OFF THE BEATEN TRACK:
Avahan's Experience in the Business of HIV Prevention among India's Long-Distance Truckers

āvāhan
INDIA AIDS INITIATIVE

BILL & MELINDA GATES *foundation*

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

OFF THE BEATEN TRACK:
Avahan's Experience in the Business of HIV Prevention among India's Long-Distance Truckers

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

CONTENTS

Off the Beaten Track 7

The Investment Decision 9

- The Role of Long-distance Truckers in the Indian HIV Epidemic 9
- The Need for a Fresh Programming Perspective 9

Reaching the Customer 11

- The Indian Long-distance Trucking Industry 11
- Trucker Lifestyle—Here Today, Gone Tomorrow 12
- Message Fatigue 12

Redesigning the Business of HIV Prevention among Truckers 13

- Selecting High-yield Intervention Sites for Best Results 14
- Acquiring Prime Real Estate Presence within a Site 15
- Standardizing and Building Trust in the Customer Interface 15
- Innovative "Surround Sound" Communication Coordinated across Locations 16
- Engaging Customers 19

Data for Programming and Impact Measurement 20

Early Results 21

Lessons Learned on the Journey 22

The Road Ahead 24

References 25

Glossary 26

OFF THE BEATEN TRACK

In 2003, the Bill & Melinda Gates Foundation created the India AIDS Initiative, later called Avahan, to curtail the spread of HIV in India.[1] To achieve this, Avahan works with high-risk populations—those who are at greatest risk of acquiring and transmitting HIV. These populations include female sex workers, high-risk men who have sex with men,* and injecting drug users, as well as bridge populations (e.g., clients of sex workers) who can act as links between the general population and high-risk populations.

The foundation has 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.

As an important component of the Avahan initiative, the foundation allocated funding of US$12 million to prevent the spread of HIV/AIDS and sexually transmitted infections (STIs) among drivers and their helpers (collectively referred to as "truckers" in this document) who are nationally mobile. The project aimed to increase safe sexual behaviors and to reduce sexually transmitted infections and new HIV infections among truckers through innovative approaches to prevention programming. In the first 18 months of operation of the project, data from behavioral tracking surveys and the Avahan's routine monitoring system revealed that only seven percent of long-distance truckers were accessing program services. Further, the routine monitoring system indicated that only 40-50 percent

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

of the population accessing services were actually long-distance truckers. Based on these data, the project team went back to the drawing board to revamp the intervention design and maximize coverage of long-distance truckers. Please refer to the box, "Refining the Intervention Design," for a description of this process.

This document describes the principles of this new intervention design and early results from its implementation.

Refining the Intervention Design

The Avahan partner, Transport Corporation of India Foundation (TCIF), initially set up intervention sites at 36 locations along major national highways. Within two years, however, program data indicated that despite a national presence, critical program gaps remained. A behavior tracking survey in mid-2005 revealed that program awareness among the target population was only 12 percent and service uptake was only 7 percent. Other data revealed that approximately 40-50 percent of services were inadvertently directed at individuals other than long-distance truckers (such as short-distance truckers and other people working at the transshipment locations).

In response the program decided to:

1. Focus interventions on the largest impact locations, thereby halving the number of locations to 17
2. Within a location maximize coverage of long-distance truckers by intelligent placement of services
3. Ensure a standardized interface across locations in order to increase brand recall
4. Enhance exposure to program services by increasing the number of service touch points in a site
5. Make truckers the face of the program by engaging them as peer outreach workers

These changes resulted in doubling of monthly communication reach and monthly clinic uptake as well as a 50 percent increase in monthly condom sales. Moreover, focusing services in and around natural traffic areas resulted in 85-90 percent of services reaching long-distance truckers.

THE INVESTMENT DECISION

The Role of Long-distance Truckers in the Indian HIV Epidemic

Truckers play an important role in the Indian HIV epidemic. Data indicate that truckers are three times more likely to have non-regular partner sex than other men in the general population in India.[2,3] One-third of truckers report commercial sex[3] and truckers are an estimated 10-12 percent of clients of sex workers.[4] HIV prevalence among long-distance truckers ranges from three to seven percent, and one to seven percent have at least one STI.[5] Truckers, therefore, constitute an easily identifiable and programmatically addressable sub-segment of men at risk.

However, truckers are not a homogenous population. Not all of India's five million truckers are clients of sex workers, and therefore are not at equal risk of acquiring HIV. Studies indicate that length of time away from home and age correlate with levels of risk behavior among truckers in India.[3] Accordingly long-distance truckers are potentially at high risk of acquiring HIV and STIs, because of the amount of time they spend away from home and their relatively young age.[3] Anecdotal information suggests that long-distance truckers may be driving 8,000 to 10,000 kilometers in a given month, which often translates into absences from home ranging from weeks to several months at a stretch. Long-distance truckers' enhanced potential risk of acquiring HIV is to some extent validated by risk behavior and biological data. A study in north India found that HIV prevalence in long-distance truckers is 3.5 times higher than the prevalence for inner-city truckers (seven percent among truckers traveling on the national highway as compared to two percent among inner-city truckers).[6]

