

THE POWER TO TACKLE VIOLENCE: Avahan's Experience with Community Led Crisis Response in India

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THE POWER TO TACKLE VIOLENCE:

Avahan's Experience with Community Led Crisis Response in India



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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 James Baer who assisted in the writing and production of this document.

Version 2, June 2009

Citation: The Power to Tackle Violence: Avahan's Experience with Community Led Crisis Response in India. New Delhi: Bill & Melinda Gates Foundation, 2009.

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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

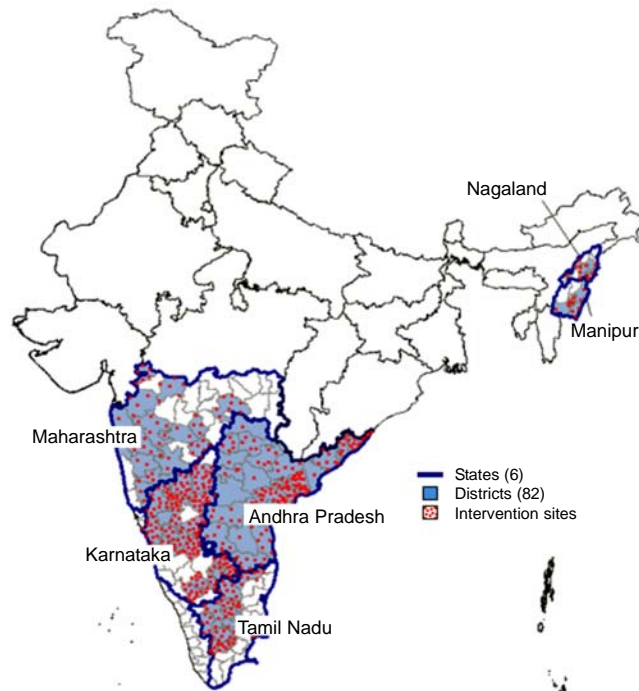


* Definitions of terms used in this publication can be found in the glossary.

** 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.

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.*

Figure I: Avahan Intervention Districts



Source: Avahan Routine Monitoring Data

An important element of Avahan's HIV prevention intervention has been the development of community led crisis response systems. These have been established across the program to address the problem of violence, harassment, abuse, and discrimination directed against members of high-risk groups.** A prompt and effective response to incidents of violence not only lessens the immediate physical danger in which a high-risk individual may find him- or herself, but can also reduce the vulnerability to high-risk behavior that may be exacerbated by violence. Crisis response systems are managed by high-risk individuals,⁵ and the process of developing these systems has helped to build their self-reliance and confidence in addressing the multiple factors that perpetuate their vulnerability to violence and to HIV.⁶

Avahan has developed crisis response systems across the six states where it works, and this publication describes Avahan's experience in the states of Andhra Pradesh, Karnataka, Maharashtra, and Tamil Nadu, including the progress and lessons learned to date. Avahan's approach to crisis response is best understood in the context of its overall interventions, including the implementation of programs at scale, and the use of data to improve programming.

* 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.

** In this publication, the term "violence" will be used to refer to physical violence and to abuse, harassment, and discrimination.



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.*
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, 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

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

** 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.

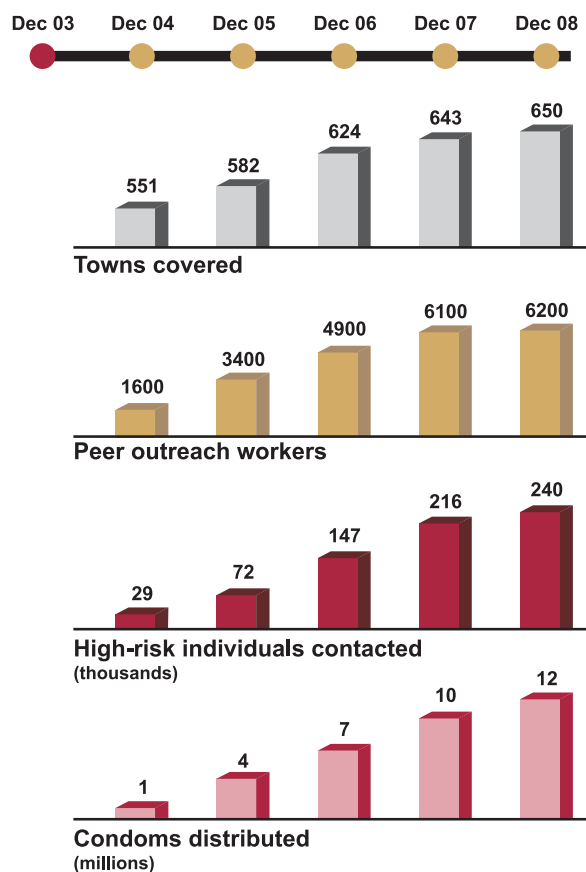
communities continue to evolve as their skills and capacity are built to take ownership of some components of the program (including in some cases crisis response systems) to ensure that HIV prevention programs and vulnerability reduction efforts are sustained beyond the life of the Avahan initiative.

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. Crisis response systems have been developed as a means to strengthen the enabling environment.

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

Figure 2: Roll-out of Footprint and Services

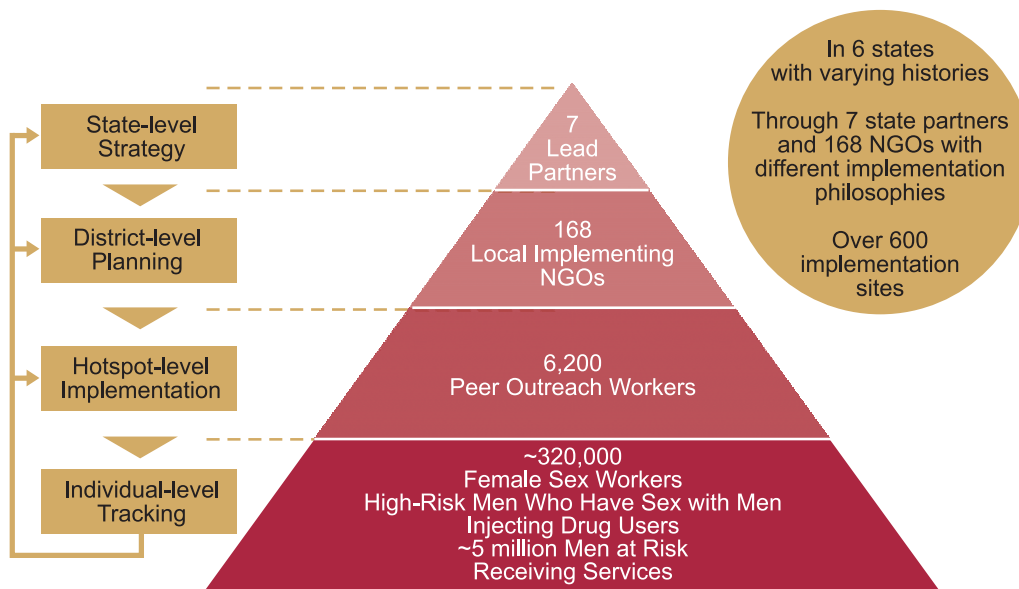


Source: Avahan Routine Monitoring Data, all six states

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.
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)

Figure 3: The Avahan Organization



Source: Avahan Routine Monitoring Data, all six states

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

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

VIOLENCE AND VULNERABILITY TO HIV

In India, violence against sex workers, men who have sex with men, and transgenders is widespread, and to an extent is condoned by society and within many institutions ranging from the police to the social welfare system. Sex work and homosexual behavior are widely viewed as immoral and deserving of punishment. Without a support system, sex workers, men who have sex with men, and transgenders are more likely to experience violence. The experience or threat of violence makes them more vulnerable to HIV (Figure 4). More generally, high-risk individuals who fear public exposure are harder to reach with HIV interventions.

