NATIONAL AIDS PROGRAMME MANAGEMENT

MODULE 4
TARGETED HIV PREVENTION AND CARE INTERVENTIONS

World Health Organization
Regional Office for South-East Asia

National AIDS Programme Management

A Training Course

Module 4

Targeted HIV prevention and care interventions

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Module 4

Targeted HIV prevention and care interventions

LEARNING OBJECTIVES

After completing this module, participants will be able:

1. To describe the rationale for using a targeted interventions approach.
2. To identify the populations to be primarily targeted.
3. To describe the key principles and characteristics of targeted interventions.
4. To describe the components of targeted interventions that have been used in the response to HIV.
5. To identify the dynamics that operates in one key environment of HIV risk and vulnerability.
6. To describe the steps required to design and implement targeted interventions.

INTRODUCTION

Different HIV epidemics require different approaches. However, regardless of the epidemic stage, it is usually more efficient to target specific populations with HIV prevention and care programmes and services. This does not mean that the impact of the epidemic is restricted to these populations.

Successful targeted interventions do not attempt to stigmatize populations at risk from the general population. They focus energy, resources and services on populations at risk, as the most efficient and effective way to reach people affected by HIV.

This module explains the rationale for targeted interventions and the key characteristics of these interventions. It assists participants to understand the environments of risk and vulnerability and to take steps to design and implement successful targeted interventions.

OBJECTIVE 1: To describe the rationale for using a targeted interventions approach

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 specific populations 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. The best-designed programmes also improve sexual and reproductive health (SRH) among these populations and improve general health by helping them reduce the harm associated with behaviours 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 infection.
- 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.
- effectively use the language and culture of the people being targeted.
- 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.

OBJECTIVE 2: To identify the populations to be primarily targeted

COLLECT AND ANALYSE DATA AND INFORMATION

Targeted interventions focus on the populations most at risk of HIV infection and most in need of HIV care, support and treatment. Good surveillance and research data provide national programmes with information about the nature, size and location of these populations. The criteria for identifying these populations are the presence of risk behaviours along with the presence of, or potential for, HIV infection in the population. In some cases, where data about a particular population are lacking, the presence of reliable information about risk behaviours might be sufficient to justify targeting it for prevention and care programmes.

TARGET THE BEHAVIOUR, NOT THE IDENTITY

In many HIV epidemics in Asia, the populations that require priority targeting are sex workers, injecting drug users (IDUs), men who have sex with men (MSM) and mobile populations. Sometimes minority ethnic populations who do not have the same access to health information and services as the general population, also require targeting.

It is important to remember that these broad groups are not homogeneous – that there are many different types of sex workers, for example, with different levels of HIV risk and different levels of access to health services. The same can be said of other target populations. Some MSM, for example, adopt an identity associated with this behaviour. They socialize with other MSM, they join community groups and they attend bars and clubs with other MSM. On the other hand, some MSM do not. They may be married to women and not identify in any way with other MSM. This information is important for programme purposes and helps to determine the effective strategies for targeting.

REMEMBER THAT PEOPLE CAN BELONG TO MORE THAN ONE TARGET GROUP

Simply stating that a population is to be targeted is not sufficient. People at risk may also belong to different populations and have a range of identities. Sex workers may also use injecting drugs. IDUs may sell sex or have sexual partners who sell sex. MSM may also sell sex or use drugs. Sex workers are often a mobile population, moving in and out of sex work environments or setting up services where mobile populations, such as migrant workers or truckers, are present.

INVOLVE THE COMMUNITY YOU WANT TO TARGET

Information, particularly from people within these populations, as well as nongovernmental organizations (NGOs) and community groups working with these populations, is required for effective planning of services and programmes. In most cases, the most important information about what places a particular population at risk of HIV infection and what can be done to reduce that risk comes from the population itself.

OBJECTIVE 3: To describe the key principles and characteristics of targeted interventions

The key characteristics of targeted interventions are as follows.

