BREAKING THROUGH BARRIERS:
Avahan's Scale-Up of HIV Prevention among High-Risk MSM and Transgenders in India

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INDIA AIDS INITIATIVE

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AVAHAN—THE INDIA AIDS INITIATIVE

This publication describes the HIV prevention interventions that the Bill & Melinda Gates Foundation has undertaken in India for high-risk men who have sex with men and transgenders.* Approximately 2.31 million people are infected with HIV in India,[1] and men who have sex with men (MSM) and transgenders are one of the population subgroups most at risk of acquiring and transmitting the virus (female sex workers and injecting drug users are the other high-risk groups).[2] The Bill & Melinda Gates Foundation began its India AIDS Initiative, known as Avahan, in 2003, as 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 best practices

3. Foster and disseminate lessons learned within India and worldwide

Avahan was conceived as a focused prevention program, offering a standardized package of proven prevention interventions to high-risk groups and bridge populations in the geographic areas most affected by the epidemic. Avahan focuses on 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.[3] In some districts Avahan and its implementing partners work alongside government- or donor-supported non-governmental organizations (NGOs), while in others Avahan is the sole HIV prevention service provider for these groups.** As of March 2009, Avahan supported prevention programs for approximately 321,000 high-risk individuals in 675 towns, in 82 out of 139 districts in these six states. This included 82,000 high-risk MSM and transgenders, 221,000 female sex workers, and 18,000 injecting drug users.*** In April 2009 Avahan entered its second five-year phase (Phase II), which focuses on the transition of the program to government, other stakeholders, and communities.

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* Detailed definitions of "high-risk men who have sex with men" and "transgenders" under the Avahan India AIDS Initiative are given in Section II, page 11. Definitions of other technical 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 about two million.

*** In addition, services are provided to 5 million men at risk (long-distance truckers and clients of sex workers). 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. http://www.gatesfoundation.org/avahan/Documents/Avahan_HIVPrevention.pdf

Figure 1: Avahan Intervention Districts

Source: Avahan routine monitoring data
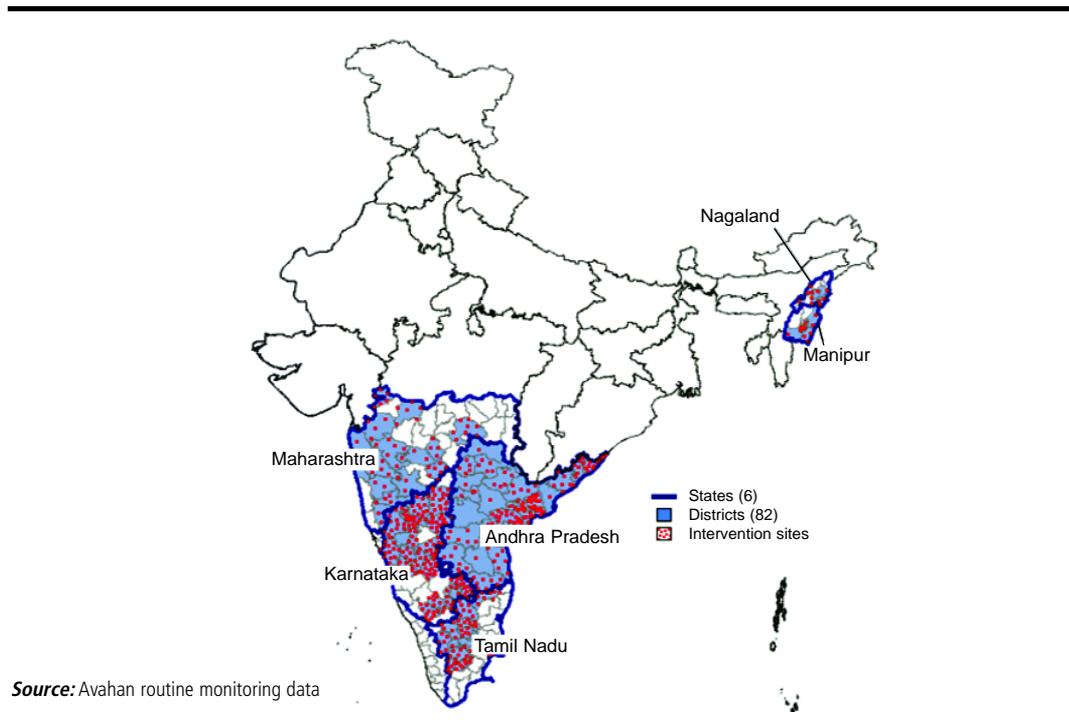
Avahan interventions

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 sexually transmitted infection (STI) clinics and self-help programs. Avahan has about 5,900 paid peers* in 69 districts across four states, including 1,500 who work with high-risk MSM and transgenders.**

2. **Program-supported clinical services to treat STIs other than HIV.** Avahan has established and funded 288 clinics in fixed locations. Services are also provided through mobile clinic vans, health camps, preferred providers (private clinics contracted to provide services to high-risk individuals), and linkages to government STI clinics. STI management services have been provided at least once for an estimated 408,000 individuals, including 70,000 high-risk MSM and transgenders.***

3. **Commodity distribution.** Avahan promotes and distributes free condoms to sex workers and MSM and transgenders through an expanding network of traditional and non-traditional outlets. Avahan also distributes lubricants to high-risk MSM and transgenders and supports needle and syringe exchange for injecting drug users. As of March 2009, Avahan was distributing over 11 million condoms free of charge every month, more than two million of which went to MSM and transgenders.

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

** Unless otherwise stated, all figures in this publication are as of March 2009, when the first five-year phase of Avahan ended. Figures refer to the states of Andhra Pradesh, Karnataka, Maharashtra, and Tamil Nadu. (In the northeastern states of Manipur and Nagaland, Avahan's work focuses on prevention with injecting drug users, although a small number of MSM identified during outreach are also served.)

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

4. **Facilitating community mobilization and ownership of the program.** Avahan works with high-risk communities (members of a particular high-risk group within a district or town) to address the factors contributing to their vulnerability, helping them to adopt safer behaviors and developing their capacity to ensure that HIV prevention programs and vulnerability reduction efforts will be sustained after the Avahan initiative is over. Across the districts served by Avahan, approximately 140 community groups or organizations have been formed, some of which are legally registered and charge nominal membership fees.

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

In implementing HIV prevention interventions for high-risk MSM and transgenders, Avahan faced some of the same challenges as with its interventions for other high-risk groups, including how to design, organize, and execute a high-quality program and scale it up rapidly. At the same time, the intervention had to take into account sociocultural factors specific to high-risk MSM and transgenders—not just in India as a whole, but also within individual states. This publication outlines some of these issues and explains the approach Avahan used to rapidly scale up HIV prevention interventions with high-risk MSM and transgenders. Finally, the progress and lessons learned to date are briefly described.

HIV RISK AMONG MSM AND TRANSGENDERS

The global experience and the Indian context

In developing countries, the initiation of HIV prevention programs for MSM and transgenders has lagged behind those targeting heterosexual transmission.* As of 2008, 44 percent of these countries did not track data for any of the five indicators on MSM developed by the United Nations General Assembly Special Session on HIV/AIDS, and 60 percent did not report HIV seroprevalence among MSM,[4] even though the risk of HIV transmission through anal sex is higher than through vaginal sex. Stigma, discrimination, and the criminalization of homosexuality in more than 80 countries are further factors in the lack of HIV prevention programs for MSM and transgenders, and they also make it more difficult for programs to access this population group.

