

FROM HILLS TO VALLEYS: Avahan's HIV Prevention Program among Injecting Drug Users in Northeast India

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Injecting Drug Users in Northeast India



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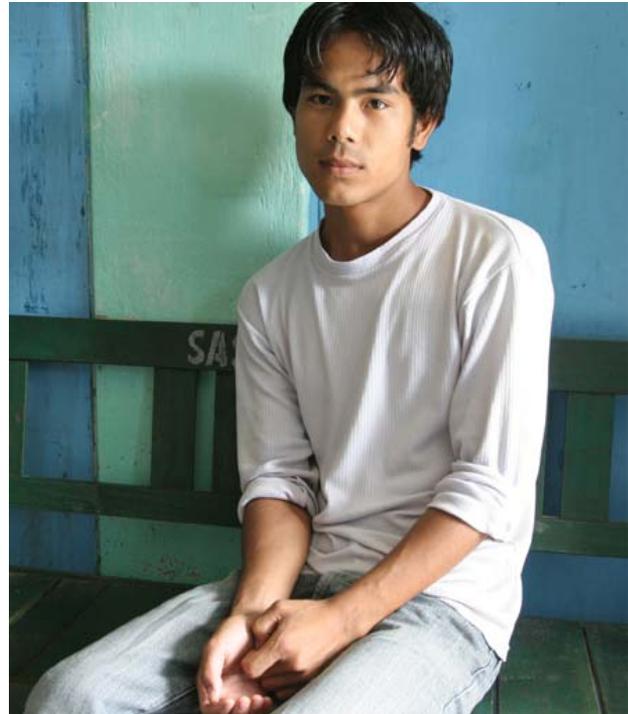
AVAHAN—THE INDIA AIDS INITIATIVE

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

In 2003 the Bill & Melinda Gates Foundation began its India HIV/AIDS Initiative, known as Avahan, a large-scale program to curtail the spread of HIV in India. The foundation has three primary goals for this initiative:

1. Build an HIV prevention model at scale in India
2. Catalyze others to take over and replicate the model
3. Foster and disseminate lessons learned within India and worldwide

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

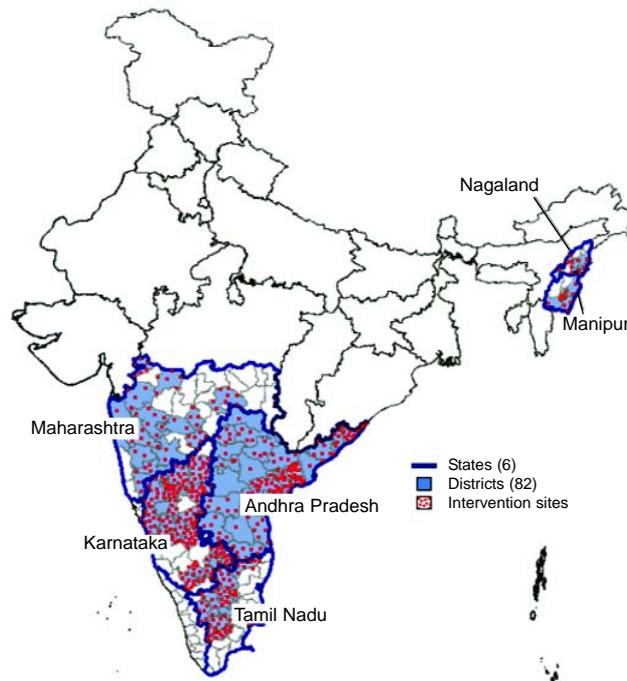


* Definitions of terms used in the publication can be found in the glossary.

** A district is an administrative subdivision of a state. In the states of Manipur and Nagaland, where Avahan works with injecting drug users, an average district has an area of 750 square miles and a population of 235,000.

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

Figure I: Avahan Intervention Districts



Source: Avahan Routine Monitoring Data

Avahan interventions

The Avahan package of prevention interventions in Manipur and Nagaland* includes:

1. **Peer led outreach.** Peer outreach workers identify high-risk individuals among their social network who are at risk and provide resources and support for safe injecting practices and safe sex, as well as encouraging their attendance at clinics and self-help programs. As of March 2009 Avahan has 480 outreach workers in 13 districts of Manipur and Nagaland.**
2. **Program-supported clinical services to treat sexually transmitted infections other than HIV and other relevant conditions.** Avahan has established 54 program-funded clinics to provide free STI diagnosis and treatment services. Treatment of abscesses and overdose management are also offered.
3. **Commodity distribution.** Avahan supports needle and syringe exchange for injecting drug users and promotes and distributes free condoms. As of September 2008, 290,000 clean needles and syringes were distributed each month by Avahan, nearly 190,000 used needles and syringes were returned, and more than 340,000 condoms were distributed monthly.

* Unless otherwise stated, the figures given below are for Avahan's programs in Manipur and Nagaland only.

** This figure includes 240 peer outreach workers, as well as 110 staff outreach workers of the NGOs implementing the initiative, who also perform some outreach. For more details, see the glossary and page 16.

4. **Facilitating community mobilization and ownership of the program.** In addition to risk-reduction services, Avahan addresses factors contributing to the vulnerability of high-risk groups and works with high-risk communities to strengthen their individual and collective agency so that they can adopt and sustain safer behaviors.⁵ Today, community committees oversee program implementation at each intervention site, and 31 community groups or organizations exist across the districts served by Avahan. The participation and leadership of high-risk communities continue to evolve as their skills and capacity grow to ensure that HIV prevention programs and vulnerability reduction efforts are sustained beyond the life of the Avahan initiative.
5. **Advocacy for an enabling environment.** Community groups associated with Avahan work with NGO staff at local levels to address societal perceptions that lead to stigmatization of HIV and high-risk communities. They advocate with the authorities and other stakeholders to secure an enabling environment (i.e., a more supportive legal framework and less hostile social atmosphere). These local efforts are supported by advocacy efforts at the state and national level.

This publication describes how Avahan's approach to HIV prevention was applied to injecting drug users in Manipur and Nagaland, the methods used to address the socio-political and geographic characteristics of these states, and the progress and lessons learned to date.



INJECTING DRUG USE AND HIV RISK

The global experience

The sharing of HIV-infected needles, syringes, and other injecting equipment by injecting drug users can spark and intensify HIV transmission, since HIV infection can be spread from injecting drug users to their sexual partners and from infected mothers to their infants. Injecting drug users are therefore a key group for the prevention of HIV transmission in several countries. They are particularly vulnerable to HIV infection because of their stigmatized and legally marginalized status: they often operate in hidden settings and are an especially hard-to-reach population.

Strategies based on the principles of harm reduction are widely recognized as the most effective approach for working with injecting drug users,⁶ even in resource-constrained settings,⁷ and do not increase the prevalence of injecting drug use.⁸ Harm reduction strategies recognize the many factors that contribute to infection risk for injecting drug users. These include frequent sharing of drugs, needles, and injection equipment, as well as personality traits that may predispose a person to drug use, and peer group norms that encourage and enable it.⁹ A comprehensive harm reduction approach includes the provision of a clean needle and syringe for each injection; the removal of used needles and syringes through an exchange program; and the provision of an oral opioid substitute for those who, while remaining addicted, choose not to inject drugs. Additional important components of harm reduction are the encouragement of condom use to prevent the sexual transmission of HIV; information and behavior change communication about drug use, HIV, and other STIs; treatment of STIs and abscesses; and basic general health care and management of opportunistic infections.

