STAYING SAFE
A Manual to Train Project Managers in IDU Interventions
“Currently ‘Injecting Drug Users’ (IDUs) are referred to as ‘People Who Inject Drugs’ (PWID). However, the term ‘Injecting Drug Users’ (IDUs), has been used in this document to maintain consistency with the term used presently in National AIDS Control Programme.”

Supported by The Global Fund to Fight AIDS, Tuberculosis and Malaria – Round 9 India HIV-IDU Grant No. IDA-910-G21-H with Emmanuel Hospital Association as Principal Recipient
Preface

The success of any strategy to reduce the harms associated with drug use, such as HIV/AIDS, depends on how well it is implemented at the grassroots level. This in turn requires significant training and capacity building of service providers and programme implementers who implement the strategies.

In India, Targeted Intervention (TI) under the National AIDS Control Programme (NACP) framework is one of the core strategies for HIV prevention among injecting drug users (IDUs). Primary health services, health education, abscess management, treatment referrals and provision of harm reduction services such as Needle Syringe Exchange Program (NSEP) and Opioid Substitution Therapy (OST) are some of the critical services provided as part of the NACP strategy to reach out to IDUs. The services are executed through peer-based outreach and Drop-In Centres (DIC) based approaches.

To further strengthen these established mechanisms under the NACP and to expand the reach to vulnerable IDUs, the United Nations Office on Drugs and Crime (UNODC) in India provides technical assistance to the National AIDS Control Organisation (NACO) through the Global Fund Round 9 Project (i.e., Project HIFAZAT) amongst others, to undertake the following:

1) Conduct Operational Research & Diagnostic studies
2) Develop Quality Assurance SOPs
3) Develop Capacity Building/Training manuals
4) Training of Master Trainers

This manual is part of a series of six training manuals developed by UNODC and has been developed for the training of Project Managers, whose functions include ensuring efficient day-to-day functioning of the IDU interventions, overseeing the management and addressing operational challenges related to service delivery. This training module aims at enhancing both the knowledge and skill-building aspects of the Project Managers using participatory and adult learning training methodologies. In addition, a conscious attempt has been made to keep the module interactive through frequent use of case study based group work, films and brainstorming exercises so as to enable better learning.

Contributions from the Technical Working Group of Project HIFAZAT which included representatives from NACO, Project Management Unit (PMU) of Project HIFAZAT, SHARAN, Indian Harm Reduction Network and Emmanuel Hospital Association were critical in articulating and consolidating the inputs that helped in finalizing this module.
Acknowledgement

The United Nations Office on Drugs and Crime, Regional Office for South Asia (UNODC ROSA) in partnership with national government counterparts from the drugs and HIV sectors along with leading non-governmental organizations in the countries of South Asia is implementing a project titled “Prevention of transmission of HIV among drug users in SAARC countries” (RAS/H13).

As part of this regional initiative UNODC is also engaged in the implementation of the Global Fund Round -9 IDU- HIV Project (i.e. HIFAZAT). Project HIFAZAT aims to strengthen the capacities, reach and quality of harm reduction among IDUs in India. It involves providing support for scaling up of services for IDUs through the National AIDS Control Programme.

We would like to acknowledge the invaluable feedback and support received from various stakeholders including NACO, Project Management Unit (PMU) of Project HIFAZAT, Emmanuel Hospital Association (the Principal Recipient of the Grant “Global Fund to Fight AIDS, Tuberculosis and Malaria - India HIV-IDU Grant No. IDA-910-G21-H”), SHARAN, Indian Harm Reduction Network and individual experts who have contributed significantly in the development of this document.

Special thanks are due to the UNODC Project H13 team for their persistent and meticulous efforts in conceptualizing and consolidating this document.
**Abbreviations**

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<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>ANM</td>
<td>Auxiliary Nurse Midwife</td>
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<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
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<tr>
<td>ATS</td>
<td>Amphetamine Type Stimulants</td>
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<td>BBV</td>
<td>Blood Borne Virus</td>
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<td>BCC</td>
<td>Behaviour Change Communication</td>
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<td>CBO</td>
<td>Community-based Organization</td>
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<td>CD4</td>
<td>Cluster of Differentiation 4</td>
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<tr>
<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
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<tr>
<td>DIC</td>
<td>Drop-in Centre</td>
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<tr>
<td>DOTS</td>
<td>Directly Observed Treatment, Short Course</td>
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<tr>
<td>FEFO</td>
<td>First Expiry First Out</td>
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<tr>
<td>FIDU</td>
<td>Female Injecting Drug User</td>
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<tr>
<td>FSP</td>
<td>Female Sex Partner</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>HIV+</td>
<td>HIV Positive Person</td>
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<tr>
<td>HRG</td>
<td>High Risk Group</td>
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<tr>
<td>Hep B and Hep C</td>
<td>Hepatitis B and Hepatitis C</td>
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<td>ICTC</td>
<td>Integrated Counselling and Testing Centre</td>
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<tr>
<td>IDU</td>
<td>Injecting Drug User</td>
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<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
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<tr>
<td>LSD</td>
<td>Lysergic Acid and Diethylamide</td>
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<td>MDR-TB</td>
<td>Multi-drug Resistant Tuberculosis</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>MIS</td>
<td>Management Information System</td>
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<td>NACO</td>
<td>National AIDS Control Organisation</td>
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<td>National AIDS Control Programme I</td>
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<td>NACP II</td>
<td>National AIDS Control Programme II</td>
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<td>NACP III</td>
<td>National AIDS Control Programme III</td>
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<tr>
<td>NDPS</td>
<td>Narcotics Drugs and Psychotropic Substances Act, 1985</td>
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<tr>
<td>NGO</td>
<td>Non-Government Organization</td>
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<tr>
<td>NSEP</td>
<td>Needle Syringe Exchange Program</td>
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<tr>
<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>N/S</td>
<td>Needle/Syringe</td>
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<tr>
<td>OD</td>
<td>Overdose</td>
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<td>ORW</td>
<td>Outreach Worker</td>
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<tr>
<td>OST</td>
<td>Opioid Substitution Therapy</td>
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<tr>
<td>PD</td>
<td>Project Director</td>
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<tr>
<td>PE</td>
<td>Peer Educator</td>
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<tr>
<td>PEP</td>
<td>Post Exposure Prophylaxis</td>
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<tr>
<td>PLHIV</td>
<td>Person Living with HIV</td>
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<tr>
<td>PM</td>
<td>Project Manager</td>
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<tr>
<td>RCH</td>
<td>Reproductive and Child Health</td>
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<tr>
<td>RI</td>
<td>Rigorous Imprisonment</td>
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<tr>
<td>RMC</td>
<td>Regular Medical Check-up</td>
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<tr>
<td>RNTCP</td>
<td>Revised National TB Control Programme</td>
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<tr>
<td>SACS</td>
<td>State AIDS Control Society</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>TI</td>
<td>Targeted Intervention</td>
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<tr>
<td>TSU</td>
<td>Technical Support Unit</td>
</tr>
<tr>
<td>UID</td>
<td>Unique Identification</td>
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<td>VCTC</td>
<td>Voluntary Counselling and Testing Centre</td>
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Introduction to the Manual

This 5-day training module has been developed in response to the need felt to provide a comprehensive curriculum for the training of Project Managers (PMs) working in Injecting Drug Users’ (IDUs’) interventions in India. It covers a broad spectrum of content ranging from a theoretical understanding of the basics of drugs and drug-related harms, to a more comprehensive exposure of the management of programmatic issues envisaged and being implemented under the National HIV response. The methodologies suggested include a balanced mixture of both information-based learning, touching on subjects such as Needle Syringe Exchange Program (NSEP), Opioid Substitution Therapy (OST), Abscess and Overdose Prevention and Management, as well as hands-on skill enhancement techniques for issues related to Advocacy, Referral and Networking, Planning, Implementation, Monitoring and Evaluation of the Program.

Design of the Package

This package has been designed to develop and clarify the perspective of the participants about their role as PMs working in Targeted Intervention (Ti) Projects for IDUs. Most of the sessions have been planned with interactive methods such as case study based group activity, brainstorming, problem solving, etc. to facilitate the process of experiential adult learning for greater participation and better recall value of the core issues.

The package contains the following components:

**Manual**
The manual has been designed for a 5-day training workshop. It is preferable that participants devote time at one stretch during the workshop. The suggested training agenda can be modified depending on time constraints and on the previous training experience of the participants.

**PowerPoint slides**
The PowerPoint slides, wherever required, have been provided in the enclosed CD. The references to the slides have been made in the various chapters to help the facilitators know when and how to use them during the sessions. It should be noted that the introductory slides and those used as separators or sub headings have not been included in this manual. But since the slide numbers of the actual presentations have been maintained for ease of reference, continuity of slides (in terms of their numbering) in the chapters may not always follow numerical sequencing, i.e. some slide numbers may seem to have been skipped. Facilitators are requested to refer to the slides in the actual presentations for better clarity.

**Case studies**
Case studies (vignettes) have been provided in many of the training sessions – especially those on skill building- with the vision that they will lead to comprehensive learning and effective situation handling. The facilitator is expected to use them for group activities to help the participants learn experientially. Key questions/tasks based on the case studies and indicative answers have been provided for each case study to aid the facilitator in providing objective feedbacks. It should be noted that the answers provided are only suggestive in nature and should not be a limiting factor for the facilitator’s response. The facilitator may enhance/expand his/her responses to add value to the session. However, care must be taken to provide information that is authentic in terms of being evidence-based.
**Film DVD**

The package also contains an animation film in English and in Hindi titled ‘*What Happened to Super Syringe?*’ and ‘*Phir Kya Hua Super Syringe Ka*’ respectively which talks about Needle Syringe Exchange Program (NSEP). Select the appropriate version, keeping in mind the region where the training is being held and familiarity/fluency of the participants with the language.

It is suggested that the film be shown during the session on ‘Waste Disposal’ and should be followed up with a discussion as recommended in the said session.

**CDs**

CDs will also be provided as a part of the package containing the following:

- PowerPoint presentations
- Case studies (prints of which may be taken for distribution to the participants)
- Pre-Post-Training Questionnaire (details provided in the section on Pre-Post-Training Questionnaires)

The CDs will contain all the necessary material in a print-ready format that can be replicated and used during the trainings.

**Annexures**

Some additional documents have been provided as annexures to support the training:

a. **Annexure I: Pre- and Post-Training Questionnaire** – This helps in assessing the effectiveness and outcome of the training program. This can be carried out using a self-administered questionnaire. A set of 24 questions on different topics covered in the training, The questionnaire has questions with multiple choice answers – where the participants have to ‘tick’ the correct answer. Each correct answer carries one mark. The correct answers are underlined in the questionnaire provided at the end of the manual. For each training program the facilitator needs to choose 20 questions – giving equitable importance to each topic and thereby develop a pre/post evaluation questionnaire. Care should be taken to remove the underlines and the marks in brackets before printing them out. The pre-training needs to be done after the ice-breaker on the first day and the post-training on the last day before the valediction. The facilitator distributes the questionnaires – explains how to answer them and allots 15 minutes for completing the ‘test’. The participants should have the option of not writing their names on the answer sheets. The same questionnaire is used in both the pre/post phase to enable easy comparison and outcome assessment.

The completed questionnaires are evaluated using the answer keys and the total marks obtained are noted. The facilitator finds the average marks obtained by all the participants for ‘pre’ and ‘post’ test. The average marks obtained at the ‘pre’ and ‘post’ evaluation may be compared to see the change brought about by the training.

b. **Annexure II: Day-Wise Feedback Forms** – The relevant forms are provided for this purpose. Copies of the same are to be given to the participants at the end of each of the first four days (Days 1 to 4) for their feedback on the day’s proceedings. It would be helpful to review the feedback forms on a daily basis so as to be able to respond to significant issues, if any, on the various topics, such as lack of comprehension of important content or perceived lack of applicability.

c. Annexure II: Handouts on Co-morbidities – These are to be copied and circulated among the participants in the session Understanding co-morbidities and ART among IDUs (Day Four Session Two). Details are provided in the chapter on the session.

Before the Workshop
A 5-day workshop needs extensive preparation and the facilitator should ensure that the following is done well in advance:

- Read the National AIDS Control Organisation (NACO) Operational Guidelines and training manual completely before the workshop.
- Understand the profile of participants attending the training so that the training can be tailored to suit their specific requirements. For example, if it is a Hindi-speaking group then the Hindi animation film will be required; if the participants are a mix of new and experienced PMs, then ensure there is space for the senior PMs to share their experiences with the new PMs.
- Prepare all materials required for the sessions – for pre-test, case studies, practice of tools, games and exercises– as specified at the beginning of the session.
- Ensure that all other arrangements have been made, e.g. projector and laptop to screen the PowerPoint presentations and the film.
- Engage resource persons wherever required; engage participants as volunteers as and when required.
- If possible, arrange for other films or newsletters/magazines that document best practices on working with IDUs from across the country. These films can be screened during the lunch break or after the day’s sessions have ended. Newsletters and magazines can be placed on the side at the training venue and participants may be encouraged to go through them.

How to Facilitate
- The facilitators should be familiar with experiential and participatory forms of learning.
- The facilitators should have the ability to ask exploratory/probing open-ended questions and should make it a point to involve all the participants.
- The facilitators should be technically competent to answer various intervention-related questions. The topics included may be adapted to suit local needs and priorities.
- As there are many hands-on sessions included, the facilitators would need to be familiar with all those processes practiced in the field so that they can actually demonstrate, as well as guide the participants, correctly. It will be important at all stages for participants to correlate the classroom teaching with field-level learning and vice versa.

How to Use the Manual
Each session provides the following information:

- **Objective**: What the facilitator hopes to achieve
- **Expected Outcomes**: The outcomes anticipated
- **Methodology**: The suggested methods and techniques to be used
- **Materials Required**: Materials may include flip charts, marker pens, handouts, etc. in addition to any preparation that is required
- **Duration**: Approximate time each session will take
A Manual to Train Project Managers in TI IDU Interventions

- **Summary of Session Flow:** A bird’s-eye view of the topics, activities and overall flow of the session
- **Tips to the Facilitator:** Pointers on how to conduct the session
- **Process:** The step-by-step details of how to conduct the session

While a comprehensive set of aids has been provided in the training kit, the trainer will have to arrange for support materials such as chart papers, marker pens, LCD projectors, etc. The ‘Materials/Preparation Required’ section lists what is required for each session. The facilitator is encouraged to review this at least one day prior to the session in order to arrange for the support materials.

Some sessions require the projection of some PowerPoint slides; such PowerPoint presentations, where needed, have been provided in a separate CD for use by the facilitator/s.

**Key Things to Remember as Facilitator**

**Do**
- Be flexible. Scheduling may have to change depending on the need of the participants
- Use different teaching methods to enhance participation and retain interest
- Ensure all teaching materials like hand-outs, charts, etc. are available before the beginning of the session
- Respect participants’ local knowledge
- Encourage participants to make presentations
- Remember, this is a participatory workshop and your role is to FACILITATE!

**Don’t**
- Let any one person dominate the discussion
- Speak more than the participants – let the participants brainstorm and discuss
- Allow distractions like mobile phones and chatting among participants
- Make the training a boring experience – intersperse the sessions with energizers/games
- Read out from the PowerPoint presentations – prepare well and use the presentation slides as cue cards to elaborate on the relevant points
<table>
<thead>
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<th>Time</th>
<th>Topic</th>
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<td>Registration of the Participants</td>
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<tr>
<td>9.30 a.m. – 10.30 a.m.</td>
<td>Introduction of the Participants and the Training Program</td>
</tr>
<tr>
<td>10.45 a.m. – 12.15 p.m.</td>
<td>Understanding Drug Use</td>
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<td>12.15 p.m. – 1.30 p.m.</td>
<td>Understanding the Community – IDU Related Vulnerabilities</td>
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<td>1.30 p.m. – 2.30 p.m.</td>
<td>Lunch break</td>
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<tr>
<td>2.30 p.m. – 3.30 p.m.</td>
<td>IDU-TI Program</td>
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<tr>
<td>3.30 p.m. – 4.30 p.m.</td>
<td>Understanding Staff Roles Including Role of Project Manager</td>
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<td>4.30 p.m. – 4.45 p.m.</td>
<td>Coffee/Tea break</td>
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<tr>
<td>4.45 p.m. – 6.00 p.m.</td>
<td>Harm Reduction – Principles and Components</td>
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<tr>
<td>6.00 p.m. – 6.15 p.m.</td>
<td>Feedback</td>
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**DAY TWO**

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<td>9.00 a.m. – 10.30 a.m.</td>
<td>Outreach and Related Management Issues</td>
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<td>10.45 a.m. – 12.15 p.m.</td>
<td>Needle Syringe Exchange Program (NSEP)</td>
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<td>12.45 p.m. – 1.45 p.m.</td>
<td>Lunch break</td>
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<tr>
<td>1.45 p.m. – 3.00 p.m.</td>
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<td>3.00 p.m. – 3.15 p.m.</td>
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<td>3.15 p.m. – 4.30 p.m.</td>
<td>Condom Programming</td>
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<td>4.30 p.m. – 5.45 p.m.</td>
<td>Female Sex Partners (FSP) and Female Injecting Drug Users (FIDUs)</td>
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<td>5.45 p.m. – 6.00 p.m.</td>
<td>Feedback</td>
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**DAY THREE**

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<th>Time</th>
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<td>Coffee/Tea break</td>
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<tr>
<td>10.45 a.m. – 12.15 p.m.</td>
<td>Referral &amp; Networking</td>
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<td>12.15 p.m. – 1.30 p.m.</td>
<td>Community Mobilization</td>
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<td>1.30 p.m. – 2.30 p.m.</td>
<td>Lunch break</td>
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<td>2.30 p.m. – 3.30 p.m.</td>
<td>Legal aspects Related to Drugs and Drug Use</td>
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<td>3.30 p.m. – 3.45 p.m.</td>
<td>Coffee/Tea break</td>
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<td>1.30 p.m. – 2.30 p.m.</td>
<td>Lunch break</td>
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<tr>
<td>2.30 p.m. – 4.30 p.m.</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>4.30 p.m. – 4.45 p.m.</td>
<td>Coffee/Tea break</td>
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<tr>
<td>4.45 p.m. – 5.45 p.m.</td>
<td>Strategic Planning</td>
</tr>
<tr>
<td>5.45 p.m. – 6.00 p.m.</td>
<td>Feedback</td>
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<tr>
<td>Time</td>
<td>Session</td>
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</tr>
<tr>
<td>9.00 a.m. – 10.30 a.m.</td>
<td>Opioid Substitution Therapy (OST)</td>
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<tr>
<td>10.30 a.m. – 10.45 a.m.</td>
<td><em>Coffee/Tea break</em></td>
</tr>
<tr>
<td>10.45 a.m. – 11.45 a.m.</td>
<td>Documentation and Reporting</td>
</tr>
<tr>
<td>11.45 a.m. – 1.00 p.m.</td>
<td>Procurement</td>
</tr>
<tr>
<td>1.00 p.m. – 2.00 p.m.</td>
<td><em>Lunch break</em></td>
</tr>
<tr>
<td>2.00 p.m. – 3.00 p.m.</td>
<td>Human Resource Management</td>
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<td>3.00 p.m. – 4.00 p.m.</td>
<td>Financial Management</td>
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<tr>
<td>4.00 p.m. – 4.15 p.m.</td>
<td><em>Coffee/Tea break</em></td>
</tr>
<tr>
<td>4.15 p.m. – 5.00 p.m.</td>
<td>Open Session</td>
</tr>
<tr>
<td>5.00 p.m. – 5.30 p.m.</td>
<td>Valedictory Session</td>
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</tbody>
</table>
Session One
Introduction of the Participants and the Training Program

Session Two
Understanding Drug Use

Session Three
Understanding the Community-IDU Related Vulnerabilities

Session Four
Understanding Targeted Interventions for Injecting Drug Users

Session Five
Understanding Staff Roles Including Role of Project Manager

Session Six
Harm Reduction - principles and components
Objective
To introduce the participants to each other, record their expectations from the training and set
ground rules for the smooth running of the sessions.

Expected Outcome
At the end of the session the participants will be introduced to each other: have a basic idea about
where (organization, state/city etc.) each comes from and what kind of experiences they bring
with them and be comfortable to interact with each other and take part in group activities.
The participants will be clear about the objectives of the training program as well as what can be
expected from this particular training program.

Duration
1 hour

Suggested Training Method
- Group activity
- Discussion

Materials/Preparation Required
- One large ball of yarn
- Flip chart/Whiteboard
- Chart papers
- Post-its
- Marker pens
- Training agenda
- Pre-test questionnaire

Process
Step 1: Introduction of the participants
The facilitator requests all the participants to stand in a circle and explains the activity. He/she passes
the ball of yarn to any one participant and requests him/her to share the following information with
all present:
- His/her name
- Name of the organization presently working for
Experience of working in the field of HIV

Experience of working among IDUs

After completion of the response the participant has to tie one end of the yarn to one of his/her fingers and throw the ball to another participant (preferably on the opposite side of the circle). The participant receiving the ball of yarn has to share the same information (as above) about himself/herself, wind the thread around one of his/her finger and pass the ball to a new participant on the other side of the circle. The activity continues till the last participant is introduced. The facilitator requests a few of the participants to pull at the yarn and see what happens (pulling by one would affect all). Now the facilitator, pointing at the mesh/web created by the yarn wound around the fingers of the participants asks them, “What do you think of it and how does it relate to your work as PMs?” The facilitator especially invites participants who are not responding voluntarily to speak, thus facilitating a discussion. He/she wraps up the activity, highlighting the following points:

In a TI there are various players:
- Within the TI (various levels of staff – PE, ORW, nurse/counsellors, accountant)
- In the organization running the TI (the director, the finance manager etc.)
- The service recipients (IDU, female sex partners)
- The community members (leaders, key influencers etc.)
- Other service providers (ICTC, ART, TB, Detox centres etc.) connected through referrals and linkages
- The SACS etc.

Activities of all levels of staff are inter-related and their individual performance affects the performance of the entire TI. The activities of the TI are also dependent on the actions of the other stakeholders – the community members, the other service providers as well as the SACS and are guided by the policies and guidelines developed by NACO.

So, the PM is not an individual who works in isolation, rather, he/she is the band master who choreographs the activities of the other staff of the IDU TI, and like an architect, builds bridges that forge alliances and linkages with other service providers for effective referral services. Project Manager (PM) on the one hand engages with the community to mobilize them for greater involvement in decision making, implementation and monitoring to improve service delivery and ownership of the program and on the other also coordinates with the SACS to ensure proper reporting of activities highlighting achievements, challenges and good practices subsequently influencing meaningful policy development.

In order to do all this, he/she needs a team that performs successfully and consistently over a period of time. The key to such a team is the leader and for an IDU TI, the PM is this leader who can help his/her team make changes in the lives of the IDUs they regularly interact with and help in halting and reversing the epidemic that threatens the entire country.

Step 2: Expectations of the participants

The facilitator distributes two Post-its to each participant and requests them to write two expectations they may be having from this training program. The facilitator, with the help of a few volunteers from among the participants, collects the Post-its and puts them up on a chart paper titled ‘Expectations’. The facilitator takes care to group similar expectations together. Volunteers can be chosen everyday to remove the expectation(s) that has/have been fulfilled that day. ‘Stocktaking’ should be done on the last day to check out the expectations that could not be fulfilled. The facilitator explains this whole process to the participants and requests them to remind him/her about it.
Step 3: **Setting the ground rules**

The facilitator then requests the participants to formulate some ground rules that will be applicable to all for the duration of the training program. He/she writes them down on a chart paper which can be put up on one of the walls/boards of the training room as a ready reckoner. The facilitator also requests the participants to formulate a set of consequences to be faced in case of breach of any of the rules. The consequences should be non-threatening/non-humiliating in nature, such as the erring participant may be asked to sing, tell jokes, or 'be clapped at for late arrival'.

Step 4: **Pre-test evaluation**

- Explain the objective of the pre-test evaluation (the evaluation is not a formal assessment of the participants; rather, it is to understand the existing level of knowledge of the participants, and reassess the same at the end of the training. This will provide feedback on the possible change that the training program has been able to make).
- Distribute the pre-test questionnaire and ask participants to fill and return back to the facilitator. The questionnaire is anonymous and does not require name and identifying information.
- Collect the filled-in questionnaires and thank the participants.

The pre-test evaluation questionnaire is found in Annexure I.
OBJECTIVE
To help participants understand the various terms associated with drug use, various types of drugs and how they affect the risk of HIV transmission.

EXPECTED OUTCOME
By the end of the session participants will be clear about various terminologies associated with the drugs and will be able to identify and understand the different types of drug use and their effects.

DURATION
1 hour 30 minutes

SUGGESTED TRAINING METHOD
- Brainstorming
- Group work
- Discussion
- PowerPoint presentation

MATERIALS/PREPARATION REQUIRED
- PowerPoint presentation
- Whiteboard/Flip chart
- Chart paper
- Marker pens

PROCESS
Step 1: Brainstorming and presentation on drugs

The facilitator initiates the discussion by asking the participants what comes to their mind when they hear the term ‘drugs’. He/she notes down the various responses on the whiteboard/chart paper/flip chart and then presents the slide on drugs from the presentation Understanding Drug Use.
Step 2: **Brainstorming and presentation on the various types/categories of drugs**

- The facilitator then asks the participants to list the names of all the drugs that they are familiar with, including their local names, and notes them on the whiteboard/flip chart.

**NOTE TO THE FACILITATOR**

Make sure to note down the various names under the 3 basic categories: Depressants, Stimulants and Hallucinogens.

- The facilitator continues with the presentation to explain the various categories of drugs; he/she uses the list of drugs mentioned by the participants to help them understand which drugs come under each of these categories.

**Depressants** - Decrease the activity of the central nervous system (CNS) and/or autonomic nervous system (ANS) including depression of respiration. Examples: Sedative hypnotics such as alcohol, benzodiazepine and barbiturates, cannabinoids at low doses and opiates have various effects on the body mentally and physically.

**Stimulants** - Increase the activity of the CNS and/or ANS. Examples: Caffeine, nicotine and cocaine, amphetamine and methamphetamine, prescribed amphetamine-like drugs, designer drugs such as pheylethlamines and methcathinone.

