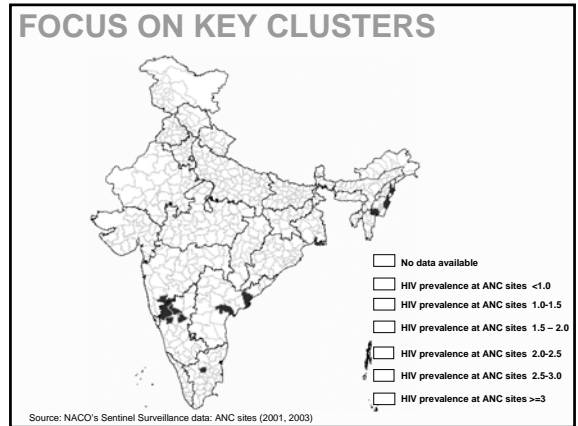
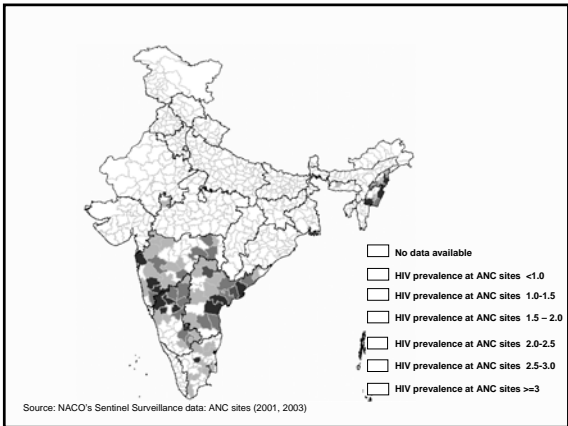
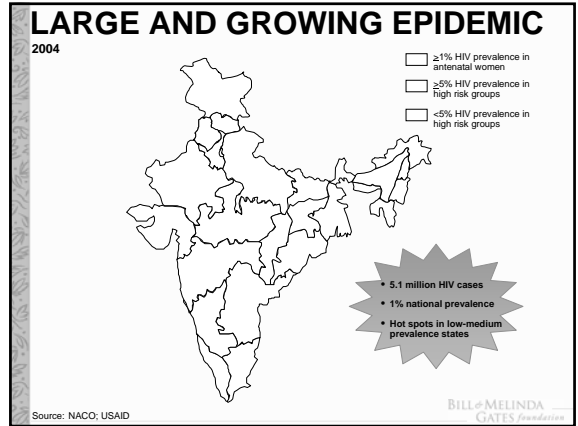
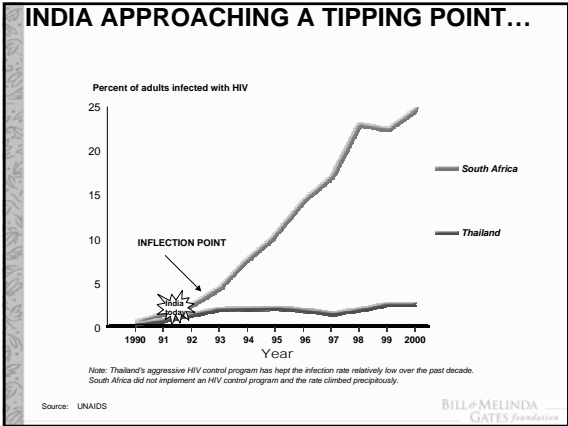


