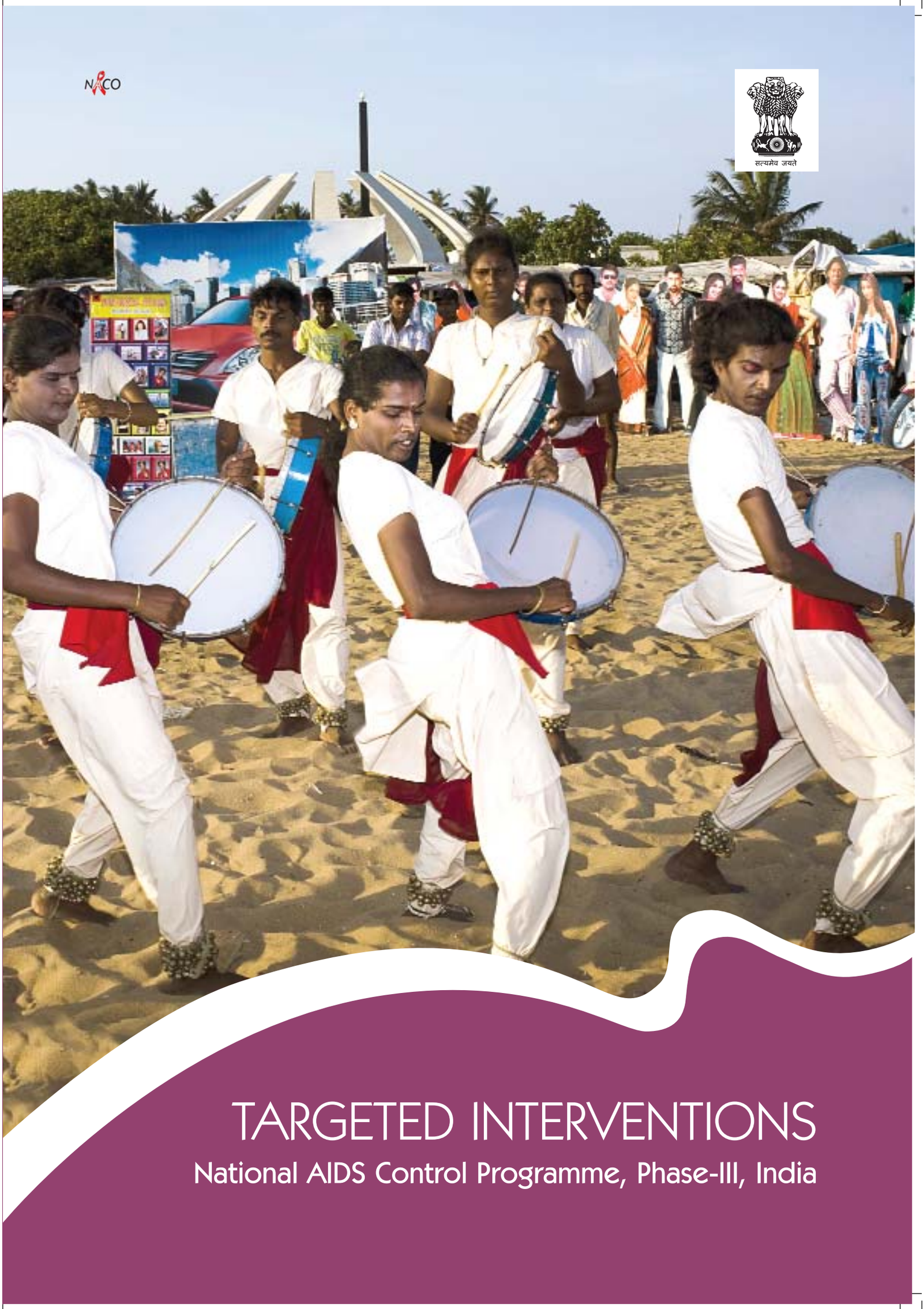

TARGETED INTERVENTIONS

National AIDS Control Programme, Phase-III, India

Publications from NACO in this series

National AIDS Control Programme: Response to HIV Epidemic in India
Targeted Interventions: National AIDS Control Programme, Phase-III, India
Condom Promotion: National AIDS Control Programme, Phase-III, India
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TARGETED INTERVENTIONS

National AIDS Control Programme, Phase-III, India

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National AIDS Control Organisation

India's voice against AIDS

Department of AIDS Control

Ministry of Health & Family Welfare, Government of India

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CONTENTS

THE HIV EPIDEMIC IN INDIA

There are an estimated 2.39million people living with HIV/AIDS in India. The HIV prevalence among general population is 0.31%, with more men infected as compared to women. About 88% of all infections are in the most productive age group between 15 - 49 years.

The HIV epidemic in India is concentrated among high risk groups (HRGs) including female sex workers (FSW), men having sex with men (MSM) Transgenders and injecting drug users (IDU). About 87% of the HIV infections in the country are due to unprotected sex. unprotected interactions between sex workers and their clients account for a large proportion of these cases. HIV transmission through injecting needles is 1.7% of all transmissions. However, it is a major HIV transmission route in the north-east region. Perinatal transmission and infections due to transfused blood and blood products account for a very small proportion.

"The HIV epidemic in India is concentrated among high risk groups"

Condom demonstration at a TI for MSM

RATIONALE FOR TARGETED INTERVENTIONS

HIV transmission in India is driven by unprotected sexual intercourse and sharing of drug injecting equipment between an infected and an uninfected individual. Not everyone in the population has the same risk of acquiring or transmitting HIV. Much of the HIV transmission in India occurs within groups or networks of individuals who have higher levels of risk due to a higher number of sexual partners or the sharing of injection equipment. These are designated as "high risk groups" (HRG), who are at high risk of contracting as well as spreading HIV infection to other population groups.

The core high-risk groups (HRG) include:

- Female Sex Workers (FSW)
- High-risk Men who have Sex with Men (MSM)
- Transgenders (TG)
- Injecting Drug Users (IDU)

Illustration of an HIV Transmission Network

Apart from the HRGs, there are other population groups, who are highly vulnerable to contracting HIV, because of the nature of their jobs as well as mobility from one place to another. These groups constitute the truckers as well as migrant population, and are called as "bridge populations".

