Introduction:

Targeted interventions are a resource-effective way to implement HIV prevention and care programmes in settings with low-level and concentrated HIV epidemics. They are also a cost-effective method of reaching people who are most at risk in more generalized epidemics.

Targeted interventions are aimed at offering prevention and care services to high risk populations (Female Sex Workers- FSW, Male having Sex with Male- MSM and Injecting Drug Users- IDUs) within communities by providing them with the information, means and skills they need to minimize HIV transmission and improving their access to care, support and treatment services.

These programmes also improve sexual and reproductive health (SRH) among these populations and improve general health by helping them reduce the harm associated with behaviour such as sex work and injecting drug use.

Implementing targeted interventions does not negate the need for broader interventions in the community. In many settings, it optimizes the use of resources by focusing on the environments and populations in which the risk of HIV infection is the greatest.

Targeted interventions

- are for people within the community who are most at risk of HIV and STI infection.
- are targeted to behaviour and practices not the identity
- involve them and their issues within the broader frame work of interventions
- are adapted to be culturally and socially appropriate to the target audience.
- focus on limited resources and where they can be used to the best benefit.
- acknowledge that barriers to accessing health-care services exist for some populations within communities.
- acknowledge that people who are at risk of HIV infection are often marginalized from the broader community, stigmatized and discriminated against.

Components of Targeted Interventions under NACP-III:

1. Behaviour Change Communication

This component involves understanding and assessment of individual and group practices/behaviour which can pose risk to HIV infection.

Development of context specific strategies/activities to address the risk of infection through peer counseling, counseling through counselors, creating enabling environment to reinforce safe practices.

Under NACP-III, the Peers, Out reach workers[1] lead the activities under this component through one to one sessions and group sessions among the community. There are also group, issue specific Information Education and Communication (IEC) materials are developed to further augment behaviour change.

2. Access to STI services

This component is aimed at improving the access to STI services as STI (both symptomatic and asymptomatic) pose greater risk for HIV infection and which is high among the High Risk Groups (HRGs)[2].

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[1] Peers are representative of the community and they lead the service provisioning component of the TI. Whereas ORWs are non-community members who work in the intervention.

[2] High Risk Groups include Female Sex Workers (FSWs), Male Having Sex with Male(MSM) and Injecting Drug Users(IDU)

Under NACP-III, the access to STI services is provided through three different approaches i.e. Project Based Clinics for HRG TIs covering 800-1000 population, Fixed day – Fixed time out reach clinics for HRG TIs covering 400-800 population and Referral clinics either with private or public facility with HRG TIs and Bridge Population[3] TIs.

Under TI budget there are provision for one part time doctor, one staff nurse (for IDU TI only) and one counselor. There are specific training modules on syndromic case management developed by NACO is available to build the capacity of these personnels.

There are no budget provision for separate clinic space and the same is run either in project office, Drop-in-centre[4] or in a space either hired by the project/ supported by the community.

There are budgetary support for medicines[5] and consumables[6] @ Rs.125/- per population covered under the project. There are specific protocols for procurement of medicines are available in the NGO-CBO guidelines, Part-I.

3. Provision of commodities to ensure safe practices

TI programme ensure safe practices by providing choices and options of easy accessibility, availability and acceptability. The commodities (only male lubricated latex condoms) supplied through peers, out reach workers and social marketing. The social marketing is supported through two channels : Direct budget provision under TI and through appointment of social marketing agencies.

For FSW TIs: there are provision of Male lubricated latex condoms and Female condoms (only in some pilot interventions) through free distribution and social marketing outlets.
For MSM TIs: there are provision of Male lubricated latex condoms and lubricant sachets through free distribution.
For IDU TIs: there are provision of Needle, Syringe and OST drugs[7] through free distribution.
For Migrant and Truckers TIs: the provision will be through social marketing mode.

Besides Condom Vending Machines and Free pick up condom boxes are placed at strategic locations to ensure uptake by clients at their convenience.

4. Enabling Environment through structural intervention

This component of enabling environment was introduced in NACP-II focusing creation of an environment facilitating the access to information, services and commodities by the high risk groups. It is essential to note that these HRGs are considered marginalized section of the society super imposed with stigma and discrimination. Also it is desirable that an effective enabling environment creates a reinforcing atmosphere for sustenance of safe practices and behaviour reducing their vulnerability.
Hence, under NACP-III, NACO envisage identification of power structures and their influence on the access and control over resources for sustaining safe behaviour and practices.