**Hallucinogens** - Alter the state of consciousness, frequently producing disturbances in thought and perception.

Examples: Indolealkylamines (such as: lysergic acid diethylamide (LSD), Dimethyltryptamine (DMT), magic mushrooms and morning glory.
**List of Drugs Under Three Basic Categories**

<table>
<thead>
<tr>
<th>Depressants</th>
<th>Stimulants</th>
<th>Hallucinogens</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin/brown sugar</td>
<td>Ecstasy</td>
<td>Ecstasy</td>
</tr>
<tr>
<td>Morphine</td>
<td>Speed</td>
<td>Speed</td>
</tr>
<tr>
<td>Codeine</td>
<td>Ice</td>
<td>Ice</td>
</tr>
<tr>
<td>Methadone</td>
<td>Methamphetamine</td>
<td>Methamphetamine</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>Amphetamine</td>
<td>Amphetamine</td>
</tr>
<tr>
<td>Pethidine</td>
<td>Phentermine</td>
<td>Phentermine</td>
</tr>
<tr>
<td>Opioids</td>
<td>Methylamphetamine</td>
<td>Methylamphetamine</td>
</tr>
<tr>
<td>Spasmoproxyvon</td>
<td>Cocaine</td>
<td>Cocaine</td>
</tr>
<tr>
<td>Pentazocine</td>
<td>Crack Cocaine</td>
<td>Crack Cocaine</td>
</tr>
<tr>
<td>Fortwin</td>
<td>Cannabis</td>
<td>Cannabis</td>
</tr>
<tr>
<td>Alprazolam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diazepam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loprazolam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetrazolam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cannabis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inhalants</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- He/she also explains that some drugs are legal whereas others are illegal, as listed in the slide.

**Step 3: Group work and presentation**

- The facilitator uses the PowerPoint slides and explains the various modes of drug use and also why many people prefer the injecting route.
The facilitator then divides the participants into 3 groups - Depressants, Stimulants and Hallucinogens - and asks them to list the drugs that are injected in their assigned categories (depressants, stimulants and hallucinogens) from among those listed on the whiteboard/flip chart.

Each group reads out the list of drugs in their category that are injected and the facilitator clarifies if necessary.

Drugs that are injected:

<table>
<thead>
<tr>
<th>Depressants</th>
<th>Stimulants</th>
<th>Hallucinogens</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin</td>
<td>Cocaine</td>
<td>Ketamine</td>
</tr>
<tr>
<td>Diazepam</td>
<td>Amphetamine</td>
<td></td>
</tr>
<tr>
<td>Buprenorphine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pentazocine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spasmorex</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Step 4: Presentation on why people take drugs: Use, abuse and dependence

People generally take drugs either to feel good (sensation seekers, or anyone wanting to experiment with feeling high or feeling different) or to feel better (self-medicators, or individuals who take drugs in an attempt to cope with difficult problems or situations, including stress, trauma, and symptoms of mental disorders).

When taken, drugs affect certain parts of the brain governing specific functions, just as in a house, there are different rooms designated for different activities.
It is clear that drug dependence is the result of complex interactions, not only between genes but also between genes and a host of environmental factors.
Use
- The ingestion of alcohol or other drugs without experiencing any negative consequences

**Example**
If a student had drunk a beer at a party and his parents had not found out we could say he had **used** alcohol

Misuse
- When a person experiences negative consequences from the use of alcohol or other drugs it is clearly misuse

**Example**
A 40-year-old man uses alcohol occasionally, his boss throws a party and the man drinks more than usual and on the way home he is arrested by the police.

Abuse/Harmful Use
- Maladaptive pattern of use resulting in physical, social, legal harm
- Continued use in spite of negative consequences
  - The same 40-year-old man continues drinking alcohol after the incident

Dependence
- A cluster of physiological, behavioural and cognitive phenomena in which use of a substance or class of substances takes on a much higher priority for an individual than other behaviours

  - Three or more of the following criteria to be present for some time in a one-year period:
    - Increasing tolerance
    - Withdrawal
    - Impaired control
    - Preoccupation
    - Continued use despite harm
    - Craving

Tolerance
- Need for increasing the amount of substance consumed to achieve intoxication or the desired effect
- Markedly diminished effect with continued use of the same amount of substance

**Example**
A person "X" started with one line of heroin smoking to get intoxicated; with time, he had to increase the dose to 1 gudula per day to get the same amount of intoxication.

A person "Y" started with 1 peg of whisky and got high; with continued use, he now consumes 3 pegs of whisky to get the same high.

Withdrawal
- Set of symptoms experienced on stopping or reducing the amount of the substance after prolonged use
- Every class of substance (e.g., alcohol, opioids, etc.) has its own unique set of withdrawal symptoms

Opioid Withdrawal
- Early symptoms
  - Anxiety
  - Restlessness
  - Yawning
  - Nausea
  - Sweating
  - Runny nose
  - Watery eyes
  - Dilated pupils
  - Abdominal cramps

- Delayed symptoms
  - Restlessness
  - Diarrhea
  - Vomiting
  - Goose bumps
  - Muscular spasm, pain
  - Chills
  - Increased heart rate, B.P.
  - Increased temperature

Impaired Control
- Impaired control of behaviour associated with substance use in terms of its starting the use of the substance, stopping the use of the substance, or controlling the level of use

**Example**
A person "X" had thought that he would consume only 1 peg of alcohol on a given day, but he is not able to stop after 1 peg; continues to take more than 1 peg; loss of control.

A person "Y" planned to stop his drug use, but is unable to do so: loss of control.
Step 5: Conclusion
The facilitator continues with the rest of the PowerPoint presentation and concludes with the slide on Drugs and HIV, highlighting how drug use increases the risk of HIV.

Drugs and HIV risks
Due to:
- Drug effects:
  - Lowering of risk perception
  - Mood changes - risk taking increases
  - High risk behaviour - sharing of N/S
  - Cognition impaired - may not remember to take precautions
  - Motor functions - may not be able to take the precautions
- Mode of use:
  - If injected: chances of sharing N/S and paraphernalia
Understanding the Community – IDU Related Vulnerabilities

OBJECTIVE
To help the participants
- Understand the profile of an IDU
- Reasons for the risks, vulnerabilities and challenges faced by them

EXPECTED OUTCOME
- Increased knowledge on drug-related harms, risks and vulnerability
- Ability to understand the physiological and psychological factors associated with drug use
- Skill to facilitate the group on issues related to drug use

MATERIALS/PREPARATION REQUIRED
- PowerPoint presentation
- Whiteboard/Flip chart
- Chart paper
- Marker pens
- Situation picture cards

DURATION
1 hour 15 minutes

SUGGESTED TRAINING METHOD
- Case studies
- Brainstorming
- PowerPoint presentation to provide information about drugs
- Group discussion

PROCESS
Step 1: Group work on situation cards and presentation
- The facilitator divides the participants into 4 groups and gives Situation Card 1 to Groups 1 and 2 and Situation Card 2 to Groups 3 and 4. He/she asks Group 1 to discuss, among themselves, answers to Questions 1 and 2 and Group 2 to discuss answers to Questions 3 and 4 of Situation Card 1. Similarly, Group 3 is asked to discuss Questions 1 and 2 and Group 4 to discuss Questions 3 and 4 of Situation Card 2. All the groups discuss their respective questions among themselves for 5 minutes and then each group shares their responses with the entire group.
Questions for discussion:

Q1. Why do you think Tony prefers injecting alone?

Q2. What are the possible reasons for his deteriorating health condition?

Q3. What are the possible reasons for not receiving treatment services?

Q4. What are the possible benefits and risks of injecting alone?

Some possible answers:

Ans 1. Most of his original peers may have either stopped drug use or may have died or moved to other areas. Perhaps he does not want to be disturbed by the police and society while injecting; he can use a larger quantity of drugs while injecting alone for a better high; lack of confidence leading to isolation, suicidal ideation/attempts and mental health problems.

Some of his friends could have stopped drug use or could be under OST. He may also choose to inject alone to protect himself from HIV and Hepatitis C Virus (HCV) after being informed by the TI outreach team. He may be on OST and would not want anyone to know that he is both injecting and taking OST simultaneously, as the dosage for OST might not be adequate.

Ans 2. Sharing of injecting paraphernalia may have led to transmission of HIV and Hep B & Hep C. He may have been affected by other illnesses like TB, etc. Mental health issues also often affect drug users. Lack of proper nutrition may also be a reason for deteriorating health.

Ans 3. Discrimination, stigma by service providers; his dirty clothes, (often stinking) and visible abscess, may have added to the fear, on the part of service providers, of contracting diseases. Self-stigma due to the use of socially unacceptable drugs; inability to stay away from them; repeated relapses may also have forced him to stay away from the services.

Ans 4. Injecting alone reduces the chances of infection of HIV and other blood-borne viruses (BBV); it also reduces the chances of stigmatization, identification by police and resultant legal consequences. However, injecting alone increases the chances of potential overdose (OD), bleeding to death if the artery is hit and other complications.

Situation Card 1: Tony has been injecting for the last 10 years. In the early days, he used to inject with his close friends and peers and there had been several incidents when they injected with the same paraphernalia. Tony now prefers to inject alone. He has also felt that his health is deteriorating. He once reluctantly went to a nearby hospital when he had a swollen leg due to injecting and the nurses suggested that he go to the nearby private hospital after learning that he was an IDU.
Questions for discussion:

Q1. What could be the reasons for individuals preferring to inject in groups?

Q2. What are the risks involved in group injecting?

Q3. How would the society respond to IDUs who gather together with the purpose of injecting?

Q4. What are the risks of the sex partners of IDUs?

Some possible answers:

Ans 1. Being in a group offers closeness, safety, commonality of purpose, a sense of bonding with each other; in some cases those who cannot find their veins to inject themselves have to depend on other injectors (called ‘doctors’ in local parlance) for injecting; in a group IDUs can pool money together to buy injectables and then share them.

Ans 2. Sharing of N/S, drugs and other paraphernalia leading to risk of transmission of HIV, Hep B & Hep C; prone to violence among peers, arrest by police; a new injector, in order to be part of the peer group, may want to inject the same quantity as the ‘seniors’ and be at risk of OD.

Ans 3. IDUs in groups are perceived as criminals, antisocial, a threat to the society and polluting the environment. Society sees them as a bad influence and is afraid of their own children also becoming drug users.

Ans 4. The sex partners may also be using drugs; may be at risk of contracting HIV, Hep B & Hep C, Sexually Transmitted Infection (STI) through sex with a high-risk partner; co-dependency, denial, social stigma, self-stigma, isolation from community is common; if uneducated/unskilled, may need to engage in sex work to support the family/IDU.

Situation Card 2: Sunny usually injects with his close friend and peer Ramesh. He also injects with the other members of his group. A general practice in the group is to share money to procure their ‘stuff’ (drugs) and inject using a common needle/syringe (N/S). Sunny has recently got married; and of late, has not been keeping well and is worried about what to do next.
Step 2: **Presentation on IDU community**

The facilitator then gives a presentation on IDU profile explaining why IDUs are in need of special care and services (Understanding IDUs)

---

**Profile of a Typical IDU**

- **The typical IDU:**
  - Male
  - In his productive years, but not likely to be regularly and gainfully employed
  - May be married, but likely to have poor social support
  - Severe dysfunction in almost all aspects of his life (social, legal, financial/occupational, relationships)

**Profile of a Typical IDU**

- Also likely that an IDU TI will encounter IDUs who:
  - Have limited resources to:
  - Sustain themselves
  - Maintain hygiene
  - Arrange basic nutrition
  - Access shelter
  - In conflict with the law (due to illicit drugs, crime)
  - Co-morbidity: physical and mental – common
  - Atypical IDUs who may require attention:
    - Women IDUs
    - IDUs belonging to better socio-economic strata, holding white-collar jobs and staying with their families
    - IDUs who are also other HRG members (FSWs, MSM, etc.)

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**Why are IDUs Vulnerable?**

- Illicit drug use; in threat of/conflict with law
- Stigma – self & societal
- Preoccupation with drugs
- Lack of resources
- Injecting drug use

**Injection-related Vulnerabilities**

- Injecting in hidden locations; mostly unhygienic in nature
- Inability to clean the injecting site properly due to:
  - Sense of urgency
  - Withdrawal symptoms
  - Non-availability of clean water, alcohol, snubs, etc.
- Injecting in unsafe parts of body:
  - Such as groin, thigh or neck
- Vein damage and accidental injury to arteries
- Abscess
- Overdose
- Risk of HIV, Hepatitis B & C

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**SHARING**

- Injecting is very often a group activity
- The sharing may involve:
  - Sharing needles
  - Sharing syringes
  - Sharing injecting paraphernalia (i.e. the cookers or pots in which drug has been prepared for injecting)

**Why Do IDUs Share?**

- **Economical reasons**: Lack of money to buy needles/syringes (N/S). Injecting equipment may be available only at a pharmacy, who may be reluctant to sell N/S or may choose to sell them at a premium
- **Psychological reasons**: They feel their bonding with each other will be strengthened by this act
- **Poor awareness**: of consequences of sharing or of safe injecting practices
**Key Learnings**

- Who is an IDU? IDUs are a marginalized, hidden population, stigmatized and hard to reach
- Various harms affect IDUs including physical, occupational, social, legal and psychological harms
- IDUs often live in unhygienic conditions with little or no health-seeking behaviour; many may be dependent drug users, finding it difficult to cut down their doses, preoccupied with drug procurement, drug use and managing or evading withdrawals from drugs.
Understanding Targeted Interventions for Injecting Drug Users

OBJECTIVE
To give participants a clear understanding of:
- National AIDS Control Programme (NACP)
- Components of NACP III
- Components of IDU TI program

EXPECTED OUTCOME
By the end of the session, participants would have an understanding of NACP and the various components of TIs for IDUs.

DURATION
1 hour

SUGGESTED TRAINING METHOD
- Discussion
- PowerPoint presentation in 3 parts

MATERIALS/PREPARATION REQUIRED
- Whiteboard
- Chart paper
- Marker pens
- PowerPoint presentation

PROCESS
Step 1: The facilitator begins the session by asking participants what they know about the development and history of the NACP. Ask a volunteer to note the responses on a chart paper.
Step 2: The facilitator then discusses the issues using PowerPoint presentation on NACP.

NACP I & II

  - Understanding the trends of HIV infection
  - Establishing blood banks – provide safe blood transfusion
  - Raising awareness in the general community

- NACP II (1999 – 2006)
  - Establishing Targeted Interventions
  - Increasing sentinel surveillance
  - Raising awareness on HIV
  - Conducting behavioural surveillance surveys

NACP III (2007–2012)

- Goal: To halt and reverse HIV epidemic in India over five years

- Objectives
  1. Preventing new infections
  2. Care, support and treatment
  3. Strengthening capacities
  4. Building strategic information management systems

NACP III (2007–2012)

- Continued emphasis on prevention
- Significant scaling-up of activities (increased targets)
- TIs with greater focused approach (sex workers, IDU and MSM interventions)
- Empowering and capacity building to manage TIs

---

NACP III (2007–2012)

- Prevention
- Care, Support & Treatment
- Strategic Information Management
- Capability Building

- High risk populations
  - Targeted interventions
  - STI care
  - Condom promotion
  - VCT
  - NSP
  - Opioid treatment
- Low risk populations
  - Blood safety
  - Integrated Counselling and Testing Sites
  - ART
  - STI care
  - IEC and social mobilisation
  - Mainstreaming
- HIV/AIDS
  - ART
  - HIV Co-infections

- Monitoring and Evaluation
  - HIV Sentinel Surveillance
  - Behavioural Surveillance
  - Monitoring and Evaluation
  - Operations research

- Institutional Strengthening
  - EPI-NSU
  - Technical assistance groups
  - Advocacy and Advocacy
  - NACO, SACS and others
  - Enhanced training activities
Step 3: The facilitator follows up by introducing the concept of **Targeted Interventions (TIs)** to the participants. He/she generates a discussion on why TIs are required for HIV prevention among High Risk Groups (HRGs) and sums up the discussion by emphasizing the following points:

- HRGs practice behaviours which are deemed ‘illegal’
- HRGs face stigma and discrimination from the general community
- HRGs remain ‘hidden’ and are not easily accessible
- As a result, HRGs are reluctant to seek services from general health care systems (e.g. Government hospitals)
- TIs deliver services specifically directed to these groups (hence called ‘targeted’)
- The services are delivered at places where the High Risk Groups (HRGs) are available (reaching out = ‘outreach’)

Step 4: The facilitator then presents the slides on Targeted Interventions.

Step 5: Next, the facilitator initiates a discussion on why TIs for IDUs are needed. For example, the facilitator may provoke the participants by stating, “We all know HIV is very high among IDUs. But why should we bother about HIV among IDUs?”

![Targeted Interventions Under NACP-III](image1)

**Components of TI**

- Condom Promotion
- Management of STIs
- Behaviour Change Communication
- Needle Syringe Exchange Programmes (NSDP)
- Enabling Environment
- Community Mobilisation
- Referral & Linkages

![Routes of HIV Transmission](image2)
Step 6: Finally the facilitator runs through the rest of the presentation and summarizes the main learnings.
Understanding Staff Roles Including Role of Project Manager

OBJECTIVE
- To ensure participants understand the roles and responsibilities of different levels of staff in the TI structure, including the role of the PM
- To help participants understand the expertise required for the same

EXPECTED OUTCOME
By the end of the session, participants will be able to differentiate clearly the roles and responsibilities of different levels of staff in a TI project.

DURATION
1 hour

SUGGESTED TRAINING METHOD
- Group work
- Group presentation and discussion
- PowerPoint presentation

MATERIALS/PREPARATION REQUIRED
- PowerPoint presentation – Roles and responsibilities of PM, doctor, counsellor/nurse, accountant, ORW and PE
- Chart paper
- Marker pens

TIPS FOR THE FACILITATOR
The focus of this session is to let participants understand the roles that each have to play to run and manage a TI for IDUs successfully and the importance of each staff member

PROCESS
Step 1: Group work
Divide the participants into four groups. According to the situations described below, ask each group to brainstorm on the possible roles of each member in the given settings.
A Manual to Train Project Managers in TI IDU Interventions

Situation 1: For providing/distributing N/S
- Who will play the lead?
- Who are the other people he/she needs to work with?
- Who will give supervisory support?

Situation 2: For providing medical care/STI management
- Who will play the lead?
- Who are the other people he/she needs to work with?
- Who will give supervisory support?

Situation 3: For procurement of N/S stock
- Who will play the lead?
- Who are the other people he/she needs to work with?
- Who will give supervisory support?

Situation 4: For monitoring of N/S and waste management
- Who will play the lead?
- Who are the other people he/she needs to work with?
- Who will give supervisory support?

<table>
<thead>
<tr>
<th>Situation</th>
<th>Providing/distributing N/S</th>
<th>Providing STI Management</th>
<th>Procurement of N/S Stock</th>
<th>Monitoring of N/S and waste management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Situation 1</strong></td>
<td>Who will play the lead?</td>
<td>Who will play the lead?</td>
<td>Who will play the lead?</td>
<td>Who will play the lead?</td>
</tr>
<tr>
<td>Providing/distributing N/S</td>
<td>PEs</td>
<td>Doctor and Nurse/Counsellor</td>
<td>ORWs and PEs for Demand Analysis, based on which the N/S stock will be procured</td>
<td>ORWs</td>
</tr>
<tr>
<td></td>
<td>Who are the other people he/she needs to work with?</td>
<td>Who are the other people he/she needs to work with?</td>
<td>Who are the other people he/she needs to work with?</td>
<td>PEs and Nurse/Counsellor</td>
</tr>
<tr>
<td></td>
<td>Who will give supervisory support?</td>
<td>Who will give supervisory support?</td>
<td>Who will give supervisory support?</td>
<td>Who will give supervisory support?</td>
</tr>
<tr>
<td></td>
<td>Project Manager</td>
<td>Project Manager</td>
<td>ORWs, Nurse/Counsellor</td>
<td>Project Manager</td>
</tr>
</tbody>
</table>

Probable Answers
Step 2: Presentation on Roles and Responsibilities of IDU TI PMs

Summarize the roles and responsibilities of the PMs

Roles and Responsibilities of PM
- Overall supervision of the project
- Capacity and skill building of the staff and the organization
- Development of work plans as per the performance indicators for outreach workers and counselors
- Development of capacity building and sustainability strategy
- Organize and conduct weekly and monthly meetings to identify shortfalls and to evolve corrective measures and further plan of action

Roles and Responsibilities of PM
- Continuous analysis of the project activities as to costs incurred to ensure cost-effective implementation
- Liaison with funding agency and local NGOs, CBOs and other groups in the community
- Conduct regular clinic and field visits, at least thrice weekly
- Reporting of activities, challenges, achievements to the management on a regular weekly or monthly basis
- Monitoring and evaluation of the program
Harm Reduction– Principles and Components

OBJECTIVE
To familiarize the participants with:

- Harms associated with injecting drug use
- The concept of harm reduction
- The hierarchy of injection-related risks
- The myths and misconceptions associated with harm reduction

EXPECTED OUTCOME
The participants will be able to understand harm reduction as a key strategy in the management of drug use and prevention of HIV among the IDUs and the comparative advantage it has over other approaches. They will also learn about the principles and components of harm reduction.

DURATION
1 hour 15 minutes

MATERIALS/PREPARATION REQUIRED
- Chart papers
- Marker pens
- ‘Sticky notes’ /cards
- Laptop
- LCD projector
- Feedback Forms – DAY 1

PROCESS
Step 1: The facilitator requests the participants to note down two harms on ‘sticky notes’/work-in-progress cards. The facilitator requests five participants to take up position beside the five chart papers marked Physical Harm, Occupational/Financial Harm, Familial/Social Harm, Psychological Harm and Legal Harm. The facilitator requests the participants to put up their ‘harms’ on the relevant chart paper. Once done with all the chits/cards, request all five participants standing next to the chart papers read out the harms from their respective charts.
Step 2: The facilitator asks the participants if these ‘harms’—physical, psychological, occupational/financial, familial/social and legal, are standalone ones or whether they are inter-related. He/she requests some of the participants to explain the inter-relationship of the harms with examples from their own experience. The facilitator helps them reconnect with the session on drug use, especially the section on dependence, and helps them understand how drug use affects the various aspects of a drug user’s life and also that of their family members. He/she also reminds them that drug dependence is a chronic relapsing disease. In spite of the best treatment facilities, relapse rates are very high, especially for those who use opioids.

Step 3: The facilitator makes the presentation on *Harm Reduction*. 

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**Drug-Related Harms**

- **Physical Harms**
  - Infections (e.g., abscess, systemic (HIV))
  - Poor nutrition, debility, weight loss
  - Overdose, death

- **Occupational/Financial Harms**
  - Absenteeism from work
  - Frequent changes of job, loss of job
  - Losses suffered/debts incurred

- **Familial/Social Harms**
  - Marital disharmony, separation/divorce
  - Loss of reputation, social ostracism
  - Stigma and discrimination

- **Psychological Harms**
  - Guilt/shame, lack of motivation
  - Depression, anxiety
  - Other mental disorders

- **Legal Harms**
  - Involvement in illegal activities
  - Arrests, imprisonment
  - Drug dealing (NPS Act)

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**Drug Abuse Management Strategies**

- **Supply Reduction Strategies**
  - To disrupt the supply and availability of drugs

- **Demand Reduction Strategies**
  - Aim to reduce the desire to use drugs and to prevent, reduce or delay the initiation of drug use

- **Harm Reduction Strategies**
  - Aim to reduce the negative impact of drug use and drug-related activities on individuals and communities

---

**What is ‘Harm Reduction’?**

- Defined as policies, programs and practices that aim primarily to reduce the adverse health, social and economic consequences of drug use without necessarily reducing drug consumption.

- More effective
  - Seeks to achieve realistic, suboptimal objectives rather than setting, fail to reach, utopian goals
  - 80% of something > 100% of nothing

---

**Regulated supply of legal drugs**

- Alcohol only for certain people, in certain settings
- Medications available only through prescriptions

**Total prohibition of illegal drugs**

- Seizures of drugs; punishment to drug dealers
Step 4: The facilitator stops the presentation at the above slide. He/she divides the participants into 6 groups and gives each group a card with one of the following statements written on it:

- Sharing N/S with multiple injectors
- Sharing N/S with only one partner
- Not sharing but reusing the same needles for multiple injections
- Injecting illicit drugs alone with a new N/S every time
- Using drugs orally
- Being on OST

The facilitator asks one of the groups to come forward and put their statement on the board. Then he/she requests the next group to come forward with one of their statements and position it either below or above the previous one according to the risks of harm involved with the practice. He/she invites the other groups to discuss the reasons for the positioning. The facilitator continues till all the cards are ranked in order starting from the one with the highest risk to that with the lowest.
Step 5: The facilitator completes the presentation by laborating safer options and principles of harm reduction.

As this is the last session of Day 1, distribute the feedback forms (Feedback Form – Day 1) and ask the participants to provide feedback on the sessions conducted through the day.
Day 2

Session One
Outreach and Related Management Issues

Session Two
Needle Syringe Exchange Program

Session Three
Waste Disposal

Session Four
Condom Programming

Session Five
Female Sex Partners (FSPs) and Female Injecting Drug Users (FIDUs)
OBJECTIVE
- To help the participants understand the basics of Outreach
- To familiarize them with the tools used for Outreach planning
- To help them ensure accessibility and availability of services through Outreach

EXPECTED OUTCOME
At the end of the session the participants will have a basic understanding of Outreach and clarity on the processes involved in the planning and implementation of Outreach.

DURATION
1 hour 30 minutes

SUGGESTED TRAINING METHOD
- Group work
- Discussion
- PowerPoint presentation

MATERIALS/PREPARATION REQUIRED
- PowerPoint presentation
- Whiteboard/Flip chart
- Chart paper
- Marker pens

PROCESS
Step 1: The facilitator opens the session by asking the participants, “What is Outreach?” and “Why do we need Outreach in IDU TI settings?” he/she then notes down the responses on the whiteboard/chart paper and presents the slides on Outreach, need for Outreach, services provided and the Outreach team.