In Asia, MSM are 19 times more likely to acquire HIV than the general population. The scale of the growing epidemic in this region is demonstrated in the Philippines, where the increase in HIV infection in MSM has been fourfold between 2005 and 2008,[5] and in Bangkok, where HIV cases among MSM jumped from 17 percent in 2003 to 31 percent in 2007.[6]

India's response to the AIDS epidemic has been led by the Government of India, which established the National AIDS Control Organisation (NACO) in 1992. A number of NGOs, some working in partnership with NACO or supported through donors, pioneered interventions for MSM and transgenders in the 1990s. Participatory mapping by MSM communities in Mumbai was organized by the Humsafar Trust in 1997-98, funded by the Maharashtra Directorate of Health Services. A year later, NACO and the Maharashtra State AIDS Control Society, working with the Humsafar Trust, began India's first pilot project to promote safer sex among MSM. The India Network for Sexual Minorities (INFOSEM) was founded in 2003, involving community-based organizations in three states through Naz Foundation India and the Humsafar Trust. It conducted a community needs assessment and capacity building workshop, and in 2006 began a Communication and Advocacy Support Program and a qualitative analysis of the social and sexual networks of MSM and transgenders in eight cities across five states.

Also in 2006, MSM and transgender groups across India gave information on their HIV prevention and care needs to an Asia-Pacific Consultation on Risks and Responsibilities. Building on this work, members of the MSM and transgender communities collaborated with INFOSEM, Naz Foundation, and NACO to develop a "Strategic Plan for Scaling up Interventions for MSM and Transgender Populations" which was accepted as part of Phase III of the National AIDS Control Program (NACP-III).[7]

Notwithstanding these efforts, surveillance data from 2007 showed that in five states—including three of the southern states where Avahan works—HIV prevalence among MSM and transgenders was greater than 10 percent (Figure 2). At the beginning of NACP-III, coverage of MSM and transgender populations in India remained low, with only 28 percent of districts having any intervention.[7]

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*   The term "men who have sex with men"(MSM) is used to denote all men who have sex with other men as a matter of preference or regular practice, regardless of their sexual identity or sexual orientation and irrespective of whether they also have sex with women. Coined by public health experts for the purposes of HIV/STI prevention, MSM is an epidemiological term which focuses exclusively on sexual practice and behavior. It does not refer to men who have sex with men only very occasionally and under exceptional circumstances such as coercion or incarceration.

Figure 2: HIV Prevalence among MSM and Transgenders in Four Avahan Intervention States
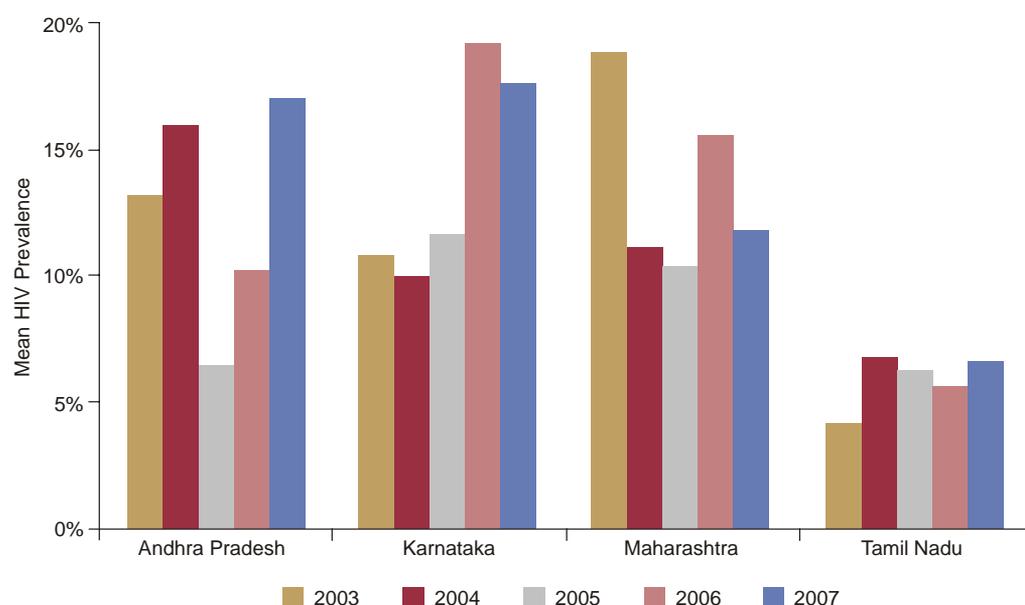
Source: *HIV Sentinel Surveillance and HIV Estimation 2007: A Technical Brief.* NACO, 2007.

Evidence from some Asian countries and the experience in India had shown that the frequency of risk behavior among MSM can be lowered by a minimum package of services including peer led outreach education, free distribution of condoms and lubricants, use of targeted media, STI screening and treatment, and voluntary HIV testing.[5,8] Promising interventions have been based on partnerships between government and civil society, with the increasing participation of community groups of MSM and transgenders.[5] Avahan adopted much of this approach for its HIV intervention in India.

Sexual identities and behaviors among MSM and transgenders

In India, male-to-male sexual behavior takes place in diverse contexts that are not generally associated with a gay sexual orientation as it is understood in the West. Men who self-identify as gay are a small minority of all Indian MSM, who tend instead to identify themselves with one of several distinct groups. *Kothis* are men who practice mainly receptive anal and oral sex with men. They exhibit varying degrees of "femininity": some assume the gender identity of a woman and may cross-dress, while others practice bisexual behavior and may marry women. Some *kothis* engage in sex work. The regular partners of *kothis* are known as *panthis* and are generally non-effeminate males who are the insertive partners in anal sex. "Double deckers" are also generally non-effeminate males who are both insertive and receptive partners in anal and oral sex with other men. Some men who do not identify as *kothis*, "double deckers," or gay engage in sex with other men for money. Such sex work tends to driven by temporary economic need and does not become a long-term occupation as it is among some female sex workers. Male sex workers may also have female partners.

The term "transgender" as used by Avahan and other service providers includes transvestites, transsexuals, cross dressers, intersexed persons (hermaphrodites), and men with gender identity disorders. Transgenders include a distinct socio-religious and cultural group in India known variously as *hijras*, *jenanas*, or *aravanis*. Although the

great majority of *hijras* are biological males, they prefer to be considered as women.[9] Some also identify as *kothis*. They form close-knit communities organized into seven main *gharanas* (clans). *Hijras* are a socially marginalized group with an ambiguous legal status.[10] Some support themselves and their communities economically through sex work.