The low social status and economic hardship faced by sex workers are compounded by the precarious legal status of sex work in India. The Immoral Traffic (Prevention) Act of 1986 does not criminalize having sex for money (it is the active solicitation of clients in public that is illegal), but even sex workers who are not soliciting are liable to arrest for creating a "public nuisance" under unrelated sections of the law.⁹ They have little legal recourse in the face of violence from pimps and madams, partners, and clients—or extortion or violence from the police themselves. The environment in which sex workers operate (on the street, in brothels, lodges, at train stations, or at home) also has implications for their vulnerability: the quantity and frequency of their clients, their freedom to go to a clinic or carry condoms, and their level of social isolation.¹⁰

In the case of men who have sex with men, the Indian Penal Code, which makes "carnal intercourse against the order of nature with any man, woman or animal" a crime punishable by imprisonment, is interpreted as including



Perpetrators of Violence, Abuse, Harassment, and Discrimination against Sex Workers, Men Who Have Sex with Men, and Transgenders

- Clients of sex workers
- Pimps, brokers, and madams
- Police
- Gang members and hooligans
- Neighbors and other members of the public
- Intimate partners or husbands
- Family members
- Health care workers, school and government officials

Common Forms of Violence Experienced by Members of High-risk Groups

- Verbal abuse
- Emotional abuse
- Physical abuse
- Unpaid sex (with sex workers)
- Forced sex
- Extortion
- Wrongful arrest, denial of legal due process
- Ostracism
- Denial of medical, educational, and governmental services and benefits

For case studies of violence and crisis response by Avahan partners, see Appendix I.

anal intercourse and is used to criminalize sex between men.* This increases the vulnerability of men who have sex with men and transgenders to violence perpetrated by the police, community members, and their own families.

From the beginning of the Avahan initiative in 2004, high-risk groups reported violence as a major concern, and local implementing NGOs saw widespread vulnerability to violence as a major impediment to effective outreach. For example, peer outreach workers were sometimes harassed by the police or arrested just for carrying condoms, and this prevented them from doing their jobs. Some female sex workers also experienced violence when they asked clients and partners to use condoms during sex.

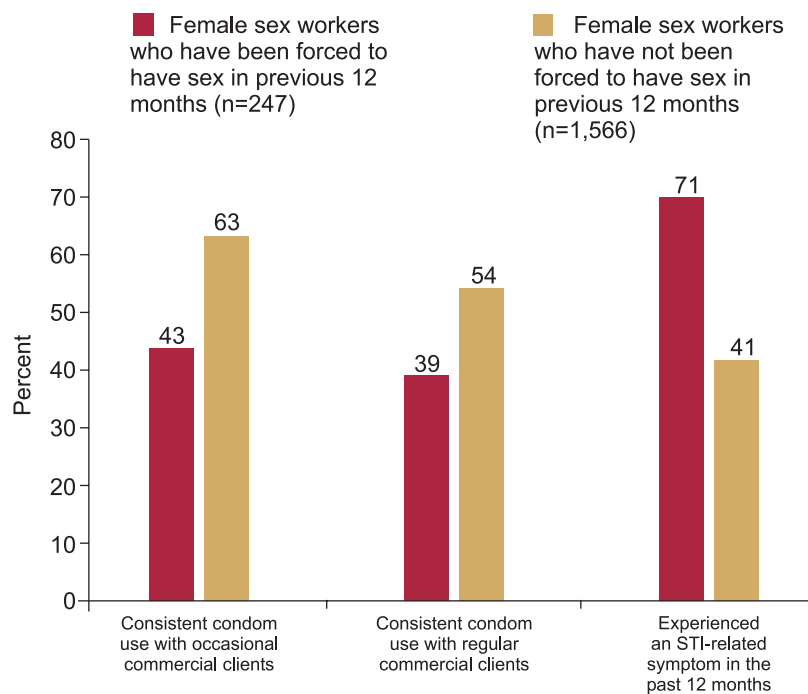
In the context of HIV prevention, violence thus has serious consequences for high-risk individuals, including those who provide outreach. It quickly became apparent to Avahan that measures to address violence needed to be part of its intervention package. Avahan studies conducted in two states in 2006 showed a link between violence and HIV risk. A survey of 661 female and 259 male sex workers in Tamil Nadu found that 52 percent of the female sex

* This law, known as Section 377, was introduced in the 19th century when India was under British rule and has not been repealed since Independence, although it is currently being challenged in the courts.

workers and 63 percent of the male sex workers reported facing emotional, physical, or social violence during the previous three months.¹¹ A survey of 1,800 female sex workers in Karnataka found that almost one in six had been forced to have sex in the previous 12 months.¹² Moreover, these sex workers reported significantly lower rates of consistent condom use with their clients and significantly higher STI-related symptoms than those who had not been forced to have sex during the same period (Figure 4).

HIV prevention interventions that not only provide information and services but also strengthen the skills, self-confidence, and collective agency of high-risk groups to address their vulnerability have been found to be more effective.¹³ Creating systems to respond to violence is a critical element in reducing vulnerability across the Avahan program.

Figure 4: Correlation between Violence and HIV Risk



Source: Karnataka Health Promotion Trust, *Integrated Biological and Behavioural Assessments among FSWs and MSM-T in Selected Districts of Karnataka, 2006*

BUILDING A COMMUNITY LED CRISIS RESPONSE SYSTEM

In the six states where it works, Avahan has developed community led crisis response systems to address incidents of violence, to act as a deterrent against future incidents, and to tackle longer-term issues of crisis faced by high-risk individuals. The systems were inspired by efforts already undertaken by grassroots NGOs and community groups before the Avahan initiative. Because violence was nearly universal and these approaches were seen to be working, similar systems were adopted and rolled out across the six states in 2006.

Today, almost all sites have established crisis response systems, and Avahan is working to increase their effectiveness by improving the support and training offered through networks of crisis response systems. The common types of crisis response activities that have evolved include:

- Responding to incidents of violence (whether by police, members of the public, or intimate partners or family) immediately as they occur
- Counseling for individuals who have been involved in a crisis to ensure they have adequate psychosocial, medical, and resource support in the immediate term
- Resolving family or community issues affecting those in high-risk groups



- Having a lawyer on call (either on retainer or pro bono) to support negotiations with authorities and to train communities on their legal rights
- Reporting and documenting incidents of violence and the actions of the crisis response system
- Advocacy, including networking with other rights groups and sensitizing police and other authorities
- Building relationships with the media to improve public perception about high-risk groups

Crisis response has become part of Avahan's broader advocacy process, through which high-risk individuals claim their rights as citizens.

