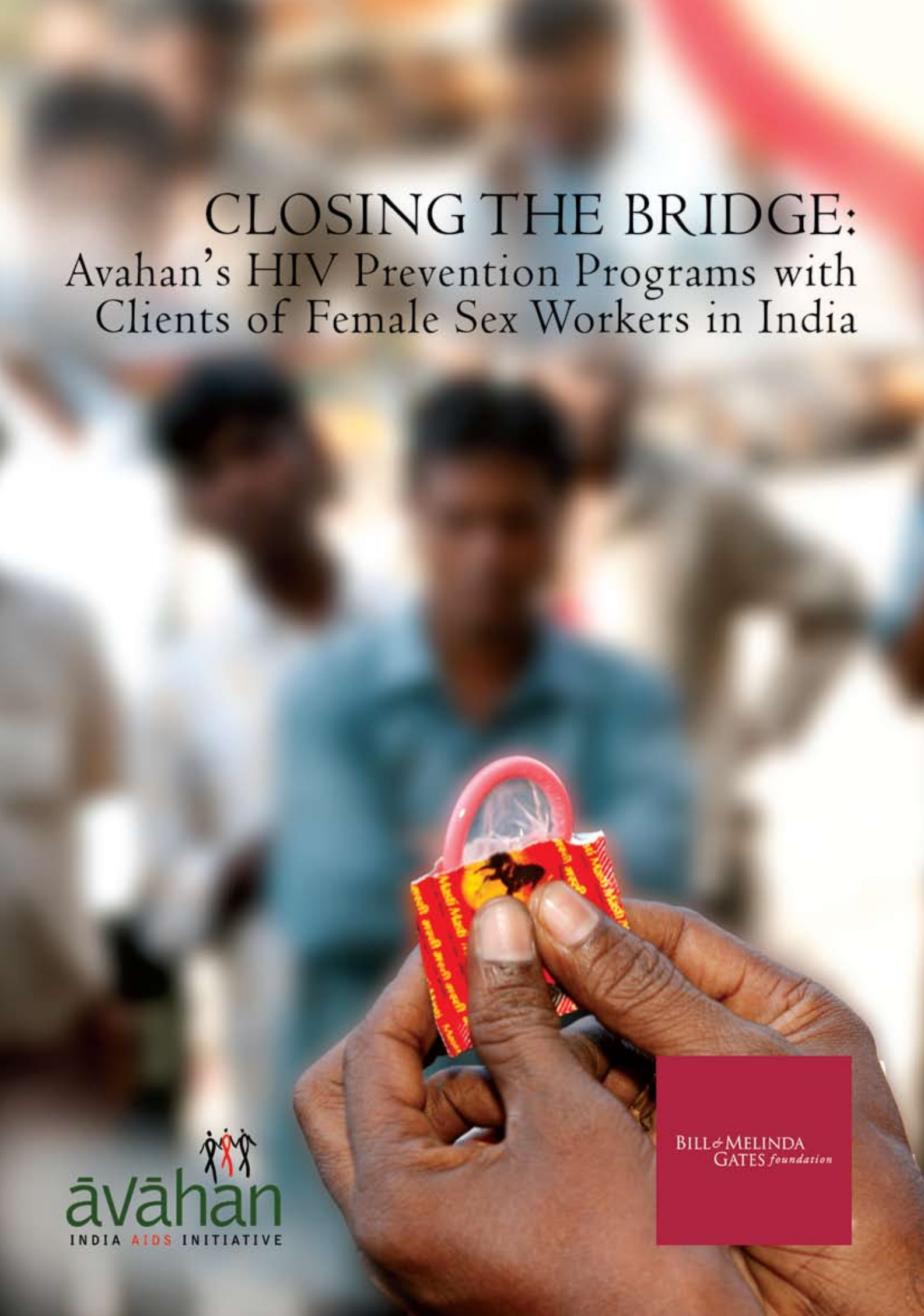

# CLOSING THE BRIDGE:
## Avahan's HIV Prevention Programs with Clients of Female Sex Workers in India

avahan
INDIA AIDS INITIATIVE

BILL & MELINDA GATES foundation

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Avahan India AIDS Initiative: Common Minimum Program

Closing the Bridge: Avahan's HIV Prevention Programs with Clients of Female Sex Workers in India

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# CLOSING THE BRIDGE:

## Avahan's HIV Prevention Programs with Clients of Female Sex Workers in India


BILL & MELINDA GATES *foundation*

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

We also thank James Baer who assisted in the writing and production of this publication.

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# CONTENTS

# AVAHAN—THE INDIA AIDS INITIATIVE

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 the country. 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.[i]

The Avahan initiative focuses on three high-risk populations in which the epidemic is concentrated: female sex workers, high-risk men who have sex with men and transgenders, and injecting drug users.[1] In addition, Avahan addresses "bridge populations"— individuals who may become infected with HIV through unprotected sex with members of a high-risk group and then transmit the virus to their low-risk/no-risk partners, especially their spouses.

This publication describes Avahan's HIV prevention interventions with male clients of female sex workers, who are the primary bridge population in India.[ii] Because clients are demographically indistinguishable from the general male population and therefore difficult to identify, Avahan designed programs to be directed at three overlapping population groups:

- **Self-identified clients:** contacted at hotspots (public places where sex is solicited) in four southern states—Andhra Pradesh, Karnataka, Maharashtra, and Tamil Nadu. These states together accounted for 83 percent of India's HIV infections in 2002.[2]
- **Long-distance truckers:** contacted at major transshipment locations along the country's national highways.[iii] Long-distance truckers are more likely than the general population to engage in commercial sex. Avahan's programs cover approximately 5 million clients and truckers.
- **Men of reproductive age** (15-49 years) in the four southern states: contacted through mass media campaigns. There are approximately 80 million men in this group.

This publication describes how Avahan implemented these programs rapidly and on a large scale, taking into account the particular social and cultural factors relevant to clients of sex workers in India. It also outlines some of the challenges, progress to date, and lessons learned.

i A complete description of the design and implementation of Avahan's 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

ii For the sake of concision, male clients of female sex workers are referred to in this publication simply as "clients."

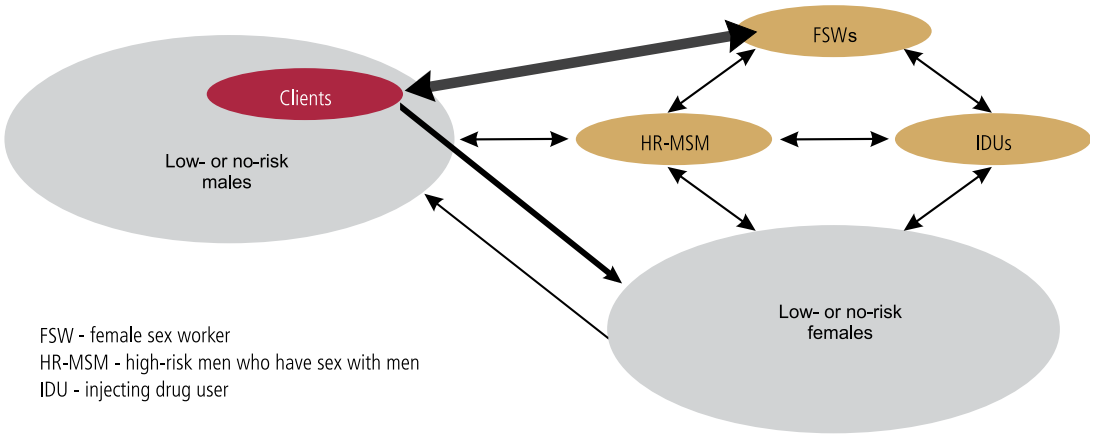
iii In this publication, "long-distance truckers" refers to truck drivers—and the helpers who travel with them—who are nationally mobile, i.e., who travel 800 kilometers (500 miles) or more in a single direction.

# CLIENTS OF FEMALE SEX WORKERS AND HIV RISK

## The need to work with clients of sex workers

When Avahan began its intervention in 2003, most epidemiological evidence suggested that India was facing a concentrated HIV epidemic. Consistent with most such epidemics in southern Asia and elsewhere,[3,4] transmission patterns were characterized by a chain of infection from high-risk to bridge populations and on to the general population (Figure 1).