A survey of self-identified MSM and transgenders conducted in 2006-07 in 12 districts of four states where Avahan works found that 35 percent identified as *kothis* (with a range of 22 to 50 percent among the states), 13 percent as *panthis* (range of six to 46 percent), 21 percent as double-deckers (range of 12 to 29 percent), 23 percent as bisexual (engaged in both homosexual and heterosexual relationships, range of three to 58 percent), and eight percent as *hijra* (range of one to 36 percent).[11]

The sexual behaviors of these subgroups of MSM and transgenders have important implications for the spread of HIV. Among bisexuals, 61 percent were married and 68 percent reported having a regular female sexual partner. The corresponding proportions among *panthis* were 20 percent married and 33 percent with a regular female partner; and among double-deckers it was 25 percent married and 20 percent with a regular female partner. However, reported consistent condom use with these regular female partners was low: 29 percent among *panthis*, 20 percent among double-deckers, and just two percent among bisexuals. Earlier research had indicated that married MSM are less likely than unmarried MSM to use condoms with sexual partners of either sex.[12]

In the 2006-07 survey, 15 percent of MSM (excluding *hijras*) who reported selling sex to other men tested positive for HIV, and 17 percent for syphilis; the proportions among MSM and transgenders who did not report selling sex

Figure 3: Focus of Avahan's Intervention among MSM and Transgenders
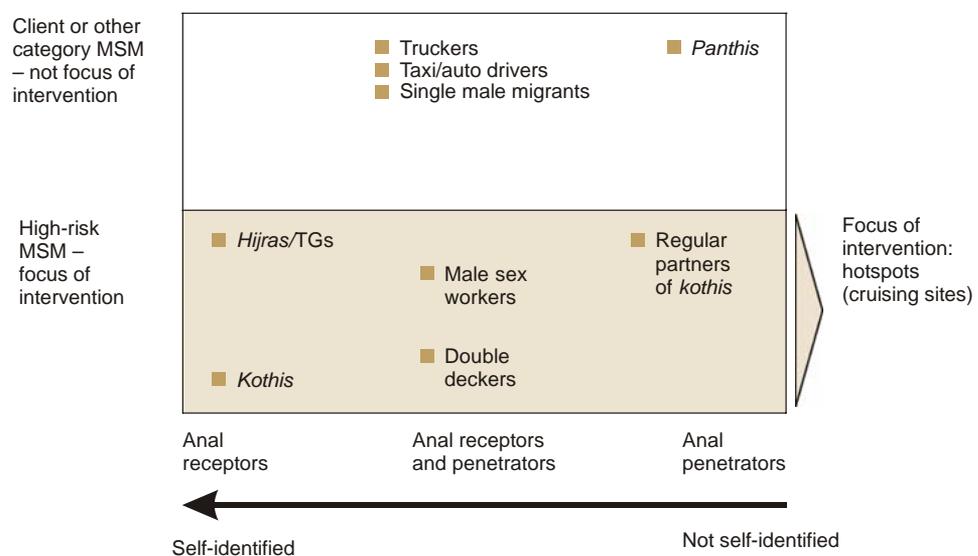
Source: Based on *Targeted Interventions under NACP III - Operational Guidelines, Volume I: Core High Risk Groups.* NACO, 2007.

to men were 11 percent and nine percent, respectively. Other research has shown that transgenders who practice sex work also have high rates of STIs including HIV.[13] Taken together, these findings imply not only a significant risk for the transmission of HIV among MSM and transgenders, but also to their female partners, including their spouses.[14]

Given the hidden nature of MSM in India, Avahan's intervention focus was on the visible MSM found in high-risk locations (e.g., "hotspots"). These more visible MSM included *kothis*, *hijras*, "double deckers," and male sex workers—groups that tend to have a large number of sex partners and who regularly practice receptive anal sex or sell sex. The intervention also focused on the male partners of these high-risk men, *panthis*, if encountered at high-risk locations (Figure 3).

Key challenges in working with MSM and transgenders

A number of social, legal, and geographic factors present challenges to effective outreach with MSM and transgenders in India. There is limited understanding and tolerance of sex between men, and men who exhibit differences in their gender identity or sexual orientation are vulnerable to stigmatization. As men are expected to marry and raise families, those whose primary sexual attraction is to the same sex may marry but continue to engage secretly in sex with men. Such men may be reluctant to access HIV prevention services if doing so associates them with an identity or behaviors that they wish to keep hidden.

The same fear of exposure and discrimination can also impede non-married MSM and transgenders from seeking HIV services. Transgenders suffer particular stigmatization, for reasons ranging from superstition to disapproval of their perceived lifestyle as beggars and sex workers. The *gharanas* to which most transgenders belong are organized very hierarchically, and the *guru* (head) of the community makes all key decisions—including, for example, whether or not the members may participate in an HIV prevention intervention or seek treatment for STIs. Since *gharanas* are quite closed communities, persuading the *guru* that an HIV intervention is beneficial is essential, and difficult.

Legal discrimination is a further factor affecting MSM and transgenders in India. Section 377 of the Indian Penal Code, which makes "carnal intercourse against the order of nature with any man, woman or animal" a crime punishable by imprisonment, has been interpreted as including anal intercourse and has thus been used to criminalize sex between men. This law has made them vulnerable to harassment and violence from the police. In July 2009 a landmark judgment of the Delhi High Court ruled that Section 377 was unconstitutional; this ruling is under appeal in the Indian Supreme Court.

THE AVAHAN PROGRAM WITH MSM AND TRANSGENDERS

Rolling out and scaling up Avahan's interventions

When Avahan began its program in late 2003, India's national program was already funding community led prevention interventions with MSM in some states. However, there were gaps in the overall coverage of interventions, as well as in the recognition and understanding among policy makers and various programmatic stakeholders of the vulnerability of MSM to HIV.

While Avahan's initial focus in the four southern states was primarily female sex workers, Avahan partners in Tamil Nadu and Maharashtra included high-risk MSM and transgenders in their interventions. Extensive analysis and experience gained through previous work (such as the India HIV/AIDS Alliance's Frontiers Project in Andhra Pradesh, and the USAID-funded AIDS Prevention and Control Project) helped guide this focus. By mid-2005, partners in all six states had initiated interventions for high-risk MSM and transgenders.

The key principles of designing, organizing, and executing for scale that informed Avahan's interventions with female sex workers were applied to these new interventions.[15] Avahan designed its programs to complement existing coverage by State AIDS Control Societies and NGOs, in order to saturate services to high-risk MSM and transgenders (defined as providing services to at least 80 percent of the identified population). Programs were also crafted to respond to the varying demographics in each of the states. For example, Avahan serves a large population of transgenders in Tamil Nadu, while in Mumbai it has developed outreach to male sex workers, who were not covered by existing interventions. Avahan worked with its local implementing NGOs to ensure that they were equipped to provide services to these new populations, and recruited additional partners where necessary.

In order to execute and manage the program effectively at scale, Avahan initiated its interventions in phases, as it had done with female sex workers. Aspects of these three phases—start-up, roll-out of basic services, and refinement of the scope of services—were customized to the multiple typologies of MSM and transgender populations. The following section describes some of the issues encountered during the implementation of the interventions, and how Avahan addressed them.

Start-up: Participatory site assessments

Before rolling out services, Avahan conducted participatory site assessments, with trained members of the high-risk groups working in teams with researchers and local implementing NGOs in order to focus outreach effectively. The site assessments established initial population size estimations, and mapped hotspots (locations where high-risk individuals gather to seek or sell sex) and existing services for MSM and transgenders. By soliciting the active involvement of high-risk community members, the participatory mapping process also helped increase their self-esteem, empowerment, and identification with the program.

