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Case Report

Achieving scale rapidly in public health: Applying business management principles to scale up an HIV prevention program in India

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1. Background

Reductions in development funding, the mixed results of the Millennium Development Goals in spite of massive financial investments,[1] and the advent of the Sustainable Development Goals[2] have sparked interest in effective, efficient, and rapid scale-up of development programs by donors and governments. The World Health Organization defines scale-up as "efforts to increase the impact of innovations that have been successfully tested in pilot or experimental projects so as to benefit more people and to foster policy and program development on a lasting basis".[3,4] In confronting an epidemic, it is often necessary to scale up services rapidly and simultaneously across multiple geographic areas to achieve population-level impact. Numerous management challenges are inherent in rapid scale-up. These include coordination, standardization, demand generation, and using data effectively to ensure program quality and refine or revise programming.

2. Organizational context

Avahan was an initiative of the Bill & Melinda Gates Foundation (BMGF) to reduce the incidence of HIV infection in India. It was a 10-year (2003–2013), vertical program that designed and delivered a proven, comprehensive package of HIV prevention services to 300,000 members of key populations most at risk of HIV (female sex workers, men who have sex with men, transgender people, and people who inject drugs) as well as 5 million men at risk (mainly clients of female sex workers). The program built on the work already done in India by the Indian government, the US Agency for International Development, the UK Department for International Development, United Nations agencies, and other international and domestic partners. Avahan itself operated in 83 districts across 6 states of India (Fig. 1), using a network of non-governmental organization (NGO) and community-based organization (CBO) partners.[5]

BMGF's office in Delhi oversaw the Avahan initiative and from the beginning worked closely with the Government of India through its National AIDS Control Organization (NACO). The government's second National AIDS Control Plan (1999–2006) had already prioritized prevention interventions with key populations, and had made significant progress in identifying many of these populations.

Building on the knowledge and experience already gained, Avahan

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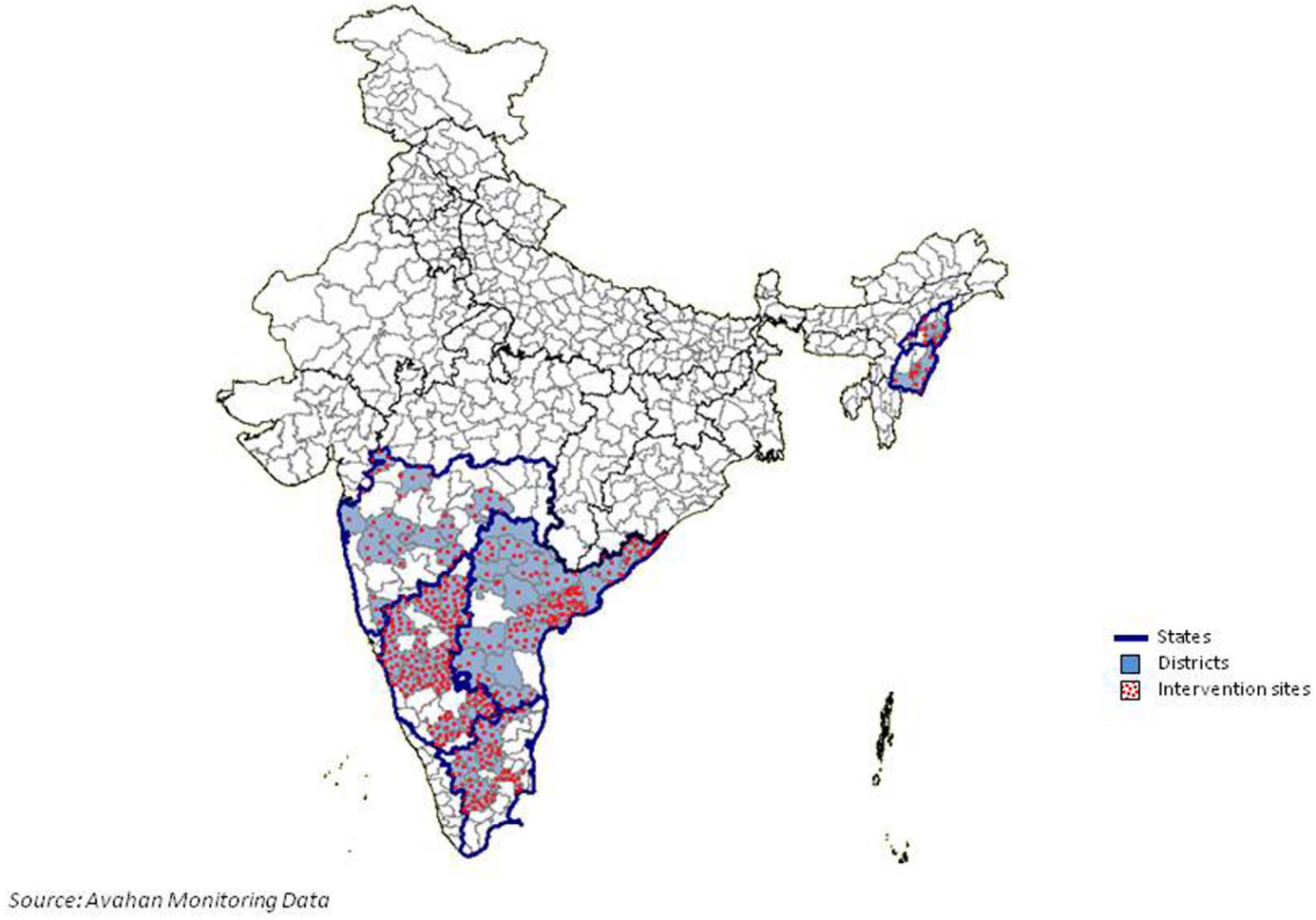