- **Place:** Targeted interventions are generally implemented at the places where the population concerned lives, works or congregates. This is an important element of targeted interventions. The population being targeted is usually cut off from mainstream services, either because it is marginalized due to stigma and discrimination, or because it is mobile. Making services available to the population is the most effective way of removing these barriers.
- **Relevance:** Reaching marginalized populations requires strategies and messages which are directly relevant to their needs, and which are provided in a language that they understand. Simply telling people to engage in safer sex and to use safer means of injecting is not enough. To ensure that the messages and strategies are appropriate, relevant and practical, they need to be developed by the population.
- **Continuity:** The populations being targeted are generally mobile or fluid. People enter and leave the environments concerned every day. The turnover of women in sex work environments, for example, is often very high. It is not possible to say at any particular point that an intervention has reached the population and that the population is protected from HIV infection. Programmes need to operate continuously or be regularly repeated in these environments to ensure that new members of the population have access to HIV prevention and care.
- **Credibility:** The populations at risk of HIV infection are often marginalized and sometimes engaged in illegal behaviours, such as selling sex, sex between men and illicit drug use, or in behaviours that they fear will be judged illegal, such as purchasing sex outside marriage. This makes them suspicious of public health and government officials. Establishing the trust of marginalized populations is an essential element of successful programmes. This usually involves the use of peer outreach workers (people from the population to be targeted), or of other outreach workers, including committed health-care workers, who can develop the trust of the population.
- **Link to mainstream services and programmes:** The aim of many targeted interventions is to ensure that marginalized populations have the access they need to HIV prevention and care. This does not always mean that services have to be population-specific. The targeted interventions may act as a bridge to bring members of the targeted populations into mainstream services, such as sexually transmitted

infection (STI) services, HIV care, support and treatment services and prevention of mother-to-child transmission (PMTCT) services. People working for targeted programmes generally need to link with mainstream services to ensure that these services are designed with the needs of the particular population in mind, and that the stigma and discrimination experienced by this population is minimized.

- **Linking prevention and care:** Bringing messages pertaining to HIV prevention alone to a target population is rarely enough. Many people in these groups are already living with HIV and successful programmes need to take this into account. Prevention-alone programmes can further marginalize people living with HIV/AIDS (PLHA) within these populations by focusing solely on protecting the population from HIV. Programmes that work across the prevention-to-care continuum assist all population members to adopt and sustain safer behaviours. They also help the people access a full range of health services, including STI diagnosis and treatment, maternal and child health, drug substitution and treatment, HIV counselling and testing services, and HIV care, support and treatment.

OBJECTIVE 4: To describe the components of targeted interventions that have been used in the response to HIV

Targeted interventions take many forms. The choice of interventions depends on the degree of marginalization of the group being targeted, the availability of other services and programmes, and the capacity of the population to participate in or lead the implementation. Here are some examples of targeted interventions currently being used in HIV.

- **Outreach:** Sending peers or people who will be trusted by the target population into the environment to make direct contact with people, to provide them with information and the means of protection, and to help them access services. Examples include:
  - Training sex workers or community health workers to visit brothels, to provide information and condoms, and to link sex workers with STI and HIV services.
  - Training MSM to go to bars and sex sites to talk to other men about HIV, distribute condoms among them, and help them access STI and HIV services.
  - Training current and ex-drug users to go into drug user environments to distribute clean needles and bleach, provide information, assist in overdose prevention and abscess care, and help people access drug treatment and HIV services.
  - Arranging mobile vans to visit sex work, MSM or IDU sites at night to provide information, prevention commodities, clinical services and referrals.
- **Promotion and distribution of means of protection:** Ensuring condom, bleach and needle/syringe distribution through outreach workers and outlets in specific areas. HIV information should be designed to be relevant to a specific population, using language that is used by them and best suits their educational needs.
- **Support for the setting up of self-help and community groups:** Facilitating self-help or community groups from within target populations and providing them with resources, drop-in centres, to work on HIV and related issues in their communities.
- **Providing clinics and linkage to other services:** Providing clinical services for particular populations – such as sex workers, MSM, clients of sex workers – in their own neighbourhoods, with links to other services.

OBJECTIVE 5: To identify the dynamics that operates in one key environment of HIV risk and vulnerability

Implementing successful targeted interventions requires specific knowledge about the environment in which the risk behaviour takes place. It is not enough to target the individual at risk, the sex worker, for instance. One must also consider how the factors in the environment affect that person's ability to absorb the prevention message, change their behaviour, opt for testing, and access care, support and treatment services. A good programme that targets individuals might fail if there is no support in the environment for the behaviours that you are trying to inspire.

Here are some examples of the barriers that individuals in the primary target groups face in the context of long-term prevention and care.

For sex workers

- For sex workers living in poverty, the client has the power to purchase unsafe sex and the sex worker may be under economic pressure to comply.
- Sexual assault by police, brothel owners and others is commonplace in many sex work environments.
- Some local laws lead to the arrest of women who carry condoms on the assumption that they are sex workers. This puts pressure on sex workers not to carry condoms and, therefore, reduces their access to the means of protection.
- Brothel owners may insist that they need to offer unprotected sex to attract clients, or may do little to support safer sex.
- Clinic hours, charges or discriminatory practices might limit sex workers' access to STI and HIV care, support and treatment services.

