MANAGING HIV PREVENTION FROM THE GROUND UP:
Avahan's Experience with Peer Led Outreach at Scale in India

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INDIA AIDS INITIATIVE

BILL & MELINDA
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AVAHAN—THE INDIA AIDS INITIATIVE

Approximately 2.5 million people are infected with HIV in India.[1] The country is home to the third highest number of people living with HIV/AIDS (after South Africa and Nigeria),[2] and its population of over one billion makes even a small increase in infection rates globally significant. The Indian HIV epidemic, as in many Asian countries, is contained within subgroups of the population most at risk of acquiring and transmitting HIV (high-risk groups*).[3] These are female sex workers, men who have sex with men, transgenders, and injecting drug users.

In 2003 the Bill & Melinda Gates Foundation began its India AIDS Initiative, known as Avahan, a large-scale program to curtail the spread of HIV in India. 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 lessons learned within India and worldwide

Avahan was conceived as a focused prevention program—reaching high-risk groups and bridge populations, in geographic areas most affected, with a standardized package of prevention interventions. The program focuses on providing coverage to high-risk groups in six Indian states (with a combined population of 300 million) that accounted for 83 percent of the country's HIV infections in 2002: Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland, and Tamil Nadu.[4] Each of these states varies greatly in terms of language and culture, and the stage and drivers of the HIV epidemic, as well as the length and extent of prior HIV prevention interventions. As of December 2008, Avahan supports prevention programs for approximately 320,000 high-risk individuals in 651 towns, in 82 out of 137 districts in these six states.** This group includes 221,000 female sex workers, 81,000 high-risk men who have sex with men, and 18,000 injecting drug users. In addition, services are provided to 5 million men at risk (truckers and clients of sex workers). Avahan works either alongside government- or donor-supported NGOs, or as the sole HIV prevention service provider in a district for these groups.***

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*   Definitions of terms used in this publication can be found in the glossary.

**   A district is an administrative subdivision of a state. An average district has an area of 2,000 square miles and a population of two million.

***   A complete description of Avahan's experience in the design and implementation of the program can be found in a separate publication, *Avahan—The India AIDS Initiative: The Business of HIV Prevention at Scale.* New Delhi: Bill & Melinda Gates Foundation, 2008.

Figure 1: Avahan Intervention Districts

States (6)
Districts (82)
Intervention sites
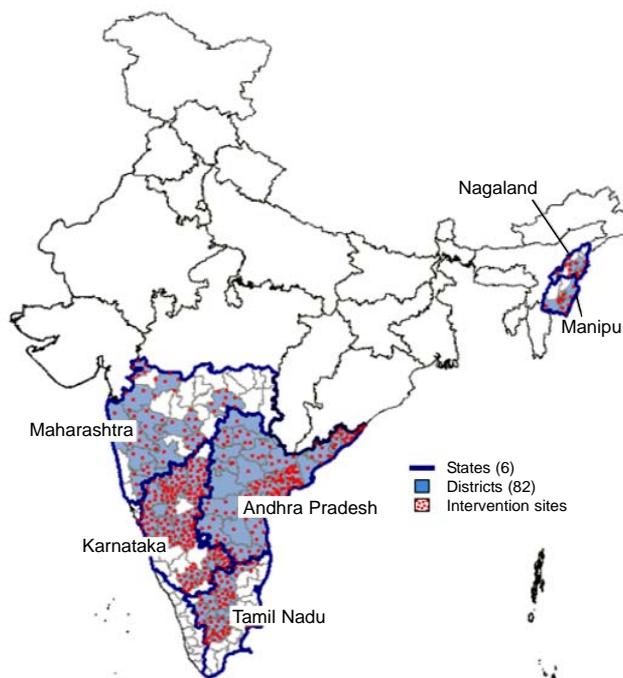
Source: Avahan Routine Monitoring Data

Peer led outreach is a critical element of Avahan's HIV prevention interventions.* Development programs have long operated with the contention that peer outreach workers—trained members of the target population—can deliver better results than people who are not members of that population.[5] In HIV programs, peers are typically used to address behavior change, under the assumption that they are best equipped to identify persons in their own community at risk of HIV and STIs, and that because they are easily accepted and trusted they can be effective in offering information and support that make behavior change viable.[6] Avahan has adopted the methodology of micro-planning in order to help peers manage their own work, which enables outreach to be scaled up while maintaining quality and developing ownership by the communities served.

This publication describes how Avahan has developed peer led outreach to female sex workers, high-risk men who have sex with men, and transgenders in the states of Andhra Pradesh, Karnataka, Maharashtra, and Tamil Nadu, as well as the progress and lessons learned to date.**

Avahan interventions

The Avahan package of prevention interventions includes:

1. **Peer led outreach.** Peer outreach workers identify high-risk individuals among their social network who are at risk and provide support and information to improve their ability to negotiate condom use and encourage their attendance at STI clinics and self-help programs. Avahan has about 5,800 peers in 69 districts across four states.***

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*   In this publication, the terms "peer outreach worker" and "peer" are used interchangeably.

**   A separate publication in this series (see inside front cover for details) addresses Avahan's experience in peer led outreach with injecting drug users in the northeastern states of Manipur and Nagaland.

*** Unless otherwise stated, all figures in this publication are as of December 2008 and refer to the states of Andhra Pradesh, Karnataka, Maharashtra, and Tamil Nadu.

2. **Program-supported clinical services to treat STIs other than HIV**. Avahan has established 302 static program-funded clinics that have provided free STI diagnosis and treatment services at least once for an estimated 344,000 individuals.* Clinic services are also provided through mobile clinic vans, health camps, preferred providers (private clinics that are screened and contracted to provide services to high-risk individuals), and government clinics.

3. **Commodity distribution.** Avahan promotes and distributes free condoms for sex workers and supports needle and syringe exchange for injecting drug users. As of December 2008, Avahan was distributing over 11 million condoms free of charge every month to sex workers, high-risk men who have sex with men, and transgenders.

4. **Facilitating community mobilization and ownership of the program.** In addition to risk-reduction services, Avahan addresses 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 safer behaviors.[7] Today, 142 community groups or organizations, some with legal registration and annual membership fees, exist across the districts served by Avahan. The participation and leadership of high-risk communities continue to evolve as their skills and capacity are built to ensure that HIV prevention programs and vulnerability reduction efforts are sustained beyond the life of the Avahan initiative.

5. **Advocacy for an enabling environment.** Community groups associated with Avahan at local levels are addressing societal perceptions that lead to stigmatization of HIV and high-risk communities. They advocate with the authorities and other stakeholders to secure an enabling environment (i.e., a more supportive legal framework and less hostile social atmosphere). These local efforts have been supported by advocacy efforts at the state and national level.

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

Implementation at scale

Avahan's charter of building an HIV prevention model across such a large geographic area and for such a large population required the infrastructure and services to be rapidly established and scaled up, so that variations within the approach and quality could then be the focus. Avahan's approach was based on the following key principles:

1. **Designing for scale.** Beginning with detailed size estimations of high-risk groups (updated every 18-24 months), Avahan established an initial denominator against which scale-up of services was planned. Based on this exercise, key locations with large concentrations of high-risk individuals were identified as priority areas where services were to be scaled up simultaneously by various partners. To support the roll-out of services, Avahan created a set of programmatic, technical, and managerial standards to guide implementation and monitor quality of the interventions. This "Common Minimum Program" (CMP) provided partners with flexible guidance for scale-up. The CMP was complemented by the *Clinic Operational Guidelines and Standards* for STI management, which provided a minimum set of standards for STI treatment services.