Responding to Incidents of Crisis

Crisis response is immediate: a community member confronted with violence or some other type of crisis can summon rapid, on-the-spot support by calling the mobile phone number of another high-risk individual who is part of the crisis response system. A team of trained community members assesses the nature and urgency of the crisis, takes steps to address any immediate danger, and provides counseling, access to medical services, and other relevant support. The team also provides access to the services of a lawyer in cases of arrest. The system seeks to respond immediately, and members work to resolve the crisis over the longer term if necessary.

Components of a crisis response system

The components of crisis response systems vary according to the high-risk group involved, the types of crises experienced, and the level of NGO support required. However, most systems share common features, including:

1. Trained crisis response system members
2. Legal support system
3. Response protocol
4. Infrastructure (mobile phone network and advertising of the system)
5. Monitoring and documentation system
6. Links with other social service providers and rights groups

Crisis response system members

The core of the crisis response system is a team of trained high-risk individuals who are available on a 24-hour basis to respond rapidly to a reported crisis. The roles they perform include:

- Dispatcher (receiving calls and sending out teams to respond)
- Legal advocate (a trained member of the high-risk community, explaining the community members' rights and the law to perpetrators of violence, including police)
- Counselor (providing support to the victim of violence)
- Social worker (referring the victim to other social services and support)
- Data collector and reporter (chronicling incidents of violence)

Crisis response is always local, so persons must be available to respond to crises in the areas where high-risk individuals live and work. Often their efforts are coordinated from a central location to route callers to a local team

Resources for a Crisis Response System

People

- A team of six designated community members (they may rotate monthly) for every 500 high-risk individuals covered
- A supportive team of peer outreach workers
- Experienced and committed lawyer(s) on call 24 hours a day, 7 days a week
- Close alliances with well-known local activists and media people who are willing to advocate on behalf of high-risk populations when necessary

Materials

- Six mobile phones
- Business cards or fliers printed with crisis hotline numbers
- Crisis management reporting forms

Venue and Budget

- A drop-in center or other venue for meetings
- A small budget to pay for local transport costs

that will respond, as well as gather data and reports, and provide back-up support. In the Avahan program, crisis response teams were set up and initially managed by the local implementing NGO working with the high-risk community. Over time, management was assumed by the community.

Legal support system

The NGO overseeing the HIV program with the community typically sources lawyers on a pro bono basis or on retainer to work with the crisis response system, both to respond to crises and to train the teams and the groups they work with (including the police) in an understanding of the rights of high-risk individuals as citizens, and the laws pertaining to sex workers and men who have sex with men. The lawyers commit to being available when needed, and will go to a police station or a home as required to help resolve conflicts. This support is needed less as high-risk individuals are trained as legal advocates. The training of police by lawyers has given police a better understanding of the law and of the rights of marginalized groups.

Response protocol

A rapid response is central to the effectiveness of a crisis response system. Quick action helps to ensure a community member's safety when he or she is threatened with, or is the victim of, physical violence. It allows for rapid medical follow-up if necessary, and in cases where arrest or detention by police is the issue, a quick response ensures that neither harassment nor unlawful detainment occurs at the police station. The possibility of a suicide attempt by a traumatized victim also necessitates a quick response to ensure that life-saving medical attention and counseling is sought in time.

While some cases are resolved on the spot, many situations require follow-up. The commitment of the crisis response team and the depth of its support system are tested in such cases, which require not just an immediate response but strategy, coordination, and sometimes additional resources. For example, if a female sex worker is forced to fight a charge of lewd conduct in court, she may require advice or financial support to hire a lawyer. The

media may need to be managed on her behalf, and she may need to be protected from people associated with the defendant. She may also require financial support for transportation costs, and help to care for her children while she is in court. The crisis response team can help the individual understand the practical, social, and financial implications of pursuing a case, so that she can make an informed decision about whether she wishes to do so.

Equipping High-Risk Groups

The basic training for teams of female sex workers, men who have sex with men, and transgenders is the same, but with each group, emphasis is given to the specific kinds of crises faced by that high-risk group. Areas covered in training include:

- Listening and communication skills
- Advocacy skills with the social services sector, media, and local leaders
- Laws relevant to the high-risk group, their legal rights, negotiating with police, and taking cases to court
- Counseling of individuals under psychological duress and assessing risks of suicide or harm
- Use of reporting mechanisms for the crisis response system

Training also takes into account the learning needs of different high-risk groups. For example, men who have sex with men are typically more literate than their female sex worker counterparts in India, and they therefore require less support for reporting and data collection activities.¹⁴

To learn more about training for crisis management see *Community Led Crisis Response Systems: A Guide to Implementation*. New Delhi: Bill & Melinda Gates Foundation, 2009.

Figure 5: Crisis Hotline Card

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మా టోల్ ఫ్రీ నెంబర్ :
1800-425-2932

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Avahan's lead implementing partners use crisis response cards, like this example designed by the Hindustan Latex Family Planning Promotion Trust for interventions in Telugu-speaking areas of southern India. It offers a free hotline to call for help in cases of violence and harassment from police, families, and gang members, as well as for more information on HIV programs.

Infrastructure: mobile phone network and advertizing the system

A phone-based communication system is integral to crisis response. Some systems involve local phone numbers staffed by team members. Members of the crisis response team are equipped with a small number of mobile phones which they take on a rotating basis in order to respond to calls. Pay-as-you-go SIM cards make it easy to establish such networks quickly. In other states partners have established crisis response phone hotlines that serve all the districts covered by that program and mobilize a response from a team local to the caller. This system also facilitates centralization of data monitoring.

The availability of the crisis response system is advertised by word of mouth, through business cards and fliers with the phone number of the team (Figure 5), and among the high-risk group during community meetings and events at drop-in centers. High-risk individuals are encouraged to memorize the hotline number or to record it in their mobile phones.

Monitoring and documentation system

Collecting, analyzing, and documenting data are important parts of a crisis response program. Clearly recording all crisis incidents and responses allows crisis response teams and communities to analyze incidents, track the overall impact of the system, and refine their prevention and response efforts, but it also has implications beyond this. At the local level, accurate records may be required for legal cases to be filed or for complaints to be lodged against individuals or institutions. At the state and national level, Avahan partners use these data to guide decision-making and to make improvements to crisis response efforts when needed. More broadly still, these data can be used to publicize at state, national, and international levels the issue of violence against high-risk groups. This may lead towards fairer treatment of individuals, legal protection, and social service provision, and in the HIV/AIDS community may influence programs to adopt provisions for crisis response.

The information that is most critical for reporting purposes is:

- Time and location of crisis
- Nature of the crisis
- Identities of the victim or victims
- Number of perpetrators, and their identities, where known
- Who responded (response team, other members of high-risk community, NGO, etc.) and the response time
- Resolution and any follow-up
- Any legal aspects (e.g., charges filed by police, or by community member or NGO)

Strong documentation systems include not only basic record sheets but also copies of police reports and medical records, photographs of involved parties, and notes from crisis response team meetings. Documentation may also be created from verbal accounts, such as storytelling at drop-in centers.