For IDUs

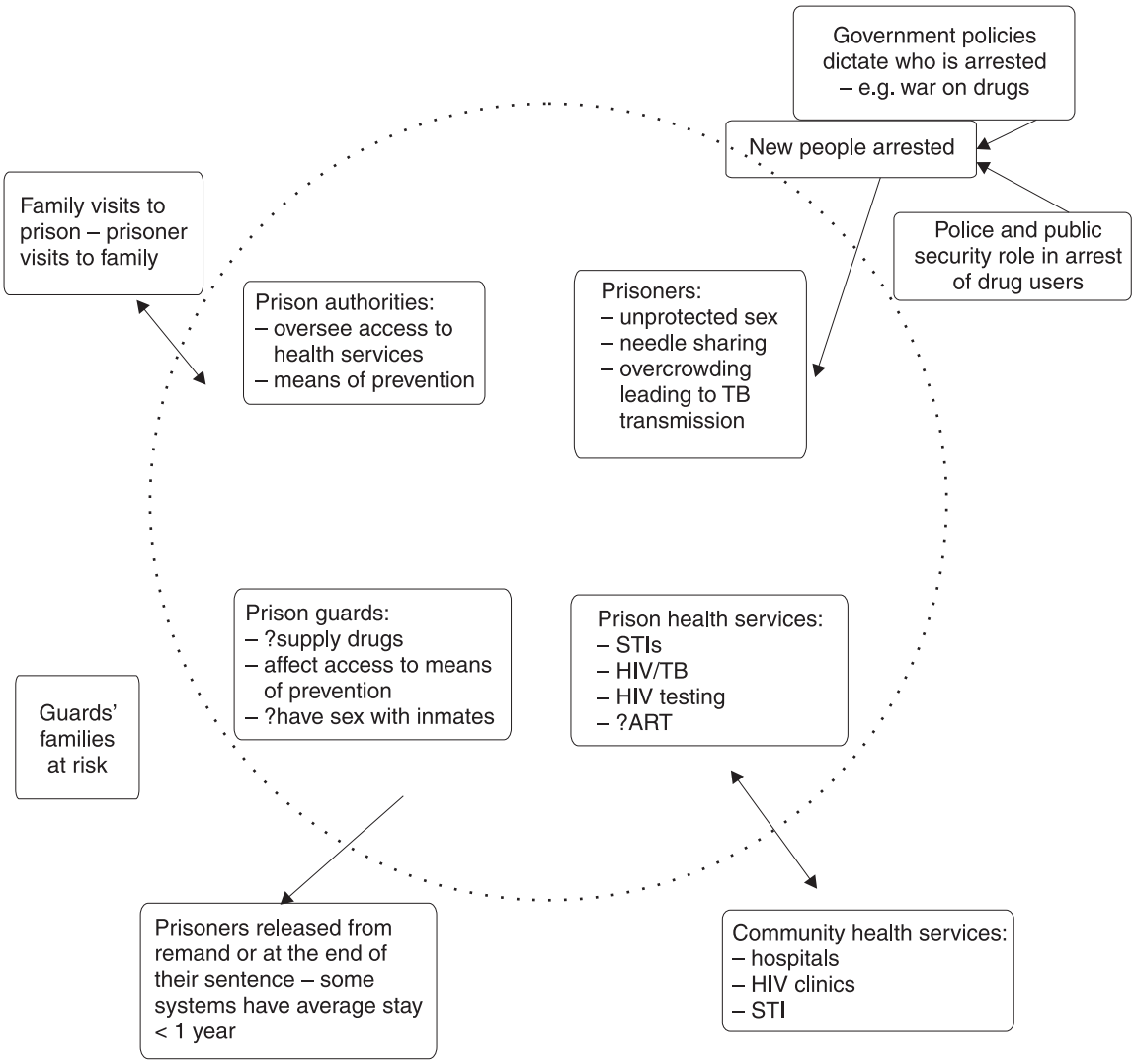
- Carrying clean injecting equipment can lead to arrest.
- The absence of non-injection alternatives (for example, drug substitution programmes) leads to an increased incidence of injecting.
- Stereotyping of drug users by medical personnel as unreliable may cut them off from HIV treatment programmes and services.
- The absence of HIV prevention and care programmes in prisons and drug rehabilitation centres, or poor links between prison and rehabilitation services, and services in the community may limit drug users' access to ongoing programmes for prevention and care.

For MSM

- Arrest or harassment of MSM and peer outreach workers by police makes it difficult to target MSM.
- Programmes that target only MSM who are identified by the fact that they join community groups may miss non-identified MSM.
- The lack of access to a lubricant (i.e., if it is not available or is too expensive) may lead to increased risk through condom breakage in anal sex.
- The stigma and discrimination experienced by feminized MSM and trans-gendered people cuts them off from programmes and services.

