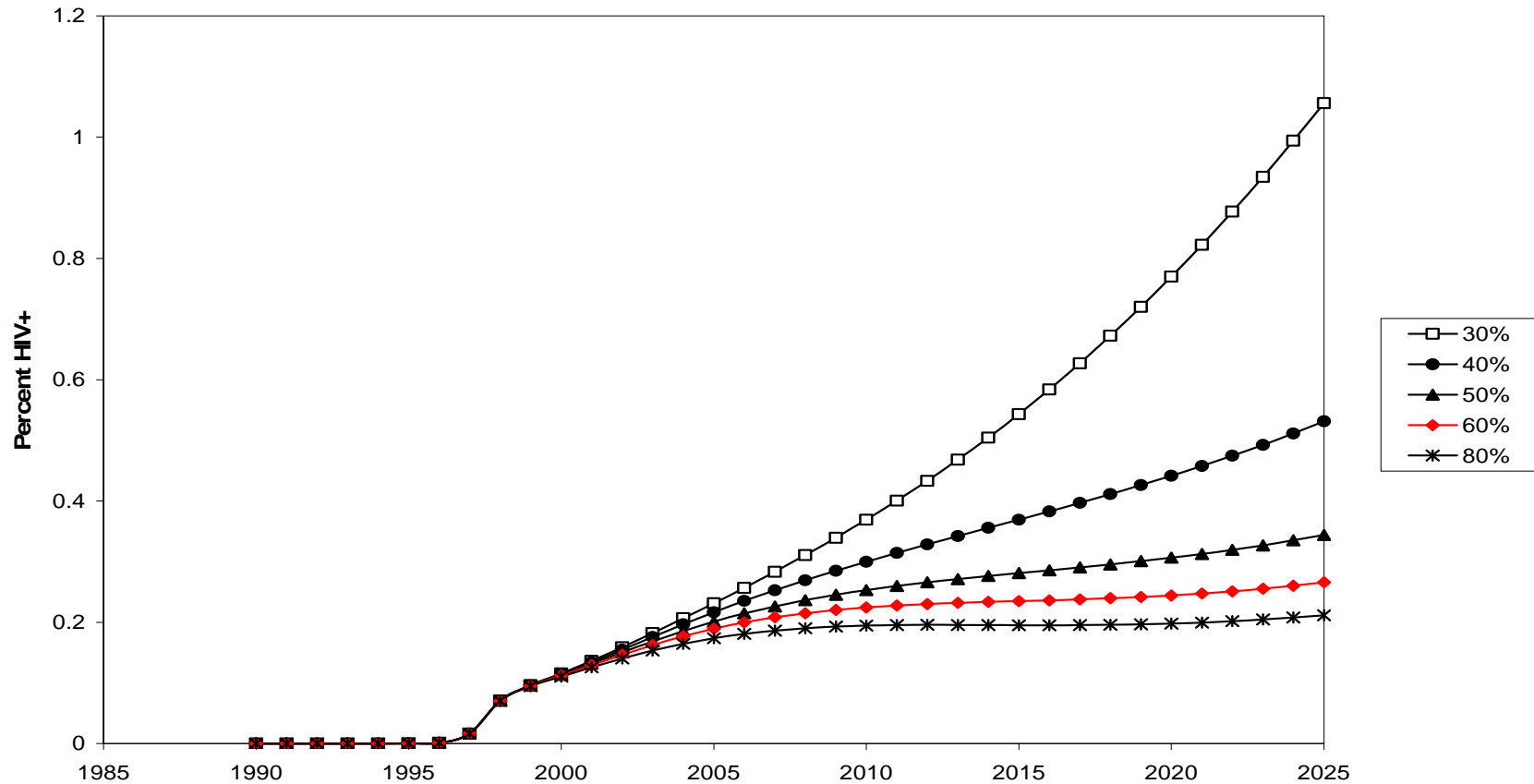


Current UNGASS indicators show high coverage even for MSM



Possibly due to lack of standard definition

Required Coverage



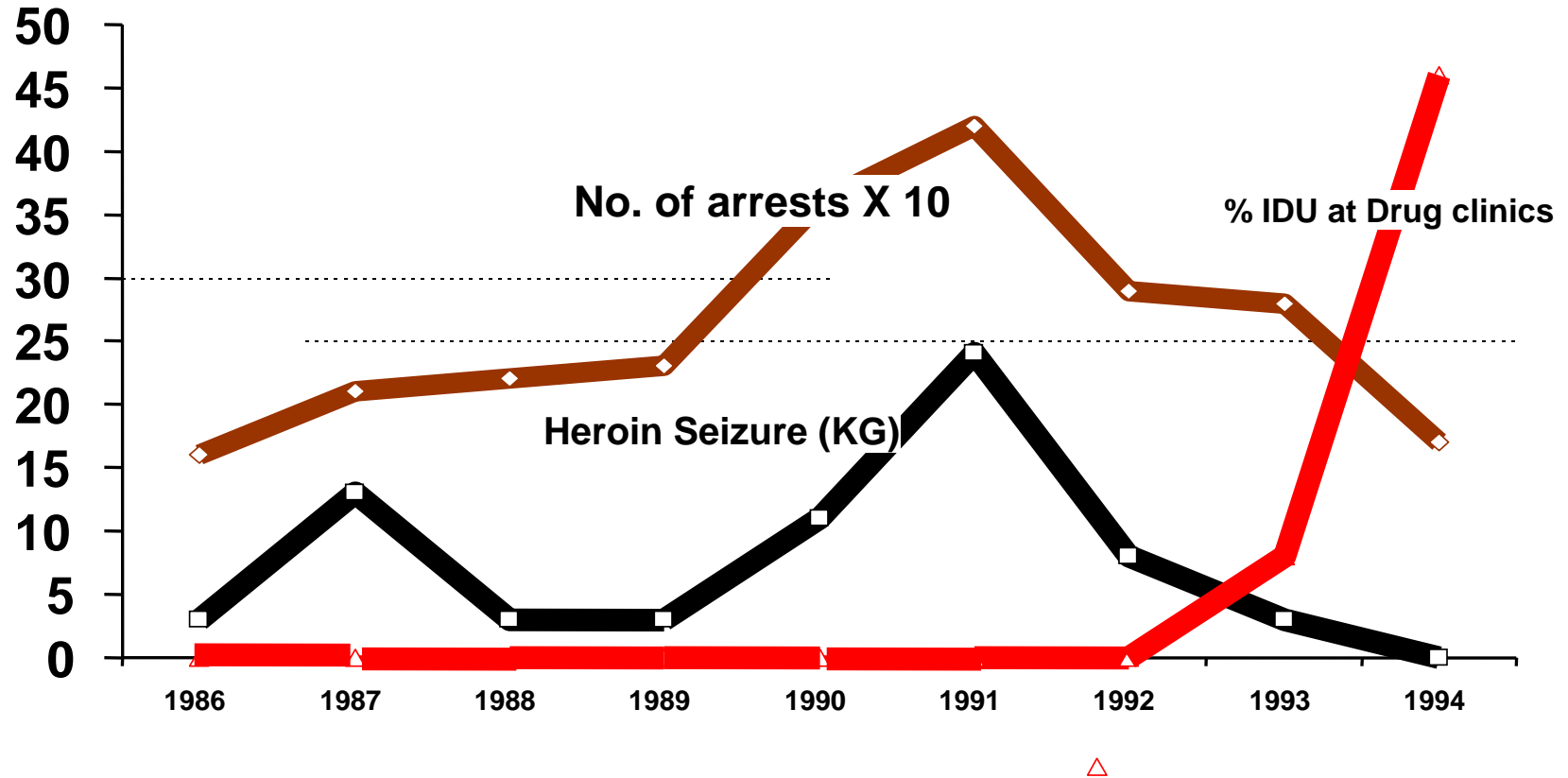
Why Standard of Intervention ?