"Outreach is a systematic approach to delivering HIV prevention services to people injecting drugs in their environments"
**Objectives of Outreach**

- **Overall Objective:** To prevent transmission of HIV & other blood-borne viruses among IDUs
- **Specific Objectives:**
  1. To ensure IDUs have easy access to and utilise available services
  2. To ensure significant reduction in needle sharing and unsafe sexual contact
  3. To prevent drug use-related harms
  4. To mobilise the IDU community

**Services Provided Through Outreach**

- **Education, advice, information on**
  - Risks of HIV, HBV/HCV, STIs and means of reducing risks
  - Safer injecting & safer sex practices
  - Prevention and management of overdose & abscess
- **Services available for**
  - STI diagnosis and treatment
  - HIV testing
  - ART
  - TB

**Services Provided Through Outreach**

- **Distribute the following commodities** regularly, as per need of the IDUs and their regular sex partners:
  - New needles and syringes
  - Abscess prevention materials such as alcohol swabs, distilled water etc.
  - Condoms – free as well as socially marketed
  - IEC materials, as and when required
- **Collect** used/old needles and syringes
- **Provide referral services**

**The Team**

**Objectives of Planning**

- Identify the number of IDUs at each site
- Estimate required risk reduction materials (like N/S and condoms) for adequate and uninterrupted supply
- Facilitate effective individual tracking vis-à-vis service access and behaviour modification
- Collect information for effective action plans
- Enhance participation of IDUs in program planning
- Identify and monitor problem areas for improved service

**Key Questions to Consider**

- How many IDUs are there in the target area?
- Can we reach all?
- How many regular injectors are there in the IDUs?
- Can we meet them according to their accessibility rather than on the basis of their risk/vulnerability?
- How many N/S or condoms do we need in a month to cover risk occasions?
- Does the outreach timing suit the IDUs?
- Can we track each individual?

Step 2: He/she explains the steps for conducting Outreach.
Step3: The facilitator asks the participants, “What are the tools used for Outreach planning?” and gives a brief explanation. He/she also explains the role of the different levels of staff at each step.
Step 4: The facilitator divides the participants into three groups and requests them to develop the following, based on the information provided in the case study given below:

- Spot analysis
- Contact mapping
- Risk and vulnerability analysis

**Case study:** Recently some IDUs have been identified in ABC area, previously known for drug use but not for IDUs. An NGO, XYZ, is about to set up an IDU TI with support from NACO.

The preliminary fact-finding and mapping have shown that one section of ABC has three major hotspots (1, 2 & 3) and two more areas (4 & 5) where IDUs inject at home.

Further information has been collected through some of the local IDUs (Red, Blue, Green and Yellow) who are quite well-known in the area and are believed to be well-informed.

The IDUs identified in these five spots are as below:

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A</td>
<td>AB</td>
<td>AH</td>
<td>CC</td>
<td>BE</td>
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<tr>
<td>3</td>
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<td>BB</td>
<td>CG</td>
<td>BJ</td>
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<tr>
<td></td>
<td>BD</td>
<td>AG</td>
<td>BC</td>
<td>CH</td>
<td>CI</td>
</tr>
<tr>
<td>4</td>
<td>CJ</td>
<td>E</td>
<td>CE</td>
<td>G</td>
<td>J</td>
</tr>
<tr>
<td></td>
<td>H</td>
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<td>AJ</td>
<td>CA</td>
<td>AE</td>
<td>BA</td>
</tr>
<tr>
<td></td>
<td>AI</td>
<td>BI</td>
<td>3B</td>
<td>AF</td>
<td>BB</td>
</tr>
</tbody>
</table>

contd...
A list of IDUs in these spots known to Red, Blue, Green and Yellow was also made and provided as shown in the table.

<table>
<thead>
<tr>
<th>IDUs</th>
<th>Daily Injector</th>
<th>No. of Injections per day</th>
<th>Weekly Injector</th>
<th>No. of Injections per week</th>
<th>Age</th>
<th>Timing</th>
<th>Drugs primarily injected</th>
<th>Sexually active</th>
<th>No. of sex partners</th>
<th>Regular female partner</th>
<th>HIV tested</th>
<th>Treated for TB</th>
<th>STI symptoms</th>
<th>Abscess</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Y</td>
<td>3</td>
<td>N</td>
<td>21</td>
<td>8 a.m. - 9 a.m.</td>
<td>Spasmo</td>
<td>Y</td>
<td>3</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
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<tr>
<td>AD</td>
<td>N</td>
<td>Y</td>
<td>3</td>
<td>27</td>
<td>8 a.m. - 9 a.m.</td>
<td>Heroin</td>
<td>N</td>
<td>0</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>CD</td>
<td>Y</td>
<td>5</td>
<td>N</td>
<td>29</td>
<td>9 a.m. - 10 a.m.</td>
<td>Heroin</td>
<td>N</td>
<td>0</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>D</td>
<td>Y</td>
<td>4</td>
<td>N</td>
<td>32</td>
<td>7 a.m. - 9 a.m.</td>
<td>Buprenorphine</td>
<td>N</td>
<td>0</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>AF</td>
<td>Y</td>
<td>3</td>
<td>N</td>
<td>19</td>
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<td>Buprenorphine</td>
<td>Y</td>
<td>2</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>Y</td>
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<td>BD</td>
<td>N</td>
<td>Y</td>
<td>2</td>
<td>45</td>
<td>12 noon</td>
<td>Spasmo</td>
<td>Y</td>
<td>1</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>CJ</td>
<td>N</td>
<td>Y</td>
<td>1</td>
<td>26</td>
<td>4 p.m. - 5 p.m.</td>
<td>Buprenorphine</td>
<td>N</td>
<td>0</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
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<tr>
<td>H</td>
<td>Y</td>
<td>5</td>
<td>N</td>
<td>29</td>
<td>3 p.m. - 5 p.m.</td>
<td>Heroin</td>
<td>Y</td>
<td>1</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>CA</td>
<td>Y</td>
<td>3</td>
<td>N</td>
<td>22</td>
<td>3 p.m. - 6 p.m.</td>
<td>Spasmo</td>
<td>N</td>
<td>0</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>AI</td>
<td>N</td>
<td>Y</td>
<td>3</td>
<td>48</td>
<td>4 p.m. - 5 p.m.</td>
<td>Heroin</td>
<td>Y</td>
<td>3</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>AB</td>
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<td>2</td>
<td>N</td>
<td>38</td>
<td>3 p.m. - 4 p.m.</td>
<td>Heroin</td>
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<td>2</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
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</tr>
<tr>
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<td>24</td>
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<td>Spasmo</td>
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<td>N</td>
<td>N</td>
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<tr>
<td>B</td>
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<td>35</td>
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<td>Heroin</td>
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<td>4</td>
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<td>Y</td>
<td>N</td>
<td>N</td>
<td>Y</td>
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<tr>
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<td>37</td>
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<td>Buprenorphine</td>
<td>Y</td>
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<td>N</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
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<tr>
<td>BH</td>
<td>N</td>
<td>Y</td>
<td>3</td>
<td>26</td>
<td>8 a.m. - 9 a.m.</td>
<td>Heroin</td>
<td>N</td>
<td>0</td>
<td>N</td>
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<td>N</td>
<td>N</td>
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<tr>
<td>AG</td>
<td>N</td>
<td>Y</td>
<td>2</td>
<td>28</td>
<td>9 a.m. - 10 a.m.</td>
<td>Buprenorphine</td>
<td>N</td>
<td>0</td>
<td>N</td>
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<td>Y</td>
<td>N</td>
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<tr>
<td>E</td>
<td>Y</td>
<td>2</td>
<td>N</td>
<td>23</td>
<td>10 a.m. - 12 noon</td>
<td>Buprenorphine</td>
<td>N</td>
<td>0</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
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<tr>
<td>BF</td>
<td>Y</td>
<td>5</td>
<td>N</td>
<td>25</td>
<td>3 p.m. - 5 p.m.</td>
<td>Heroin</td>
<td>Y</td>
<td>2</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
</tbody>
</table>
Step 5: The facilitator explains the meaning of ‘Conducting Outreach’ using the following slides.

**Conducting Outreach**
- **Step 1:** Building rapport with the IDU and the general community
- **Step 2:** Delivering services in the field; referrals to DIC and other services
- **Step 3:** Creating enabling environment
- **Step 4:** Documentation and Analyses

**Services Provided in Outreach**
- Needle Syringe Exchange Program (NSEP)
- Behaviour Change Communication (BCC)
- Condom Promotion
- Referrals
- Creating enabling environment

He/she wraps up the session by discussing the need for monitoring of outreach programs and the PM’s role.

**Monitoring**
- Field level: ORW with the PEs
- TI level: PM with ORWs and PEs

**Monitoring Through Field Visits**
- PM should visit the hotspots two to three times a week, some may be surprise visits
- During the visits the PM should be meeting:
  - Some IDUs
  - Some stakeholders (local: tea, paan sellers, pharmaceutical shop owners/staff, community leaders/key influencers, police etc.)
  - The PEs and ORWs working in the hotspot

**What to Monitor**
- Coverage as per target and plan
- Reaching out to identified population as per plan
- N/S supply as per calculated demands
- Other provisions (cotton swab, distilled water as planned by TI) for safer injecting
- Condom supply as per calculated demand
- Referral to DIC
- Follow-up on referrals
- BCC at the field level
- Documentation

**Monitoring Through Document Review**
- The following records/documents should be reviewed every fortnight:
  - Outreach plan including spot analysis
  - N/S stock register
  - DIC registration records
  - DIC service utilisation registers
  - PE weekly planning & activity sheet (Form B1 for IDUs)
  - PE-wise individual HRG sheet compiled for IDU intervention (by ORW) (Form C)
  - Monthly CMIS report

**Monthly Review Meeting**
- The PM should also conduct review meetings at the DIC with the ORWs at least once in a fortnight
- During the review meeting the PM should base the discussion on his/her findings from:
  - Field visit
  - Record/documentation review
  - ORW PE field level

**Roles and Responsibilities of PM**
- Ensure:
  - Outreach team conducts outreach planning
  - Outreach team meets on a weekly basis updating on the previous week and planning for the coming one
  - Enough commodities are available at the DIC/NGO office for outreach activities
  - A backup plan for outreach staff taking leave/being absent
  - Vacancies due to staff drop-outs are filled up
  - Set up a routine monitoring mechanism for supervision
  - Monitor the outreach activities
  - Build the capacity of the outreach team
OBJECTIVE

- To provide participants with a basic understanding of:
  - Safer injecting practices
  - NSEP
- To help participants understand how to plan, conduct and monitor NSEP

EXPECTED OUTCOME

At the end of the session, participants will have clear understanding about:

- Safer injecting practices
- Aspects of planning and implementing a successful NSEP (what, where, who, how and when)

DURATION

2 hours

SUGGESTED TRAINING METHOD

- Role play
- Group work on case studies
- Brainstorming
- PowerPoint presentation

MATERIALS/PREPARATION REQUIRED

- PowerPoint presentation
- LCD projector
- Chart papers
- Maker pens
- Flip charts
- Whiteboard

PROCESS

Step 1: The facilitator invites three volunteers to come and demonstrate typical injecting practices (one each) for heroin/brown sugar, injectable pharmaceuticals (buprenorphine, pentazocine, diazepam) and non-injectable pharmaceuticals (dextro-proxoyphene etc.). The facilitator encourages the participants to point out the risks of the various steps and the unhygienic practices involved. He/she also facilitates a discussion on the possible consequences of such practices. The facilitator notes down the responses on the whiteboard/chart paper and sums up the discussion with the presentation on injecting practices and safer injecting.
Step 2: The facilitator then presents the concept of NSEP – the need for planning and issues on implementation using the PowerPoint presentation on NSEP.
**Who Implements NSEP?**

1. PEs and ORWs in areas where IDUs congregate/reside
2. Health workers (nurse/counsellor/ANMs) at DICs/clinics
3. PEs/others designated as Secondary Distributors (SDs) in far flung areas difficult for ORW/PE to reach
4. Sometimes, NSEP may be implemented by a local key informant

**Where?**

- At hotspots/sites where IDUs can be accessed
- Static/Fixed sites - Clinics or DICs

**What Will Be Distributed?**

1. Needles: 24", 26"
2. Syringes: 1ml, 2ml, 5ml, 10ml
3. Other equipment: filter, cooker, tourniquet (where budget permits)
4. Need-based IEC
5. Alcohol/spirit swabs (to prevent abscesses)
6. Swabs, bandages, etc. (to manage abscesses)
7. Condoms
8. Distilled water

**NSEP - Operational Aspects**

- NSEP should operate all 7 days of the week
  - At times when IDUs need it most
- The planning should be based on:
  - Spot analysis
  - Contact mapping
  - Risk and vulnerability analysis
- A carefully planned outreach will determine
  - Locations/contact points for delivering NSEP
  - Number of N/S required
  - Timing of operation
  - Division of IDUs and areas amongst the outreach team
  - Individual tracking and monitoring

**Operational Aspects**

- N/S distribution should be accompanied by IDUs returning used N/S
  - However, the return should not be a prerequisite for distribution
- Collection of used N/S from IDUs reduces number of used N/S available for recirculation and so reduces risk of contamination/sharing
- The return rate of N/S depends on:
  - The relationship between IDU and staff
  - Conductive environment for NSEP

**For a Successful NSEP**

Ensure:
- Easy accessibility of N/S
- Confidentiality of the IDU and partner
  - Many IDUs are fearful of being identified and seen as IDUs by the public and family/friends while accessing NSEP
- Supply (delivery) meeting demand – in quantity and quality
- Behaviour and attitude of outreach staff during interaction with IDUs and partners
Step 3: The facilitator divides the participants into four groups and asks them to work on the case studies provided to each group and present their findings to the larger group. He/she requests the larger group to share their observations.

**Case study:** XYZ is an IDU TI working with 500 IDUs. The project has 10 hotspots in both rural and urban settings. The following table provides hotspot-wise data of the distance of the hotspots from the DIC and the categorization of the IDUs based on the volume of injecting.

<table>
<thead>
<tr>
<th>Name of the Hotspots</th>
<th>Distance from the Dic</th>
<th>No. of IDUs Injecting Daily</th>
<th>No. of IDUs Injecting Weekly</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>3 Injections Per Day</td>
<td>2 Injections Per Day</td>
</tr>
<tr>
<td>A 0 km.</td>
<td>8</td>
<td>19</td>
<td>16</td>
</tr>
<tr>
<td>B 3 km.</td>
<td>12</td>
<td>23</td>
<td>8</td>
</tr>
<tr>
<td>C 7 km.</td>
<td>23</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>D 15 km.</td>
<td>18</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>E 2 km.</td>
<td>9</td>
<td>22</td>
<td>19</td>
</tr>
<tr>
<td>F 1 km.</td>
<td>4</td>
<td>29</td>
<td>14</td>
</tr>
<tr>
<td>G 18 km.</td>
<td>17</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>H 1.5 km.</td>
<td>5</td>
<td>31</td>
<td>14</td>
</tr>
<tr>
<td>I 2 km.</td>
<td>8</td>
<td>21</td>
<td>9</td>
</tr>
<tr>
<td>J 3 km.</td>
<td>3</td>
<td>9</td>
<td>18</td>
</tr>
</tbody>
</table>

**Group 1**
Calculate the N/S demand for a month (calculation should be done based on daily and non-daily injectors) for each site.

Also plan procurement of N/S for the project for one year, based on the demand analysis and include maintenance of buffer stock.

**Group 2**
Set up a NSEP distribution system including delivery mode and points for these sites. Mention the steps to be taken for setting up secondary delivery points.

**Group 3**
Make a work plan for delivering the NSEP services to ensure that every injecting episode is safe. This should include the activities – their frequency and the staff responsible.

**Group 4**
Develop a system of monitoring the NSEP with key verifiable indicators.
### The demand calculation

<table>
<thead>
<tr>
<th>Name of the Hot-Spot</th>
<th>Distance from the DIC</th>
<th>No. of IDUs Injecting Daily</th>
<th>No. of IDUs Injecting Weekly</th>
<th>N/S Demand Daily</th>
<th>Total N/S Demand Daily</th>
<th>N/S Demand per Week</th>
<th>Total N/S Demand per Week</th>
<th>Total Monthly N/S Demand</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>0 km</td>
<td>8</td>
<td>3</td>
<td>24</td>
<td>16</td>
<td>78</td>
<td>6</td>
<td>105</td>
</tr>
<tr>
<td>B</td>
<td>3 km</td>
<td>12</td>
<td>7</td>
<td>36</td>
<td>8</td>
<td>90</td>
<td>14</td>
<td>110</td>
</tr>
<tr>
<td>C</td>
<td>7 km</td>
<td>23</td>
<td>5</td>
<td>69</td>
<td>11</td>
<td>94</td>
<td>10</td>
<td>122</td>
</tr>
<tr>
<td>D</td>
<td>15 km</td>
<td>18</td>
<td>4</td>
<td>54</td>
<td>9</td>
<td>69</td>
<td>8</td>
<td>98</td>
</tr>
<tr>
<td>E</td>
<td>2 km</td>
<td>9</td>
<td>5</td>
<td>27</td>
<td>19</td>
<td>90</td>
<td>10</td>
<td>124</td>
</tr>
<tr>
<td>F</td>
<td>1 km</td>
<td>4</td>
<td>5</td>
<td>12</td>
<td>14</td>
<td>84</td>
<td>10</td>
<td>103</td>
</tr>
<tr>
<td>G</td>
<td>18 km</td>
<td>17</td>
<td>1</td>
<td>51</td>
<td>6</td>
<td>75</td>
<td>2</td>
<td>86</td>
</tr>
<tr>
<td>H</td>
<td>1.5 km</td>
<td>5</td>
<td>9</td>
<td>15</td>
<td>14</td>
<td>91</td>
<td>18</td>
<td>115</td>
</tr>
<tr>
<td>I</td>
<td>2 km</td>
<td>8</td>
<td>6</td>
<td>24</td>
<td>9</td>
<td>75</td>
<td>12</td>
<td>93</td>
</tr>
<tr>
<td>J</td>
<td>3 km</td>
<td>3</td>
<td>9</td>
<td>9</td>
<td>18</td>
<td>45</td>
<td>18</td>
<td>69</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>321</td>
<td>346</td>
<td>124</td>
<td>791</td>
<td>108</td>
<td>126</td>
<td>1025</td>
</tr>
</tbody>
</table>

The monitoring indicator would include:

- Knowledge of safer injecting practices
- Peer-wise/hotspot-wise demand vs. distribution
- Distribution vs. return rate
- Number of injectors whose N/S demand has been met
- Timely ordering of N/S stock and buffer stock for at least three months
- Number of abscesses reported
Step 4: After the group work, the facilitator divides the participants into new groups and gives each group two cards, each having one of the statements below. He/she requests them to discuss among themselves whether it is a correct or incorrect practice. He/she then requests each group to take turns with their cards and come up to the whiteboard/chart paper and place the card under the appropriate head – Correct Practices or Incorrect Practices. The groups should justify the placement of the card. The facilitator helps the participants place the cards under correct heading, by providing reasons, in case placed wrongly.

<table>
<thead>
<tr>
<th>Correct Practices</th>
<th>Incorrect Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always wear thick latex/plastic gloves when handling used N/S</td>
<td>Pick up a used N/S from any side</td>
</tr>
<tr>
<td>Use puncture/leak-proof containers with proper lid for collection and transportation of used N/S</td>
<td>In case of needle stick injury - suck out as much blood as possible</td>
</tr>
<tr>
<td>Use a tong, if possible, to pick up used N/S</td>
<td>In case of needle stick injury – Post-Exposure Prophylaxis (PEP) should begin after 72 hours</td>
</tr>
<tr>
<td>Do not recap used N/S</td>
<td>Bend/break N/S manually when you receive them from clients</td>
</tr>
<tr>
<td>Do not handle used N/S manually</td>
<td>Separate needles from syringes when collecting from IDUs</td>
</tr>
</tbody>
</table>

Step 5: The facilitator shares the slides on collection of used N/S with the participants.
Step 6: Facilitator also explains the role of the PM.

**Monitoring of NSEP**
- Monitor NSEP on a regular basis
- Three types of monitoring tools should be employed:
  - Weekly review meetings with outreach staff regarding coverage, areas of weakness and next week’s work plan
  - Record based monitoring to analyse and review coverage, number of IDUs reached, frequency, number of N/S distributed and the return rates
  - Field based monitoring: PM should regularly visit hotspots, interact with clients, observe the outreach staff and also interact with other community members
- Observation from the field visits should be tallied with the records entered by the CRW to get a realistic picture of the quality of the services being offered

**Role of the PM in NSEP**
- Supervise NSEP outreach staff
- Build staff capacity and skill on NSEP
- Develop work plans with ORWs and PEs
- Liaise with other agencies, local NGOs, CBOs and other groups in the community

**Points to Remember**
- NSEP is the backbone of IDU TI programs
- NSEP faces major resistance from the general community; significant efforts must be dedicated to conducting advocacy
- NSEP serves not only to provide a safe method of injecting, but also as an entry point into the IDU community
- Collection of the returned N/S and safe disposal is as important as distribution of N/S

\*Remember this is a Needle Syringe Exchange Program, not a mere N/S distribution program\*
Waste Disposal

OBJECTIVE
- To enable participants to gain skills in waste disposal management

EXPECTED OUTCOME
By the end of the session, participants would have clear understanding of the following:
- How to set up a waste disposal system
- How to ensure that systems are followed
- How to organize community collection of used N/S
- How to manage needle stick injury

DURATION
1 hour

SUGGESTED TRAINING METHOD
- Group work
- Discussion
- Screening of the film, “What Happened to Super Syringe?”
- PowerPoint presentation

MATERIALS/PREPARATION REQUIRED
- Film – “What Happened to Super Syringe?”
- Chart papers
- Marker pens
- PowerPoint presentation
- Laptop
- LCD projector
**PROCESS**

**Step 1:** Screening of the film, "What Happened to Super Syringe?"

- The facilitator shows the film, ‘What Happened to Super Syringe?’ and then initiates a discussion on the right ways to collect and safely dispose of N/S.

**Step 2:** Discussion and presentation – Safe disposal of used N/S

- The facilitator follows up with the presentation on safe disposal of used N/S and the role of the PM.

---

**Need for Safe Disposal of Used N/S**

- Needle Syringe Exchange Programme (NSEP) is a major component of the harm reduction strategy adopted by NACO.
- Disposal mechanism of the used N/S in the intervention sites is a huge challenge to the strategy.
- If proper disposal mechanism is not followed, there is a real chance of transmission of HIV and other blood-borne diseases not only among the IDUs, but also to the general community.

**How to Set Up the Systems?**

- Link up with waste management agencies (Common Bio-waste Treatment Facility) wherever available.
- Link up with Government Medical College/ large hospital which has a proper waste disposal system in the city/ town.
- In case a waste management agency is not available, arrange for transport of the disinfected sharp wastes to the hospital disposal system.

**When Services are not Available...**

- Local mechanisms may be adopted for disposal of needles and syringes:
  - For needles: Construction of sharp pits for disposal of the disinfected needles, or encapsulation.
  - For syringes: Shredding, or mutilation and burial on site.

**Needle-stick Injury – What Should One Do?**

- **Do**
  - Be calm and cool.
  - Remove gloves, if appropriate.
  - Wash the exposed site thoroughly with running water.
  - Irrigate with water or saline solution if exposure sites are eyes or mouth.
  - Wash skin with soap and water.

- **Don’t**
  - Panic.
  - Put the pricked finger into the mouth.
  - Use alcohol, chlorine, bleach, betadine, iodine, or any other antiseptic on the wound.
**Needle-stick Injury – What Should One Do?**
- Post exposure Prophylaxis (PEP) – Take antiretroviral medications as soon as possible after injury so that exposure will not result in HIV infection
- PEP should begin within 72 hours after exposure to needle-stick injury
- The closest ICTC from where PEP drugs are available should be contacted
- Treatment should continue for four weeks, if the person can tolerate it
- Contact/inform a supervisor (PM, counsellor or DIC/doctor) immediately
- Most cases of needle stick injury by outreach staff are not reported; PM should routinely enquire in staff meetings

**Role of the PM**
The PM should ensure:
- Regular planning and conducting of safe disposal of used N/Ss
- Guidelines are properly followed
- Provisions (gloves, puncture proof boxes, chemicals, etc.) are always available with buffer stocks
- Linkages with waste management agencies/hospitals (where available) are established and maintained
- Availability of PEP medicine (through linkage)
- Display of protocol for dealing with needle-stick injury
- Staff is trained on safe disposal, needle-stick injury
OBJECTIVE
To help participants understand

- Management of condom stock in the program – assessing condom demand, procuring condom and managing the stock, setting up distribution points
- Social marketing of condom – the concept and strategy to increase social marketing of condoms among IDUs
- Process to ensure successful uptake of condom use by the IDUs

EXPECTED OUTCOME
By the end of the session, participants will have:

- Increased knowledge on condom programming
- An understanding of the management issues related to condom programming

DURATION
1 hour 15 minutes

SUGGESTED TRAINING METHOD
- Case studies
- Group work
- Discussion
- PowerPoint presentation

MATERIALS/PREPARATION REQUIRED
- Case studies
- PowerPoint presentation
- Laptop
- LCD projector
- Chart papers
- Marker pens

PROCESS
Step 1: The facilitator divides participants into four groups and gives one case study to each. He/she requests the groups to work on their individual case and present the results to the larger group.
Case study 1
During a review meeting, XYZ, the PM of an IDU intervention, shared that the condom uptake in the community is very low in some hotspots whereas others are asking for more than their assessed needs. He discussed his concern with the ORWs and PEs and the team felt that there was a need to review the condom-demand analysis.

Q Discuss and share the process that the PM would follow to review the condom-demand analysis for the community.

Case study 2
A PM who has joined recently and does not have much experience of running an IDU intervention finds that the condom stock is low and that condoms need to be procured immediately.

Q What are the steps, he/she would need to follow to procure condoms for the TI? What is the process he/she will follow at each step?

Case study 3
An IDU intervention for working among 400 IDUs has been sanctioned to an NGO working with drug users for the last five years. The TI has identified and registered the population and has initiated providing service to the community. However, when it comes to condom distribution, the PEs and ORWs have reported to the PM that the community is reluctant to take condoms from them.

