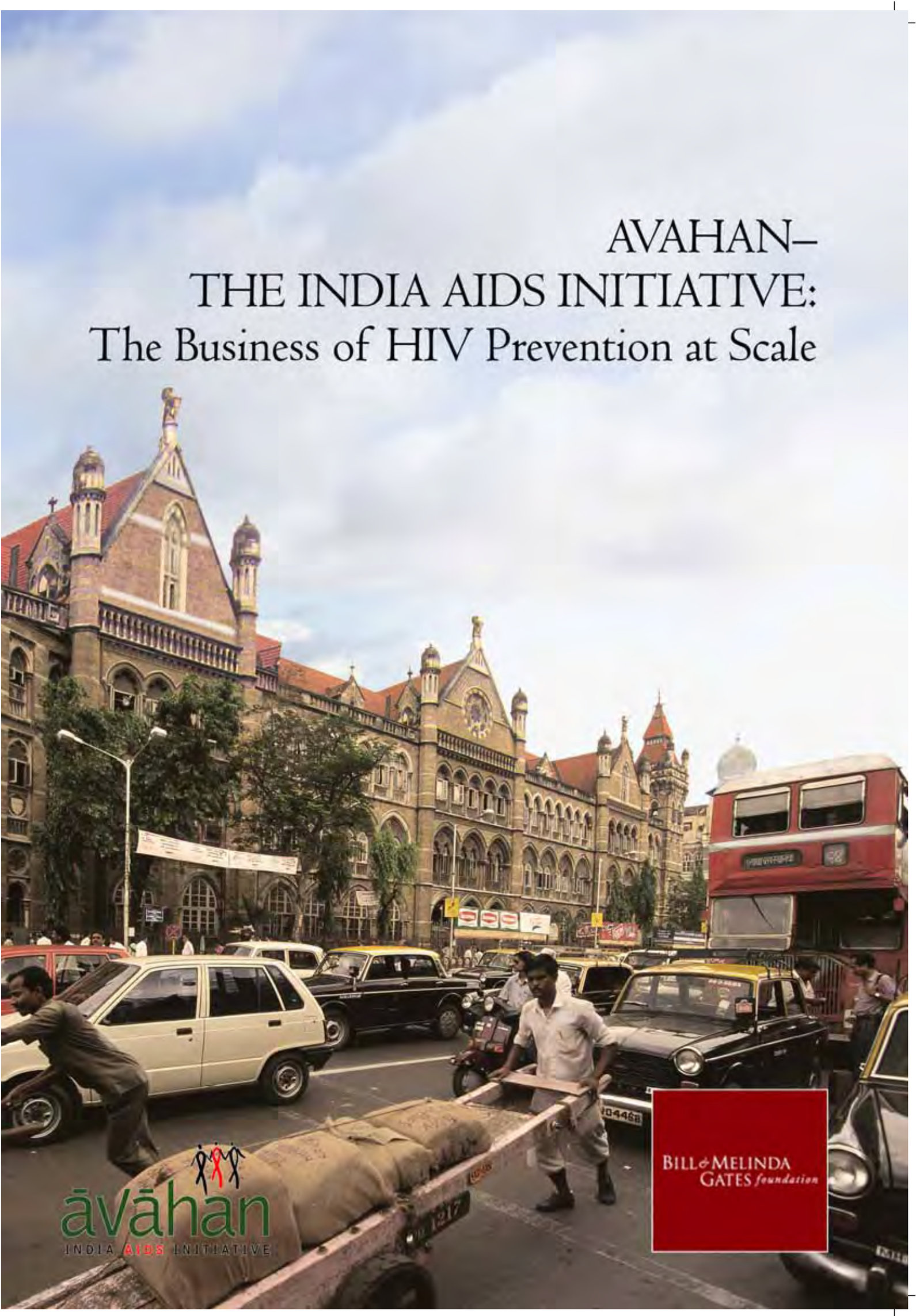
AVAHAN–
THE INDIA AIDS INITIATIVE:
The Business of HIV Prevention at Scale



Publications from Avahan in this series

Avahan – The India AIDS Initiative: The Business of HIV Prevention at Scale

Off the Beaten Track: Avahan's Experience in the Business of HIV Prevention among India's Long-Distance Truckers

Use It or Lose It: How Avahan Used Data to Shape Its HIV Prevention Efforts in India

Managing HIV Prevention from the Ground Up: Avahan's Experience in Peer Led Outreach at Scale in India

The Power to Tackle Violence: Avahan's Experience with Community Led Crisis Response in India

Managing HIV Prevention from the Ground Up:
Avahan's Experience in Peer Led Outreach at Scale with Injecting Drug Users in India

Also available at: www.gatesfoundation.org/avahan

AVAHAN–

THE INDIA AIDS INITIATIVE:
The Business of HIV Prevention at Scale

āvāhan
INDIA AIDS INITIATIVE

BILL & MELINDA GATES *foundation*

This publication was commissioned by the Bill & Melinda Gates Foundation in India. We thank all who have worked tirelessly in the design and implementation of Avahan. We also thank Chris Parker who assisted in the writing and production.

Citation: Avahan—The India AIDS Initiative: The business of HIV prevention at scale. Bill & Melinda Gates Foundation. New Delhi, India. 2008.

CONTENTS

AVAHAN—THE INDIA AIDS INITIATIVE

In 2003 the Bill & Melinda Gates Foundation began its large HIV prevention program, the India AIDS Initiative, later called Avahan, to curtail the spread of HIV in India. At the time, there was an understandable sense of urgency about the rising prevalence of HIV in the world's second most populous country.

The foundation had three primary goals for this initiative:

1. Build an HIV prevention model at scale in India
2. Catalyze others to take over and replicate the model
3. Foster and disseminate learnings within India and worldwide

Avahan has successfully built a large-scale HIV intervention program in its first five years. It operates in six states in India, which have a combined population of 300 million people. Within these states, it provides prevention services to nearly 200,000 female sex workers, 60,000 high-risk men who have sex with men,* and 20,000 injecting drug users, together with 5 million men at risk.

Avahan addresses nearly 280,000 individuals from populations most at risk and approximately 5 million men at risk

Avahan is now, in keeping with its second goal, beginning to hand over the program to "natural owners," like the Government of India and communities it has served since the beginning. The program has also begun work on the third goal of disseminating learnings from this initiative, and this document is a part of that effort. Throughout this document, "Avahan" refers to the effort of the partner organizations, hundreds of grassroots NGOs, thousands of peer educators, and others working on this initiative.

This publication describes the Avahan initiative and provides an overview of the evolution of the Avahan strategy and its implementation; a description of the key elements of the program and how Avahan achieved its first goal of rapidly rolling out services to a large and hard-to-reach population across a large geographic area; how Avahan monitors and evaluates the initiative; the preliminary results and learnings; and its plans for the future.

* Definitions of terms used in the publication can be found in the Glossary at the end of this document.

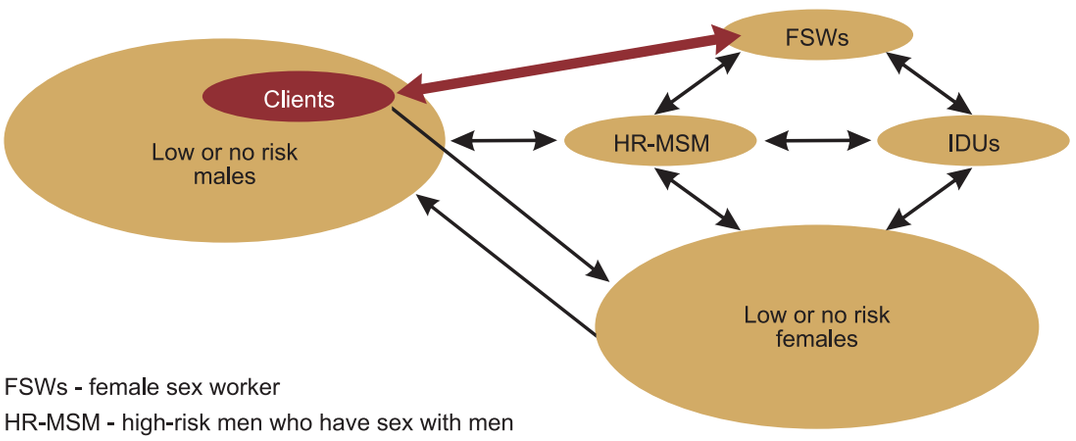
THE FOUNDATION'S CONSIDERATIONS AND RESPONSE

By 2003, increased funding and advocacy for care and treatment had led to HIV prevention losing emphasis among HIV practitioners. Globally there was evidence that working with populations at greatest risk (high-risk groups) and bridge populations in early and concentrated epidemics translated into HIV reduction among general populations.[1] However, there were few examples of HIV prevention interventions that provided services for a large portion of high-risk individuals at a country or regional level. This resulted in prevention practitioners calling for a "bridging of the prevention gap" by increasing access of high-risk groups to a combination of proven interventions.[2]

In 2003, UNAIDS studies reported that Asia presented the greatest risk of expansion of the global epidemic.[3] Experts believed that the region accounted for 20 percent of infections at the time and projected that in the absence of a vigorous prevention response, Asia could contribute up to 40 percent of all new infections globally by 2010.[4] Estimates by the Indian government placed the number of HIV-infected people at 5.1 million. By 2002, government surveillance data gathered from attendees at government-run antenatal clinics (ANC) showed that HIV prevalence was over one percent in 51 districts across India (1-4 million people per district).[5] Of these, 39 districts were located in four southern and two north-eastern states of India.

In India, and in most of the rest of Asia, two major factors contribute to the growth and the ultimate size of the HIV epidemic. These are the population of sex workers and their clients, and then the frequency of unprotected sex

Figure 1: Asian HIV Transmission Dynamics



FSWs - female sex worker
HR-MSM - high-risk men who have sex with men
IDU - injecting drug user

Source: Tim Brown, East-West Center

between them.[6] Injecting drug users and men who have sex with men are also at risk and contribute to the overall epidemic. Limited data from published studies and sentinel surveillance of high-risk groups in India at the time indicated that HIV transmission in south India was primarily sexual, and in the north-east mainly related to injecting drug use.[7]

The Indian national response had a sound strategy addressing high-risk groups. However, coverage of these groups was variable, and in general low.[8,9] The foundation initiated a design process with a team of technical experts. They conducted a careful review of data on the epidemic and looked at the prevention program coverage by existing Government of India and other donor-supported programs. After consultation with the Government of India, the foundation began Avahan in mid-2003. The initial funding commitment for the India AIDS Initiative was US $200 million for five years, with an additional US $58 million committed in 2006.

Avahan's aim was to help slow the transmission of HIV to the general population by raising prevention coverage of high-risk and bridge groups to scale by achieving saturation levels (over 80 percent) across large geographic areas.[10] Experts thought such an approach would be difficult to accomplish in India, due to the scale and diversity of the country and the risk of further stigmatizing these groups.