## Figure 1: HIV Transmission Patterns in India




***Source:*** Tim Brown, East-West Center

At the time the intervention was designed, limited population-level data were available on sexual behavior among Indian men. A 2001 general population study showed that 12 percent reported having had sex with one or more non-regular female partners in the previous 12 months.[5,iv] In Maharashtra and Andhra Pradesh (two of the high-prevalence states in the south where Avahan provides HIV programming) 15 percent and 19 percent of men, respectively, reported one or more non-regular partners in the previous 12 months. Nationally, self-reported condom use was low, with only 34 percent of men reporting consistent condom use with all their non-regular partners.[v] Interventions to increase men's condom use with sex workers have been shown to be critical to controlling the spread of HIV in other settings,[6,7] and there was evidence that clients exercised some power in decision making around condom use during commercial sex acts.[8] However, intervention coverage was low: the proportion of clients exposed to an HIV intervention in the previous year ranged only from 18 percent to 31 percent across the four states

iv A non-regular partner was defined in this study as any sex partner other than a spouse in the case of currently married men. Among men who were not currently married, a non-regular partner was any sexual partner with whom the man did not have sex on a regular basis. Non-regular partners could include commercial sex partners.

v Consistent condom use was defined in this study as reporting using a condom on every occasion of sex with all non-regular sex partners in the previous 12 months.

to be covered by Avahan.[5,vi] A survey of long-distance truck drivers conducted in 2000 found that just 11 percent had been approached by staff from a non-governmental organization (NGO) talking about HIV prevention during the preceding year.[9]

## What do we know about clients of female sex workers?

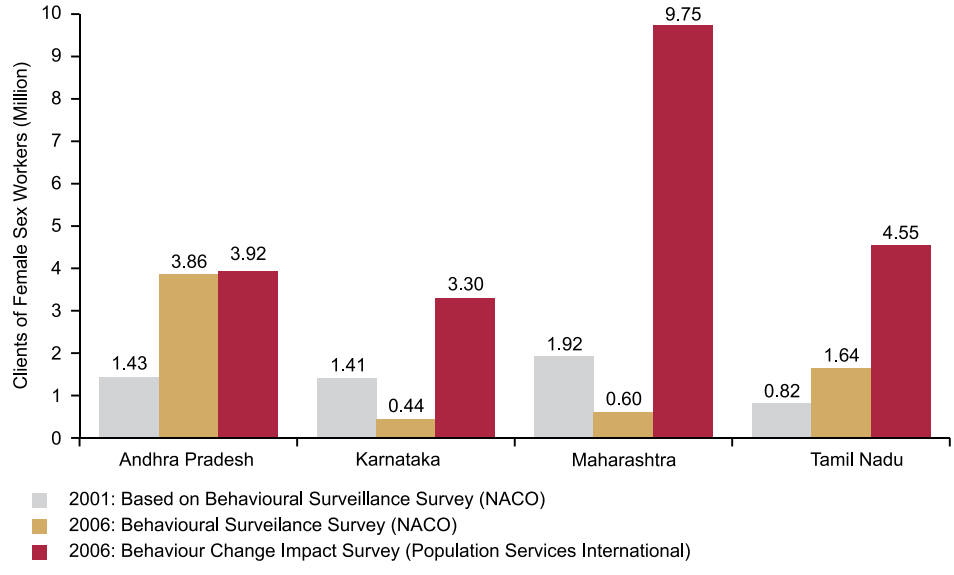
While clients are demographically similar to the general male population, their sexual risk behaviors, and the prevalence among them of sexually transmitted infections (STIs) including HIV, are very different. Understanding these differences was important in order to design effective programs.

### Population size

There are approximately 80 million men aged 15-49 in the four southern states where Avahan works. Estimating the number who are clients is very challenging, and different methods have produced figures that vary considerably within and between states (Figure 2). One of the reasons for this is that the demographics of self-identified clients are not significantly different from those of the general male population.

Baseline data gathered by the Indian National AIDS Control Organisation (NACO) in 2001 showed that in the states where Avahan was to work, the great majority of clients[vi] were under the age of 36; worked in local transportation, petty business, non-agricultural labor, services, or as truck drivers; were literate; and lived in the town or city where they reported that they last had a commercial sex encounter. Between one-third and half of them had lived in this town or city since birth, which indicated that the majority of clients were not migrant workers, as had earlier been surmised, although a small proportion (fewer than eight percent in three states, but 17 percent in Karnataka) traveled away from home at least every two weeks.[8]

## Figure 2: Estimated Population of Male Clients of Female Sex Workers in Four Intervention States




***Source:*** NACO, Population Services International

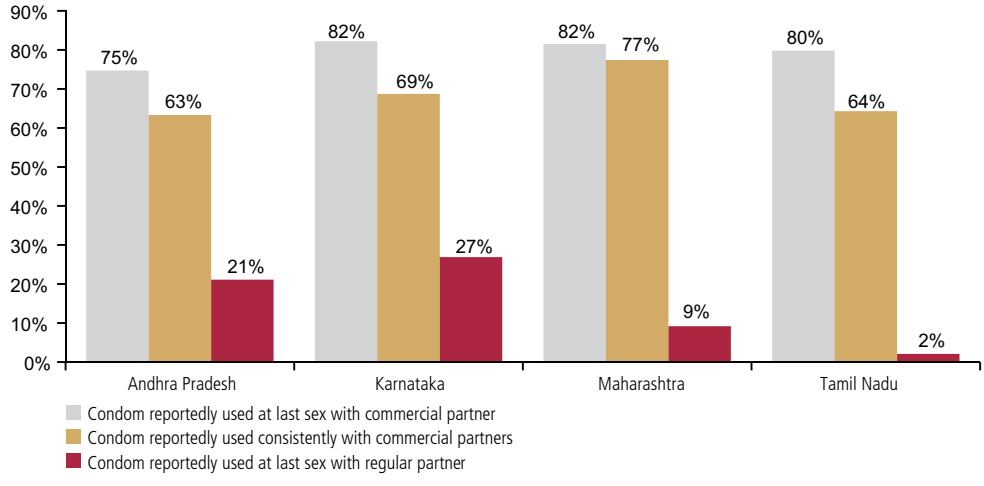
vi A client was defined in this study as a male (regardless of age) who self-identified as having bought sex for money in the previous month.

Self-reported measures of male client populations are known to be subject to biases and other limitations, as are measures that extrapolate from the average numbers of sex acts reported by female sex workers and clients in surveys. When Avahan began its interventions in 2003-04, it used an indirect size estimation of the male client population based on figures in the 2001 NACO *Behavioural Surveillance Survey* (represented by the gray bars in Figure 2). For program planning purposes, the total number of clients in the four states where Avahan was to work was estimated to be 5.6 million.

## Sexual risk behaviors

In 2001, before Avahan began its intervention, reported condom use by clients at their last encounter with a female sex worker varied from 75 percent to 82 percent among the four states (Figure 3). However, consistent condom use ranged only from 63 percent to 77 percent.[vii] The average number of commercial partners during the previous three months ranged from 3.1 to 4.6.[8] Clients reported that they first had sex an average of 2.1 to 3.8 years before marrying (depending on the state), and a significant proportion—between 27 percent and 59 percent—reported that the first time they had sex was with a commercial partner.

## Figure 3: Reported Condom Use among Male Clients of Female Sex Workers, 2001




***Source:*** *NACO Behavioural Surveillance Survey* 2001

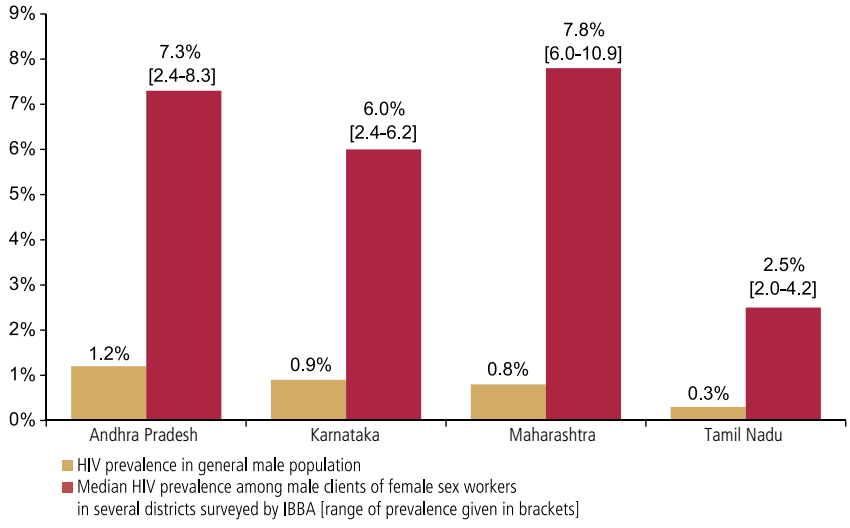
## HIV and other sexually transmitted infections