Q Identify the barriers to condom use for an IDU. As a PM, plan a strategy for condom promotion to increase condom uptake among IDUs. What would be the primary and secondary distribution channels and systems for the TI?

Case study 4
An IDU intervention has been working with 500 IDUs for the past 3 years. The condom analysis of the project has been worked out by the Outreach team and the monthly condom demand is 2000. However, the PM has noticed that for the last 6 months, the condom distribution is falling short of the demand. On an average, the TI is distributing 400 – 600 condoms per month. The PM tried to address the issue with the Outreach team, but failed to arrive at a conclusive reason for the shortfall.

Q What steps can the PM take to review the condom distribution program? What will be his/her indicators to monitor the effectiveness of this strategy?
Step 2: Following the presentation by the groups, the facilitator uses the PowerPoint presentation on Condom Programming, to sum up the key issues and learning of the session.

**TIPS FOR THE FACILITATOR**

These are all colloquial terms for condoms in various languages and countries

<table>
<thead>
<tr>
<th>Any Guesses?!!</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>Love glove</td>
</tr>
<tr>
<td>Brazil</td>
<td>Little skirt</td>
</tr>
<tr>
<td>China</td>
<td>Contraceptive basket</td>
</tr>
<tr>
<td>Lebanon</td>
<td>Coat</td>
</tr>
<tr>
<td>Nigeria</td>
<td>Penis-Hat</td>
</tr>
<tr>
<td>France</td>
<td>English raincoat</td>
</tr>
<tr>
<td>Germany</td>
<td>Naughty bag</td>
</tr>
<tr>
<td>Greece</td>
<td>Overcoat</td>
</tr>
<tr>
<td>Hong Kong</td>
<td>Small rubber</td>
</tr>
<tr>
<td>Hungary</td>
<td>Safety tool/Roof proof Vest</td>
</tr>
<tr>
<td>U.K./S. Africa</td>
<td>French leather</td>
</tr>
<tr>
<td>Ireland</td>
<td>Johnny</td>
</tr>
<tr>
<td>USA</td>
<td>Jimmy hat</td>
</tr>
<tr>
<td>India</td>
<td>Hirosh</td>
</tr>
</tbody>
</table>

**Condom Promotion in HIV Prevention Program**

The core imperative of NACP III has been ensuring availability, accessibility and correct and consistent usage of condoms by HRGs

- **Ensuring availability alone is not enough** – distribution does not mean that the distributed condoms will be used
- **Ensuring accessibility is not enough** – access does not ensure usage
- **The goal is increased correct and consistent USE of condoms by IDUs**

**Strategies of Condom Promotion**

**Two broad strategies for condom promotion for IDUs**

- **Primary strategy**
  - Free supply of condoms to IDUs and their sex partners through TIIs by NGOs/CBOs

- **Secondary (optional) strategy**
  - Social marketing of condoms by NGOs/CBOs in collaboration with Social Marketing Organizations (SMOs)

Condoms should always be available to IDUs and their sex partners for free. If and when demand for socially marketed condoms arises, appropriate mechanisms must be in place to ensure that the free and socially marketed supplies do not overlap.

**Condom Promotion at the TIs**

Condom promotion at the TI level is driven by the peers, ORWs and Counsellors.

The activities include:

- Ensuring easy availability and accessibility of condoms to the community
- Condom promotion through one-to-one and one-to-group interaction by the outreach team
- Promotion during counselling sessions - identifying barriers and initiatives to overcome the barriers/ myths
- Enhancing negotiation skills of the community
- Condom demonstration for correct and consistent use
- Design and develop IEC targeting perceived availability
- Distribution and placement of IEC

**Planning Condom Program for IDU TI**

Assessing condom demand:

- The demand analysis of condoms assist the program in understanding the condom requirement of the population they are working with
- The process of calculating the condom demand per HRG per month is based on individual sexual encounters
- The outreach team (including the peers and ORWs) needs to assess the demand of each IDU

**Calculation:**

- **Condom demand (for a month):** No. of sexual encounters of individual IDU in a week X 4
- **There is a need to review the demand analysis by the outreach team on a quarterly basis**

Continued...
Planning Condom Program for IDU TI

- The TI needs to develop strategy of condom promotion among the IDUs through free distribution and social marketing.
- Peer-wise condom demand and distribution targets need to be set and the ORWs/PM need to monitor and supervise on a weekly and monthly basis the demand vs. distribution of condoms by the peers.
- Based on the condom demand, the PM needs to procure condoms for distribution among the IDUs (a buffer stock of at least three months should always be maintained at the TI level).

Planning Condom Program for IDU TI

- Free condoms are available either from SACS or from the district health facilities.
- Stocking and recording of condom at the Project Office and DIC levels. The main stock can be maintained at the Project office and sub stock can be maintained at the DIC level.
- Distribution points need to be set up. Peers are the main distribution points, in case of free condoms.
- ORWs, during their field visits, and counsellors, during their counselling sessions, are required to act as distribution points.
- Condoms should be available at the Project Office/DIC.

What is Social Marketing??

It is adoption of a commercial technique

- To influence voluntary behaviour change of the target audience.
- To improve personal welfare and welfare of the society which they are part of.
- Aimed at those who have limited ability to pay.
- Consumer spends money on product, therefore values it, puts it to correct use.

Principles of Social Marketing

Social marketing principles and techniques are often used to:

- Improve health.
- Prevent injuries.
- Protect environment.
- Contribute to community.

Social Marketing of Condoms at the IDU TIs

- Outreach team needs to identify the preferred brand of condom.
- Procure the preferred brand of condom in small quantity.
- Review the feedback of the community on the usage.
- Identify and list all locations/channels, which can be used as distribution points.
- With PMs
  - Medicine shops
  - Other shops
  - Clinic
- Medicine shops/other shops/clinics can function as outlet/distribution points for the program.
- Regular visits to the outlets for stock checking and review.
- Money recovered from the sale of condoms needs to be rolled for procuring more condoms for the program.
- Periodic monitoring of the program through feedback from the community regarding availability and usage.

Review of Condom Program

Condom gap analysis

- A TI can review the effectiveness of their condom program by looking at the condom gap analysis.
- Condom gap analysis assesses the individual condom requirement of an IDU vs. the condoms that the IDU received from Peers/TI and the condoms procured/received by the IDU from other sources.
- The review indicates the gap in the distribution pattern and also gives an estimate of how many more condoms the project can provide to the community.

Role of the PM

- Ensure condom demand is calculated initially and updated quarterly.
- Ensure that there is no stock out of condoms at the NGO/DIC.
- Ensure that a buffer stock of at least three months is always available with the NGO.
- Monitor and supervise the supply chain management of condoms (stocking and distributing condoms).
- Obtain regular feedback from the users on the availability and quality of condoms.
- Ensure that the Peers and ORWs are trained to promote consistent condom use.
- Ensure that condom-related records are properly maintained.

Session Four  55
Female Sex Partners (FSPs) and Female Injecting Drug Users (FIDUs)

OBJECTIVE
- To help the participants understand the basic issues related to the FIDUs and FSPs and how they are related to drug use and vulnerability to HIV
- To facilitate the process of planning the delivery of services to FIDUs and FSPs

EXPECTED OUTCOME
- The participants will learn about the differences in needs of male and female IDUs and FSPs
- They will also become aware about the various services needed for prevention of transmission of HIV/STIs among the FIDUs and FSPs
- They will learn about the various modes of service delivery and their strengths and weaknesses with respect to the FIDUs and FSPs

DURATION
1 hour 15 minutes

SUGGESTED TRAINING METHOD
- Debate
- Group work
- PowerPoint presentation

MATERIALS/PREPARATION REQUIRED
- Case studies
- PowerPoint presentation
- Whiteboard/Flip chart
- Chart paper
- Marker pens

PROCESS
Step 1: The facilitator divides the participants into two groups and requests them to debate the statement, “FIDUs and FSPs do not need any specialized services for prevention, treatment and care of HIV among them”.

The facilitator allocates 2 minutes to the participants to prepare and decide on their speakers. Each side is allowed five speakers who can speak for 2 minutes each, with 2 more minutes for wrapping up at the end.
Step 2: Once the debate is over, the facilitator divides the participants into four groups and asks them to do role plays on the following situations:

**Group 1**
A female IDU takes N/S from the PE but never comes to the Drop-in Centre (DIC).

**Group 2**
A female IDU is married to a male IDU. Even though the male IDU receives regular services from the nearby IDU TI, both he and his wife avoid the PEs and ORWs when they try to approach her.

**Group 3**
The wife of a male IDU, on OST, has not been keeping well for a long time but is not prepared to come to the DIC.

**Group 4**
The wife of a male IDU already has two children – one of whom often falls ill. The wife is pregnant but is not prepared to discuss the situation with the PE or ORW of the nearest IDU TI.

The facilitator requests the participants to highlight the following aspects through their role plays:
1. The barriers in accessing services in the given situation.
2. The services needed for the FIDUs/FSPs in the given situation.
3. The steps the PM can take to overcome the barriers and ensure the requisite services are accessed.

The participants are given 5 minutes to prepare and then share their role play with the others. Each role play should not exceed 5 minutes and should be followed by a debriefing (5 minutes) during which the larger audience shall answer the following questions:
1. What are the services needed for the FIDUs/FSPs in the given situation?
2. What are the barriers to accessing services in the given situation?
3. What steps the PM has taken to overcome the barriers? What more could be done?

The responses are noted on the whiteboard/flip chart.

Step 3: The facilitator wraps up the session with the PowerPoint presentation on ‘FIDUs and FSPs’.
Female Sex Partners of IDUs
What makes FSPs vulnerable to HIV/STI?
- Women are biologically more vulnerable to HIV
- High HIV prevalence among IDUs
- Difficult to negotiate correct and consistent condom use
- FSPs may also be using drugs themselves so added risk of sharing injecting equipment

Female Injecting Drug Users
- As per NACP III, the number of female IDUs in the country is estimated to range from 10,005 to 33,392
- Due to lack of adequate strategic information, specially data, it is widely believed that the phenomenon of female IDUs is only in the NE region of India

Female Injecting Drug Users
What makes FIDUs more vulnerable to HIV?
- Biologically, women are more vulnerable to HIV
- There is double stigma attached to being a FIDU. This makes accessing safe injecting equipment more difficult
- Women are economically less empowered and thus may get involved with pedalling / sex work to support their drug use. This further increases their vulnerability

Female Injecting Drug Users
Other factors that increase vulnerability:
- Economic burden of their partner’s drug use may push them into sex work
- Social burden, particularly the stigma attached to being a partner of a drug user, becomes a barrier to accessing preventive healthcare
- Also vulnerable to domestic abuse and violence

Female Injecting Drug Users
- However, a 100 site comprehensive study titled ‘Women and Drug Use in India: Substance, Women and High Risk Assessment Study’ carried out on substance use and women in India by UNODC in 2008 showed that:
  - 32.4% of female IDUs were from the North-east
  - 24.6% were from the eastern region
  - 15.3% from the northern region
  - 17.1% were from the south
  - 10.6% were from the western region

Special Interventions Required?
Yes! Special interventions are required for these vulnerable groups because:
- Existing services are not gender responsive
- FIDUs aren’t able to access existing treatment services as these lack facilities for co-accommodation/childcare
- Both FIDUs and FSPs require special SRH services
- They find it difficult to confide in male service providers
Thus services and service delivery needs to be tailored to meet specific needs of FSPs and FIDUs

Strategies for Reaching Out
- Community and institution-based gender-sensitive and user-friendly services at both the non-governmental and governmental levels
- Support through vocational training and creation of self-help groups
- Self-help groups for partners of IDUs to be able to cope with their situations
- Networking of services in the community for medical, legal or financial aid for women
Session One
DIC and its Management

Session Two
Referral and Networking

Session Three
Community Mobilization

Session Four
Legal Aspects of Drugs and Drug Use

Session Five
Advocacy
Drop-in Centre and its Management

OBJECTIVE
To help the participants understand the various aspects of a Drop-in Centre (DIC).

EXPECTED OUTCOME
By the end of the session, participants would have understood the need for a DIC, management related issues like how to set up the DIC, ensure smooth running of the DIC on a day-to-day basis, organize activities in the DIC and monitor them.

DURATION
1 hour and 30 minutes

SUGGESTED TEACHING METHOD
- Group work
- PowerPoint presentation

MATERIAL/PREPARATION REQUIRED
- Chart paper
- Marker pens
- Pencils and erasers
- PowerPoint presentation
- LCD projector
- Laptop

PROCESS
Step 1: Brainstorming on the importance of DIC in the IDU settings
The facilitator asks the participants, “Why is there a need for a DIC?” and notes down the responses on the whiteboard/flip chart. He/she then follows it up with the question, “What are the activities of a DIC?” and then shows the following slides from the PowerPoint presentation on DIC.
NOTE TO THE FACILITATOR

Services provided at a DIC

- Needle and Syringe Exchange – IDUs can exchange their used needles for clean, new ones at the DIC
- IEC – Continued education through leaflets and pamphlets on HIV, HCV, STIs
- Sharing and caring – Access to other IDUs and PEs for sharing information and seeking mutual support
- Psychosocial support – Counsellor available to address issues on behavioural change related to high-risk behaviour and drug use
- Wound and abscess management – Diagnosis, treatment and management of abscesses by a doctor and a nurse
- STI treatment – Syndromic treatment of sexually-transmitted infections (STIs) as per established guidelines
- Condom distribution – Access to free condoms

Step 2: Group work

- The facilitator divides the participants into four groups and requests each group to work on their assigned question and then present it to the larger group one at a time.

**Group 1**. What will the steps before setting up a new DIC? What will the criteria be for the selection of the site of DIC?
NOTE TO THE FACILITATOR

The following steps should be followed before selecting a location for DIC:

- Mapping of IDUs and hotspots
- Mapping of services and referrals
- Consideration of feasibility and budgetary issues
- Opinion of the IDUs through group discussions
- Opinion of the general community residing nearby
- Advocacy with the local community leaders and police
- The final choice will depend upon:
  - Proximity of proposed site to the hotspots, services and referrals
  - Acceptability of the site to the IDU and general community
- Once a location is chosen on the basis of the above steps, the TI (NGO) should hold advocacy meetings with the general community residing near the proposed site
- All the concerns of the general community should be addressed by the TI staff

For details please refer to SOP on DIC for IDU Interventions developed by UNODC for NACO

Group 2. List and organize the ‘day-to-day’ operations at the DIC. (Define the roles of different staff in the day-to-day activities of the DIC.)

<table>
<thead>
<tr>
<th>Day-to-day operations</th>
<th>Staff responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. The DIC staff should open the centre on time and be ready to provide the services to clients as needed.</td>
<td>DIC in-Charge. Decision regarding timing to be taken in consultation with the IDUs</td>
</tr>
<tr>
<td>b. The clients visiting the DIC are registered and intake forms are filled in.</td>
<td>ORWs, counsellors, supported by the PEs</td>
</tr>
<tr>
<td>c. The basic information of the client is recorded and the client is made aware of the various harm-reduction services available at the DIC.</td>
<td>ORWs, counsellors, supported by the PEs</td>
</tr>
<tr>
<td>d. The client is then provided the services available at the centre and an information leaflet of activities such as NSEP, OST, meeting, group discussions related to harm reduction are provided.</td>
<td>ORWs, counsellors, supported by the PEs</td>
</tr>
<tr>
<td>e. After accessing specific services, the client can spend time at the DIC and read a paper, book or magazine, watch TV, play games such as chess, carom, listen to music, tape, play an instrument (e.g. guitar), interact with the staff or other clients or just rest in the recreation room.</td>
<td>ORWs supported by the PEs</td>
</tr>
<tr>
<td>f. The client may participate in group discussions, training or education classes, talk to peers, and seek advice on personal problems, counselling services and other social issues.</td>
<td>ORWs, counsellors, supported by the PEs</td>
</tr>
<tr>
<td>g. The client may also access referral services provided through the DIC such as medical referrals, HIV testing and ART services.</td>
<td>Counsellors, doctors for medical issues</td>
</tr>
<tr>
<td>h. The client may attend counselling, peer counselling, group meetings and sharing of experiences.</td>
<td>ORWs, counsellors, supported by the PEs</td>
</tr>
<tr>
<td>i. Stock checks, inventories, reports and all other DIC records should be finalized at the end of each day.</td>
<td>ORWs, counsellors, supported by the PEs</td>
</tr>
</tbody>
</table>

For details please refer to Standard Operating Procedure on “Drop-in Centre for Injecting Drug Users”, UNODC ROSA, 2012
Group 3. How will you engage the local community?

**Process for engagement of local community**

**Step I: Define/identify the problem**
Project managers need to understand the nature, profile and context of the community, coupled with the local history of drug use and its responses. This will enable the program staff to decide which strategies are appropriate and determine how they should be implemented.

**Understand the community needs and problems:**
- What is the history of drug use in the community?
- What are the patterns and trends of drug use?
- What statistics or research is available?
- What are the existing services and interventions?
- What do people know about drug use?
- What are community attitudes and beliefs towards drugs and their users?
- How has the community changed – the people, the place?
- How does the community operate to address issues of concern?
- What networks operate in the community?
- What groups have influence in the community?
- What conflicting values are there in the community?
- What are the main concerns of the various stakeholders, including IDUs?

**Step II: What are we trying to achieve?**
Any response to harm reduction and drug use requires a clear understanding of what is to be achieved. The aims and objectives will differ depending on the stakeholders that are being addressed. For example, advocacy with law enforcement authorities would enable the outreach staff to function without being arrested; the community where the DIC is situated may need to be sensitized on the services being provided. The aims and objectives should be clearly defined beforehand to understand how various stakeholders can be engaged in soliciting support for the TI activities.

**Step III: Who will be involved?**
Successful and sustained responses are characterized by the widest possible community involvement and good relationships between stakeholders. ‘Who should be involved?’, and ‘How they will work together?’ are the key questions. Finding the most appropriate means of bringing people together to work on issues is a critical aspect of any response.

**Step IV: What are the options for engagement?**
Depending on the aims and objectives and the stakeholders to be engaged, various options can be considered. These may include:
- Health education program
- Group meeting with community
- Advocacy with law enforcement personnel and local business community
- Involving the local community in observing important drug/HIV related days

contd...
Step V: How do we know if it is working?
Reflection on the successes and failures, the positive and negative outcomes of programs, is essential for refining and strengthening existing and planned responses. After conducting the programs, the aims and objectives should be revisited to assess if those have been met. The success in meeting the objectives should encourage the team to continue the strategies adopted for engagement. In case the objectives have not been met, the strategies adopted should be revisited.

For details please refer to SOP “Drop-in Centre for Injecting Drug Users”, UNODC ROSA 2012

Group 4. How will you monitor the performance of a DIC?

NOTE TO THE FACILITATOR

Indicators for monitoring DIC:

1. Number of clients
   - Registered at DIC
   - Visiting DIC
   - Receiving services at DIC
     - N/S
     - Condoms
     - Medical check-up
     - STI check-up/treatment
     - Abscess management
   - Receiving referral service
     - TB
     - ICTC
     - ART
     - Others

2. No. of used N/S received and disposed of

The PM should monitor the performance of the TI based on the above indicators recorded in the relevant registers maintained at the DIC. In addition, he/she should conduct group discussions with the clients visiting the DIC and the staff every fortnight to understand the issues and challenges. During his/her field visits the PM should also collect information from the IDUs and the larger community regarding their issues and perception concerning the DIC.

For details please refer to SOP on DIC for IDU Interventions developed by UNODC for NACO
Step 3: The facilitator makes the presentation on DIC

### Location of DIC
- A DIC should be located where IDUs:
  - Reside
  - Congregate
  - Find it easy to access
  - Do not face discrimination
  - Can enter freely without any fear of the surroundings

### Establishing a DIC
- The final selection will depend upon:
  - Proximity of proposed site to the hotspots, services and referrals
  - Acceptability of the site to the IDU and general community
  - Once a location is chosen on the basis of the above steps, the TI (NGO) should hold advocacy meetings with the general community residing around proposed site
  - All concerns of the general community to be addressed by the TI staff

### Establishing a DIC Infrastructure
- A DIC should have adequate space for:
  - Recreation/rest
  - Counselling
  - Medical examination/Treatment/Dressing of abscess
  - Safe disposal of used needles and syringes
  - Stocking of supplies
  - Basic amenities like a toilet and kitchen
  - Essential furniture
  - Timings of DIC should be decided in consultation with the IDUs

### Establishing a DIC Stocks and Displays
- The following should be stocked:
  - Needles and syringes
  - Condoms
  - Puncture proof N/S collection and disposal containers and chemicals
  - Abscess prevention and treatment material
  - IEC materials
  - Notice on rules and regulations should be prominently displayed
  - Confidentiality policy should be displayed

### Establishing a DIC Human Resources
- Staff in DIC
  - Full-time: PM, Nurse/Counsellor and ORW
  - Part-time: Doctor (minimum 3 days per week)
- ORWs will take turns to carry out DIC related work
- One staff member must be designated as DIC in-Charge.

### Basic Rules at the DIC
- Some basic rules of the DIC include:
  - Make every effort to help the IDU and partner feel valued and comfortable
  - Take informed consent before testing and medication
  - Display confidentiality policy
  - Display rules and regulations prominently

### Role of the PM
- The roles and responsibilities of the PM in DIC functioning are as follows:
  - Supervision of clinic activities on regular basis
  - Facilitating advocacy meetings and focus group discussions
  - Development and monitoring of weekly work plan as per the performance indicators for ORWs and counsellors
  - Arrangement of weekly and monthly meetings to identify shortfalls and evolve corrective measures/plan of action
  - Capacity building of staff and organization
  - Overseeing MIS
  - Developing DIC policies and plans
  - Continuous analysis of the project activities
  - Advocacy and engagement with the local community
Referral and Networking

OBJECTIVE
- To provide participants with an understanding of the basics of referral and networking
- To facilitate understanding of the processes involved in:
  - Analysis of referral services needed
  - Referral mapping
  - Establishment and maintenance of linkages
  - Analysis of effectiveness of referral

EXPECTED OUTCOME
Participants have an increased knowledge of the importance of linking services to address the multiple needs of IDUs and the steps needed to set up a referral network for outreach programs and evaluating its effectiveness.

DURATION
1 hour 30 minutes

SUGGESTED TRAINING METHOD
- PowerPoint presentation
- Brainstorming
- Group work
- Discussion

MATERIALS/PREPARATION REQUIRED
- Chart paper
- Marker pens
- Pencils and erasers
- PowerPoint presentation
- LCD projector
- Laptop

PROCESS
Step 1: The facilitator uses the PowerPoint presentation to walk participants through the rationale for networking and the key steps involved in the process of setting up a referral network for Outreach programs.
Step 2: The facilitator divides the participants into four groups and requests them to work on the questions assigned.

**Group 1.** How will the PM plan referral mapping?

**Group 2.** What steps should the PM take to establish and maintain the linkages?

**Group 3.** How should referral and networking be documented?

**Group 4.** How would the PM analyse the effectiveness of referral linkages and identify the challenges/barriers?

Step 3: The facilitator uses the PowerPoint presentation on referral and sums up the discussion by highlighting the steps in networking and the importance of establishing a system of referrals; how to analyse the effectiveness of the linkages and use the findings; and how to strengthen the linkages and networks.
Steps in Networking & Referrals

1. Referral mapping
   - The PM along with other staff, including outreach and community members, should prepare a map wherein services available in locality/-town are identified
   - Key questions to be considered during mapping:
     - What services does the agency offer?
     - Will the agency provide services to IDUs and their partners?
     - Will they maintain confidentiality of the client and the sex partners?
     - How can your TI benefit from linkages with the agency?
     - How far is the agency from the DIC/IDU hotspots?
     - Who is the appropriate contact person to formalize the linkage?

2. Referral database
   - Preparation of simple database to include:
     - Name of the agency
     - Type of services available
     - Key person/contact person
     - Address
     - Telephone number
     - Office timings

3. Referral Protocol
   - Referral protocol should provide guidelines for making referrals
     - Explaining how and when referrals are to be made
     - Steps to be taken when making a referral
     - Following up on a referral
     - Documentation or forms required to complete the referral
     - A referral form should accompany the protocol

4. Setting up System of Referrals
   - ORW/TI staff to accompany referral cases
   - Referral slip/card to be printed in triplicate
   - Referral card to be collected from referral agency by TI staff at the end of the month to ascertain number of IDUs/partners who accessed referred service

5. Referral Analysis
   - Analysis of the referrals should be conducted at the end of the month by PM & shared with TI staff in monthly meetings
   - Analysis should be based on the referral records:
     - No. of clients referred
     - No. of successful referrals
     - Reasons should be ascertained for low and unsuccessful referrals and this should be addressed in the networking meetings
   - Regular meetings should be conducted by TI team led by the PM with the referral agencies to resolve barriers and ensure continuity of effective services
Community Mobilization

OBJECTIVE
To develop an understanding amongst participants in building community ownership by empowering IDUs in rights assertion, mitigating the impact of drug use and HIV specifically through:

- Collectivization
- Creating a space for community events
- Giving the community a role in the decision making and management of programs
- Building capacities of IDUs in taking ownership of, and responsibility for, the program

EXPECTED OUTCOME
Participants will have increased understanding of the characteristics of a community; will be able to facilitate community-led service delivery through community-based mechanisms and establish norms to sustain behaviour change; follow steps in formation of support groups and implement community mobilization/collectivization.

DURATION
1 hour 15 minutes

MATERIALS REQUIRED
- PowerPoint presentation
- LCD projector
- Whiteboard
- Chart papers
- Flip charts
- Marker pens

SUGGESTED TRAINING METHOD
- Group work
- Discussion
- PowerPoint presentation
**PROCESS**

Step 1: The facilitator opens the session by asking the participants, "What is a community?"

**TIPS FOR THE FACILITATOR**

A community is typically characterized by a sense of belonging, a sense of purpose and common goals, a high degree of cooperation and participation in pursuing common goals, an inter-personal climate characterized by mutual respect, a sense of fraternity and/or fellowship, etc.