Figure 2: Roll-out of Footprint and Services
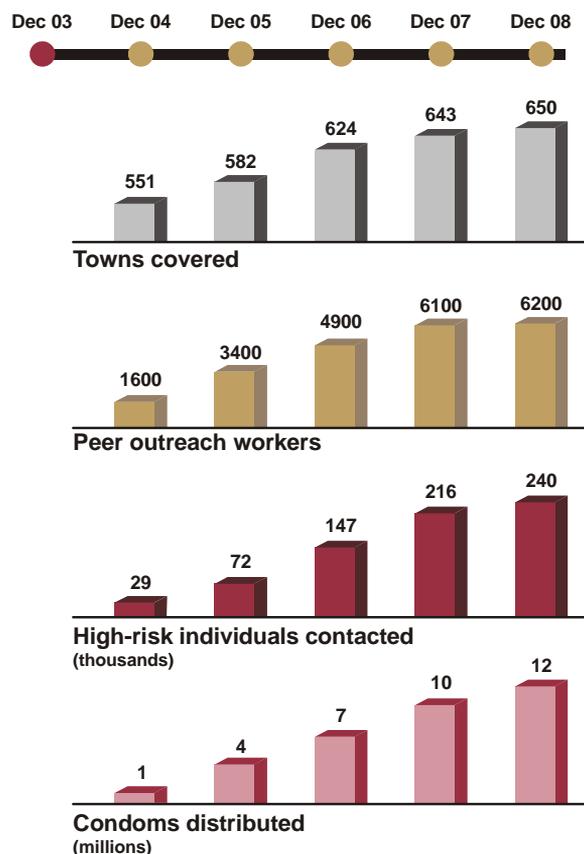
Source: Avahan Routine Monitoring Data, all six states

2. **Organizing for scale.** Avahan may be thought of as a "virtual organization" composed of several different partners including local and international NGOs, universities, and research organizations. This virtual organizational structure was designed deliberately to enable rapid and simultaneous scale-up across geographic areas, facilitate standardization of key elements, and share best practices across all implementation programs. Avahan partners include:

- Lead implementing partners (seven total across six states), who grant to and support 168 local implementing NGOs

- Capacity building partners

- Monitoring and evaluation partners

- Knowledge building partners (for more information on each of these partners and their specific roles, see Appendix II)

3. **Executing and managing for scale.** To execute and manage such a large-scale program, Avahan sought on one hand to establish high-quality and accessible services, and on the other to increase interest in the services and address barriers to service uptake. For quality and access, Avahan simultaneously:

- Created its footprint (infrastructure for service delivery) across all intervention locations

- Customized the intensity of services and the mode of delivery (e.g., static clinics versus mobile clinics) according to the size and needs of the target populations

- Maintained an execution focus that set milestones for partners and used frequent data reviews to inform mid-course corrections

Figure 3: The Avahan Organization
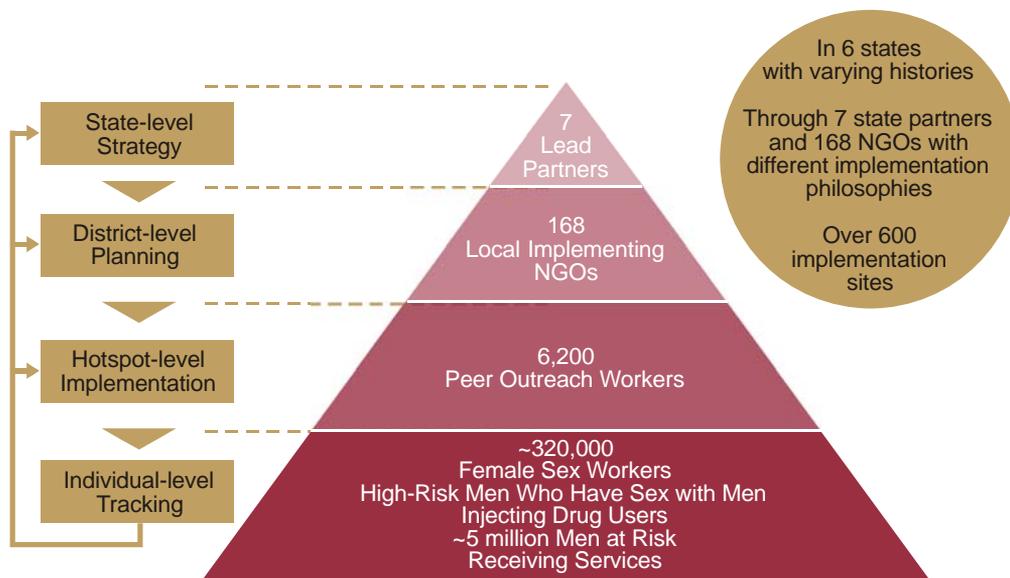
Source: Avahan Routine Monitoring Data, all six states

To generate demand for programs and address barriers to service uptake, Avahan engaged in advocacy and community led programs to reduce stigma and violence, and to improve opportunities for communities to organize themselves and to start their own self-help initiatives.

Using data to improve Avahan

Avahan gathers and uses data from a variety of sources within and outside the program to inform and continuously improve programming.[8] Avahan data range from those collected by individual peer outreach workers and the 35-85 community members each one contacts, to a snapshot of the entire Avahan program, including infrastructure (e.g., number of clinics and drop-in centers), human resources (e.g., number of peer outreach workers), 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). External data sources include HIV prevalence data from the Government of India's sentinel surveillance system of antenatal clinics, and national- or state-level behavioral surveillance surveys conducted by the Indian National AIDS Control Organization.

Avahan uses data for many purposes at different levels of the program, including:

1. Investing and allocating resources across districts, populations, and sites

2. Initiating outreach and setting up services

3. Identifying impediments to scale-up and making course corrections

4. Increasing depth of outreach and service utilization

5. Monitoring quality (peers may do this at the site level with their own outreach data, and centrally this is done with computerized management information systems and surveys)

6. Measuring the impact of HIV prevention interventions on the epidemic in India

PEER LED OUTREACH—
ACHIEVING SCALE, QUALITY, AND
OWNERSHIP OF HIV PREVENTION

Taking HIV prevention outreach to scale in India

In India, small-scale interventions using peer led outreach have achieved three- to fivefold reductions in STI prevalence among sex workers.[9] However, there have been few models for large-scale outreach led by peers.[10] Given the number of people affected by the epidemic in India, the challenge for Avahan was to develop rapidly scaled, peer led HIV prevention interventions that would achieve high coverage.

A concomitant challenge was to maintain the quality of coverage even as programs were growing rapidly in scale and intensity. Local implementing NGOs could provide only limited oversight of the increased numbers of high-risk individuals they were serving, even when their knowledge and access were supported by the resources of the state-level lead implementing partners. In addition, the particular vulnerabilities faced by high-risk individuals are often complex, and the program had to find effective ways to support them in changing their behavior. This required field staff with an intimate understanding of the problems and an ability to help communities address them.

The solution was to devolve responsibility from NGO staff to the peer outreach workers and make peers the primary component of the intervention. Avahan achieved this by equipping peers to manage outreach themselves, with their own methods and tools developed for analysis and tracking, rather than relying on a limited number of staff supervisors for direction.

The key to implementing this approach was the methodology of micro-planning, which uses specially designed tools that allow peers—including those who have low literacy skills or are illiterate—to record and analyze data on the specific personal and social factors that make each individual vulnerable to high-risk behavior, and to track their outreach at daily, weekly, and monthly intervals. This makes outreach more organized, enables peers to prioritize those most immediately at risk, and identifies more chronic problems over time. In addition, outreach data are made available to the implementing NGOs and lead implementing partners to track program development and outcomes that can in turn inform the overall program.

Peer outreach workers have significantly accelerated the pace and intensity of Avahan's outreach. As members of high-risk groups themselves, peers have essential access, credibility, and insider knowledge. They make behavior change more viable by linking a deep understanding of vulnerability with information and services. All this occurs within a management system designed to build outreach capability in successive steps, and in which peers train one another, evaluate their own performance, and have scope to progress individually and as a group to supervise outreach. This process is designed to encourage high-risk groups to develop ownership of interventions and empower high-risk individuals to become leaders within the intervention program—giving input to decisions about program implementation and assuming management roles—and also within their communities.