Given the charter, size, and anticipated complexity of the initiative, the foundation opened an India office with local staff to manage the initiative. Staff with a mix of for-profit and public health backgrounds were recruited with the intent of marrying the private sector management and public health skills necessary for quickly rolling out such a large-scale program.

Avahan's Strategic Choices

The following are key strategic choices made in the initial design and subsequent evolution of Avahan:

1. Focusing prevention efforts on high-risk groups
2. Concentrating efforts on the six states with the majority of HIV cases at the time
3. Basing the initiative on global best practices in HIV prevention
4. Scaling services across intervention geographies rapidly to contain the spread of the epidemic
5. Creating the foundation's first in-country office to facilitate rapid scale-up
6. Investing in knowledge-building, evaluation, and dissemination
7. Articulating an explicit goal to transfer the funding and management of the program to natural owners including government and communities

AVAHAN PROGRAM DESIGN

Avahan was conceived as a focused prevention program—reaching high-risk groups and bridge populations, in geographies most affected, with a known package of prevention interventions. The following sections describe the program design.

Targeting high-risk populations

The program focuses on providing coverage to high-risk groups: female sex workers, high-risk men who have sex with men, transgenders known as *hijra*, injecting drug users, and clients of sex workers, who are covered under men at risk interventions. While this focus on high-risk and bridge populations addresses the major epidemic drivers in India, transmission from already infected men to their partners requires additional interventions. The second National AIDS Control Program (2000 - 2006), through its expansion of HIV testing centers and focus on preventing HIV transmission in pregnancy, was already addressing this gap. This has since been expanded in the third phase of the National AIDS Control Program.

Intervention geographies

The six states that Avahan decided to work in accounted for 83 percent of the HIV infections in India in 2002.[11] These states—Tamil Nadu, Karnataka, Andhra Pradesh, Maharashtra, Nagaland, and Manipur—together comprise a large area, with a combined population of 300 million, approximately the size of the population of the United States. They vary greatly in terms of language and culture, and also in the stage and drivers of the HIV epidemic, and length and extent of prior HIV prevention interventions. The foundation staff worked closely with national- and state-level AIDS control authorities to identify districts in which Avahan would operate interventions. The intent was to avoid duplication and to ensure complementary coverage programming within the high-risk groups and bridge populations.

Avahan decided to work across six states in India that accounted for 83% of the country's HIV infections

As of December 2007,* Avahan supports prevention programs for approximately 279,000 high-risk individuals in 605 towns, in 83 out of 130 districts in these six states. Avahan works either alongside government- or donor-supported NGOs, or as the sole HIV prevention service provider for these groups in a district. In two of the southern states Avahan provides sexually transmitted infection (STI) clinical services for sex workers who receive other prevention services from the government or other donors' programs.

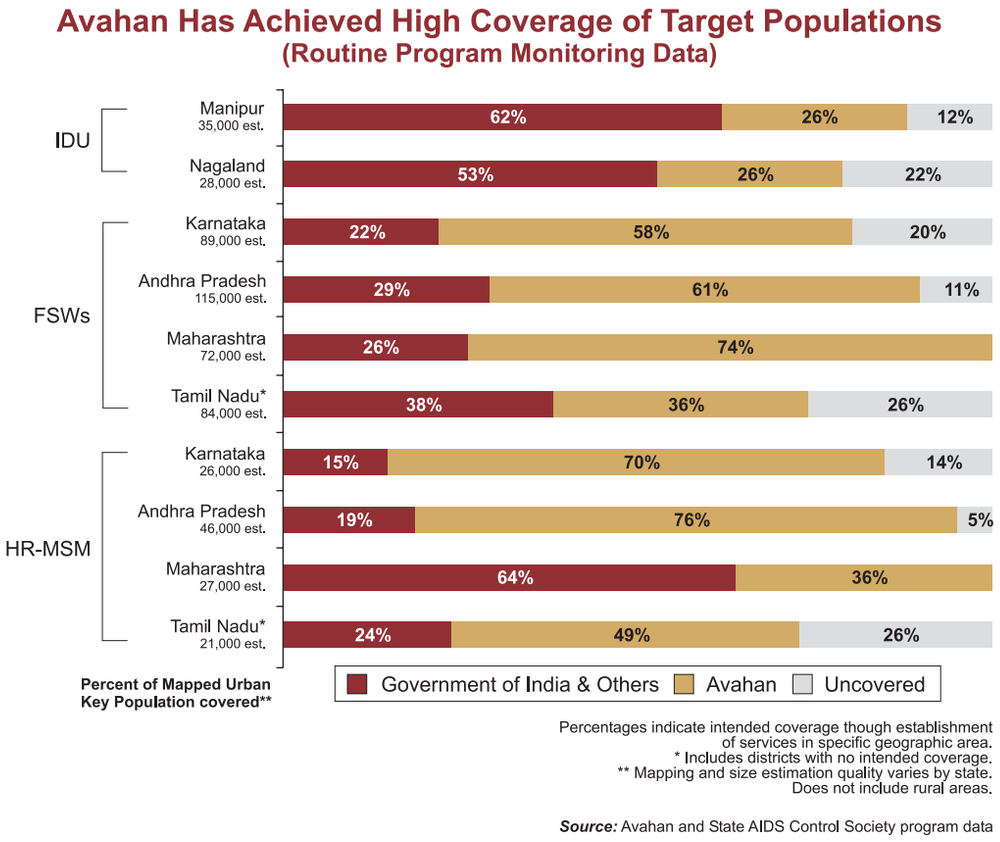
In the four southern states, Andhra Pradesh, Tamil Nadu, Karnataka, and Maharashtra, Avahan also provides prevention services to approximately five million men at risk, including men congregating at sex solicitation venues ("hotspots") and long-distance truckers. These services are concentrated in the main 100 towns in the districts

* All program statistics are as of December 2007, unless otherwise specified. The roll-out of the third phase of the National AIDS Control Program resulted in some changes in Avahan geographies.

where Avahan has operations. Avahan also works along 8,000 km of primary trucking routes along national highways to reach a mobile population of two million long-distance truckers. Long-distance truckers are essential to the strategy. They are an identifiable and programmatically addressable segment of men at risk, accounting for approximately 10-12 percent of the clients of female sex workers.

Avahan has operations in 605 towns across six states

Figure 2: Saturating Coverage through Complementary Programming



Percentages indicate intended coverage though establishment of services in specific geographic area.
* Includes districts with no intended coverage.
** Mapping and size estimation quality varies by state. Does not include rural areas.

Source: Avahan and State AIDS Control Society program data

The prevention package for high-risk groups

The Avahan package of prevention interventions is designed to address both proximate and distal determinants of HIV risk.[12] Proximate determinants of risk include factors such as presence of STIs, condom use, type and frequency of sexual activity, and type of partner. Prevention services such as outreach, behavior change messaging on safe sex, free or socially marketed condom distribution, needle and syringe exchange (for injecting drug use), and treatment of STIs address proximate determinants of risk. Distal determinants include stigma, violence, legal environment, medical infrastructure, mobility and migration, and gender roles. They are addressed through structural interventions and community mobilization aimed at reducing stigma, violence, and barriers to accessing entitlements.[13]

Avahan's package of prevention services has proven effective elsewhere in decreasing STI and HIV rates among high-risk groups[14,15] and is consistent with the overall strategy of the National AIDS Control Organization in India.

Figure 3: Avahan Intervention Sites for Men at Risk - Hotspots and Truck Stops

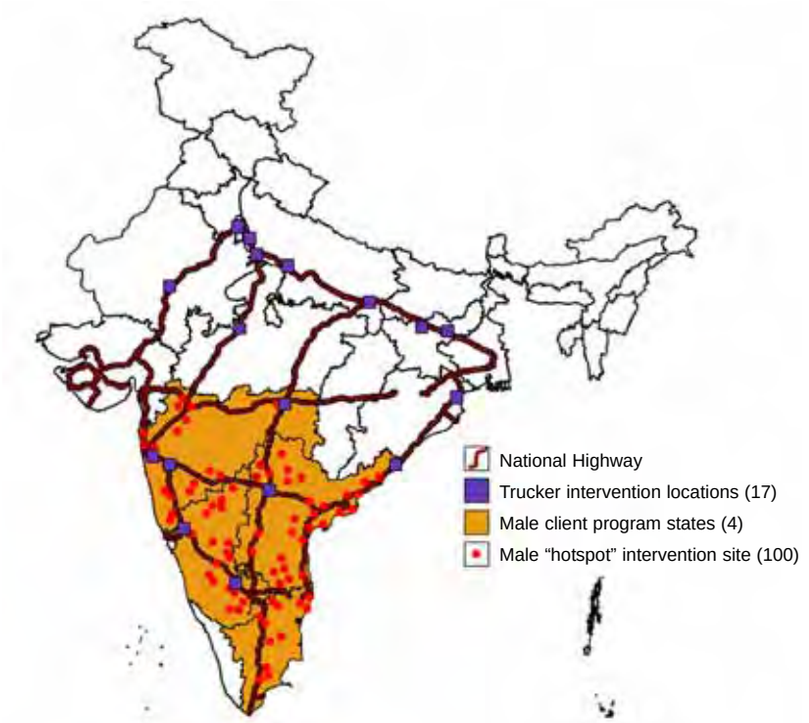
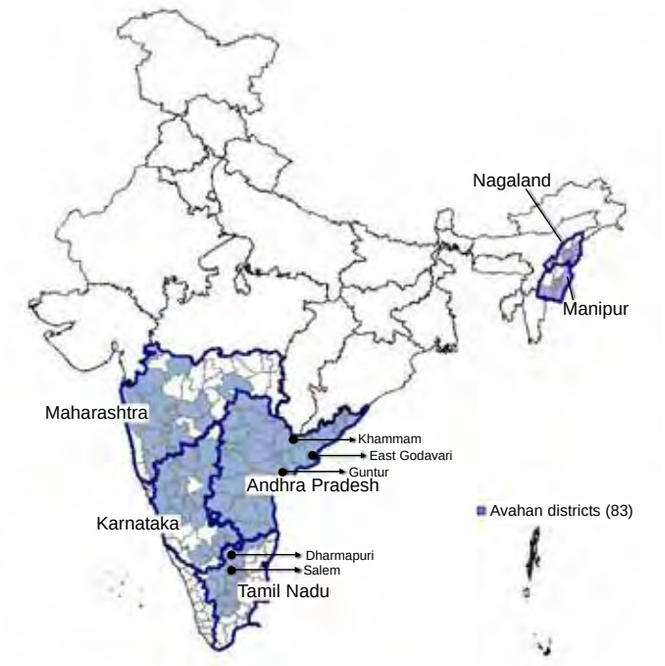