Case Study I: Mapping through Participatory Site Assessments

India HIV/AIDS Alliance, Andhra Pradesh

The India HIV/AIDS Alliance's site assessment for MSM and transgenders was conducted with the participation of members of these communities. The goals of the assessment were to estimate the number of MSM and transgenders, identify subgroups and patterns of mobility, and map existing services such as treatment for STIs and the availability of condoms. The tools used were mostly visual rather than written, since many community members had low levels of literacy. The Alliance also conducted half-day workshops with the community to explore vulnerability factors and risk behaviors and gather suggestions on how interventions should be implemented at each site. Participants also discussed safe sex techniques and other risk reduction strategies.

By inviting community members to discuss the challenges of HIV/AIDS and possible solutions, the assessment initiated a process of community mobilization. One team member commented, "From the participatory site assessment we gained employment, respect, and self-esteem. We learned how to work with other community members and how to communicate with the police. We even gained respect from the police." The experience motivated members of the high-risk community to assert themselves and to participate in the new intervention.

Roll-out of basic services: Peer led outreach

Outreach led by peers is an important component of Avahan's interventions, on the premise that trained members of high-risk groups are more aware of the needs of their communities, and can reach them and deliver services more effectively than people who are not members of these communities. A separate monograph describes peer led outreach and micro-planning in detail,[16] but the interventions with MSM and transgenders required some specific strategies identified below to address the diversity of the communities and the social divisions between them.

As with female sex workers, Avahan found it necessary to recruit peer outreach workers from the specific subgroups of high-risk MSM and transgenders—*kothis*, "double deckers," *hijras*, and male sex workers—so that the community members could identify with and trust them. In order to maximize acceptability of services, Avahan adopted a flexible approach to deal with local contexts and experiences, such as the reluctance of different high-risk groups and subgroups in some locations to mix with one another. This was an issue at the drop-in centers established by Avahan to provide a safe space for high-risk individuals to come together. Drop-in centers are housed next to program-managed medical clinics and serve as a hub of community life. In some cases, MSM were uncomfortable sharing the center with the female sex worker community. The same divisions could occur within the MSM and transgender communities, with male sex workers sometimes reluctant to visit the drop-in center when other MSM were present, or *kothis* uncomfortable sharing facilities with transgenders. Where this issue arose, Avahan responded by creating separate drop-in centers for particular subgroups of MSM, or setting aside specific hours for them at existing centers.

Avahan found that many MSM and transgenders seemed to participate in program activities primarily because they valued feeling part of a community, rather than because they wanted to learn about HIV. Some implementing NGOs responded to this by organizing social events aligned with needs expressed by the community, such as fashion shows at drop-in centers, and incorporated HIV education and provision of services such as regular STI screenings into these activities.

Transgenders tend not to gather publicly in large groups except during religious festivals and events. Avahan promoted program services and conducted outreach during such events. *Gurus* were often uncomfortable with the idea of their followers working as peers rather than in their traditional ways of earning money, so Avahan worked to build rapport with the *gurus* and enlist their support. In some cases, this included making them responsible for leading individual self-help groups.

Case Study II: Peer Led Outreach and Micro-planning with Male Sex Workers

Hindustan Latex Family Planning Promotion Trust, Andhra Pradesh (HLFPPT)

HLFPPT's program had to take into account the extreme reluctance of many MSM to identify themselves or to admit that they solicit sex, whether as sex workers or as clients. The program began outreach by using informal networks to make contact with members of the community at local festivals or birthday celebrations. Through one-on-one interactions and by offering informational materials about HIV, peer outreach workers began to establish the program's identity in the eyes of the community. By fostering an accepting and non-judgmental environment, and treating community members with respect, the peers gained their confidence and were able to approach them at hotspots. This allowed HLFPPT to make outreach more comprehensive.

All peer outreach workers are trained to use outreach materials, which were modeled on those used with female sex workers, with changes to reflect the specific sexual risk behaviors and vulnerability factors of MSM and transgenders. Micro-planning was introduced as a methodology to help peers record and analyze data on the risk and vulnerability of each individual they contact. The micro-planning tools, designed in consultation with the peers, are also used to verify whether each individual is receiving the minimum service package of communication sessions, clinical services, condoms, and counseling. During weekly planning meetings, peer and staff outreach workers plan their service delivery strategically to ensure maximum coverage of each hotspot. Each peer outreach worker thus becomes the manager of his site, monitoring his own targets and achievements with the help of the other peers.

Roll-out of basic services: Clinical services and provision of commodities for safe sex

Avahan's package of clinical services includes presumptive treatment for STIs alongside syndromic management and regular screening; referrals for HIV testing, counseling, treatment and care; and referrals for screening diagnosis and treatment of tuberculosis. Because many medical professionals were unused to treating MSM and transgenders, Avahan provided training on diagnosis and treatment to the 400 project doctors who work at its clinics, based on its *Clinic Operational Guidelines and Standards*. These contain specific guidance on oral and anal STIs among MSM and transgenders. The training also sensitized doctors to the wider health care needs of these communities and provided information to counteract discriminatory attitudes and behaviors.

Some local implementing NGOs also work with preferred health care providers, who receive referrals for services following appropriate orientation. Referral clinics make up about 30 percent of the total number of clinics, and community members helped identify providers with whom they felt comfortable. In some cases they negotiated clinic timings and the fees paid by Avahan to the providers, and monitoring of services was taken up by community committees.

Avahan also conducts health camps at hotspots, sometimes using mobile facilities, in order to further increase access to services by the community. These services are tailored to the needs of individual subgroups of the community: for example, health camps may be offered early in the morning and late at night so that transgenders can visit them when they are not working. One of Avahan's lead implementing partners trained community members to assist the medical teams and facilitate follow-up visits at static clinics, health camps, and preferred provider clinics. This has helped increase community involvement and contributed significantly to monitoring the quality of health services.

The following two case studies show how Avahan tailored the provision of clinical services and commodities to the needs of high-risk MSM and transgenders, both within a specific intervention population, and across the whole program.

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Case Study III: Closing the Condom Gap with Transgenders Through Custom-made Condoms and Lubricants
Family Health International (FHI), Mumbai

In Mumbai and Thane, FHI's Aastha Project learned that a major reason for low condom use among male and female sex workers and transgenders was dissatisfaction with the quality of the low-cost and free condoms available locally. Male sex workers and transgenders complained that these condoms were liable to tear during anal sex, and that they had insufficient lubrication.

FHI worked with a major domestic manufacturer of condoms to develop one that met World Health Organization specifications but was stronger and had more lubricant. Since the manufacturer had never before produced condoms for such a specialized market, FHI monitored every aspect of the manufacturing process to ensure that the new product would be completely reliable.

The condom was called the "Aastha condom," building on the brand already identified with FHI's outreach. FHI developed a condom distribution plan based on the frequency with which each individual had sex, using micro-planning data gathered by peer outreach workers. The Aastha condom, along with a pouch of water-based lubricant gel, was widely promoted during one-to-one communication sessions and at group meetings, and condom depots were set up at accessible places and regularly re-stocked.

Sex workers were encouraged not only to use the condoms but also to share their feedback. A suggestion of flavored condoms was taken up, and after testing, a *paan* (betel leaf) flavored condom was introduced. Peer outreach workers reported increased condom usage by male sex workers with their paid partners.

## Case Study IV: Building Skills for Management of Sexually Transmitted Infections in MSM and Transgenders

FHI provides technical support to Avahan's lead implementing partners for the provision of effective, high-quality clinical services for STIs. In 2005 and early 2006 FHI trained 67 technical officers from across the program in the management of STI services with MSM and transgenders, and assisted them as they trained a further 365 staff in the clinics run by the local implementing NGOs.