[3] Bridge population include Long Distance travelling truckers and Short stay single male migrants at destination places.
[4] Drop-in –centre is a safe space located at a place convenient to the community to provide services, a hub for communication/interaction among the project staffs and community members.
[5] The list of medicines are annexed – Annexure 1
[6] The list of consumables are annexed – Annexure 1
[7] OST (Opoid Substitution Therapy) which aims at to improve the quality of life by proving opportunity to transition them from injecting mode to non-injecting and thus preventing HIV and other blood-borne diseases. Presently in India, Bruprenorphine will be introduced in IDU TIs from October,2008.

There are provision for building the capacity of HRGs to advocate for themselves in creating enabling environment as well as control of requisite resources to address the issues of stigma and discrimination.

5. Community Organising and Ownership Building

NACO envisage that engaging Community Based Organisation (CBOs) in programme management through developing their capacity and ownership will lead to steering of community agenda through themselves only. Presently the TIs have been able to provide services through peers representing the community, where community playing a passive role. Experience shows such strategy has not been able to achieve the desired scale and coverage, reduce the violence and discrimination which impede active participation in accessing services optimally. Thus it has not been able to develop community norms to steer the programme in its desired manner which can further sustain the behaviour change.

Hence, NACO envisage to mobilise the at-risk communities to play proactive role in implementation as CBOs, while the NGOs will continue to play the role as capacity builders and support agents, thereby putting the prevention responsibility on those who are themselves at risk.

6. Linkages to Care and Support Programme

NACO has experienced that lack of mechanism to strengthen linkage care and support programme(ICTC, ART, Community Care Centre, RNTCP Programme, Detox Centre) has affected access to these essential services meant to reduce vulnerability. NACO under NACP-III has envisaged to build the capacity of the counsellors and health care providers at care and support institutions and building their perspectives and sensitivity.

Implementation Organogram of Targeted Interventions:

NACO Level:
TI Division comprising of National Programme Officer, Programme Officer (FSW, MSM and IDU), Technical Officer and NACO Technical Support Unit.

State Level:
TI Division comprises of Joint Director/Deputy Director/Additional Director of TI, Technical Support Unit. There are 29 SACS, 6 UT AIDS Cotntrol Society (Pondicherry, A & N Islands, Lakshadweep, Daman and Diu, Dadra Nagar Haveli and Chandigarh) and 3 Municipal AIDS Control Societies (Ahmedabad, Mumbai and Chennai). There are 20 states having Technical Support Units.

Project Level:
At project level the project is implemented by Project Manager, Peer Educator, Out Reach Workers, Counsellor, Part time Doctor, Staff Nurse (only in IDU) for HRG Tis.
In case of TIs working with Bridge Population the organogram has Project Manager, Voluntary Peer Leaders,Out Reach Workers, Counselor, Part time Doctor.

Recruitment of NGOs/CBOs for TI Programme:
Under NACP-III, there are specific protocols prescribed in the Part I and II of NGO-CBO Guidelines. As a part of which an empanelment process in initiated based on the requirement arising from the existing epidemiologic and mapping information available at state level.

Following empanelment, the state technical advisory committee makes recommendation of the shortlisted applicants and Joint Appraisal Team Visit is made. Based on the standard protocols the JAT recommends further recruitment of NGOs/CBOs to undergo contracts with SACS to implement TIs.

Budget Allocations:

The budget allocations are available in the NACO website under Budgets of Targeted Interventions

Technical Support and Capacity Building Activities:

Under NACP- III, Technical Support Unit will be in place to build the capacity of SACS and NACO officials of TI programme. The SACS along with other stake holders like resource centres will lead the process for building the technical capacity of the NGOs/CBOs.

Monitoring and Evaluation Framework:

Based on the standardised formats for monitoring tools SACS/TSU/NACO team make regular visits to ensure quality implementation of the TIs.

Annual internal evaluation is carried out by a team comprising of SACS/TSU member, one external consultant and one financial expert based on standardised tools developed by NACO.

Based on the performance of the TIs in the annual evaluation the TIs are extended for future contract period.