The development of the peer led outreach approach in Avahan

Avahan implemented peer led outreach in phases, recognizing that it was not feasible to attain complete and in-depth coverage immediately. This phased roll-out allowed time to build the capacities of the implementing NGOs and to be responsive to local programming contexts, as well as to formalize innovations from individual partners and disseminate them across the program. The phases can be summarized as follows:

Start-up

- Contracting state lead partners and local implementing NGOs

- Recruiting and training high-risk individuals in mapping, in order to estimate size of high-risk population for programming

- Establishing the peer outreach network:

  - Setting standards for peer outreach (e.g., appropriate peer ratio, selection criteria, and norms for hiring peers)

  - Defining denominators for each of the peers and introducing tools for planning outreach

  - Recruiting peers based on detailed social network mapping

  - Training initial peers on outreach planning

  - Setting standards for peer performance and beginning outreach

Expanded Roll-out of Services

Improving outreach and service delivery

- Introduction of micro-planning to enable peers to analyze gaps in service delivery and prioritize outreach

- Redefinition of role of the peer from educator to case manager for HIV prevention

- Project monitoring (focused on the number of condoms distributed and clinic visits by individual) is supplemented by field visits to assess the quality of peer interaction with community members, so that the relative impact of interactions and "opportunity gaps" in service levels can be understood

Refinement of Scope *(current phase)*

Building peer capacity to become opinion leaders and change norms of behavior in the community

- Peer outreach expanding from risk reduction focus to address underlying vulnerability. High-risk individuals are linked not just to services but to crisis response systems, local advocacy efforts, and community groups.

- Peers from different geographic areas network to learn from one another across districts and states.

- Peers are increasingly community leaders who set norms for health-seeking behavior and role models as responsible program partners—they practice safe sex, go to the clinic, and take initiative to tackle community priorities.

Avahan initiated the start-up phase of its intervention in early 2004. Avahan's lead implementing partners initially focused on contracting NGOs, conducting size estimations of the high-risk groups through mapping exercises, building the infrastructure for scale, setting up clinics, recruiting peer outreach workers, and introducing services to high-risk groups. At this early stage the focus was on recruiting peers from local areas across Avahan's broad coverage area.

By January 2006, 3,000 peer outreach workers (about half of the current total) had been trained to visit solicitation spots, where they distributed condoms to their colleagues and provided HIV-related information and referrals to STI clinics and other services. However, at this point only a quarter of the total estimated denominator of high-risk individuals was being contacted by peers or NGO outreach staff on a monthly basis, and only a quarter of these individuals ever visited the clinic.* While Avahan still lacked robust data on the extent of condom use and STIs, reports from high-risk individuals in the program made it clear that outreach had to be improved.

In the next phase of the intervention, expanded roll-out, Avahan's lead implementing partners began shifting their focus from scaling up infrastructure to intensifying services. The partners consulted peers and NGOs to devise ways of increasing demand and outreach. Together, they decided to make better and more consistent use of the peers' depth of knowledge about the sex work environment and underlying risk factors such as violence, fear of the police, and dependence upon abusive partners. The range of activities of peer led outreach was expanded, and peer selection, oversight, and training were enhanced. Most importantly, the additional component of micro-planning was introduced so that peers could analyze and plan their work with greater depth and autonomy.

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* The total estimated denominator is the number of high-risk individuals profiled to receive services by the program as of December 2008. In the states of Andhra Pradesh, Karnataka, Maharashtra, and Tamil Nadu it was 297,000 (217,000 female sex workers and 80,000 men who have sex with men). For the purposes of measuring Avahan's progress in this publication, this number is applied as a constant over the lifetime of the program (i.e., from January 2004 onwards).

In mid-2006, Avahan undertook a number of efforts to refine the scope of outreach. Lead implementing partners conducted program reviews to understand what adjustments were needed in program emphasis and monitoring. Local implementing NGOs identified gaps in coverage that needed to be addressed. High-risk groups were consulted to enhance their role in the program, in large part through the work of peers. Peers were issued identity cards to show that they were involved in HIV prevention work if stopped by the police. They began receiving additional training using participatory methods (e.g., role-play and group discussions) to understand issues such as power and self-confidence and how these relate to condom negotiation skills. Efforts to tackle vulnerability that had been proving effective on a local basis were analyzed and disseminated among partners, and crisis response systems were introduced across the six Avahan states to tackle and prevent violence against high-risk individuals.[11]

Peer led outreach services

Peer outreach workers deliver a standardized service package, which ensures a minimum quality of services as well as the comparability of reporting data across the program. In the start-up phase of the Avahan initiative, the essential elements of the package were limited to the following:

- Weekly one-to-one meeting with each of the 35-85 high-risk individuals in the peer's assigned area

- Referral and/or accompanying high-risk individual to clinic for regular quarterly check-up and STI services

- Need-based distribution of condoms (principally free with some socially marketed) and demonstration of their correct use*

In the expanded roll-out phase, micro-planning was introduced and the following services added to increase the quality and effectiveness of outreach:

- Discussions of risk and vulnerability to better understand the situation of the high-risk individual and enable her/him to reflect on own situation

- Meetings with regular partner of high-risk individual

- Peer-facilitated group meetings with some of the peer's contacts

- Dialogue-based communications to address barriers to uptake of safe sex and other health-seeking behaviors

- Encouraging membership in community groups for social support and community empowerment

- Informal meetings with lodge owners, pimps, and madams to keep lines of communication open

Avahan has just begun a final stage to refine the scope of outreach and at the same time is working to enable the Government of India and high-risk communities to take stewardship of the program. As the Government of India supports HIV prevention work with high-risk communities through its National AIDS Control Programme, many of the lessons learned through programs such as Avahan's are being applied, but there remains tremendous scope to learn in this phase.

Using data to improve peer led outreach

Two further components of peer led outreach are the methodologies of local-level mapping and micro-planning, which enhance the ability of peers to use data, giving them a more informed perspective of the risk and vulnerability of each high-risk individual they serve. Mapping precedes outreach activities and identifies and defines the people to be reached. Micro-planning is introduced once outreach activities have begun, and it allows peers to refine and strengthen their outreach by recording and analyzing data about their contacts.

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* This package describes Avahan's targets during this phase. During the first year of outreach, NGO staff distributed condoms and peers played a considerably less prominent role in outreach.

Mapping and micro-planning are based on lessons from participatory development theory,[12,13] and recognize that strategy at the macro level must be driven by in-depth knowledge at the micro level. Avahan partners have adapted these methodologies so that peers do not simply gather data but also use it to analyze risk and plan and manage their own outreach.

Local-level mapping

Initial population size estimations are conducted through broad mapping of target areas, a process which is repeated every 18-24 months. Outreach planning continues with local-level mapping, which takes place in two stages. First, peers draw street maps of "hotspots" (locations where sex or sex work is solicited or practiced) to determine a "beat" within which they will operate. These pictorial representations mark sex solicitation venues (such as bus stations, parks, public toilets); significant buildings such as hospitals, police stations, and shops or kiosks stocking condoms; and locations where a drop-in center or clinic might be helpful to the high-risk community. The numbers and locations of high-risk individuals are marked on the maps, which typically depict an area of a few square kilometers. Mapping helps determine how many peers are needed in a given area, and which peers are best suited to work at particular hotspots due to their knowledge of those locations.