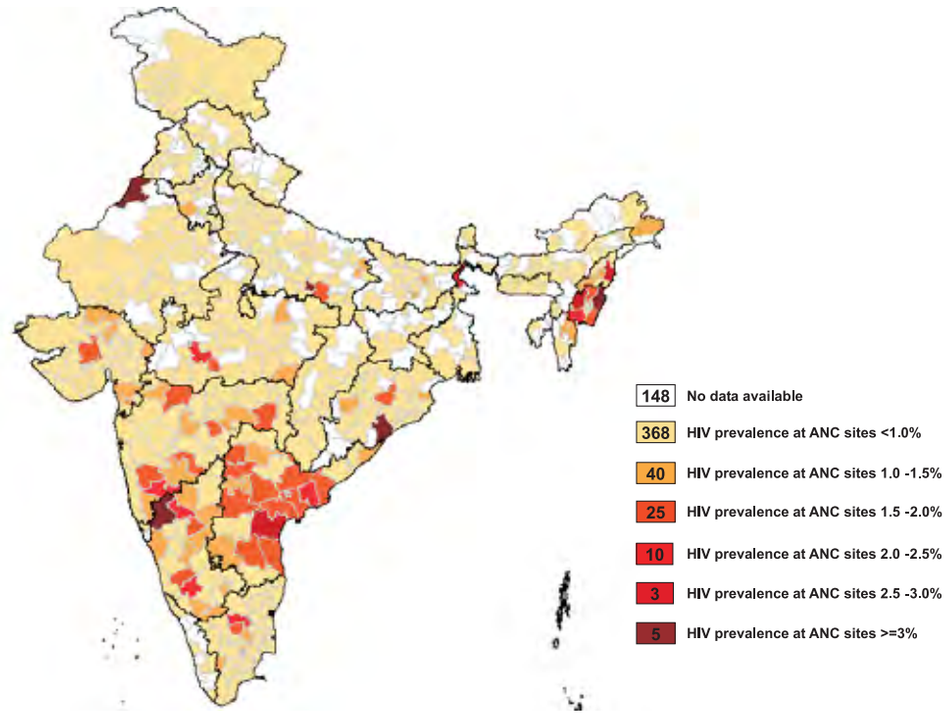
Long-distance truckers are also nationally mobile and so have the potential to expand the geographic spread of HIV by linking the epidemic from relatively higher-prevalence areas in southern India to lower-prevalence areas in the north (see Figure 1). For these reasons, long-distance truckers are an important bridge group to work with to slow the spread of HIV into the general population.[7]

The Need for a Fresh Programming Perspective

When the foundation began designing the Avahan initiative in 2003, there were hundreds of individual HIV projects working with truckers across state and highway locations in India. The intervention design of these projects was largely based on the strategy of the Healthy Highways program commissioned by the United Kingdom Department for International Development (DFID) in 1995. The DFID program was envisaged and originally operated as a consolidated national program. A 1999 DFID-sponsored review of the project prior to handover to the Government of India stressed the importance of an integrated national approach to programming and management to maintain effectiveness of interventions.[7] However, the project lost its unified national character when project management was handed over to the government in late 2000. This was largely because the central management team of the project was replaced by independent state bodies that managed trucker interventions along with other government-sponsored HIV projects.

Given the large number of projects already in place, the foundation considered whether there was need to invest in trucker programming. However, evidence at the time indicated that these projects were operating as standalone interventions without coordination within or between states. The movement pattern of long-distance truckers across states meant that these standalone interventions were unable to sustain a continued and effective

Figure 1: HIV ANC Prevalence By District In India (2006)



Source: NACO Sentinel Surveillance data: ANC sites (2006)

relationship with this population in particular. The DFID review pointed out that "much greater scale and intensity" were required in programming for long-distance truckers. Language barriers and absence of a standard network of services were also factors reducing the efficacy of standalone projects. In effect, state-run interventions ended up almost exclusively reaching inner-state and regional truckers, while long-distance truckers remained largely unaddressed by existing interventions.

The DFID review also identified outreach quality as a major area of concern and recommended participatory peer-led approaches to communication as opposed to didactic messaging by social workers. Existing communication needs assessments also indicated message fatigue among this population as the HIV prevention messages had not evolved over an eight-year period, and these messages appeared to have lost their relevance with truckers.[8] This was corroborated by the fact that prevalence of HIV and other STIs in this population continued to be high, and reported self-risk perception of truckers for acquiring HIV remained low despite almost a decade of HIV programming.[3,6] Based on these findings and consultations with programming experts, the foundation felt that HIV prevention among long-distance truckers was a gap and that a program could be built on the extensive experience of trucker programs in India.

The foundation commissioned a grant to the Transport Corporation of India Foundation (TCIF) to design and implement an enhanced HIV prevention model for long-distance truckers. TCIF is a social development trust promoted by the Transport Corporation of India (TCI), one of Asia's foremost surface transport organizations with more than 1,000 branches in India. Due to the parent company's scope of operations and stature as a market leader within the industry, TCIF was thought suitable to be the lead management partner for this project who would in turn subcontract grassroots NGOs to deliver services at intervention locations.

REACHING THE CUSTOMER

The Indian Long-distance Trucking Industry

Approximately five million truck drivers and helpers travel the 66,000 km of national highways in India. Around 40 percent of these truckers (up to two million) are long-distance truckers traveling 800 kilometers or more in a single direction. These truckers can be classified into three distinct segments: free agents, port operators, and express cargo operators. Please refer to the box, "Segmenting India's Long-distance Trucking Industry," for a description of the segments of the trucking industry. The so-called free agents constitute the largest sub-segment of long-distance truckers and are the focus of the Avahan trucker project. They work in a highly unorganized industry with as many as 77 percent working for small operators who own five or fewer trucks.[9] Of the remainder, only six percent work for fleet operators owning more than 20 trucks. There are only a handful of large fleet operators in India managing more than 1,000 trucks. To transport cargo, the relatively large fleet operators usually contract trucks for a fixed period or for one-time loads. The actual drivers of these trucks are often employed on a one-time, single-trip contract. This job uncertainty, coupled with a surplus of drivers, has created a highly transient and tumultuous work environment for truckers in India.