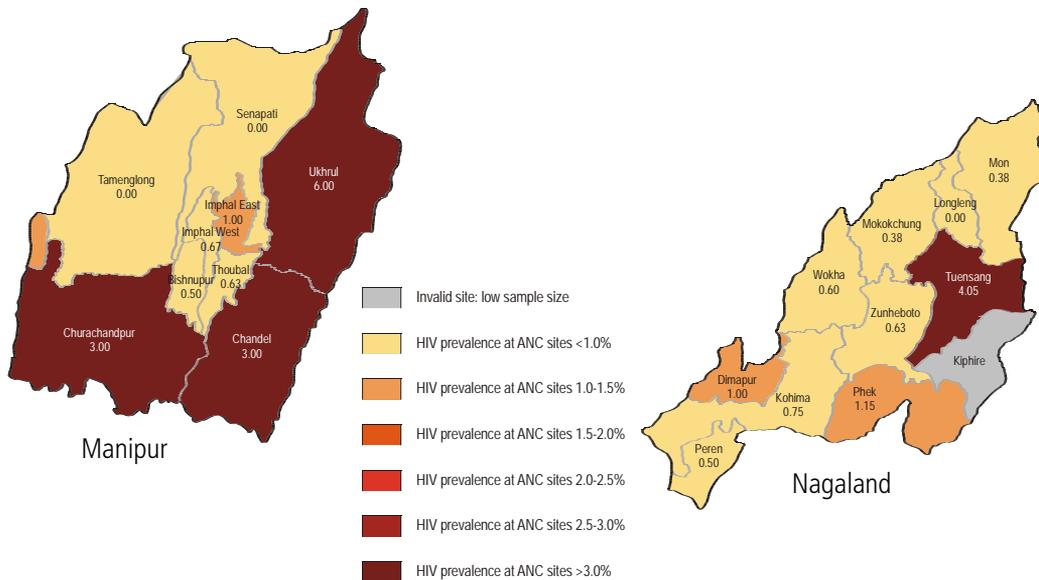


The Manipur and Nagaland context

Injecting drug use is estimated to contribute to almost two percent of all new HIV infections in India, but in the eight northeastern states of the country it is the major route of HIV transmission.¹⁰ It is estimated that there are more than 62,000 injecting drug users there.¹¹ They represent between a quarter and a half of all injecting drug users in India, even though these states account for less than four percent of the country's total population. By the mid-1990s, HIV prevalence among drug users in northeast India exceeded 50 percent, because of the dual epidemics of drug use and HIV.¹² Interventions with injecting drug users were initiated in 1993.

Manipur and Nagaland together have a population of approximately 4.7 million. This is 0.4 percent of India's population, but the two states account for 3 percent of the country's cumulative AIDS cases.¹³ Injecting drug users may constitute 1.9 percent to 2.7 percent of the adult population in these states.¹⁴ Following the establishment of HIV prevention interventions, HIV prevalence among injecting drug users in Manipur has declined from 24.5 percent in 2003 to 17.0 percent in 2007, and in Nagaland from 8.4 percent to 1.9 percent over the same period.¹⁵ However, the prevalence of HIV in antenatal clinic (ANC) attendees, which in 2007 was 0.8 percent in Manipur and 0.6 percent in Nagaland, remains higher than in all other Indian states except one,¹⁶ and there are also stark variations in prevalence between districts (Figure 2).

Figure 2: HIV Prevalence in Manipur and Nagaland



Source: NACO Sentinel Surveillance Data (2007)

Geographic and socio-political factors combine to enhance susceptibility to drug use. Manipur and Nagaland are next to the "Golden Triangle" (Myanmar, the Lao People's Democratic Republic, and Thailand), where drug smuggling is widespread, particularly along the porous border with Myanmar. Both states contend with longstanding inter-ethnic conflict and armed insurgency by secessionist movements. This situation has deterred development, leading to high levels of unemployment (ranging from 38 percent to 63 percent in the districts covered by Avahan) and poverty, as well as migration within and out of the states.¹⁷



Several factors had further implications for the design of Avahan's HIV prevention program and the effectiveness of service delivery for injecting drug users:

1. **Demographics.** While the great majority of injecting drug users in Manipur and Nagaland are male, approximately seven percent are female,¹⁸ and many of these also engage in sex work, increasing their risk of acquiring and spreading HIV. In Nagaland in particular, a significant minority of drug users begin injecting as teenagers. They are particularly hard to reach because they may fear that accessing services will lead to their exposure as drug users.
2. **Geography.** The population density of Manipur and Nagaland is very low compared with the rest of India—only one-third of the national average. The hilly topography and relatively poor infrastructure make it time-consuming and difficult to travel between towns and villages to reach these dispersed populations.
3. **Socio-political context.** The political instability within the states has obvious repercussions for medical and drug treatment infrastructure and service delivery. Daily life can be disrupted by outbreaks of violence, *bandhs* (one- or two-day strikes) called by insurgents or other organizations, and the activities of the large police and military forces, all of which can severely restrict people's ability to go out (including, for example, to visit a drop-in center or clinic). The heavy police and insurgent presence deters drug users from carrying syringes and needles, which can lead to the sharing of injecting equipment.
4. **Cultural factors.** Nagaland has 14 major tribes, and Manipur twice as many. Many different languages are spoken. Nagaland is predominantly Christian, while Manipur's valley areas are largely Hindu and its hill areas Christian. Church leaders have great authority in Christian communities, and in general they strongly disapprove not just of drug use but also of harm reduction programs, which they see as encouraging drug use and sexual promiscuity. Government and insurgent leaders often share these attitudes.
5. **Type of drug injected.** In Manipur, heroin and dextroproxythene (spasmo-proxyvon) are the main drugs of choice.¹⁹ Heroin is much less common in Nagaland, where almost all drug users use spasmo-proxyvon and other pharmaceutical drugs.²⁰ Users of different drugs have varying affinities with one another. Heroin users and spasmo-proxyvon users tend to view themselves as distinct groups and often do not mix with users of the other drug.

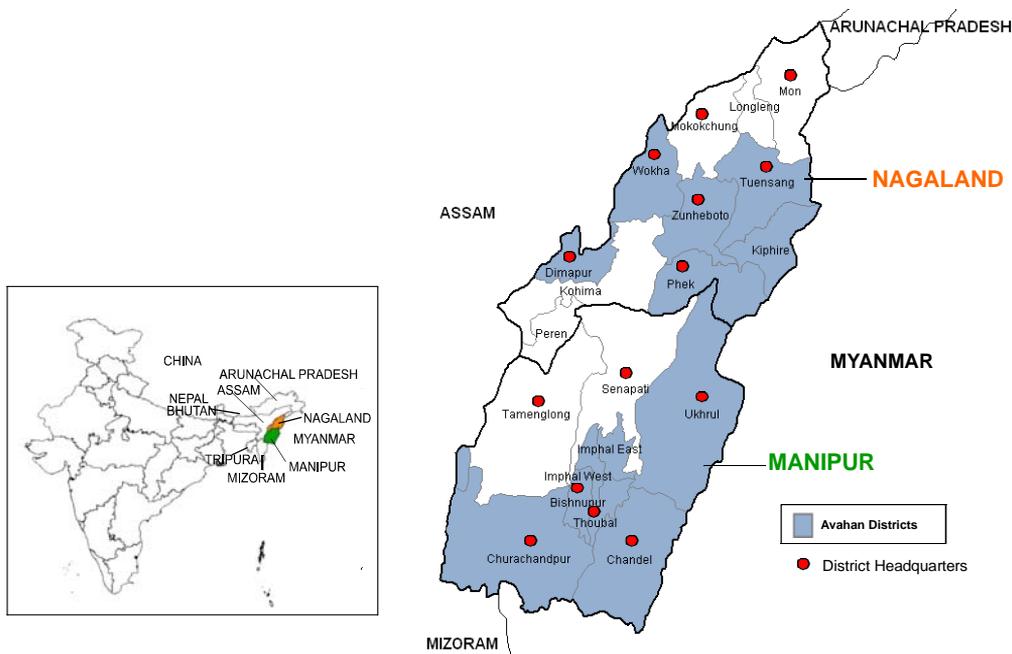
THE AVAHAN PROGRAM IN MANIPUR AND NAGALAND