- To stop funding **ineffective intervention**
- Not to pick up **partial elements** of effective interventions
- Interventions varying in **elements, dosage, frequency of administration**
- **Counter productive programs**
- Decide on the **delivery unit** of the intervention

What is wrong with current interventions ?

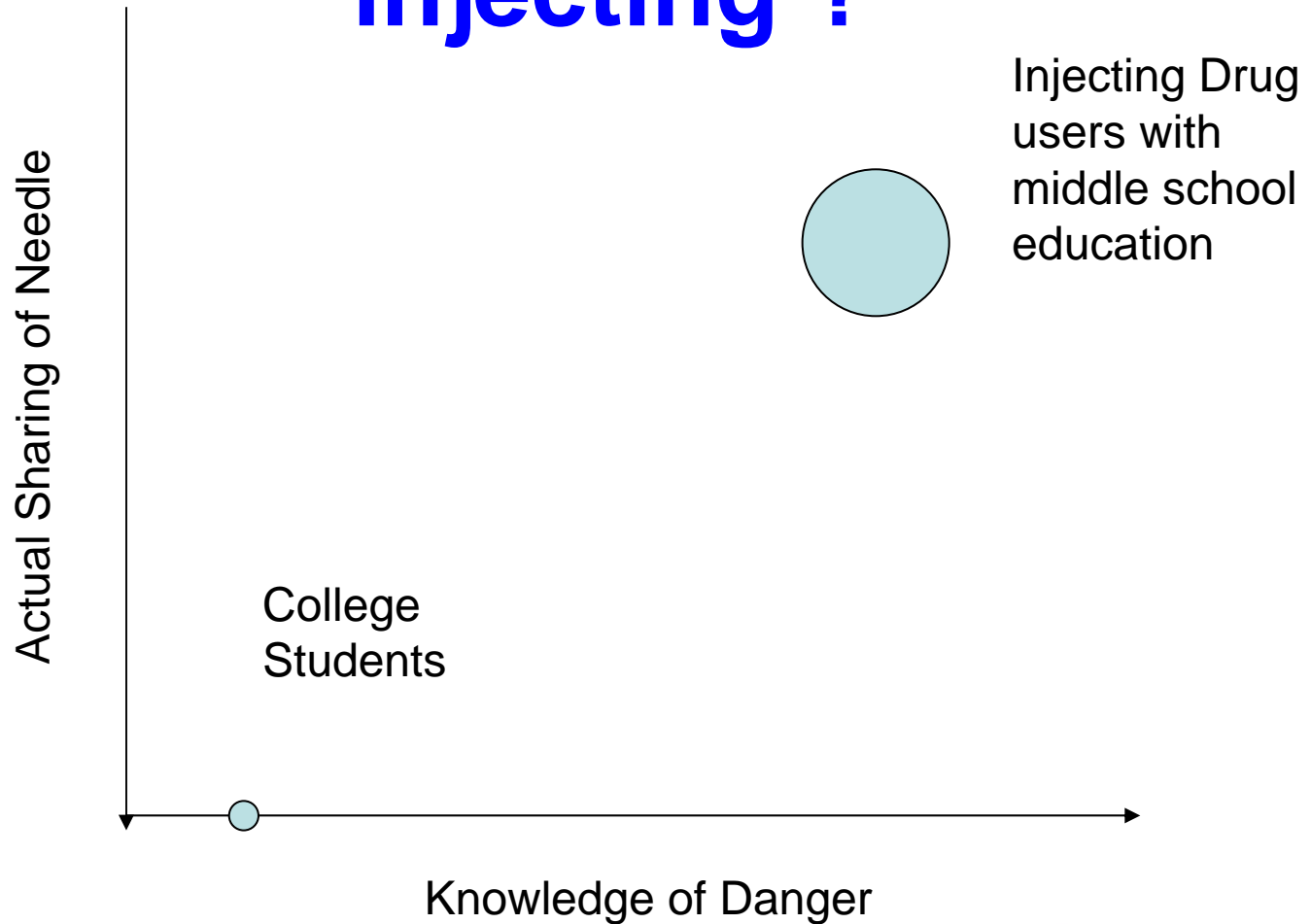
- Funding often diverted to **ineffective intervention**
 - Interventions are only **partially implemented**
 - Interventions vary in **quality, dosage, frequency of administration**
 - **Counter productive programs**
 - Undefined delivery unit hinders **delivery at scale**
- **Rehabilitation of sex workers, abstinence, Supply reduction of drug**
 - Only, awareness program, no or part access to prevention tool (only NS or Substitution), services not community owned, no involvement of community.
 - Define the **quality of interventions**
No of peer education /mth, needle/wk, dose of substitution etc
 - **Mass arrest, mass testing, Legal measures against MSM , SWs, IDU**
 - Is it NGO, CBO, Government, INGO, where they are based