This fragmented industry setting has spawned a host of middlemen called "brokers" who link small truck owners with larger operators or to customers of transportation services. Brokers work out of offices located in major transshipment hubs along national highways and specialize in a few destinations on fixed route categories (e.g., north-east). The owners of the actual trucks "register" their trucks with brokers to obtain consignments.

From a programming perspective, the absence of a well-defined and regulated industry architecture limits options for intervention design. The road transport sector is regulated by the Motor Vehicles Act 1998. This Act specifies regulations for truck operators in terms of hours of work of truckers, condition of vehicles, facilities and amenities provided to truckers, etc. However, enforcement of provisions of the Act is limited to units employing five or more truckers. Therefore a vast majority of fleet operators do not fall within the ambit of this Act. This rules out structural and policy interventions to promote preventive behavior (e.g., requiring that truckers carry condoms, undertake routine health checkups and timely STI treatment). The fragmented truck ownership pattern also implies that work-place interventions are not feasible. In such an environment, brokers assume a key role since they are the most continuous and stable element in truckers' lives and provide a convenient nucleus for service delivery.

Segmenting India's Long-distance Trucking Industry

The Indian long-distance trucking industry consists of three distinct segments: free agents, port operators, and express cargo operators. Truckers tend to specialize in any one of these segments, primarily because it is difficult to build business networks in more than one segment. The free agent segment accounts for approximately 70 percent of the two million long-distance truckers; port operators account for approximately 20 percent; and express cargo employs the remaining ten percent of truckers. The free agent segment is also the most fragmented, with a vast majority working for small transport operators (owning a maximum of five trucks). These truckers can be accessed either through commercial transshipment locations, or for those who are on long-term contract with companies, at the premises of these organizations. The Avahan trucker model of working in transshipment locations concentrates on the free agent sub-segment of long-distance truckers.

Long-distance truckers also work to transport goods to and from ports. These truckers can be accessed at transshipment locations around ports. The model of intervention used to access free agents can be extended to truckers in this segment as well. However, truckers working to transport express cargo are very different. These truckers congregate only at company-owned transshipment premises and bypass commercial transshipment hubs entirely. Truckers working for express cargo operators are employees of these companies, and therefore a work-place intervention model can be used to access them. The Avahan trucker program is working to customize and transfer its intervention experience with free agents to other sub-segments. It is engaged in dialog with other intervention agencies operating at ports and with companies dealing in express cargo to expand coverage to these sub-segments.

Trucker Lifestyle—Here Today, Gone Tomorrow

A cost-effective intervention requires extended access to large numbers of truckers. In India trucking is not a secure job, and truckers are constantly on the move, trying to maximize their earnings from round-trips. Truckers spend as much as 67 percent of their time on the road.[10] Halting time is split across small *dhabas* (road-side cafes), interstate border check-posts, and transshipment locations. Interventions at *dhabas* are inefficient because not enough truckers gather at these locations at any given point of time. At interstate border check-posts, truckers are focused on clearing paperwork and therefore interventions at these locations are unable to effectively engage with truckers. Transshipment locations are the only type of halting place providing an efficient and effective intervention environment—truckers are present in sufficient numbers and for a long enough period.

Message Fatigue

Past programming efforts have had some unintended consequences among truckers in India, particularly perceived stigma and message fatigue from behavior change communications. This is largely due to the didactic messaging approach followed by NGOs in outreach activities with the population. Anecdotal information indicates that truckers also feel singled out and stigmatized by the repeated focused HIV messaging they received through "external" outreach staff.

REDESIGNING THE BUSINESS OF HIV PREVENTION AMONG TRUCKERS

The programming challenges outlined above—truckers being constantly on the move, fragmented ownership patterns in the transportation industry, and a high level of message fatigue—informed the redesign of the Avahan program for trcukers. This new program design addressed these issues by delivering conventional HIV prevention services in a manner that drew upon key principles of consumer marketing. In fact a comparison with McDonald's business strategy and the Avahan trucker program reveals interesting parallels. The box, "Adapting the Golden Arches Approach to Delivering HIV Prevention," discusses this in greater detail.

Adapting the Golden Arches Approach to Delivering HIV Prevention

It is not easy to find a more universally recognized symbol in the world than the golden arches. McDonald's operates approximately 37,000 outlets across 119 countries, reaching nearly 47 million people every day. A majority of these outlets are operated by franchisees. McDonald's global success has been based on certain key principles: convenience and accessibility, universal standardization, and rigorous quality control.

Convenience and accessibility: It is very difficult to find an unsuccessful McDonald's outlet. They occupy the "primest" of the prime real estate locations. McDonald's could well be a real estate business! This strategic placement of outlets provides McDonald's an edge over competitors in terms of customer accessibility and visibility—in other words, more business.

Universal standardization: McDonald's is fanatical about standardization of processes, systems, and customer interface across the world. Franchisees and employees are trained at the famous "Hamburger University" at Illinois, United States. The training curriculum emphasizes consistent standards for restaurant operations, service, quality, and cleanliness, thereby ensuring a consistent customer experience across the world. McDonald's also works closely with franchisees on other operational issues—for example, sales strategy, financing, and food processing. McDonald's was also the first fast food chain to launch a central advertising campaign and brand icon to build universal recognition of McDonald's outlets.