Avahan's program in Manipur and Nagaland, known as Project ORCHID, was initiated in 2004 by its lead implementing partner in these states, the Australian International Health Institute (Nossal Institute for Global Health) at the University of Melbourne, in collaboration with a sub-grantee, Emmanuel Hospital Association (EHA).*

Avahan's mandate in these states was two-fold:

1. Build a model of high-quality HIV prevention programming with injecting drug users in selected locations
2. Strengthen local capacity to expand this model beyond Avahan intervention locations

Figure 3: Avahan's Work in Northeast India



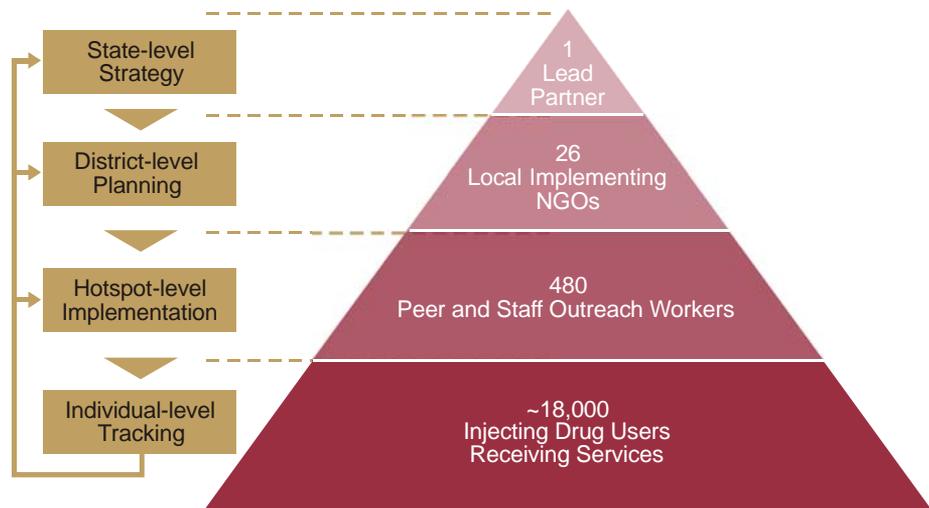
Source: Avahan Routine Monitoring Data

Unlike in the states of southern India (where Avahan works with female sex workers, men who have sex with men, and transgenders), attaining saturation coverage in the northeast through scale-up of the intervention was not a primary objective. Before the Avahan initiative, the State AIDS Control Societies (SACS) in Manipur and Nagaland were already working with NGOs to provide HIV prevention outreach to between 50 percent and 60 percent of

* Since 2009, EHA has been the primary grantee and the Australian International Health Institute the sub-grantee.

the estimated total number of injecting drug users. Avahan collaborated with the SACS to select districts where there were no interventions, or where its outreach would complement existing interventions, thus increasing overall coverage of the injecting drug user population. The program began in nine districts, and in 2005 four more were added, making a total of seven in Manipur and six in Nagaland. Figure 4 shows the structure of the Avahan initiative in Manipur and Nagaland.

Figure 4: The Avahan Organization in Manipur and Nagaland



Source: Avahan Routine Monitoring Data

To achieve rapid implementation, several elements of the program had to be initiated simultaneously, including the contracting of local implementing NGOs, capacity building of NGOs and peer outreach workers,* and advocacy with stakeholders to allow outreach services to begin. These elements are described below.



Building NGO capacity to initiate services

During the first year of the program, the lead implementing partner dedicated a team of staff to developing resources for local NGOs that had already been implementing outreach programs to injecting drug users, and these NGOs were invited to contract with Avahan. The team created guidelines and manuals on project management, human resources, finance and operations, and pre-grant inquiry. It also conducted workshops on proposal writing. This helped to ensure that the NGOs would be able to fulfill the terms of their contracts.

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

The lead implementing partner dedicated approximately 50 percent of its time and resources to building the capacity of the implementing NGOs. Staff and volunteers were trained in program management, communication, and advocacy, using classroom-based modules and input from field visits. In parallel, the lead implementing partner began building the infrastructure for roll-out of the program, setting up clinics and drop-in centers, recruiting peer outreach workers, and introducing harm reduction services to more injecting drug users.

Providing outreach services

Avahan's package of HIV prevention services draws on global experience in harm reduction and HIV prevention, with some modifications based on the conditions and experiences in Manipur and Nagaland:

1. **Needle and syringe exchange program.** To prevent the re-use of injection equipment (or the use of unsterilized equipment), clean needles and syringes are distributed and used needles and syringes are collected, either directly from the injecting drug users or from areas where injections take place, such as public bathrooms and dealers' homes. As of September 2008, the project had distributed a total of 9.1 million needles and syringes, with an average of 21 needles and syringes per injecting drug user each month and a return rate of 64 percent. More than 65 percent of these needles and syringes are distributed through outreach by peers rather than at drop-in centers. This feature distinguishes the program from most other needle and syringe exchange programs and is essential for its effectiveness because of the geography of the region and the restrictions on movement mentioned above.
2. **Treatment of sexually transmitted infections.** Avahan has established 54 clinics, providing STI management on at least one occasion to each injecting drug user profiled by the project. Because of a shortage



of doctors in the northeast, nurses are trained to work in the STI clinics on a full-time basis. Doctors are hired on a part-time basis (at least two days a week) to supervise the nurses. The clinics also provide treatment for other general ailments.

3. **Early identification and treatment of abscesses.** Abscesses are a particular risk when spasmoproxyvon is injected. Injecting drug users with abscesses are referred to the project clinics for treatment.
4. **Condom distribution.** Avahan promotes and distributes condoms to injecting drug users on a regular basis for use with their sexual partners. In September 2008, for example, 343,000 condoms were distributed, an average of 24 condoms per injecting drug user contacted.
5. **Overdose management.** To reduce the number of deaths from drug overdose, the project has organized a community led overdose management system, and all nurses at the NGO-run clinics are equipped with naloxone to treat overdoses.
6. **Referrals.** Injecting drug users are referred as needed to government-run integrated counseling and testing centers for HIV testing and counseling, to drug detoxification or rehabilitation centers, and to antiretroviral therapy centers and directly observed treatment short-course centers for treatment of HIV/AIDS and tuberculosis, respectively.
7. **Oral substitution therapy.** An important component of the harm reduction package, oral substitution therapy in the Avahan initiative is the prescription of buprenorphine as a substitute for injecting drugs. Beginning in May 2006, oral substitution therapy was introduced at some Avahan-run clinics. Funding came first from the UK Department for International Development, and after January 2008 from India's National AIDS Control Organisation (NACO) under the National AIDS Control Program III. Since April 2009, Avahan has been working closely with NACO for the expansion of oral substitution therapy in Manipur and Nagaland, with the aim of rapidly increasing coverage for injecting drug users to between 10 percent and 20 percent.

Effective and sustainable delivery of this prevention package depends upon the other elements of the Avahan approach: peer led outreach, community mobilization, and advocacy for an enabling environment.* The risk behavior of injecting drug users, as well as the geographic, socio-political, and cultural context in Manipur and Nagaland, required adaptation of the approach used elsewhere by Avahan. These differences are highlighted below with examples and case studies.