Figure 4: Avahan Intervention Sites for High-Risk Groups in Six States



The Avahan program elements for high-risk groups include:

1. Peer led outreach education
2. Program supported clinical services to treat STIs other than HIV
3. Commodity distribution—promoting and distributing free condoms for sex workers and needle and syringe exchange for injecting drug users
4. Facilitating community mobilization and capacity for community ownership of the program

Peer led outreach and education

Outreach to high-risk individuals by peer educators drawn from the same community is a vital part of Avahan's HIV prevention efforts with female sex workers, high-risk men who have sex with men, injecting drug users, and truckers. Peer educators identify those among their social network who are at greatest risk and provide support and information that help improve their ability to negotiate condom use and their attendance at STI clinics and self-help programs. For more information, see the Avahan publication on peer led outreach.[16]

Using Peer Outreach and Micro-planning to Improve Avahan's Reach

As part of continuous program improvement, Avahan partners use "micro-planning" as an approach to fine-tune implementation at the grassroots level. Micro-planning involves peer educators gathering detailed, multi-faceted information from "hotspots" (high-risk venues where commercial sex is solicited) to understand the nature of intervention needed. This is followed by systematic, ongoing outreach to the high-risk groups in these venues. Peer educators manage and monitor 25-50 peer members in their assigned group and work about four hours per day. Their activities include sharing prevention information with their colleagues, distributing condoms (and as appropriate needles and syringes), making referrals to clinics and other services, and gathering information on each individual's risk profile, including their vulnerability to violence and their ability to access services. Data are recorded with low-literacy tools. Their micro-planning records are discussed during weekly meetings with peer supervisors or field officers who monitor performance, provide additional training, and help the peer educators prioritize her/his workload. The process of peer training, supervision, and problem-solving empowers members of the communities and prepares the ground for the community to eventually take over management of components of the program itself. It also fosters leadership among individuals who can go on to advocate for the wider rights of these groups.

Management of STIs

Avahan has established 412 program-funded clinics that have provided free STI diagnosis and treatment services at least once for an estimated 340,000 individuals.* All Avahan partners and the grassroots NGOs follow uniform protocols for STI management, which are locally adapted from the *Clinic Operational Guidelines and Standards* for STI management developed by Avahan.[17]

Avahan distributes about 10 million free condoms each month

At all service sites, STIs are addressed through a combination of presumptive treatment, syndromic management, and regular screening. Avahan's peer educators help drive attendance at the clinics, encourage sex workers and others to promote utilization, reinforce condom use, and facilitate follow-up and partner treatment. These clinics are also linked to other clinical services including HIV testing centers, tuberculosis testing and treatment centers, and HIV care including antiretroviral treatment.

* Due to high mobility and turnover in the high-risk groups, the number of individuals accessing clinical services at least once is larger than the estimated denominator in Avahan intervention areas.

However, Avahan partners in the states and grassroots NGOs adapt service delivery approaches to meet the needs of the high-risk communities in their areas. This might entail establishing fixed clinics close to hotspots, or mobile clinics in vans or tents. These are supplemented by satellite clinics or pre-scheduled clinic days within brothels. In areas with low numbers of high-risk group members, private providers are trained and contracted to provide clinical services.

Free prevention commodities distribution

As of the end of 2007, Avahan partners distribute approximately 10 million free condoms monthly to sex workers, high-risk men who have sex with men, and injecting drug users. NGOs and their peer educators estimate the number of condoms needed by high-risk groups based on the number of commercial partners. These condoms are in turn distributed by peer educators within their network. The need for lubrication with condoms has been addressed in some areas by working with condom manufacturers to increase the lubrication in packaged condoms, and by the distribution and social marketing of lubricant. In two north-eastern states, Avahan also supports a free needle and syringe exchange program for injecting drug users.

Community mobilization

Community participation is critical to the success of any development initiative,[18] and globally, community mobilization is considered essential to HIV/AIDS programming. In addition to risk-reduction services, Avahan provides interventions to address factors contributing to the vulnerability of high-risk groups. Avahan works with high-risk communities to strengthen their individual and collective agency so that they can adopt and sustain the practice of safer behavior.[19]

The process of community mobilization began with the recruitment of community guides to map the high-risk populations in each of the Avahan districts. As services became established, interested and skilled community members were engaged as peer educators. They undertook systematic efforts to determine the needs of individuals through social network mapping and micro-planning. Additionally, they began advising the program on key issues such as the location of clinics and drop-in centers, and hiring of doctors or contracting of private providers. The program made a concerted effort to recruit community members to work in clinics, run drop-in centers, and oversee outreach. One natural consequence of this deliberate and formal engagement with high-risk communities was the strengthening of skills and confidence among a large base of individuals.

As the program expanded, it created a platform for increasing numbers of community members to interact with each other. They started coalescing and expressing greater interest in directly engaging with issues of major importance to them. These included stigma (of HIV and of belonging to marginalized groups), violence inflicted by authority figures such as police or clients, and denial or non-availability of essential entitlements such as ration cards. In many parts of the program, community members began forming self-help groups. The program instituted formal skills training for community members in areas such as media handling, advocacy, and legal literacy. With the support of the program, community members increasingly started shaping the local advocacy activities and leading activities such as the violence response systems and negotiations with local power structures.

Today community groups, some with legal registration and annual membership fees, exist in more than half of Avahan's 83 districts. Their participation and leadership continue to evolve as they lead activities in 650 drop-in

centers across the program and begin to mobilize with a collective voice to oversee programs and advocacy with the government.

The prevention package for men at risk

The program elements for men at risk differ from those for high-risk groups in scope and intensity and include:

1. Enhanced distribution and social marketing of condoms. This is complemented by a condom normalization effort that uses mass media to promote the use of condoms.
2. Behavior change communication activities using interpersonal, mid-, and mass media.
3. STI treatment either through clinical services provided in truck stops or through a franchised network of private STI providers.

Avahan reaches up to 650,000 men at risk through interpersonal or mid-media events each month

Condom social marketing and normalization

The lack of widely available condom stocking retail outlets outside conventional family planning services supported by the government or traditional outlets like chemist shops was identified as a major structural barrier to safe sex between male clients and female sex workers. This was especially so in the states of Karnataka and large tracts of interior Andhra Pradesh. Avahan's social condom marketing efforts aim to address this particularly through the creation of non-traditional outlets in all the southern districts in which Avahan works. Examples of non-traditional outlets include tea and *pan* shops (tobacco and cigarette shops), roadside restaurants, local all-purpose grocery stores, vending machines at truck stops, and health clinics. This effort is supported by promoting condom normalization through a combination of active mid-media efforts (street theatre, retailer promotions) and mass media campaigns (television, radio, movies, billboards). Over 147,000 outlets stocking condoms have been opened by Avahan in high-risk venues in the four southern states and across the national highways. By the end of 2007 these outlets were selling about 5 million socially marketed condoms per month to men at risk.

Behavior change communications with men at risk

Men at risk are reached with behavior change communication efforts in places where they are found in high numbers such as hotspots or in transshipment locations along the national highways. Both one-on-one and one-to-group interpersonal communication sessions are held. A variety of different mid-media activities such as drama, street theatre, entertainment shows, and competitions are also used to provide education on HIV, STI symptoms and treatment, safe sex, and condoms. In December 2007 alone about 650,000 men in hotspots and transshipment locations participated in an interpersonal or mid-media event.

STI clinical services for men at risk

STI services for men at risk are delivered differently to men at risk at hotspots or to truckers at transshipment locations. In the 100 focus towns, a franchise of privately owned clinics (branded as "Key Clinics") was built around major hotspots. This network of 736 clinics provides fee-paid STI consultations and treatment. The clinics were established by identifying physicians who were already seeing a high volume of STI cases and enrolling them into the franchise. Franchise participants were given training on STI management, and the clinics were branded uniformly. They were also promoted through mass media and local promotions at the hotspots. Pre-packaged STI syndromic treatment kits containing antibiotics, condoms, instructions, and partner referral cards were developed to improve provider prescribing and patient adherence. These pre-packaged kits are sold through the clinics and through chemist' shops in the vicinity.

STI management needs for truckers at truck stops are addressed through program-funded clinics located at major transshipment locations along the national highways. These clinics are branded, provide free consultation services, and either sell pre-packaged prescription kits or write prescriptions.

Over 5,500 men per month seek care for an STI in one of these service site mechanisms—the transshipment clinics and the Key Clinics. For more information on Avahan's work providing STI clinical services for truckers, see Avahan's publication on trucker programming.[20]

Advocacy to support implementation

The foundation has invested in a set of advocacy initiatives to support the core implementation program. The three main focus areas of Avahan's advocacy efforts have been:

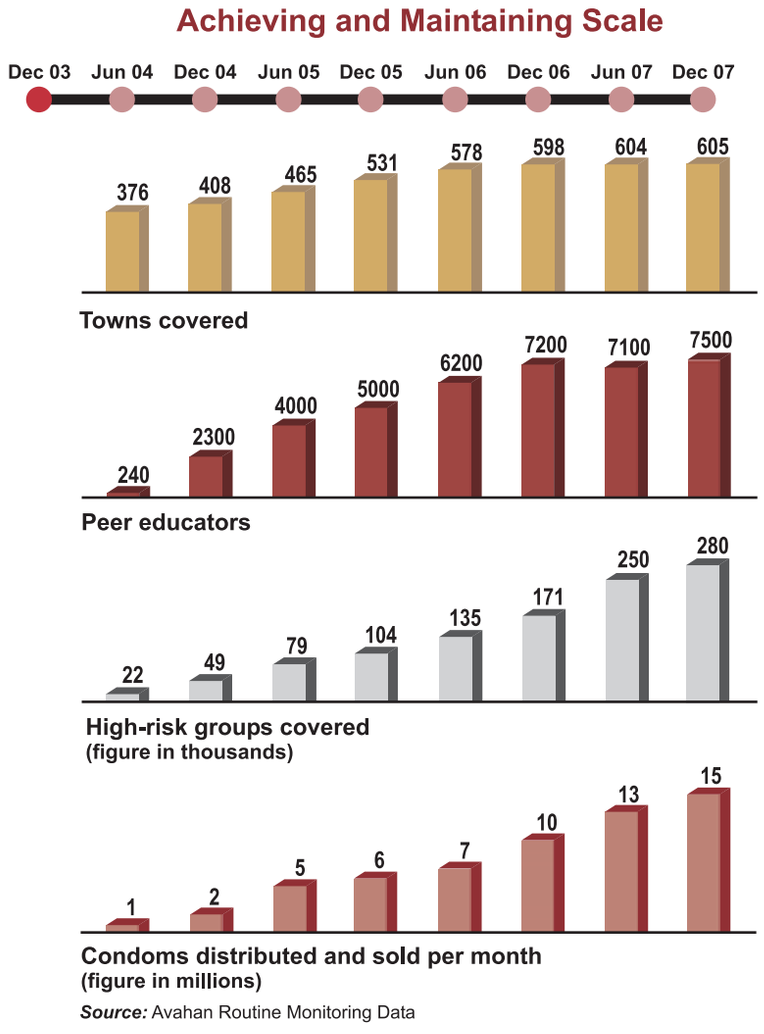
1. Increasing the commitment to, and resources for, HIV programming in India
2. Reducing stigma—both around HIV as well as around marginalized groups (e.g., female sex workers, men who have sex with men, and injecting drug users)
3. Addressing issues in the local environment that prevent adoption of safe sex practices and access to entitlements (e.g., violence, police harassment)

The long-term prevention of HIV requires the sustained efforts of government and civil society. Since the beginning of the Avahan initiative, there has been much advocacy to increase funding and political support for HIV prevention, and to encourage greater dialogue around the issues of HIV and AIDS. Other advocacy endeavors include efforts to alter police practices that harm HIV prevention programming (e.g., the arrest of sex workers for carrying condoms). High-risk groups are also educated about their legal rights, to prevent such abuses of power against them. A major effort has also been underway to improve the quality and quantity of HIV media coverage in vernacular papers across the six Avahan focus states. Avahan partners conduct wider public education and mass media outreach addressing the stigma faced by people infected with HIV. Avahan collaborates with national film celebrities, sports stars, and business leaders to reach millions of people through public service announcements. These efforts attempt to address societal perceptions that lead to stigmatization of HIV and high-risk communities.