Strengthening an enabling environment

Avahan's crisis management systems work with other structural interventions, such as advocacy with police, legal empowerment workshops, and media sensitization, to address the circumstances that make high-risk individuals vulnerable to HIV.

Violence, whether actual, threatened, or feared, compromises the effectiveness of HIV programs when peer outreach workers are prevented from doing outreach. Avahan has sought support from law enforcement officials at the state and district levels, so that peers can work without harassment. In many places it has proved effective

to get the highest-ranking police official to sign peers' ID cards and issue a letter supporting their HIV prevention work. The cards and letters are carried by peers so that police on the beat can see the endorsement. Avahan has provided support across the program to share best practices like this.

While there has been some success in gaining support from high-level law enforcement officers, ongoing efforts are required to educate and maintain relationships with local police. Officers frequently hold misconceptions about HIV and high-risk communities which lead them to discriminate. Education is a continual process, and even when headway is made, local officers are frequently reassigned and work must begin again as new officers arrive.

Some lawyers are keen to work for a crisis response system because of the prestige of high-profile voluntary work; but while they may make valuable contributions to the program, they often initially hold prejudices against high-risk groups. Trainings for lawyers address misconceptions about HIV and negative attitudes toward high-risk groups.

The media can influence attitudes about HIV, HIV-positive individuals, and high-risk groups. Avahan has worked with local, state, and national journalists to help them understand issues from the perspective of high-risk groups, speak with advocates from these groups, and generate more constructive coverage. At the same time, high-risk individuals have been trained to develop and implement strategies for effective advocacy with the media.

Management of crisis response systems at scale

Crisis response was not a part of the original Avahan program design. However, in the initial period of program implementation (2004-2005), Avahan staff learned through interaction with high-risk communities that violence and discrimination were barriers to the adoption of safe sex practices and were considered of greater immediate importance to address than HIV prevention. Violence was also preventing the program from reaching these communities with services.

Field visits during this period revealed that in some areas, approaches to addressing violence were already being implemented within the context of the program. These were local responses, either set up by NGOs experienced in rights-based programs, or somewhat ad hoc community efforts. Although they were on a small scale, it was clear that crisis response systems improved access to marginalized high-risk communities and built trust with them.

In 2006, Avahan implementing partners reviewed the best practices in crisis response and agreed to incorporate crisis response across the program. Teams from a number of states presented their models, and there were learning visits to sites where crisis response was being implemented. Lead implementing partners then worked with their NGOs to understand the nature of violence occurring locally and spurred community led efforts to initiate a response system. In 2007 indicators measuring the presence and quality of crisis responses were added to the Avahan management information system.



Today, the important role of community led crisis management in HIV prevention interventions is reflected in the fact that it has been added to the operational guidelines for targeted interventions of the Government of India's National AIDS Control Program III.

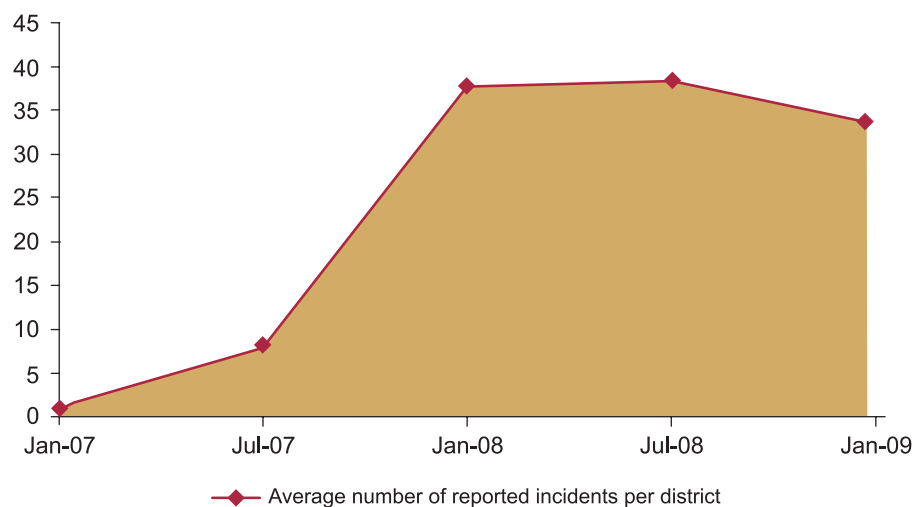
Progress to date

Crisis response systems were built rapidly across the Avahan program: within six months the number of crisis response teams had increased from a few dozen to several hundred; as of December 2008, there were 690 teams. Some crisis response systems are centralized at a district level, with the team members spread throughout the district; in other systems, teams are set up at the local level. This variety is captured in the case studies in Appendix I.

Response teams were established across the program by January 2007, but the number of reported incidents of violence showed a significant increase only in the second half of the year (Figure 6). Response teams have reported that the increase was due to growth in awareness of the system and the increasing willingness of high-risk individuals to report incidents of violence. Growing use of the system may also be linked to its perceived effectiveness: a rapid response to crisis was defined early on as a characteristic of the system (Figure 7). Avahan protocols established a response time of 24 hours or less, but some partners have in fact attained consistent response times of under one hour in dense urban areas.

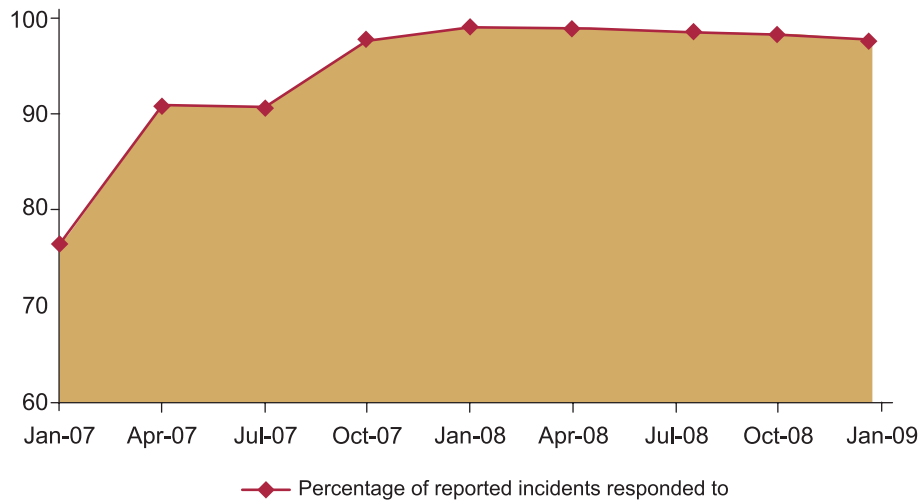
While the absolute numbers of reported incidents may appear low relative to the overall denominator of high-risk individuals, it should be borne in mind that the perceived threat of violence, and a hostile social environment, can inhibit health-seeking behaviors by high-risk individuals.¹⁵ Each incident of violence that is addressed and resolved can therefore have a positive effect upon the wider community. Furthermore, a single reported incident often involves more than one high-risk individual, so the actual number of high-risk individuals assisted by the program is higher than the simple number of cases.*

Figure 6: Crisis Reporting



* See Appendix I for case studies of crisis response that give examples of this.