Supply reduction and police action precipitating risky behavior among injectors

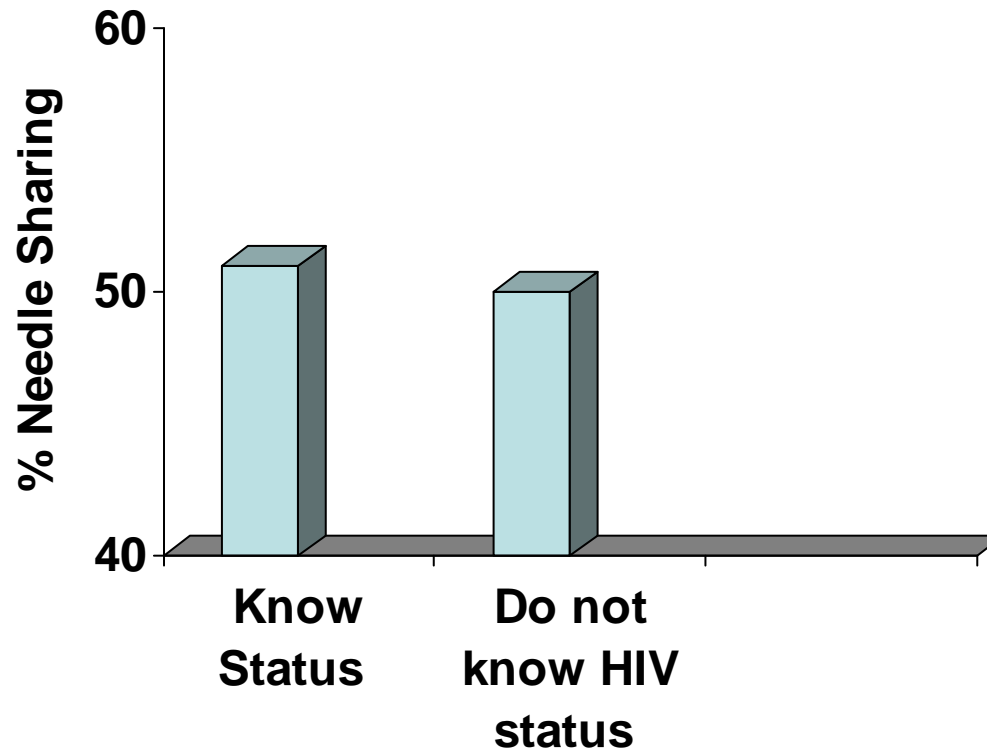


Leaflet Alone Program for IDUs

More Knowledge = more injecting ?

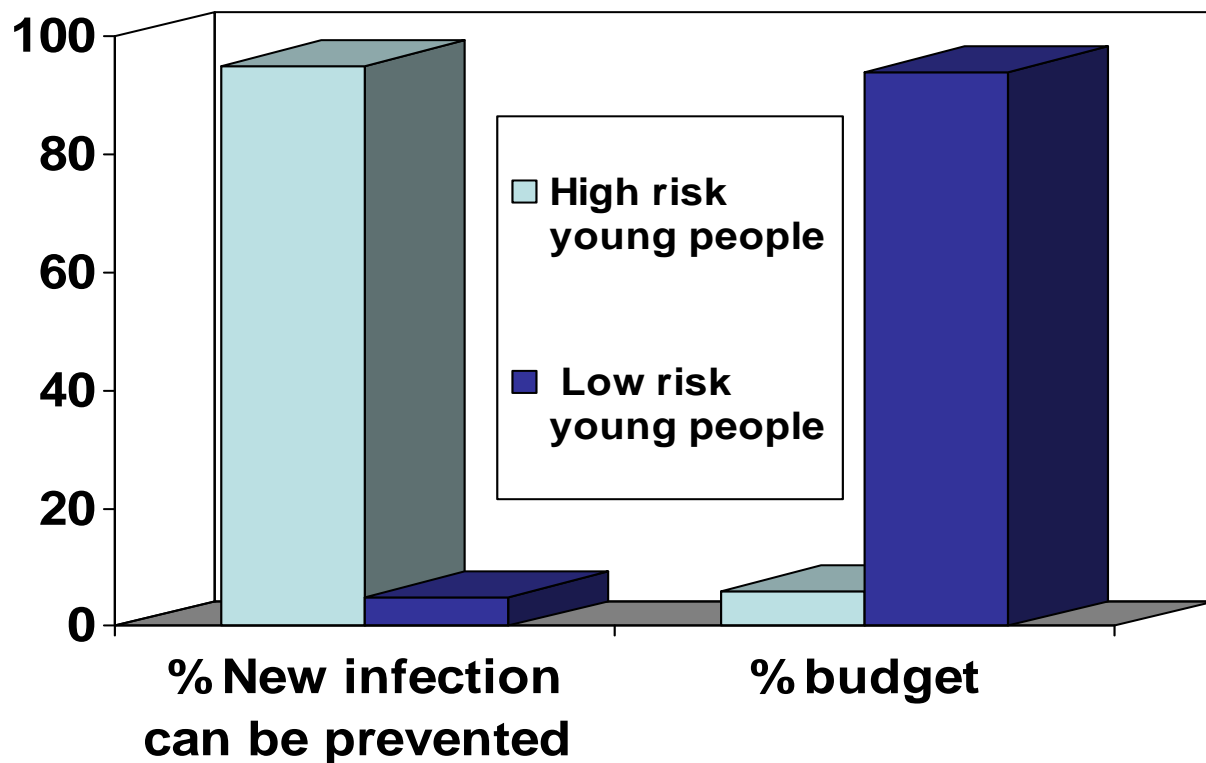


Testing alone does not work



Diversion of Funds

- Funding often diverted to **ineffective intervention** ➤ **Rehabilitation of sex workers, abstinence, demand reduction**



HIV money is often diverted away from high-risk youth (e.g., sex workers, men who visit sex workers, IDU, MSM) to programs targeted for low-risk youth and/or “upstream” programming (life skills, etc.)

Note : UNICEF, UNFPA and UNESCO
Source: AEM and UBW 2004-05

What does NOT work

Avoid counter-productive programs like:

- Arrest and detention
- Mass testing
- Raising awareness without tools and services