Fig. 1. The Avahan landscape.

and the government agreed on the districts in which Avahan would work: either ones with high HIV prevalence where there were no government or other donor interventions (about 50% of the allocated districts), or districts where such interventions existed but HIV prevalence remained high. In each state where Avahan worked, it had 1 or 2 lead partners. These were large NGOs, some of which were already experienced in implementing HIV interventions in parts of their respective states. State lead partners were responsible for sub-contracting and supervising the field operations of implementing agencies (NGOs and CBOs) at the district level. These local implementing agencies were chosen for their strong links with key players and their understanding of the local environment.

Despite the prior experience of some partners in India, there were few models available for scale-up along the ambitious lines proposed by Avahan, let alone in such a relatively short period of time. The management challenges posed to the foundation and its partners, and Avahan's responses and experiences, including some mistakes made along the way, and lessons learned, are the basis for this case report.

3. Personal context

An important factor influencing Avahan's approach to scale-up was that a significant proportion of its design and management team was drawn predominantly from the private sector.[6] This staffing strategy was intentional: BMGF believed that the public-health field could learn from the private sector and from management theory and practice. Large private-sector businesses are complex entities not dissimilar to large-scale development programs, and the process of scaling up and managing programs is akin to building and managing a commercial enterprise. Avahan's scale-up strategy drew lessons from big companies and those in emerging sectors such as organized retail and telecom that had successfully overcome the challenges of India's complex and diverse environment. Avahan thus served as a laboratory in which management practices from the private sector were adapted and implemented for public-health goals.[7] This approach complemented and strengthened the essential public-health expertise that was also present in the program team.

4. Problem

Although the types of HIV prevention services needed were well established thanks to prior interventions, delivering them at scale to those most at risk of infection in India presented several challenges for program management. The first was the identity and demographics of the key populations. While in some countries HIV prevalence is high throughout the adult population, in India estimated prevalence was only 0.43% in 2003, although given the country's status as the world's second most populous nation, this meant that an estimated 2.7 million people were infected.[8] Analysis of the available epidemic data suggested that more than 80% of people living with HIV in India were in just 6 of the country's then 27 states. Nevertheless, these states together accounted for 30% of the population, or around 300 million people. Similar to other Asian countries, the Indian epidemic was concentrated among female sex workers, men who have sex with men, transgender people and people who inject drugs (with clients of male and female sex workers acting as a “bridge” population with the general population).