Comprehensive data on HIV and STI prevalence among clients of sex workers were not available when Avahan began its intervention, but more recent surveys conducted by Avahan have confirmed some initial assumptions: HIV prevalence is considerably higher among clients of sex workers than among the general male population (Figure 4), and rates of syphilis among clients range from 3.1 percent to 10.1 percent across the districts surveyed.[viii] (Rates of gonorrhea and chlamydia are considerably lower, with the highest district rates being 1.6 percent and 4.5 percent, respectively.)[10]

vii A client in this study was defined as a male (regardless of age) who self-identified as having bought sex for money in the previous month. Consistent condom use was defined as reporting using a condom on every occasion of sex with a commercial partner in the previous three months.

viii The *Integrated Behavioural and Biological Assessment (IBBA), Round 1*, from which these statistics are derived, defined a client as a male between the ages of 18 and 60 who had paid for sex with a female in the previous month.

## Figure 4: HIV Prevalence among General Male Population and among Male Clients of Female Sex Workers, 2006




***Source:*** *National Family Health Survey (NFHS-3)* 2005-06 [general population data], *IBBA* 2005-2007 [client data]

## The framework of Avahan's response

Two particular challenges confronted Avahan in designing and implementing interventions for clients of sex workers. The first was to maximize coverage despite the difficulty of identifying clients among the general population. The second was to provide prevention services quickly, and at the scale required to have an impact, to complement programs working with female sex workers themselves.

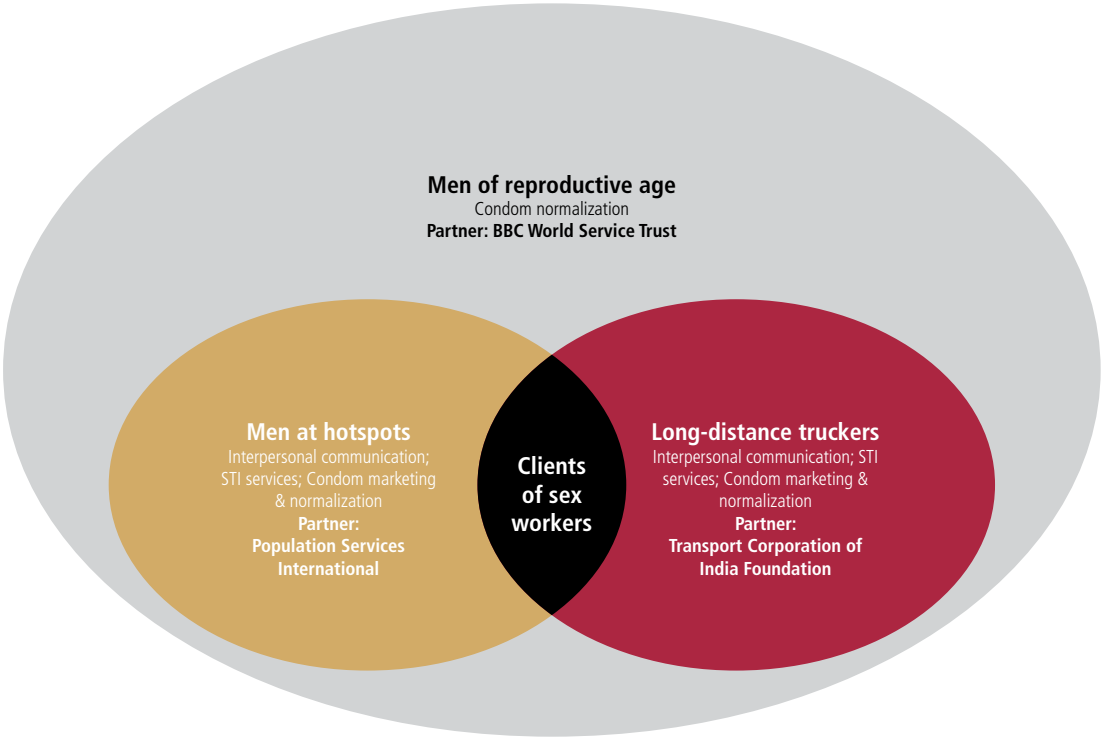
Avahan's framework for outreach incorporated all men of reproductive age, with additional programmatic focus on two distinct subgroups more likely to be clients: men identified as clients at hotspots, and long-distance truckers (Figure 5). The programs for these two subgroups were complementary, using strategies derived from global best practices: HIV awareness activities and condom education; management of STIs; and social marketing of condoms to make them available and accessible. The interventions were set in the context of a mass-media campaign for condom normalization, directed at all men of reproductive age and their partners, to make the idea of using condoms more acceptable and so to encourage their use by clients of sex workers.

### Maximizing Coverage

Hotspots are places where sex workers and their clients congregate; they may be parks, bus or railway stations, red light districts, or simply areas within commercial neighborhoods. Surveys have indicated that approximately 27 percent of men found at hotspots have been clients of sex workers within the previous 12 months—a considerably larger proportion than in the general population.[11] Therefore the first and most direct level of outreach was to clients of sex workers at hotspots.

To ensure that condoms would be available and accessible to clients, Avahan implemented intensive social marketing of condoms at an expanded range of retail outlets at or around known hotspots.[12] Outreach to clients also included interpersonal communication programs to encourage condom use and ensure that men knew how to use condoms correctly. This communication was delivered through street theatre presentations and one-to-one and

## Figure 5: Male Population Subgroups Addressed by Interventions for Actual and Potential Clients of Female Sex Workers




one-to-group discussions. Finally, diagnosis and treatment of STIs was offered near hotspots through franchised clinics.

The second group addressed by interventions were long-distance truckers. In studies conducted in 2001, 36 percent of long-distance truckers and 47 percent of their helpers reported having had commercial sex partners in the past 12 months,[9] and truckers constituted 10 percent of sex workers' clients.[8] Avahan's outreach to long-distance truckers took place along India's national highways, at transshipment locations, where truckers rest and receive their work assignments. As with clients of sex workers at hotspots, long-distance truckers received interpersonal communication, as well as access to condoms and fee-for-service diagnosis and treatment of STIs.

The third level of outreach was to all men in the reproductive age group. A coordinated television, radio, and print media campaign was designed to normalize the idea of talking about and using condoms among men and their partners. This would influence condom use among men who have sex with non-regular partners, including sex workers.

## Rapid scale-up

To ensure that interventions could be rolled out and scaled up rapidly, existing infrastructure and resources were used wherever possible. At hotspots, existing private health clinics were franchised into a recognizable brand to ensure visibility and standardize high-quality STI treatment. Since the long-distance trucking industry in India is unorganized, social networks of long-distance truckers were used to recruit peer outreach workers, and profes-

sional networks of trucking brokers helped ensure that information and clinical services were well located to make outreach effective. Research on the media consumption habits of men in the general population enabled the development of a multimedia campaign which capitalized on social networking to spread and reinforce the message of condom normalization. Where adequate infrastructure did not exist (such as branded clinics at transshipment locations for truckers), it was created by the program.

# REACHING CLIENTS OF SEX WORKERS AT HOTSPOTS

## The strategy for improving availability of condoms and clinical services

Avahan's partner in hotspot programming was Population Services International. The initial approach was to focus social marketing of condoms on hotspots and the areas immediately surrounding them, and to provide clinical treatment of STIs in these locations.

Condom social marketing efforts were directed at improving the availability and accessibility of condoms. This involved increasing the volume of stock at pharmacies; these were the traditional outlets for condoms and continued to account for the bulk of sales. At the same time, the range of venues at or near hotspots where condoms were sold was expanded to include non-traditional outlets such as restaurants, tea and coffee shops, *paan* shops,[ix] bars, clubs, and some hotels and lodges.[12] Because many non-traditional outlets (unlike most pharmacies) stay open seven days a week and late into the evening, condoms became more accessible at times when commercial sex was often being negotiated. There was also a drive to ensure that condoms and promotional materials were clearly visible at all outlets.