Elements of Intervention

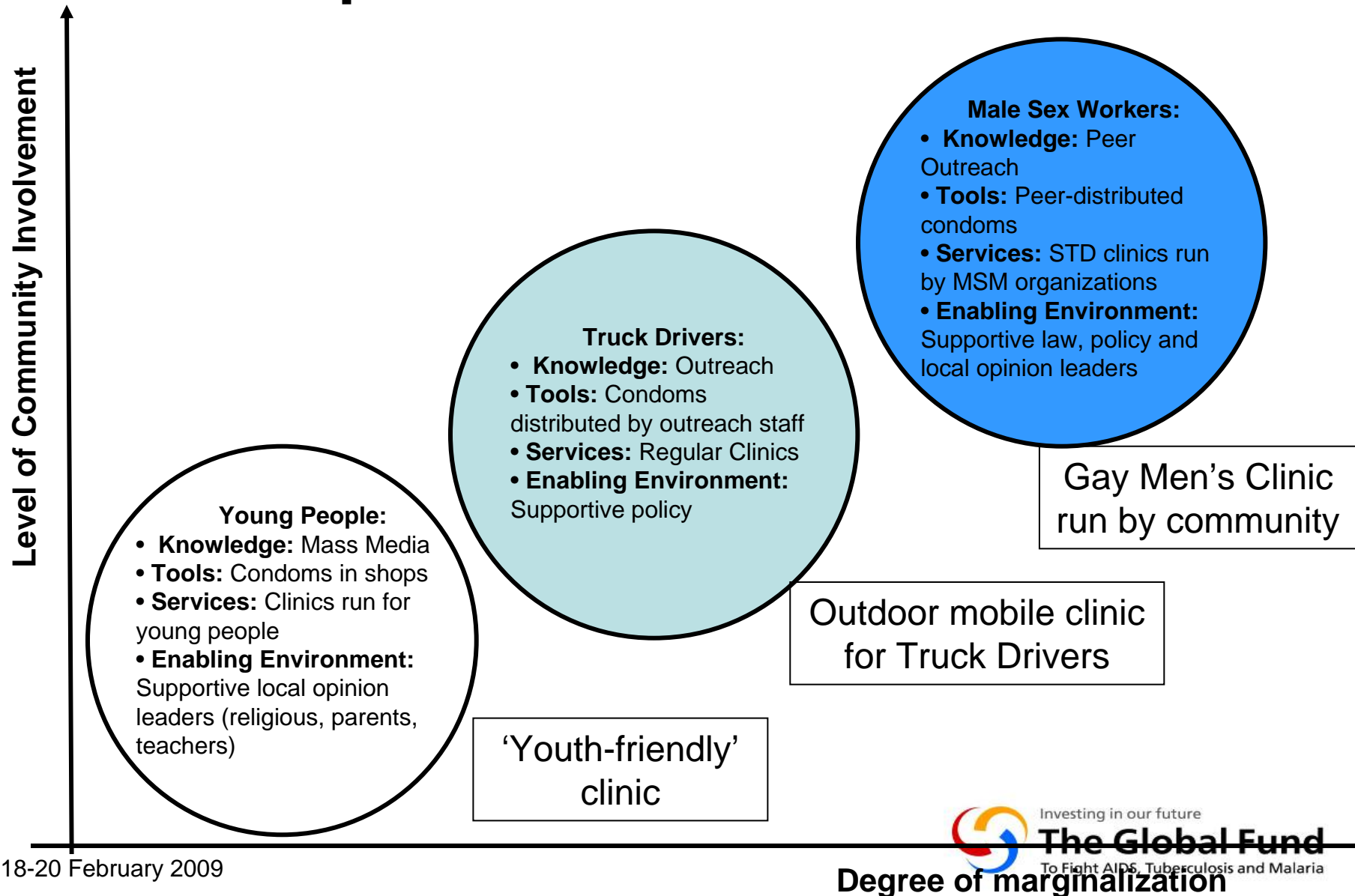
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Elements of Effective Prevention

- Imparting knowledge:
 - Mass media campaigns, peer education
- Preventive services and commodities:
 - Condoms, lubricants and needle exchange
- Treatment services (for prevention)
 - STI Treatment and drug substitution treatment
- Enabling Environment
 - Local advocacy, supportive policies, facilitated access

Involvement of the Community

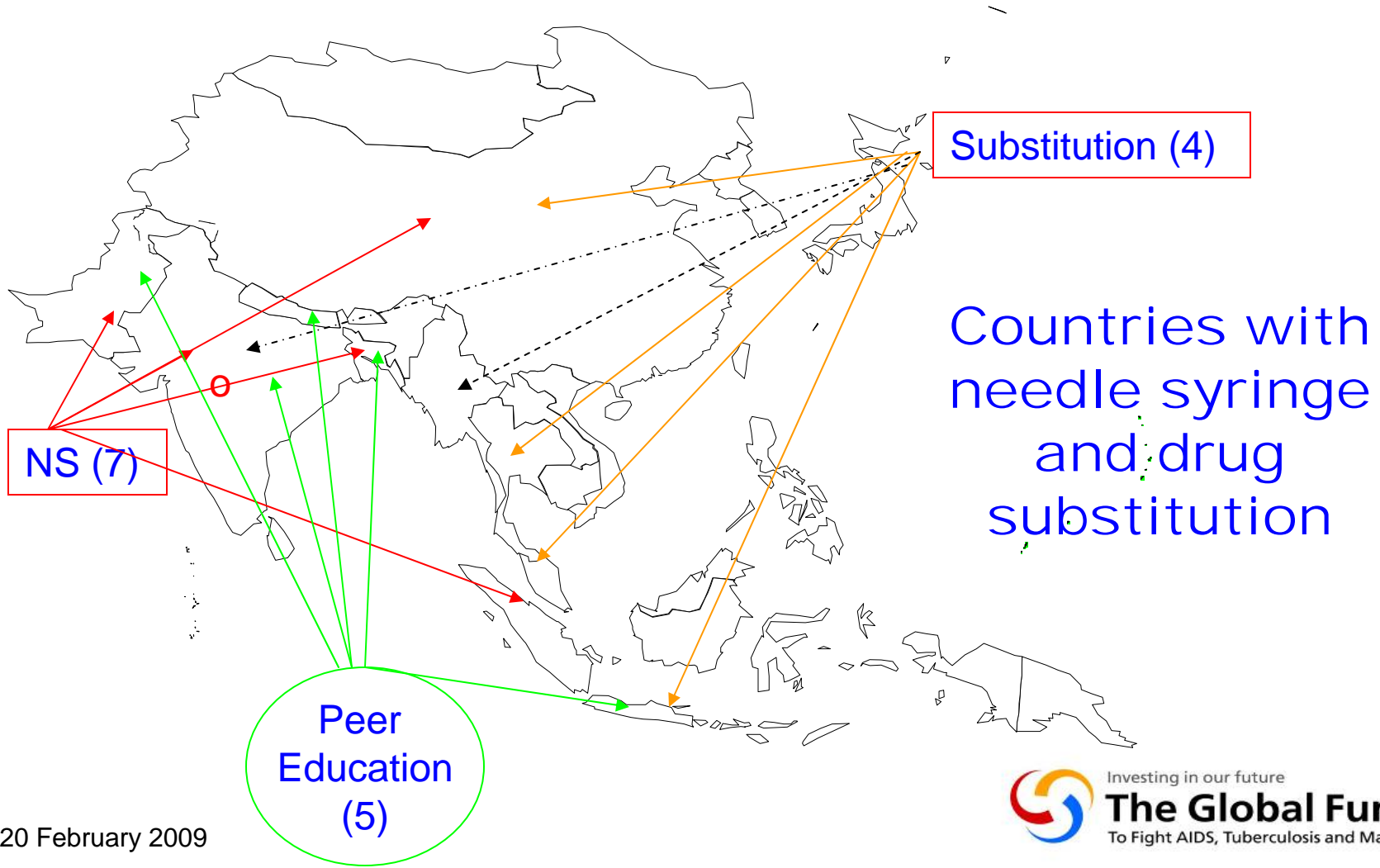
Marginalized Communities Need More Local Empowerment/Involvement