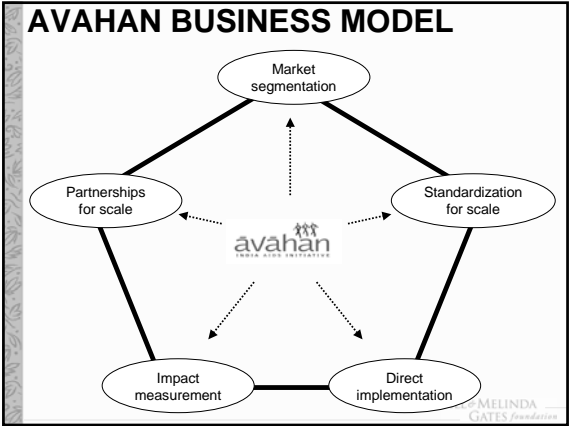
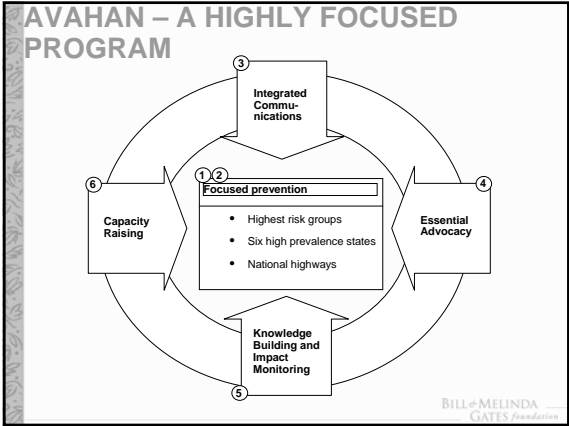


## DISCUSSION

- Indian epidemic- Avahan response
- Scale up high risk groups
- Scale up low risk

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### Progress to Date

- ✦ \$160M in grant commitments approved
- ✦ Key population members reached: 124,036
- ✦ STI clinics up and running: 165
- ✦ Drop in centers: 200
- ✦ Peer and Outreach workers: 2,783
- ✦ Intervention locations: 100+

↓

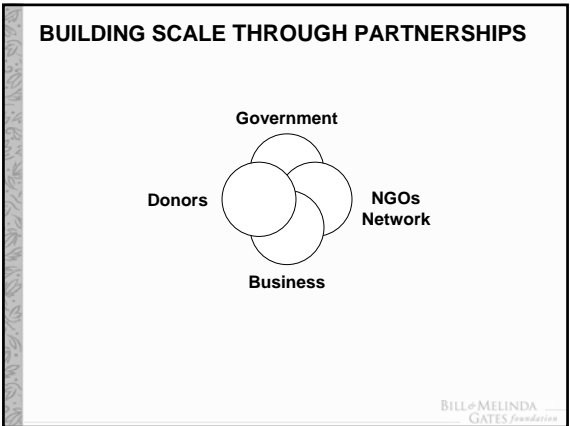
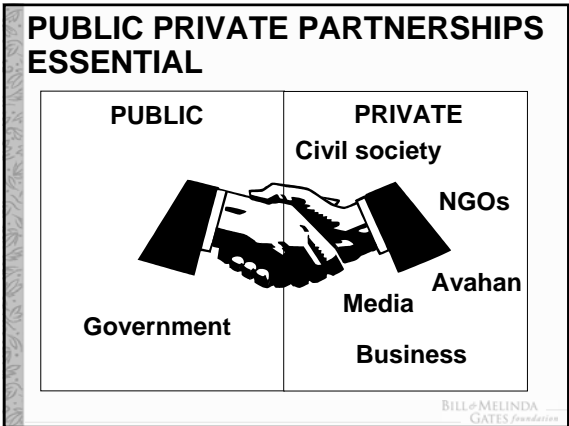
Scaling up is the key challenge –  
Outcomes heavily dependent on effective partnerships

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### DISCUSSION

- **Scale through partnerships**
- **Scale through partnerships**

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## Government

- ✦ Linkage with Union Health Secretary
- ✦ State level planning with SACS
- ✦ Collaboration with State Coordinating Committees in six states
- ✦ Monitoring and Evaluation efforts

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## Avahan NGO Network

- ✦ Few implementers
- ✦ Centralization and coordination at state level
- ✦ Strong capacity building support from technical partners
- ✦ Emphasis on community ownership

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## Donors and advocates

- ✦ Coordination with international and bilateral donors
- ✦ Engagement of international expertise (WHO panel) to disseminate M&E findings
- ✦ Mobilize NRIs and other influentials for advocacy