Avahan also focused on increasing the availability and quality of STI treatment at hotspots. Since research showed that men with symptomatic STIs preferred to seek medical care from private clinics or pharmacies rather than government health clinics,[8] Avahan identified private health providers located near hotspots and franchised them to provide STI treatment. The providers were trained in syndrome management and given ongoing technical support. Avahan established required standards for service delivery and provided supplementary training and supervision for clinic staff to ensure that these were met. A "Key Clinic Network" brand was created to increase the visibility of all the franchised clinics and the demand for their services. The brand promoted Key Clinics as places for quality health care that respected the dignity and confidentiality of patients. This reflected research showing that clients of sex workers were more likely to visit clinics that were not identified as being primarily for STIs.


## Refining the strategy and creating demand

When the intervention was analyzed after about 18 months, some of the assumptions on which it had been planned were challenged. Its impact was found to be limited

ix *Paan* is a preparation of nuts and spices wrapped in a betel leaf which is chewed after a meal.


by a focus on supplying commodities and services, without sufficient efforts to generate demand for them. In order to stimulate demand for condoms and reinforce safe sex messages, the project developed a "surround and engage" strategy using a variety of media, including interpersonal communication, advertising, and mid-media events such as street theatre. At hotspots, "Visibility, Accessibility, Touchability" (VAT) shows aimed to increase men's motivation to use condoms, and their confidence about using them correctly, through demonstrations with penis models. The VAT shows were supplemented by informal one-on-one discussions led by trained interpersonal communicators, and skits performed by street theatre groups. By using these different media, and changing the themes addressed every few months, the program aimed to keep messaging fresh, while reinforcing a coordinated message about consistent, correct condom use.

The approach to the provision of clinical services was also revised, since it was found that the existing network of 2,000 clinics was neither cost-effective nor conducive to high-quality services. A detailed cost-benefit analysis led to a refocusing of the clinic franchise on 100 towns that were estimated to account collectively for 65 percent of commercial sex within the four states. This gave the program potential access to the majority of clients of sex workers, while freeing up resources for activities to increase demand for services. The Key Clinic Network brand was advertised on television and in movie theatres, as well as through messages on billboards, buses, and auto rickshaws. Two advertising campaigns took place, in 2005 and 2006. Motivational messages encouraging men to seek treatment through the Key Clinic Network were developed, and these were delivered by the interpersonal communicators and actors in their condom presentations.

At the end of 2007, oversight of the franchised clinics transitioned from Avahan to the Government of India. Although the government did not retain the franchise model, it modified this approach to develop an expanded network of preferred health care providers for targeted interventions for all high-risk groups.

## Results

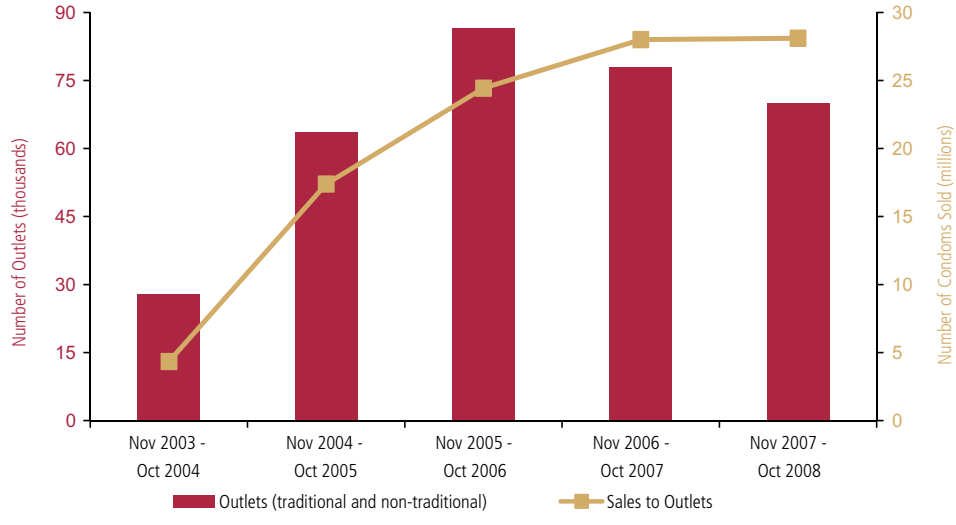
Over the course of the Avahan program there was a significant increase in the proportion of hotspots where condoms were consistently available, from 35.6 percent in August 2005 to 79.1 percent in November 2008.[12,x] The

x Program criteria specified that in order to be considered "covered," hotspots with up to 30 female sex workers should have at least five outlets selling condoms, those with 30-95 sex workers should have at least 10 outlets, and those with more than 95 sex workers should have at least 15.

use of non-traditional outlets to market condoms played a key role here, since there were no pharmacies at some hotspots, which had previously left these areas uncovered.

The number of condoms sold by the program to traditional and non-traditional outlets increased more than five-fold over a period of three years (Figure 6).[xi] The growth in condom sales outstripped the rate of increase in the number of outlets, indicating an increase in the average sales volume per outlet. This might be attributable not only to improved promotion, but also to better accessibility and availability of condoms, which was due to the location of outlets at or near hotspots, and the longer opening hours offered by non-traditional outlets compared with traditional ones. Although the number of condom outlets declined during the last two years of the program, sales to outlets continued to grow and then stabilized, which suggests that programming to drive demand was successful in ensuring consistent sales.

## Figure 6: Growth in Program-supported Traditional and Non-traditional Condom Outlets and Sales in Four Intervention States



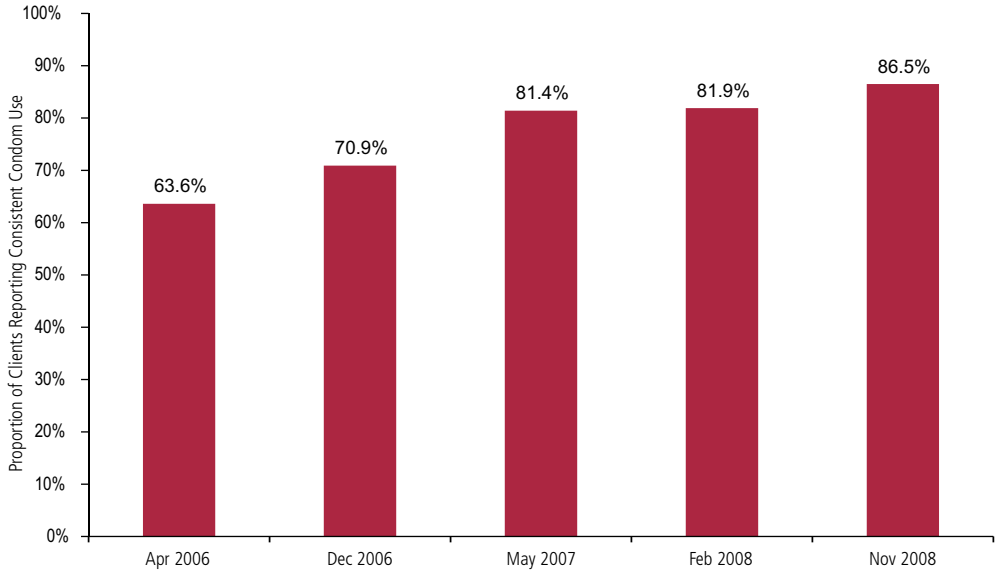

***Source:*** Population Services International monitoring data

The greater availability and accessibility of condoms was accompanied by a significant increase in consistent condom use reported by clients of female sex workers,[xii] from 63.6 percent in April 2006 to 81.4 percent a year later (Figure 7), rising to 86.5 percent in November 2008. A further factor driving this change in behavior may have been the messaging through VAT shows, interpersonal communication, and other media. In November 2008 those men who had been exposed to both interpersonal communication and mid-media reported higher consistent condom use in (89.4 percent) than those who had been exposed to neither, or only to static media (82.0 percent).

xi Because Avahan tracked only those condoms sold through the program, it is not possible to say with certainty whether there was an overall increase in condom sales in the four states.

xii A client was defined as a man aged 18 or older who had paid for sex with a sex worker during the previous 12 months. Consistent condom use was defined as reporting using a condom at last sex with a female sex worker, reporting always using condoms during sex with such partners in the past 12 months, and confirming that there was no exception in the past 12 months to having always used a condom with a female sex worker.