"The transmission of HIV beyond HRGs occurs through their low risk sexual partners"

As shown in the illustration, the transmission of HIV beyond these HRGs often occurs through their sexual partners, who also have low risk sexual partners among the general population. For example, a client of a sex worker might also have a wife or other partner who is at risk of acquiring HIV from her high risk partner. Given this pattern of epidemic transmission, it is most effective and efficient to target prevention efforts towards HRG population to keep their HIV prevalence as low as possible and to reduce transmission from them to the bridge population. Therefore, there is a need to have targeted interventions among high risk groups as well as the bridge populations (migrants and truckers).

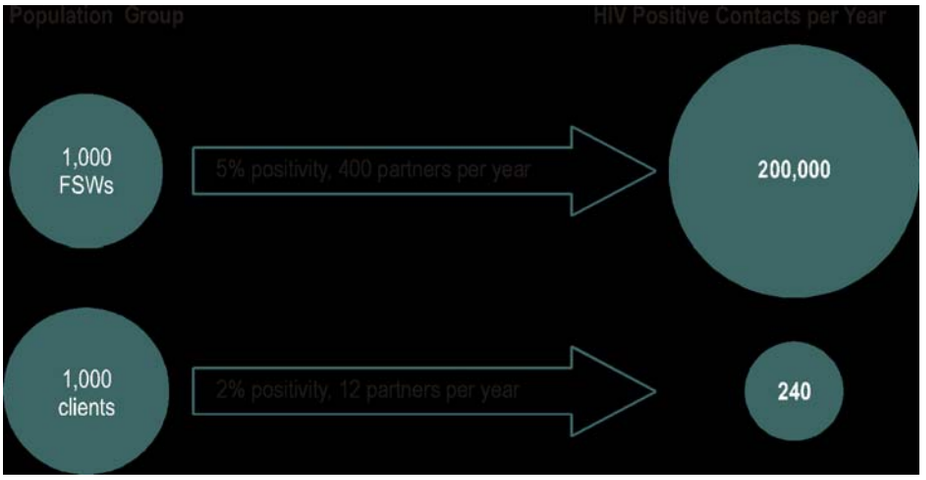
DEFINITION AND TYPOLOGIES OF HIGH RISK GROUPS

Under the National AIDS Control Programme, the targeted interventions are designed to control and reverse HIV among FSW, MSM, IDU, high risk migrants and truckers with specific strategies and deliverables. TIs are desiged based on the estimations through mapping. The importance of intervention with various HRGs is critical to achieve the NACP-III (2007-12) goal of halting and reversing the epidemic.

Female Sex Workers (FSWs)

FSWs have many sexual partners concurrently. Generally, full time FSWs have at least one client per day. Some FSWs have more clients than others. The number of clients may even go up to 100 or more clients in a month. The higher risk of FSWs is reflected in a substantially higher prevalence of HIV among them than in the general population. In India, as per the Sentinel Surveillance carried out in 2008-09, HIV prevalence among FSWs is 4.9%, which is ten times more than among pregnant women attending antenatal clinics. The relative importance of FSWs as a HRG can be summarized by estimating the number of sexual contacts occurring between FSWs and clients. Within one year, 1,000 FSWs may have sexual contacts with 300,000 to 1,000,000 clients. In contrast, 1,000 'high risk' men who have 612 sexual partners in a year will have a total of 6,000 to 12,000 sexual contacts in a year. Since the HIV prevalence is much higher among FSWs, a higher proportion of their sexual partnerships could result in a greater HIV transmission. As illustrated in the figure, the number of HIV positive sexual contacts for 1,000 FSWs is much greater than for the same number of high risk men. This demonstrates the strategic importance of focusing prevention programmes on FSWs.

HIV Positive Contacts Among FSWs and their Clients



Typologies of Female Sex Workers (FSWs)

"Targeted interventions address HIV infection among high risk groups and bridge populations"

For the purpose of TIs, a female sex worker (FSW) is an adult woman, who engages in consensual sex for money or payment in kind, as her principal means of livelihood. In any given geography, sex workers are not a homogeneous group. Sex workers can be categorized into 6 main typologies, based on where they work and more specifically on where they recruit or solicit clients and not where they live or actually entertain the clients. The major typologies of FSW in India are described below:

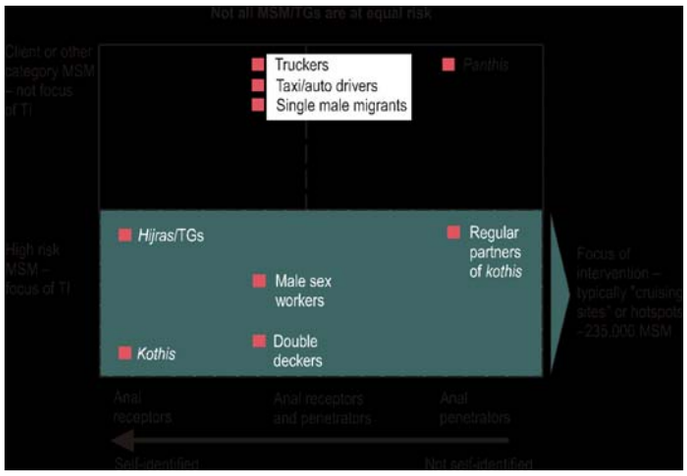
- **Street-based** sex workers are those who solicit clients at the streets or in public places such as parks, railway stations, bus stands, markets, cinema halls.
- **Brothel-based** sex workers are those whose clients contact them in recognized brothels, that is buildings or residential homes where people from outside the sex trade know that sex workers live and work.
- **Lodge-based** sex workers are those who reside in what is known as a lodge (a small hotel) and their clients are contracted by the lodge owner, manager or any other employee of the lodge on the basis of sharing the profits. These sex workers do not publicly solicit for clients.
- **Dhaba-based** sex workers are those who are based at *dhabas* (roadside resting places for truckers and other long distance motorists) or roadside country motels. Like lodge-based sex workers, these sex workers do not publicly solicit clients, but rather are accessed by clients who come to these locations.
- **Home-based** or **'secret'** sex workers operate usually from their homes, contacting their clients on the phone or through word of mouth or through middlemen (e.g. auto drivers). Generally, they are not known to be working as sex workers within their neighbouring areas.
- **Highway-based** sex workers are those who recruit their clients from highways, usually from among long distance truck drivers.