During follow-up visits to the clinics, FHI learned that the staff were facing a number of challenges in providing effective services to MSM and transgenders. There was mutual embarrassment among clients and doctors about discussing personal sexual issues and risk behaviors, and the providers were unable to understand local MSM terminologies for self-identities and risk behaviors. Clinical examinations were usually not performed owing to the reluctance of clients and the limited experience of physicians in proctoscopic examinations.

In consultation with the technical officers and clinic staff, FHI developed a training module to sensitize clinic staff to the sexuality issues and health needs of MSM and transgenders. This enabled them to provide better management of STIs and other common health problems. An FHI-supported training course was held in July 2006 for 23 technical officers. The participatory training techniques included case studies, role plays, demonstration on pelvic models, and hands-on clinical experience. The curriculum addressed sexuality issues and the epidemiology of STIs in MSM and transgenders; clinical issues such as history taking, oral and proctoscopic examinations, and management of STIs and common ano-genital problems; and health education and counseling. Training participants also visited MSM clinics and the STI department of a public hospital.

Subsequently, the technical officers trained MSM clinic staff across the program, and offered ongoing supportive supervision at the clinics. Over time, the staff gained the confidence of the MSM and transgender communities, and rates of proctoscopic examination for clinic attendees increased from 18 percent in 2007 to 79 percent in 2008 (Figure 4).

Figure 4: Growth in Proctoscopic Examinations of MSM and Transgender Patients at STI Clinics

Proportion of MSM and transgenders visiting clinic for STI check-up who received proctoscopic examination
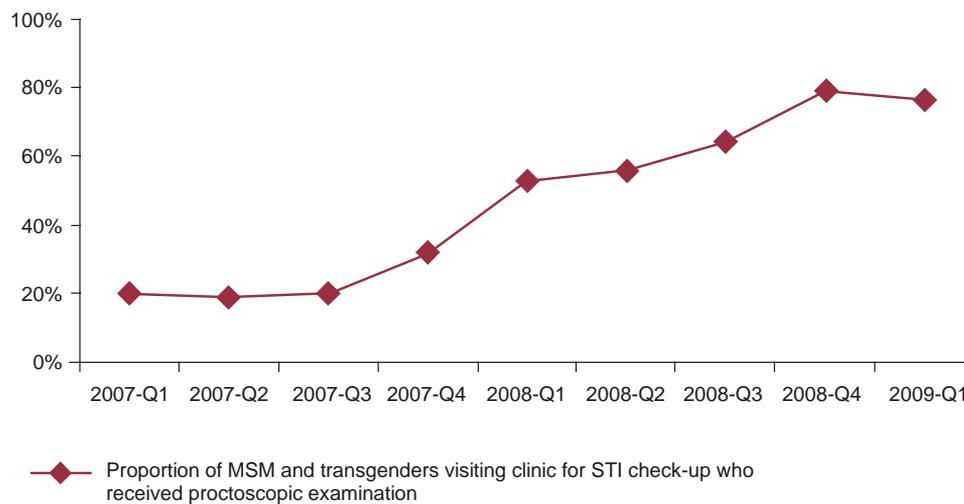
Source: Avahan routine monitoring Data

Refining the scope of services: Community mobilization

Like other groups working with MSM and transgenders, Avahan found that community mobilization was essential not only to establish the intervention on the ground (through mapping and peer led outreach), but also to drive demand for HIV prevention services and create a basis for the long-term sustainability of programs. Community mobilization can result in concrete actions to make community members safer—as in the violence response program described below—or in structures such as community-based organizations that analyze and act on a range of issues affecting the community. In both examples, it is the community members themselves who shape and lead local advocacy efforts.

Rapid response to violence

Like other high-risk groups served by Avahan, MSM and transgenders may face violence, harassment, discrimination or abuse from family members, clients, police, and members of the wider community. Violence— whether threatened or actually experienced—further isolates already marginalized individuals, making them less likely to access health services or advocate for their rights, and harder for outreach workers to reach. Female sex workers who are victims of violence have reported lower rates of condom use with clients and greater frequency of STIs,[17] and it seems reasonable to suppose that this association would also hold for MSM and transgenders. Violence can also be directed against peer outreach workers, hampering their ability to do their work.

In the first year of the intervention, systems to address incidents of violence were already being implemented by some local partners. Although they were on a small scale, it became clear that these crisis response systems improved access to marginalized high-risk communities and helped build trust with them. While not a part of the original Avahan design, crisis response was soon incorporated as a common element across the program. Networks of crisis response teams, formed by members of the high-risk communities themselves, were established to provide a rapid response to reports of violence. An individual who has been attacked, arrested by the police, or thrown out

of their home, can call a hotline staffed by a response team member, who mobilizes one or more team members. The response team offers assistance to the victim, identifies the perpetrators where possible, documents details of the incident, and strategizes a response. This might mean filing a police report in the case of an attack or harassment; filing a complaint of wrongful arrest (the crisis response teams have access to the voluntary services of lawyers); or engaging the perpetrators of abuse or discrimination in dialogue to try and resolve the situation. In other cases, a longer-term approach such as a media campaign might be planned in conjunction with the program's advocacy team.

The development of crisis response systems has increased the confidence and sense of safety of the various communities of MSM and transgenders. At the same time, it has helped to increase their trust in the Avahan program, further facilitating outreach and uptake of services.*

Case Study V: Responding to Violence against a *Hijra* Sex Worker
Karnataka Health Promotion Trust (KHPT)

Suma, a *hijra* sex worker in Bangalore, called the local crisis response team one evening after she was badly beaten by a former client. The man had been harassing her for many months, demanding free sex and money and abusing her verbally in public. He had also beaten her at least once before and had threatened to disfigure her permanently. On the particular evening, the man had publicly accused her of using him for free sex and stealing his money. He stripped off her clothes, kicked and beat her. She ran for help to her clan house, but he followed her there and continued to beat her.

KHPT's local partner Sangama, which works with MSM and transgenders in Bangalore, pioneered the development of crisis response teams and provided a model which Avahan used to roll out crisis intervention across its program. The team consists of peer and staff outreach workers and drop-in center supervisors. When Suma called the team, they advised her to go immediately to the local police station with another member of her community to file a complaint. A member of the response team met her there. After giving a verbal complaint, Suma was taken to hospital by the team member for a medical examination. While the team member was taking her home, they were waylaid by her attacker, who assaulted her again. The team member summoned a constable and inspector from the police station, and they arrested the man. Suma returned to the police station and this time filed a formal written complaint against her assailant.

The crisis response team helped Suma move home and change her mobile phone number. They stayed in contact with the police, who had released her attacker after warning him to stay away from Suma. When two months later the man tracked Suma down and threatened her verbally, the team again summoned the police, who arrested and fined the man.

The several episodes in this case highlight the environment of ongoing hostility against MSM and transgenders. Crisis response is vital to ensure that community members receive support in the face of immediate danger. While the threat of violence can never be eliminated, it can be mitigated by the ongoing support offered by crisis response teams. At a broader level, however, the team is responding to Suma's case and to similar incidents by developing advocacy strategies to address the problems of transgenders and sex workers who are targeted by clients.