## Figure 7: Reported Consistent Condom Use by Men with Female Paid Partners in Hotspots in Four Intervention States




***Source:*** Lipovsek et al.[13]

# REACHING LONG-DISTANCE TRUCKERS

## The outreach strategy

Since truckers are mobile, an intervention restricted to the four southern Indian states where hotspot programming was being undertaken was unlikely to provide an effective level of coverage. Avahan's strategy—implemented by its partner, the Transport Corporation of India Foundation—was to provide services along national highways in multiple states.[xiii]

Truckers are not a homogeneous group in terms of their sexual behavior. The length of time they spend away from home appears to correlate with risk behavior: long-distance truckers report higher rates of sex with female sex workers or non-regular partners than their short-distance counterparts, and lower rates of last-time and consistent condom use.[14] Because of this, and since prevention programs for short-distance truckers were already being implemented by NACO, Avahan established interventions along national highways at transshipment locations—which are used by long-distance truckers—rather than the state highways used primarily by short-distance truckers.[xiv] Thirty-six sites were initially chosen, based on the numbers of long-distance truckers to be found in these locations.

Another factor affecting the program was that there were generally no qualified providers for medical services at the transshipment locations, which were situated far from towns. Rather than franchising private providers as it had done at hotspots, Avahan therefore had to develop its own branded network of clinics for treatment of STIs.

## Refining the strategy

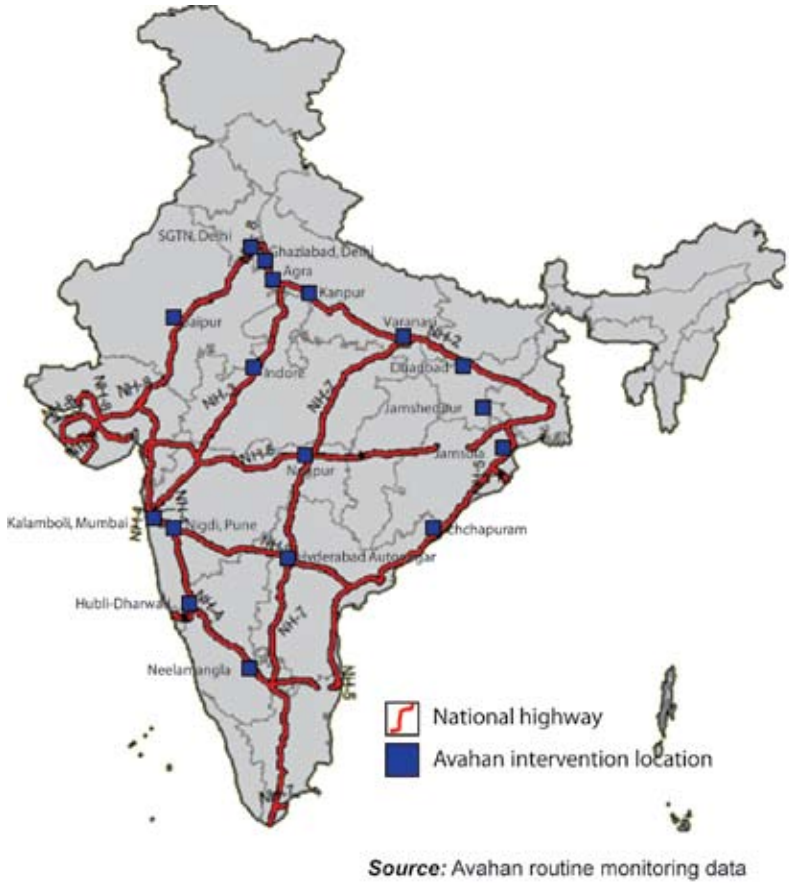
The program was designed to address gaps in existing state-supported programs for truckers, which operated as standalone interventions without coordination. However, an evaluation of Avahan-supported interventions in 2005 revealed that they were themselves too independent of one another and insufficiently focused on long-distance truckers (as opposed to short-distance truckers and other workers). As a result, only seven per cent of long-distance truckers took advantage of the services offered, and only 12 per cent of them were aware of the program.

xiii A complete description of the program can be found in a separate publication, *Off the Beaten Track: Avahan's Experience in the Business of Prevention among India's Long-Distance Truckers.* New Delhi: Bill & Melinda Gates Foundation, 2008. http://www.gatesfoundation.org/avahan/Documents/Avahan OffTheBeatenTrack.pdf

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

As with the hotspot programming, Avahan responded to these findings by redesigning the program with a narrower and more concentrated focus. From mid-2006 the number of intervention sites was reduced from 36 to 17 (Figure 8). These sites still gave potential access to one-third of the country's two million long-distance truckers, while allowing Avahan to concentrate resources to make services more comprehensive at each intervention location, and more consistent across locations. (The program was discontinued at two further sites in the second half of 2008, after monitoring showed that this would not adversely impact outreach, leading to a final total of 15 intervention sites.)

## Figure 8: Intervention Sites for Long-distance Truckers as of August 2006




***Source:*** Avahan routine monitoring data

New models of outreach were developed to maximize coverage and uptake of services. At each transshipment location, services were offered at multiple points with a high concentration of long-distance truckers, such as the offices of the brokers who assign work to drivers. Brokers are one of the most predictable elements in the working lives of truckers, who spend a significant amount of time waiting for assignments at their offices. This made them familiar and effective places to receive services. In addition to the program-run clinic in a fixed venue at each transshipment location, satellite clinics were now held in the mornings and afternoons, rotating among brokers' offices with high volumes of long-distance truckers. Clinics offered treatment for general ailments so that truckers could use the

services without the stigma of appearing to seek treatment for STIs. Interpersonal communication sessions were developed, including one-to-group and one-to-one educational sessions, together with mid-media activities such as street plays and health games played at kiosks. These sessions were timed to coincide with clinic hours, giving participants immediate access to services for diagnosis and treatment of STIs at the program-run clinics.

A crucial change in the presentation of the interpersonal communication sessions was that these were now delivered by peers—a cadre of current and former truckers and transport workers who were specially trained for this work. Previous outreach efforts had often involved didactic sessions delivered by salaried outreach workers, but truckers did not identify with them, which hampered the effectiveness of the outreach. Truckers proved much more receptive to educators of a similar background, language, and culture. Themes addressing beliefs about HIV and sexual behaviors were selected based on issues raised in discussions. These were coordinated between intervention locations and changed every six months to remain relevant and fresh.

The coordination of educational messages between sites was part of a broader standardization and branding of the entire outreach program. The program's name—*Khushi,* meaning "happiness" in Hindi—had been chosen through focus group discussions with truckers. This brand identity was now strengthened by standardizing the services offered at all sites, giving a uniform appearance to clinics, outreach materials, signage and advertising, and including the *Khushi* logo on all of these. This helped truckers recall the brand and easily recognize the services as they traveled from place to place.

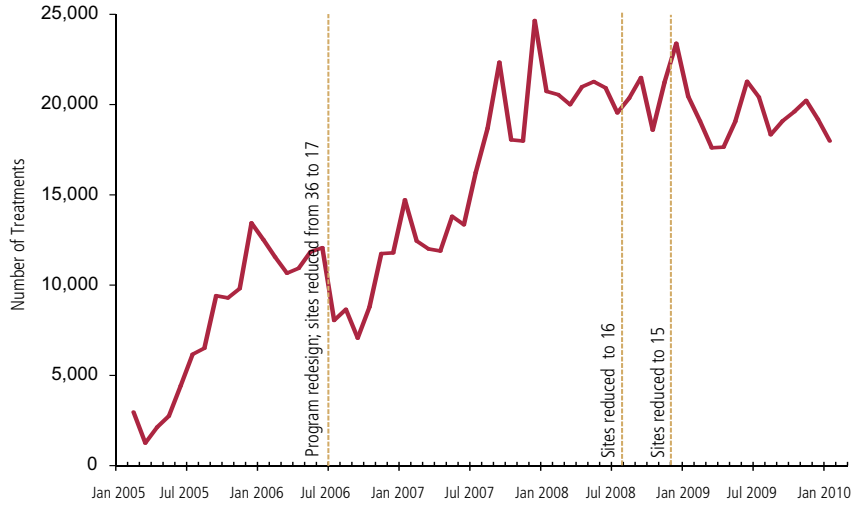
Research showed that many truckers had low self-esteem because of the rigors of their work, and that this was associated with risky sexual behaviors. The branding and marketing of the whole program aimed to encourage healthy sexual behavior by associating it with positive values that were important to truckers, such as professional pride, masculinity, and happiness.