Figure 7: Crisis Response



Partners also report that the confidence instilled in the high-risk community by the successful resolution of violent incidents—which is regularly publicized at community meetings, for example—increasingly leads community members to address incidents of violence themselves, often without recourse to the crisis response team. This may lead to underreporting of violence to the local implementing NGO.* Nevertheless, this empowerment of the community demonstrates the significant value which crisis response systems add as a component of HIV prevention.



* Other causes of underreporting of violence are outlined in the section "Lessons Learned" below.

LESSONS LEARNED

One of the major challenges in addressing violence in a scaled HIV program is to build a system that, while based on common principles, responds to the immediate local context in which violence occurs. Another challenge is to ensure that beyond addressing violence locally, crisis response will inform state and national policy making so that violence is reduced overall. Avahan has implemented crisis response across diverse geographic and cultural contexts with varied high-risk groups confronting a range of types of violence. Nevertheless, some challenges and lessons apply across the program, and these are outlined below.

Rapid scale-up of community led crisis response systems is possible in multiple contexts.

Avahan has been able to set up crisis response systems in almost all of the 69 districts of Andhra Pradesh, Karnataka, Maharashtra, and Tamil Nadu where it works, by using its "virtual organization," setting common minimum standards, and consistently working with communities as partners in making crisis response appropriate to the local context. Crisis response was initially rolled out at the local level across the program, and scale was then achieved by building a network among local response systems and establishing common reporting norms.

It is important to manage the high-risk community's expectations of the program.

Establishing a crisis response system may raise expectations that cannot always be met. High-risk, marginalized communities live in inherently unstable environments that make them vulnerable physically, emotionally, economically, and medically. The crisis response system may not have the resources to support individuals' long-term needs, and the social programs operated by other providers may be inadequate. It is also important to manage the expectations of the dedicated staff and community members who facilitate that support.

Reporting and data collection require sustained attention at all levels of the program.

While reporting, monitoring, and documentation have been a part of crisis response systems from the beginning, data collection remains the weakest component of Avahan's crisis response systems. Avahan has had to institute common operational definitions and a training curriculum for reporting, and reporting must be carefully monitored at all levels. Gathering and reporting accurate data on violence is complicated by a number of factors:

- When a crisis response system is established, it may take several months for community members to become familiar with it and to trust it enough to begin reporting violence.
- Reporting does not always cover all kinds of violence equally. For example, while it is acceptable within the sex worker community to report police violence, some female sex workers, as well as some men establishing their first intimate relationships with other men, are reluctant to report violence by their partners. It also appears that home-based sex workers do not use crisis response systems to the same extent as street- or brothel-based sex workers, but it is not yet clear whether this is because they experience lower levels of violence, or because they are too isolated to seek help.
- Reporting and data collection can be controversial, since they may be seen as distilling the victims' experiences to a series of numbers which does not reflect the emotional trauma experienced. Reporting may also be perceived by implementing NGOs as the burdensome imposition of donor requirements on the community's efforts. It is necessary to make an effective counter-argument that accurate reporting enables the advocacy that will ultimately lessen the violence faced by high-risk groups.

It may be useful to add questions to behavioral surveys to understand the nature and extent of violence. This may reveal more about the violence experienced by high-risk groups and the extent to which crisis response serves their needs.

Crisis response systems may provoke retaliatory violence.

A further challenge to the success of community led crisis response is the possibility of retaliatory violence locally. When power structures are challenged, they may respond by increasing the level of violence against the community. Similarly, the intimate partner of a newly empowered sex worker may respond to her assertiveness by committing more violence, but she may not report this, either because it is so commonplace or she is ashamed. Men who have sex with men have reported similar violence when they have entered same-sex relationships for the first time. It is difficult to isolate retaliatory violence as a factor in the increased reporting of violence that arises when crisis response systems are established, but qualitative evidence from the Avahan program suggests that such a correlation does exist, and research in other countries has made similar findings.¹⁶

Working effectively with complex police structures, systems, and individuals is critical to the program's success.

Although the primary challenge with the police might appear to be that of sensitizing beat constables and officers to respond to violence against high-risk individuals (and not to commit it themselves), advocacy and sensitization work must take place at all levels of the police hierarchy. Such work must be undertaken on a systematic and ongoing basis, because police are frequently rotated to different beats, and supportive officials may be transferred, which means that new relationships must be built.

It is important to foster links with non-HIV organizations for a broader structural approach to addressing violence.

Communities must be networked not only within the context of HIV interventions, but with other civil society groups that will strengthen their ability to fight and negotiate with strong structures and systems. Forming links with groups outside the public health sector provides crisis response systems with immediate back-up for advocacy, a source of mentoring support, and access to social, economic, and psychological resources critical to addressing the roots of crises. The groups that are most useful are rights organizations and social programs (government and public). Resources for programs to address such systemic issues are limited, and the continuity of care in India remains problematic, but basic access to such programs is sought as a minimum entitlement.

Community led crisis response is sustainable.

The crisis response system has strong potential to be self-managed by high-risk communities, for whom it is a felt need given the day-to-day reality of violence. They easily understand the benefit of a formal violence response mechanism and can use it to mobilize as a group. Similar systems have long been established within community-based organizations globally.¹⁷ One challenge is to develop the resources required to operate scaled systems that do not solely rely on community funding. Collecting data through the response system therefore becomes important to prove the extent of the problem and the need for funding.

THE FUTURE

Over the past two years, high-risk communities in the Avahan intervention have begun addressing violence systematically through crisis response systems. The future holds important challenges in terms of whether these systems can remain low-cost and locally led and can attract autonomous sources of funding, and whether lessons from these can be captured for HIV prevention efforts elsewhere.

The challenges inherent in running a crisis response system that is both truly effective and community led are significant, but by and large crisis response systems appear to be evolving in effective ways in the districts served by Avahan. The resources required to establish and maintain a crisis response system can in many cases be found in the community. However, at the local level Avahan must strengthen structural interventions. High-risk communities must be networked with groups that can contribute to their crisis response efforts and influence stakeholders, especially those with institutional power. Their access to social entitlements, including housing loans, ration cards, and voter registration cards must be fostered. Ultimately, communities need organizational development support to operate their own initiatives to address vulnerability.

The issue of violence and vulnerability to HIV has received considerable attention, but there is a shortage of data from large-scale HIV programs showing the associations between violence and HIV risk, and few large-scale HIV programs incorporate addressing violence as an integral component of service delivery. The findings on violence and the impact of crisis management systems on HIV risk are tentative but compelling, and Avahan is uniquely positioned to inform other large-scale programs in the coming years as more evidence is built.