Case Study VI: Forming a District-wide CBO
Pathfinder International, Maharashtra

Pathfinder International began an intervention in mid-2005 with MSM in the Beed district of Maharashtra. When the local implementing NGO began working with a small group of MSM in one of the towns, it discovered that the majority of men frequenting the cruising sites came from Udgir, a town in the neighboring Latur district. The existing program in Latur was expanded to include Udgir, and significant numbers of MSM were identified in the town.

The Udgir group proved to be vibrant, and in 2007, after being introduced by Avahan to MSM groups in other places, the members formed Jankalyan Gramin Vikas Mandal, a community-based organization (CBO), to pursue general health issues. Initially the CBO's membership was not restricted to MSM, and its reach was only local. Pathfinder and the local implementing NGO encouraged the CBO members to use their commitment and energy on a larger scale, rather than setting goals that would benefit only people in Udgir. Gradually the CBO began to involve MSM from across the district, and in 2008 a district-wide CBO exclusively for MSM was formed. Of the estimated district MSM population of 1,700, more than 400 have joined the CBO, which has a governing board of 13 community members.

Members of the CBO now address issues of concern and advocate for their rights, using a district-wide committee structure to plan their own activities. Increasing numbers of community members are declaring their identity as MSM, and the district has seen positive health outcomes: program contacts with high-risk MSM increased from a monthly average of 289 in the six months prior to the formation of the CBO to 526 in the six months following. Clinic visits by MSM increased in the same way from a monthly average of 192 to 238. In addition, some HIV-positive individuals have gained the confidence to access anti-retroviral treatment services locally, where in the past they had traveled to a neighboring district to avoid public exposure.

The experience in Udgir showed that a few active and dedicated community members in a single town can provide the spark for eventual mobilization of the wider community, and that locally existing networks can be leveraged to catalyze this process. The primary challenge for the implementing partners is to foster a democratic and broad-based organization by encouraging the community to look beyond their immediate local priorities, at the same time working to keep the organization cohesive.

Refining the scope of services: Advocacy

Avahan's partners at the state and local levels work with high-risk communities to advocate with key stakeholders on issues specific to the communities. Advocacy with the police helps increase their sensitivity to MSM and transgenders. Advocacy with government officials has helped ensure transgenders receive social entitlements from which they are frequently excluded, such as ration cards, voter cards, and other forms of official identification, as well as banking services.

Community members have been trained to work with the media, and teams of peer outreach workers now create their own audiovisual materials for advocacy purposes. Legal literacy sessions help increase community members' understanding of their rights and responsibilities as citizens.

Progress to date

Although Avahan as a whole began outreach to MSM and transgenders later than to female sex workers, the program achieved scale rapidly. Within about one year of the start of the intervention, Avahan programs were responsible for coverage of 27 percent of all enumerated high-risk MSM and transgenders in the four southern states. By 2008 this had increased to 70 percent, complementing the coverage by the Government of India (GoI) and other organizations (Figure 5).

Case Study VII: Creating an Enabling Environment for the Transgender Community
Tamil Nadu AIDS Initiative (TAI)

In its work with transgenders (known in Tamil Nadu as *aravanis*), TAI found that their high-risk behaviors were associated with their marginalization in a society that perceived them only as beggars and prostitutes. TAI, together with strong leaders from the *aravani* community, worked with a few supportive politicians to transform policy, access to services, and public perception in support of transgenders in the state.

With TAI's support, in 2006, January 18 was declared the first *Aravanigal Dinam* (Transgenders Day) by leaders in Tamil Nadu. The slogan for the first annual observance was "We Too for a Healthy Society," to promote the *aravani* community as socially responsible. They undertook a blood donation drive and sponsored a series of speeches and street theatre presentations to convey messages about health, HIV, and the stigma and discrimination faced by their community.

In subsequent years, *Aravanigal Dinam* has featured activities by as many as 3,000 community members on themes of health and community service. *Aravanis* made organ donation pledges; prayed for children in hospitals and welfare centers; ran community kitchens to serve meals to entire neighborhoods; and planted 30,000 trees. *Aravani* leaders also produced a short film about their lives and their efforts at disease prevention.

Aravanigal Dinam now lasts for a week, and the events have helped to mainstream transgenders into Tamil Nadu society. In 2007 the state's social welfare minister and health secretary presided over the week's closing event. As *aravanis* and local implementing NGOs have worked with senior officials and police in each district to plan the activities, the community has begun to see concrete socio-economic benefits. During 2008, the state government established a special social welfare board to look into issues concerning *aravanis* and to conduct a statewide census of the community. The government now finances sex reassignment surgery at public hospitals for *aravanis*, so that they do not have to resort to unqualified "quack" doctors. *Aravanis* also now have the right to be classified as a "third gender" for the purposes of receiving ration cards and applying for admission to educational institutions.

Recruitment of peer outreach workers attained scale rapidly: the ratio of peer outreach workers to MSM and transgenders across the program decreased from 1:218 in January 2005 to 1:67 by January 2007 (Figure 6). It is worth noting, however, that approaches to peer led outreach have varied among partners: for example, in Bangalore and some other parts of Karnataka, MSM and transgender peers are employed full-time rather than part-time, and the ratio of peers to clients is closer to 1:100.

The introduction of micro-planning in mid-2006 had a positive impact as peer outreach workers learned to manage and prioritize outreach more effectively. Over an 18-month period beginning in July 2006, the ratio of peers to MSM and transgenders dropped by about half (meaning that each peer had roughly twice as much time to spend on outreach), while the proportion of the total enumerated population of MSM and transgenders who were contacted monthly more than trebled, reaching 72 percent by July 2008 (Figure 6).

Monthly clinic attendance by MSM and transgenders has not yet reached the goal of 33 percent of the total estimated population (which would equate with 100 percent attendance every quarter), but attendance has increased significantly, particularly since January 2007, from seven percent to 17 percent (Figure 7). The proportion of MSM and transgenders giving an STI symptom as the reason for their visit has declined from a peak of 24 percent to a low of six percent.

Advocacy with government authorities led to an increase in the monthly number of MSM and transgenders receiving government identification cards, particularly since the second phase of the intervention began in April 2009 (Figure 8).