## Results

The number of long-distance truckers treated in the *Khushi* clinics grew over the course of the program (Figure 9), with an average of 17,700 treatments performed each month after the reduction in the number of intervention sites

and the program redesign in mid-2006. Clinic visits continued to increase for more than a year after this redesign, showing the positive impact of intensifying outreach at the remaining sites.

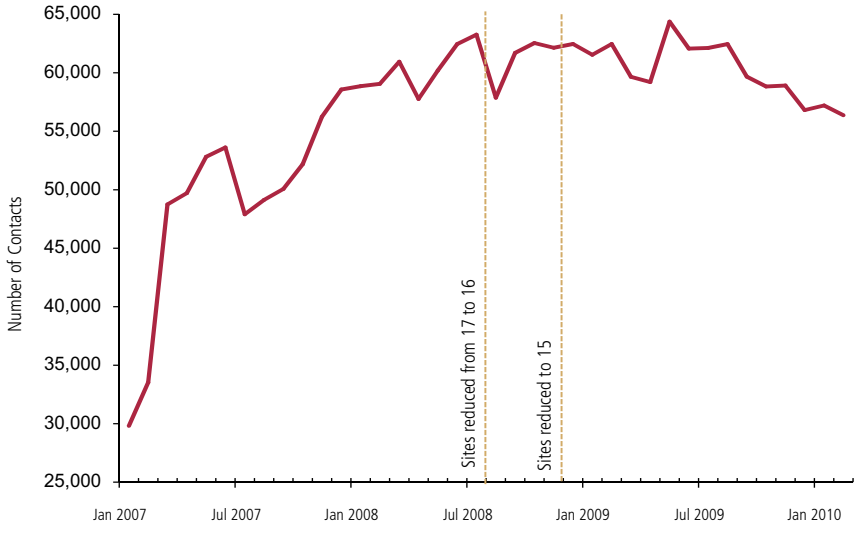
## Figure 9: Treatments Performed Monthly at *Khushi* Clinics




***Source:*** Avahan routine monitoring data

Interpersonal communication sessions (one-to-one and one-to-group) led by peers began in January 2007, and averaged nearly 57,000 contacts per month (Figure 10).

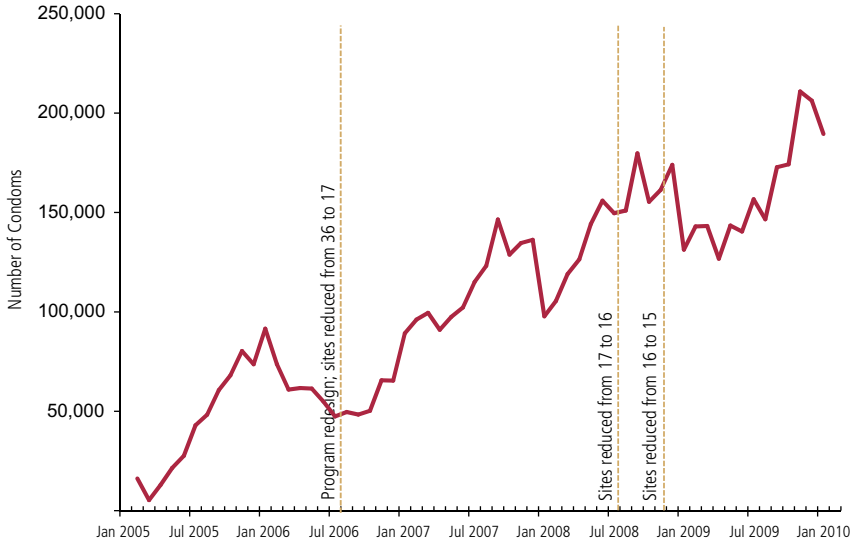
## Figure 10: Monthly Contacts through Interpersonal Communication




***Source:*** Avahan routine monitoring data


The number of condoms socially marketed to long-distance truckers by the program increased, with monthly sales averaging 117,000 after the redesign of the program. From March 2008 monthly sales consistently exceeded this average, peaking at almost 211,000 in November 2009 (Figure 11).[xv]

## Figure 11: Average Monthly Number of Condoms Sold at Trucker Transshipment Locations

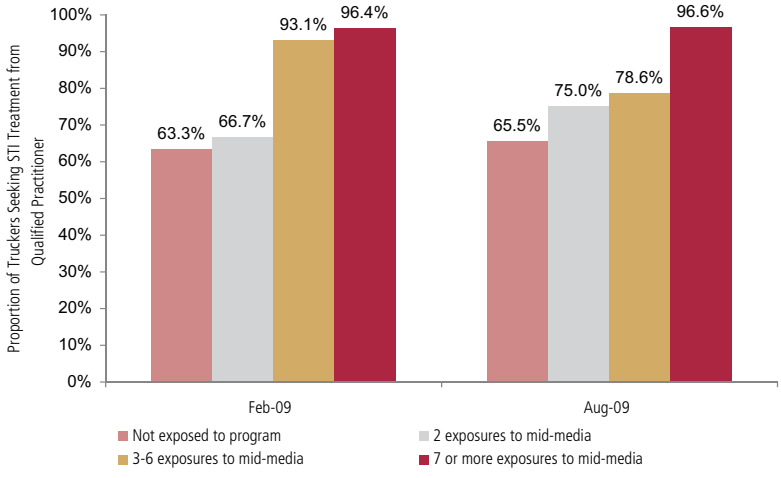



***Source:*** Avahan routine monitoring data

xv These socially marketed condoms are a subset of the condom sales recorded in Figure 6. Figure 6 represents sales to all condom outlets by stockists, while Figure 11 represents sales to truckers (the end users) by outlets located at transhipment locations.

Two rounds of behavioral surveys conducted in 2009 among long-distance truckers at intervention locations showed that exposure to the mid-media programs had an impact on whether truckers sought treatment for STIs from a qualified medical practitioner. This impact was still greater if these truckers had seen participated in three or more mid-media events (Figure 12).

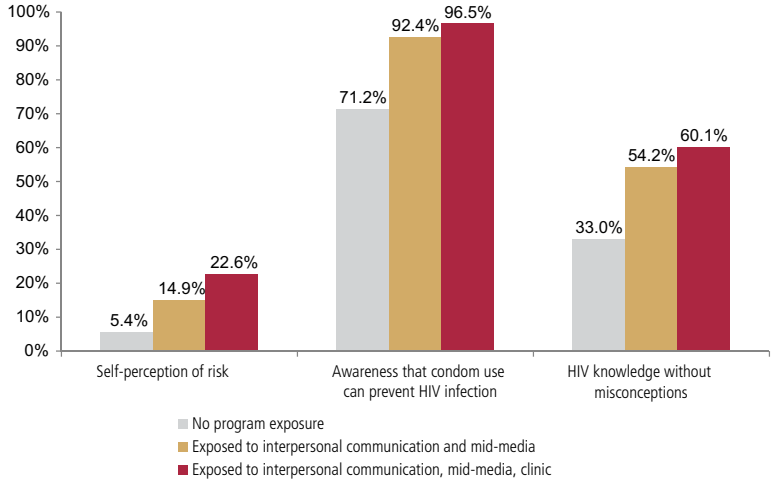
## Figure 12: Effect upon Treatment-seeking Behavior of Truckers' Exposure to *Khushi* Program Mid-media




***Source:*** Transport Corporation of India Foundation: Behavioral Tracking Surveys

Truckers who were exposed to the program also showed greater awareness of HIV, more accurate knowledge about it, and greater awareness of their own risk of infection (Figure 13).

## Figure 13: Impact of Program Exposure on Knowledge and Attitudes of Long-distance Truckers




***Source:*** Transport Corporation of India Foundation: aggregate of Behavioral Tracking Surveys, February and August 2009

# REACHING MEN IN THE REPRODUCTIVE AGE GROUP TO INFLUENCE SOCIETAL NORMS

## The strategy for condom normalization

Avahan partnered with the BBC World Service Trust to design and implement an advertising campaign to normalize the idea of condom use among the general population, where social norms discouraged open discussion of condoms. The approach was to increase social support for condom users by encouraging people—and especially men—to talk about condoms rather than seeing them as something embarrassing and unmentionable. At the same time, the campaign aimed to replace negative associations of condom use with connotations of smart and responsible behavior. It was designed to appeal to women as well as men, and to target all reproductive age groups, working on the hypothesis that if general attitudes towards condoms changed as intended, condom use by men who engaged in high-risk behaviors would increase.