Figure 4: Hotspot Map
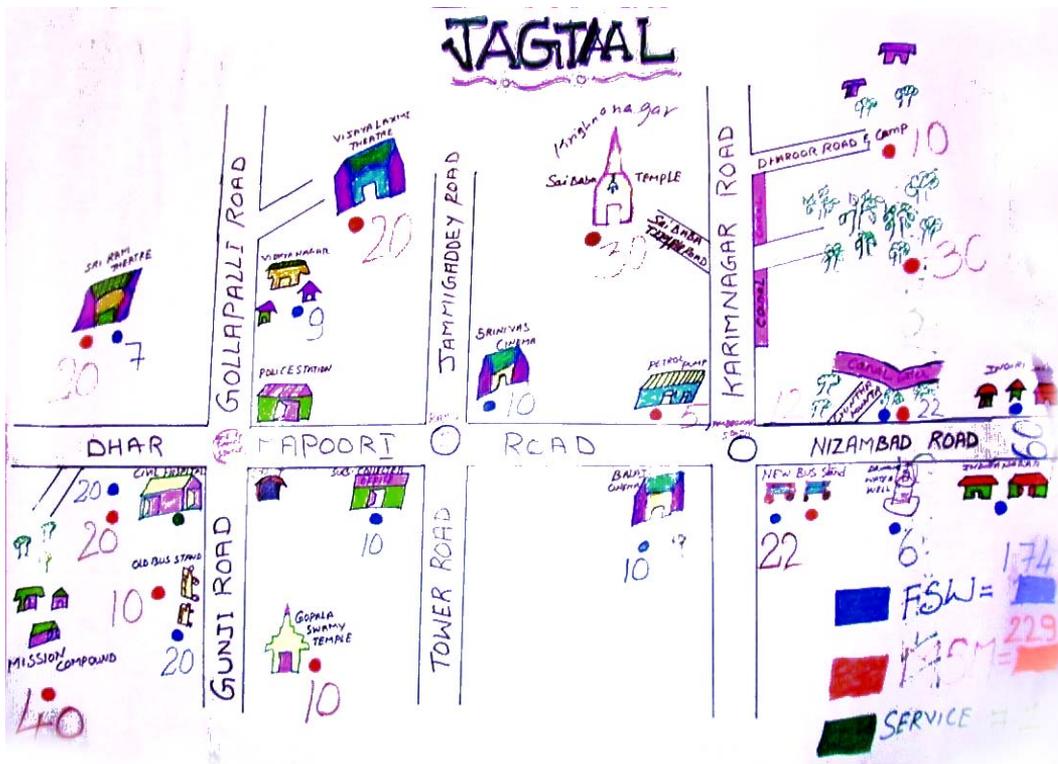
Source: Alliance for AIDS Action Project, International HIV/AIDS Alliance

Figure 5: Social Network Map
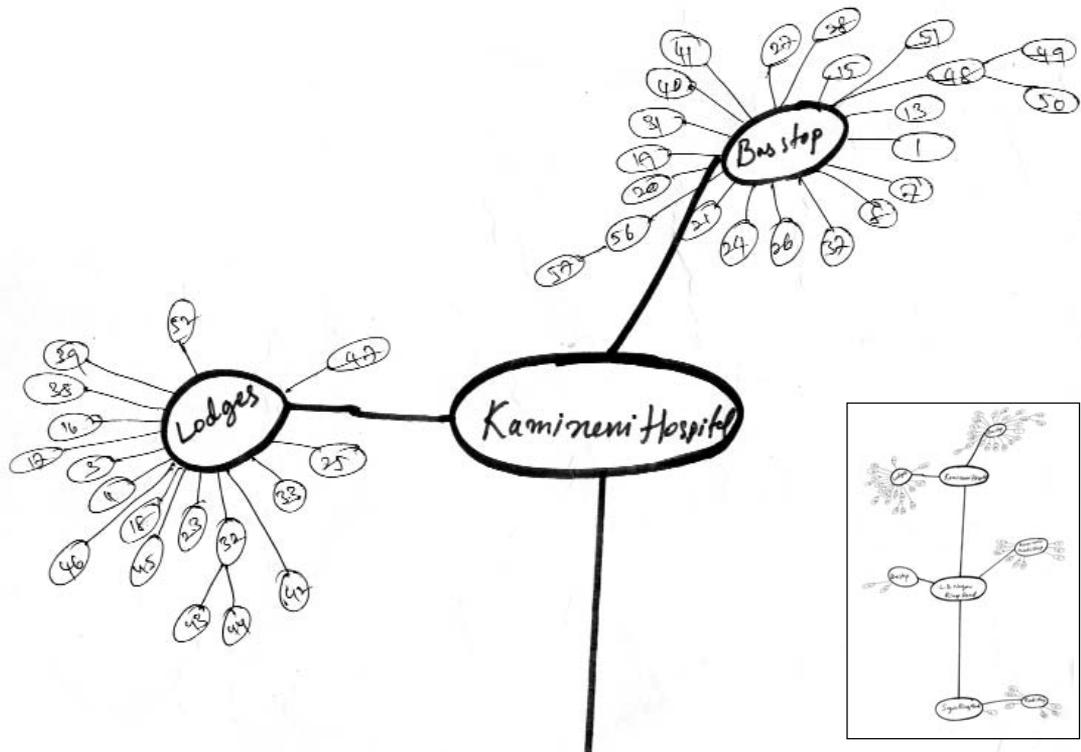
Source: Alliance for AIDS Action Project, International HIV/AIDS Alliance

In the second stage, peers create maps of their social networks within their beat. These non-topographical maps list the names of their friends and acquaintances in the high-risk communities, and use symbols or colors to mark their typologies and baseline risk characteristics (e.g., number of clients per month), and the connections between them. Social network maps help ensure that coverage of high-risk individuals at each hotspot is as complete as possible and avoids overlap in outreach between peers' social networks.[14]

Examined together, the maps provide visual and symbolic representations of the total high-risk population across several locations. Used as a reference during weekly outreach planning, they help define outreach during the program's start-up phase and refine it during the expanded roll-out phase. During this second phase, local-level mapping is repeated on a regular basis (every six months or more frequently, depending on the mobility of high-risk groups at the site) in order to accurately reprioritize work according to changes in the field. Beyond the maps' usefulness in planning work, the process of mapping itself builds strong community involvement in the program.

Micro-planning

Micro-planning tools allow peers to increase the quality of their outreach while simultaneously increasing the number of high-risk individuals with whom they are in regular contact. Peers use these low-literacy management

tools to collect data, analyze risk, and directly plan outreach based on the individual needs and vulnerabilities of the high-risk individuals they are serving, and identify gaps in outreach. Specifically, these tools:

• Give peers an in-depth understanding of the changing risk and vulnerability factors for each high-risk individual they serve

• Enable peers and their supervisors to track each high-risk individual's progress over a period and to prioritize and monitor outreach

• Allow peers to manage and plan their own work

• Improve program service delivery levels

• Provide ways for peers to participate in the NGO's program planning, including determining priorities and devising improvements

Each of Avahan's lead implementing partners was responsible for designing its own micro-planning tools with active input from the peer group. Some partners designed standardized tools for use by all their implementing NGOs, while others gave individual NGOs the flexibility to design tools to suit the particular context of their high-risk groups and the peers serving them. While the designs vary, and some partners have designed multiple tools customized to their particular contexts for outreach and monitoring, there are two tracking forms common to all:

1. **A daily tracking form** (sometimes a card or flipbook) in which the peer records details of daily or weekly interactions with each assigned group member. The tool in Figure 6 is designed to be used by low-literate or illiterate peers who can complete the forms with symbols and stickers rather than in writing.