The facilitator needs to emphasize that community mobilization begins with a set of committed individuals who aim to do something different for their own people.

Step 2: The facilitator uses the PowerPoint presentation, ‘Community Mobilization’ to walk participants through the definition of community mobilization and the need for it in the IDU context. He/she also clarifies the objectives of community mobilization and its indicators.
Step 3: After the presentation, the facilitator divides the participants into four groups and requests each group to work on their assignment and present it to the larger group.

**Group 1.** Why is community mobilization important in an IDU TI? How can it help in improved service delivery?

**Group 2.** How would you analyse the level of community participation in your program?

**Group 3.** What are the barriers to community mobilization?

**Group 4.** What steps will you take for greater involvement/participation of the community?

Step 4: The facilitator then sums up the discussion of the session.

### NOTE TO THE FACILITATOR

The process of mobilization must start with a community identifying its own concerns. A recurring theme among communities seriously affected by drug use and HIV is their concern about the growing number of IDUs who are vulnerable to HIV due to their practices and behaviours and in the circumstances in which they live. The motivation that energizes their efforts comes from a variety of sources - compassion, religious commitment and recognition that unless they support each other while they are able, they will have no one to depend on if their own community needs help some day.

Given below are critical steps in the process of genuine community mobilization:

- Recognition on the part of community members that they are already dealing with the impacts of drug use and HIV and that they can be more effective if they work together. **Point to highlight from the point of view of the community:** “We need to support each other to deal with this”.

- The sense of responsibility and ownership that comes with this recognition is the starting point for identifying possible responses. **Point to highlight from the community’s point of view:** “This is happening to us so it’s up to us to do something about it”.

- Identification of internal community resources and knowledge, individual skills and talents. **Key issues to consider:** “Who can, or is already doing what?”; “What resources do we have?”; “What else can we do?”

- Identification of priority: “What we’re really concerned about is…”

- Community members can plan and manage activities using their internal resources

- Community members can increase the capacity of other community members to continue carrying out their chosen activities, to access external resources once internal means are exhausted, and to sustain their efforts over long term

*Explanation of process of community involvement in community mobilization*
Some challenges in community mobilization:
- Keeping ownership alive at community level
- Achieving long-term sustainability
- Systematically mobilizing communities throughout a large area
- Responding to peer driven needs (monetary and food support, etc.)
- Community can be sensitive to collection of information for the purpose of M&E and for mobilizing donor support.

Barriers to community mobilization:
- Judgemental attitude of service providers
- Bringing all the community members together on one platform
- Unpredictable behaviour of IDUs due to overwhelming need to “do” drugs
- Low self-esteem of IDUs
- Social and legal status of IDUs results in denial of their rights and entitlements
- Lack of capacity of the community members and awareness of rights
Legal Aspects Related to Drugs and Drug Use

OBJECTIVE
To help participants understand the following:

- Important legal provisions related to drugs and drug use, particularly the Narcotics Drugs and Psychotropic Substances (NDPS) Act
- Basic human rights, including specific rights related to arrest and imprisonment
- Relevant legal services such as Free Legal Aid, etc.

EXPECTED OUTCOME
By the end of the session, participants would have:

- Increased knowledge on the offences, penalties and other important provisions under NDPS Act
- An understanding of how these provisions may be applicable in the day-to-day TI functioning
- Increased knowledge on basic human rights, rights on arrest and rights in prison
- An understanding of the context in which these rights of the drug user/TI staff may be violated
- Basic knowledge of legal service authorities, provision of Free Legal Aid

DURATION
1 hour

SUGGESTED TRAINING METHOD
- Case studies
- PowerPoint presentation
- Brainstorming

MATERIALS REQUIRED
- PowerPoint presentation
- Case studies
- Whiteboard /Flip charts
- Chart papers
- Marker pens
**PROCESS**

Step 1: The facilitator divides the participants into four groups. Groups 1 and 2 are requested to take up Case Study 1; and Groups 3 and 4, Case Study 2. He/she requests the groups to present their group work to the larger group.

**Case study 1**

X, a peer educator, was giving new needle to a client Y at a hotspot when a policeman came and arrested Y for possession of heroin and X for committing the offence of providing injecting equipment to a user. X has called you, his/her project manager from the local police station, where he and Y are locked up, informing you of the incident.

**Questions for discussion:**

Q1. What would your next step be in addressing this situation?

Q2. How can you help Y? Can X apply for immunity under NDPS?

Q3. What possible steps could have been taken to avoid this situation?

**NOTE TO THE FACILITATOR**

Some correct answers:

A1. Explain to the police officer that X is a PE at your TI, which is running a government-funded harm-reduction program to provide users with new needles and syringes.

A2. Y can apply for immunity if he was caught with less than 5 gm. of heroin, i.e., small quantity and if he volunteers to go for treatment at a government recognized centre.

A3. Advocacy with the local police station.

**Case study 2**

A, the wife of your client B, comes to the DIC asking for your help. She informs you that the police have arrested her husband. They have not told her why he was arrested. B is registered at your TI for OST and is also on ART. A is worried and seeks your help.

**Questions for discussion:**

Q1. What rights does B have on arrest? Have any of these rights been violated?

Q2. What help can an IDU TI provide B?

Q3. Who else can help B?
Step 2: The facilitator sums the session with the presentation on the legal issues.

**NOTE TO THE FACILITATOR**

Some correct answers:

A1. Right to know the reason for arrest has been violated.

A2. IDU TI can advocate with the police to let B continue ART and OST in prison.

A3. B, or A or the TI on his behalf, can contact the district/state legal service authority and ask for free legal help.

---

**In Drug Use Legal? What are the Laws on Drugs?**

- Use of some drugs is legal while others are illegal.
- **Legal Drugs**: Tobacco, bhang, prescribed medicines, etc.
- **Illegal Drugs**: Opium/Heroin, Charas/Ganja, LSD, Amphetamines, etc.

3 central Acts on drugs and drug use; most relevant to TI is **Narcotics Drugs and Psychotropic Substances (NDPS) Act, 1985**.

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**What Does NDPS Say?**

- Gives a list of drugs that are illegal
- Production, sale, possession, consumption, transport, etc., are among the offences
- Punishment includes jail or/and fine; depends on the offence, type and quantity of drug

**Example**

Possession of up to 5 gms. (small quantity) of heroin is punishable with 6 months imprisonment or/and Rs. 10,000 fine. If found with more than 5 gms. but less than 155 gms. of heroin then may be looked upon as drug seller. If found with more than 250 gms. then will be looked upon as drug trafficker; punishment may be up to 20 years.

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**What does NDPS tap?**

**Small and Commercial Quantities of Important Drugs**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Small Quantity</th>
<th>Commercial Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>10 gms</td>
<td>100 gms</td>
</tr>
<tr>
<td>Heroin</td>
<td>1 gms</td>
<td>100 gms</td>
</tr>
<tr>
<td>Cannabis (marijuana)</td>
<td>100 gms</td>
<td>1 kg</td>
</tr>
<tr>
<td>Codeine</td>
<td>10 gms</td>
<td>1 kg</td>
</tr>
<tr>
<td>Cocaine</td>
<td>10 gms</td>
<td>1 kg</td>
</tr>
<tr>
<td>Phencyclidine</td>
<td>10 gms</td>
<td>1 kg</td>
</tr>
<tr>
<td>Opiates</td>
<td>10 gms</td>
<td>1 kg</td>
</tr>
<tr>
<td>Methadone</td>
<td>100 gms</td>
<td>1 kg</td>
</tr>
</tbody>
</table>

---

**What if the Drug User is Arrested Under NDPS?**

- Immunity from Prosecution: If addict* arrested with small quantity (e.g., up to 5 gms. of heroin or up to 100 gms. of Charas), he/she can avoid prosecution if he/she volunteers for drug dependence treatment at a good recognized centre (Section 64A, added in 2001)

- Has to complete treatment; if treatment is left incomplete then sent back to Court

- The drug user may be arrested for any other crimes like theft, robbery, etc.

*Addict: Immunity only applicable to persons who are medically certified as drug dependent.

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**Does the Drug User Have Any Rights?**

Yes!!

A drug user has all the Fundamental Rights guaranteed by the Constitution of India including Right to Life and Health.

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**What are the Rights on Arrest?**

Rights on arrest and in detention:

- Right to know reason for arrest
- Right to inform one person – friend, relative of the arrestee
- Right to be taken to magistrate within 24 hours
- Right to health i.e., right to continue any prescribed medication he/she may be on (such as ART, OST, etc) and right to medical checkup every 48 hours
- Right to ask for lawyer - If he/she does not know any lawyers, a lawyer will be appointed to him/her (it) can network with District Legal Services Authority for free legal aid
OST and NDPS

- **Section 4 of the NDPS Act**: Central Govt. can take measures with respect to identification, treatment, education, after care, rehabilitation and social re-integration of addicts.

- **Section 71 of the NDPS Act**: Gives the Govt. power to establish centers for the purpose outlined in Section 4 AND the power to provide narcotic drugs and psychotropic substances to addicts registered with it.

- All OST centres established and funded by the Govt. operate under these sections.

**Summary**

- Drugs such as opium/heroin, charas/ganja, Diazepam, LSD, etc. are illegal.

- NDPS Act - Possession and consumption are punishable.

- If arrested under NDPS, can avoid jail/fine by volunteering for treatment (Sections 64 and 64A).

- When arrested, right to know reason; inform someone; and ask for lawyer.

- Right to health even after arrest.

- Govt.-funded OST centres operate within Section 71 of NDPS.
ADVOCACY

OBJECTIVE
To help participants understand the basics of advocacy, its benefits in the IDU context and the process of development of advocacy strategy.

EXPECTED OUTCOME
At the end of this session, the trainee will have a clear understanding of:
- The issues involved in advocacy
- The need for, and benefits of, advocacy in the IDU context
- The critical steps in conducting advocacy
- The process of developing an advocacy strategy

DURATION
2 hours

SUGGESTED TRAINING METHOD
- Case studies
- Small group work
- Discussion

MATERIALS REQUIRED
- PowerPoint presentation
- LCD projector
- Whiteboard
- Chart papers
- Flip charts
- Marker pens

PROCESS
Step 1: The facilitator uses the PowerPoint presentation on ‘Advocacy’ to walk participants through the definition of advocacy and explains the need for advocacy in the IDU context.
What is Advocacy?
- Organized effort to influence policy change/decision making
- Action directed at changing approach of an individual/institution/group
- Process to persuade all influential individuals/groups/organizations through dialogue to adopt an effective approach to an issue

Advocacy is called for when...
- Needed programs are not in place, not being done well, or not brought to scale, because:
  - The law doesn’t allow them
  - Present policies don’t fit with them
  - Institutional structures impede them
  - People don’t see them as priorities or oppose them outright

Effective Advocacy is...
- Communication for change targeted to
  - Laws, policies and their execution
  - Institutional structures and protocols
  - Social and cultural environments to reach program goals

Effective Advocacy is...
- Based on clear strategic thinking
- Focused on a needed change
- Limited to priority issues
- Targeted to those who can make changes
- Results-oriented
- Evidence-based
- Developed through broad-based participation of concerned stakeholders

But since we can’t communicate with laws, policies or institutional protocols...
Effective advocacy is communication for change targeted to the people who have the power to change the laws, policies, institutional structures and social environments, to reach program goals

Need for Advocacy in IDU Context
- IDUs are often looked down upon as ‘criminals’, bad elements, negative influencers on the society
- IDUs remain hidden from mainstream of society
- IDUs are often not able to access general health as well as tailored services freely as a result of stigma
- Often, NSE & OST programs for IDUs are met with resistance from the general community and law enforcement agencies
- Society often forgets the needs of an IDU

Benefits of Advocacy
- Advocacy benefits both implementers and IDUs:
  - Implementers
    - Enables them to implement their programs without any interference or hassles from the various stakeholders
  - IDUs
    - Enables them to access needed services without fear of stigma/discrimination, ridicule & violence
Step 2: The facilitator divides the participants into four groups and asks them to discuss the questions based on the case studies provided and share their answers with the larger group. He/she asks Group 1 to take up Questions 1 and 2 and Group 2 to take up Questions 3 and 4 respectively, based on Case Study 1. Similarly, the facilitator asks Group 3 to discuss Questions 1 and 2 and Group 4 to concentrate on Questions 3 and 4 of Case Study 2. Upon completion of group work the facilitator requests each group to present their findings to the larger group.

**Case study 1**

XX is a current injector, also working as a PE with an IDU TI. He/she has come to seek help from the PM. Yesterday, for the second time in recent months, XX was roughed up by local youths near one of the hot spots during a needle syringe exchange and was handed over to the local police station, accused of encouraging drug use in the community. The PM has spoken to several peers in his/her project area who are facing the same problem.

**Questions for discussion:**

**Q1.** Why do you think the peers are facing this problem? Is this a common problem that they encounter?

**Q2.** What can the PM do to help the PE and ensure continuity of services?

**Q3.** Besides the local police, are there other levels of police officers and groups whom the project may need to address in its advocacy efforts? Who would these be and why would it be important to address them? Who could be the others to advocate with?

**Q4.** What would be the content of their advocacy and their means of advocacy?
NOTE TO THE FACILITATOR

As per the existing laws, (NDPS Act), use of drugs is illegal. NSEP as a method to prevent HIV among IDUs is endorsed in the National AIDS Prevention and Control Policy formulated by the Government of India in 2002.

However, it is observed that TI service providers are often harassed by the police and imprisoned when they distribute needles and syringes in the field.

To avoid such situations, the senior staff of the TI led by the PM should strongly advocate with the law enforcement authorities at the local level. The local police stations, the officer-in-charge and constables should be sensitized on the issue of drug use and HIV, harm-reduction principles and policies related to distribution of needles and syringes for HIV prevention. The TI staff should also obtain a letter of support from senior police officers after due sensitization, and this letter should be distributed to the Outreach staff involved in NSEP. Finally, a letter from the respective SACS should also be obtained and prominently displayed in the DIC.

In addition to the police, advocacy should also be conducted with the following:

- Local political leaders
- Local youth leaders
- Religious leaders
- Key community influencers (teachers, doctors, lawyers/judges, etc. whose opinion matters in the society)
- Members of the local drug users/IDU community

*This should be an ongoing process to be repeated at regular intervals and also at critical times.*

Some key points to remember:

**Advocacy with law enforcement agencies** - Getting support for harm-reduction services is essential to avoid the police from targeting IDU or the field staff.

a) **Senior police officers**

   Visit senior police officers and give them updates on the project including reports, pictures, and issues on a regular basis.

b) **Get support for the TI project**

   Generate support by sharing challenges with the local police team, get no-objection certificate from the district police officer for smooth functioning of the TI, explain the goals and how it will help in preventing further spread of HIV among the general population by giving IDUs an opportunity to change if provided with right information. Give officials the contact numbers of TI staff for any IDU to be referred to the project on drug use and HIV issues.

c) **Educate police officers on drug use issues and risks**

   After gaining trust, explain the risk involved to the police, at the station or in the streets while frisking. Explain potential risk of accidental injury which may cause blood borne virus (BBV) infections; remedies like prophylaxis can be elaborated on; and finally encourage the inclusion of drug use response in their training and education program. Focus should be on changing the attitude of the police, since drug use is illegal as per law.
d) Use supportive police to do more advocacy

After conducting training for police identify ‘champions’ who have shown understanding on harm reduction. They can be tapped for further training to gain more support.

e) Periodic visits to the police station

In consultation with the district officer, arrange a weekly, bi-weekly or monthly visit to the police station by the NGO team to update the police on program achievements and issues. Avoid providing sensitive information which may break the bond of trust between the NGO team and the IDU. If the IDU feels that the NGO is helping police in their activities, the whole effort will be diluted.

f) Drugs, HIV events, meetings with police and community

NGOs should invite police officers to attend meetings related to general discussion on new issues; invite them as special invitees when observing important days/events (e.g. World AIDS Day). This encourages partnership efforts and supportive attitudes amongst police, NGO and finally the IDU.

For details please refer to Standard Operating Procedures on “Outreach for Injecting Drug Users” and “Needle Syringe Exchange Program for Injecting Drug Users, UNODC ROSA 2012

Case study 2

ABC is the PM of an IDU TI which has four hotspots. The nearest government hospital that provides ICTC, ART, and TB treatment is 20 km. from the project site/DIC. During analysis ABC finds that though referrals for ICTC, ART and TB are high, success rates in terms of accessing these services are low. Upon discussion with some of the clients and ORWs/PEs he found that the discriminatory attitude of the health-care providers is a major barrier. When asked to share about instances when they were discriminated against, some IDUs could not give concrete examples but shared their apprehensions based on ‘things’ they have heard from others or events that had happened in ‘some other places at some other time’. However, there were others who could narrate personal experiences of discrimination by the service providers.

Questions for discussion:

Q1. What steps/plans does ABC need to take to overcome the barriers?

Q2. Who will ABC need to advocate with and how will he identify the issues on which he needs to advocate?

Q3. Develop an advocacy strategy for ABC based on the case study.

Q4. How would he advocate for rights of drug users to access services without fear (from various pressure groups)?
NOTE TO THE FACILITATOR

Stigma attached to drug use, particularly injecting drug use and subsequent discrimination by the health-care providers is common. Some health-care providers are afraid of transmission of the BBV through casual contact or contact during medical procedures – accidental exposures. Abscesses and other wounds enhance the fear.

But sometimes the DUs/IDUs may also be affected by self-stigmatization, originating from their own experiences of interactions in other settings or from those shared by others. Some of them may also be affected by the pressure of social stigma being internalized. Whatever the origin may be, the DUs/IDUs affected often suffer from low self-esteem, shame, guilt and fear of being harassed. IDUs, already overwhelmed by drug dependence, injection-related morbidities, may not want to be diagnosed with TB, STIs or HIV to add to their ‘woes’.

In order to resolve these issues the IDU TIs will have to address both the service providers and the recipients. Advocacy should be conducted with the health-care providers at the local hospitals where relevant services like abscess management, TB, ART, ICTC, etc. are provided. The service providers should be made aware about drug use – its nature and effects – particularly through the injecting route, highlighting how it affects the lives of the users and their family members. Information should also be provided on the nature of drug dependence and how it is not possible for most to ‘just stop’ and remain ‘stopped’.

They should also be helped to understand the aspect of ‘preoccupation’ associated with drug use and how drug-related issues can take priority above all else, which may also affect follow-up or adherence to treatment. Information on the potential risk of accidental injury which may cause BBV infections and effectiveness of prophylaxis should also be shared.

Inclusion of other health professionals with hands-on experience of dealing with IDUs can be very effective.

Simultaneously, advocating with IDUs in the community and at the DIC settings will also be necessary to help them overcome their self/internalised stigma. Advocacy meetings should also be conducted with the networks of IDUs and their self-help groups, if available.

Apart from advocacy efforts, some IDUs may need counselling to help them overcome their own internalised/self-stigma, low self-esteem, sense of guilt and fear which affect accessing of services. Accompanied referral, at least in the initial phase, can be useful. Development of self-help groups to facilitate accessing of services, especially in the hospital settings, are often beneficial.

At a later stage bringing the IDUs and the service providers on one platform to share and discuss issues may further help in each understanding the others’ fears, apprehensions and issues and thus enable greater cooperation.
Advocacy

Step 3: The facilitator continues with the PowerPoint presentation to discuss the various steps to be taken for advocacy efforts and the advocacy matrix.

**NOTE TO THE FACILITATOR**

The steps involved in advocacy are:

- **Analysis**
- **Strategy**
- **Action/research**
- **Evaluation**

**Analysis**

The PM should take the lead role in analysing advocacy needs, planning/strategizing and conducting advocacy. The PM, along with the concerned team members, analyses the identified problem:

- Identifies key stakeholders
- Existing norms, policies, practices affecting the problem
- Effect of implementation or non-implementation of these policies
- How it affects the problem – now and also in future
- Players/organizations involved in putting those policies into practice
- Channels of potential access to influential people and decision-makers

**Strategy**

The strategy builds on the analysis to direct, plan and focus on specific goals, objectives, activities and suggests a clear path to achieve them. The PM ensures that every advocacy effort has a strategy and leads the development of the strategy. He/she may take the help of others in the NGO, e.g., the project director or other senior management members. The strategy should include:

- Potential solutions to the problem
- Process of arriving at these solutions
- Target individual/agency/group with power to make the change
- Message/s that can make the change
- Channel/s or messengers to be used

contd...
Potential solutions to the problem
- Process of arriving at these solutions
- Target individual/agency/group with power to make the change
- Message/s that can make the change
- Channel/s or messengers to be used
- Indicators to measure the change

**Action**
- The PM should ensure that the strategy is converted into action and the effects of the action/s are closely monitored to determine if the desired result is being achieved
- He/she should orchestrate the actions of the various players/advocates to ensure the campaign follows the planned strategy
- Implementation of the campaign may arouse various reactions by decision-makers and influential groups, which the PM should track
- He/she should bring about changes in the strategy by speeding up/slowing down the process or bringing in other players as and when needed to reach the desired goal

**Evaluation**
- PM with his/her team should evaluate the results constantly to track to processes and their effects
- Since advocacy often provides partial results, a team needs to review regularly what has been accomplished and what more remains to be done
- Process evaluation, such as assessing whether progress has been made in identifying advocacy allies, may be more important (and more difficult) than evaluating the impact on actual decisions
- Evaluation should be used as the first step in re-analysis, leading to an ongoing cycle of advocacy work and evaluation
- Advocacy is successful if it is planned and executed with active involvement of the IDU community
- Success of advocacy depends upon the careful execution of the steps in the process of advocacy
- The key steps in the process of advocacy include conducting an analysis of the situation, developing an advocacy strategy, undertaking action to achieve advocacy goals and regular monitoring and evaluation to assess the outcome of advocacy
- An effective advocacy strategy must clearly identify specific target audiences
- In order to reduce the stigma that is associated with injecting drug use and associated risk of HIV, awareness programs are necessary for the general population
- Creating an enabling environment for the community is one of the fundamental prerequisites of community mobilization. Advocacy activities help to create this environment
Step 4: The facilitator divides the participants into three groups, and requests them to develop an advocacy matrix for their level. The matrix should indicate the list of important stakeholders for advocacy, key issues for advocacy and the methods to be adopted.

**Group 1.** Micro level for peers & ORWs

**Group 2.** Middle-management level for counsellor/PM

**Group 3.** Macro level for the PDs

The facilitator requests each group to make their presentation and then put it up on different walls of the training hall. He/she requests that each presentation be ‘manned’ by one member while the others go around to the other presentations and provide their inputs which are to be noted down by the person ‘manning’ the presentation. After all the presentations have been visited, the group members are requested to reconvene to discuss the inputs received and modify their presentations if they feel necessary.

Step 5: The facilitator sums up the session with the remaining slides.
Day 4

Session One
Clinical Issues – (Abscess; STI; Overdose; Detoxification)

Session Two
Understanding Co-morbidities and ART Among IDUs

Session Three
Planning and Implementing the Work Plan

Session Four
Monitoring and Evaluation

Session Five
Strategic Planning
Clinical Issues – (Abscess; STI; Overdose; Detoxification)

OBJECTIVE
To enable the participants to understand how to handle the serious health consequences pertaining to abscess, STI, overdose, detoxification and arrange for providing related services.

EXPECTED OUTCOME
By the end of the session, participants would have a clear understanding about the basics of how to ensure that an IDU receives clinical services for abscess, STI, overdose and their management.

DURATION
1 hour 30 minutes

SUGGESTED TEACHING METHOD
- Brainstorming
- Screening SPYM Film
- Summarizing, using NACO poster
- PowerPoint presentation

MATERIALS/PREPARATION REQUIRED
- Chart papers
- Marker pens
- Film by SPYM ‘Safe Injecting, Abscess Prevention and Management, Overdose Management’
- PowerPoint presentation
- Laptop
- LCD projector

PROCESS
Step 1: Brainstorming
- The facilitator begins the session by asking participants to think of common medical problems faced by the IDUs and notes them on the whiteboard/flip chart. He/she also asks the participants about the probable services that are needed to address them.

Step 2: Presentation on Abscess Prevention and Management
- The facilitator shares the PowerPoint presentation on ‘abscess’ and discusses issues dealing with abscess formation, prevention and management and why it is important to treat abscess.
Step 3: **Summarizing using the NACO Poster, ‘Abscess Prevention and Management’**

- The facilitator summarizes the session using the NACO poster on ‘Abscess Prevention and Management’ and also asks the participants what the role of the PM should be. He/she notes the responses on the flip chart.
Step 4: Screening SPYM Film, ‘Safe Injecting, Abscess Prevention and Management, Overdose Management’

- The facilitator screens the section on Abscess Prevention and Management from the short film on ‘Abscess Prevention and Management and Overdose Management’, pausing the film when the section is over (at 8 minutes).
- The facilitator discusses the issues raised in the film on safer injecting practices and abscess prevention and management and provides clarifications if necessary.

Step 5: Discussion on Overdose
The facilitator initiates a discussion on what is overdose, the reasons for overdose and the symptoms. He/she lists the results/outcomes of the discussion on the whiteboard/flip chart.
- The facilitator follows it up with the slides on overdose.

**Overdose Prevention – Education**
- Avoid mixing drugs
  - If you are drinking alcohol and injecting together, inject first and wait for it to take effect before you start drinking.
- After abstinence, if you are using opioids:
  - Divide the normal dose in half, do a tester shot and allow the drugs to take effect before you do more.
  - Try changing the route of administration, i.e., if you usually inject, try snorting.
  - If you have a new dealer or unfamiliar supply, use a small amount at first to see how strong it is.
- Avoid using alone, if you overdose, you need someone to help you.
- Take care of your health
  - Eat well, drink plenty of water, and sleep properly.

**Overdose Management**
- First aid should be provided before medical help arrives.
- Remember the acronym ‘SCARE ME’: follow the steps.
- Management of Opioid Overdose
  - S - Stimulate by waking the client
  - C - Call for medical help
  - A - Maintain the airway
  - R - Rescue breathing
  - E - Evaluate
  - M - Muscular injection of Naloxone
  - E - Evaluate and Support

- Airway maintenance
  - Make sure nothing is blocking the airway, and there is nothing in the mouth. If necessary, use finger to get the stuff out.
- Rescue breathing and recovery position
  - Put the client in recovery position.
  - If the client is not breathing, then rescue breathing should be done.
**Recovery position**
Step I: Raise the right hand next to the face.
Step II: Bring the left hand across the chest.
Step III: Raise the left knee.
Step IV: Turn the person to his right, with his face pointing towards the ground, with his head resting on his left arm and his right arm on the ground. This will prevent him from choking.