The creative strategy was to make the campaign as interactive as possible, using traditional mass media along with new media (such as the internet and cell phone ringtones) to stimulate audience participation, so that the direct response of viewers and listeners would achieve one of the goals of the campaign—getting people to break with convention and actually talk about condoms. Adopting techniques associated with the commercial sector, the campaign established a brand using a logo, slogan, and mascot, which were applied across all media platforms to cement and sustain public awareness.

Previous HIV advertising had tended to rely on donations of airtime from broadcasters, which gave campaign organizers little control over the channels on which the messages were disseminated, or the times at which they were broadcast. By contrast, this campaign adopted techniques common to the marketing of other products. Research established the most popular channels and viewing times, and a media agency was used to buy advertising in bulk. This allowed for financial discounts while making it possible to saturate multiple media markets with concentrated six-week bursts of advertising. The campaign was designed to achieve 90 percent coverage of the target audience, and the primary medium was television, because this was most cost-efficient for reaching a mass audience, including the illiterate. Radio, print, and outdoor advertising were used to amplify the message, and new media—the internet and the rapidly expanding cell phone market—were exploited to make the campaign more interactive.

The campaign was rolled out in four phases over two years, beginning in December 2007. Each advertisement was designed to stimulate conversation and discussion about condoms rather than being didactic. This was done by presenting familiar social scenarios in a light-hearted way to depict talking about condoms as smart and responsible behavior for men. The campaign mascot, featuring in all the advertisements, was a clever and cheeky animated parrot—a symbol of talking—and the slogan attached to each example of positive talk about condoms was "The one who understands this is a winner."

Although the campaign was designed primarily for the four southern states where Avahan works, NACO decided to adopt the campaign, and the three later advertisements were broadcast nationwide, dubbed into a number of regional languages.

## The advertising campaign

Each of the four advertisements in the campaign was designed to elicit an interactive response from the viewer and stimulate conversation about condoms. The first advertisement did not mention condoms directly but instead presented a riddle, offering prizes to those who phoned in and gave the correct answer—which was "condom." Approximately 400,000 people called in over a three-week period, and post-exposure research showed that 70 percent of those who saw the advertisement discussed it with their friends.

Each of the following three advertisements centered on people saying or hearing the word "condom" in a familiar and public context—with positive consequences. In the second advertisement, a team playing the traditional Indian sport of *kabbadi* wins after throwing the opposing team off its stride by chanting "condom." This reinforced the idea that condoms are associated with smart strategy and winning. A print ad running in three newspapers invited people to send an SMS to the paper to say whether they agreed that "smart men talk about condoms." "Yes" responses averaged 89 percent.

The next advertisement showed a wedding celebration interrupted by a mobile phone whose ringtone is a jingle on the word "condom," eliciting approval rather than embarrassment on the part of all the wedding guests. Viewers were able to download the same ringtone to their own phones; three quarters of a million people did so. This was the first time a ringtone had been used as part of a health campaign, and extensive media coverage of the campaign followed in national and international news media and on more than 200 web portals.[xvi]

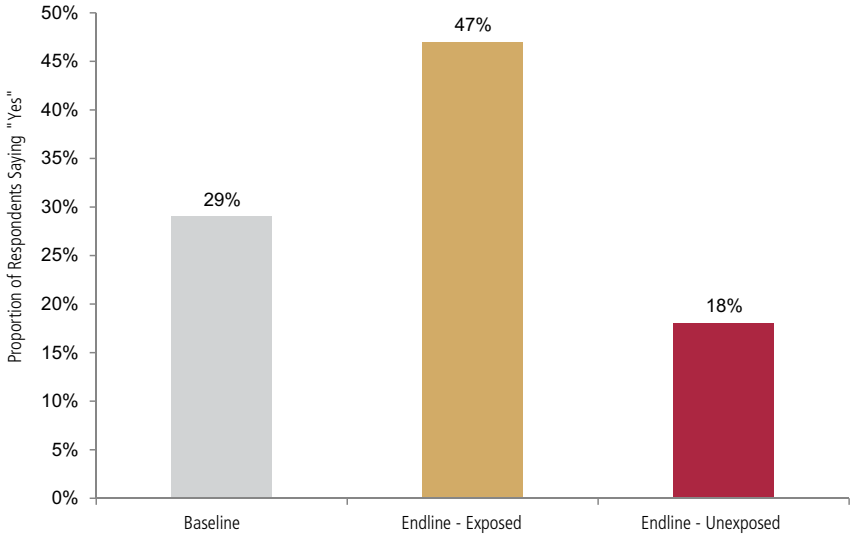
In the final advertisement, gender and age stereotypes were tackled as a middle-aged woman waiting in line at a post office pets a puppy whose name happens to be "Condom." She proclaims her support of condoms and condom users, earning the applause of everyone else at the post office.


xvi The cell phone ringtone developed for the campaign can be downloaded from www.condomcondom.org, which has further details about the campaign.

## Results

The first condom advertisement was broadcast in the four southern states, where it reached 52 million men. The remainder of the campaign, broadcast nationwide, reached 139 million men across India. In early 2009, research compared attitudes towards condoms among men aged 15 to 49 with attitudes from a baseline study conducted in 2007, before the campaign began. The research showed an increase of more than 60 percent in the proportion of men who had discussed condoms in the previous 30 days, while among those unexposed to the advertisements, the proportion who had discussed condoms declined by one-third (Figure 14).

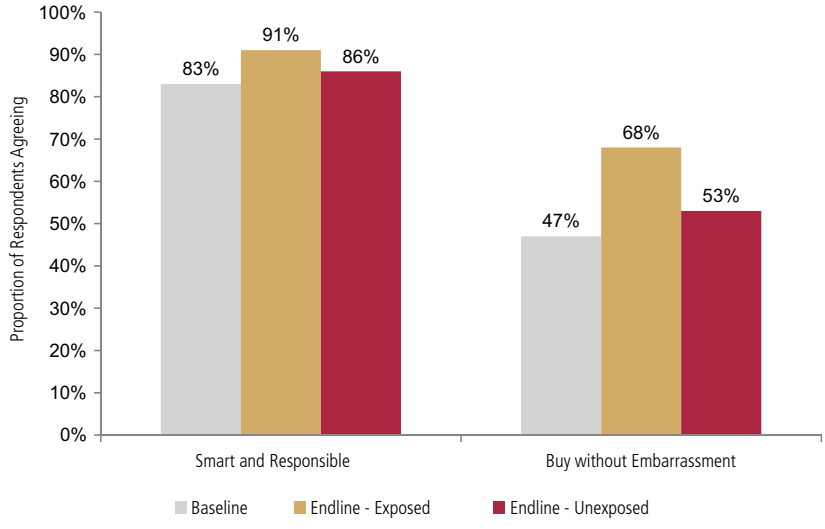
## Figure 14: Response to the Question: "Have you discussed condoms in the last 30 days?"




***Source:*** BBC World Service Trust. Baseline: 2007, endline: Jan-Feb 2009.

There were statistically significant increases in men's positive attitudes towards condom use and purchase during the campaign period (Figure 15), with larger increases among those exposed to the campaign.[xvii] The difference was particularly marked among men saying that they could purchase condoms without fear or embarrassment.

## Figure 15: Responses to the Statements: "Use of condoms reflects smart and responsible behavior" and "I can buy a condom from any shop without any fear or embarrassment"

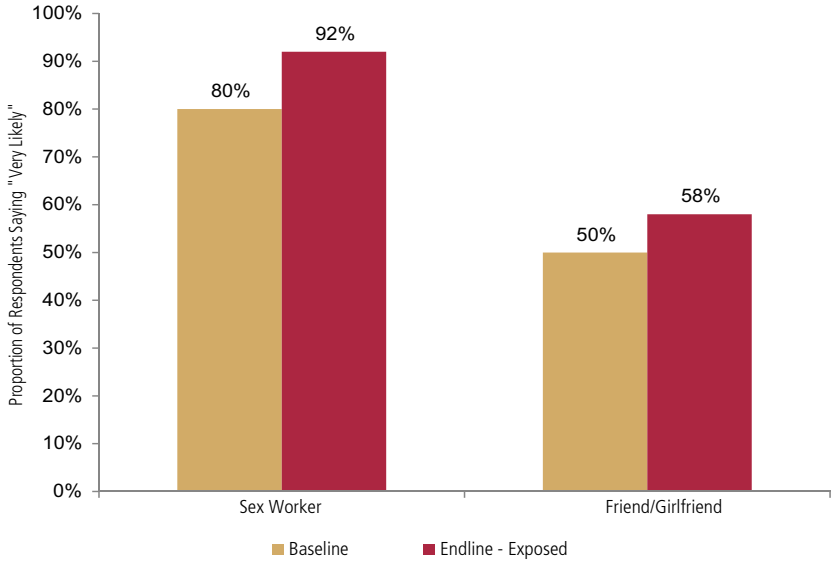



***Source:*** BBC World Service Trust. Baseline: 2007, endline: Jan-Feb 2009.


xvii The increase in positive attitudes among those unexposed to the campaign may be attributable to initiatives by State AIDS Control Societies and NGOs to promote condom use that took place during the same period. Nevertheless, the difference in attitudes between those unexposed and those exposed to the Trust's campaign is also statistically significant.