Figure 6: Daily Tracking Form
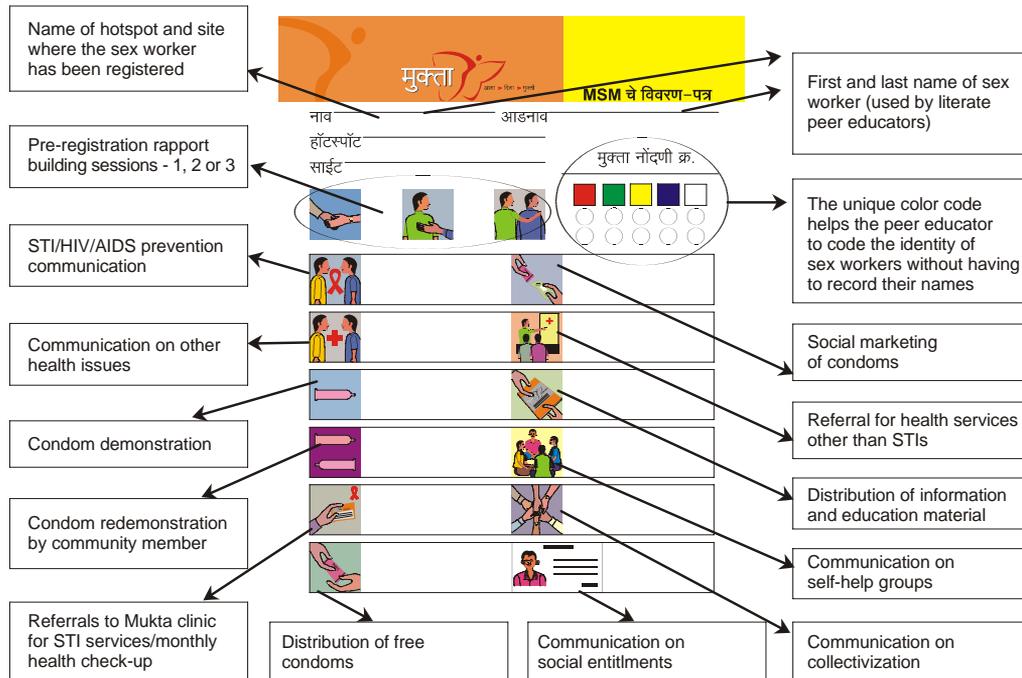
Source: Mukta Project, Pathfinder International

2. **A monthly tracking form** (sometimes known as a micro-planning calendar) that aggregates data from the peer's interactions with each high-risk individual over a period of a month. The peer transfers information from the daily tracking form to the monthly tracking form at least once a week.

Management of peer led outreach at scale

Peer selection

Peer selection has developed through the roll-out of the Avahan program. In the start-up phase, peers were identified by each NGO from among high-risk individuals who participated in the initial mapping of hotspots. In the expanded roll-out phase, additional peers were selected from the peers' caseloads to be representative of the different geographic areas and typologies of high-risk groups covered by the program. In the refining scope phase, as peer leadership matures and communities become involved in decision-making, peer selection committees are being established at the NGO level with representation from members of the high-risk group, peers, and NGO staff.

In order to be effective, peers must have a commitment to HIV prevention, knowledge of the site they will cover, and be trusted by the high-risk individuals in that location. They must also be of a similar age and typology as the individuals to whom they are providing outreach.[15] Peers should ideally demonstrate the potential for leadership, so that over time they can develop into opinion leaders who will advocate effectively for their own health and rights, and for those of their fellow community members.

Peers work four or five hours per day, six days a week, and attend weekly review meetings to share and evaluate their work and plan the next week's activities. They receive a monthly honorarium as compensation for potential loss of income while working for the program; the level of the honorarium is generally based on the rates set for peers by state governments and tends to be in a range comparable to US$20-$30 per month.

Peer training

Training for peers has evolved over the course of the program to serve their changing role in outreach, providing peers with enhanced critical thinking and leadership skills over time. In the start-up phase, an initial training of peers, spread over five days, was organized for each NGO by the lead implementing partner. This was reinforced through on-the-job mentoring over an 18-month period. The training covered topics such as:

*   Goals and objectives of HIV prevention programs and peer outreach

*   Roles and responsibilities of peers, and code of conduct

*   Information and counseling about HIV prevention

*   Condom distribution and promotion

- Referrals to other available services such as STI clinics and HIV counseling and testing centers

- Interpersonal and group communication skills

As the program has developed, experienced peers have been used for the training of new peers, and cross-training also takes place through visits to the sites of programs run by other implementing NGOs or lead implementing partners.

In the expanded roll-out phase, the bulk of peer training is typically carried out by the local implementing NGOs. At the local level, leading peers are identified to assist the NGO in training new peers, and lead implementing partners provide master trainers when necessary to ensure quality and a participatory approach. In this phase, training is an ongoing process that covers an increasing range of areas required for effective outreach, such as:

- Use of mapping and micro-planning tools to identify and solve problems in outreach

- Negotiation skills with community members, outside stakeholders, and power brokers

- Promoting the self-esteem of high-risk individuals

- Leadership

In the refinement of scope phase, training is focused on skills for crisis management, advocacy, and community leadership. Again, state-level master trainers support the work of NGO staff and peers in training. Areas covered include:

- Building a sense of community and support in high-risk groups (introduction to the concepts of community mobilization and the development of community-based organizations)

- Peers' role in promoting "sustainability" of the program: peer career path opportunities (see "Peer Progression" section below)

Peer progression

Peer progression is an incentive system designed to promote experienced peers, dismiss ineffective ones, and generate greater community ownership of the program. Skilled peers have the opportunity to progress to new levels of responsibility, oversight, and remuneration in the program. This can occur within the implementing NGO, as peers become staff outreach workers, field officers, or project coordinators; or within the structure of community committees (e.g., management, advisory, and advocacy committees) that provide oversight and leadership to the program. Decisions about promotion (or dismissal) of peers are made by a committee of program staff, peers, and high-risk community members. This system recognizes that high-risk communities have a significant role in determining the effectiveness of outreach. While peers have begun to be promoted to some of the positions mentioned above, there is still scope for Avahan to learn more about how to manage peer progression effectively.

Peers may also leave their positions to seek out other leadership opportunities, such as becoming resource persons for training purposes, networking with other high-risk groups beyond their locality, and working with other non-HIV programs. Fostering these opportunities for leadership beyond the program depends upon the more comprehensive approach of community mobilization that Avahan supports.

Progress to date

After three years of implementing peer led outreach with micro-planning, Avahan has achieved significant scale and intensity of service delivery. As of December 2008, a total of 227,000 high-risk individuals were being contacted on a monthly basis, representing 76 percent of the total estimated denominator (Figure 7). Avahan defines saturation coverage as 80 percent of this denominator.[16]

Figure 7: Outreach by Program

Percentage of total estimated denominator contacted through program outreach during month
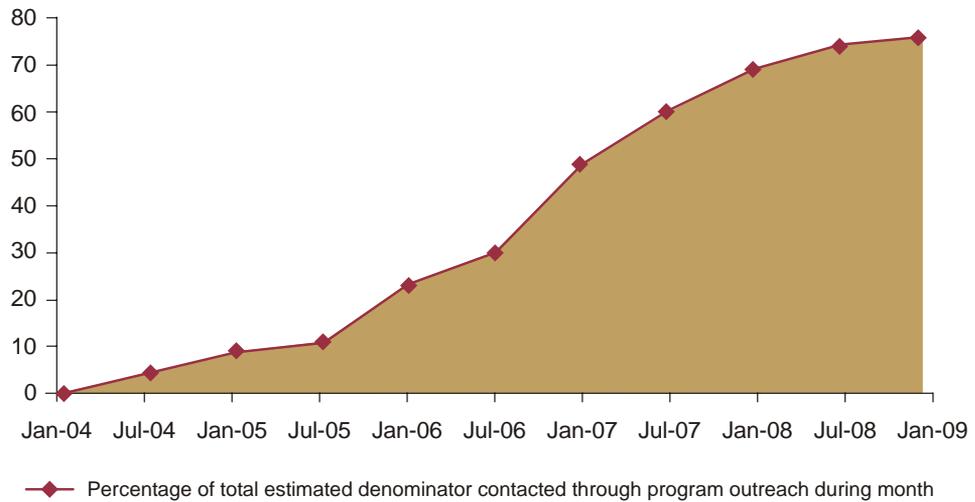
The intensity of service delivery is reflected in the fact that outreach contacts and clinic attendance both increased more than three times in as many years (2006-2008), and the number of free condoms distributed monthly also more than tripled during this period. Avahan achieved this significant expansion in service provision with a relatively small increase in human resources: the number of peers less than doubled between January 2006 and December 2008 (Figure 8).