It is important to note that certain typologies (brothel and lodge/*dhabha*-based sex workers) tend to have higher client volumes than home based sex workers, and they therefore have a higher risk profile, requiring special focus even within the category of female sex workers. New entrants into these categories also warrant special focus.

Men having Sex with Men (MSM) and Transgenders

MSM/TGs are another important group who are highly vulnerable to HIV and are also a strategically important group for focusing HIV prevention programmes. It is important to know that not all MSM have many sexual partners, and are therefore at a substantially increased risk for HIV compared to others. However, there are MSM sub-populations which do have high rates of partner change as well as high number of concurrent sexual partners. These sub-groups of MSM who often engage in anal sex with multiple partners are at particularly high risk, since HIV is more transmissible through anal sex than by other sexual practices. Members of the transgender population who have many male partners are also at high risk. Many men who have sex with high risk MSM and transgenders also have other partners including both males and females. Targeted interventions for these HRGs are strategically critical for controlling the HIV epidemic.

Sex Network Dynamics Among MSM and Transgenders



Typologies of MSM and Transgenders

The term 'men who have sex with men' (MSM) is used to denote all men who have sex with other men as a matter of preference or practice, regardless of their sexual identity or sexual orientation and irrespective of whether they also have sex with women or not. Coined by public health experts for the purpose of HIV/STI prevention, this epidemiological term focuses exclusively on sexual practice. This term does not refer to those men who might have had sex with other men as part of sexual experimentation or very occasionally depending on special circumstances. It should be noted that not all of those who engage in male to male sex do not necessarily identify themselves as homosexuals or even men. There are several subgroups among MSM. For the purposes of intervention, these groups are defined as below.

"Brothel and lodge/*dhabha* based sex workers have higher client volumes and therefore a higher risk"

- **Hijras:** *Hijras* belong to a distinct socio-religious and cultural group, a 'third gender' (apart from male and female). They dress in feminine attire (cross-dress) and are organised under seven main *gharanas* (clans). Among the *hijras* there are emasculated (castrated, *nirvan*) men, nonemasculated men (not castrated, *akva/akka*) and intersexed persons (hermaphrodites). While one subset of *hijras* is involved in blessing and gracing during births, marriages and ceremonies, another is involved in begging, and a third group is involved in sex work. For the purposes of TIs, *hijras* are covered under the term 'transgenders' or TGs.
- **Kothis:** The term is used to describe males who show varying degrees of 'femininity' (which may be situational), take the 'female' role in their sexual relationships with other men, and are involved mainly – though often not exclusively – in receptive anal/oral sex with men. Some proportion of *Kothis* has bisexual behaviour and many may marry a woman. Self identified *hijras* may also identify themselves as *kothis*. Many *kothis* assume the gender identity of a woman.
- **Double Deckers:** those males who both insert and receive during penetrative sexual encounters (anal or oral sex) with other men are termed as Double Deckers. Some equivalent terms used in different states are Double, *DupliKothi* (West Bengal) and *DoParatha* (Maharashtra).
- **Panthis**: The term *panthi* is used by *kothis* and *hijras* to refer to a 'masculine' insertive male partner or anyone who is masculine and seems to be a potential sexual (insertive) partner. Some equivalent terms used in different States to denote masculine insertive partners are *Gadiyo* (Gujarat), *Parikh* (West Bengal) and *Giriya* (Delhi).

Injecting Drug Users (IDUs)

IDUs are another HRG for which targeted interventions are of critical importance. HIV is highly transmissible through the sharing of needles and other injection equipment as a result of which, it can spread very rapidly within networks of IDUs who share injecting equipment with each other. Once HIV prevalence is high in the IDU population, it can expand quickly into their sexual networks. Some IDUs are also sex workers, which can quickly link HIV transmission in the IDU networks to transmission in the larger high risk sexual networks. Interventions that are implemented early (HIV prevalence <5% among IDUs) are most effective in halting the spread of the HIV epidemic among IDUs.

Profile of Injecting Drug use in India

HIV interventions targeting the majority of IDUs can stabilize and even reverse the infection. IDUs are not injectors at all times in their injecting lifespan. They may inject, then fall back into non-injecting drug use (e.g. oral), or abstinence, and then return to injecting drug use. For the purpose of intervention, NACO defines IDUs as those who have used any drugs through injecting route at least once in the last three months. In India, most of the IDUs inject opioids as the primary drug, either alone or in combination with other drugs from the non-opioid class (e.g. diazepam, promethazine, chlorphenaramine, etc.).

NACP-III provides additional focus on IDU interventions to ensure saturation of coverage of IDU populations and quality service delivery. IDU TIs also reach out to spouses of drug users. According to mapping estimates of 2009 the number of IDUs in the country is 1,77,000 of which approximately one third are in the Northeastern states.

Truckers

There are about 5 million truckers (i.e., truck drivers and other crew members) in India, covering the stretch of 65,559 km of the National Highways. Out of these around 40 percent (or, about 2 million) ply on long-distance (or inter-city) routes. The Ministry of Road Transport and Highways states that as of March 2003, the total number of registered motor vehicles in India was 6,735,391, of which 2,159,824 were multi-axle/articulated vehicles (i.e. trucks and Lorries). As per NACO's surveillance reports 2007; the HIV prevalence amongst Truckers was 2.51%. A study in North India by Transport Corporation of India Foundation (TCIF) found that HIV prevalence among Long Distance Truckers (LDTs) was 7% which is 3.5 times higher than inner city truckers (2%). The overall prevalence of HIV/AIDS among LDTs has been reported to be 4.6% as against 0.36% among general population. The national Behavioural Surveillance Survey (BSS) of 1999 indicates high risk sexual contacts during transit (87%) and poor condom usage (11%) as the factors that cause vulnerability to Sexually Transmitted Infections (STIs) and HIV/AIDS among truckers. For truckers immediate sexual needs appear to take precedence over the possible long term consequences of unprotected sex. Reportedly, close to 36% of truckers are clients of sex workers and 15-20% of clients appear to be truckers. The vulnerability of Truckers is accentuated by:

1. Poor living conditions and driving conditions resulting in poor self esteem
2. Uncertainty of income and life and too much pressure (leading to a fatalistic approach to life and work)
3. Carrying large sums of money during long road trips
4. Concentration of sex work in and around trans-shipment locations

Long-distance truckers move throughout the country, those who are at higher risk of HIV can form transmission 'bridges' from areas of higher prevalence to those of lower prevalence. In order to prioritize

IEC activities with a trucker at a TI site in Delhi

sites where larger number of Long Distance Truckers halted for the longest amount of time, NACO commissioned a nation-wide mapping of truckers' sites so as to identify locations where interventions could be set up for optimum coverage. A total number of 128 sites (including 6 ports) were identified, out of which 18% sites were high priority; 30% were medium priority. 41% of high priority TSLs are in the north zone. Nearly, 70 percent of the high priority TSLs are in Andhra Pradesh, Uttar Pradesh and Mumbai. In addition, the mapping study also provided micro-maps of the locations, indicating the presence of condom outlets and STI service providers.

"Truckers and migrants constitute bridge populations spreading infection to general population"

High Risk Migrants

A migrant is anyone in the age group of 15-49 years who moves between source and destination within the country once or more in a year. There is increasing evidence and growing recognition of the importance of migration/mobility in the spread of HIV infection. Prevalence of HIV amongst migrants (many of whom are informal workers) is the highest in any group, after the High Risk Groups of FSW, MSM and IDUs. There are studies that have shown that informal workers are significantly at higher risk than general population. Their knowledge levels are lower and they have non-regular partners or visit sex workers. Only 25-29% of them use condoms during these encounters, compared to 42 percent by others. In another study, 2/3rd of the locations where informal workers operate, sex workers were also found to operate. Agriculture sector employs the largest labour force. Other than the Agriculture sector, the five key sectors of manufacturing, construction, textiles, tobacco and mining employ 99 million workers accounting for 59% of the informal workers, of whom 34% are female. This has led to the National AIDS Control Programme, Phase-III referring to migrants as one of the core groups which need to be addressed.

A migrant village in Uttar Pradesh

GUIDING PRINCIPLES FOR TARGETED INTERVENTIONS IN NACP-III

Based on the HIV scenario as well as preponderance of transmission through high risk groups, the primary focus of NACP-III is to halt and reverse the spread of the HIV epidemic in India by 2012. The programme hopes to achieve this through saturation of coverage of high risk groups through targeted interventions.

NACP-III plans to cover 80% of HRGs with primary prevention services, including:

- Supply of Condoms
- Risk reduction materials, e.g. needle syringes to IDU
- Treatment for sexually transmitted infections (STI)
- Behaviour change communication
- Creating an enabling environment with community involvement and participation, and
- Referral and Linkages to services such as ICTC, ART, STI clinics, among others

NACP-III goal is to scale-up interventions for high-risk groups (HRG), both in terms of numbers (coverage, number of targeted interventions) and quality of interventions.

A group of transgenders in Andhra Pradesh

Two important structural interventions have been added in the NACP-III strategy:

1) Strengthening enabling environment for TIs, and

2) Community organization and ownership.

The guiding principles for targeted interventions for addressing HRG populations in NACP-III are:

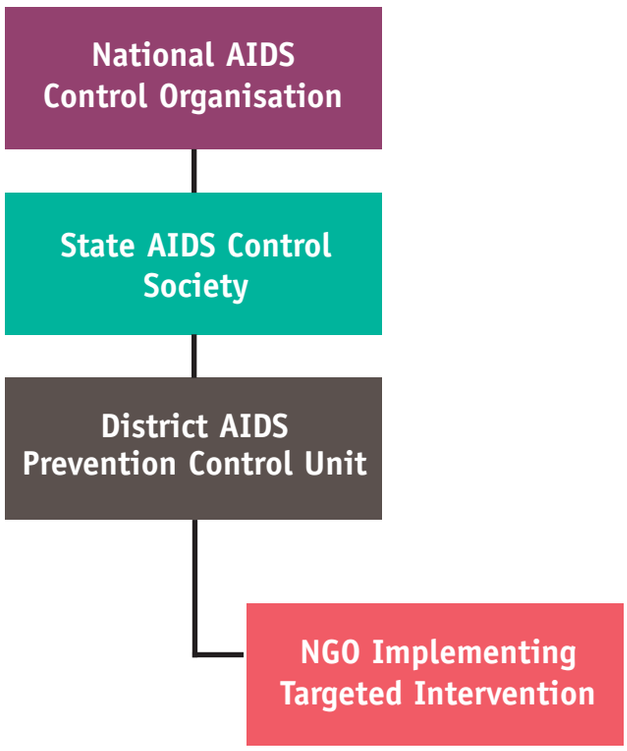
- Focus on coverage of sex workers, MSM, TG as well as IDUs
- Develop linkages between TIs and continuum of care
- Focus on creating an enabling environment (including equitable access to services)
- Foster development of community-based organizations (CBOs) to ensure ownership of the programme by the community
- Set up technical support units (TSUs) at the state level to enhance the capacity of partners and quality of interventions.

"Harm reduction, BCC, referral to services are key strategies under Targeted Interventions"

ORGANIZATIONAL STRUCTURE FOR TI IMPLEMENTATION

The National AIDS Control Organization (NACO) is the governing body for HIV/AIDS activities in India and works at the national level to implement the targeted interventions. In the states, various State AIDS Control Societies (SACS) work directly with the TI implementing NGOs. National level and state level technical support units (TSUs) provide technical support for implementing the programme.