**Rescue breathing**
Step I - To check for breathing, put your ear near the client’s mouth and nose and listen for his breath while watching to see if the chest is rising and falling constantly.
Step II - Lay the client who has overdosed flat on his back.
Step III - Take a deep breath and then place your own mouth over the client’s mouth making a tight seal with your lips.
Step IV - Exhale completely into the client’s mouth. If you are doing this correctly, you should be able to see his chest rise as the air goes in.
Step 6: **Screening of the rest of the film**
The facilitator then screens the overdose section of the SPYM film (8.00 minutes to 12.20 minutes).
- He/she clarifies issues, if any, and asks the participants, *“What should the role of a PM be?”*
  He/she notes the responses on the flip chart

Step 7: **Discussion on STI**
- The facilitator asks the participants, *“What are STIs, their signs and symptoms?”*, *“Why is it important to deal with STIs when trying to prevent HIV?”*
- The facilitator follows up by making a short presentation on STI

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**Introduction**
- As the name suggests these are infections which transmit from one person to another through sexual route
- These infections are usually caused by microorganisms such as bacteria or virus

**Common STIs**
- Syphilis
- Gonorrhoea
- Chancre
- Herpes
- LGV

**Consequences of STI**
- Risk of transmission to partner
- Increase in symptoms leading to pain, disability
- Spread of infection to other parts of body
- Increased risk of HIV

**Linkage of STIs & HIV**
- Persons suffering from STI have 2 to 4 times increased risk of getting HIV infection
- HIV decreases immunity and increases vulnerability to getting STI
- Genital ulcers –sores make it easier for HIV to enter the body

**Link between STIs & HIV**

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NOTE TO THE FACILITATOR

STIs can be transferred to and from any of the organs involved in sexual acts, i.e., penis, vagina, anus and mouth (lips and tongue). So the signs and symptoms may appear on any of these organs.

The facilitator follows this up by asking the participants, “What should the role of the PM be in STI prevention and management?” and notes down the responses on the flip chart.

Step 8: Detoxification

- The facilitator begins the discussion by asking the participants, “What do you understand by detoxification?”, “Why is it needed?”; and “Where are detoxification services available?”
- He/she follows it up with the presentation, using the slides on detoxification.
Step 9: The facilitator wraps up the session on the role of the PM with the following slides. He/she refers back to the earlier responses from the participants in this regard and clarifies as required.
Understanding Co-morbidities and ART Among IDUs

OBJECTIVE
To educate the participants on co-morbidities and ART among IDUs.

EXPECTED OUTCOME
By the end of the session, the participants will have enhanced understanding about ART and various co-morbid conditions that IDUs face and will be able to facilitate access of IDUs to appropriate services. In addition, they should be able to teach their staff about co-morbidities and ART, and guide them on how to deal with the co-morbid conditions.

DURATION
1 hour 45 minutes

METHODOLOGY
- Brainstorming
- Discussion
- Group work
- PowerPoint Presentation

MATERIALS/PREPARATION REQUIRED
- Flip chart
- Marker pens
- PowerPoint presentation on co-morbid conditions and ART
- LCD projector
- Whiteboard
- Handouts on Hepatitis, TB, mental illness

PROCESS
Step 1: The facilitator begins the session by asking the participants, “What is meant by the term co-morbidity?”

NOTE TO THE FACILITATOR
Co-morbidity is presence of two or more medical conditions together in an individual (also called as co-occurrence). The conditions can occur simultaneously or one condition can precede the other.
Step 2: The facilitator asks participants to brainstorm on various other conditions that occur more commonly among IDUs as compared to non-IDUs (The facilitator should ask the participants to recall the section on harms caused by drug use).

Step 3: **Group work**
- The facilitator divides the participants into three groups and requests each group to discuss and analyse one of the three co-morbid conditions – Hepatitis, TB and mental illness. He/she asks the groups to prepare to come forward and ‘teach’ the larger set of participants about the particular co-morbidity they have been assigned. They can use the handouts (slides) related to each morbidity from the presentation below to help them prepare.
- Give the groups 15 minutes to work on their presentations. Encourage them to come forward and present the information in any way they wish to the larger group – as a simple lecture, through diagrams, through a role-play. Other groups can ask questions and clarify doubts/queries, etc.

Step 4: The facilitator then uses the Power Point presentations on each of the co-morbid conditions, so as to ensure that everyone understands them.
Hepatitis
- Hepatitis is inflammation of the liver
- Liver can be inflamed by toxins, infection, alcohol, etc.

Viral Hepatitis
5 types of viral hepatitis: A, B, C, D, E

<table>
<thead>
<tr>
<th>Type of virus</th>
<th>Route of transmission</th>
<th>Prognosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Eating unhygienic food</td>
<td>Transient; very good prognosis</td>
</tr>
<tr>
<td>B</td>
<td>Injection, sexual</td>
<td>Chronic infection</td>
</tr>
<tr>
<td>C</td>
<td>Injection, sexual</td>
<td>Chronic infection</td>
</tr>
<tr>
<td>D</td>
<td>Occurs along with Hepatitis B</td>
<td>Worsens prognosis of Hepatitis B</td>
</tr>
<tr>
<td>E</td>
<td>Eating unhygienic food</td>
<td>Poorer than Hepatitis A</td>
</tr>
</tbody>
</table>

Hepatitis C
- Hepatitis C is a bloodborne infection caused by Hepatitis C virus
- Hepatitis C infection is a major concern among IDUs
- 80-90% IDUs infected with Hepatitis C in some parts of India

Transmission of Hepatitis C
- Sharing of contaminated injecting equipment in majority of cases
- Other injecting equipments such as spoons, tourniquet, swabs, water in addition to IV/S
- Contamination of hands during mixing of drug
- Transfusion of infected blood and blood products
- Sexual route
- Mother to baby (5% chance)
- Health-care workers are at risk for HCV infection because of needle-stick accidents

Hepatitis C
- Not transmitted by:
  - Sneezing
  - Coughing
  - Hugging
  - Sharing eating utensils & drinking glasses

Hepatitis C
- Stages of infection:
  - Acute: Some (20%) infected individuals have symptoms during this stage:
    - Fatigue, nausea, loss of appetite, vomiting, jaundice
    - 25% of individuals clear the virus from their body by 2 years of infection

Hepatitis C
- Chronic: 75% of infected individuals will have chronic hepatitis with presence of virus in body and ability to transmit it to others
- Symptoms include: Fluid retention that causes the swelling of belly and legs, jaundice, weight loss, mental disturbances
  - About 45% do not develop liver damage
  - About 30-40% develop mild liver damage
  - About 10-20% develop liver cirrhosis
  - About 1-5% develop liver failure or liver cancer

Hepatitis C
- Prevention of Hep C:
  - Do not share needles or any drug paraphernalia
  - Do not share razors and toothbrushes
  - Practice safe sex by use of condoms and barriers
  - Health-care workers should use gloves when dealing with blood
  - Do not donate blood if one has Hep C
Hepatitis C - Management
- EDUCATE every IDU on
  - The transmission dynamics of Hep C
  - Stress use of safe injecting equipment (not only N/S, but also others)
  - Teach the clients on safe injecting techniques

Hepatitis C - Management
- Instil hope in the patient that not every case is fatal
- Take it easy; get plenty of rest
- Healthy and well-balanced diet is essential
- DO NOT DRINK ALCOHOL of any kind
- Avoid intake of fatty foods
- Avoid medicines and substances that can cause harm to liver (such as paracetamol for fever)
- Avoid prolonged, vigorous exercise until symptoms start to improve

Hepatitis B
- CAUSED BY INFECTON WITH HBV
Symptoms:
- Jaundice
- Extreme tiredness
- Mild fever
- Headache
- Loss of appetite, nausea and vomiting
- Constant pain on the right side of the stomach
- Diarrhoea or constipation
- Muscle aches or joint pain
- Skin rash

Hepatitis B
Transmission
- Unsafe sexual practices
- Sharing of needles and other equipment such as cotton, cookers, tourniquets, straws, pipes, swabs, water
- Health-care workers are at the risk for HBV infection because of needle-stick injuries
- From mother to child
- Sharing of needles used for body piercing or tattooing
- Sharing of razors and toothbrushes

Hepatitis B
Diagnosis
- Through ELISA blood test
- Management: It depends upon whether the infection is acute or chronic
  - There is no specific treatment for acute hepatitis B. But it is important to maintain comfort and adequate nutritional balance, including replacement of fluids that are lost from vomiting and diarrhoea
  - For Hepatitis B+ patients, fatty food, alcohol and high intake of salt is avoided
  - Chronic Hepatitis B+ can be treated with drugs, including interferon and antiviral agents

Hepatitis B
Prevention
Hepatitis B can be prevented by taking Hepatitis B vaccine. It is very effective and safe and is given in 3 doses. It can be given at any age
- 1st injection – at any given time
- 2nd injection – after one month
- 3rd injection – 6 months after the first dose

Hepatitis B Other ways to protect oneself
- Practice safe sex
- Do not share needles while injecting drugs
- Do not share anything that might have blood on it, such as razor, toothbrush, etc.
- Health workers should follow standard precautions, handle the needles and sharps carefully
- If pregnant, notify health practitioner in case of any of the risk factors for HBV infection
Tuberculosis (TB)
- Caused by a microscopic organism - bacteria - *Mycobacterium tuberculosis*
- Can affect any body part
  - Usually affects lungs
  - Other sites: lymph nodes, bone, brain, spinal cord, genital urinary system, etc.

Tuberculosis
- TB is contagious and spreads through air:
  - Transmitted from one person to another through droplets
  - When an infected person sneezes, coughs or talks, tiny droplets of saliva/mucus spread to another person, who can get infected
- If not treated, each infected person with active TB will infect 10 - 15 people every year
- TB is not transmitted by touching clothes or shaking hands of an infected person

Risk factors for contacting tuberculosis
- Living with a person who has active TB
- Poverty
- Homelessness
- Nursing home residents
- Prison inmates
- Alcoholics
- IDUs
- Diabetes
- Certain cancers
- HIV infection
- Health-care workers, including doctors and nurses

Symptoms of active tuberculosis
- Generalised tiredness/weakness
- Weight loss
- Fever
- Night sweats
- Cough
- Chest pain
- Coughing up sputum
- Coughing blood
- Shortness of breath
- If other systems involved, symptoms according to function of organ Brain: Fits, Unconsciousness

Other important considerations
- TB is the leading killer of people with HIV
- HIV infected people are 20-40 times more likely to develop active TB
- Multi-drug resistant TB (MDR-TB): Form of TB that is difficult to treat as it fails to respond to standard treatment. It is also expensive to treat

IDU related issues for TB
- IDUs have a very high rate of TB
  - Reasons are many - poverty, homelessness, poor living conditions, low immunity, poor nutrition, high HIV rates
- Early symptoms of TB may be mistaken for other conditions
  - Example
    - Weight loss, weakness or tiredness; general debility
    - Cough, chest pain; chronic bronchitis associated with co-morbid smoking
Tuberculosis
- During every follow-up, symptoms of TB must be positively ruled out
- Baseline screening must be ensured by referral to the physician
- Clients should be educated on signs/symptoms of TB
- Clients with symptoms resembling TB must be referred to nearby DOT centre
- For those on treatment for TB: Counselling for adherence; physically verify whether the client is taking TB medicines or not

Mental illness
- There are various kinds of mental illness that can co-exist with drug dependence in an IDU
  - Depression
  - Anxiety disorders
  - Psychosis

Depression - Symptoms
- Symptoms in an individual for at least two week duration leading to difficulty in work OR personal suffering
  - Low mood/sadness
  - Reduced energy
  - Reduced interest in work and pleasure
  - Reduced concentration
  - Disturbed sleep
  - Loss of appetite
  - Reduced self-esteem and confidence
- Feeling guilty for even small mistakes
- Feeling hopeless and helpless
- Suicidal acts/attempt

Mental illness - Depression
- Depression is morbid state of sadness
- Affects the productivity and normal functioning of an individual

Mental illness - Anxiety Disorders
- Anxiety is unreasonable fear, or fear which is more than what is expected in the given situation
- The fear is termed an illness if it:
  - Occurs without any reason
  - Is more than what is expected in the given situation for a majority of individuals
  - Affects the individual’s work and social life

Mental illness - Anxiety Disorders - Symptoms
- Apart from anxiety as the main symptom, one or more of the following exist/are:
  - Excessive unrealistic worrying
  - Trembling/shaking
  - Churning stomach
  - Nausea
  - Diarrhoea
  - Headache
  - Backache
  - Heart palpitations
  - Sweating/flushing
- Numbness/pins and needle sensation in arms, hands or legs
- Restlessness
- Easily tired
- Poor concentration
- Easy irritability
- Muscle tension
- Frequent urination
- Sleep difficulties
- Easily startled

Mental illness - Anxiety Disorders - Types
- Examples of anxiety disorders:
  - Phobias: irrational fear of a specific object, animal or situation, e.g. phobia for heights, spiders, water, exams
  - Panic disorder: repeated panic attacks (state of extreme anxiety and fear with sense of dying without any reason)
  - Obsessive compulsive disorder: for e.g., the individual may have repeated thoughts of being dirty/unclean and repeatedly washes his hands

Mental illness - Psychosis
- Psychosis is characterised by a loss of reality, disorganisation in thoughts, perception and behaviour
  - Example
    - Schizophrenia
    - Acute psychosis
Day 4

NOTE TO THE FACILITATOR
The facilitator should emphasize here on the need for strengthening referral and networking, educating the clients on prevention and ensuring adherence to the treatment prescribed and periodic training of the Outreach staff on these co-morbid conditions.

Step 5: The facilitator then asks the participants what their role would be if the IDUs in their TIs have these co-morbid conditions.

Mental Illness – Providing Services to the IDU
If the IDU presents with one of the symptoms of mental illness, refer to the counsellor/doctor of the TI, refer to psychiatrist if available in the nearby hospital.

Step 6: The facilitator then initiates a discussion on ART. He/she asks the participants what they know regarding ART, including the processes to be followed for initiation and maintenance of ART. The responses should be noted down by the facilitator on a chart paper/whiteboard. Following this, the facilitator should show the PowerPoint slides to the participants.
**What is ART?**
- ART stands for Antiretroviral Therapy
- This is the main type of treatment for HIV or AIDS
- It is not a cure, but it can stop people from becoming ill for many years
- Thus, ART
  - Delays the progress of HIV
  - Prolongs the person’s lifespan
  - Improves the overall quality of life

**ART for IDUs**
- IDUs are often excluded from ART services because of many misconceptions and also because of stigma they have to face
- Service providers have a lot of misconceptions:
  - They believe that IDUs are very poor at adhering to ART drugs
  - They believe that IDUs need to be clean of drugs to start ART!

**Facts**
- Worldwide studies have shown there is no difference in adherence levels between IDUs and non-IDUs when it comes to ART!
- Response to ART by IDUs is similar to response by non-IDUs
- All IDUs who are medically eligible for ART should receive care and treatment as per the national guidelines

**Starting ART**
Steps to start ART

1. HIV positive IDUs
2. Refer to ART Centre: blood tests, CD4 cell count, other infections
3. CD4 cell count $> 350/mm^3$
4. 6-monthly follow-up for repeating CD4 cell count
5. Initiate ART
6. Regular follow-up to ensure ART adherence

**Issues Related to ART**
- Adherence
- Opportunistic infection (OI)
- Positive prevention
- Care and support

**Adherence to ART**
- It is very important that a person who is on ART adheres to the treatment!
- If a person discontinues taking the drugs it can lead to resistance, making it necessary to start on stronger drugs (2nd line ART) and limiting future treatment options
- Counselling is important before starting on ART. Counsellors at the T1 centres and at ICTC/ART centres are trained in counselling on ART

**Opportunistic Infections (OIs)**
- Clients with advanced HIV infection are vulnerable to infections and malignancies that are called ‘opportunistic infections’ because of the client’s weak immune system
- TB, Pneumonia, malaria, drug reaction, acute diarrhoea, anaemia, etc. are some examples of OIs. Start ART after treating these conditions
- If ART is started on time then incidence of OIs reduces
- Clients coming to DIC with OIs should be referred to hospitals for further treatment

**Positive Prevention**
- Positive prevention aims to increase the self-esteem, confidence and ability of HIV+ people to protect their own health and to avoid passing on the infection to others
- Focus on preventive methods: Safer injecting and safer sex
  - Safer behaviour helps to prevent transmission of HIV to the partner
  - Safer behaviour also helps in delaying the progression of HIV
- Healthy and balanced diet is important
Step 7: The facilitator then begins a discussion with the participants on what the roles and responsibilities of the PM are to ensure that adequate ART services are provided to HIV+ IDUs. The discussion should highlight the following points:

**Role of PM in ART services**

- Ensure
  - All the IDUs are tested for HIV through referral to ICTC
  - HIV+ IDUs are referred to ART centre
  - All HIV+ IDUs are registered at the ART centre
  - HIV positive IDUs eligible for treatment are initiated on ART
  - Clients on ART are regularly followed up
  - Those with severe OIs are referred to CCC
  - Those not eligible for ART get their CD4 cell count tested regularly

- Create referral mechanisms to facilitate availability of above-mentioned services to IDU clients
- Establish a mechanism to monitor the above-mentioned services
- Advocacy with the healthcare agencies to ensure availability of services

Step 9: The facilitator wraps up the session by asking the participants to recall highlights of each co-morbid condition and ART as discussed above.
Planning and Implementing the Work Plan

OBJECTIVES
- To help participants understand the importance of planning and implementation for all levels of staff so that the individual pieces put together can make the whole picture complete
- To help participants understand how to develop and execute plans for the entire team in a way that if they meet the project objectives
- To help participants develop the skills for monitoring and execution of project work plans

EXPECTED OUTCOME
- Participants understand the concept of planning and implementation
- Participants will be able to develop a work plan and implement it in keeping with the knowledge and skills imparted through the training

DURATION
1 hour

METHODOLOGY
- Brainstorming
- PowerPoint presentation
- Case study based group work

MATERIALS/PREPARATION REQUIRED
- PowerPoint presentation to highlight concepts of planning and implementation
- List of NACO IDU Monitoring Indicators

PROCESS
Step 1: Brainstorming and discussion
The facilitator initiates the session by brainstorming on key words that best describe the concepts of planning and implementation and thereafter, defines and explains both the concepts. He/she then goes on to explain them with reference to the NACP objectives and activities under IDU TI relating the two to help participants understand how the work at the TI level helps achieve the objectives of the national response. He/she also explains the components and method of developing a work plan with examples.
**Work Plan Is...**
- A planning and management instrument, that provides a framework and guideline for carrying out work during a given period to achieve the targets set
- In the context of IDU program work plan involves:
  - Planning and designing activities
  - Setting targets and distributing them into smaller targets over the timelines available
  - Allocating human and other resources to facilitate the implementation of activities

**Components of a Work Plan**
- Specific and measurable targets to be achieved by the project within a specified period of time
- Activities/tasks to be applied under specific component or focus area
- Measuring effectiveness of activities through pre-fixed monitoring indicators viz. quantitative (e.g. No. of N/S being distributed to the IDUs) and qualitative indicators (e.g. No. of IDU reporting abscess)

**Components of a Work Plan** (Contd.)
- Human resource planning refers to staff members responsible for carrying forth specific activities/tasks
- Time Plan refers to the period within which the activity should be completed and frequency of it being reported by the concerned staff
- Budget/Fund plan, refers to the fund availability for carrying out a specific project activity/tasks
- Means of verification refers to tools which are used to collect, analyse and report the data/information viz. Reports, MIS formats, etc.

**Implementation**
Project Implementation refers to putting plans into action.
Activities and tasks need to be broken down further into:
- Monthly/weekly plans
- Well-defined targets
- Roles of individual staff
- Indicators for monitoring
- Budgetary implications

**NACP III- Goal and Objectives**
- Objective: Prevention of new infections
  - Objective: Care, support and treatment
  - Objective: Strengthening variables
  - Objective: Balance strategic information management systems

**Services through TI**
- Prevention of new infections & Care, support and treatment
  - Directly provided through TI
  - Provided through linkages

**Basic services direct from TI**
- NSEP
- Condom promotion
- STI management

**NSEP work plan**
**Example**

**Focus Area** | Indicator | Target calculation | Target | Responsibility | Means of verification
---|---|---|---|---|---

**NSEP**
- % of all who are injecting daily are provided at least one needle and one syringe every day
- % of daily IDUs identified
- Smw in 6th IDU
- PE (only) diary tracking
- Other field diary/OW summary sheet
Step 2: **Group Work**

The participants are divided into four groups and each one is asked to develop a work plan based on the information provided and in line with the example shown.

**Case study**

An NGO, XYZ, runs an IDU TI program for 500 IDUs and has 2 ORWs, 8 PEs, 1 nurse/ANM and 1 doctor. Of the 500 IDUs, 400 are daily injectors, 50 inject 3 times a week, 30 inject twice a week and 20 inject once a week. The IDUs are distributed over 15 hotspots; 100 tested HIV+; 50 were diagnosed with TB.

The groups are requested to develop work plans as below:

**Group 1:** NSEP, Condom Promotion  
**Group 2:** STI & Abscess Management  
**Group 3:** ICTC, ART, Primary Medical Care and Co-morbidity (TB)  
**Group 4:** Networking, Advocacy and Community Mobilization

The facilitator provides the participants with copies of the NACO IDU Monitoring Indicators to help them develop the work plan.

**NOTE TO THE FACILITATOR**

The illustrative work plan given below is based on the above case study. Please note that this is an ideal situation, where other factors like problems in some hotspots resulting in unequal service delivery and outputs among the hotspots, referral centres not being responsive enough, etc. (which need to be factored in along with varied levels of performance of the staff when developing the work plan), have not been taken into consideration. Furthermore, each component, e.g., NSEP, will also need a lot of planning processes to be factored in, which have not been shared in the given example. The same goes for the monitoring processes that need to be planned. Since there are no standardized indicators for these processes yet, ensure that the participants, at least, include them and regard timely performance of these activities as their indicators. Remind the participants also to plan for the documentation and reporting processes.
### Example of work plan based on NACO indicators

<table>
<thead>
<tr>
<th>Focus area</th>
<th>Indicator</th>
<th>Target calculator</th>
<th>Target</th>
<th>Responsibility</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Annual</td>
<td>Qtrly.</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Estimated no. of HRGs (based on mapping)</strong></td>
<td></td>
<td>500</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>As per MOU</td>
<td>500</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outreach</strong></td>
<td>No. of HRG ever contacted (at least once) with project services</td>
<td></td>
<td>100% of the target (as per MOU)</td>
<td>500</td>
<td>500</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>% of regular contacts (HRG met and given any project services at least twice a month)</td>
<td>80% for TIs who have completed 3 years of implementation and above</td>
<td>500</td>
<td>500</td>
<td>400</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>% of hotspot sites that have updated micro plan</td>
<td>All hotspots have a micro plan updated on quarterly basis</td>
<td>15</td>
<td>5</td>
<td>1-2</td>
</tr>
<tr>
<td><strong>NSEP</strong></td>
<td>% of HRG injecting daily who are provided with at least one needle and one syringe every day</td>
<td>100% of injecting daily identified HRG</td>
<td>145440</td>
<td>36360</td>
<td>12120</td>
</tr>
</tbody>
</table>

1. The target approved for the intervention
2. Apart from the 400 daily IDUs being reached daily the 100 weekly injectors are also to be reached at least once a week
3. 400 are daily injectors, 50 inject 3 times a week, 30 inject twice a week and 20 inject once a week
4. (XX depends on the number of weekly injectors in the hotspots targeted for N/S distribution to weekly IDUs)
5. ([(400*7=2800) + (50*3=150)+(30*2=60)+(20*1=20)] = 3030.)

---

**Contd...**

### Planning and Implementing the Work Plan
<table>
<thead>
<tr>
<th>Focus area</th>
<th>Indicator</th>
<th>Target calculator</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of needles and syringes returned—“needle and syringe exchange rate”</td>
<td>80% for TIs who have completed 3 years and above</td>
<td>116352, 29088, 9696, 2424</td>
<td>PE, ORW, ORW+PM</td>
</tr>
<tr>
<td>STI Care</td>
<td>% of HRG visited STI clinic (in DIC)</td>
<td>30% for TIs who have completed 3 years and above</td>
<td>PE, ORW+ANM+Doctor, PM</td>
</tr>
<tr>
<td></td>
<td>% of HRG visited STI clinic for RMC</td>
<td>60% for TIs who have completed 3 years</td>
<td>PE, ORW+ANM+Doctor, PM</td>
</tr>
<tr>
<td></td>
<td>% who come for syphilis screening at least once a year</td>
<td>25%</td>
<td>PE, ORW+ANM+Doctor, PM</td>
</tr>
<tr>
<td></td>
<td>No. of HRG who received abscess management in the month</td>
<td>5% for TIs who have completed 3 years</td>
<td>ANM+Doctor, PE+ORW, PM</td>
</tr>
<tr>
<td>Condoms</td>
<td>% of HRG received condom from Project as per estimated demand</td>
<td>100% of estimated demand</td>
<td>PE, ORW+ANM, PM</td>
</tr>
<tr>
<td>Focus area</td>
<td>Indicator</td>
<td>Target calculator</td>
<td>Responsibility</td>
</tr>
<tr>
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<td>---------------------------------------------------------------------------</td>
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<tr>
<td></td>
<td></td>
<td>Annual</td>
<td>Qtrly.</td>
</tr>
<tr>
<td>Linkages</td>
<td>% of HRG referred twice during the year to ICTC</td>
<td>90%</td>
<td>450*2 times</td>
</tr>
<tr>
<td></td>
<td>% of HRG tested twice for HIV at ICTC</td>
<td>70%</td>
<td>350*2 times</td>
</tr>
<tr>
<td></td>
<td></td>
<td>% registered at ART (of those tested positive)</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>% registered at TB/DOTS centres (of those diagnosed)</td>
<td>100%</td>
</tr>
<tr>
<td>Detoxification</td>
<td>% of HRG referred to detoxification</td>
<td>10%</td>
<td>50</td>
</tr>
<tr>
<td>Enabling</td>
<td>Crisis management team formed</td>
<td>80%</td>
<td>50</td>
</tr>
<tr>
<td>Environment</td>
<td></td>
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<td>Community Mobilization</td>
<td>% of hotspots where group meetings were conducted with at least 10 HRGs</td>
<td>In 80% of the hotspots group meetings were conducted twice a year</td>
<td>PE and ORW daily report, meeting registers</td>
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<td></td>
<td>No. of meetings/events held with more than 50% of the HRG 50%</td>
<td>Two meetings per month in DIC with 30-40 HRGs</td>
<td>Event register/group meeting register and Minutes of SHG/CBO/community meetings</td>
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<td>Meeting at DIC level</td>
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<td>Meeting register/ORW daily report</td>
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<th>Primary</th>
<th>Supportive</th>
<th>Supervisory</th>
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</table>
Step 3: **PowerPoint presentation**

The facilitator summarizes the session with key learnings and the role of the PM.