Rigorous quality control: Finally, standardization is enforced through intense monitoring of operations of restaurants and suppliers. McDonald's, to a large extent, has set the industry standard for quality control. Company employees conduct regular, unannounced audits at food supplier premises as well as at franchisee outlets. This scrutiny of operations ensures quality standards are maintained across the globe.

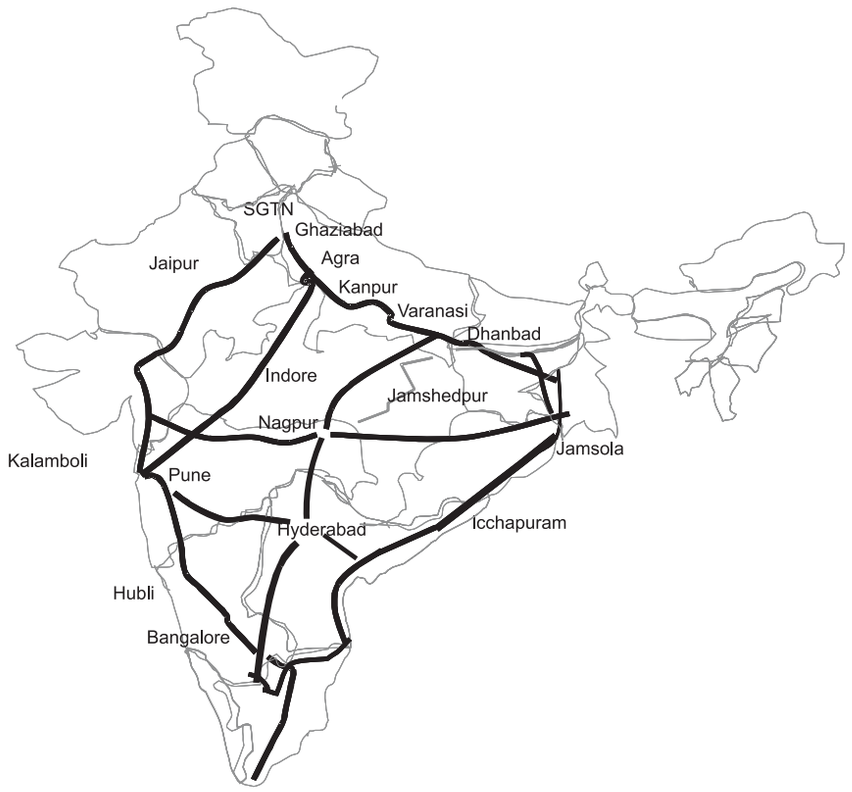
These exact qualities were what Avahan needed to become accessible and recognizable to the amorphous mass of truckers traversing the length of Indian highways. Convenience of access (through intelligent placement of services) and standardization of customer interface were critical to achieving sustained engagement and uptake of services with this population. The Avahan trucker program utilizes these principles to deliver a globally proven package of HIV prevention services, including behavior change communication, treatment of curable STIs, and condom promotion.

The following are the key principles of the design adopted by the Avahan trucker program:

Selecting High-yield Intervention Sites for Best Results

While transshipment locations were seen as the most suitable for delivering HIV prevention services to truckers, the next question was which of the hundreds of transshipment locations in the country were the best-suited for intervention. Previous programs had invested in a large number of intervention sites—close to 200. Some were transshipment locations and several were *dhabas* along highway stretches, in order to reach truckers en route. However, detailed analysis of movement patterns revealed that long-distance trucking traffic was concentrated only at transshipment locations on the national highway network. Moreover, most truckers specialized in one or two route categories, restricting themselves to moving back and forth between two transshipment locations. Therefore, after careful assessment of the industry and the hundreds of transshipment locations in the country, the program chose to work in just 15 locations, supplemented with presence at two major interstate border check-posts for program visibility on particular route segments. This set-up allowed the program access to 48 percent of the free agent long-distance truckers in the country. The free agent segment was the most critical from an intervention perspective for two reasons: (1) this segment accounted for the vast majority of long-distance truckers (70 percent); and (2) the next largest segment (port operators) was being covered by a large intervention program at the time. While the Avahan program's explicit focus is on the free agent segment, it is building partnerships to reach long-distance truckers operating in other segments.

Figure 2: The Avahan Trucker Program



Acquiring Prime Real Estate Presence within a Site

The next challenge was placement of services within an intervention site. The program had chosen to work in the largest transshipment locations in the country, each of which was spread across a stretch of 6-8 square kilometers, servicing 10,000-70,000 truckers per month. This monthly traffic was a mix of long-distance truckers between consignments, as well as short-distance and local truckers picking up goods for inner-state distribution. The priorities were: (1) focus on providing services to the long-distance truckers within this total traffic; and (2) maximize coverage of long-distance truckers spread across the site. Field reports revealed that in order to get their next consignment, long-distance truckers would congregate at the office of the broker who would commission their next load. Long-distance truckers were reluctant to leave broker premises, fearing they might miss out on work. Therefore, broker premises provided "natural traffic" areas where large groups of long-distance truckers (upwards of 50) could easily be accessed.

The decision to focus investment on a limited number of high-yield locations allowed the program to maximize coverage among the 10,000-70,000 truckers in these selected sites, as opposed to dividing resources across a large number of intervention sites. This meant that the program could invest in multiple service touch-points within an intervention site. Each intervention site now offers high-visibility multimedia communication activities set up in and around broker and transporter offices. These natural traffic areas also provide the space for satellite clinic services that are allied with a large static clinic at each location. This substantially increases the visibility of the program and also offers truckers easy access to health services. The ease of access and enhanced visibility offered by satellite clinics result in satellite clinics accounting for as much as two-thirds of the 18,000-strong monthly patient load at program clinics (one-third at fixed clinics). The project also conducts monthly health camps at the intervention sites on a fixed day to provide truckers quality specialist health services, building visibility through corporate sponsorship of these events.