APPENDIX I

CASE STUDIES OF AVAHAN COMMUNITY LED CRISIS RESPONSE SYSTEMS

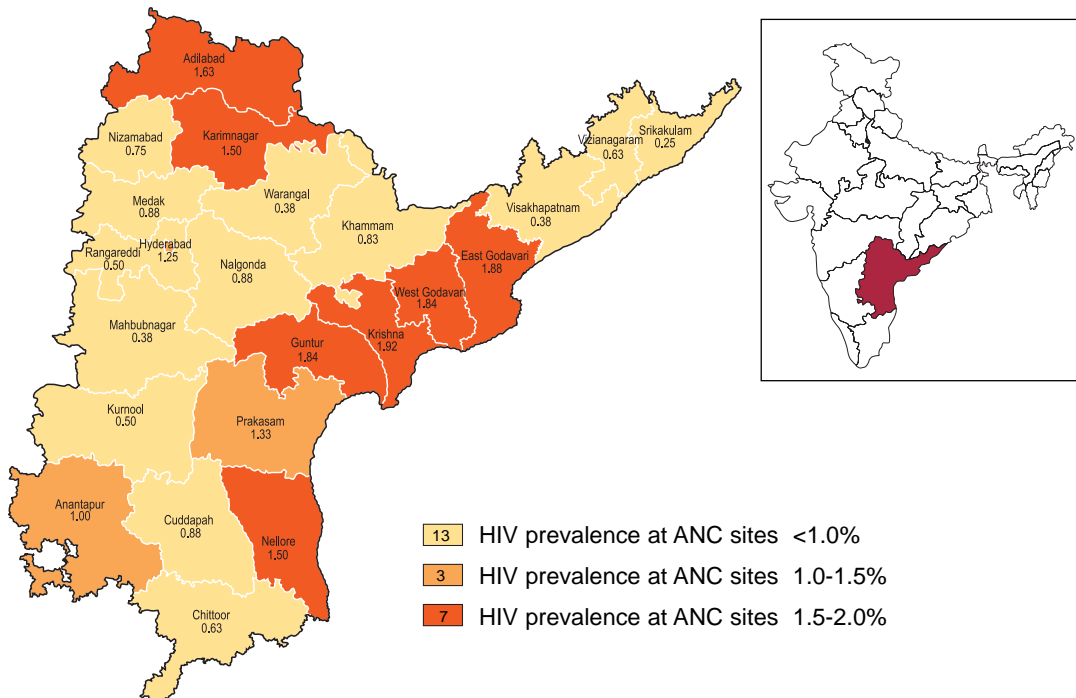
Sexual assault: Turning antagonists into supporters

In Andhra Pradesh state, the International HIV/AIDS Alliance serves more than 47,000 female sex workers and 22,000 high-risk men who have sex with men and transgenders, covering 14 districts of the state.

In a town in southern Andhra Pradesh state, a man took a male sex worker to an isolated outdoor area one evening for a commercial sex transaction. The exchange became non-consensual when a dozen more men, notified by the first, arrived and sexually assaulted the sex worker until the following morning. When they finished they beat him unconscious.

When members of the male sex worker community noticed that their colleague was missing, a search was initiated by two members of the crisis response team (known as a rapid action team) set up by the community-based organization (CBO) which is the Alliance's local implementing partner.

Figure 8: Andhra Pradesh: HIV Prevalence by District



Source: NACO Sentinel Surveillance Data: ANC sites (2007)

Rapid action teams have been established at each hotspot where incidents of violence have been reported and where there are at least 20 high-risk individuals. Each team has between five and seven members, plus a peer outreach worker or staff outreach worker. The team members are from the community and from the hotspot itself. Their names and the team phone number are given out to the community at the monthly CBO meetings. Two members are on duty with mobile phones at any given time to ensure 24-hour coverage.

At the time of this incident, the CBO had developed to the point where the community was resolving nearly all crisis incidents without involving the police; they found this approach preferable as it maintains the privacy of the people concerned. Team members approached two of the men and asked them about the incident. Initially the men denied involvement, but eventually they and the other members of the group admitted what they had done. They agreed to attend a meeting arranged by the team members, with about 30 other community members present. The goals of the CBO and the HIV prevention project were described to the men, and they were told that as part of the community of men who have sex with men they should treat other community members well. They apologized to the sex worker whom they had assaulted and reimbursed his medical expenses. As a result of the advocacy work, these men began attending the project clinic for regular check-ups and became involved in community mobilization and advocacy for the needs of male sex workers.

Supporting a victim of violence and creating an enabling environment for outreach work

Hindustan Latex Family Planning Promotion Trust (HLPPT) coordinates the Swagati Project, which serves 21,000 female sex workers in nine coastal districts of Andhra Pradesh state, and its Nestam Project reaches 10,000 men who have sex with men and transgenders across the same area.

In a village of West Godavari district, in the state of Andhra Pradesh, a female peer outreach worker working for Swagati was taking a new female sex worker to a drop-in center at a nearby village. The peer was confronted and severely beaten by a group of residents of the village who knew that she was a sex worker and had observed her on previous occasions talking to other women and accompanying them out of the village. Not knowing about the peer's work for Swagati, the village residents assumed she was exploiting these women.

The following morning the peer went to the drop-in center at the nearby village and reported the incident to the staff outreach worker. The outreach worker contacted members of the district-wide advocacy committee established by Swagati to respond to crisis incidents. Each advocacy committee has 10 members from the high-risk community. Three to five members of the committee form a rapid response team supported by staff of the local implementing partner and a human rights lawyer. Teams are generally mobilized in response to calls made to a statewide crisis hotline established by HLPPT.

In this case, within three hours of receiving the call from the outreach worker, the advocacy committee met with the peer at the drop-in center, together with some of the other peers and community members. The committee members documented the details of the incident and discussed how it made outreach work impossible in this village. They felt that reporting the incident to the police might negatively affect their day-to-day work as well as relationships with people in the village, and they decided to attempt to resolve the situation through dialogue with the village leaders. They would have recourse to the police and to Swagati's legal resource persons if this approach failed.

Swagati's local NGO partner contacted the village president and arranged a meeting with him and the other members of the village council at a central location in the village. Members of the advocacy committee, peers, and other sex workers explained the activities of Swagati to the councilors. They responded by expressing interest in the project, apologized for the violence against the peer, offered financial support for her medical treatment, and

agreed to work to ensure that such violence would not happen again. The community members encouraged the councilors to play a role in preventing HIV infection by opening a drop-in center in the village. After initial resistance, the council agreed to this plan, and a drop-in center was opened and inaugurated by the councilors.