The campaign also positively affected the proportion of men saying that they were likely to use condoms with commercial sex workers or with female friends or girlfriends (Figure 16).

## Figure 16: Response to the Question: "How likely are you to use a condom the next time you have sex with a commercial sex worker, female friend, or girlfriend?"




***Source:*** BBC World Service Trust. Baseline: 2007, endline: Jan-Feb 2009.

# LESSONS LEARNED

The challenge facing Avahan was to locate, within the large and amorphous group of sexually active males, the small but numerically significant subgroup who are clients of sex workers, and design effective programs for them. Avahan's experience confirmed some approaches that had been used previously in HIV prevention programming, as well as providing some new lessons.

Avahan reasoned that interventions located at or near hotspots and on long-distance trucking routes would reach the highest concentrations of clients. As other programs had shown, increasing clients' access to condoms and clinical services for STIs involved focused social marketing, advertising, and branding. Avahan identified and prioritized the factors affecting condom use, and research findings were used to prioritize positive messages that would surmount behavioral barriers. Research also identified a strong correlation between social norms, support, and beliefs about condom use, and clients' decisions to use condoms. This led to the development of a mass media advertising campaign to creatively influence these factors.

Avahan's experience confirmed that an integrated range of communication activities was required to motivate and enable effective condom use. Audiences needed to hear a message repeatedly in order to fully understand and act on it. This led to the "surround and engage" approach of exposure to multiple activities (interpersonal communication, street theatre, game shows, etc.). The variety of media used made it possible to present the same message consistently in fresh ways. Research indicated that changing themes every three months also helped to avoid message fatigue.

Several other lessons came out of the interventions with clients:

**A smaller, focused intervention can be more effective than a widespread, diffuse one.**
Once it had identified the subgroups of men most at risk for HIV and made them the focus of its programming, Avahan reviewed its progress and found that more effective use of resources could be made by strategically concentrating its interventions in the areas most frequented by clients. This meant concentrating its hotspot outreach on 100 towns which accounted for 65 percent of sex work in the four program states. Similarly, higher volumes of long-distance truckers could be reached using fewer intervention sites by locating these along the most heavily-traveled routes. Intensive activities (the "surround sound" communications strategy) at the intervention locations helped reinforce messaging.

**The effectiveness of coverage can be increased by building on existing systems and structures.**
Identifying and winning the cooperation of partners on the ground takes time but is crucial for success. When franchising clinics for men at hotspots, it proved most effective to identify and select providers who were already serving clients of sex workers.

In the long-distance trucking industry, the majority of workers are independent operators rather than belonging to companies, and the lack of organization and regulation in the industry limited the options for designing an intervention. Analysis suggested that a logical point of contact for the truckers would be the brokers who assign work to them, since truckers gather regularly in their offices. Once the brokers' initial hesitation about becoming involved was overcome, the intervention was able to use their offices for interpersonal communication sessions and satellite clinics.


Using peer outreach workers drawn from current and former long-distance truckers, rather than professional outreach workers from NGOs, made outreach more effective. Peers had greater credibility and could also leverage their social networks for outreach contacts. Here again, brokers were able to help by identifying truckers who might be interested in becoming peer outreach workers.

**A franchise model can help improve delivery of clinical services.**

Franchise models for implementing STI services can be successful, provided there is a focus on training and support, and provision of packaged drugs. Avahan found that providers needed ongoing encouragement to participate in in-service workshops to address gaps in care, as well as to receive visits for monitoring and support. Regular collection and analysis of data was also important for evaluating the effectiveness of the program. In addition, it was necessary to use branding to address clients' reluctance to visit clinics that were specifically identified with STIs, as well as health care providers' reluctance to be exclusively identified in this way.

**Brand identity can increase use of services and the effectiveness of a program.**

Each of the three interventions developed a brand identity: the Key Clinic Network for clients at and around hotspots, *Khushi* clinics for truck drivers, and the talking parrot motif and slogans for the condom normalization campaign. Branding helped clients to identify and recall services and trust their quality, thus encouraging health-seeking behaviors.

**Establishing robust data collection and analysis procedures is crucial for assessing progress, making course corrections, and refining the program.**

Avahan was able to evaluate the outcomes of its initial interventions and to refocus them because its partners were collecting and reporting data on program indicators on a monthly basis. Data were also used to refine individual aspects of the programs; for example, lists of the precise locations of hotspots were the basis for identifying new condom outlets. Hotpots were classified according to the number of sex workers present, and standards were developed for the number of outlets for each size of hotspot. Monitoring sales enabled Avahan to investigate and respond to outlets with low sales volumes. Finally, condom coverage was tracked through lot quality assurance sampling.[12] This technique uses simple procedures to collect quantitative data such as the number of outlets stocking condoms at or near hotpots, and qualitative data such as the visibility of stock and signage, and opening hours and days of the outlet. Analysis of these data made it possible to improve condom coverage.

Ensuring accurate and timely reporting of data by private sector providers was not without difficulties. Some doctors in the Key Clinic Network were inconsistent about keeping patient logs; in these cases data were verified by soliciting a verbal tally of patients seen in the previous month through a phone call. The standard of patient treatment in clinics was monitored through simulated patient surveys ("mystery patients").

# THE FUTURE

During the Avahan initiative, Avahan and its partners disseminated and replicated approaches that had been found effective. Each of the three programs described above has finished but has been adapted by other organizations, with the support of Avahan's partners.

Avahan has worked with donor organizations and the Government of India to establish a Condom Technical Support Group to assist NACO in generating demand for condoms. Although NACO distributed 600 million condoms annually, by 2006 sales had remained flat for several years. The Technical Support Group is reducing inefficiencies in the distribution and uptake of free condoms, and is using its professional expertise in marketing, demand creation, advertising, and brand promotion to create a strategic plan for socially marketed condoms, together with a national distribution network. The experience gained by Population Services International in condom programs for men at and around hotspots has contributed to this planning. In its first two years, the Technical Support Group has helped NACO achieve annual growth of 15 percent in socially marketed condoms.

Prevention interventions with long-distance truckers will eventually be handed over to NACO, with support given by the Transport Corporation of India Foundation as the Technical Support Unit. The ultimate goal is for state governments to take responsibility for these programs.

The adoption by NACO of the campaign designed by the BBC World Service Trust led to nationwide dissemination of the advertisements, and NACO has retained the Trust as a Technical Support Unit for condom normalization. Ongoing research into the barriers to condom normalization has identified individuals' perception of their own risk of infection as a particular issue, and the Technical Support Unit is assisting in the development of a campaign to address this.

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# GLOSSARY AND ABBREVIATIONS

Bridge populations are persons who have sexual contact with people at high risk of infection with STIs including HIV, and also with members of the general population.

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

HIV: Human immunodeficiency virus

IBBA: *Integrated Behavioural and Biological Assessment*

Long-distance truckers are truck drivers and their helpers who are nationally mobile, i.e., who travel 800 kilometers (500 miles) or more in a single direction.

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, some of whom are long-distance truckers.

Mid-media are communications activities for large groups, such as street plays, films, and health games played at kiosks.

NACO: Indian National AIDS Control Organisation

NGO: Non-governmental organization

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.

STI: Sexually transmitted infection

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

# VALUES OF THE FOUNDATION

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

Designed by Poonam Bevli Sahi, at FACET Design, New Delhi Tel: +91-11-24616720

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

Avahan's ten year charter has three distinct 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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