For prisoners

Environment of risk and vulnerability for prisoners, their families and the community



EXERCISE A

(Country group work followed by intercountry group discussion)

In country groups, choose a population at particular risk of HIV infection and in need of prevention and care services.

Describe the environment in which that population lives, using the diagram for prison environments as an example. Choose the environment of sex work, injecting drug use, male-to-male sex, or any other high-risk environment. Consider the following questions as you draw the diagram.

- Who are the people at risk of HIV infection in this environment?
- How do people flow through the environment – who comes in, who leaves?
- What are the different subpopulations within the environment?
- Who has the power to facilitate or block HIV prevention and care initiatives?
- What structures support safer behaviours or access to care, support and treatment?
- What structures work against this?

Use the diagram to explain the dynamic nature of the environment of risk.

Inform the facilitator when your country group is ready for intercountry group discussions.

EXERCISE B

(Country group work followed by intercountry group discussion)

In country groups, using the population your group chose for Exercise A, assess current interventions in your country against the criteria set out in the table below and identify and prioritize steps to strengthen the programme.

Element	Present situation	Steps to strengthen the programme
1. Strategic information		
What were the sources of information for designing this programme?		
What sources of data and information exist now?		
What are the gaps in knowledge, data and information?		
2. Participation of target population		
How have target populations been involved in the designing, implementation and evaluation of the programme?		
3. Range of strategies adopted		
Describe the range of strategies and services aimed at helping this population respond to HIV?		

Element	Present situation	Steps to strengthen the programme
4. Link to mainstream services		
In what ways does the programme for this population link to mainstream services?		
How is the access of the target population to mainstream services enhanced by the programme?		
5. Focus on the environment		
How have the barriers to successful implementation been reduced?		
What other players in the environment of risk are involved?		
6. Prevention-to-care continuum		
Do the interventions focus on the continuum of prevention and care?		

Inform your facilitator when you are ready for intercountry group discussions.

OBJECTIVE 6: To describe the steps required to design and implement targeted interventions

Putting all these elements together, it is possible, under the national programme, to design and implement a set of targeted interventions to reduce HIV transmission, both among the specific population and outside it, and to improve the population's access to HIV care, support and treatment.

In summary, the steps that will make these interventions work include the following.

Conduct initial mapping and make contact with the population

Complement behavioural surveillance information with information from the population, from groups which work within the population and from services that support it.

Involve the target population in the design, implementation and evaluation of the interventions, messages and services

This will maximize relevance, sustainability and ownership. Your priorities may not be the same as theirs. Listen to the target population and incorporate its needs into programme design. For example, your priority might be that female sex workers should use condoms, while theirs might be that their children should have access to education. Gaining their long-term trust and participation may depend on providing them with the things that they consider their highest priority.

Identify and support implementing partners who either have the trust of the population or can demonstrate that they can gain this trust

The prospect of HIV funding attracts many different groups. Make sure that the groups you fund have established links with the population that you wish to target, or will be acceptable to that population.

Obtain high-level support

Try to involve national or local leaders. Endorsement by a Minister, Governor or Mayor can ensure the collaboration of sectors other than health. Support the development of local implementing committees (for example, condom core group in 100% Condom Use Programme).

Involve the groups in the environment that have the power to affect the success of the interventions

Venue owners, police and security, local government officials, religious and community leaders, health service providers, clients of sex workers, drug suppliers, employers of migrant or mobile workers all have the power to "make or break" your programme. Make sure that they are also targeted.

Support long-term programming

It takes time to build a successful programme among a marginalized population. Interventions need to be sustained over time for the most effective long-term results.

RESOURCES

1. *Effectiveness of community-based outreach in preventing HIV/AIDS among injecting drug users*, WHO, 2004 (www.who.int/hiv/pub/idu/idu/en/).
2. *HIV/AIDS prevention amongst injecting drug users – advocacy guide*, WHO, 2004 (www.who.int/hiv/pub/idu/iduadvocacyguide/en/index.html).
3. *Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users*, WHO, 2004 (www.who.int/hiv/pub/prev_care/en/effectivenesssterileneedle.pdf).
4. *Targeted HIV/AIDS prevention and care in sex worker settings – an on-line toolkit*, WHO, 2003 (www.who.int/hiv/pub/prev_care/swtoolkit/en/index.html).
5. "Reorienting the clinical environment", In: *Clinical guidelines for sexual health care of men who have sex with men*. IUSTI Asia/Pacific, 2006.

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