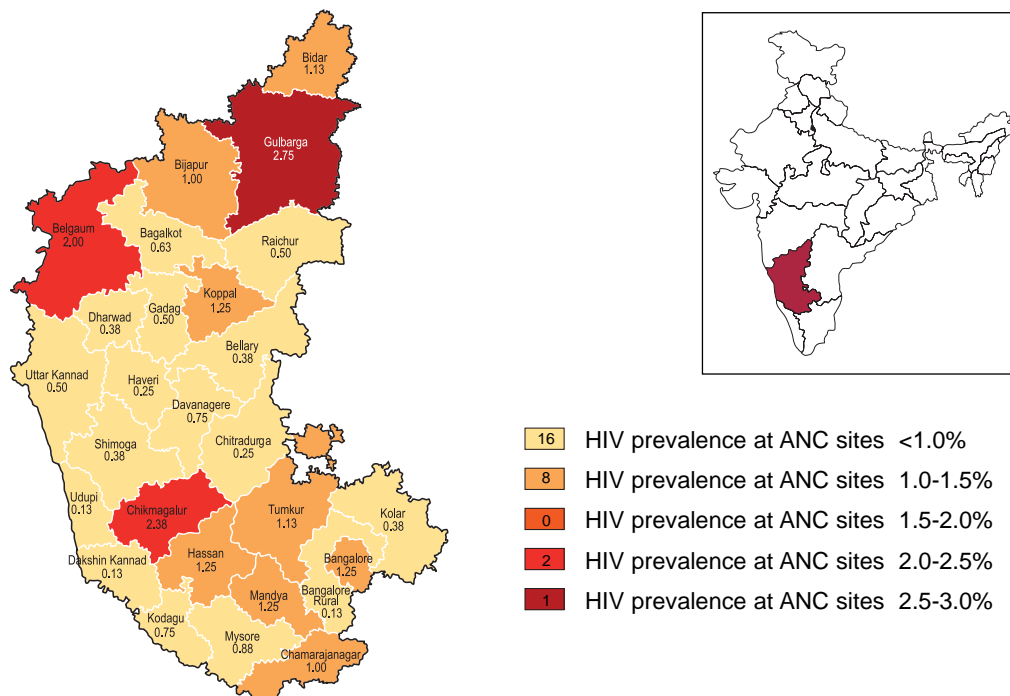
Crimeless victims: Confronting wrongful arrest

The Karnataka Health Promotion Trust (KHPT) serves 80,000 female sex workers and 19,000 high-risk men who have sex with men and transgenders through its Sankalp and Corridors Projects, which operate in 16 districts of Karnataka state and three of Maharashtra state.

In Bangalore, Karnataka, a police sub-inspector arrested a *hijra** in a park that is one of the city's principal cruising areas. The *hijra* was engaged in field work as a peer outreach worker for Sangama, a sexual minorities rights organization that works with transgenders and high-risk men who have sex with men. The police were apparently using the arrest to strengthen a case against six *hijras* whom they had previously arrested at the same location for soliciting. The police arrest report stated that as a *hijra* she had no right to be in a public place and was likely to be spreading dangerous diseases such as HIV. The peer was not formally charged with any crime, but the police did not release her or produce her to a magistrate within 24 hours as legally required.

Across the state of Karnataka, crisis management systems are established in all districts where KHPT operates, with trained community members, telephone help-lines, and legal support. Crisis management subcommittees are being formed at the district level within CBOs to make the addressing of crises systematic and formal.

Figure 9: Karnataka: HIV Prevalence by District



Source: NACO Sentinel Surveillance Data: ANC sites (2007)

* *Hijra* is a term widely used in India to denote transgendered individuals and eunuchs.

Sangama has a crisis response team consisting of a dozen peer outreach workers, drop-in center supervisors, and staff outreach workers, serving 6,200 high-risk men who have sex with men and transgenders in four zones of Bangalore. Two team members in each zone are equipped with phones to respond to calls.

The arrested peer, knowing she was legally entitled to a phone call, contacted the crisis response team. Eight members of the team immediately went to the police station. The police refused to talk to them, and the team members contacted the Sangama lawyer. The lawyer remonstrated with the police but was also unable to secure the release of their colleague.

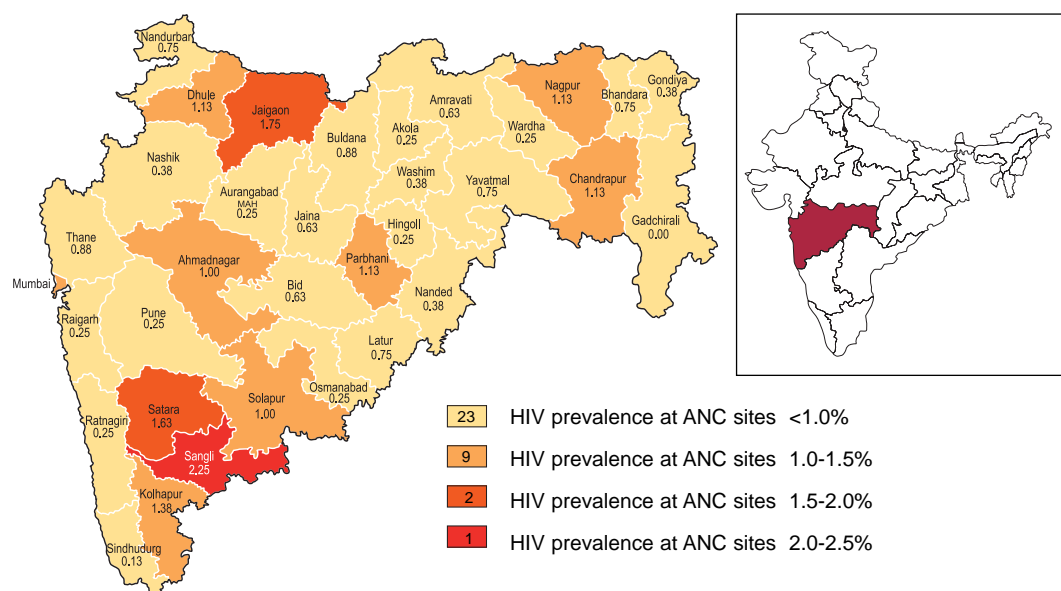
Sangama's lawyer filed a writ of habeas corpus for not producing the arrested peer in court or releasing her. In order to put pressure on the police to release the peer, copies of the habeas corpus petition were sent to the National Human Rights Commission, the Chief Justice of the Karnataka High Court, and the police station. The peer was released after 36 hours, and Sangama proposed filing suit against the police for illegal arrest and detention. Ultimately the peer decided not to pursue the case to avoid the difficulties of dealing with the court system.

Saying no: Sex workers in Mumbai confront extortion by a gang member

Family Health International's (FHI) Aastha Project serves 27,000 female sex workers and 3,000 high-risk men who have sex with men and transgenders in Mumbai and Thane districts of Maharashtra state.

Sex workers are often victims of harassment by gangs which extort money or force them to provide sex with no payment in return. Resistance is met with the threat of violence, or actual physical abuse. In South Mumbai, gang members were extorting daily payments from street-based sex workers, and one man started beating those who were unable to pay.

Figure 10: Maharashtra: HIV Prevalence by District



Source: NACO Sentinel Surveillance Data: ANC sites (2007)

The sex workers were being served by the Aastha Project. At each project site there is an "Aastha gat," a group of 15-20 community members who meet regularly to improve their self-reliance, address issues of marginalization, and give feedback on the services provided by the project. An advocacy committee has been added to each Aastha gat for rapid response to crisis situations. Each committee has five or six members, including the peer outreach worker for that site, and the committee gives the group members and peers direct access to legal experts at the district level. FHI's advocacy officer trains each local implementing NGO's staff and peers in implementing a rapid response system. Staff, advocacy committee members, and peers sensitize stakeholders, including the police, to their work.

Some of the sex workers who were being harassed contacted members of the advocacy committee, who convened an emergency meeting within half an hour with a staff outreach worker. They decided that on the following day, all 40 sex workers at the site would refuse to give the gang member any money. The outreach worker and four advocacy committee members agreed to be present to intervene if required, and when notified of the action, the police promised to support it.