THE AVAHAN IMPLEMENTATION APPROACH

Avahan's charter of building an HIV prevention model across such a large geography and for such a large population required an implementation approach—the design, the organization, and the execution—oriented to that goal. Avahan scaled up infrastructure and services rapidly—at the end of two years of implementation 83 percent of the enumerated high-risk population had been contacted by a peer outreach worker at least once.

Figure 5: Roll-out of Footprint and Services



Source: Avahan Routine Monitoring Data

Avahan's approach to scaling up across intervention geographies was based on the principles of:

- Designing for scale
- Organizing for scale
- Executing and managing for scale

Designing for scale

Prior to intervention start, Avahan partners conducted detailed size estimations of high-risk groups across the districts they were to cover. These exercises helped establish an initial denominator against which Avahan planned scale-up of services. These initial estimates have since been refined by Avahan partners every 18–24 months for two reasons. First, as the program expanded and established trust with the communities, the estimates were validated through ongoing services. Second, some adjustments were required periodically due to mobility and turnover among these groups.

Based on this mapping and size estimation exercise, key locations that contained large concentrations of high-risk populations were identified as priority areas. This was done without compromising the need for simultaneous scale-up for different populations across different districts. For example, Avahan saturated coverage of sex workers in major urban areas with the highest populations before expanding sex worker coverage to less dense, peri-urban areas. The two male client programs focused on intervention locations with the highest concentrations of men at risk.

To support the roll-out of services, Avahan created a set of standardized basic program elements to guide implementation and monitor quality of the interventions. Using input solicited from the extended Avahan organization, Avahan created a "Common Minimum Program"—a set of basic implementation standards for technical and managerial areas to guide programs, while giving them the flexibility to customize implementation based on local needs. This was complemented by the *Clinic Operational Guidelines and Standards* for STI management, which provided a minimum set of standards for STI treatment services. The Common Minimum Program is a living document which has already undergone three revisions over five years, allowing for innovations at the local level to be channeled back to the Avahan program level.

Avahan's Common Minimum Program

The Common Minimum Program (CMP) aims to build a common vision and define a set of operating standards for the Avahan virtual organization (see below). In its larger sense, the CMP includes well-documented guidelines for programmatic and technical approaches, key project milestones, a common management framework, and a common set of indicators against which the program could be monitored.

Programmatic and technical standards aim to facilitate a program-wide common minimum approach to launching and running interventions on the ground, supported by guidelines and, where appropriate, tools. The guidelines cover the following areas:

- Community participation
- Clinical services for prevention
- Outreach and behavior change communication

Key project milestones aim to provide time-bound measurable targets for the program to guide intervention. These quantitative milestones cover pace of infrastructure and service roll-out as well as specified desired service utilization levels. These targets form the basis of regular reviews and discussions across partners. The milestones in the CMP have evolved with the program life-cycle from start-up to mature phase and at each stage have helped set direction and clarify priorities across the Avahan organization, thereby phasing the program.

Common program management framework articulates the management process for execution. These include:

- Defined relationships across the virtual organization and clarified ownership of specific areas for lead implementing partners (see following page), capacity building and other partners, NGOs, and peers
- Management support guidelines for such areas as intensity of field engagement and relationship with local stakeholders
- Formal review process guidelines

Data collection for decision-making includes tools and processes for data collection and analysis to inform decision-making at all levels. This includes metrics for program-wide analysis of Avahan, predictive and warning capabilities for a district, the ability to look at individual NGO level data, and individual risk assessment and planning by peers. These include:

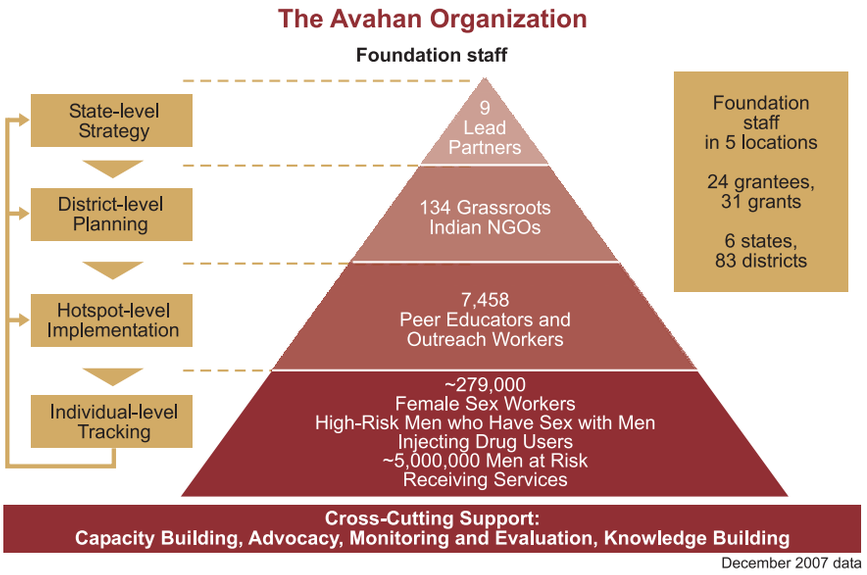
- Grassroots up to program-wide routine monitoring metrics and indicators
- Qualitative assessments
- Quantitative assessments (surveys)
- Repeat mapping and size estimation exercises
- Estimated condom (or needle/syringe) needs of target community

Organizing for scale

Avahan may be viewed as a virtual organization composed of several different entities including local and international NGOs, universities, and research organizations. This virtual organization structure was designed with the explicit intent of enabling rapid and simultaneous scale-up across geographies, facilitating standardization of key elements, and sharing of best practices across all implementation programs. Avahan partners include:

1. Lead implementing partners, who grant to and support grassroots NGOs
2. Capacity building partners
3. Other supporting partners
4. Monitoring and evaluation partners
5. Knowledge building partners

Figure 6: The Avahan Organization



Lead implementing partners

Between December 2003 and March 2004, Avahan made its major implementing grants. Seven of the nine lead implementing partners work at the state level on prevention programming for high-risk groups. The remaining two grants support programs for men at risk. These large national or international NGOs sub-grant to, manage, and support 134 grassroots NGOs.

Capacity building partners

Capacity building partners have worked with lead implementing partners to set Avahan-wide standards and raise capacity levels in key technical areas (STI management, interpersonal communication, community mobilization, and advocacy) to facilitate rapid, quality program scale-up and improvement. As program improvements in these key technical areas have been secured, many of these capacity building partners have been phased out.

Other supporting partners

A number of other partners address advocacy and communications. These partners work on a wide range of activities including development of mass media campaigns to address issues such as stigma and discrimination against HIV and promoting condom use. Others work to improve the quantity and quality of reporting on HIV in the English language and vernacular press at the state level, and assist in national-, state-, and local-level advocacy strategy development.

Evaluation partners

Evaluation partners are responsible for implementing Avahan's monitoring and evaluation framework.

Knowledge building partners

Knowledge building partners are responsible for generating learnings around issues that can inform HIV prevention programming. These include the role of mobility and migration in the HIV epidemic; structural interventions and their impact on risk behaviors and vulnerability; and the management of STIs.

Avahan Governance Structure

Central level:

Gates Foundation office in New Delhi: Thirteen program officers manage the grants, provide technical input, and manage the day-to-day operations of the overall Avahan initiative.

Technical panels: A technical panel consisting of 17 national and international experts in HIV programming provides technical counsel for program design, reviews grant proposals, and provides ongoing input and advice as the program is implemented.

Board of directors: A board of 23 members provides high-profile advocacy and oversight of the initiative.

WHO evaluation advisory group: A World Health Organization-convened team provided technical input for the evaluation design and continues to provide ongoing advice on evaluation issues and analysis as data become available.

State level:

State advisory committee: Foundation staff, State AIDS Control Societies, program directors of lead implementing partners in the state, and major state-level HIV stakeholders meet regularly to exchange ideas and experiences and coordinate activities.

Partner/NGO level:

Community advisory committees: Partners have created fora for community members to provide input into the project activities in their respective communities, both at start-up and during the life of the project.

For more information on each of these partners and their specific roles, please refer to the Appendix.