<table>
<thead>
<tr>
<th>Key Learning</th>
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</thead>
</table>
| - Planning is the process of mobilization of resources (human, financial & material) for achieving objectives/target.  
- The work plan is a guide to project implementation and a basis for project monitoring. It helps to:  
  - Finish the project in time  
  - Ensure that activities are completed as per priority  
  - Clarifies who will be responsible for:  
    - Conducting activity  
    - Supporting  
    - Supervising | - Determines when to start the project implementation.  
- Planning is not an end in itself. It is a means to enable implementation.  
- While implementing unexpected hurdles could be overcome if one has a contingency or back-up plan  
- A plan is as good as its implementation. Detailed and accurate planning lessens problems faced at the implementation stage |

<table>
<thead>
<tr>
<th>The Role of the PM - Work Plan</th>
<th>Role of the PM - Implementation</th>
</tr>
</thead>
</table>
| - PM is the key player and leads the processes.  
- PM divides the planning teams to take charge of individual components e.g.- outreach, NSEP, referral, etc.  
- PM explains the steps clearly to the various teams and helps them develop their respective components  
- Once the individual components are planned in line with the targets and the available budgets, PM helps the teams to:  
  - Break it down into quarterly, monthly, weekly & daily targets  
  - Put together the individual component plans into a larger plan for the entire TI  
  - Resolve conflict of activities, if any  
  - Helps individual staff to develop their own work plan based on the TI plan | - PM is the person ultimately responsible for the implementation of activities  
- PM needs to distribute responsibilities of supervision to the various levels of staff and help them develop plans and systems to monitor progress (This monitoring plan should also be included in the work plan)  
- PM should also have his/her own plan for monitoring/supervision of the implementation  
- PM should hold regular meetings with the supervisors to monitor implementation and report progress to the project director |

<table>
<thead>
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<th>Role of the PM - Implementation</th>
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</tr>
</thead>
</table>
| - In case of non-implementation/lower rate of implementation PM should by discussion with the respective teams find out the reasons  
- Once reasons are found out, PM should take the necessary steps to address them at the earliest  
- For activities like NSEP, abscess management, condom promotion, STI management which are dependent on provisions- PM should ensure timely procurement and buffering of stocks  
- For activities which are staff intensive like outreach- PM should ensure earliest recruitment, in case of staff turnover | - Implementation of project activities should also be linked to financial implementation  
- PM should regularly sit down with the finance personnel to take stock of financial implementation rates  
- PM should make sure that processes of reporting and accounting are followed in a timely manner to ensure continued flow of funds for uninterrupted implementation |
Monitoring and Evaluation

OBJECTIVES
To help participants understand
- What monitoring & evaluation (M&E) is
- Various types of indicators used for M&E of the IDU TI program
- The process of M&E in an IDU TI program
- The importance of M&E in assessing and reviewing the progress of the project

EXPECTED OUTPUT
By the end of the session, participants will have:
- Increased knowledge on concept and process of M&E
- The skill to facilitate the group on issues related to M&E of a program

DURATION
2 hours

METHODOLOGY
- Brainstorming
- Group work
- Case study
- PowerPoint presentation

MATERIALS/PREPARATION REQUIRED
- Chart papers
- Marker pens
- Case study
- PowerPoint presentation

PROCESS
Step 1: Brainstorming
- The facilitator writes the words ‘Monitoring’ and ‘Evaluation’ on two chart papers; asks each of the participants to say one word each that comes to their mind when they hear the terms and notes them down on the appropriate chart paper.
**Step 2: PowerPoint presentation**

The facilitator then explains the basics and importance of M&E in reviewing the progress of the project using the PowerPoint presentation, ‘Monitoring and Evaluation’.

<table>
<thead>
<tr>
<th>What is Monitoring?</th>
<th>What is Evaluation?</th>
</tr>
</thead>
</table>
| A continuing function that uses systematic collection of data on specified indicators to provide management and the main stakeholders of an ongoing development intervention with indications of the extent of progress and achievement of objectives in the use of allocated funds. It allows to continuously improve the program at each stage. | Evaluation is judgement:  
- Made of the relevance, appropriateness, effectiveness, efficiency, impact and sustainability of development efforts  
- Based on agreed criteria and benchmarks among key partners and stakeholders  
Evaluation:  
- Involves a rigorous, systematic and objective process in the design, analysis and interpretation of information to answer specific questions  
- Provides assessments of what works and why  
- Highlights intended and unintended results and provides strategic lessons to guide decision-makers and inform stakeholders  
It is the periodic assessment about the impact/outcome and effectiveness of the project. |

<table>
<thead>
<tr>
<th>Introduction to M&amp;E System</th>
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</tr>
</thead>
</table>
| Effective M&E can:  
- Provide managers with information needed for day-to-day decisions  
- Provide key stakeholders with information to guide the project strategy  
- Provide early warnings of problems  
- Help empower primary stakeholders, especially beneficiaries, and involve them more  
- Build understanding and capacity amongst those involved  
- Assess progress and so build accountability  
In summary a good effective M&E system is a tool for managing impact. | Efficieny: Were inputs (staff, time, money, equipment) used in the best possible way to achieve outputs; could implementation been improved/was there a better way of doing things  
Impact: What has been the contribution of the project been to the higher level development goals; did the project have any negative or unforeseen consequences  
Sustainability: Have the necessary systems been put in place to ensure the project itself and more particularly, will the project benefits continue once the project and its (foreign) funding has ended |

<table>
<thead>
<tr>
<th>Introduction to M&amp;E System</th>
<th>Introduction to M&amp;E System</th>
</tr>
</thead>
</table>
| Evaluators of projects frequently have five standard questions that need to be answered. The M&E system should thus be designed to provide answers to those questions  
- Relevance: Did the project address priority problems faced by the target areas and communities  
- Was the project consistent with policies of both donors and recipient governments (or agencies)  
- Effectiveness: Have activities, outputs and outcomes been achieved | Contd... |

<table>
<thead>
<tr>
<th>Introduction to M&amp;E System</th>
<th>Introduction to M&amp;E System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Types of Indicators</td>
<td>Contd...</td>
</tr>
</tbody>
</table>
| Output indicators show that the project or activity has successfully taken place and that the pre-conditions are in place to achieve the outcomes/objectives of the program  
Output indicators measure activities directly realized within programs  
These activities are the first step towards realizing the operational objectives of the intervention and are measured in physical or monetary units | Contd... |

| What is an Indicator? | Example:  
Proportion of IDUs on NSEP = Number of IDUs on NSEP/number of population contracted to the TI x 100. |
|-----------------------|---------------------------------------------------------------|
NOTE TO THE FACILITATOR

The facilitator also needs to point out that, though evaluation is presently an external process, all PMs should be able to perform an internal evaluation to help in better understanding of the work being done and future strategic planning.

Step 2: Group work

The facilitator divides the participants into four groups and asks each group to develop an M&E framework for the components mentioned below. The framework may be developed based on the NACO Monitoring Indicators (see Annexure II) and the sample provided below:

Group 1: Outreach

Group 2: NSEP

Group 3: STI service

Group 4: Referral

- The facilitator also requests the participants to provide the processes to be followed for regular monitoring, e.g., the meetings to be held (with what regularity; who is to attend the meetings; the tools to be used; and who will be primarily responsible for conducting these meetings).
- He/she requests the groups to share their group work for discussion in the larger group.

M&E framework (sample)

<table>
<thead>
<tr>
<th>Objective</th>
<th>Activities</th>
<th>Output</th>
<th>Monitoring indicator</th>
<th>NACO Performance Indicators</th>
<th>Means of verification</th>
</tr>
</thead>
<tbody>
<tr>
<td>To ensure that the IDUs are reached through outreach services on a regular basis</td>
<td>1. One-to-one interaction</td>
<td>The community is aware of and is accessing the services available from the project</td>
<td>1. No. of IDUs reached regularly</td>
<td>No. of HRG ever contacted (at least once) with project services</td>
<td>1. Peer diary</td>
</tr>
<tr>
<td></td>
<td>2. Hotspot/DIC meeting</td>
<td></td>
<td>2. No. of IDUs met through hotspot/DIC level meetings &amp; events</td>
<td>% of regular contacts (HRG met and given any project services at least twice a month)</td>
<td>2. Minutes of hotspot/DIC level meeting</td>
</tr>
<tr>
<td></td>
<td>3. Event/awareness program</td>
<td></td>
<td>3. No. of IDUs contacted (for any project service)</td>
<td></td>
<td>3. Events register</td>
</tr>
</tbody>
</table>
The following activities should be monitored weekly:

- Coverage of IDUs and their sex partners as per target and coverage plan
- Reaching out to the identified IDUs with services as per plan
- Needle and syringe supply as per calculated demands
- Other provisions (cotton swab, distilled water as planned by the TI) for safer injecting
- Condom supply as per calculated demand
- Referral to DIC
- Follow-up on referrals
- BCC at the field level

Monitoring should also be done fortnightly to see whether:

- New clients entering the hotspots are being identified and registered
- Old, registered clients leaving (not coming to the hotspots) or moving from one hotspot to another are being recorded
- New and emerging hotspots, and changes in terms of geographical location, number of IDUs, etc. in the present ones are being documented and plans are being made to respond to the changing scenario/s
- Profile of IDUs is being updated to document the changing behaviour pattern, e.g., the drugs being injected, injecting and sexual practices, etc.
- Liaising with the stakeholders is being done regularly
- Level of acceptability in the community is increasing or decreasing

Monitoring is conducted at two levels:

- Field level by the ORW with the PEs
- TI level by the PM with ORWs and PEs

**At the field level:** The ORW should regularly observe the PEs and their interactions with the IDUs and local people.

He/she should also make it a point to personally meet a few IDUs at each hotspot and discuss whether:

- They are being contacted regularly and at a time suitable to them
- They are receiving needles, syringes and other provisions for safer injecting and condoms as per their requirements
- The conduct of the PEs is appropriate
- Other services are required

He/she should also discuss issues related to their drug use, injecting and sexual practices, new IDUs, emerging hotspots, etc.
The ORW should conduct weekly meetings for each hotspot with the relevant PEs and discuss the following:

- Coverage
- Contacts made
- N/S supply
- Other provisions
- Condom supply
- Referral to DIC
- BCC at the field level
- Follow-up

ORW should also review records/documentation. The ORW should see the relevant sections of the PE diary/tracking sheet to check for contacts with clients (one-on-one or in groups), number of needles, syringes and condoms distributed, referrals and follow-ups and check if they are matching.

At the TI level: The PM should monitor the outreach at least on a fortnightly basis. The PM should plan regular visits to the hotspots two to three times a week. He/she should also conduct some surprise visits.

During the visits the PM should meet

- Some IDUs
- Some stakeholders (locals – tea, paan sellers, pharmaceutical shop owners – staff, community leaders/key influencers, police, etc.)
- The PEs and ORWs working in the hotspot

The PM should also review the following records/documents at least every fortnight:

- Outreach plan, including spot analysis
- Needle and syringe stock register (this will provide the situation of the stock and also the number of needles and syringes received by individual PEs and ORWs)
- DIC registration records (number of clients who have been referred from the outreach team)
- DIC service utilization registers (abscess management, counselling, STI treatment, referral, etc.)
- PE weekly planning and activity sheet and individual HRG sheet compiled PE-wise for IDU intervention (by ORW) (Form C)
- Monthly CMIS report

The PM should also conduct monthly review meetings at the DIC with the ORWs at least once in a fortnight. During the review meeting the PM should base the discussion on his/her findings from:

- Field visit
- Record/documentation review
- ORW-PE field level reports

(Refer to Standard Operating Procedure on Outreach for Injecting Drugs for NACO)
## Monitoring NSEP

Monitoring of NSEP is important to ensure that the project’s aims and objectives are being met. It also provides relevant information that can assist the project for better and more effective delivery of services. Monitoring should be conducted routinely by the TI staff.

### Outreach-based monitoring

The ORWs should monitor the work of the PEs, and take stock of the NSEP activities on a day-to-day basis. This includes visiting the hotspots and interacting with the clients to enquire whether they are receiving the services, maintaining records on a regular basis, preparing updates on a weekly basis to look for deficiency in services, and finally reviewing the work with the PM and counsellor.

### Monitoring by senior TI staff

The PM and counsellor should also monitor NSEP activities on a regular basis. Three types of monitoring tools should be employed:

a) **Weekly review**: The PM should conduct meetings with the outreach staff on a weekly basis. In this meeting, the progress of the activities conducted in the preceding week should be monitored. This involves reviewing in terms of which team has been weak, which hotspots have not been adequately covered, etc. thus giving ideas for the next week’s work. A workplan for the next week should be prepared during the weekly review.

b) **Record-based monitoring**: The PM should analyse the records on a monthly basis to review the coverage of hotspots, number of IDUs reached regularly, number of N/S distributed and the return rates of the N/S.

c) **Field-based monitoring**: The PM should visit the hotspots independently and randomly. During the field visits, he/she should interact with the clients, observe the work of the outreach staff, and also interact with other community members. His/her observations during the field visits should then be tallied with the records entered by the ORWs. This will help the PM to get a realistic picture of the nature of the services being offered by his team.

Finally, annual evaluation of the NSEP can be conducted. Evaluation helps to ensure that the program objectives are being met and provides information for further expansion of programs and for policy development. A range of qualitative and quantitative evaluation techniques can be used, such as client satisfaction surveys, specific operational research projects.

*(Refer to Standard Operating Procedure on Needle Syringe Exchange Program for Injecting Drugs for NACO)*

## Monitoring STI services

Monitoring of STI services has to be conducted at both the clinic level and the TI level.

**At the clinic level**: The doctor should lead the M&E at the clinic level. He/she should check that the following documents are being regularly filled up:

- Health card / patient record register/STI records
- Doctor’s / Nurse’s Record Sheet, DIC Activity Sheet

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**contd...**
The doctor should check the following with the ANM:

- Sexual history is being recorded for the clients visiting the clinic
- Follow-up cases are reporting to clinic as scheduled
- Partner notifications and their treatment are being done regularly
- All identified STI cases are completely adhering to the treatment

He/she should also conduct weekly meetings with the ANM and the ORWs to check the numbers of IDUs visiting the clinic for STI services and the number of follow-ups to be conducted.

At the Ti level: The PM should set targets for the number of IDUs who should be visiting the clinic for STI screening, regular medical checkups and syphilis screening, based on the NACO indicators at the beginning of the year during the framing of the work plan. He/she, along with the ORWs and the PEs, divides the target over the year in terms of monthly and weekly figures. He/she should meet regularly with the outreach team to take stock of the target and how far it is being achieved.

PM should also monitor that procurement and stocking of STI medicines and condoms is being done regularly.

Referral and linkages

PM should ensure that all necessary linkages for referral have been forged and are being updated through regular meetings with the referral partners.

The targets for referral – mainly for ICTC, ART and TB – should be set in the work plan and updated in keeping with the changing numbers of individuals tested for HIV and those diagnosed with TB. The new targets should be converted to monthly and weekly targets and communicated to the ORWs, and through them to the PEs, for reaching the goals.

The PM with his/her team should regularly conduct analysis of the referrals based on the referral records and take necessary action to sort out issues affecting successful referral, if any.

Step 3: The facilitator shares the process of review and the tools for planning and review (of PM, Counsellor, ORWs and peers) to reiterate the importance of reviewing and monitoring the program on a weekly and monthly basis using the rest of the presentation.
**Monitoring at PM’s Level**

At Outreach/Site level, ensure that:
- IDU: Peer ratio of 40:1 is maintained
- All the PEs are of same age group as IDUs in a given site
- ORWs fill in registers within 24 hours of the activity conducted
- ORWs have filled in the ‘IDU registration form’ for the new IDUs identified in the area
- Sufficient IEC/BCC material is available with ORW for distribution at site level
- Once a week, interact with selected IDUs (8-10 members) to know the program inputs and quality services given
- Visit referral centres to know status on patients referred with regard to those availing services at referral centres

**Monitoring at PM’s Level**

- Ensure that the consumables/stock are available and no stock out of medicines is reported
- Stock registers are updated on a daily basis
- Ensure weekly meeting with the peers, to plan the week ahead and review the weekly achievement
- Develop weekly plan of activities for each PE
- Prepare weekly movement plan for self and share with PM
- Meet all the PEs at site level and provide field-level support Check daily diaries and types of services being given during every visit

**Monitoring at PM’s Level**

- Ensure that sufficient IEC/BCC materials are available with each PE
- Give feedback on the performance, based on the field observations during weekly and monthly meeting
- Conduct group meetings at each site during the month
- Conduct mid-event activities as per plan during the month
- Support Project Director in conducting advocacy meeting
- Contact all the listed IDUs at the site regularly with project service
- Identify new IDUs and ensure he/she is registered under the site
- Distribute N/S to each IDU and ensure that adequate no are distributed as per the requirement

**Monitoring at PM’s Level**

- Ensure the PEs are conducting activities as per weekly activity plan
- Ensure all the new IDUs identified by the PE during the month have been registered with the program
- Collate the site-level information on weekly basis from the PE daily diaries
- Take feedback from the community regarding the project service
- Ensure that the PEs distribute condom and N/S to the community as per their requirement
- Gather information about the field challenges faced by the PEs and resolve the issues

**Monitoring at PM’s Level**

- Distribute condoms to each IDU and ensure enough condoms are distributed as per requirement
- Report incidents of violence at the site level to the ORW
- Ensure that the IDUs on OST are not dropped out from the service
- Ensure that the IDUs with STI complaints visit the clinic for treatment
- Ensure all the IDUs have been tested at ICTC twice in a year
- Accompany the IDUs for testing at ICTC
- Ensure all the IDUs have been screened for Syphilis twice in a year

**Conducting Participatory Review**

- Involve the community in the review
- Involve team members, donors and other stakeholders
- Provide them information about project’s goal, objectives, performance indicators, targets and achievement
- Discuss qualitative impact of the program
- Identify gaps in the program
- Discuss the solutions
- Prepare an action plan
NOTE TO THE FACILITATOR

Monitoring is the routine tracking of key elements of program performance.

Evaluation is the periodic assessment of the program in terms of the impact/outcome and effectiveness of the project.

Together, M&E tells us:

- Where we are now in respect of our targets
- Where we are likely to go in future
- The extent to which program goals and objectives are being achieved or are likely to be achieved in future
- How program performance can be improved
- Whether the program is worth implementing

The process of periodic review at various levels:

- Weekly review meeting (PEs & ORWs)
- Monthly meeting (PM and the project staff in presence of the PD)
- Feedback from the community/stakeholders
Key Learnings

- **Goal:** The goal of implementing TIs among IDUs and their sexual partners is to prevent transmission of HIV.

- **Indicators:** The variables used to measure progress towards the goals
  - No. of IDUs in regular contact
  - No. of IDUs on NSEP
  - No. of N/S returned to the peers
  - No. of condoms distributed vs. target
  - No. of abscesses managed
  - No of IDUs on OST
  - No. of IDUs tested for STI
  - No. of IDUs referred to ICTC
  - No. of IDUs tested at ICTC
  - No. of HIV+ cases registered at ART centre
  - No. of TB patients registered at DOTS centre

- **Targets:** The quantified level of the indicators that a project/program wants to achieve in a given time frame
  - Regular contact: 80% of the denominator (in a month)
  - NSEP: 50–80% of the denominator (in a month)
  - Return rate: 50-70% of the distribution (in a month)
  - Condom: 100% of the demand
  - Abscess management: 10–5% of NSEP in a decreasing trend (in a year)
  - OST: 20% of the denominator
  - Syphilis screening: 25% of the denominator (in a year)
  - ICTC referral: 60–90% of the denominator (twice in a year)
  - ICTC testing: 30–70% of the denominator (twice in a year)
  - ART registration: All HIV+ persons identified
  - TB-DOTS: All TB patients identified

- Involving team members, donors, stakeholders as well as the community in the review process by getting their feedback makes the system more transparent and participatory
Strategic Planning

OBJECTIVES
To help the participants to
- Understand the basics of strategic planning
- Use learnings from program components to plan future interventions
- Conduct a Strength Weakness Opportunities and Threat (SWOT) analysis to assess the gaps in the current intervention; analyse information and use findings and trends for future
- Collect information on emerging hotspots; newer trends among IDUs

EXPECTED OUTCOME
- Participants have an understanding of strategic planning and the critical steps on how to plan to meet the objective, based on evidence.
- Participants will be able to link the intervention findings to the objectives of NACP III (i.e. reduce new infections) and ensure the intervention meets the guideline requirements.

DURATION
1 hour

METHODOLOGY
- Case studies
- Small group work
- Discussion
- Presentation

MATERIALS REQUIRED
- Flip charts
- Marker pens
- PowerPoint presentation
PROCESS
Step 1: *PowerPoint presentation*

The facilitator uses the PowerPoint presentation to walk participants through the basics of strategic planning and the need for strategic planning to prepare a road map to achieve the overall objective.

**What is Strategic Planning?**
- Process to establish priorities on what you will accomplish in the future
- Forces you to make choices about what you will do and what you will not do
- Pulls the entire organization together around a single game plan for execution
- Broad outline on where resources will get allocated

**Why do Strategic Planning?**
- If you fail to plan, then you plan to fail – be proactive about the future
- Strategic planning improves performance
- Counter excessive inward and short-term thinking
- Solve major issues at a macro level
- Communicate to everyone what is most important

**Fundamental Questions to Ask**
- Where are we now? (Assessment)
- Where do we need to be? (Gap/Future End State)
- How will we close the gap (Strategic Plan)
- How will we monitor our progress (Balanced Scorecard)

**A Good Strategic Plan should . . .**
- Address critical performance issues
- Create the right balance between what the organization is capable of doing vs. what the organization would like to do
- Cover a sufficient time period to close the performance gap
- Be Visionary – convey a desired future end state
- Be flexible – allow and accommodate change
- Guide decision making at lower levels – operational, tactical, individual

**Strategic Planning Model**

<table>
<thead>
<tr>
<th>Where are we?</th>
<th>Where do we want to be?</th>
<th>How will we do it?</th>
<th>How are we doing?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background Information</td>
<td>Mission / Values / Guiding Principles</td>
<td>Goals / Objectives</td>
<td>Progress / Balanced Scorecard</td>
</tr>
<tr>
<td>SWOT - Strengths, Weaknesses, Opportunities, Threats</td>
<td>Major Goals</td>
<td>Specific Initiatives</td>
<td>Take Corrective Action</td>
</tr>
<tr>
<td>Gap</td>
<td></td>
<td>Action Plans</td>
<td>Feedback / rhetoric - measure</td>
</tr>
</tbody>
</table>

**Prerequisites to Planning**
- Senior leadership commitment
- Who will do what?
- What will each group do?
- How will we do it?
- When is the best time?
What are Action Plans?
- The Action Plan identifies the specific steps that will be taken to achieve the initiatives and strategic objectives—where the rubber meets the road.
- Each initiative has a supporting Action Plan(s) attached to it.
- Action Plans are geared toward operations, procedures, and processes.
- They describe who does what, when it will be completed, and how the organization knows when steps are completed.
- Like initiatives, Action Plans require the monitoring of progress on Objectives for which measures are needed.

Characteristics of Action Plans
- Assign responsibility for the successful completion of the Action Plan. Who is responsible? What are the roles and responsibilities?
- Detail all required steps to achieve the Initiative that the Action Plan is supporting. Where will the actions be taken?
- Establish a time-frame for the completion of each step. When will we need to take these actions?
- Establish the resources required to complete the steps. How much will it take to execute these actions?

Link Budgets to Strategic Plan
- The world’s best Strategic Plan will fail if it is not adequately resourced through the budgeting process.
- Strategic Plans cannot succeed without people, time, money, and other key resources.
- Aligning resources validates that initiatives and action plans comprising the strategic plan support the strategic objectives.
Step 2: The facilitator wraps up the session by emphasizing the key issues to be remembered and the importance of strategic planning.

Key Learning
- What planning is/How to evaluate program outcomes/success and informs future goals and decisions.
- Laying the foundation of strategic planning/Creation of a vision and mission that serves as a building block for all future activities.
- Reviewing data to understand and analyze the same to assess gaps and find solutions to link these back to the objectives.
- To use findings from M&E systems to feed into the planning/redesigning of programs in keeping with the goals and objectives of the overall IDU program.

NACP III - Goal and Objectives
- Objectives: Preventive of new infections.
- An objectives: Care, support and treatment.
- Objective: Strengthening capacity.
- Objectives: Building strategic information management systems.

Services Through TI

Some Final Thoughts
- Integrate all components from the top to the bottom: Vision > Mission > Goals > Objectives > Measures > Targets > Initiatives > Action Plans > Budgets.
- Use previous year’s data to make strategic changes/re-define course of intervention.
- Assess gaps in service and take corrective action.
- Seek external expertise (where possible and permissible).
Day 5

- Session One: Opioid Substitution Therapy (OST)
- Session Two: Documentation and Reporting
- Session Three: Procurement
- Session Four: Human Resource Management
- Session Five: Financial Management
- Session Six: Open Session
Opioid Substitution Therapy

OBJECTIVES
To inform participants about:
- Basics of Opioid Substitution Therapy (OST)
- Benefits of OST to IDUs
- Myths surrounding OST
- Role of the PM in the implementation of OST

EXPECTED OUTCOME
By the end of the session, participants would have a clear understanding of the need for OST and be able to debunk the myths surrounding OST and its operationalization under NACP III.