When the gang member demanded his regular payments the following day, all the community members refused to pay up. Taken aback by this unexpected organized resistance, and by the presence of the advocacy committee members and project staff, the gang member left, threatening retaliation. But he did not return that day, and supported by increased vigilance on the part of the police, the community members suffered no further harassment.

Mobilizing to confront police violence

Pathfinder International's Mukta Project serves 10,000 female sex workers and 4,000 high-risk men who have sex with men and transgenders in 10 districts of Maharashtra state.

Violence by police is a common problem confronted by Avahan's partners implementing interventions at the local level. In a town near the city of Pune, a female sex worker was brutally beaten by a police constable, who believed she was the partner of a gang leader. One of the sex worker's regular clients was familiar with the Mukta Project and informed the victim's peer outreach worker about the incident. The peer and the Mukta field officer took the victim to a nearby government hospital for treatment. They also reported the incident at the police station, but the police refused to register a complaint against the constable.

The constable returned to the victim's house in the middle of the following night and beat her again, as well as her three young sons. Upon learning of this, members of the sex worker community mobilized to take action. Nine of them went to the police station, accompanied by the advocacy officer of the local implementing NGO, its field officer and project coordinator, and the Mukta project officer from Pathfinder International.

At the police station the group met the police inspector, who was familiar with Mukta, having attended a sensitization program organized for the police. The inspector agreed that the violence committed against the community member was unacceptable. He asked the community members not to press a formal complaint against the constable but promised to speak with him and ensure an end to the harassment. While the victim was initially prepared to take all necessary legal steps in order to get justice, she trusted that the inspector's pledge would resolve the situation because of his high rank and authority within the police hierarchy. This pledge was recognized as an unusual and very significant commitment. As a consequence of the meeting, the community experienced no further police harassment.

This incident led to the formation of an advocacy committee in the town, and the sex worker who had been beaten was selected by the community to be president of this committee. Advocacy committees now function in almost every town served by Mukta. Each committee has 15-19 members, 70 percent of whom are from the sex worker

community. The others are local people of influence such as police, lawyers, government officers, and social activists. The committee addresses issues raised by the sex worker community and leads advocacy programs. Its community members are trained by the NGO's advocacy officer to act as a rapid response team for crisis situations.

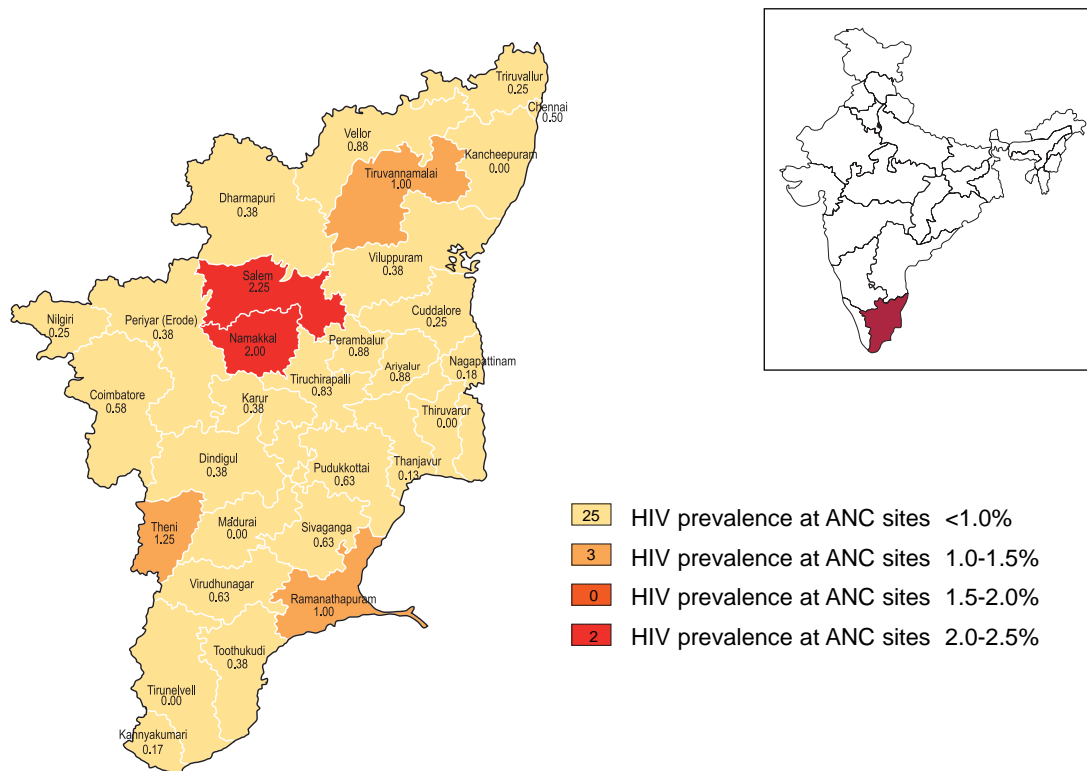
Resolving domestic violence

Tamil Nadu AIDS Initiative (TAI) is Avahan's lead implementing partner in 12 districts of Tamil Nadu state, serving 34,000 female sex workers and 14,000 men who have sex with men and transgenders.

A peer outreach worker working for TAI in the town of Salem came into conflict with her husband over her involvement with the local implementing NGO. The couple had opened a tea stall together, using money that the peer had obtained as a loan through a scheme run by the NGO. Her husband felt threatened by her increasing confidence and the self-assurance which resulted from her work. Following a series of quarrels, the husband beat the peer, threw her out of their home, and burned all her clothes. A friend took her to a nearby drop-in center, where she was given clothes from a community-run clothes bank. She was also offered temporary shelter through another organization.

The crisis response team spoke to the peer's husband. They counseled him on domestic violence and warned that if he did not reform they were prepared to take legal action. In response, he left the town. The peer returned to her home and continued running her tea stall. After several weeks, her husband returned, showing remorse. The

Figure II: Tamil Nadu: HIV Prevalence by District



Source: NACO Sentinel Surveillance Data: ANC sites (2007)

peer accepted him back on the condition that he would never threaten or hit her again and he would accept her work as a peer and small business owner.

Each of TAI's implementing NGOs has formed a crisis response task force that operates at the NGO level, as well as smaller crisis response teams that serve two sites each. These local teams consist of peers, elected community representatives, and a staff outreach worker. TAI has established a community crisis management center that receives calls from across the state, dispatches teams to respond, monitors and reports on progress, and analyzes responses and outcomes. Since the formation of CBOs, some drop-in centers have started offering short-stay facilities for women and their children who have been forced to leave home due to intimate partner violence.



APPENDIX II

AVAHAN PARTNERS

Lead implementing partners

Emmanuel Hospital Association—Manipur and Nagaland

Family Health International—Maharashtra (Mumbai and Thane)

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

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

Pathfinder International—Maharashtra

Tamil Nadu AIDS Initiative—Tamil Nadu

University of Manitoba—Karnataka and three districts in Maharashtra

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

Advocacy committees are formed by many local NGOs to address crisis response issues and to work with community leaders to alleviate the violence experienced by marginalized populations.

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.

Continuity of care is the uninterrupted provision of services appropriate to an individual's changing needs.

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.

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.

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

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.

VALUES OF THE FOUNDATION

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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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