Partial Elements of Intervention leads to incomplete results

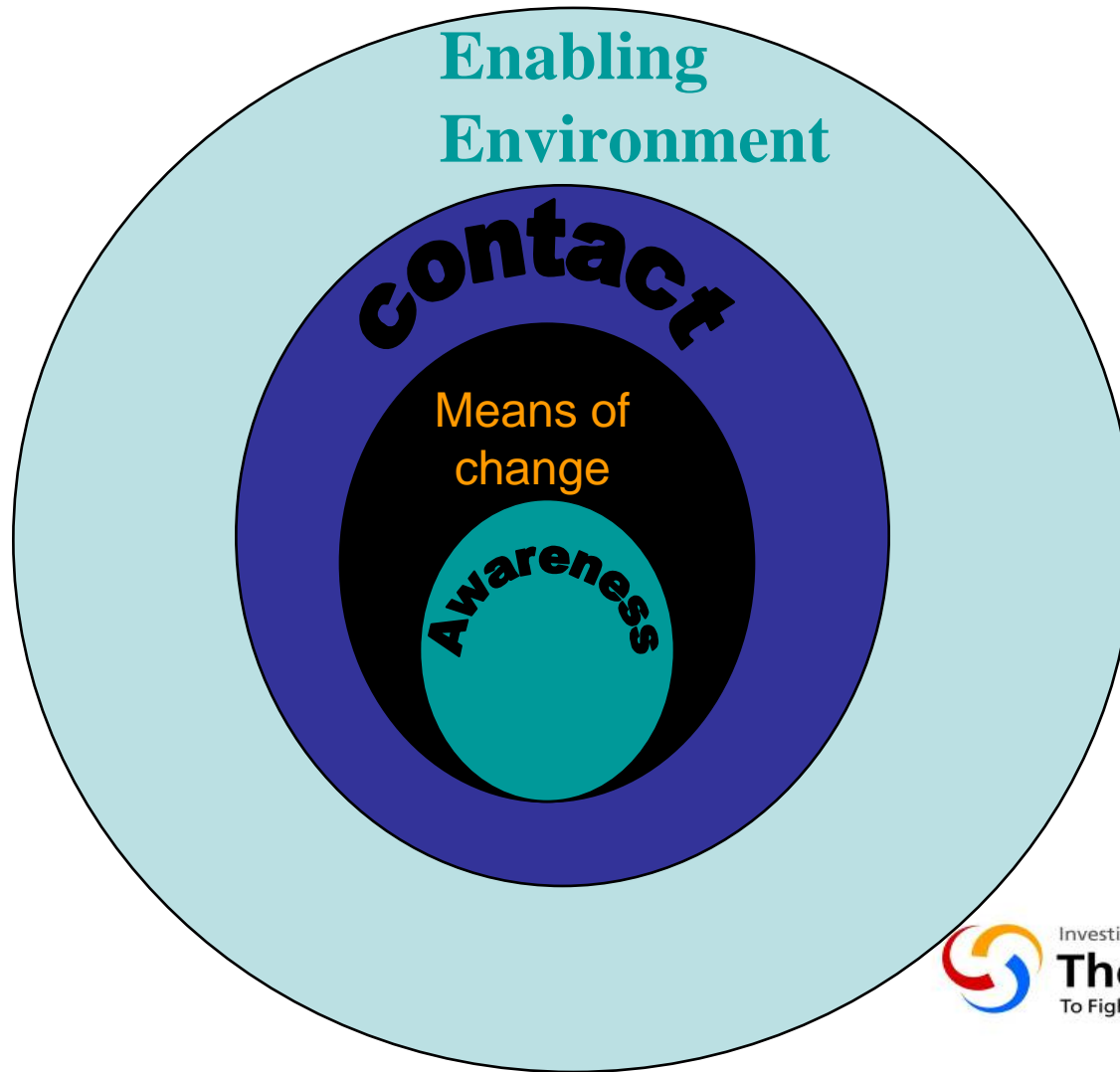
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No surprise- IDU epidemic continues to grow even in successful countries



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Essential elements of behavior change programs



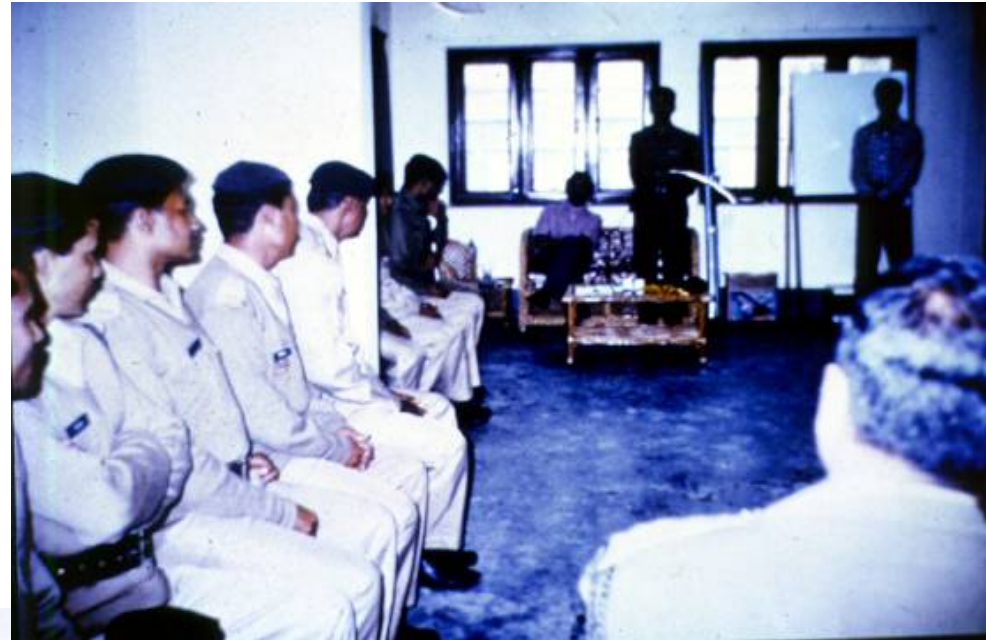
Define the quality and dose

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Peer education for sex workers individual/group street and brothel