Calculation of Site Denominator and Route-based Planning and Delivery of Services

The program adopted an interesting approach to identify route-based site denominators. Extensive interviews were held with transport operators (brokers and transport owners) to ascertain the number of trucks dispatched per month by route category and the number of truckers employed per truck. Based on estimated cycle times across routes, and using an average number of truckers per truck, the program estimated the total throughput at an individual transshipment location. This helped put monthly service uptake data in perspective, and also helped identify major route categories serviced by presence at a single location. At a program level, the aggregate trucker denominator was found to be 766,000 unique long-distance truckers, and this universe when broken down by route category yielded the data in the chart above.

Route Categories	Distribution of Truckers (%)
North-East	21
North-West	18
North-South	26
West-South	7
South-East	10
West-East	18
Total	**100**

Standardizing and Building Trust in the Customer Interface

In order to address the challenge of fragmented engagement with a mobile population, the program focused on building a uniform look and feel of services across intervention sites. This helps facilitate recognition and recall of services, thereby creating sustained engagement. Moreover, the program's nationwide network of clinics is

branded across the 17 locations. This network of Khushi clinics (*khushi* is Hindi for happiness) is staffed by over 80 doctors, nurses, and counselors. To avoid becoming stigmatized as "STI clinics," the clinics treat a range of general health ailments in addition to STIs so that truckers won't hesitate to be seen at the clinics. The brand and logo were developed in consultation with truckers through focus group discussions. This brand is independent of any organization and is used by NGOs across the program. Khushi is a brand that belongs to the trucking community. It stands for shared values the program is trying to promote such as responsible masculinity and pride in the trucking profession.

The program has created prolific signage to build brand awareness and recall for Khushi clinics. These signs, with the Khushi logo, are prominently posted at check-posts, along highways, and at several points in the intervention locations themselves. All signs on Khushi clinics and highway signs, as well as communications, have the Khushi logo displayed. The program has also used celebrity endorsement (actors from Hindi films) to help build trust and create visibility for the brand.

A Khushi Clinic

Innovative "Surround Sound" Communication Coordinated across Locations

Message fatigue among truckers, coupled with the fact that HIV prevention commodities for this group are socially marketed (namely condoms and medication for treatment of STIs), meant that the program had to approach behavior change communication from a fresh perspective. Consumer research indicated that low self-esteem and self-respect were major causes for truckers to engage in risky sexual practices without regard for future health consequences. The existing model of delivering communications in trucker intervention (didactic one-to-one and one-to-group sessions conducted by salaried outreach workers) had resulted in insufficient communication reach and was stigmatizing and antagonizing for the audience. Finally, the highly mobile nature of the population meant that the program had to synchronize communication across locations to create message recall. The program

therefore adopted the following behavior change communication package:

1. Peer led dialogue-based interpersonal communications
2. Synchronized mid-media
3. Limited mass media to facilitate message recall en route

Peer led dialogue-based interpersonal communication

The Avahan trucker project is the first Indian national program to successfully use active truckers along with former truckers as peers to reach their fellow truckers. This dialogue-based interpersonal communication approach now employs 348 truckers and ex-truckers (50 percent of whom are active truckers) across the major transshipment locations where the program operates. They have been fully trained and conduct approximately 5,000 group discussions with fellow truckers every month. These peer workers use nine participatory tools and visual aids to facilitate discussions among groups of 10-12 fellow truckers about HIV, STIs, common misconceptions, and the importance of condom use. The tool used by peer educators with a pictorial depiction of the main themes is shown below.

Figure 3: Peer Outreach Tool

 STI is caused by unprotected sex	 Unprotected anal sex is riskier	 Intoxication with alcohol and drugs enhances risky behaviour	 Using two condoms at the same time does not provide additional protection
 Even a single unprotected sexual act can be harmful	 It is important to know the correct way of using a condom	 Condoms enhance sexual pleasure	 STI should be treated by a qualified doctor
 Complete the STI treatment as per the Doctor's advice	 Condom protects against unwanted pregnancy and STI	 STI increases the chances of HIV infection	 A healthy looking person can also be carrying an STI infection

Typical group participatory sessions last 60-90 minutes with the timing, frequency, and location synchronized with available clinical services. In these group discussions, truckers usually want to discuss common issues related to HIV risk, such as use of condoms with known casual and commercial sex partners and in male-to-male sex, and alcohol usage.

Trucker Peer Network—Learning from Tupperware

The Tupperware success story is an example of how far a business can go by selling an old tired product in a fresh new way. Tupperware is the brand name of a home products line that includes preparation, storage, and serving products for the kitchen and home. Tupperware debuted in 1946 as a much-improved line of airtight plastic food containers. However, the brand failed to take off despite superior product quality and design. Tupperware then went on to do something outrageous at the time—the company pulled the brand from retail outlets and instead developed the concept of direct marketing.

The company started selling its products exclusively through "word-of-mouth" marketing at "Tupperware parties," where women in a neighborhood got together to see the product line. The concept was that unless women, who were mostly in the kitchen at the time, understood the concept of Tupperware thoroughly, they would not be interested in the product. Hence, instead of advertisements, the company put its energy into getting women together for a party where they could relax and discuss business with Tupperware. The idea was a hit, and today Tupperware is a world leader and a household name.