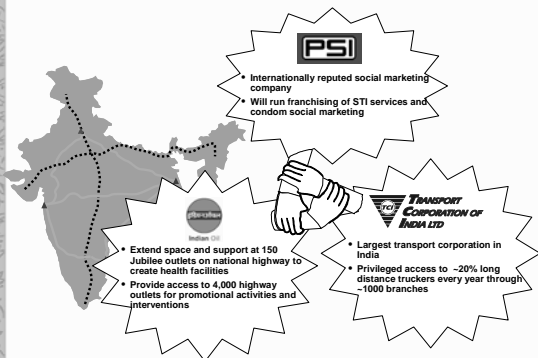
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## Business

- ✦ Leverage related industries and trade groups
- ✦ Identify and mobilize CEO AIDS champions
- ✦ Create work place programs to provide HIV prevention/care services and adopt appropriate policies

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## HIGHWAYS – A UNIQUE PARTNERSHIP



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## WITH PARTNERSHIPS WE HOPE TO..

- ✦ **Build effective model(s)** for HIV prevention that can be replicated internally and elsewhere.
- ✦ Collaborate to segment and **saturate** key areas in the shortest possible time.
- ✦ Ensure program management is owned and driven by the **community**.
- ✦ Bring business and other the **non-health sectors** to the table.
- ✦ Apply rigorous **monitoring and evaluation** to track program efficacy.

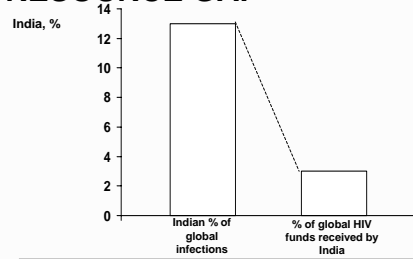
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## DISCUSSION

- HIV/AIDS prevalence in India
  - Scale of the funding gap
- Meeting the funding gap

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## RESOURCE GAP



HIV/AIDS prevalence in India represents:

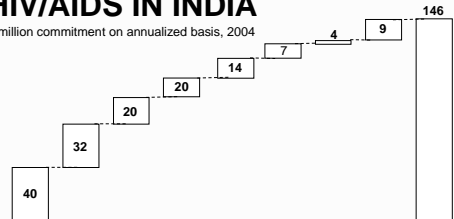
- Approximately 13% of global HIV/AIDS prevalence
- But India receives less than 3% of global funding for HIV/AIDS.\*

\*Of total 2004 \$6.1bn includes domestic (government) spending, estimated out-of-pocket spending by directly affected individuals and their families, and funding from bilateral donors, multilateral agencies, and the private

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## LIMITED RESOURCES TO FIGHT HIV/AIDS IN INDIA

\$ million commitment on annualized basis, 2004



BMGF World Bank Global Fund\* USAID, CDC, NIH\*\* DFID Govt. of India UNICEF Others\*\*\* (<\$1.5 million annualized) Annualized commitment for HIV/AIDS

\*Additional \$165M/5Yrs is likely to be available as of 2005

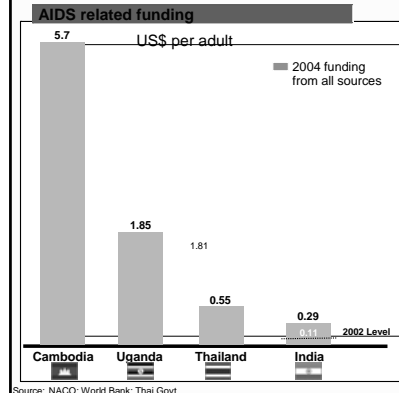
\*\*Amount for HIV/AIDS programs. Does not reflect \$15M in HIV/AIDS related research funding from NIH

\*\*\*Includes SIDA, CHARCA, UNFPA, UNDP, CIDA, IAVI, UNODC, ILO, UNIFEM, WHO, AusAID, UNESCO

Source: UNAIDS resource mapping spreadsheet, The Global Fund

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## LOW OVERALL AIDS FUNDING IN INDIA



A fully funded prevention and care program could potentially cost over \$1 billion a year

Source: NACO, World Bank, Thai Govt.

## Summing up...

- Epidemic growing – prevention is still the need of the hour
- Partnerships are key to achieving saturated coverage
- Advocacy needed to increase resources and counter stigma, apathy, and denial

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# END

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