TI Implementation Structure



Executive committee, headed by Health Secretary of the concerned state approves the selection of the NGO/CBO for implementation of the project. Technical Resource Gropups (TRGs) comprising of subject experts have been consituted at the National level to provide inputs for effective implementation of the programme to cover different populations including female sex workers, injecting drug users, men having sex with men, truckers and migrants. TRG is comprised of panel of experts and representatives of donors.

INTERVENTION PACKAGE UNDER TARGETED INTERVENTIONS

Prevention strategies under targeted intervention focus on the following five major components to reach the goal of halting and reversing the HIV epidemic among HRGs and Bridge population:

- Behaviour change communication
- Treatment for sexually transmitted infections (STI)
- Distribution of condoms and other risk reduction materials
- Ownership building
- Creating an enabling environment
- Needle syringe exchange programme
- Opiod substitution therapy

" Peer led outreach activities and linkages to services are key components of TI intervention packages "

Components of TI/Intervention Packages

- Outreach and communication focusing on peer-led, NGO supported outreach and behaviour change communication. This includes differentiated outreach based on risk and typology and interpersonal behaviour change communication (IPC)
- Services include Promotion of condoms, linkages to STI services and health services with adequate referral and follow-up system

  A. Promotion/distribution of free condoms and other commodities (e.g. Lubricants for MSM) and TG

A Drop-in-Centre at TI in Karnataka

B. Provision of basic STI and health services and regular medical check ups

C. Linkages to other health services such as Integrated Counselling and Testing Centre, ART, TB

D. Provision of safe spaces (drop-in centres or DICs).

- Creating an enabling environment

A. Advocacy with key stakeholders/power structures

B. Crisis management systems

C. Legal/rights education.

- Community mobilization

Building community ownership of the TIs (community refers to HRGs including FSWs, high risk MSM and IDUs).

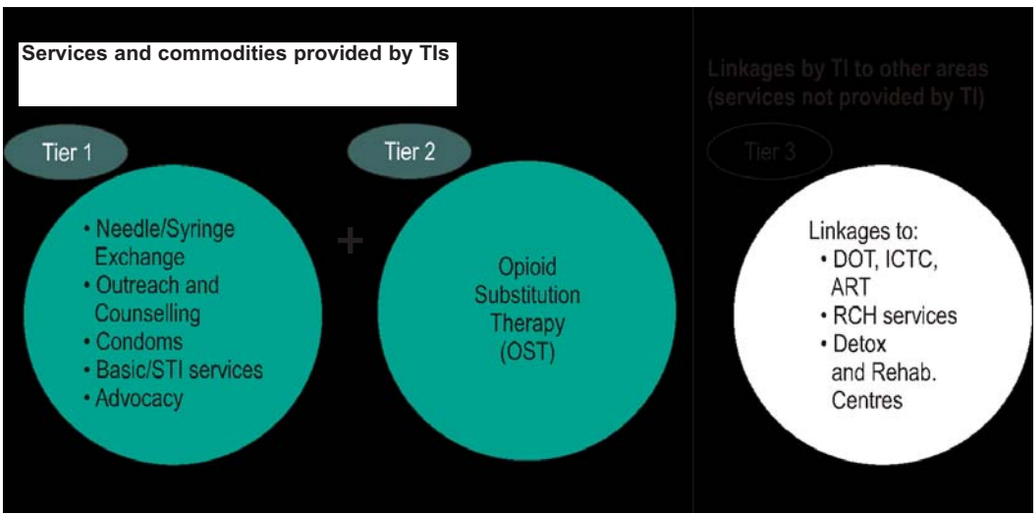
A. Collectivization

B. Creation of a space for community events

C. Building capacity of FSW, MSM and IDU groups to assume ownership of the programme.

In case of IDU population, apart from the above components, a number of additional specific interventions are provided in the TI. The strategy adopted for reaching out to IDUs is 'harm reduction' The services provided under harm reduction include services such as **Needle/Syringe Exchange Programme** (NSEP) and **Opioid Substitution Therapy** to bring about behaviour change from sharing of contaminated injection equipment to safer equipment, and from injecting drug use to substitution treatment and subsequently detoxification and rehabilitation (provided through linkages with drug detoxification centres). There are three tiers of harm reduction. While NACP-II focused primarily on Tiers 1 and 3, NACP III also focuses on Tier 2 – opioid substitution therapy (OST). The services provided by the TIs and linkages to other services are outlined in Figure 4.1 below.

Services Under TIs



ROLL OUT OF TARGETED INTERVENTIONS

Intervention sites are identified based on mapping data of HRG population. The mapping of the population groups is done by independent experts and is then validated by another group of experts. The mapping users the participatory research assessment methodology, using HRG community members.

"Intervention sites are identified on the basis of mapping data of HRG population"

Selection of NGOs/CBO

The selection of organizations for implementing TIs is done as per guidelines prepared by NACO for this purpose. The detailed guidelines can be accessed on the NACO website www.nacoonline.org

Recruitment and Training of Community Volunteers

Community volunteers are identified and trained on various aspects of the TI programme including:

- Basic induction on HIV/AIDS and understanding the FSW/MSM/TG community and dynamics of sex work
- Skills in identifying and building rapport with FSW/MSM/TGs and methodology of site validation

Site Assessment

The assessment is conducted by trained members of the local HRG group, who conduct a series of interactive exercises with members of their community, using visual tools (drawings and maps) to solicit information.

Sex workers involved in planning

The objectives of the site assessment are to determine the site-specific design of TIs through:

- Contact with at least 50% of the estimated HRGs in the area where the TI would operate
- Gaining details on risks/vulnerabilities by typology and location for HRG members to plan for provision of services
- Initiating interventions

Apart from the quantitative information gained in the assessment, there are a number of qualitative outcomes:

- Contacts with community helps the project to meet at least 50% of the estimated population in a given location on a one-to-one or group basis
- Generates interest and curiosity about the project
- Dispels myths about the intervention before it even begins, and communicates correctly the scope and plan of the project avoiding false promises
- Identifies potential peer educators for future involvement.

Establishment of Basic Services

In order for the community to have faith in the project and see early signs of benefit from it, basic prevention services (as per TI guidelines for FSW/MSM/TG/IDU and bridge population) should be in place as early as possible.