Achieving coverage through peer led outreach

Among injecting drug users, the most effective harm reduction approach is a community-based outreach program whose workers are current or former injecting drug users (peers). The contribution of peer led outreach to the reduction of HIV prevalence among injecting drug users is now well established.²¹ Peers have essential access, credibility, and insider knowledge. They make behavior change more viable by linking a deep understanding of risk and vulnerability with information and services.

In the global context, peer led outreach services have been introduced over the past two decades where re-use of needles and injection equipment by multiple persons is prevalent, especially in settings where injecting drug users are reluctant to access services and commodities at facilities such as drop-in centers. The approach is designed to access hidden or partly hidden populations of injecting drug users in their own environments and engage them in a process to enable the reduction of risky injecting and sexual practices.

* These elements are described in detail in another Avahan publication, *Managing HIV Prevention from the Ground Up: Avahan's Experience with Peer Led Outreach at Scale in India*. New Delhi: Bill & Melinda Gates Foundation, 2009.



Peers were identified by each NGO from among injecting drug users who participated in preliminary mapping exercises to identify hotspots. (This was in line with Avahan's approach to selecting peers in other states.) As the program developed, additional peers were selected to reflect the different geographic areas and typologies of drug user covered by the program.

Peers are supervised by staff outreach workers of the local NGO, who are themselves mostly former injecting drug users. In contrast to most of Avahan's programs with female sex workers in south India, these staff outreach workers also perform outreach with limited caseloads of injecting drug users. The overall ratio of outreach workers (peers and staff) to injecting drug users averages 1:50.

Peer outreach workers deliver the package of HIV prevention services described above, which ensures minimum quality and comparability of reporting data across the program.

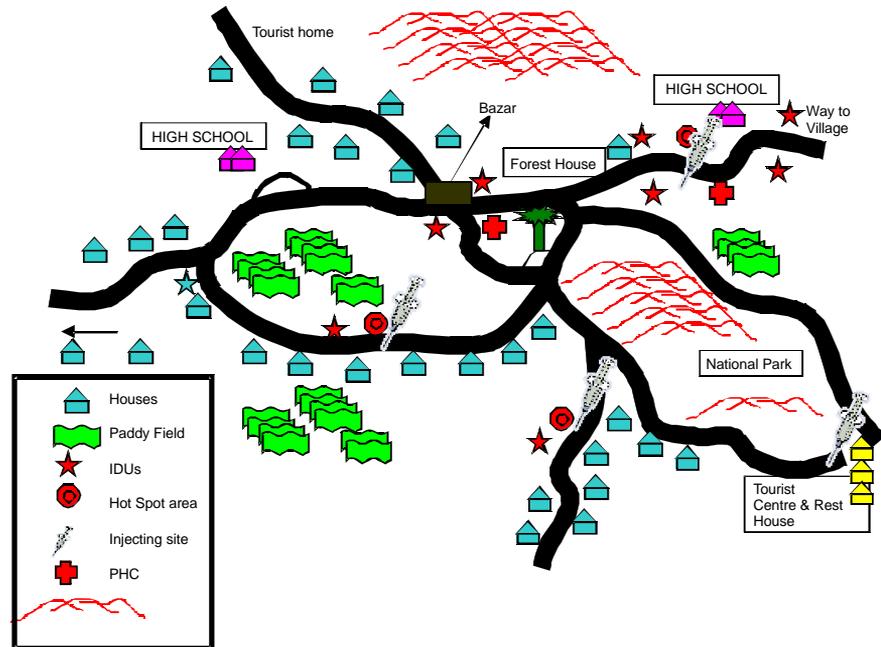
Mapping and micro-planning

Mapping and micro-planning are key to Avahan's approach.* Mapping of an area by members of the drug-using community enables an initial estimation of the number of people involved in using drugs and their location (Figure 5), and plots their relationship with other users. Mapping is repeated on a regular basis to refine and revise this data. Micro-planning allows peers to record and analyze data on the personal and social factors that make each individual vulnerable to high-risk behavior. Peers track their interactions with injecting drug users at daily, weekly, or monthly intervals (Figures 6 and 7).** As the movements of police and insurgent forces can lead to shifts in injection sites and hotspots, these plans are regularly updated by the peers and outreach workers. With this method the NGOs are able to prioritize those most immediately at risk and those not seen routinely.

* For a detailed description of mapping and micro-planning methodologies, see *Managing HIV Prevention from the Ground Up: Avahan's Experience with Peer Led Outreach at Scale in India*. New Delhi: Bill & Melinda Gates Foundation, 2009.

** Most injecting drug users served by Avahan are educated and 80 percent of them are literate, and the micro-planning tools reflect this. By contrast, micro-planning tools used by female sex worker peers in Avahan's programs in other states are specially designed to be completed with stickers and symbols since most of these peers have low literacy or are illiterate.

Figure 5: Hotspot Map



Source: Project ORCHID

Figure 6: Daily Tracking Form

DAILY INDIVIDUAL TRACKING SHEET									
Name of Peer:									
Sl No.	Name/ID No.	Address	1 ml Syringe/ Needle		2 ml Syringe/ Needle		Condom	1-to-1 Communication	Referral
			Distributed	Returned	Distributed	Returned			

Source: Project ORCHID

Figure 7: Monthly Tracking Form

MONTHLY INDIVIDUAL TRACKING SHEET																	
Name of ORW:					Name of PE:								Month				
Sl. No	ID Code	Name	Area	No. of Contacts	Received N/S				Returned N/S	Condom Received				No. of clinic visits for health services	Any incidents faced	No. of 1-1 PC	Any other services given
					Week 1	Week 2	Week 3	Week 4		Week 1	Week 2	Week 3	Week 4				

Source: Project ORCHID

The form in Figure 7 was designed by the lead implementing partner to ensure comparability of data across the program. It lists all the injecting drug users in a given site managed by a specific peer or staff outreach worker. The services provided to each injecting drug user every week are marked against his/her name. The peer transfers information from the daily tracking form to the monthly tracking form at least once a week, and the NGO's staff outreach worker analyzes the data along with the peer. This gives a clear understanding of how each peer is managing the delivery of services in his/her respective area. The outreach worker discusses with the peer any difficulties in delivering services, and plans are made for future outreach.

Avahan's approach to mapping and micro-planning makes peers not merely data collectors, but also data users, with the skills and authority to plan and manage their own outreach. This has proved essential in Manipur and Nagaland, where the highly dispersed population and the difficulties of travel make a more centralized approach to outreach impractical.

Secondary distributors

Because it is essential that injecting drug users have access to clean needles, syringes, and condoms for each injecting or sex act, Avahan introduced a further level of frontline workers in rural or isolated areas where injecting drug users were scattered and frequent contact from outreach workers was not practical. NGO staff enlisted the support of a local individual (e.g., an ex-user) or business (restaurant or kiosk) to act as a "secondary distributor," stocking enough needles, syringes, and condoms to meet the needs of the injecting drug users profiled by the program in the locality for a period of a week or so, as well as receiving used needles and syringes. Secondary distributors are educated about harm reduction and keep a log of commodities distributed to each user (as well as used needles and syringes received).

Peer training

Training has been critical for successful peer led outreach because of the heavy demands the program makes on peers. Because most peers are current drug users (staff outreach workers at the implementing NGOs are mostly former users), they must be able to manage their own drug use so that they can do effective outreach work.



Training was initially centralized, with a three- or four-day curriculum designed by the lead implementing partner and implemented by the NGOs. As the program developed, many NGOs found on-the-job training more effective than a centralized approach, for several reasons. New peers can learn by accompanying a more experienced peer to observe and participate in outreach. On-the-job training is also preferable in an environment where travel to a centralized location can be difficult or even dangerous, and because trainee peers prefer not to travel far from their sources of drugs. Quality control of capacity building is assured through frequent visits to the sites by project officers of the lead implementing partner to interact with outreach workers and peers. Injecting drug users who are not peer outreach workers are encouraged to attend capacity building sessions organized by the NGO. This enhances their trust in the program and enables the NGO to identify motivated community members who might take leadership roles in the future.