Figure 5: Responsibility for Coverage of Enumerated High-Risk MSM and Transgenders in Four Avahan Intervention States
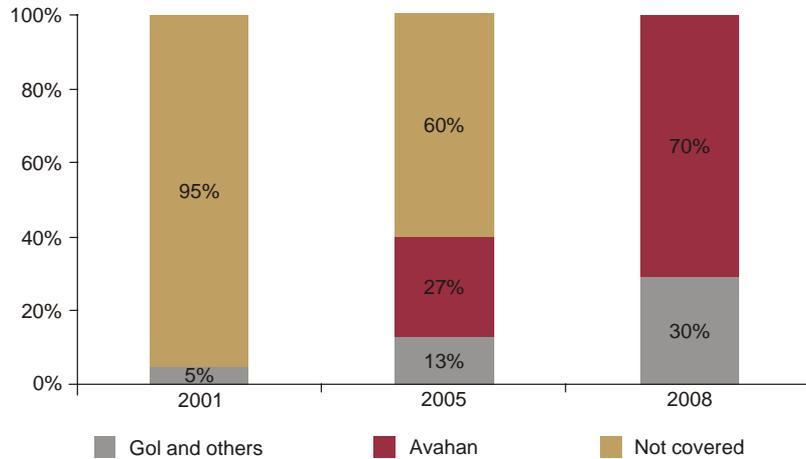
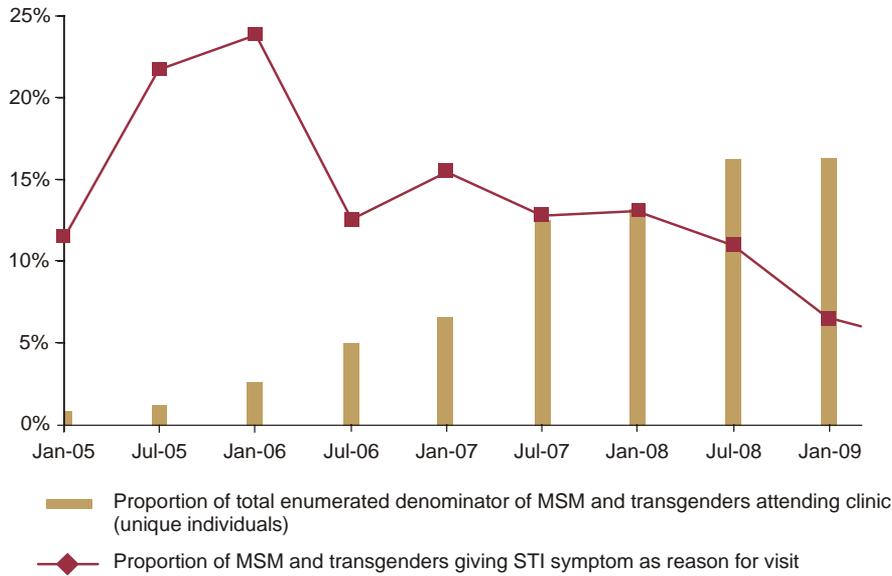**Source:** NACO and Avahan routine monitoring data*

Figure 6: Ratio of Community Members to Peer Outreach Workers and Monthly Outreach Contacts by Program
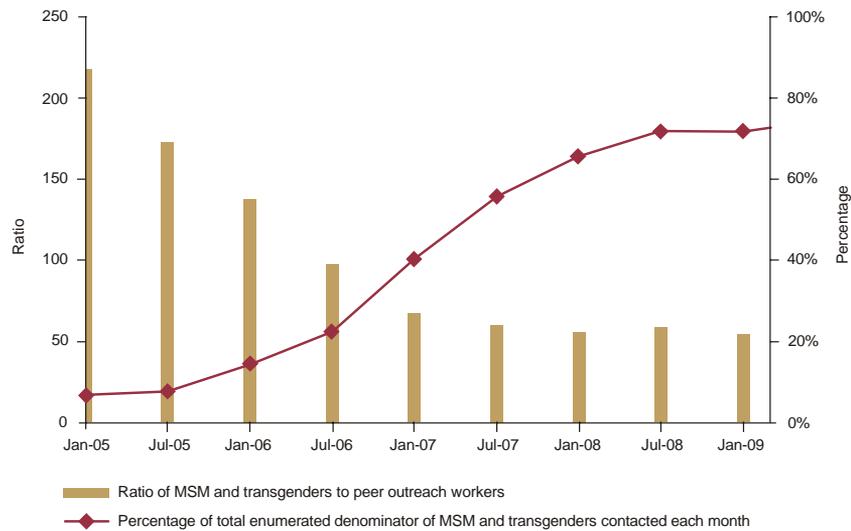
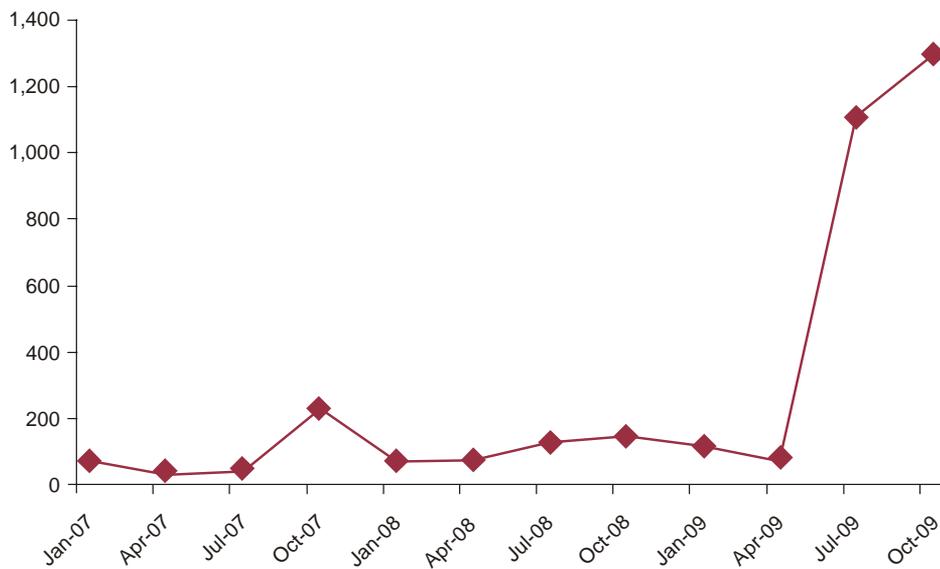**Source:** Avahan routine monitoring data

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* "Enumerated" MSM and transgenders means those identified and counted by the program, and this number has increased as the program has become established and gained visibility. In Figure 5, the denominator used for each year is the total enumerated MSM and transgenders in 2008, since it is assumed that all of them existed in previous years, but some went uncounted as the interventions were expanding. (The 2008 population estimation inevitably also excludes some still-hidden high-risk MSM and transgenders and other MSM.) Government/others coverage figures are derived from the number of funded targeted interventions, assuming 1,000 individuals per intervention. Avahan coverage figures are derived from routine monitoring data.

Figure 7: Clinic Attendance

Proportion of total enumerated denominator of MSM and transgenders attending clinic (unique individuals)

Proportion of MSM and transgenders giving STI symptom as reason for visit

Source: Avahan routine monitoring data

Figure 8: Number of MSM and Transgenders Assisted by Avahan to Get Government ID

Source: Avahan routine monitoring data

LESSONS LEARNED

A "one size fits all" approach to interventions is unlikely to be successful.

Avahan's basic intervention package of peer led outreach, STI services, condom distribution, community mobilization, and advocacy has been effective in providing coverage to high-risk MSM and transgenders, just as it was with female sex workers. At the local level, however, programs must be flexible and sensitive to the differences in self-identity, class, language, and education that characterize MSM and transgenders. These subgroups often may not perceive an affinity or common interest with each other. In addition, the status of each subgroup within wider society varies regionally, according to local culture and customs.

Community involvement, while bringing its own challenges, is key to effective outreach.

Interventions gain credibility in the eyes of the community through the involvement of community members at multiple levels, from peer outreach workers to field officers to the project director. This helps outreach to individuals who may be largely invisible to outsiders (in the case of MSM) or part of closed social structures (transgenders). Developing outreach and community mobilization efforts within pre-existing networks such as informal groups or CBOs (or clans in the case of transgenders) can be successful, as long as consistent, hands-on support is given to build their capacity. At the same time, it is necessary to guard against factionalism—both within and between subgroups—that might otherwise limit the effectiveness of these efforts. It can also be challenging to develop and maintain a program focus if the existing group's goals are not broadly aligned with those of the intervention.