The basic services that can be established quickly are:

- Referral systems for treatment of STIs
- Availability of free condoms (and lubricants) through the project/staff/guides/volunteers
- Setting up of a drop-in centre (DIC, also known as a safe space).

Peer Educator (PE) Selection and Training

A peer educator (PE) is a person from the HRG who works with her/his colleagues to influence attitude and behaviour change. PEs are responsible for providing information on HIV/STIs, harm reduction, and promoting condom use and other risk reduction materials among colleagues/peers, which ultimately results in building peer pressure for behaviour change.

Peer education enables members of a given group to affect change among other members of the same group. It is considered to be one of the most effective and sustainable tools for changing group behaviour.

Peer educators play an important role in TI implementation as they can:

- Help to build trust and establish credibility with the vulnerable group
- Provide a vital two-way link between the project staff and the community
- Provide important information about the vulnerable group to other stakeholders and the wider community
- Provide a link between the service and the community (for instance, by introducing people or accompanying them to the service facility).

Role of the Peer Educator

- Conducting outreach, including identifying new HRGs from his/her community as well as maintaining regular contact with this network. This might entail contacts on a weekly or bi-weekly basis within any given month.
- Meet all of her/his contacts minimum once in 15 days
- Providing dialogue-based IPC to FSWs/MSM/TGs/IDU
- Encouraging service and commodity uptake—motivate FSW/MSM/TGs/IDU to come to DIC
- Distribute condoms, fresh needle-syringes, and make referrals
- Advocacy with the known power structure
- Training of new PEs from within the project and outside
- Maintain support ORW to the DIC
- Generating demand for welfare programmes and facilitating identification of beneficiaries.

"Outreach planning is conducted by a team of ORWs and PEs, with support of the Programme Manager"

Outreach Planning

The objective of outreach planning is to plan for ensuring that the existing structure and staff is able to reach out to the HRG in the project area on a regular basis, in order to have maximum coverage and impact on HIV prevention. Outreach planning is conducted by a team of outreach workers and 4-5 PEs, with overall support by the Programme Manager. During an outreach planning process, information from the PEs and outreach workers is made use of and a systematic plan to reach out to the community is drawn.

The elements of outreach planning serve the following purposes:

Objective	Quantifier	Tool
Improve quality of outreach	Reach all contacts at least once	• Spot analysis • Contact mapping • Geographic and social networks
	Reach all contacts regularly	• Sex work typology-wise outreach planning • Site load mapping • Seasonal calendar • Force field analysis
Improve service levels	STI clinic attendance, condom distribution	• Preference ranking • Peer map for condom distribution • Condom accessibility and availability mapping
Build PE capacity to monitor her/his own performance **Continuously improve Programming**	Monitors own performance and fills gaps proactively Uptake of services	• Peer education card • Peer calendar • Opportunity gaps analysis

Conducting Outreach

An effective outreach plan will also help in conducting effective outreach in the community. The emphasis during outreach is to ensure regular contacts with the HRGs, as well as linking them to services and DIC. Periodic reviews with the outreach team are conducted in order to fine tune the outreach plan further and additional area of focus are then decided.

Community Mobilization

This includes building community-led service delivery and building community based organizations (CBO). Creating community norms is important to sustain behaviour change among individuals in any community. Community mobilization in an HIV/AIDS programme context mainly aims for collective actions and also to influence norms within the community for safe behaviour and to address other structural barriers. The community mobilisation process should provide opportunity to each and every community member in the project area to participate in collective decision-making on various issues that affect the community, by establishing successful democratic processes. It also should provide an opportunity to everyone to become the selected or elected leader or representative in various organizational/social forums.

Creating an Enabling Environment

Providing services, supplying condoms and raising awareness may not by themselves result in sustained behaviour change. TIs must also address barriers to change and work towards creating an enabling environment that ensures the right conditions for change among individuals and the community. It is critical to advocate with policy makers, law enforcers and opinion makers to ensure a supportive environment for intervention.

Linkages with Other Services

TIs cannot operate in a stand-alone manner. NACO/SACS are implementing various programmes in the fields of HIV prevention and care at the District level. The District AIDS Prevention and Control Unit (DAPCU) are in the process of being operationalised and will function as a nodal agency at this level.

Peer education and outreach at TI site

SUPPORT MECHANISMS TO ENSURE QUALITY OF INTERVENTIONS

Developing the capacity of the State AIDS Control Societies (SACS) and NACO is a major thrust of NACP-III. 14 officials at NACO and 48 officials in the SACS have been trained with experts on various aspects HIV/AIDS and targeted intervention in order to Support TI programme implementation at NACO as well as in various states. In addition, Technical Support Units (TSUs) have been established at NACO and in 20 states to provide technical support to implementing NGO and CBO partners. All the states have focal person for the Targeted Intervention, looking after the quality and management aspects of the intervention.

"TSUs established in 20 states to provide technical support to NGO and CBO partners"

Capacity Building Activities for TIs

Technical support units and State Training and Resource Centres (STRC) have been established in order to improve the quality of targeted interventions on the ground. As a part of decentralization and developing ownership of the programme at grass root level, at district level, District AIDS Prevention and Control Units (DAPCU) are being set up to support TIs and increase access of HRGs to key services.

A. State Training and Resource Centre (STRC)

Eighteen State Training and Resource centres (STRC) have been established and another three are in progress. STRCs are designed to provide training and develop the capacity of TI projects staff to ensure

Capacity Building activity by STRC at Amritsar, Punjab

the quality of interventions. The STRCs work closely with states and technical support units to develop the capacity of partner organizations. STRC work with NGO and CBO to develop learning sites or best practice sites in each state. Important topics for staff training on TIs include programme management, outreach activities, peer education, counseling, STI control programming, reporting, and documentation. A total of 18,996 out of 23,598 (96%) programme staff have been trained in the year 2009-10 by SACS and STRC. NACO has conducted the performance review of STRCs with the external experts.