Figure 8: Peer Outreach Workers


Number of peer outreach workers
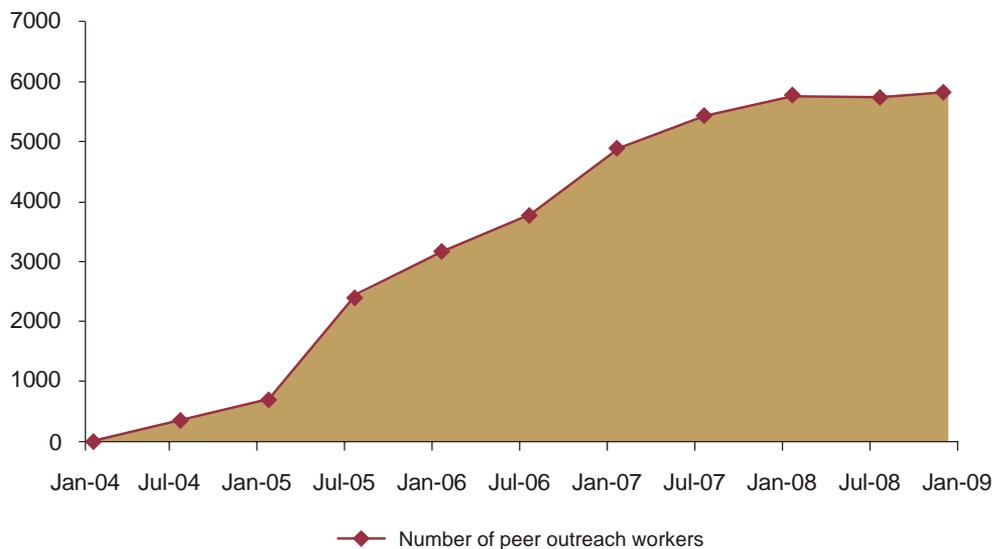
By building peers' skills and introducing micro-planning in 2006, Avahan was able to transfer most outreach work from NGO staff to peers. By the end of 2006, when micro-planning had been rolled out across the Avahan program, peers had taken over the vast majority of the program's monthly contacts with high-risk individuals (Figure 9).

Figure 9: Outreach by Peers

Peers' share of high-risk individuals contacted through outreach
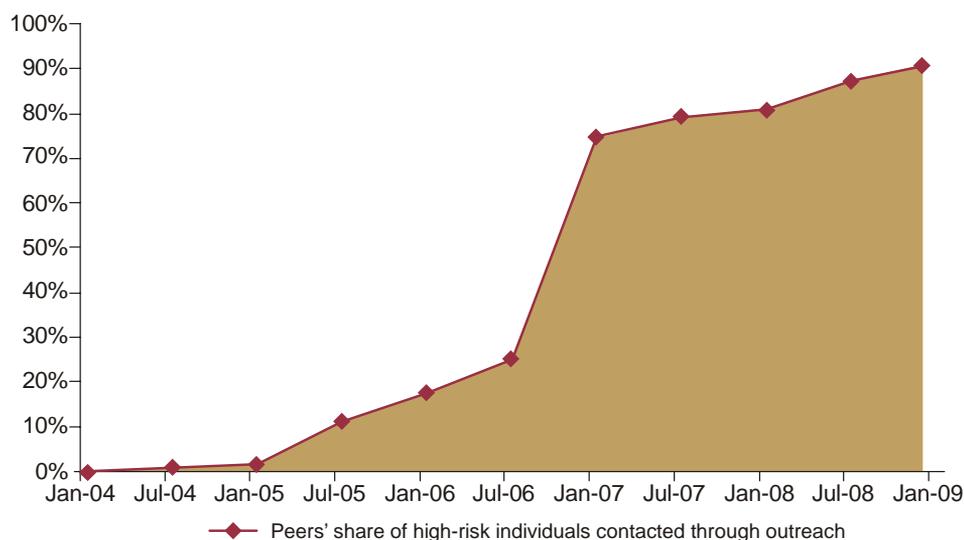
As management in Avahan focused on a gap between the number of condoms distributed and the number of sex acts that should be covered, peers' efforts were focused on condom distribution and uptake (Figure 10). Peers increased their average distribution from 160 condoms per peer in January 2006, to 1,193 per peer in December 2008. Peers now deliver more than 6.9 million condoms per month; together with condoms distributed through other forms of outreach, distribution covers the estimated monthly total number of sex acts for the denominator of high-risk individuals.

Figure 10: Condom Distribution by Peers

Average number of condoms distributed per peer
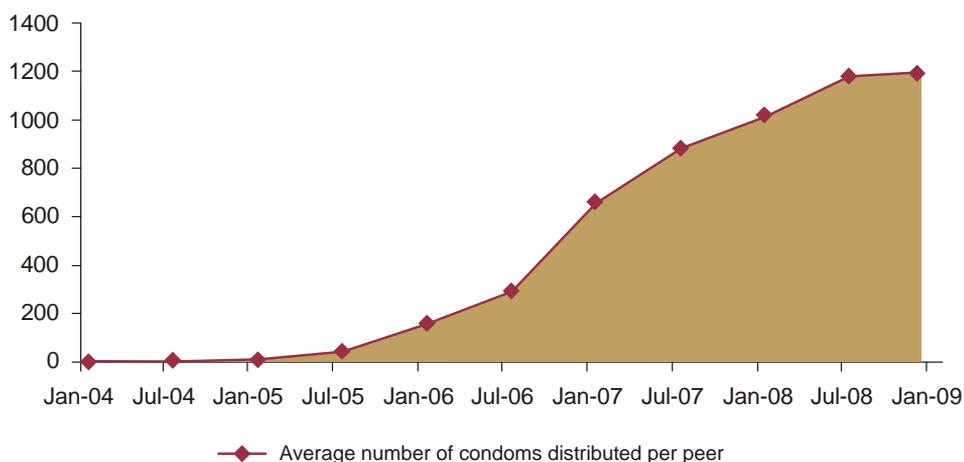
Similarly, uptake of clinical services increased at a faster rate than the increase in peers, and progressed towards the Avahan target of 33 percent of the total estimated denominator, although this target is yet to be attained (Figure 11). (The target of quarterly clinic attendance by each high-risk individual means that in any given month, 33 percent of the total estimated denominator should attend a clinic.)