This perceptive strategy of using word of mouth is exactly what Avahan bet on to counter historical intervention baggage among truckers—messaging fatigue and cynicism towards HIV prevention programs. A mix of currently active and ex-truckers was recruited and trained extensively on HIV-related issues (means of transmission, methods of prevention, etc.) and facilitation skills. Peer outreach workers approach truckers in relaxed informal settings such as tea stalls or roadside cafes. The discussion starts with some topical issue, with HIV being brought in gradually. The peer assumes the role of a facilitator as opposed to an educator, skillfully navigating the discussion from problem identification to self-reflection and brainstorming around potential solutions. Program services are brought in only if there is need expressed by the group for such services.

This cadre of peers is an invaluable asset for the program. Several peers reach out within their networks informally as well, to encourage truckers to adopt safe sex practices and access program services if necessary. Peers who drop out of the formal network due to time constraints continue to engage with the program and refer truckers to program services.

Synchronized mid-media

In order to enhance exposure to communication, the program adopts a layered approach in which interpersonal communication is complemented by several mid-media events at intervention locations. Events include street plays, supplemented with kiosks where truckers can play games that reinforce select themes. Films are also used to deliver HIV messages and tell truckers about available services. These mid-media events usually contain messages harvested through peer discussions about the need to reduce the number of sexual partners; using condoms even with known commercial partners; and the sexual exploitation of helpers by truck drivers. Approximately 1,000 of these mid-media events are held each month. Again, the frequency, location, and timing of these events are synchronized with medical services at various locations within each intervention point. Typically, depending on the format, an audience of 50 to 200 attends one of these events. The themes for these mid-media events are standardized across locations to build message recall. The mid-media messages center around nine common themes that highlight misconceptions most prevalent in the trucker community. These messages are altered across sites every six months, so the program stays fresh and engaging for the target population.

Apart from a mix of street plays, game shows, and film shows held every day across locations, the program conducts large-scale edutainment events at each of these locations every quarter. These events attract corporate sponsorships and typically see an attendance of 1,000-3,000 truckers. These trucker *utsavs* (festivals in Hindi) are immensely successful. They create interest and visibility around the program, resulting in a 20-30 percent immediate increase in uptake of services, sustained for close to four weeks, and a long-term average increase of 8-10 percent.

Select mass media to reinforce program recall en route

The final aspect of the "surround sound" effect employed by the program is the use of select mass media, namely audio cassettes and outdoor visibility. This helps the program create engagement with the truckers outside the physical boundaries of intervention locations and helps increase recall of services. Audio cassettes contain popular local songs interspersed with spoofs on Hindi film actors delivering HIV prevention messages and endorsing Khushi services. The program also builds recall of services through billboards at popular roadside cafes and along the highway.

Engaging Customers

The program has engaged with truckers in several ways in its endeavor to become and stay relevant to the target population:

1. **Consumer research to develop the program's positioning platform:** The program's overarching positioning theme was developed through extensive consumer research by a professional consumer marketing research firm, consisting of focus group discussions and in-depth interviews with truckers across multiple ethnicities, age groups, and route categories. Based on this research, the project is attempting to move beyond the utilitarian "health benefit" positioning of safe sex practices towards making such behavior aspirational for truckers. This involves using positive cues (enhanced self-esteem, being responsible, being in control and hence masculine) to promote behavior change.
2. **Peers (fellow or former truckers) are the face of the program:** All interpersonal communication and a large portion of mid-media events are facilitated by peer workers using language, anecdotes, and themes the population can identify with.
3. **Harvesting peer discussions to inform communication themes:** Peer discussions form the basis of themes presented in all mid-media activity. These discussions dispel myths and fears, like the idea that condoms are unnecessary in anal sex or that masturbation can lead to impotency. These discussions also help identify psychological barriers to condom usage such as condom usage not being the mark of a "real" man. These insights are then creatively addressed in subsequent mid-media communications and are also highlighted by peers in their discussions.

DATA FOR PROGRAMMING AND IMPACT MEASUREMENT

The Avahan trucker program collects and analyzes data from many sources in order to track clinical service uptake, assess communications effectiveness including reach and recall, and document consequent outcomes, if any, in terms of behavioral and biological indicators. The following are the main sources of data on which program decisions and impact assessment are predicated:

1. **Routine monitoring system:** The routine monitoring system captures monthly data on service uptake at each site. Each implementing NGO collects data on a set of process and output indicators. This includes numbers reached through interpersonal communication sessions, attendance at mid-media events, referrals by peers to clinical services, footfalls (attendance) at static and satellite clinics, number of truckers diagnosed with STIs at the clinics, sales of socially marketed condoms, and other indicators.

2. **Ongoing behavior and exposure tracking surveys:** While monthly service uptake data are useful to track output measures by site, it is necessary to supplement this with reported exposure and behavioral outcome data to understand if the program is on the right track. The project conducts bi-annual behavior tracking surveys (previously these surveys were conducted annually) at six of its largest sites. This helps assess program exposure and changes in attitudes, knowledge, and behavioral indicators across the universe of truckers available at these locations. These data also help establish coverage of services and recall of the Khushi brand among long-distance truckers at a site. In addition, the program conducts smaller dipstick surveys to assess exposure to communication activities and efficacy of individual communication elements. One round of such a survey was conducted in 2007 across three large intervention sites.

