Setting new standards for targeted HIV prevention: the Avahan initiative in India

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EDITOR'S CHOICE

This special issue provides a first round of analyses of various aspects of the work of Avahan—a groundbreaking HIV prevention initiative in India supported by the Bill and Melinda Gates Foundation.

While it is one of the largest programmes of its kind, Avahan is not the only, nor the first, HIV prevention programme with sex workers and other populations at high risk in Asia.[1–3] For example, in Thailand and Cambodia, the national 100% condom campaigns were the main large-scale intervention leading to a countrywide decline of HIV. However, the Indian initiative is using a more comprehensive approach through powerful synergies between evidence informed strategy, community empowerment, structural interventions and business style management. In addition, and in contrast to traditional interventions with sex workers, it is rightly focussing on clients as well, not just on the sex workers. The project demonstrates in a convincing way that intensified HIV prevention with marginalised and often difficult to reach populations can be brought to a very large scale with high coverage and penetration of the interventions. It also shows the importance and power of local level data collection, at least at the district level, for meaningful results for programme management and steering.

Whereas its record on programme implementation is undisputable, it is probably too early to state with confidence that Avahan has had an impact on reducing the spread of HIV in the targeted populations and beyond as it may take several years more to measure such an impact. Nevertheless, all empirical and modelling results point in the same direction suggesting that the massive interventions are slowing down HIV transmission in the participating communities. Regrettably, no biological and behavioural baseline data are available from the start of the project and a progressive introduction of interventions by district in a randomised fashion was not possible. Several articles in this supplement provide creative attempts to address this problem, though such indirect methods cannot fully substitute for empirical observations and a randomised intervention or a randomised phased in programme. Results from the planned new round of biological and behavioural surveys should provide precious information on the impact of the initiative.

The reports would also have gained from more in-depth analysis of the governmental HIV prevention interventions. They may underestimate the importance of the public sector contribution to the results, since in many districts at least some targeted HIV prevention activities had been going on for a number of years as a result of the National AIDS Control Organisation's emphasis on targeted interventions. However, implementation has been uneven among Indian states. Community empowerment, in particular of sex workers and men who have sex with men, seems to be a major achievement of Avahan and it is unfortunate that no report is presented about this key aspect of the initiative.

It is only too rare, as is the case here, that an HIV prevention programme—or any health programme—invests so seriously in monitoring and evaluation, publishes detailed reports and will make the data available for additional independent investigations. The papers illustrate once again that evaluation of complex health programmes such as Avahan can only be meaningfully achieved through triangulation of different evaluation approaches, as was discussed in recent meetings convened by UNAIDS and by the Global Fund. The lack of a reliable biological test to measure HIV incidence remains a formidable handicap to assess the impact of HIV prevention programmes worldwide. Its development should be considered a 'grand challenge' in diagnostic research.

The evaluation reports are limited to epidemiologic, quantitative management measurements and mathematical modelling, with a noteworthy absence of reports on qualitative research. Such research is essential in complex evaluations, not only to clarify epidemiological findings and to ensure that the right questions are asked in the quantitative research, but also to assess aspects such as the empowerment of sex workers and programme management—two original aspects of Avahan.

What next? It is vital for the AIDS response in India that the Avahan initiated programmes continue and become sustainable. The immediate challenge for Avahan is the transition to a programme whose unit cost approaches what is affordable in the public sector as is its explicit goal from the start of the initiative. Many small and large demonstration projects have failed in this regard, but in contrast to Avahan they had usually not included such transition in their programme design and funding. Therefore, carefully documenting and evaluating both the substantive and the management aspects of the handover to the public sector (or to a public-private partnership as Prasada Rao powerfully argues for)[4] should be relevant for improving HIV prevention programmes, which are often suffering from poor management and evaluation.[5]

In addition, the now well-established systems for monitoring and evaluation should continue, even beyond the life of Avahan strictu senso, using biological epidemiological, management and qualitative research. Just as for the whole AIDS response, we need a long-term view on evaluation that suffers from inexcusable short-term myopia. As the spread of HIV is driven by complex behaviours and structural determinants, and the available interventions are less than perfect, the population level impact of even highly intensive programmes such as Avahan may take several years after they reach their maximal coverage.

Reducing HIV transmission from clients of sex workers to non-commercial partners, mainly wives, should be addressed in future programmes, even if it is unclear whether in the long-term HIV transmission will increase outside high risk populations.

Finally, prevention activities in high-risk communities can no longer occur without

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the provision of antiretroviral treatment—for humanitarian reasons in the first place, but perhaps also because of their theoretical potential to reduce infectiousness at the population level, making sex workers and other high-risk communities a priority for antiretroviral treatment access on epidemiological grounds.

In this time of global financial and economic crisis, one of the strongest messages coming out of Avahan is that not focussing HIV prevention programmes where HIV is primarily spreading, and not investing in solid multi-prong monitoring and evaluation, are no longer acceptable. In that sense as well, Avahan has set new standards for HIV prevention.

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Community engagement in HIV prevention in Asia: going from 'for the community' to 'by the community'—must we wait for more evidence?

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The HIV epidemic in Asia is predominantly defined within the marginalised communities and their partners. The term 'communities' here refers to people who are living with HIV or injecting-drug users (IDUs), sex workers and clients, men who have sex with men (MSM), transgender population and intimate sexual partners, essentially population groups predisposed to higher risks of HIV.[1 2] The prevention of HIV among these communities is considered crucial to a successful HIV intervention response in Asia. Although any behaviour change programme must be addressed and tailored to these communities, the rationale, purpose, extent and means of engagement of these communities have often been debated.[2–5] However, despite recent rhetoric about the role of the affected communities in the response to HIV, significant involvement of the community has rarely been the mainstream practice. Instead, community involvement has been described as minimalistic, tokenistic and incomplete.[2 3 6]

One of the most common characteristics of these communities is that they are socially marginalised and often criminalised, even if their behaviour or actions are not illegal by law or immoral by belief. This makes it difficult to reach out to such high-risk population groups through existing health or social services, either because the services are not available or accessible to the marginalised community members, or because of the perceived or actual judgemental attitude, stigma and discrimination by healthcare workers and those associated with the field.[7] For example, STI clinics are not open in the evening time when sex workers actually work. Similarly, physicians do not examine for anal STIs.[3] This has led to the concept of 'community friendly' clinics and services which would be run by a range of service providers like private practitioners, community organisations, NGOs and even government bodies.[8]

While engagement and community ownership of intervention would seem simple, logical and humane, its acceptance has not been simple. Part of the reason lies in the current social, political and legal contexts and structures whereby these populations/communities are marginalised. For example, politicians might often avoid a discussion of issues and rights of these communities, especially when the view is unfavourable among the public. Interestingly, another dimension stems from the previous successes of HIV prevention itself, such as in the early days of Thailand and Cambodia.[9–11] In these examples, HIV prevalence was controlled and reversed successfully through the involvement of the brothel owners and power structures, with minimal involvement of the sex workers themselves in the design and implementation of interventions.[6 9] Following the stunning success of these two countries, several large funding agencies in Asia provided funds for STI services and condom programmes without sufficient attention to factors affecting utilisation or uptake, and in turn effectiveness of the services. An important lesson was that unless services were people-driven rather than target-driven, sustained changes in behaviours were not achieved.

Soon, another stream of programmes emerged from the now well-known Sonagachi project that provided evidence of community mobilisation, self organisation, and overall tolerance and acceptance of these interventions and services. This eventually resulted in a high level of condom use and consequently lowered levels of HIV infection among these groups, as compared with other parts of the country.[12 13]

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