Executing and managing for scale

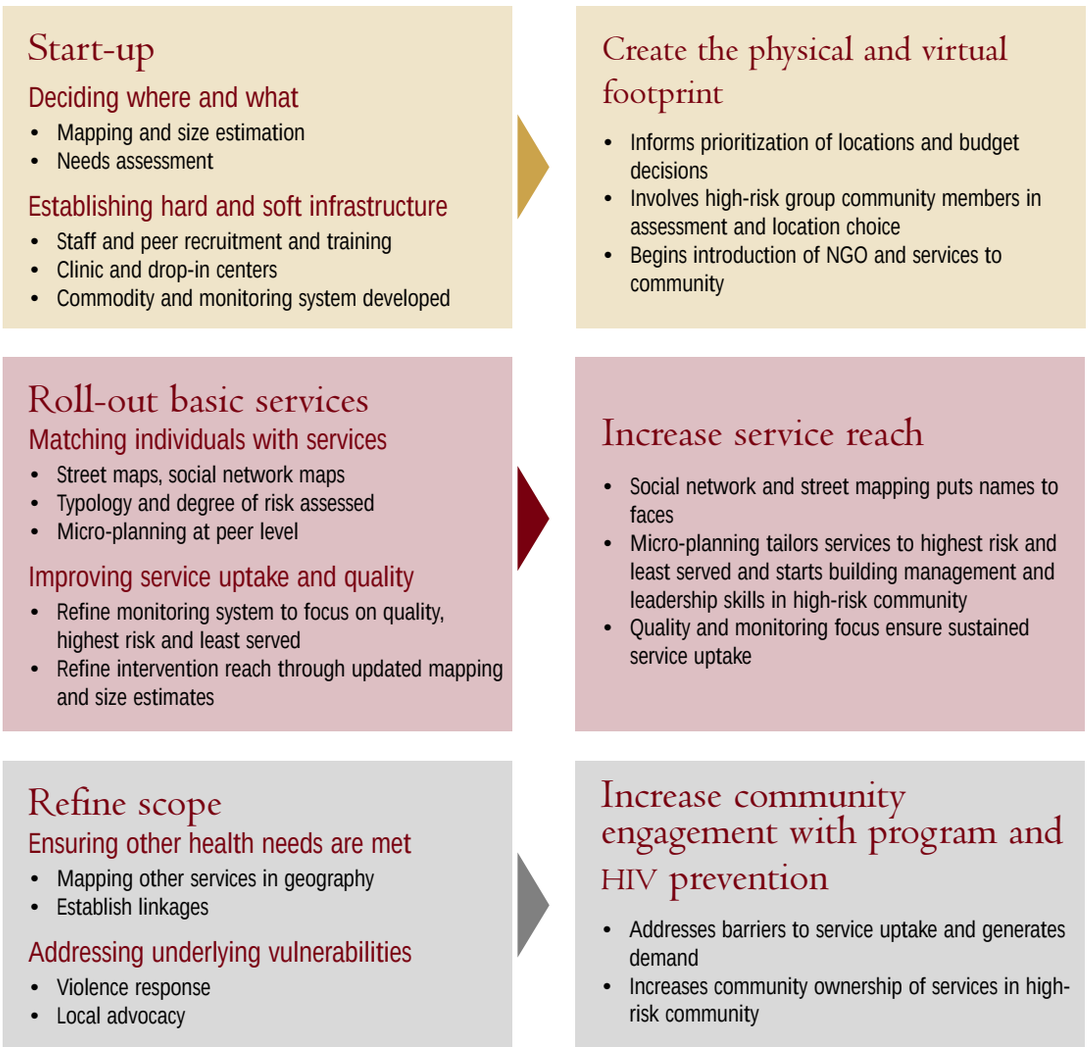
The implementation of the program entailed establishing high-quality and accessible services (the supply side) and addressing barriers to service uptake and increasing interest in the services (the demand side). The virtual organization described above implemented the program elements across the designated Avahan geographies.

Simultaneous creation of delivery footprint

The delivery footprint, Avahan's service infrastructure, was created simultaneously across the entire intervention geography. This was achieved by ensuring that all the nine service delivery grants were made nearly concurrently and were coupled with aggressive milestones for the first year. These milestones focused both on soft infrastructure (e.g., sub-granting to organizations, hiring human resources including peers, and skills training) and hard infrastructure (e.g., clinics and drop-in centers, commodity procurement systems) all informed by mapping and size estimation data. These partners quickly sub-granted to local NGOs, who inherited the overall milestones for their intervention areas.

Avahan's site-level roll-out of prevention interventions was conceived in three distinct but overlapping phases: 1) establishing the prevention infrastructure at each location across intervention geographies; 2) increasing quality and intensity of coverage of the local community; and 3) expanding the scope of services by layering on select additional activities (referral linkages with health services and strengthening community participation and leadership) as core interventions matured. The typical roll-out of prevention interventions at an Avahan site is described in Figure 7.

Figure 7: Phases of Avahan's Roll-out of Services

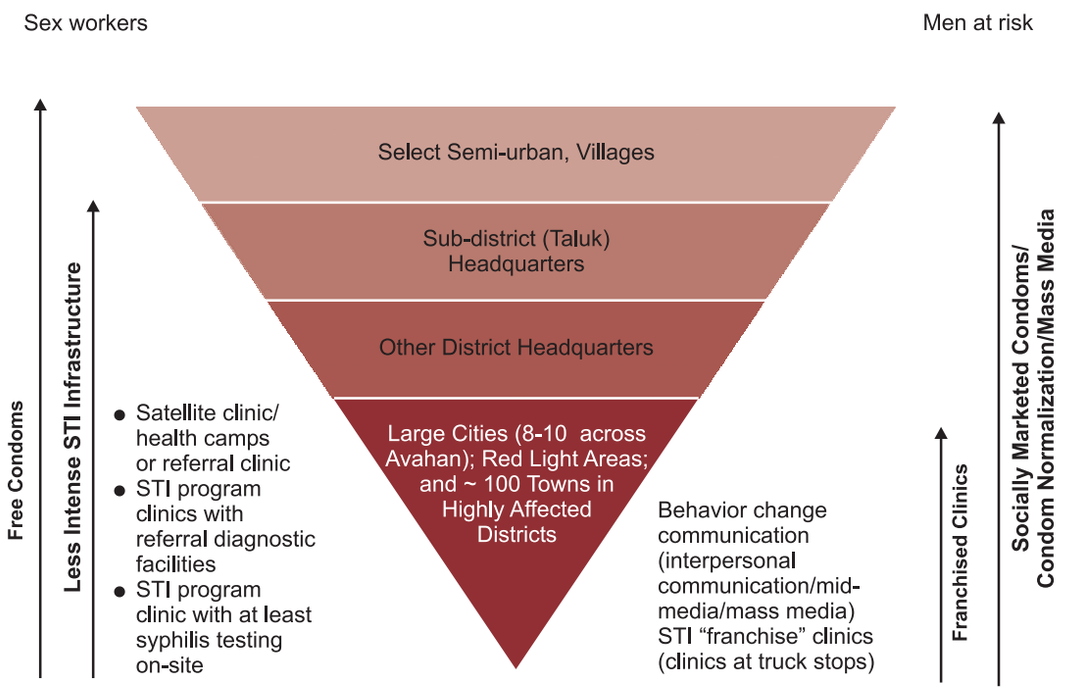


Customizing services to populations

While the broad technical elements were standardized, the service package and intensity of delivery were customized by population and location. For example, social marketing is broadly promoted everywhere that Avahan works with female sex workers and male clients. However, in the 100 towns which have hotspots estimated to contain 65 percent of female sex workers, Avahan takes a more intensive approach and adds extra mid-media and interpersonal communication components to reinforce condom use.

For female sex workers, high-risk men who have sex with men, and injecting drug users, program-funded clinics have been established where Avahan provides clinic space and pays the salaries of the physicians, nurses, and counselors. In places with fewer numbers of sex workers, Avahan employs a mobile clinic and a physician who visits on scheduled days, or contracts a private provider to provide services to sex workers at fixed times each day. This customization of delivery approaches and interventions enables Avahan to maximize reach with available resources. At the local level, Avahan relies on needs assessments and micro-planning undertaken by peers to determine the optimal combination and intensity of those services (see "Using Peer Outreach and Micro-planning to Improve Avahan's Reach," on page 13).

Figure 8: Varying Scale and Intensity of Technical Components



Addressing barriers to service uptake and generating demand

There were two major elements to increasing service uptake in Avahan: reducing barriers and generating demand for services. Avahan identified major vulnerabilities that inhibited service uptake at a local level such as violence, stigma, and economic barriers common to marginalized populations (e.g., lack of ration cards and inability to access social entitlements). These vulnerabilities were addressed through training in legal literacy and local police advocacy supported by state-level advocacy, and by facilitating linkages to government programs.

Avahan also identified and addressed a few key areas to help generate demand for engagement with the program. These included, for example, providing primary care services for children in the program-funded clinics, and earmarking 10 percent of the budget of the NGO to be used for services that are a priority for the local community.

Maintaining execution focus

At every level within Avahan, maintaining a continued execution focus was key to rapid scale-up. The underlying management process followed at every level included: 1) setting milestones in line with the Common Minimum Program; 2) frequent and regular field visits by lead partners, capacity building partners, and foundation staff to attain close knowledge of field realities and customize standards and milestones to local conditions; 3) scrutiny of routine monitoring data; and 4) regular, frequent, and formal joint progress reviews of the program and the data to take corrective action as needed. This frequent and close examination of the data resulted in many small course corrections and a few major shifts in implementation.

One of the central tenets of Avahan implementation, particularly from early 2006, has been the extensive devolution of data collection and its use for decision-making to the front-line peer educators, allowing them to tailor service components and coverage intensity to individual community members' needs. The underlying management process allows for timely refinements, corrective actions, and program shifts. The monitoring and evaluation system is described in the next section and further details on the use of routine and other data can be found in the Avahan data use publication.[21]

MEASURING IMPACT AND MONITORING PROGRESS

Avahan has an extensive routine monitoring system, supplemented with large-scale data collection activities to meet the monitoring and evaluation needs of the program.

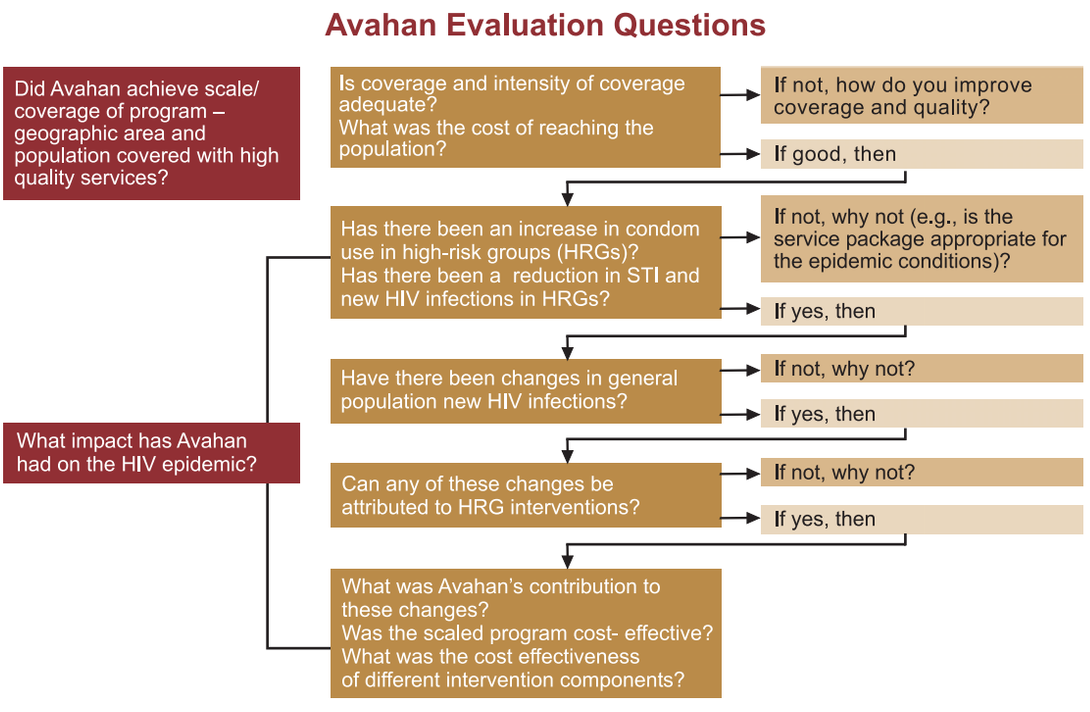
Measuring impact

Given Avahan's charter—to build and transfer a scaled program with well-known prevention interventions—it is essential to document all the processes as a measurement of epidemic impact and program cost-effectiveness. These measurements include speed, service coverage, quality, and value for money.