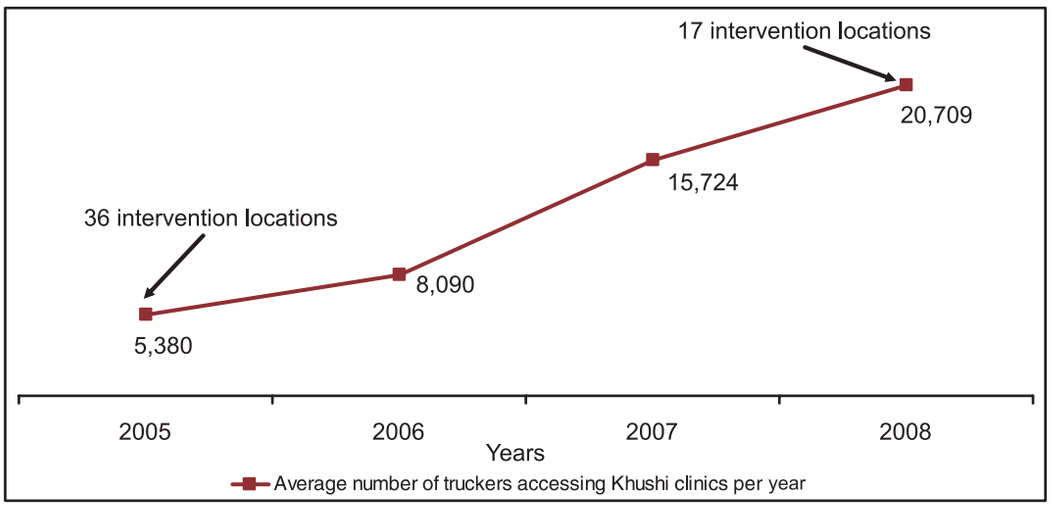
3. **Cross-sectional survey—Integrated Behavioral and Biological Assessment (IBBA):** This survey was designed to measure behavioral and biological trends at a population level. The first round of the IBBA was conducted in mid-2007 and the next round is planned for 2009-10. These surveys are intended to provide trends related to prevalence of HIV and other sexually transmitted infections, behavioral information such as condom usage and commercial sex transactions, and data on program exposure and recall such as uptake of clinical services, contact by peer educator, and brand recall of *Khushi*.

EARLY RESULTS

Early data from TCIF's routine monitoring system and recent rounds of the communication exposure and behavior tracking surveys indicate that the program is on the right track. These early indicators are summarized below:

1. **Expanding communication reach:** The multi-media communication plan has resulted in a doubling of monthly reach across the program (in terms of monthly contacts through peer led interpersonal communication and participation in mid-media activities). This is substantiated by the fact that reported exposure to program communication, as measured by last year's communication effectiveness survey at major sites, is as high as 72 percent.
2. **Increasing brand recall:** The second indication that the program is headed in the right direction is the increase in brand recall as measured by the behavior tracking survey. The most recent round of the behavior tracking survey (conducted in January 2008) shows that recall of the Khushi brand is as high as 70 percent. Recall was only 12 percent in May 2005, which was prior to the introduction of the new program design.
3 **Growing service uptake:** The increased visibility and recall of services and improved access have resulted in a dramatic increase in uptake of clinical services. Monthly clinic uptake across the 17 intervention locations has increased by a factor of 2.5. Therefore, despite a halving of the number of intervention locations, in May 2006, clinic service uptake across the program has almost doubled. The last round of the behavior tracking survey indicated that almost one-fifth of the truckers sampled had accessed services at the Khushi clinics, as compared to seven percent in May 2005.

Figure 4: Trend in Clinic Service Uptake over the Last Four Years



LESSONS LEARNED ON THE JOURNEY

The following are the key lessons that the Avahan trucker program has learned in its five-year journey of implementation:

1. **Less is more when dealing with a mobile population:** A major learning for the Avahan trucker program has been that it is unnecessary and in fact inefficient to spread resources across a large number of locations. Contrary to the natural inclination of reaching mobile populations by operating across a large number of sites, it makes the most sense to limit program presence to a few high-impact locations. This enables the program to saturate coverage in these large locations and derive greatest value from available resources.
2. **For mobile populations, route-based planning and delivery of services is essential:** The risk of HIV in truckers is related to the length of time spent away from home. Differences in routes traveled translate into differences in the length of time spent away from home by truckers as well as in their access to commercial sex. The IBBA substantiated this to some extent, since HIV prevalence in truckers across route categories ranges from three to seven percent. Therefore, a route-based approach to planning and delivery of services helped prioritize route categories and obtain high coverage on critical route segments.
3. **Denominators are essential for program planning and assessment:** At the beginning of the program, program effectiveness was analyzed through absolute numbers of communication contacts and clinic attendance. However, the absence of a denominator created two issues. One, since the program did not know where truckers were, it could not proactively plan service delivery around high-density pockets. Two, absolute

numbers did not provide any idea of program performance. These numbers were meaningless without having a sense of the universe of truckers available at the location. A brokerwise census helped establish the flow at each transshipment location against which the program plans delivery and assesses service uptake.

4. **Output indicators should be supplemented with regular outcome data to fine-tune the program:** While the routine monitoring system helps track trends in communication reach, condom sales, and service uptake, it cannot provide population-level coverage information (e.g., to determine what proportion of the total universe of truckers available at a location has accessed program services). To monitor effectively, the program found it essential to supplement routine monitoring data with survey-based methods that can provide behavioral outcome and program exposure data at a population level.

5. **Systematic peer outreach is possible with a mobile population:** Trucker programs in India, including the Avahan trucker program in the early days, did not employ active truckers as peer workers. While the benefits of peer outreach were clear, the logistics of recruiting, training, and managing a cadre of active truckers who are always on the move made this potentially unfeasible. However, the Avahan trucker program has learned that by leveraging a mix of currently active and ex-truckers, the program can create a stable pool of peer workers. Moreover, even if there is turnover, trained peer workers go on to become advocates for the program and do the program a great service by informally sharing information within their networks.