Despite these differences, Avahan has found that it is possible to mobilize these communities collectively around shared issues such as discrimination and violence. Different models for mobilization have been found to be appropriate for different settings: where networks of female sex workers and MSM overlap, co-programming is possible; community mobilizers may work full-time at some NGOs, and part-time at others, depending on the profile and needs of the community.

Issues of community visibility and power must be carefully considered in programming and community mobilization efforts.

Fear of public exposure may make some MSM more reluctant to campaign publicly for their rights than transgenders or female sex workers, for whom occupational solidarity and economic necessity can make public advocacy a more compelling option. On the other hand, traditional patriarchal attitudes may lead men to claim dominant roles in areas within the intervention (e.g., program management committees) where women also participate. A challenge for implementing organizations is to remain sensitive to these dynamics in order to mobilize high-risk communities effectively while minimizing internal conflict.

Advocacy with key stakeholders is essential to sensitize them to community needs.

Stigma and discrimination are frequently named by MSM and transgenders as their highest issue of concern. Self-stigma (internalized homophobia) is strong among MSM, and it can exacerbate their high-risk behaviors and make them unwilling to seek health services. Effective interventions must address this as well as the stigma, discrimination, harassment, and abuse which come from the wider community and public institutions.

Discriminatory attitudes and misconceptions of service providers must be addressed systematically.

Implementing NGOs that have not previously worked with MSM and transgenders may stigmatize those who have sex for pleasure rather than out of economic necessity, and they may lack understanding of the legal and social dimensions of discrimination faced by these communities. Similarly, even doctors who are willing to provide clinical services may initially be reluctant to perform internal examinations upon men, and lack clinical experience with the anatomical differences of transgenders. Continued uptake of services can be encouraged by carefully educating all NGO and medical staff about health care needs of MSM and transgenders, and by establishing monitoring and evaluation systems that include feedback from community members about their satisfaction with services.

THE FUTURE

Avahan's experience has shown that it is possible to rapidly implement and scale up HIV prevention interventions for high-risk MSM and transgenders in a developing country with complex demographic and social factors. Avahan is working to evaluate the effects of its programs on the epidemic and on HIV risk behaviors among high-risk groups, and it will continue these efforts as further data become available.

The epidemic of HIV among high-risk MSM and transgenders remains a cause for concern in India, with recent data suggesting a prevalence of approximately seven percent in this population group in 2008-09.[18] Avahan remains committed to increasing access to high-quality prevention services, while looking to the long-term sustainability of these programs. An important aspect of this is to strengthen links between community- and government-run clinics, and increase referrals to testing services for HIV and other STIs, and to anti-retroviral treatment centers when required. Advocacy with local stakeholders will continue to be important, to increase sensitivity to issues surrounding HIV and understanding and acceptance of the communities of MSM and transgenders.

At the state and national level, Avahan is working with State AIDS Control Societies and the Government of India to disseminate the approaches and skills that it has found effective.

At the same time, Avahan will continue working to strengthen recently formed community-based organizations and help them develop links to other groups—both within and outside the field of HIV—that can provide relevant resources and support. Community-based organizations must further develop their democratic governance structures and skills in leadership and in networking, as well as the ability to mobilize resources and to interact with governmental and non-governmental bodies. They thus may form a strong base capable of creating and sustaining demand for accessible and accountable services, as the provision of HIV prevention programs transitions from Avahan to state and national government.

AVAHAN PARTNERS

Lead Implementing Partners

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

The India HIV/AIDS Alliance serves 23,000 high-risk MSM and transgenders and 48,000 female sex workers, covering 14 districts of Andhra Pradesh state.

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

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

Hindustan Latex Family Planning Promotion Trust (HLFPPT) coordinates the Nestam Project, which serves 11,000 high-risk MSM and transgenders in nine coastal districts of Andhra Pradesh state, while its Swagati Project reaches 25,000 female sex workers across the same area.

http://www.hlfppt.org

Corridors and Project Sankalp, Karnataka Health Promotion Trust, Karnataka

The Karnataka Health Promotion Trust (KHPT) serves 21,000 high-risk MSM and transgenders, and 64,000 female sex workers, through its Sankalp and Corridors Projects, which operate in 16 districts of Karnataka state and three of Maharashtra state.

http://www.khpt.org/project.html

Aastha Project, Family Health International, Maharashtra

Family Health International's (FHI) Aastha Project serves 3,000 high-risk MSM and 26,000 female sex workers in Mumbai and Thane districts of Maharashtra state.

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

Mukta Project, Pathfinder International, Maharashtra

Pathfinder International's Mukta Project serves 6,000 high-risk MSM and transgenders and 14,000 female sex workers in 10 districts of Maharashtra state.

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

Project ORCHID, Emmanuel Hospital Association, Manipur and Nagaland

Emmanuel Hospital Association (EHA), working with its sub-grantee, the Australian International Health Institute (Nossal Institute for Global Health), serves 18,000 injecting drug users and 1,100 high-risk MSM in 13 districts across the states of Manipur and Nagaland.

http://www.eha-health.org/eha-in-manipur/orchid

Tamil Nadu AIDS Initiative, Voluntary Health Services, Tamil Nadu

Tamil Nadu AIDS Initiative (TAI) serves 15,000 high-risk MSM and transgenders and 35,000 female sex workers, in 12 districts of Tamil Nadu state.

www.taivhs.org

Several of the partners listed below have completed 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.

Partners for 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 development partners

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

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

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

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

Constella Futures (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 University is documenting the implementation of community led interventions and identifying elements of successful approaches.

Family Health International (FHI) is responsible for monitoring and evaluation data collection across the 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 for Population Sciences (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 documented geographic variation in HIV-1 prevalence, its determinants, and intervention coverage for 115 districts in southern India and supported additional activities for evaluation.

Government support partners

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

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

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GLOSSARY

Bridge populations are persons who have sexual contact with people at high risk of infection with STIs including HIV, 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 so that they can hold systems accountable for effective HIV prevention services, and advocate for others services that they require. CBOs may also carry out self-help initiatives and more general advocacy for high-risk groups. Membership in a CBO often entails a nominal annual fee, and regular attendance at 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 combine their direct knowledge of vulnerability to HIV with collective action to overcome the barriers they face, increase their self-reliance, and reduce their HIV risk.

Community ownership means that a high-risk community has control over the activities the program undertakes, and significant understanding of, and influence over, service delivery. Community-owned programs display leadership, initiative, representation, and oversight by community members, and the programs have accountability systems to ensure that the program's interests do not supersede those of the community.

Drop-in centers were established early on in the Avahan initiative to provide a safe space for high-risk groups to come together. The centers are often basically equipped but clean rooms that accommodate 50-150 people, with cushions and mattresses on the floor, and bathing facilities. 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 in the Avahan initiative 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 peer outreach workers for recording and analyzing risk and vulnerability during outreach. Peer outreach workers use a visual tool to collect data with which they directly plan further outreach, based on the needs of the individuals they are serving.

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 peer outreach workers 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.

Vulnerability refers to the circumstances which negatively impact the ability of a high-risk individual or group to remain uninfected by HIV. Vulnerability for a sex worker or a man who has sex with men is linked to abuse, violence, and social stigma, and impacts his or her control in sexual encounters.

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.

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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