Avahan's experience in Manipur and Nagaland has been that turnover of peers is frequent among most NGOs. Turnover may occur for positive reasons (e.g., a peer becomes an outreach worker, decides to enter a detoxification program, or takes another job) or for negative ones (poor job performance, relapse into hard-core drug use that prevents them from working, or death), or because a peer moves out of the area. Continual motivation of peers, especially those who are current drug users, and identification of potential new peers, has therefore been important to the program's sustainability. Peers receive an honorarium (equivalent to about US\$30 a month) in line with levels set by the state government to compensate them for their time and work.

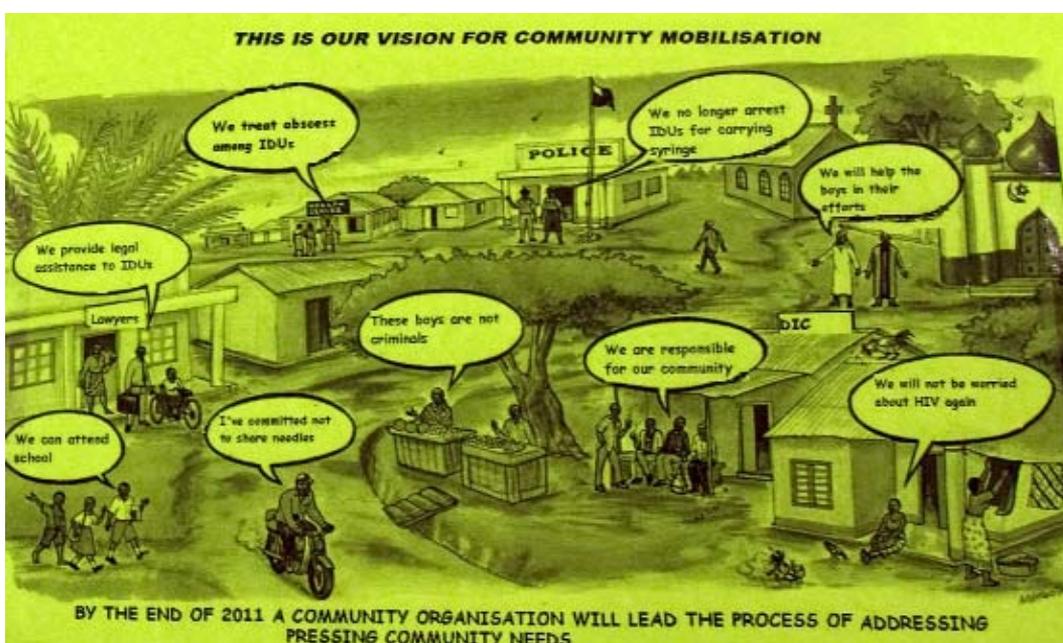
Mobilizing the community

Avahan's community mobilization approach aims to foster the involvement of injecting drug users in the program, which leads to ownership of interventions and empowers groups and individuals to take responsibility for their lives. Community mobilization is also essential to the long-term sustainability of the program.

Several barriers exist to mobilization beyond the demographic and geographic challenges already mentioned. High-risk individuals are often under the influence of drugs, and their focus on obtaining their next dose leaves little room for involvement in other activities. Injecting drug users, to an even greater extent than other high-risk groups, face stigma and discrimination from members of the general population, opinion leaders, and pressure groups in the region. Finally, as with Avahan's outreach in other states, many implementing NGOs were initially unsure of the community's ability to mobilize and did not fully appreciate the importance of mobilization to a sustainable intervention.

Avahan began institutionalizing community mobilization in Manipur and Nagaland from November 2007 onwards, once outreach was well established. The lead implementing partner formed a community mobilization advancement team to provide technical and managerial support to both injecting drug users and NGO staff, through classroom training and onsite visits. The team also helped establish a learning site to promote locally based learning and problem solving (see case study below), and it facilitated a series of exposure visits for community members to other states to witness strong community mobilization in action. Collaboration in the planning of community mobilization gave the staff of the NGOs and the injecting drug users confidence in the community's potential.

There are now more than 50 community committees overseeing program implementation at the site level across the program, including drop-in centers, clinics, referrals, and program monitoring. More than 30 informal community groups have been developed, and two registered community-based organizations (CBOs) have been formed. District-wide community events are held to discuss issues of concern to injecting drug users and to encourage wider mobilization.



Source: Project ORCHID

Implementing NGOs have reported that the establishment of program committees increased both the quality of services and the demand for them. Likewise, oral substitution therapy significantly accelerated the process of community mobilization, partly by offering community members the stability needed to focus on activities other than looking for their next dose of drugs, and partly by increasing the community's trust in the overall program.

Case Study: Community Mobilization and a Learning Site at Kumbi

Kumbi lies in a remote and troubled area in the south of Bishnupur district in Manipur. Avahan's local implementing NGO in Kumbi is the Dedicated People's Union (DPU), founded by a group of former injecting drug users and professionals who started to implement harm reduction for injecting drug users in the area. Program staff provided services, and mobilized and organized the community by using their own experience and knowledge as former drug users.

DPU ensured that community members were involved in each element of the program, from the initial needs assessment to monitoring and evaluation. As services developed, support groups and committees comprised of injecting drug users were founded to address their needs and give them ownership of the program. For example, the drop-in center committee facilitated a feedback process from the injecting drug users to the NGO staff. This led to a change in the center's opening hours and other facilities to meet the community's requirements. Community members also started income-generating activities, such as producing handicrafts and decorative items. A community-run barbershop at the site generates income for the staff and DPU, and is also used to motivate members to access clinical services: they receive a free haircut if they have visited the STI clinic.

The Kumbi Learning Site was developed to demonstrate community mobilization of injecting drug users to other implementing groups, by sharing practical program experiences and practices. Kumbi offers a comprehensive overview of the skills required for outreach and community mobilization, including outreach planning, documentation, capacity building, and strategies for meaningful community organization. Each visitor receives integrated presentations, case studies, field visits, and discussions with community members. Trainee groups are typically comprised of 80 percent community members and 20 percent NGO staff. While immersion training activities were initially conducted at the Kumbi Learning Site, the Kumbi staff and community members now provide capacity building support to other communities and NGOs in their own locations.



Advocacy for an enabling environment

Prolonged political struggle and years of militarization in the northeast of India have made Manipur and Nagaland extremely volatile. A variety of opinion leaders and non-state forces exercise great influence on people's daily lives. These include insurgent groups, as well as civil society groups such as churches (especially in predominantly Christian Nagaland), mothers' groups, and student organizations. Unofficial policies and practices adopted towards injecting drug users by some of these organizations have included arrest, forced detoxification, harassment and beatings, incarceration, and ostracism from the community.

In this context, creating and sustaining a supportive environment for HIV prevention is essential. An additional concern is that as drug users become more aware of services and gain confidence in accessing them, public resistance to the program may become more vocal. Carefully planned, ongoing advocacy with government, religious and women's groups, media, anti-drug organizations, and other formal and informal power brokers has been necessary in order to reduce opposition and allow the program to function at all. Advocacy with stakeholders was initiated by the lead implementing partner, but at the same time local NGOs were given a series of advocacy skills training sessions so that they would be able to conduct effective advocacy activities in their own localities.