6. **Adopting a synchronized multi-media approach helps counter challenges of fragmented engagement with the target population:** In order to build a sustained relationship with a mobile population, the Avahan program decided to synchronize communications across sites and amplify themes through different media. Limited reach through peer-based one-to-one messaging was supplemented by other communication vehicles. This helped scale communication exposure dramatically.

7. **Promotion of socially marketed health services can benefit from conventional consumer marketing wisdom:** Due to a decade of prevention programming with truckers, there was a large amount of HIV messaging fatigue and stigma for programs to contend with. This forced the program to design innovative platforms for promoting services. Drawing upon consumer research approaches, focus group discussions were utilized to identify attractive attributes that the program brand could adopt. It was apparent that the program needed to evolve beyond traditional utilitarian appeal to a more holistic platform that made safe sex aspirational for truckers. The Khushi brand is promoted not as a health services brand but more as a symbol of community pride and self-respect.

THE ROAD AHEAD

As the Avahan trucker program enters its fifth year of implementation, transfer of program learnings and institutionalizing a response to HIV within the transportation sector assume great importance. The following are the priorities of the program in this context:

1. **Strengthen the platform of transition to the national program:** The third phase of the national program recognizes the importance of long-distance truckers and the fact that they require an intervention approach different from their regional counterparts. The Avahan trucker program has therefore been working closely with the national program to transfer key learnings from its intervention experience.
2. **Promote a sector-wide response by expanding linkages with other companies in the transportation sector:** TCIF is using its intervention experience over the last five years to guide other companies in the transportation sector on their social responsibility agenda. TCIF is proactively seeking out companies with an explicit (e.g., tire and truck manufacturers) or implicit (consumers of transportation services, such as steel companies) focus on truckers to inform these organizations of the importance of HIV prevention and the need to mount a sectoral response. It is also advising companies on cost-effective ways to deliver health services to their trucking fleets. In 2007 alone, TCIF reached out to seven national companies and 70 midsized regional players to provide services to truckers.
3. **Improve coverage of other segments of long-distance truckers:** The program is fortifying partnerships with intervention agencies and corporate partners operating at ports and in the express cargo segment. Avahan is working with these agencies to modify the intervention design according to the operating environment in these segments, so as to optimize utilization of available intervention resources in these segments.

REFERENCES

1. *Avahan—The India AIDS Initiative: The Business of HIV Prevention at Scale*. New Delhi: Bill & Melinda Gates Foundation, 2008.

2. National AIDS Control Organization India. *Baseline Behavioral Surveillance Survey, 2001 General Population Report*. New Delhi: National AIDS Control Organization India, 2001.

3. Family Health International and Department for International Development. *Healthy Highways Behavioral Surveillance Survey*, 2000. New Delhi: Family Health International and Department for International Development, 2001.

4. National AIDS Control Organization India. *Baseline Behavioral Surveillance Survey, 2001, Female sex workers and clients of female sex workers*. New Delhi: National AIDS Control Organization India, 2001.

5. Indian Council of Medical Research and Family Health International. *National Interim Summary Report—India, Integrated Behavioral and Biological Assessment (IBBA), Round 1*. New Delhi: Indian Council of Medical Research and Family Health International, 2007.

6. Family Health International, Department for International Development, UK. "Prevalence of Sexually Transmitted Infections and HIV among Long Distance Inter-city Truck Drivers and Helpers of Northern India," impact assessment for HIV/STI prevention programs baseline report series. New Delhi: FHI and DfID, 2000.

7. Wison D, et al. *Review of Healthy Highways Project by JSI (UK) and Organization Development Associates on behalf of Department for International Development, India*. New Delhi: JSI and Organization Development Associates, 1999.

8. Family Health International. *Communication Needs Assessment in Maharashtra, Avert- Impact Project*. New Delhi: FHI, 2001.

9. Estimate by the Central Institute of Road Transport, 1998.

10. Debroy B, Kaushik PD. *Barriers to Inter-State Trade and Commerce—The Case of Road Transport, 2002, Background Paper for the Commission for Contemporary Studies*. New Delhi: Rajiv Gandhi Institute, 2002.

GLOSSARY

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

Brokers are trucking industry middlemen who link small truck owners with larger operators or customers of transportation services. Brokers work out of offices located in major transshipment hubs along national highways and specialize in a few destinations on fixed route categories.

Dhabas are roadside restaurants.

Edutainment events are large-scale entertainment events conducted by the program. These events last four to six hours and consist of local entertainment activities interspersed with messages on safe sex behaviors and information on program services.

Free agents are long-distance truck drivers who work for small operators who own five or fewer trucks.

Helpers are assistants who are apprenticed to long-distance truck drivers and travel with them.

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 is 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.

Khushi is the Hindi word for happiness. Khushi is the brand name used by clinics for the Avahan trucker program.

Long-distance truckers are truck drivers and helpers who are nationally mobile. The transportation industry defines them as truckers traveling 800 kilometers or more in a single direction.

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

Natural traffic areas are places in transshipment locations where large groups of long-distance truckers congregate, such as brokers' offices.

"Surround sound" communications refers to the use of multi-media communications (interpersonal dialogues, mid-media activity, and select mass media channels) to reinforce messaging.

Transport owners or fleet owners are individuals or organizations who own and operate vehicles, as opposed to brokers who act as middlemen for consignments without necessarily owning any vehicles.

Transport establishments are organizations in the business of providing transportation services. It includes transport owners or brokers.

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.

Truckers in this document refers to drivers and the helpers who travel with them.

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