B. Technical Support Unit (TSUs)

A National Technical Support Unit (NTSU) as well as state TSUs have been established to provide technical support on key aspects of the TI programme by visiting interventions on the ground. The TSU oversee the implementation of the TIs in the respective state along with the SACS. They ensure that the NACP-III guidelines are followed by the TIs and facilitate implementation along with the partner organizations. They facilitate the designing, planning, implementation and monitoring of TIs in the states along with the SACS and provide management and technical support to the SACS.

C. Supportive Supervision and Monitoring

Under NACP-III, NACO has developed operational guidelines for targeted interventions including guidelines for NGO/CBO procurement management, NGO financial management and TI programme management. NGOs and CBOs are selected by transparent processes and work under clearly defined contracts and deliverables. NGO proposals are scrutinized by an expert committee and final approval is granted by executive committee constituted at the state level to monitor the overall HIV programme for the state.

At the same time a strong component of monitoring and evaluation has been built in as an integral part of the TI in order to capture the progress of the project and gain feedback on its efficiency and

Supportive supervision at FSW TI site

effectiveness. Monitoring systems and protocols make it possible to understand needs and analyze available data to understand the impact of the project. As a part of this, a Computer-based Management Information System (CMIS) has been created to record process and outcome indicators of TI including information on behaviour change, STI management, NSEP, oral substitution therapy, condom promotion, advocacy and mainstreaming, referral services and organizational capacity. This will help provide both qualitative and quantitative information which is precise, user-friendly and timely in nature. Data will be shared by the TI NGOs to the SACS and from SACS to NACO in a time bound manner thus helping inform the state and national programmes about the status of the interventions on the ground and also help them provide feedback and support to these NGOs.

"NACO has standardised evaluations through a common nationwide CMIS"

SACS officials provide regular mentoring and monitoring for implementing NGOs/CBOs, and external experts conduct annual evaluations, which provide the basis for contract extension decisions for NGOs/CBOs. NACO has standardized the evaluations through the use of a common nationwide tool. Team leaders for each evaluation team are trained directly by NACO at various region training centres throughout the country. Specific deliverables are now part of NGO contracts to ensure that NGOs meet their targets both in quantity and quality. The types of deliverables are determined by the age of the project, and these deliverables are now a focal point for monitoring visits and annual reviews.

D. Annual Evaluations

An independent annual evaluation of the NGO TI is an inbuilt mechanism to see the progress of the TI, identify gaps for strengthening and handholding. NACO has developed standard evaluation tool and manual to ensure the uniformity of evaluation across the country. The evaluations were conducted by trained external consultants. Programmatic, management and financial aspects related to TIs were evaluated. The extension of contracts with NGOs is based on the recommendations of evaluations.

In case of IDU programme, GFATM Round 9 has provided grant for capacity building activities for which EHA is the principal recipient (PR). Under this project the PR with support from NACO, and other sub-recipients and stakeholders will develop the capacities of 5 Medical colleges (Regional Technical Training Centres), 10 STRCs and 13 TIS (Good Practice Centres) in the field of Harm Reduction. Additionally, several resource material (guidelines, manuals and SOPs) shall be developed and trainings will be rolled out for IDU TI staff.

PROGRESS UNDER NACP-III

At the beginning of NACP-III, there were 789 TIs in the country. It was envisaged that a total of 2100 TIs would be required to achieve the goal of 80% saturation. With HRGs becoming the focus in NACP-III, TIs implementing both core and non-core groups were discontinued. In addition, external evaluation exercises have been conducted annually to ensure that all the TIs have been assessed on parameters laid down by NACO.

At present there are 1691 (1511 NACO managed and 180 donor partner managed) Targeted Intervention projects operational across the country. The expansion of TI projects has increased coverage of high risk population as shown in the table below:

Typology	NACP III Estimates (in Lakhs)	Mapping Estimates	Present Coverage (in Lakhs)	No. of TIs	Percentage Covered through TI
Female Sex Workers (FSW)	12.63	8.68	6.78	464	78%
Men-who-have-sex-with-Men (MSM)	3.51	4.12	2.85	168	69%
Injecting Drug Users (IDU)	1.86	1.77	1.42	266	80%
Migrants	42.0	42.0	13.56	245	32%
Truckers	35.0	20.0	6.77	69	33%
Core Composite				299	

OST administration

Thematic Updates

"Migrant strategy revised to target migrants at source, transit and destinations"

Opioid Substitution Therapy

Currently, there are 52 centres in the country implementing OST programme in IDU TI settings by NGOs. 4800 IDU are being reached out with OST using Buprenorphine. The centres are accredited centres and are integrated with the existing IDU TI programme. The supply-chain mechanism set up in place is fully functional with no reportage of stock out in any of the states. The monitoring and supervision reportage is in place, and all the states are sending reports to NACO on physical achievement as well as stock updates are provided on a monthly basis.

NACO has initiated a pilot of OST delivery through public health settings in 5 districts of Punjab. The pilot has been running since October, 2010 and established the feasibility and effectiveness of this model of OST. NACO plans to scale-up OST in more than 100 disticts based on this model for which initial assessment has been started.

TI Programme for Truckers

There are 133 Trans-shipment Locations with 2 million long distance truckers. All these sites have been further assessed by the Technical Support Group (TSG) for truckers to design the gaps and requirements for handholding. To increase the cost effectiveness of the programme, only 81 sites were found to be eligible for full fledged interventions with Targeted Intervention (as the number of truckers were >5,000), while the remaining 42 TSLs, are to be covered by Condom Social Marketing and focused IEC programme (as the number of truckers are <5000).

Outreach activities at a beach in Vizag

Currently there are 79 truckers interventions being implemented covering 11.35 lakhs long distance truckers.

Targeted Intervention for Migrants

Under NACP-III, NACO has 212 migrant Targeted Interventions across the country in 124 districts reaching out to about 3.66 million migrant informal workers who are engaged in construction, factory work, stone cutting and agriculture etc. Apart from this there are other destination focused migrant programmes in the country implemented by AVERT Society, CARE and Nirman Mazdoor Sangathan (supported by ILO & UNAIDS).