Advocacy



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Most Effective Package

Activity	Periodicity	QualityRef
Peer education	Once in fortnight	See Checklist
Prevention Tools	Condom all sex acts, Needle syringe for 80% of all injections	See Checklist
Prevention Treatment	STI SWs, MSMs @ 2/yr Methadone/ Buprenorphine for at least 30% of IDUs	Guideline
Enabling environment	Local Advocacy with all power structures	Checklist
Referral	For ART, Livelihood programs	Checklist



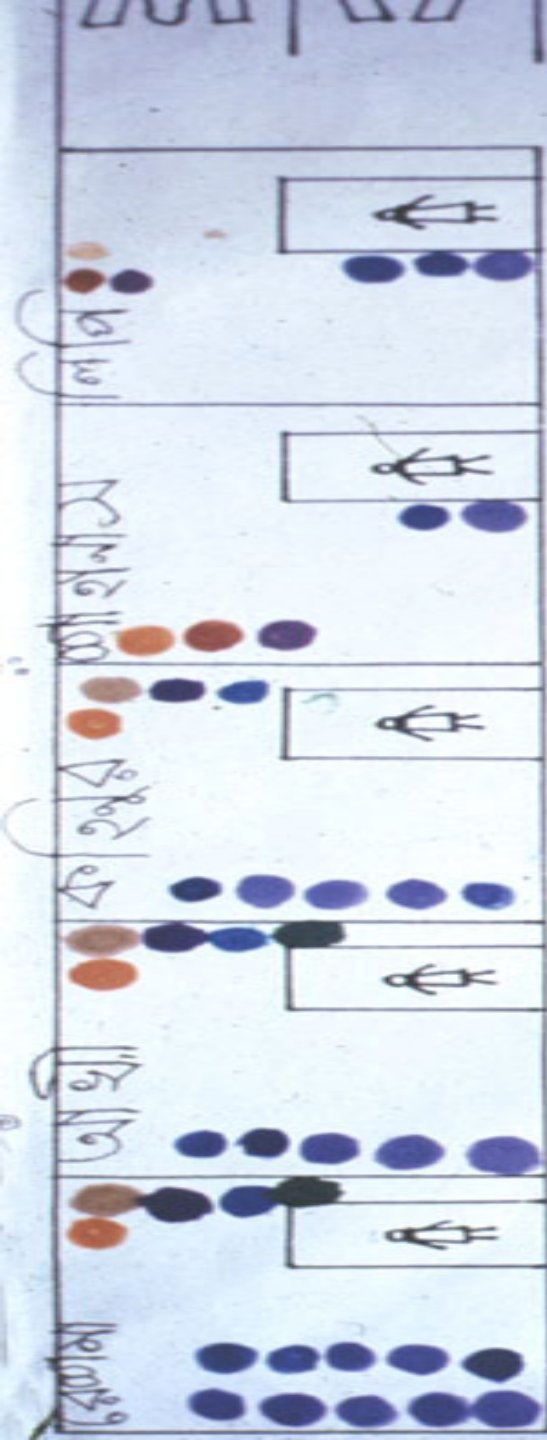
Monitor the Response

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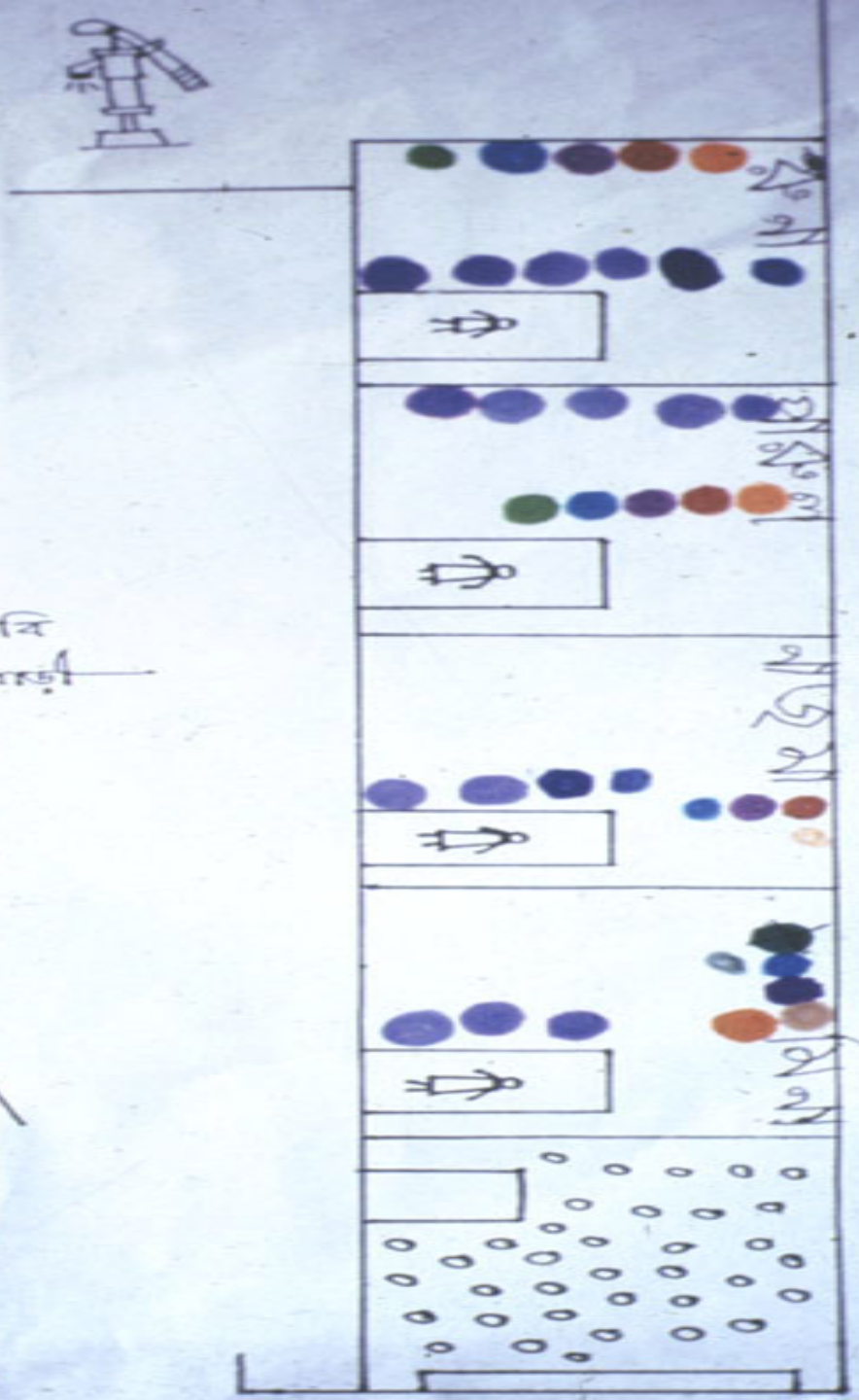
Local Monitoring for Midcourse Correction