Measuring public health impact of a large-scale initiative is complex under any circumstances. Given the diversity of the epidemic's drivers in India, the initiative's size and complexity, and the multi-player environment that includes the government and other organizations, measuring Avahan's epidemic impact is even more challenging.

The evaluation framework for the program was conceived in consultation with impact assessment experts from around the world. This was further refined by the Evaluation Advisory Group (convened by the World Health

Figure 9: Avahan Evaluation Framework



Organization), which oversees Avahan evaluation activities and processes. Figure 9 presents a hierarchy of evaluation questions that need to be answered to measure Avahan's epidemic impact.

To answer these critical evaluation framework questions, Avahan employs several major evaluation elements including:

1. Size estimation, mapping, and routine monthly monitoring to gather data across the program on denominators, service provision, and utilization, including systematic, periodic quality checks.

2. Avahan-supported surveys that measure changes in behaviors, STIs, and HIV in the target populations, including:

- Repeated representative bio-behavioral surveys in over 27,000 participants drawn from high-risk groups and clients across 29 districts and from truckers along the national highways to monitor trends. This survey is called the Integrated Behavioral and Biological Assessment (IBBA).
- Special behavioral surveys and general population surveys in a few districts to specifically obtain data for modeling.
- Regular behavior tracking surveys in several districts to supplement the IBBA and enable monitoring changes in community mobilization and local advocacy.

3. Mathematical transmissions dynamics modeling to estimate population-level impact, the number of HIV cases averted, and contribution of key intervention components.
4. Synthetic and integrative statistical analysis of multiple data sets including ANC HIV data from 15-24 year olds, coverage data, etc.
5. Additional analyses that integrate all existing data sources, including other external data sources from government. These also include mathematical plausibility modeling to estimate plausibility of attributing trends in 15-24 ANC data (proxy for new infections) to intervention effect.
6. Costing and cost-effectiveness analysis.

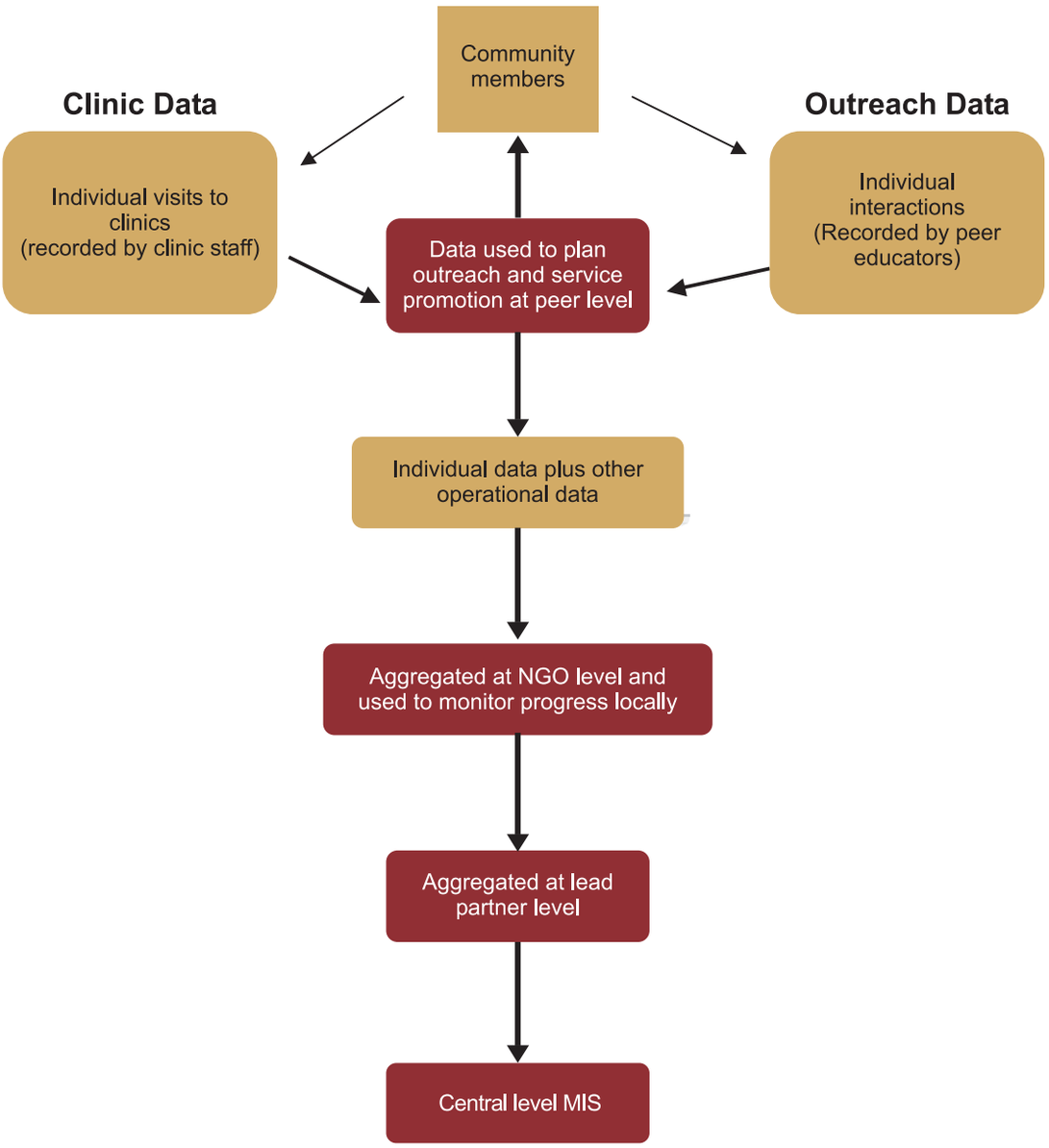
Monitoring progress

The Avahan routine monitoring system is both a logical and physical assembly of data on program operations captured across intervention geographies. It is used to capture and track data, and to inform course corrections in the operation of this program at multiple levels ranging from the smallest logical unit of the peer educators and the 25-50 community members they see,* all the way up to providing a snapshot of Avahan program-wide status.

Data on standard indicators and metrics are available at the Avahan, lead partner, and grassroots NGO levels. These typically cover infrastructure (e.g., number of clinics and drop-in centers), human resources (e.g., number of peer educators), service utilization (e.g., number of condoms distributed, number of individuals visiting a clinic in a month), and community engagement (e.g., number of community members engaged as staff in STI clinics, number of community members who are members of any group). See Figure 10.

* A peer educator typically works in a small locality where she personally has contact with between 25 to 50 high-risk group members. An outreach worker, who is a professionally trained social worker or an experienced peer educator employed by the NGO, works with between 10 and 20 peer educators. An NGO will have 5-10 outreach workers on average.

Figure 10: Routine Monitoring Data Flow



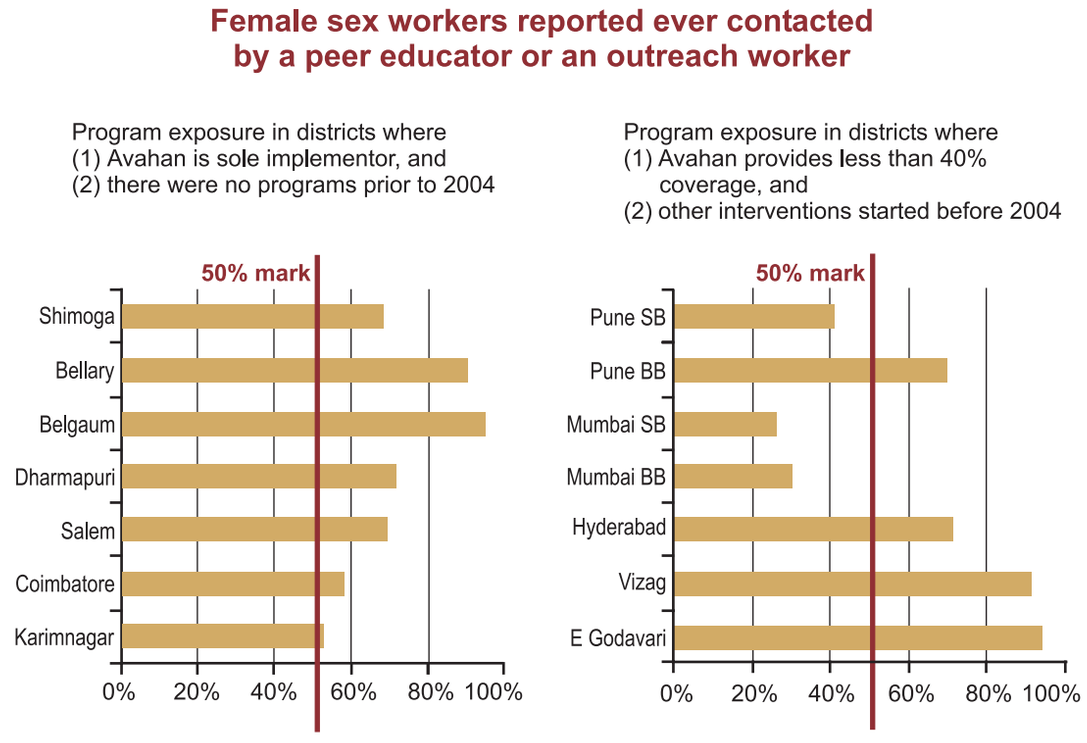
The monitoring data are reviewed periodically at peer and group, NGO, lead partner level and Avahan-wide to assess performance against milestones and to make sure the long-term program goal of saturating coverage has been reached. The focus of the review might shift among different indicators and metrics, based on the life-cycle of program implementation. For example, over time the focus has moved from indicators related to geographic and physical footprint (coverage of outreach and other services, quality of program implementation) to a focus on scaling up and improving scope expansions such as tuberculosis or care referrals. The Avahan data use publication[21] provides a detailed account of how programmatic shifts and implementation refinement were achieved through use of routine monitoring and other data sources.