Figure 11: Clinic Attendance

Percentage of total estimated denominator attending clinic
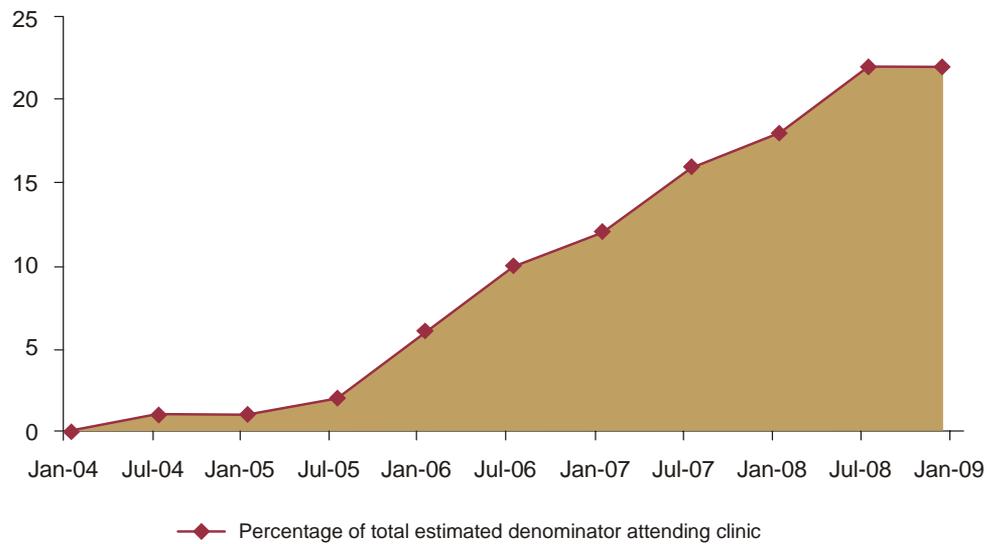
In the absence of controls it is not possible to isolate all the relevant factors in this growth in the scale and intensity of outreach. However, it does seem intuitive to attribute the growth at least in part to the introduction of micro-planning starting in January 2006, which appears to have increased the efficiency and effectiveness of outreach.

LESSONS LEARNED

Mid-way through its ten-year commitment, Avahan has assimilated a number of lessons from its experience implementing peer led outreach with female sex workers, high-risk men who have sex with men, and transgenders in the four southern Indian states of Andhra Pradesh, Karnataka, Maharashtra, and Tamil Nadu. These lessons vary among partners, programming contexts, and the typology of high-risk individuals, but several are common across the program, informed by both program monitoring data and qualitative learning from the field.

Scale and intensity of outreach improve when peers do micro-planning.

Empowering peers and working with NGOs to be more supportive in performing basic outreach duties were the first steps in gaining peer ownership of outreach. This was enhanced considerably with micro-planning, which gave peers tools to understand their entire caseload at a glance. This allowed them to prioritize outreach and review their progress. Their problem solving in turn led to the addition of new data points to those already tracked by peers, including indicators on violence, which is now understood to be linked to condom use and clinic attendance.[17] Condom distribution and clinic attendance rose significantly after peer led micro-planning was introduced across Avahan in 2006.

Assessing denominators on a regular basis is critical to determining outreach targets and evaluating coverage.

Avahan began with the intention of saturating the coverage of high-risk groups in the highest-prevalence areas of India not covered by other HIV prevention programs. This focus on coverage is driven down through the program. In the start-up phase, initial size estimation helped Avahan determine relevant resource allocation and define the focus for the intervention. This information, correlated with program data from micro-planning, can help inform gaps in coverage and ensure accurate need-based resource allocation. Avahan's experience has been that updating of size estimates through mapping is critical to ensuring that all high-risk individuals in a given area are reached. Although Avahan did not take a standardized approach to mapping, it recommends such an approach for new programs.

Investing in building peers' skills is critical to the program's effectiveness.

When Avahan began, peers were seen simply as communicators who would meet with their colleagues to do condom demonstrations and share informational materials on condom use. As the role of the peer evolved to become that of a manager of outreach, it became apparent that annual classroom-based training was insufficient to develop peers' skills. There had to be a constant effort on the part of staff outreach workers to develop each peer's skills in managing her caseload. Contests for best peer were introduced to foster healthy competition, recognition, and positive group dynamics among peers. Formal and informal sessions are carried out on everything from micro-planning to negotiating with power brokers.

The peer led outreach approach must be built over time in order to attain greater leadership from peers.

Avahan took a pragmatic approach to peer led outreach, developing the role of the peer gradually until today it is almost unrecognizable from its form in the first year of the program. Initially, Avahan concentrated on recruitment and the basic training of peers to distribute condoms and help determine where services should go. A huge shift

occurred when micro-planning was introduced throughout the program in 2006. Each peer started to manage her own caseload of colleagues, dealing with problems and prioritizing work with the help of visual monitoring forms. As roles and expectations changed, new relationships between peers and NGO staff had to be managed through team building and participatory processes. Today this approach to outreach appears to be more effective and is more empowering for high-risk individuals.

Peer led interventions pave the way for more sustainable community leadership.

The program started to change after the introduction of micro-planning and as Avahan invested in more interpersonal and participatory approaches to HIV prevention. Peers started to advocate for changes in services, they began forming community groups, and self-help initiatives began to develop. Peers are now regarded as the leaders of high-risk community efforts. As a consequence of working closely with peers, Avahan has begun to develop a group of leaders who, given the right opportunities over the next five years, may lead other work on behalf of high-risk groups in India.

THE FUTURE

HIV and community development programs have long incorporated solutions for engaging communities in outreach. Avahan's experience offers lessons for the rapid scale-up of high-quality peer led outreach through peer management of data and outreach. Notwithstanding its scale, Avahan has attempted to enhance the participatory nature of HIV prevention led by high-risk groups in India.

In the next phase, Avahan will continue to concentrate on peer led outreach in ways that aim to strengthen the leadership of high-risk individuals in demanding access to services and holding systems accountable for effective HIV prevention services. Avahan's partners must continue to address barriers to coverage and uptake, maximize the quality of clinical services, and develop better referral systems to allow high-risk individuals access to comprehensive health services.

Avahan's long-term challenge—that of transferring the responsibility for program interventions to their natural owners in India—still lies ahead. Avahan will work closely with national- and state-level HIV programs under the National AIDS Control Organization to align operations and transfer managerial and technical best practices as appropriate.

Ensuring that peer led and peer managed HIV prevention outreach continues to develop in India is important not only for the individuals who will benefit from the work, but also as an opportunity to inform methods for scaling up peer led outreach globally.

APPENDIX I

FURTHER CONSIDERATIONS FOR PEER LED OUTREACH TO HIGH-RISK MEN WHO HAVE SEX WITH MEN

Across Avahan, peer led outreach to high-risk men who have sex with men and transgenders is similar to outreach for female sex workers. However, some characteristics of the population necessitate different approaches.

Avahan covers about 81,000 high-risk men who have sex with men. These include sex workers and men who have multiple partners for pleasure, and these subgroups do not necessarily mix with one another. Because of the fundamental social divisions within this community in India, success as a peer outreach worker is largely predicated on identity. Peers must be recruited from the subgroups so that they have credibility with and understand the particular risk factors of the group they are serving.

The stigmatization suffered by high-risk men who have sex with men and transgenders, and the secrecy in which many of them feel compelled to live, can make outreach difficult. For example, married high-risk men who have sex with men are often reluctant to access services because attending a clinic or visiting a drop-in center may imply an identity that they are unwilling to acknowledge. Other high-risk men who have sex with men may be less interested in specific HIV awareness-raising activities than in social events that promote a feeling of community. In these cases, Avahan has found it effective to organize social events such as fashion shows at drop-in centers and to incorporate HIV education into the activity.

As in the rest of Asia, it has taken longer for India to establish HIV prevention outreach to high-risk men who have sex with men—an issue that may be traced to a significant deficit of data on this population and no existing programs to learn from. Rights groups have suggested that this was linked to deep-rooted stigma and discrimination and the illegality of homosexual sex, factors which push the population underground. Implementing NGOs have demonstrated a nascent ability to engage with high-risk men who have sex with men, but they have needed assistance from Avahan's lead implementing partners in understanding issues of sexuality and gender rights as they pertain to this group (e.g., education on legal discrimination, or to address judgmental attitudes towards men who engage in high-risk sex for pleasure rather than out of economic necessity). Alongside this sensitization effort, many NGOs have overcome the problem of stigma in their own organizations by recruiting high-risk men who have sex with men to work as staff (in contrast to female sex worker outreach programs, where supervisors often are not community members).