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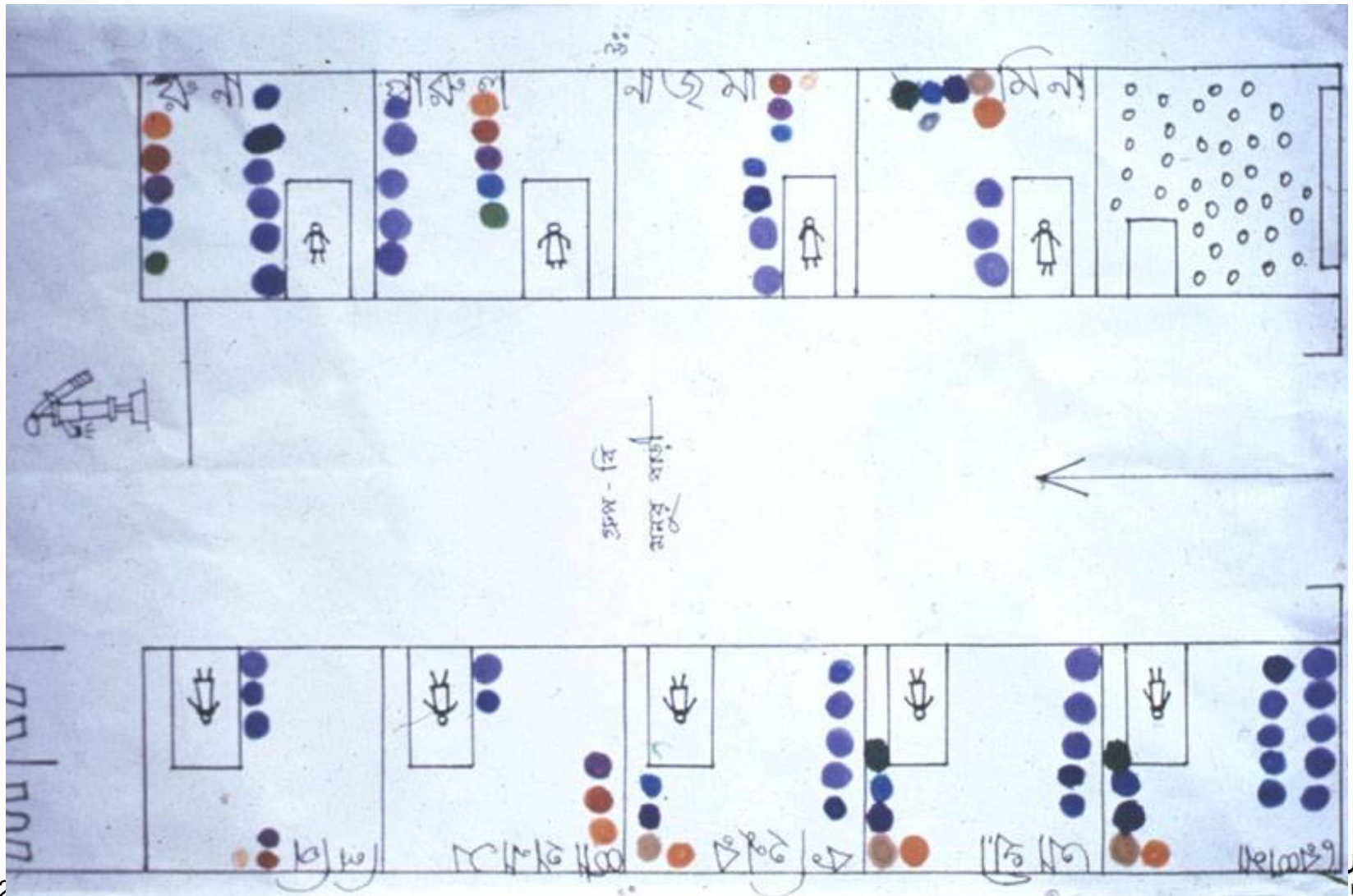




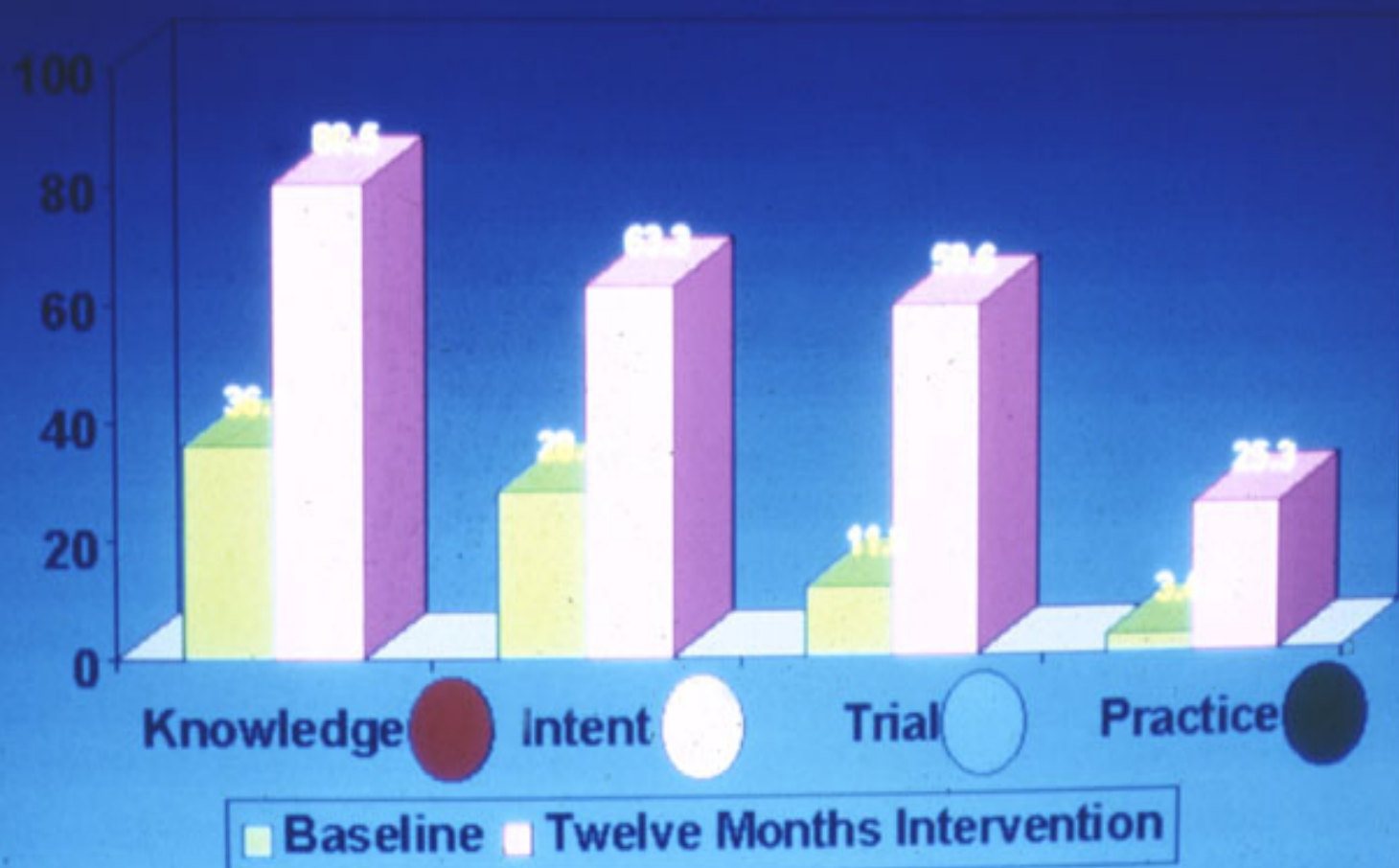
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Local Monitoring and Evaluation