Preliminary results

Data from the first round of the IBBA, Avahan monitoring data, and some additional studies indicate that Avahan is moving in the right direction.

1. **Broad programmatic footprint achieved by December 2005:** By December 2005, Avahan was working with 134 NGOs in 533 towns in 83 districts in 6 states, providing services for a population of 272,000 high-risk group members and bridge populations. By late 2005, monitoring data indicated that at least 65 percent of enumerated high-risk population members had been contacted at least once through outreach, and 47 percent of those contacted had visited an STI facility at least once.
2. **Increasing depth and intensity of service delivery:** As measured by routine program monitoring data and confirmed by the IBBA in 2006, Avahan achieved a high coverage within two years. The coverage is comparable to other long-standing programs supported by State AIDS Control Societies or other donors. Data from August 2005 to December 2006 show increasing coverage of high-risk groups with services.
3. **Rising levels of condom use:** Multiple data sources prove that reported condom use in commercial sex acts is increasing. Polling booth surveys (which are used to decrease social desirability biases in reporting) of female sex workers in Karnataka and intercept surveys of male clients at hotspots in south India show increased reported condom use. This trend is also seen in the national program's behavioral surveillance surveys among female sex workers and their clients done in 2001 and 2006.[22,23]

Figure 11: HIV Prevention Service Coverage



BB – Brothel-based, SB – Street-based

Source: Integrated Behavioral and Biological Assessment 2006

4. **Decreasing curable STI prevalence in female sex workers:** The level of curable STIs among female sex workers appears to be decreasing, as compared to the handful of historical studies that are available. Much of these data are available in those areas that have long-standing prevention interventions with high-risk groups operating at reasonable scale.

Figure 12: Increasing Depth and Intensity of Service Delivery

	Aug '05	Dec '06
% of high-risk group individuals profiled	43%	89%
% of profiled high-risk group individuals ever attending clinic	25%	90%
Individuals contacted by peer outreach worker	79,000	171,000
Free condoms distributed	1.3 million	4.6 million
% of high-risk group individuals contacted monthly	41%	70%

Source: Avahan Routine Monitoring Data

LEARNINGS

As Avahan nears the end of its first five years of implementation, a number of lessons have been learned from its successes, failures, and course corrections that will be relevant in its next phase, and possibly to other large, complex multi-partner programs and donors.

Lessons relevant to large, complex programs:

1. **Develop and articulate implementation standards and guidelines early in the program.** Avahan's Common Minimum Program defines the minimum standards expected in different program areas including community mobilization, communication, clinical services, advocacy, monitoring and evaluation, and program management. The Common Minimum Program based on the combined experience of all the partners was developed only a year into the initiative (and continues to be refined as major new learning emerges). However, the program would have benefited from having created this from the beginning.
2. **Execution focus coupled with responsiveness makes for a living program.** While it is essential to set standards and benchmarks that include numeric as well as qualitative measures for program services, it is equally essential to actively find and promote local innovations to tailor these standards to field realities. Avahan used periodic analysis of monitoring data, quality assessments, and field visits to keep the program on track. This was achieved by strengthening NGOs' management skills and systems to facilitate peer input into the program to drive service uptake. Local innovations were shared through partner meetings, cross-sharing directly between partners, and ultimately through updates of the Common Minimum Program.
3. **Going to scale implies knowledge of the denominator.** The very definition of scale requires an assessment of the area to be covered. Avahan's experience shows that while initial size estimation can be used for preliminary resource allocation and focus, repeated formal size estimation as well as programmatic data can help inform scale-up (and its measurement) consistently.

4. **Engaging communities as co-owners of the program enhances program scale-up and evolution.** In Avahan's experience, involving high-risk communities in the program helped align program services with their needs and drove the rapid uptake of services. Initially Avahan engaged with the community in discrete activities such as community mapping but then began developing processes and systems to involve them more directly in the services. Working with the communities also helped the program understand and address their underlying vulnerabilities, paving the way for them to adopt safe sex behaviors. Increasing the program ownership by communities bodes well for the development of an active, aware, and articulate set of customers for HIV prevention services, which is a key consideration for the long term.

Lessons relevant to donors who fund large programs:

1. **Build in processes that explicitly foster cross-sharing of experiences between partners.** The foundation staff adopted a system of partner meetings to be held semi-annually. These partner meetings were designed as a means to share lessons learned and to discuss Avahan-wide issues. After several meetings, partners felt that more focused fora would enable better sharing of information. Subsequently, smaller meetings with mid-level managers, for example, for all program management, program directors, monitoring and evaluation, or community mobilization staff, increased cross-learning among the partners.
2. **Facilitate an environment where partners will be comfortable going back to the drawing board if required**. In a large and complex initiative like Avahan, it is essential to allow for a period of reshaping and re-design in response to information from monitoring data and field visits. It is easier for partner agencies to accept such a period of re-design if this is built into the project plan from the outset. The funder must also to ensure that partners do not see this period of adjustment as a failure on their part.

THE FUTURE

Avahan has built a high-quality, scaled HIV prevention program over the last four years. Early data indicate increased condom use in commercial sex transactions and lower STI levels among high-risk groups, as compared to data that were available prior to Avahan. Over the next few years, the foundation hopes to have adequate data to evaluate the impact that Avahan is having on HIV transmission.

In the meantime, the Indian HIV programming landscape has changed. In April 2007, the Government of India launched the third National AIDS Control Program, with a budget that is four times the size of the previous program. Avahan, along with other donors and stakeholders, worked with the National AIDS Control Organization to shape strategic priorities and draw up guidelines for programming. Size estimation and coverage data from Avahan were also used to inform the planning process. In July 2007, the Government of India revised the HIV prevalence estimates significantly downward as a result of a significant increase in the number of surveys and quality of HIV data in the country.[24] HIV prevention continues to be a high priority and the expanded availability of resources enables the Government of India to achieve saturated prevention coverage of high-risk and bridge groups across India.

Key challenges for the future include addressing barriers, maximizing the quality of clinical services, developing better referral systems, and ultimately transferring custodianship

For the immediate future, Avahan must sustain the intensity of its interventions and continue to improve them as necessary. Challenges for the program include addressing barriers to coverage and uptake, maximizing the quality of clinical services, and developing better referral systems to allow members of high-risk groups access to comprehensive health services. However, Avahan's greatest longer-term challenge, that of transferring the custodianship of its program to its natural owners in India, still lies ahead. This will require Avahan to:

1. Work closely with national- and state-level HIV programs to align operations and transfer managerial and technical best practices as appropriate. To this end, Avahan and the foundation continue to work in close partnership with the National AIDS Control Organization and the State AIDS Control Societies, and other stakeholders.
2. Foster the evolution of today's nascent community groups into strong, registered entities that are equipped to demand and access public health services as well as gain other entitlements.

And finally, Avahan intends to document the approaches and learnings from its experience of implementing a large-scale HIV intervention program.

APPENDIX

Avahan Partners

As Avahan reaches the end of its "build and operate" phase, several of the partners listed below have completed the work on their grants. These partners are indicated by the use of the past tense to describe their work. Work by other partners is ongoing.

Lead implementing partners

Avahan has seven lead implementing partners working in six states who are responsible for implementing prevention interventions for female sex workers, high-risk men who have sex with men, and injecting drug users through sub-grants to grassroots NGOs:

Emmanuel Hospital Association and Australian International Health Institute—Manipur and Nagaland

Family Health International (FHI)—Maharashtra (Mumbai and Thane)

Hindustan Latex Family Planning Promotion Trust (HLFPPT)—Andhra Pradesh (coastal districts)

International HIV/AIDS Alliance (IHAA)—Andhra Pradesh (interior districts)

Pathfinder International—Maharashtra

Tamil Nadu AIDS Initiative (TAI)—Tamil Nadu

University of Manitoba—Karnataka and three districts in Maharashtra

Two grantees are responsible for programming for men at risk:

Population Services International (PSI) provides prevention services for men at risk in commercial sex settings across 100 towns in the four southern states and supports condom social marketing in Avahan districts.

Transport Corporation of India Foundation (TCIF) provides prevention services for long-distance truckers in 17 truck stops along the major national highways.

Cross-cutting, advocacy, and capacity development partners

American India Foundation (AIF) mobilized non-resident Indians in the U.S. in supporting HIV/AIDS activities in India.

BBC World Service Trust (BBC WST) is developing mass media interventions to address the normalization of condom use in men across the four southern states.

Care International was responsible for building the capacity of implementing partners in community led interventions, and it is now responsible for a community learning site on community led approaches in Rajamundry, Andhra Pradesh.

Center for Advocacy and Research (CFAR) is working to increase the quantity and quality of HIV reporting at the state and local level.

Constella Futures worked at the national, state, and local levels for advocacy strategy development support for issues related to HIV prevention in high-risk populations.

Family Health International (FHI) is supporting implementing partners to deliver uniformly high-quality clinical services including services for STIs, counseling, and basic HIV management.

Family Health International (FHI) and INP+ (HIV positive people's network) are working to build the organizational capacity of the local NGO, INP+, to expand its support to people living with HIV/AIDS networks and individuals.

Heroes Project mobilizes local celebrities and develops media company partnerships for a general public awareness campaign.

Mirabai Films wrote and produced four short films with A-list Indian directors in the Indian Bollywood style, depicting positive human stories about individuals, families, and communities affected by HIV and AIDS.

Program for Appropriate Technology in Health (PATH) was responsible for building the capacity of implementing a dialogue-based approach to communication interventions.

University of Manitoba is responsible for the development of a community learning site for community led approaches in Mysore, Karnataka.

Evaluation and knowledge building partners

Corridors of the University of Manitoba is examining the impact of source and destination interventions for migrant sex workers in northern Karnataka and southern Maharashtra.

Duke and Yale Universities are documenting the implementation of community led interventions and identifying elements of successful approaches.

Family Health International (FHI) is responsible for monitoring and evaluation data collection across the program to measure outcome and impact through large-scale, cross-sectional biological and behavioral surveys in core and bridge populations.

International Center for Research on Women (ICRW) gathered and documented data on gender-related stigma and sexual violence and their consequences for HIV among mobile populations.

International Institute of Population Studies (IIPS) implemented an HIV/AIDS module and HIV prevalence assessment in the six high-prevalence states as part of the National Family Health Survey 3 (NFHS-3) (a demographic and health survey).

Population Council is documenting major migration routes for men and sex workers and investigating facilitators and potential intervention points for possible HIV prevention interventions.

University of Laval is modeling the impact of Avahan interventions, doing costing and cost-effectiveness analyses, and performing additional studies to acquire data for the model including general population surveys, special behavioral surveys, and polling booth surveys.