Governmental support is crucial in giving the program credibility with local officials. Each state's coordinating committee, chaired by the state Health Secretary, coordinates activities between the government and Avahan and fosters complementary, rather than overlapping, coverage. High-level and one-to-one meetings with government officials have taken place to educate them on the state of the epidemic, its impact, and the goals of the program. Representatives of the lead implementing partner and the injecting drug user community, in conjunction with the Nagaland SACS, have addressed the Nagaland Legislative Assembly three times.

High-ranking police officers attend training sessions, and crisis response systems have been established in some districts to resolve cases of arrest or violence against injecting drug users. Advocacy efforts have resulted in the development of a workplace policy on HIV/AIDS in the police department in Nagaland, and the establishment of an HIV/AIDS cell in each battalion unit.

Advocacy with insurgent groups is usually conducted through indirect means. For example, public events and rallies are held to educate the general public about issues of stigma and discrimination against injecting drug users. Because many non-state actors promote what they understand to be the social agenda of the wider community, it is hoped that influencing the community will also affect the behavior of these other groups. In addition, the program engages with some prominent academics, doctors, and religious leaders with access to the insurgent groups; once sensitized to the program's objectives, they can act as informal proxies for it and promote its acceptance among insurgent group members.

The church is the most respected institution in the Christian-dominated hills of Manipur and Nagaland, and it has great potential to shape the way communities view drug use and drug users. Sensitization workshops are held for church members, and Avahan has found that even brief visits to drop-in centers by church leaders can help destigmatize the setting within the local community. Alternative programs such as drug detoxification were introduced to establish a foothold before introducing other components of harm reduction in places such as Ukhrul in Manipur, where needle and syringe exchange, oral substitution therapy, and condom distribution were viewed

with skepticism. Winning over religious leaders in order to build a positive environment for the program has relied on some unusual strategies: for example, music programs organized through a church-based NGO have been highly effective in some areas, and have also led to greater mobilization of the injecting drug user community. Avahan has supported the development of HIV/AIDS policies for some church organizations.

Advocacy with the general community takes the form of events like sports meets and neighborhood clean-ups—activities which the wider community does not necessarily associate with injecting drug users and which therefore sensitize them to the ways in which drug users can contribute to community life. Journalists are invited to cover these events in order to show the drug using community in a positive way. Dissemination of the program's achievements has also been effective in increasing governmental and public understanding and support.

Case Study: The Impact of Advocacy in Zunheboto, Nagaland

Zunheboto is a district of Nagaland whose principal town has the same name. Before Avahan began working in the town in 2004, drug users there faced severe prejudice and discrimination. They were liable to be harassed by the police, insurgent groups, a local tribal women's group, youth associations, and local elders. When apprehended, drug users were frequently beaten, locked up, fined, and at times tied up and left in the middle of the town with placards hung on them with their name and their father's name. These measures largely met with public approval as an appropriate way to deal with drug use.

Avahan's local implementing NGO in the town of Zunheboto is the Salvatus Christian Society, an association of the Baptist church. When the NGO began offering a needle and syringe exchange program and promoting condoms, it was confronted by several challenges: social animosity towards drug users; strong resistance to harm reduction measures from the general community and even family members of injecting drug users; and the reluctance of injecting drug users to identify themselves, which made contacting them for service delivery very difficult. Although a drop-in center was established, it typically would receive no more than 20 visits from injecting drug users in a month.

While efforts to provide services to injecting drug users continued, measures to create social awareness and to sensitize key stakeholders and opinion shapers were undertaken. Over a period of several years, senior staff from the lead implementing partner and the NGO conducted a series of programs and one-to-one advocacy initiatives. These included:

- Sensitization meetings with the tribal women's organization, both at the association level and at local neighborhood levels
- Individual and group discussions with local commanders and senior cadres of the insurgent groups
- Advocacy with church leaders, including pastors, deacons, deaconesses, women's leaders, and youth departments
- Meetings with traditional government administrators as well as student bodies and town council members

Salvatus Christian Society was able to use its respected status as a church organization to advocate effectively. The broader church was used as a platform to spread awareness, and its influence and infrastructure enabled it to play a key role in reaching audiences across a wide area. All these measures

gradually brought about shifts in social attitudes. As people became more aware of and sensitive to the problems of injecting drug users, hostility towards them decreased markedly.

Through this process, the church gradually recognized its responsibilities towards people with HIV and AIDS and became more and more supportive of the program. Church leaders frequently visited the drop-in center, which helped to destigmatize the environment. Musical programs held at the center for the whole community also helped make it more accepted and enabled people to access information without having to identify themselves as a drug user. On an average day the drop-in center now hosts around 30 injecting drug users—more than it once hosted in an entire month. The injecting drug users are much less inhibited about accessing services and are consequently more able to focus on their health and well-being.

Program monitoring and management

Avahan gathers and uses data from a variety of sources within and outside the program to inform and continuously improve programming. Avahan data include those collected by individual peer outreach workers, as well as a broader picture of the program such as infrastructure, human resources, service utilization, and community engagement. External data sources include HIV prevalence data from government surveys.*

In early 2005, a review of data showed that initial attempts at outreach had met with only limited success: the total number of contacts was lower than planned, and most of these were one-time rather than repeat contacts. Consultations with the implementing NGOs raised a number of issues, among them the difficulty of identifying



* A complete description of Avahan's use of data in program management can be found in a separate publication, *Use It or Lose It: How Avahan Used Data to Shape Its HIV Prevention Efforts in India*. New Delhi: Bill & Melinda Gates Foundation, 2008.

injecting drug users and of overcoming the stigmatization that made it difficult for them to access services. In response, the program introduced new strategies to improve outreach:

- District Support Teams were formed in both states, consisting of four or five local and external experts, to help develop outreach plans for each underperforming NGO through intensive *in situ* support. In Nagaland, the teams organized musical events at drop-in centers to attract young people: this enabled injecting drug users to access information at the centers without identifying themselves as drug users. Secondary distributors were recruited to help provide needles and syringes to people in isolated hill areas.
- Strong advocacy was implemented with opinion leaders, the armed forces, and pressure groups to enable the operation of the program.

Together with micro-planning, these efforts led to a steady increase in outreach.

In Manipur and Nagaland, as in the other states where Avahan works, regular monitoring of NGO performance and service delivery in the field has proved critical to ensuring that coverage targets are met and high-quality services delivered. Monitoring includes:

- Monthly field visits by project staff from the lead implementing partner, who spend a minimum of three days per week with the NGOs, where they conduct focus group discussions with injecting drug users and NGO staff, provide on-site training and orientation of clinical and outreach staff, and verify project data
- Joint quarterly reviews of all NGOs by the lead implementing partner
- Analysis and sharing of the monthly project indicators with the NGOs