CHANGE IN KNOWLEDGE, INTENT, TRIAL AND PRACTICE OF CONDOM USE AMONG SEX WORKERS AFTER TWELVE MONTHS INTERVENTION

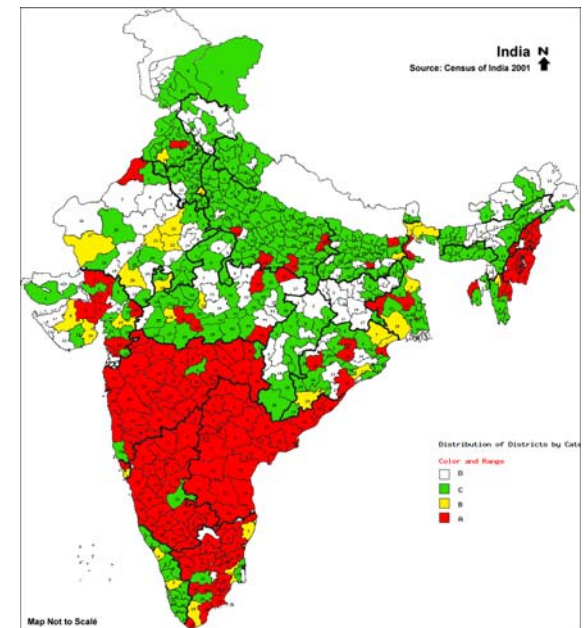


Define the Delivery Unit and Scale-up

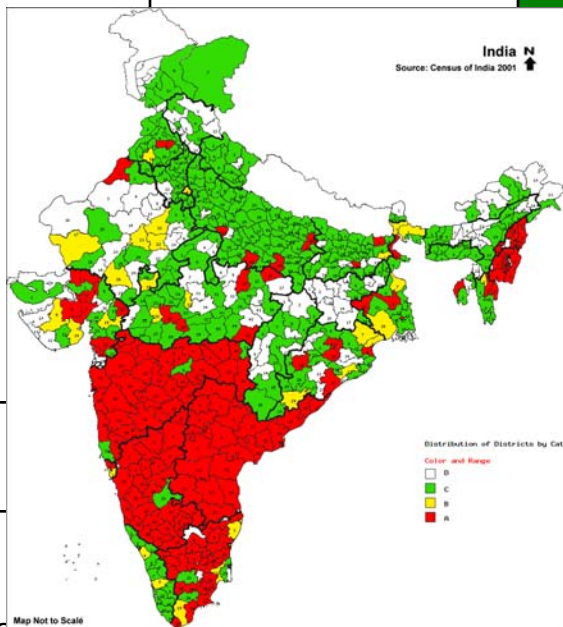
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Tips for Scaling up

- Estimate by Population Number
- Plan Services by geographic and administrative unit
- Make a differential package
- Use data to classify



District-level	Type I	Type II	Type III	Type IV
<p>human resource and management structure</p>	<p>Add an HIV strategic information analysis function to an existing manager at the district level, who is responsible for immediate assessment and classification of the region.</p>	<p>A manager responsible for immediate assessment and classification (in several regions) according to risk and disease in these areas</p>	<p>(1) Part-time epidemiologist or HIV specialist to alert when treatment needs to be scaled-up; and (2) State/province/district-level managers to cover each zone, NGO manager, field supervisor, outreach worker and peer educators for prevention.</p>	<p>(1) Part-time epidemiologist or HIV specialist to alert when treatment needs to be scaled-up; (2) State/province/district-level managers to cover each zone, NGO manager, field supervisor, outreach worker and peer educators for prevention; (3) Manager and/or clinician to monitor and ensure quality of treatment and impact mitigation programs</p>



THE THREE S'S OF SCALE

Same product: define what to scale

- Lucidly defining the 'product' or 'solution' or 'package of services' is essential,

Standard supervision

a common set of indicators against which the programme could be monitored as well as supervision standards.

Scale simultaneously; build quality

- Establishing the basic infrastructure and services for prevention is a critical first step. Increasing quality and intensity of prevention intervention delivery can be layered on once a basic 'footprint'

Table 3.6: Unit costs of prevention, treatment and impact mitigation, and programme management needed for an effective response

Intervention	Unit cost
Interventions for most-at-risk populations, including elements as outlined above.	100 USD
Treatment for adults including cost of transport and lab testing	450 (first-line) and 5000 (second-line) USD annual
Treatment for children	130 USD
Impact mitigation for affected women and children (in addition to ART cost estimated separately as above)	1000 USD per affected woman life time 100 USD per orphan per year
Surveillance and Programme Management	15 per cent of total programme cost
Enabling Environment at state and national level involves media and interventions required across all sectors	(10 per cent of the total cost of prevention and awareness interventions targeted for general population as presented in Table 3.1, excluding the costs of such prevention programmes as captured above)

Source: Background paper for the Commission on costing resource needs for Asia, available in the Technical Annex.

In Lieu of Summary....

- MARP intervention will decide the future of AIDS epidemic outside Sub Saharan Africa
- We need to think strategic and at scale
- Content and Coverage remains the key

YES WE CAN