A final factor that differentiates outreach with high-risk men who have sex with men in the Indian context is that this community is generally literate and better educated than women or female sex workers, which allows these men to more readily assume supervisory positions and use different outreach tools (i.e., ones not designed for low levels of literacy).

APPENDIX II

AVAHAN PARTNERS

Lead Implementing Partners

Alliance for AIDS Action Project, International HIV/AIDS Alliance, Andhra Pradesh

The International HIV/AIDS Alliance is one of Avahan's two lead implementing partner's working in Andhra Pradesh state. Its Alliance for AIDS Action project spans 14 districts of the state, with 35 local NGOs and 1,500 peers who oversee programs for 47,000 female sex workers and 22,000 high-risk men who have sex with men and transgenders. They manage 132 drop-in centers across the 49 towns where they operate.

http://www.aidsalliance.org/sw7224.asp

Swagati and Nestam Projects, Hindustan Latex Family Planning Promotion Trust, Andhra Pradesh

The other Avahan lead implementing partner in Andhra Pradesh, the Hindustan Latex Family Planning Promotion Trust (HLFPPT), operates the Swagati project with 21,000 female sex workers and the Nestam project with 10,000 high-risk men who have sex with men and transgenders. Each project serves nine districts of Andhra Pradesh state, covering 57 towns, with one implementing NGO per district. These NGOs work with 900 peers (known locally as Community Guides), and 82 drop-in centers have been established.

http://www.hlfppt.org

Corridors and Project Sankalp, Karnataka Health Promotion Trust, Karnataka

The Corridors and Sankalp projects began in the last quarters of 2005 and 2003, respectively, and were implemented by the Karnataka Health Promotion Trust (KHPT), Avahan's lead implementing partner in the state of Karnataka through the University of Manitoba. The Corridors project covers six border districts of northwestern Karnataka and southern Maharashtra, while Sankalp covers 13 further districts of Karnataka. Across the KHPT program, 11 local NGOs and CBOs work through over 1,200 peers and outreach workers to serve 80,000 female sex workers and 19,000 high-risk men who have sex with men and transgenders in 16 districts of Karnataka and three of Maharashtra. Including the dense urban area of Bangalore, the two projects cover 167 towns, with 186 drop-in centers in operation.

http://www.khpt.org/projects.htm

Aastha Project, Family Health International, Maharashtra

The Aastha Project was initiated in 2004 by Family Health International (FHI), Avahan's lead implementing partner in Mumbai, Mumbai Suburban, and Thane districts of Maharashtra state. FHI works with 17 local NGOs that have a network of more than 500 peers who reach 27,000 female sex workers and 3,000 high-risk men who have sex with men and transgenders. FHI operates 27 drop-in centers.

http://www.fhi.org/en/CountryProfiles/India/res_AasthaProject.htm

Mukta Project, Pathfinder International, Maharashtra

Pathfinder International is Avahan's lead implementing partner in 10 districts of Maharashtra state, including the city of Pune. Project Mukta works through 15 local NGOs and 300 peers and has established 41 drop-in centers

in 44 towns. Mukta currently serves 10,000 female sex workers and 4,000 high-risk men who have sex with men and transgenders.

http://www.pathfind.org/site/PageServer?pagename=Programs_India_Projects_Mukta

Project ORCHID, Emmanuel Hospital Association, Manipur and Nagaland

Project ORCHID is implemented by Emmanuel Hospital Association (EHA), Avahan's lead implementing partner in the northeastern states of Manipur and Nagaland. Project ORCHID covers 32 towns in 13 districts of the two states. Working through 30 NGOs, 426 peers serve 18,000 injecting drug users, 4,000 female sex workers and 1,000 high-risk men who have sex with men.

http://www.eha-health.org/projectorchid

Tamil Nadu AIDS Initiative, Voluntary Health Services, Tamil Nadu

The Tamil Nadu AIDS Initiative (TAI) is implemented by Voluntary Health Services (VHS), Avahan's lead implementing partner in 12 districts of Tamil Nadu state since 2004. Today TAI works through 25 NGOs to serve 34,000 female sex workers and 14,000 high-risk men who have sex with men and transgenders. The program's 1,300 peers manage activities at 42 drop-in centers across 289 towns.

http://www.taivhs.org

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.

Men at risk

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

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

Cross-cutting, advocacy, and capacity building 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 (now Futures Group International) 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. It has also worked to build the organizational capacity of the Indian Network of People Living with HIV/AIDS (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 lead implementing partners for 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 of data collection across the Avahan 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).

Laval University 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.

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 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.

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GLOSSARY

Agency is a term adopted in rights-based approaches to development 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 both with persons who are frequently infected with and transmit STIs, and also with the general population.

Community-based organizations (CBOs) in the Avahan context are locally formed organizations of high-risk individuals which seek to provide support, capacity building, and other resources to their members that will allow them to continue to access and demand services and to hold systems accountable for effective HIV prevention services. They may also choose to carry out high-risk group advocacy and self-help initiatives. Membership often entails a nominal annual fee, and attendance at regular meetings is expected. Leadership positions within a CBO are filled through election by the membership.

Community mobilization is the process of uniting members of a community to utilize their direct knowledge of vulnerability to HIV 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 are in place to ensure that the program's interests do not supersede those of the community, and that adequate representation of the community is established.

Drop-in centers were established early on in the Avahan initiative to provide a safe space for high-risk individuals to come together. The centers are often basically equipped but clean rooms that accommodate 50-150 people, with cushions and mattresses on the floor, bathing facilities, and a mirror. They are often housed next door to the program-managed medical clinic. With no similar refuge available, drop-in centers have become the hub of community life, each serving from 5 to 11 contact points or hotspots where high-risk groups solicit and practice sex.

An enabling environment in the context of Avahan's work is one in which social inequity and violence, harassment, abuse, and discrimination against people with HIV and high-risk groups are reduced, and the self-confidence of high-risk individuals and their collective identity are strengthened, so that they can advocate for, and take ownership of, effective HIV prevention interventions.

High-risk groups are female sex workers, high-risk men who have sex with men, transgenders, and injecting drug users.

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

Men at risk refers to men who engage in high-risk sexual activities, including commercial sex and sex with non-regular partners. In the Avahan initiative 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 methodology used by peers in their outreach for recording and analyzing risk and vulnerability during outreach. Peers use a visual tool to collect data which they use to directly plan outreach based on the individual needs of the population they are serving.

Participatory development is a broad term encompassing theories and methods of implementing development programs with the people at the grassroots who are the intended beneficiaries of those programs. Mapping is a participatory tool that has been used with a variety of groups, ranging from farmers in Africa (to improve agricultural systems) to sex workers in India (to understand where HIV programs can interface with daily life). Avahan has adopted these mapping methodologies as part of its approach to rapidly scaling outreach across diverse geographic areas.

Peer outreach workers (peers) 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 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 35-85 members of their community to influence attitudes and provide support to change risky behaviors.

Staff outreach workers (outreach workers) are experienced peers or professionally trained social workers employed by an implementing NGO to supervise between five and seven peers each. An NGO typically has 5-10 outreach workers on staff.

Typology of sex workers refers to the different locations where they solicit sex, such as on the street, in a brothel, at home, in a hostel, or in some other location.

Vulnerability refers to the circumstances which impact a high-risk individual's or group's control over acquiring HIV. Vulnerability for a sex worker or a man who has sex with men is linked to abuse, violence, and social stigma, and impacts her/his agency in sexual encounters.

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- This is a family foundation driven by the interests and passions of the Gates family.

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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 elements. The first is to build and operate a scaled HIV prevention program, with saturated coverage for populations 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 is to encourage the replication of best practices by fostering and disseminating lessons learned from the program.

Now in its sixth year of operation, Avahan reaches more than 220,000 female sex workers, 80,000 men who have sex with men and transgenders, 18,000 injecting drug users, and about 5 million men at risk.

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