University of Toronto is documenting geographic variation in HIV-1 prevalence, its determinants, and intervention coverage for 115 districts in southern India and supporting additional activities for evaluation.

Government support partners

Hindustan Latex Family Planning Promotion Trust (HLFPPT) provides technical and management support to the National AIDS Control Organization and State AIDS Control Societies for condom programming across India.

Public Health Foundation of India (PHFI) provides technical and management support to the National AIDS Control Organization and State AIDS Control Societies to strengthen programs with high-risk groups.

REFERENCES

1. Merson MH, et al. Effectiveness of HIV prevention interventions in developing countries. *AIDS* 2000; 14 Suppl 2:S68-84.
2. Global HIV Prevention Working Group. *Access to HIV Prevention: Closing the Gap.* May 2003.
3. UNAIDS. *Report on the Global HIV/AIDS Epidemic.* UNAIDS: Geneva, 2002.
4. Stover J, et al. Can we reverse the HIV/AIDS pandemic with an expanded response? *Lancet Infect Dis* 2002; 360:19-20.
5. Indian National AIDS Control Organization (NACO). Sentinel Surveillance data: ANC sites. New Delhi: NACO, 2003.
6. Moses S, et al. *AIDS in South Asia: Understanding and Responding to a Heterogeneous Epidemic.* Washington, DC: World Bank, 2006.
7. Chandrasekaran P, et al. Containing HIV/AIDS in India: The unfinished agenda. *Lancet Infect Dis* 2006; 6:508-521.
8. Options. *Evaluation of HIV/AIDS Targeted Interventions in Reduction of HIV Transmission in Five States in India - Draft National Level Report.* United Kingdom: Options, 2003.
9. A Draft Report on: Independent Evaluation of National AIDS Control Programme. Johns Hopkins University, USA; Indian Institute of Health Management Research, Jaipur; Indian Institute of Management, Calcutta.
10. Nagelkerke NJ, et al. Modelling HIV/AIDS epidemics in Botswana and India: Impact of interventions to prevent transmission. *Bulletin of the World Health Organization* 2002; 80:89-96.
11. Indian National AIDS Control Organization (NACO). Sentinel Surveillance data. New Delhi: NACO, 2003.
12. Boerma JR, Weir SS. Integrating demographic and epidemiological approaches to research on HIV/AIDS: The proximate-determinants framework. *J Inf Dis* 2005; 191(Suppl 1):S61-67.
13. Blankenship KM, et al. Structural issues in Public Health. *AIDS* 2000; 14 (suppl 1):S11-S21.
14. Ghys PD, et al. Increase in condom use and decline in HIV and sexually transmitted diseases among female sex workers in Abidjan, Cote d'Ivoire, 1991-1998. *AIDS* 2002; 16:251-258.
15. Alary M, et al. Decline in the prevalence of HIV and sexually transmitted diseases among female sex workers in Cotonou, Benin, 1993-1999. *AIDS* 2002; 16:463-470.
16. *Managing HIV Prevention from the Ground Up: Avahan's Experience in Peer Led Outreach at Scale in India.* New Delhi: Bill & Melinda Gates Foundation, 2008.
17. Family Health International. *Clinic Operational Guidelines and Standards: comprehensive STI services for sex workers in Avahan-supported clinics in India.* New Delhi: Family Health International, 2007.
18. Hickey and Mohan (eds.) *Participation: From Tyranny to Transformation.* London: Zed Books, 2004.
19. Cleaver F. "Institutions, agency and the limits of participatory approaches to development," in Cooke and Kothari (eds.) *Participation: The New Tyranny?* London: Zed Books, 2001.

20. *Off the Beaten Track: Avahan's Experience in the Business of HIV Prevention among India's Long-Distance Truckers.* New Delhi: Bill & Melinda Gates Foundation, 2008.

21. *Use It or Lose It: How Avahan Used Data to Shape Its HIV Prevention Program in India.* New Delhi: Bill & Melinda Gates Foundation, 2008.

22. National AIDS Control Organization (NACO), the Ministry of Health and Family Welfare India. *National Baseline High Risk and Bridge Population Behavioral Surveillance Survey, 2001.* New Delhi: National AIDS Control Organization (NACO) and the Ministry of Health and Family Welfare, 2002.

23. National AIDS Control Organization (NACO), the Ministry of Health and Family Welfare and Centre for Social Research India. *National Behavioral Surveillance Survey (BSS), 2006, Female Sex Workers and Their Clients.* New Delhi: National AIDS Control Organization (NACO), the Ministry of Health and Family Welfare and Centre for Social Research, 2007.

24. National AIDS Control Organization. *Technical Report - India HIV Estimates 2006.* New Delhi: National AIDS Control Organization, July 2007.

GLOSSARY

Agency is a term adopted in rights-based approaches to describe the choice, control, and power that poor or marginalized individuals or groups have to act for themselves to claim their rights (civil or political, economic, social, and cultural) and hold others accountable for their rights.

Bridge populations are persons who have sexual contact with persons who are frequently infected with and transmit STIs, and also with the general population.

Community mobilization (CM) is the process of uniting such persons from a community to utilize their intimate knowledge of vulnerability to overcome the barriers they face and realize reduced HIV risk and greater self-reliance through their collective action.

Community ownership means that the community has control over the activities the program undertakes, and significant understanding of and influence over service delivery. Community-owned programs have significant leadership, initiative, and oversight by communities, and accountability systems in place to ensure that the program's interests do not supersede the community's interest, and that adequate representation of the community is established.

Condom normalization entails creating a supportive environment for condoms, by using communications to reduce stigma and shame around condom use and purchase.

Distal determinants or underlying determinants are the socio-cultural, economic, and demographic context and the availability of intervention programs that influence the proximal determinants.

Drop-in centers were established early on in the program to provide a safe space for high-risk populations to come together. The centers themselves are often basically equipped but very clean rooms that fit between 50-150 people, have cushions and mattresses on the floor, bathing facilities, and a mirror, and are housed next door to the program managed medical clinic. With no similar refuge available, drop-in centers became the hub of community life serving approximately 5 to 11 contact points or hotspots where high-risk populations solicit and practice.

High-risk groups in this monograph refers to female sex workers, high-risk men who have sex with men, transgenders, and injecting drug users.

High-risk men who have sex with men in this monograph refers to the self-identified men who have sex with men in India to whom Avahan provides services. This group of men are not representative of all men who have sex with men in India, and in the settings where Avahan works are at high risk on account of their large number of sex partners and the fact that a disproportionate percentage sell sex or practice anal receptive sex.

Men at risk refers to men who engage in high-risk sexual activities, including commercial and non-regular-partner sex. In Avahan this translates into a programmatic focus on men congregating at points of sex solicitation. A large proportion of these men are long-distance truckers.

Micro-planning is the system peers use for recording and analyzing risk during outreach. The peers use a low-literate management tool to collect data which they use to directly plan outreach based on the individual need of the population they are serving.

Mid-media refers to large group format participative communication activities such as street plays and game shows.

Peer educators are representative members of a community who serve as a link between the program and the community. They manage the program on the ground through outreach and operate to serve a population with whom they have a similar occupational, behavioral, social, or environmental experience and among whom they are trusted and a role model. Peers work with members of their community to influence attitudes and provide support to change risky behaviors.

Presumptive treatment for STIs involves treating individuals in a group for an STI based on the overall prevalence in the group and not on individual clinical signs or symptoms.

Proximal determinants are a set of factors, both biological and behavioral in nature, that affect exposure to, transmission of, and duration of infectivity of HIV and include such factors as sexual behavior, circumcision, and antiretroviral treatment.

Structural intervention is used to refer to interventions that work by altering the context within which health is produced or reproduced. Structural interventions locate the source of public health problems in factors in the social, economic, and political environments that shape and constrain individual, community, and societal health outcomes.

Syndromic management of STIs involves treating for all common etiologic agents that cause a syndrome, including a constellation of clinical signs and symptoms.

Traditional/nontraditional outlets in the context of condom distribution, refer to places where consumer goods, such as condoms, are sold. Traditional outlets refer to outlets that carry all consumer goods including toiletries, etc. Nontraditional outlets refer to outlets that are engaged in other products and services such as tea shops, roadside cafes, barber shops, and phone booths. These outlets do not sell any consumer products, but due to their location (in and around hotspots), operating hours (open till late in the night), and the rapport their owners may share with men at risk (tea shop owners), they are critical for condom distribution.

Transshipment locations are places where loading and unloading of goods takes place along national highways. Large national loads brought to the location by long-distance truckers are usually broken up into smaller, regional and local consignments for redistribution. Long-distance truckers then pick up their next consignment at the location.

Vulnerability means the circumstances which impact an individual or a high-risk group's control over acquiring HIV. Vulnerability for sex workers is linked to abuse, violence, and social stigma and impacts their agency in sexual encounters.

VALUES OF THE FOUNDATION

- This is a family foundation driven by the interests and passions of the Gates family.
- Philanthropy plays an important but limited role.
- Science and technology have great potential to improve lives around the world.
- We are funders and shapers—we rely on others to act and implement.
- Our focus is clear—and limited—and prioritizes some of the most neglected issues.
- We identify a specific point of intervention and apply our efforts against a theory of change.
- We take risks, make big bets, and move with urgency. We are in it for the long haul.
- We advocate—vigorously but responsibly—in our areas of focus.
- We must be humble and mindful in our actions and words. We seek and heed the counsel of outside voices.
- We treat our grantees as valued partners, and we treat the ultimate beneficiaries of our work with respect.
- Delivering results with the resources we have been given is of the utmost importance—and we seek and share information about those results.
- We demand ethical behavior of ourselves.
- We treat each other as valued colleagues.
- Meeting our mission—to increase opportunity and equity for those most in need—requires great stewardship of the money we have available.
- We leave room for growth and change.

Designed by Poonam Bevli Sahi, at FACET Design Tel: 011-24616720

The Avahan India AIDS Initiative, funded by the Bill & Melinda Gates Foundation and managed by an in-country foundation team, is a large and ambitious HIV prevention program.

Avahan's ten-year charter has three distinct parts. The first is to build and operate a scaled HIV prevention program, with saturated coverage for those most at risk, in the six states which account for the bulk of HIV infections in India. The second is to transfer the program to the Government of India and other implementers in the country; and the third encourages the replication of best practices by fostering and disseminating learnings from the program.

Avahan is in its fifth year of operation, reaching populations most at risk including nearly 200,000 female sex workers, 60,000 men who have sex with men and transgenders, 20,000 injecting drug users, and about 5 million men at risk.

To read this and other papers in the series, please go to
www.gatesfoundation.org/avahan

or contact us at
publications@india.gatesfoundation.org

Avahan-India AIDS Initiative
Bill & Melinda Gates Foundation
A-10, Sanskrit Bhawan, Qutab Institutional Area
Aruna Asaf Ali Marg, New Delhi - 110067
India