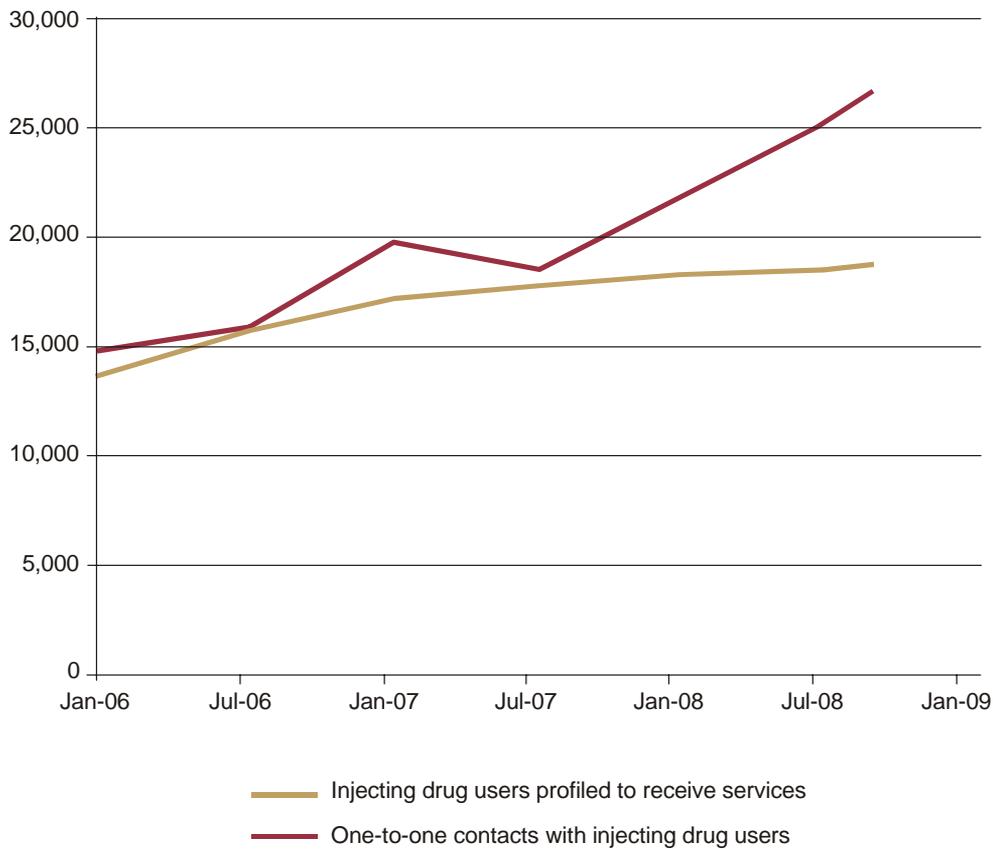


Progress to date

As of March 2009, Avahan has a network of 480 peers and outreach workers who undertake outreach to 18,000 injecting drug users (Figure 8). (Additional peers and outreach workers provide dedicated outreach to 4,400 female sex workers and 1,100 high-risk men who have sex with men.)

The implementation of peer led outreach led to an increase of 35 percent in the number of profiled injecting drug users between January 2006 and September 2008, while the number of one-to-one contacts with them by peers or outreach workers grew by nearly 80 percent during this period (Figure 8).

Figure 8: Outreach by Peers



This intensified contact was accompanied by an increase in the number of needles and syringes distributed and returned, and in the number of clinic visits (Figures 9 and 10). (The peak in distribution in January 2008 was due in part to a concerted effort made to reach people when they were concentrated in their home towns around the holiday season.)

Figure 9: Needle/Syringe Exchange Program

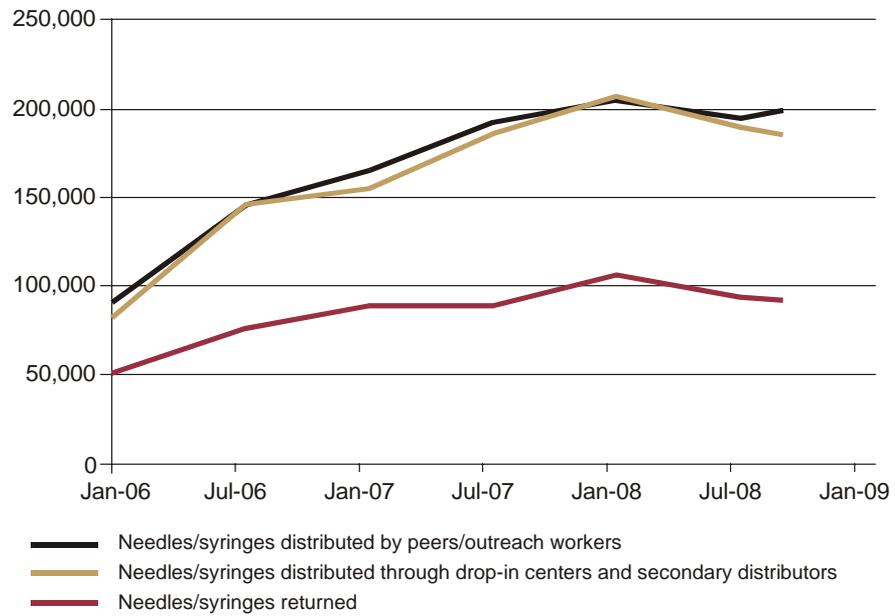
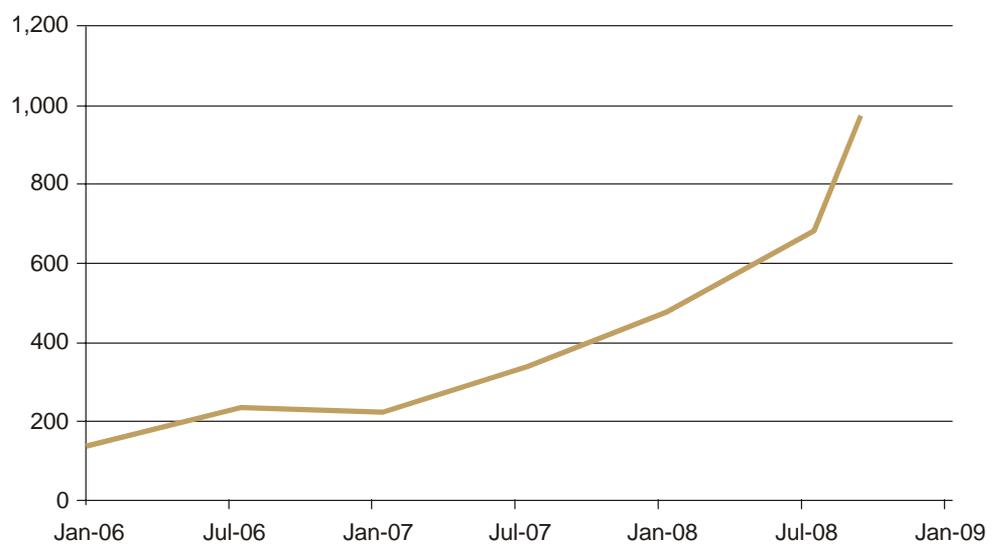
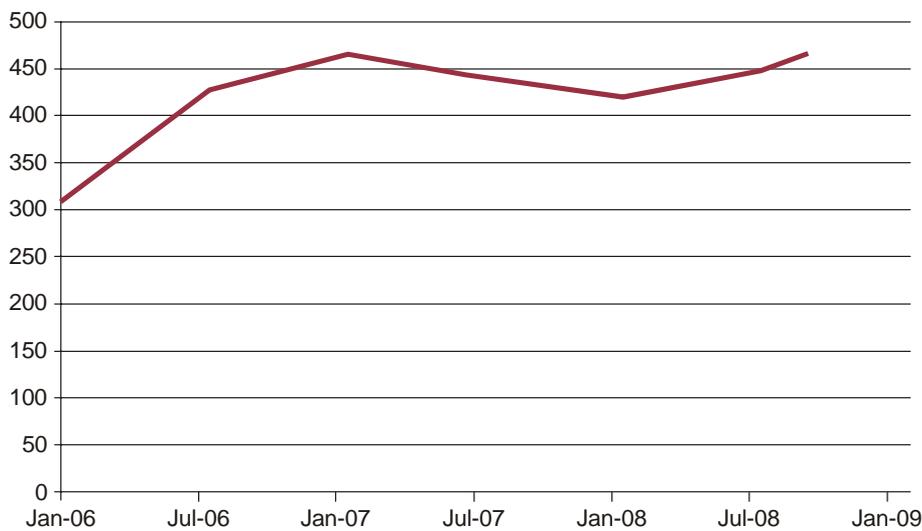


Figure 10: Monthly Clinic Visits



During 2006, as Avahan focused on developing the infrastructure and capacity for outreach, there was an increase of almost 50 percent in the number of peers and outreach workers (Figure 11). This meant that by the time micro-planning began in January 2007, Avahan was already reaching in excess of its initial target of 18,000 injecting drug users. The goal and impact of micro-planning were therefore not so much to increase the scale of outreach as to improve the intensity of service delivery.