NACO was focusing its migrant interventions only at the destination points till date. However, evidences and experience suggest that the synergy between source, transit and destination should have better impact on the epidemic as compared to the only destination approach. Accordingly the policy has been revised to cover the source and the transit points along with the destination points. Under revised strategy 122 districts have been selected after the analysis of high out-migration data. Each source district will cover about 50,000 migrants and their families who frequently migrate to high prevalence states or districts. In each district, 5 blocks will be selected as intervention points where outreach workers will closely work with grassroots workers such as ASHA (Accredited Social Health Activist) and Anganwadi Workers in IEC campaigns. The existing services of National Rural Health Mission (NRHM) structure will be utilized for distribution of communication materials, providing information on services available at destination points, risk reduction with referrals to services for HIV counseling & testing and STI treatment.

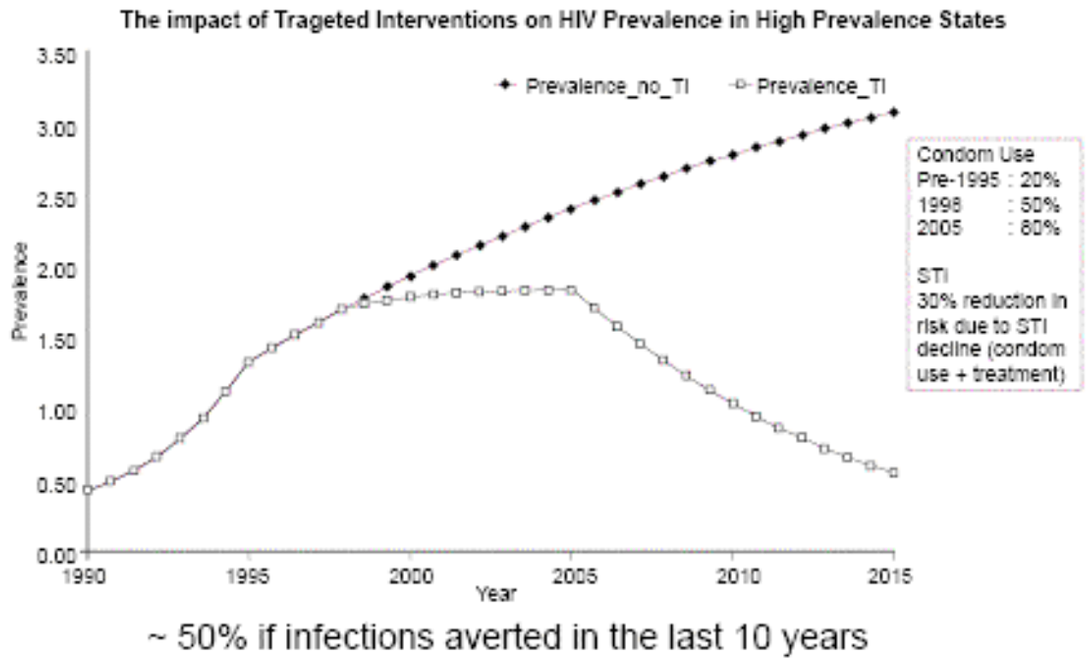
71 Transit locations have been selected where the congregation of migrants is quite high. The migrants will be provided reinforcement of risk reduction messages through mid-media and mass media programmes.

A group of migrant women at a Railway platform

CONCLUSION

The HIV epidemic in India is concentrated among high risk groups. Therefore, NACP-III has given high priority to Targeted Interventions (TI) to enable greater focus on these groups. The graph demonstrates the impact of TIs in averting the infection among high risk groups:

Measurable Impact of TIs



It is hoped that with the current strategy the NACP-III goal of halting and reversing the epidemic will be achieved.

ACRONYMS

AIDS	Acquired Immuno-deficiency Syndrome
BCC	Behaviour Change Communication
BSS	Behavioural Surveillance Survey
CCC	Community Care Centre
CSMP	Condom Social Marketing Programme
CSW	Commercial Sex Worker
CVM	Condom Vending Machine
FC	Female Condom
FSW	Female Sex Worker
HIV	Human Immuno-deficiency Virus
HLFPPT	Hindustan Latex Family Planning Promotion Trust
IDU	Injecting Drug User
IPC	Interpersonal Communication
LAC	Link ART Centre
MoHFW	Ministry of Health and Family Welfare
MSM	Men who have Sex with Men
NACO	National AIDS Control Organization
NACP	National AIDS Control Programme
NFHS	National Family Health Survey
NRHM	National Rural Health Mission
NGO	Non-Governmental Organization
NSS	National Service Scheme
OI	Opportunistic Infections
RTI	Reproductive Tract Infection
SACS	State AIDS Control Society
SMO	Social Marketing Organization
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TI	Targeted Intervention
TSG	Technical Support Group
ART	Anti Retroviral Therapy
ICTC	Interpersonal Counseling and Testing Center

NACO envisions an India where every person living with HIV has access to quality care and is treated with dignity. Effective prevention, care and support is possible in an environment where human rights are respected and where those infected or affected by HIV/AIDS live a life without stigma and discrimination.

NACO has taken measures to ensure that people living with HIV have equal access to quality health services. By fostering close collaboration with NGOs, women's self-help groups, faith-based organisations, positive people's networks and communities, NACO hopes to improve access and accountability of the services. It stands committed to building an enabling environment wherein those infected and affected by HIV play a central role in all responses to the epidemic - at state, district, and grassroots level.

NACO is thus committed to contain the spread of HIV in India by building an all-encompassing response reaching out to diverse populations. We endeavour to provide people with accurate, complete and consistent information about HIV, promote use of condoms for protection, and emphasise treatment of sexually transmitted diseases. NACO works to motivate men and women for a responsible sexual behaviour.

NACO believes that people need to be aware, motivated, equipped, and empowered with knowledge so that they can protect themselves from the impact of HIV. We confront a stark reality - HIV can happen to any of us. Our hope is that anyone can be saved from the infection with appropriate information on prevention. NACO is built on a foundation of care and support, and is committed to consistently fabricate strategic responses for combating HIV/AIDS situation in India.

NACO
National AIDS Control Organisation
India's voice against AIDS
Department of AIDS Control
Ministry of Health & Family Welfare, Government of India
www.nacoonline.org