Figure 11: Peer and Staff Outreach Workers



Although the number of peers and outreach workers did not increase once micro-planning was implemented (in fact it actually declined by about 10 percent during 2007), the number of one-to-one contacts grew by 10 percent during 2007, needle and syringe distribution by peers increased by a quarter, and the number of clinic visits doubled.

In the absence of controls it is not possible to isolate all the factors in the growth in the intensity of outreach, but it does seem intuitive to attribute it at least in part to the increased skills and efficiency of peers and outreach workers. The data suggest that Avahan's intensive focus on capacity building and equipping peers with micro-planning skills had a significant impact on the effectiveness of outreach.

LESSONS LEARNED

Mid-way through its 10-year effort, Avahan has assimilated a number of lessons from its experiences in Manipur and Nagaland. These lessons are informed by both program monitoring data and qualitative learning from the field.

In a resource-poor and volatile environment, outreach must be both preceded and accompanied by a focus on building infrastructure, building capacity, and advocacy with stakeholders.

Avahan's approach to HIV prevention interventions involved a roll-out of infrastructure simultaneously with capacity building. In Manipur and Nagaland it proved especially important to catalyze the skills of the existing NGOs and their outreach workers while recruiting new peers, so that the high-risk community would experience effective outreach from the beginning. An additional crucial component in this region was advocacy, because of the array of social, religious, political, and military organizations that opposed a harm reduction approach on principle.

In the challenging geographic and socio-political environment of northeast India, Avahan's approach to service delivery through peer led outreach proved to be not merely a worthy principle but a necessity for success.

Equipping peers to be managers of their own outreach is core to the Avahan approach. In the southern Indian states where Avahan works, peer led outreach through mapping and micro-planning has boosted outreach to new levels and has bolstered community mobilization. But in Manipur and Nagaland micro-planning proved absolutely essential to achieving any level of high-quality outreach. This is because distance, difficult terrain, poor transportation and communication systems, and disruption due to insurgent and military activities meant that a centralized, staff-driven approach was incapable of providing effective coverage.

Implementation guidelines must be flexible enough to permit creative solutions to be found to outreach challenges.

Approaches such as the use of secondary distributors helped ensure that supplies of needles, syringes, and condoms are available in rural or mountainous areas that cannot be reached frequently by peers. The move to less formalized, on-the-job training ensured that new peers could be trained where travel to a centralized training location was difficult. The decision to train nurses to run the clinics, rather than using doctors as was the case with Avahan's clinics in the south of India, overcame the problem of the shortage of highly skilled medical professionals in the northeast. On the other hand, the high literacy rates of most injecting drug users in this region facilitated communications, record-keeping, and data analysis for peers, making this aspect of the program less challenging than in Avahan's work with mostly illiterate female sex workers.

The importance of oral substitution therapy to harm reduction and therefore HIV prevention would have justified Avahan's funding and expansion of the program at an earlier date.

Avahan's lead implementing partner and local implementing NGOs report that oral substitution therapy has had a significant effect upon their programs, making injecting drug users more receptive to the other components of outreach, such as HIV and STI education and safe sex promotion, as well as more willing to take leadership in the program and engage in efforts for community mobilization. The infrastructure requirements for effective

implementation of oral substitution therapy, combined with the cost of administering it and the lack of data on its effective implementation in resource-poor settings at the time, were reasons why Avahan did not initially fund its introduction. However, with hindsight it does seem clear that the positive impact of oral substitution therapy would have justified an earlier adoption of funding and expansion strategies by Avahan.



THE FUTURE

HIV and community development programs have long incorporated solutions for engaging communities in outreach. Avahan's experience offers lessons for the implementation of peer led outreach with quality through peer management of data and outreach in a challenging geographic and socio-political environment.

Several further challenges confront Avahan and its partners as they continue to develop HIV prevention interventions: the need to expand harm reduction to include other services such as prevention, testing, and treatment for hepatitis C, which has a very high prevalence among injecting drug users; expansion of oral substitution therapy; effectively meeting the needs of female injecting drug users; HIV prevention education for oral users of drugs (particularly youth) so that they do not transition to injecting use; and prevention education for the non-injecting sexual partners of injecting drug users. In addition, an ongoing challenge in Manipur and Nagaland is the continued resistance of many churches and other religious groups to harm reduction, as well as harassment from anti-drug organizations. Expanded oral substitution therapy, which is more acceptable to such groups than needle and syringe exchange programs, will greatly enhance community support.

Avahan will continue to develop the capacity of its implementing partners and seek to share what it has learned with other agencies implementing HIV prevention interventions in Manipur and Nagaland.

Avahan's long-term challenge—that of transferring the custodianship of program interventions to their natural owners in India—still lies ahead. Avahan will work closely with national- and state-level HIV programs under the National AIDS Control Organisation to align operations and transfer managerial and technical best practices as appropriate. In addition, the program must foster the evolution of today's nascent community groups into strong, registered entities that are equipped to demand and access public health services as well as to gain other entitlements.

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GLOSSARY

Agency is a term adopted in rights-based approaches to development to describe the choice, control, and power that poor or marginalized individuals or groups have to act for themselves to claim their rights (civil or political, economic, social, and cultural) and hold others accountable for their rights.

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

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

Community mobilization is the process of uniting members of a community to utilize their direct knowledge of vulnerability to HIV to overcome the barriers they face and realize reduced HIV risk and greater self-reliance through their collective action.

Drop-in centers were established early on in the Avahan initiative to provide a safe space for high-risk individuals to come together. The centers are often basically equipped but clean rooms that can accommodate several dozen people. 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.

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

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

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

Men at risk refers to men who engage in high-risk sexual activities, including commercial sex and sex with non-regular partners. In the Avahan initiative this translates into a programmatic focus on men congregating at points of sex solicitation. A large proportion of these men are long-distance truckers.

Micro-planning is the methodology used by peers in their outreach for recording and analyzing risk and vulnerability. Peers use specially designed tools to collect data which they use to directly plan outreach based on the individual needs of the population they are serving.

Ownership means that the community has control over the activities the program undertakes, and significant understanding of, and influence over, service delivery. Community-owned programs have significant leadership, initiative, and oversight by communities, and accountability systems are in place to ensure that the program's interests do not supersede those of the community, and that adequate representation of the community is established.

Peer outreach workers (peers) are representative members of a community who serve as a link between the program and the community. They manage the program on the ground through outreach and serve a population with whom they have a similar occupational, behavioral, social, or environmental experience and among whom they are trusted and a role model. Peers work with 35-85 members of their community to influence attitudes and provide support to change risky behaviors.

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

Vulnerability refers to the circumstances which impact a high-risk individual's or group's control over acquiring HIV. Vulnerability for an injecting drug user in the states where Avahan works is linked to unemployment, poverty, legal sanction, and social stigma.

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The Avahan India AIDS Initiative, funded by the Bill & Melinda Gates Foundation and managed by an in-country foundation team, is a large and ambitious HIV prevention program. Avahan's ten-year charter has three distinct elements. The first is to build and operate a scaled HIV prevention program, with saturated coverage for populations most at risk in the six states which account for the bulk of HIV infections in India. The second is to transfer the program to the Government of India and other implementers in the country; and the third is to encourage the replication of best practices by fostering and disseminating lessons learned from the program.

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

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