DURATION
1 hour 30 minutes

METHODOLOGY
- Discussion
- Group work
- PowerPoint presentation

MATERIALS/PREPARATION REQUIRED
- Whiteboard
- Chart papers
- Marker pens
- Projector
- PowerPoint presentation - OST

PROCESS
Step 1: The facilitator begins the session by posing the question, “What is OST?” [OST is the “administration of daily dosage of Opioid medicines to patients with opioid dependence under medical supervision (prescribed)”.]

Step 2: The facilitator then takes the participants through the presentation on OST, highlighting what OST is, the Philosophy of OST, benefits of OST, and any myths that the PMs have encountered/expressed. He/she ensures that all the myths and misconceptions regarding OST are addressed.
Opioid Substitution Therapy

**Hierarchy of Harm Reduction**

- Never start using drugs
- Even if using drugs, don’t inject
- If injecting, get assistance to stop injecting drugs
- If not able to stop injecting, don’t share
- If not able to stop sharing, ensure clean equipment before every use

**What is OST?**

Defined as:
Administration of daily dosage of opioid medicines with long-lasting effects to patients with opioid dependence under medical supervision (prescribed)

**OST Under NACP III**

- Is a medical intervention
- Includes following medicines:
  - Buprenorphine (available in India)
  - Methadone (soon to be available in India)
- Administration of buprenorphine sublingually (under the tongue); doses used in OST are not available in pharmacies
- Regulated under the Narcotics Drugs and Psychotropic Substances (NDPS) Act, can be dispensed only in approved centres
- OST is not currently available in all the TI NGOs

**Philosophy of OST**

- Drug of abuse (e.g. Heroin)
- OST medication: (e.g. Buprenorphine)
- An illicit, medically unsafe, short-acting, more addictive, opioid, taken by injecting route...
- Substitution treatment...Legal, safer, long-acting opioid medication of known purity and potency along with psychosocial rehabilitation

**Injecting vs. OST**

- High chances of BBV & other BBVs
- Not prescribed medically
- Severe withdrawal symptoms
- High chance of overdose
- Crowding

- Low chance of BBV
- Prescribed medically
- Minimal withdrawal symptoms
- No chance of overdose
- No crowding

**Why OST?**

- Life of an IDU is chaotic
- Life revolves around drugs – procuring, using & recovering from its effects
- Hence, not able to focus on other activities, responsibilities
- Involved in illegal activities to procure drugs

**Why OST?**

- No withdrawals, Craving
- No need for injecting
- Stabilised for longer period of time (at least 24 hours)
- Able to focus on other issues – family, personal health, work, society

Contd.
**Why OST?**

- OST medicines have long period of action
- Help in breaking the chain of opioid use (shown in earlier slide)
- Dose is adjusted → no cravings or withdrawals → no high
- Patient able to focus on other areas of life because of stabilisation

**OST: Basic Facts**

- OST is given ONLY to those who use opioids and are dependent on them
- Those who are not dependent on opioids but are dependent on other drugs, do not benefit from OST
- Specific inclusion and exclusion criteria for OST
- Initiated only by a physician, after examination
- Patient has to visit the centre daily for receiving the dose, in front of the nurse
- OST medicine alone does not suffice: additional psychosocial counselling helps in increasing retention

**Criteria for OST**

**Inclusion Criteria**

- Diagnosed case of opioid dependence with injecting drug
- > 18 years of age
- Attempted detoxification earlier
- Willing to provide informed consent

**Exclusion Criteria**

- Severe medical illness
- Established history of severe side-effects to buprenorphine
- Unable/incapable of providing informed consent
- Concomitant use of other drugs

**Steps to Initiate OST**

- Detailed history-taking and physical examination by a doctor
- Assess the client to initiate OST
- Initiate OST after fulfilling inclusion and exclusion criteria
- Explain concept of OST to client

**Client on OST Also Requires...**

- Psychosocial intervention:
  - Information about treatment including dosage, duration, relapse, etc.
  - Referrals to ICTC, TB, ART, etc.
  - Motivational support
  - Counselling for employment, harm reduction, etc.
- Family Support:
  - Enhances retention of IDUs to treatment & improves their chances of staying away from drugs

**Steps to Initiate OST**

- Consent form signed by the client before starting OST
- Administration of medicines by nurse
- Daily attendance at clinic for receiving medicine (Daily Observed Treatment = DOT)
- Regular follow-up by doctor and nurse
- Regular psychosocial therapy with counsellor

**Termination of Treatment**

- Treatment continues till the client
  - Is stabilized psychologically & socially
  - Stops injecting (drugs)
  - Starts working and being productive
- Duration of treatment
  - Usually 9 to 12 months; some may require longer time to stabilize
**OST Alone is not Enough...**

- OST is a facility based program and should be provided in addition to:
  - NSDP
  - BCC
  - General health care
  - Linkages/referrals
    - ART
    - DOTS
    - ITC, etc.

**Myth #1: Patients are Still Addicted**

- **Fact:** Addiction is pathologic use of a substance and may or may not include physical dependence
- Physical dependence on a medication for treatment of a medical problem does not mean the person is engaging in pathologic use and other behaviors.

**Myth #2: Buprenorphine is Simply a Substitute for Illegal Drugs**

- **Fact:** Buprenorphine is a replacement medication, it is not simply a substitute
- Buprenorphine is a legally prescribed medication, not illegally obtained
- Buprenorphine is a medication taken sublingually, a very safe route of administration
- Buprenorphine allows the person to function normally

**Myth #3: Providing Medication Alone is Sufficient for Opioid Addiction**

- **Fact:** Buprenorphine is an important treatment option. However, the complete treatment package must include other elements, as well
- Combining pharmaco-therapy with counselling and other ancillary services increases the likelihood of success

**Key Areas of Work**

- **Role of PM in OST-Tis:**
  - The PM is a key person in the OST team
  - Co-ordinating and communicating with all stakeholders (clients, their families, staff, SAGS, NACO, other service providers, local administration, law enforcement, media and the general community)
  - Maintaining stock registers for buprenorphine
  - Supervision of record maintenance
  - Procurement & storage of buprenorphine

**Conclusion**

OST:
- Is cost-effective
- Is simple
- Has minimal side-effects
- Has minimal chances of overdose
- Requires regular follow-up, family support & acceptance
- Does not require extensive clinical set-up
- Acts best if provided supplementarily with other services
OBJECTIVES

- To ensure participants understand the need for, and importance of, using different formats to document various activities of outreach
- To help participants get hands-on training on using specific documents for outreach
- To understand the importance of TI deliverables and their relevance to outreach activities (e.g., converting new contacts to regular contacts, further converting regular contacts for various harm-reduction services; increase in use of condoms)

EXPECTED OUTCOME

By the end of the session participants would get trained on using the various formats required to document the outreach activities effectively.

DURATION

1 hour

SUGGESTED TRAINING METHOD

- Practice on Outreach/Reporting formats
- Presentation

MATERIALS/PREPARATION REQUIRED

- Chart paper
- Marker pens
- Formats (enough copies of each for all the participants to practice)
- PowerPoint Presentation
- Copies of the various documentation forms and registers recommended by NACO for IDU TIs (provided in the CD)

Process

Step 1: Dissemination and practice of all the formats

- The facilitator divides the participants into four groups
- Each participant will be given a set of all the documents required to be maintained by the TI.
- Each group is asked to fill all the necessary documents in order to generate the CMIS input for the information as follows:
  Group 1. Conduct the Outreach
  Group 2. Manage the STI cases
**Group 3. Organize meetings**

**Group 4. Provide referral services**

- The facilitator gives the groups 15 minutes to work on the documents provided and asks them present their work.

- The facilitator wraps up the session by addressing the concerns raised during the group work and taking the participants through all the formats using the PowerPoint presentation on ‘Documentation’. He/she also explains the other documentation required, e.g. registers to be maintained to facilitate the documentation according to the NACO guidelines. The facilitator explains the roles and responsibilities of each level of staff in the documentation process.
Role of PM

- Build the capacity of the various levels of staff for documentation.
- Many PEs will find it difficult to read and write, so the PM should ensure that ORWs responsible for individual PEs help them with their daily documentation, preferably every day after the field work.
- PM should regularly check various registers to be filled up and also tally the records being fed into the MIS reports.
- PM should plan for preparing the monthly MIS reports together with the MIS officer.
- PM should ensure timely reporting to SACS.
Procurement

OBJECTIVE
To help participants understand:
- Basics of procurement
- How to strengthen procurement systems
- The requirements of a procurement process
- What stock-keeping is

EXPECTED OUTCOME
Through this session, participants will be able to:
- Understand the process of procurement and how to prepare a procurement plan
- Acquire the skill to understand and carry out the procurement procedure of floating a tender/collectiong estimates/preparing a comparative statement and finally releasing the purchase order
- Understand stock-keeping and maintain the required documentation

DURATION
1 hour 15 minutes

METHODOLOGY
- PowerPoint presentation
- Practical case activity
- Brainstorming
- Case study

MATERIALS/PREPARATION REQUIRED
- PowerPoint presentation
- Case study on preparing a procurement comparative statement
- Case study on stock-keeping

PROCESS
Step 1: Presentation
- The facilitator goes through the presentation on ‘Procurement’ to give participants an understanding of procurement.
- The facilitator links procurement to program budget, stock-keeping and stock maintenance.
Step 2: **Group work**

- The facilitator divides the participants into three groups and provides them with case studies to work on. He/she requests individual groups to share their findings with the larger group.

**Case study 2**

The Project Manager of KSTZ, an NGO working with 325 IDUs, calculated the demand for needles, condoms and STI medicines and gave a requisition note to the Accountant. The Accountant procured the requisite commodities from the open market. After 3 months, the PM does a stock verification of condoms and STI medicines and finds that old stocks of condoms and medicines are lying un-utilized at the DIC and are due to expire.

**Questions for discussion:**

**Group 1.** Do you feel that the Accountant followed the NACO procurement guidelines? If not, please state the steps for procurement the Accountant should have followed

**Group 2.** Does the PM have a system of stock-keeping and verification in place? If not, what should the process of stock-keeping and recording be?

**Group 3.** Do you feel that the PM had a system in place linking procurement to stock? If not, what should he have done?

**Some possible answers:**

**A1.** First, set up a procurement committee and call for quotations; shortlist a minimum of three quotations; select the lowest quotation. This exercise has to be done yearly.

**A2.** Central stock register, DIC stock register, daily updation of stock register and balance in hand; recording the expiry dates in the stock book, plan distribution based on expiry date.

**A3.** Procurement planning and stock-keeping is based on demand. Once commodities are procured they are entered in the central stock register and based on monthly requirement of the ORWs, transferred to the sub-stock register and distributed on a weekly basis. When there is three months’ stock in hand, the ORWs need to send a requisition to the PM, who, after verification, approves the requisition and sends it to the Accountant for procurement.
Applicable Procurement Procedure
- Contracting
  Low value, proprietary and specialist goods and services can be procured through single quotation when the available options of the service are limited or specialized
- Direct Purchases (both Assets & Consumables)
  Securing three quotations from three suppliers for office equipment, consumables, lubricants, STI drugs, office furniture, audio video equipment, condoms, etc.

Steps for Direct Purchases
- Issuing Purchase Order based on the above evaluation signed by the NGO head, PM and Accountant
- Receive goods and record in chalan
- Entering the goods received in the asset/stock register maintained by the project
- While procuring drugs the same should be manufactured by WHO-GMP certified manufacturers

Procurement Control
- Goods ordered are actually received into store and record of receipt on challan verified
- Relevant accounting records are updated according to receipt of goods
- A stock register should be maintained for individual drugs at the main office and at clinic sites

Steps for Direct Purchases (Contd.)
- Preparing specifications of goods to be procured
- Issuing quotation enquiry to prospective suppliers
- Securing at least three quotations from suppliers
- Making comparative statement of the goods offered and evaluating substantial responsiveness/compliance of the goods to the required specifications and quantity

Procurement Control (Contd.)
- All purchases must be authorized and approved before the goods and services are ordered
- Verification must be done that all goods received and services rendered are according to specifications and in quantities requisitioned for
- All purchases must be accurately reflected in the books of account and suppliers are paid only in accordance with the agreed terms

Stock Keeping
- System for purchase of drugs and stock-keeping to be developed; a procurement plan would need to be in place
- Quantity, type of drugs depends on past history, patient load, preference of doctors, etc.
- All drugs purchased need to be checked for quality, quantity and expiry against purchase order
- Stocks should be held securely and access restricted

Inventory Management
- An Assets register to be maintained with details of all assets purchased (i.e. date/make/quantity/cost etc.)
- Register to be updated regularly and signed by GB members
- Identification numbering needs to be done of all assets
- Physical verification must be done at least once a year
- Old assets would need to be written off with specific permission of the GB
- No disposal of assets must be done without permission

Stock Maintenance
- One person to be made responsible for stocks and stock books
- Regular checking of stocks is essential with signature of stock keeper
- Material to be issued based on requisitions duly authorized
- Stock registers to be maintained at office & clinic at different stages of distribution
- First in, first out (FIFO) policy must be followed
- Special care must be taken to avoid expiry
- Expired consumables to be written off with permission of management
A PM’s Take Away
A PM must be involved in the process of tendering /selection of comparative quotations for all assets and consumables.
He/she should understand the need to form a procurement committee and also the processes that need to be followed.
A PM must ensure prescribed procurement guidelines are followed for both assets and consumables.
A PM should be able to link Program Procurement with requisitioning, stock-keeping and disbursement, by ensuring the relevant documentation is in place:
- System of Requisitioning
- Maintaining of stock registers
- Records of disbursement
Human Resource Management

OBJECTIVES
To help participants understand:
- The concept of Human Resource Management (HRM)
- The components of HRM
- How an effective HR policy can contribute to the growth of an organization

EXPECTED OUTCOME
Through this session, participants will be able to understand:
- The concept and components of HRM
- The process to develop the skills required to perform their jobs within the project
- The required skill sets for individual staff members and ways of managing staff

DURATION
1 hour

METHODOLOGY
- PowerPoint presentation
- Flip charts
- Marker pens
- Handouts

MATERIALS/PREPARATION REQUIRED
PowerPoint presentation

PROCESS
Step 1: PowerPoint Presentation

- The facilitator presents the concept of Human Resource Management with the help of the PowerPoint presentation on Human Resource Management.
Objectives of HRM

- Attract, nurture and retain talent
- Reflect the dynamics and demand of the public health sector
- Encourage staff participation or involvement in management decisions
- Promote a very strong sense of belonging among the staff
- Provide effective services to the High-risk Group

Components of HRM

- Job analysis (skills required for ORW, PE)
- Human resource planning (number of ORW, PE required)
- Recruitment (selection of ORW, PE)
- Performance appraisal
- Staff development

Service Rules

An HR Policy containing a set of service rules is in place, this document has been approved by the concerned authority, and should contain, at the minimum, guidelines on:
- Working hours
- Leave on public holidays
- Recruitment and selection procedures
- Staff attendance/leave policy
- Staff incentives/salaries/overtime/benefits
- Promotion plans
- Disciplinary and grievance procedures
- Conflict resolution initiatives
- Service rules need to be gender-friendly and made available to all staff members. There is a need to develop a mechanism for amending and reviewing the policy

Recruitment Procedures

- For all positions the following records should be maintained:
  - Number and details of candidates who appeared in the interviews
  - Procedure for selection/interview record
  - Job application form and education certification of the selected person
  - Job description

Staff Welfare

Staff welfare would include policies on:
- Insurance of staff
- Vaccination for staff (since the project staff is at risk of contracting HIV through accidental injuries)
- Training of staff on universal precautions
- Orientation on PEP and the steps to administer and manage the same
- Facilities of medical leave & maternity leave
- Training & professional development
- Sexual harassment policy
- HIV policy
- Substance abuse policy
- Confidentiality and non-disclosure
- CIPA

Training and Professional Development

The training activity at TI NGO is aimed at enhancing the competency levels of the employees in TI towards increasing their productivity and equipping them with the most updated skills. It also aims at:
- Improving performance
- Updating employees’ skills
- Avoiding obsolete managerial systems
- Solving organizational problems
- Orientation of new employees
- Preparing for promotion and managerial succession
- Satisfying personal growth needs

HIV/AIDS Policy

- TI NGO recognises HIV/AIDS as a workplace issue and will treat it like any other serious illness or condition
- It recognises that its staff members shall not be discriminated against, directly or indirectly, on the basis of their real or perceived HIV status or that of a dependant
- There would be no forced testing for staff in NGO/NGO/TSU
- If any staff desires to get tested for HIV, NGO would direct him/her to the nearest VCTC
Session Four

Human Resource Management

**HIV/AIDS Policy**
- NGO/TI NGO/TSU recognises that only information that has been provided voluntarily by a staff member about his/her HIV status will be maintained in medical files, which will be kept separate from personnel files. All such information will be treated with utmost confidentiality.
- NGO will provide all assistance (like counselling & psychological support) to staff member living with HIV/AIDS to accommodate the staff member’s condition, as with any other staff member with a serious medical condition.

**Sexual Harassment Policy**
- TI/employees have a right to expect a workplace free from sexual harassment.
- This policy prohibits all employees from engaging in unwelcome sexual conduct or making unwelcome sexual overtures, visual, verbal, or physical.
- Such conduct has the purpose, or effect, of interfering with an employee’s work performance or creating an intimidating, hostile, or offensive work environment.

**Substance Abuse**
- No employee is allowed to consume, possess, sell or purchase any alcoholic beverage on any property owned by or leased on behalf of TI, or in any vehicle owned or leased on behalf of NGO/TI.
- No employee may use, possess, sell, transfer or purchase any drug or other controlled substance which may alter an individual’s mental or physical capacity within the premises of the organisation.
- The exceptions are aspirin or ibuprofen-based products and legal drugs which have been prescribed to that employee and are being used in the manner prescribed.

**Substance Abuse Policy**
- NGO implementing TI will not tolerate employees who report on duty while impaired by use of alcoholic beverages or drugs.
- All employees should report evidence of alcohol or drug abuse to a supervisor or a personnel representative immediately. In cases where the use of alcohol or drugs poses an imminent threat to the safety of persons or property, an employee must report the violation. Failure to do so could result in disciplinary action for the non-reporting employee.
- Employees who violate the Anti-substance Abuse Policy will be subject to disciplinary action, including termination.

**Staff Leave and Back-ups**
An organization needs to develop staff leave policy which would include:
- Overstay of leave
- Procedure of taking leave
- Privilege leave
- Sick leave
- Leave without pay
- Maternity leave
Also the process of handover of responsibility to another employee, who has been assigned the task by the PM, should be in place.

**Staff Burnout**
- Burnout is a state of physical, emotional and mental exhaustion. It is marked by physical depletion and chronic fatigue, by feelings of hopelessness and helplessness and by the development of a negative self-concept attitude towards life.
- Affects:
  - Physical health
  - Emotional State
  - Relationship
  - Work
- The organization, on a regular basis, plan sessions on various stress management techniques to handle and cope stress for the employees.

**Rotation of Outreach Staff**
- The organization needs to have a system in place where the ORWs and PEWs can be contracted on a rotation basis, so as to provide equal opportunity to the community members.
- This would also assist the program in identifying new networks of the IDU community.
- It is also important to have a rotation policy, where there are current injectors as PE/ORWs, as because of their injecting behaviour they might not be able to fulfill their responsibilities as PE/ORW.
- Therefore, rotation policy will assist the program to develop a second line of PE/ORW, who can be used in case of emergencies.

**Grievance and Redressal Mechanisms**
- Every organization needs to develop a system for redressal of grievances from the employees.
- Under normal working conditions, job-related problems, questions or complaints of employees need to be addressed in the simplest, quickest, and most satisfactory way.
Staff Appraisals - Performance Reviews
- All organizations should have a system by which the full potential of the employees can be recognized in their current position which would help them plan their progression.
- Provisions:
  - Every employee should go through the performance appraisal.
  - All promotion decisions will be linked to the performance appraisal.
  - Performance appraisal will serve as one of the sources to determine training needs of the employee.

Employment Records
- Personnel files should contain:
  - Application made by the employee for the job.
  - Personal information form.
  - Letter of provisional offer (if applicable) and acceptance thereof.
  - Appointment letter indicating terms of employment and their acceptance.
  - All records related to confirmation, i.e. letter of confirmation, etc.
  - Appraisal form.
  - Commendation or criticism of work, all memorandums issued to the staff.
  - Change in personal attributes and updating records (like acquiring additional professional qualification, etc.)
  - Resignation letter.
  - Acceptance of resignation and copy of final settlement of dues.
  - Signed copies of letter of appointment, confirmation or any other change affecting remuneration should be sent to the accounts department responsible for paying the employee.

Equal Opportunity and Work Diversity
- Recruit, hire, train, and promote persons in all job classifications, irrespective of race, colour, religion, gender, or national origin.
- Ensure that promotion decisions are in accordance with principles of equal employment opportunity by imposing only job-related requirements for promotion opportunities.
- Ensure that all personnel actions, such as compensation, benefits, transfers, leaves (including maternity) and TI NGO/NACO-sponsored training, education, social and recreation programs will be administered irrespective of race, colour, religion, gender, age, national origin, or other protected status.
- Provide for the prompt, thorough, and impartial consideration of all complaints of discrimination in TI.

TI IDU Staff Positions
As per the NACO HR policy guidelines, TIs have the following staff members:
- Project Director
- Project Manager
- Staff Nurse/Counsellor
- Accountant and MIS Officer
- Outreach Worker
- Peer Educator
- Doctor (part-time)

Conclusion
- Effective management of human resources is the key to a successful program.
- OCs clearly mention the responsibilities of each staff member.
- Each staff member should sincerely carry out his/her duties.
- It is possible to work collectively towards reducing HIV/AIDS!
OBJECTIVES
To help participants understand:
- Basics of financial management
- How to strengthen financial management systems
- The need for financial accountability
- The requirements of reporting and audit
- What the finance related risks are and how to reduce them

EXPECTED OUTCOME
After this session, participants would:
- Understand the key components of Financial Management and how to plan budgets, monitor expenditure, and report and audit the financial situations.
- Acquire the skill to understand and maintain the accounting trail and validate program activities.

DURATION
1 hour

METHODOLOGY
- PowerPoint presentation
- Brainstorming
- Group work on case studies

MATERIALS/PREPARATION REQUIRED
- PowerPoint presentation
- Case studies and related questions
- List of steps for procurement

PROCESS
Step 1: PowerPoint Presentation
- The facilitator walks the participants through the presentation on ‘Financial Management’ to help them understand the basic concepts of Financial Planning.
What is Financial Management?
- Managing of Financial Resources
- Optimum utilisation of resources
- Utilisation of funds for the right purpose
- Ensure records are maintained for all financial transactions

Components of Financial Management
Discussion Points
- Planning
- Budgeting
- Accounting
- Reporting
- Monitoring
- Staff Welfare
- Audit
- Legal Adherence
- Financial Policies
- Governance Structures

Responsibility of NGOs
- Responsible and accountable for implementing the planned activities as formally approved by the donor/funding agency
- Adherence to the terms of the MoU if any between donor and NGO
- Ensure the prescribed accounting standards are maintained
- Responsible for providing strong organizational governance, well-developed systems of functioning in terms of accountability and transparency

Monitoring the Finances - Role of the PM
- Ensure the all expenditure is as per the budget. (any variance needs to get approval)
- Maintain and monitor the programme trail and while validating expenditure ensure that the larger accounting trail is also in place.

Planning & Budgets
- What is a Financial Plan & Budget?
- Who prepares this? Program staff or financial staff?
- What needs to be put into a budget?

Monitoring the Accounting trail
- Expense — Cash memo — voucher — cash book — ledger — trail balance — income and expenditure statement, balance sheet
- Program plan — activity to be performed — authorisation from the program head for the expense related to the activity — perform the activity — maintain the relevant program records
- Program plan — activity to be performed — authorisation from the program head for the expense related to the activity — perform the activity — maintain the relevant program records
- Was this a planned/budgeted activity who authorised activity and the expenditure? Was project head aware? Have reports and evidence of the activity been maintained.

Discussion points
- Prepare an expenditure sheet
- Get necessary sanctions
- Discuss recording both programme & finance

EXPENSES SHEET

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Partner/Name</th>
<th>Amount</th>
<th>Sign of Payee</th>
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<tbody>
<tr>
<td>Date</td>
<td>Date</td>
<td>Rs.</td>
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<td></td>
<td></td>
<td>p.</td>
<td>Sanctioned</td>
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</tbody>
</table>

**Total Balance in hand/due**
Step 2: Brainstorming

- The facilitator asks participants to think of all the words that come to their mind when they encounter the term ‘financial management’ and notes them down on the whiteboard/flip chart.
- He/she then asks the participants to list the words under the following three heads:
  - Only Financial
  - Only Programmatic
  - Financial and Programmatic
- He/she uses these words to establish the links for the financial accounting trail and explains using the PowerPoint presentation on ‘Financial Management’:

<table>
<thead>
<tr>
<th>The accounting trail</th>
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</thead>
<tbody>
<tr>
<td>Expense ----- cash memo ----- voucher ----- cash book ----- ledger ----- trail balance ----- income and expenditure statement, balance sheet</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>The programmatic trail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program plan ----- activity to be performed ----- authorization from the program head for the expense related to the activity ----- perform the activity ----maintain the relevant program records</td>
</tr>
</tbody>
</table>

- The facilitator thereafter links program budget, program activity and costs and encourages participants to find the links to legitimize expenditure.

Step 3: Group work

The facilitator divides the participants into four groups and asks them to work on the case studies provided.

Case study (for Groups 1 & 2)

A certain project needs to conduct a community event at one of the project sites some distance away from the HO. It is expected that a doctor will be available for checkups and that interpersonal communication (IPC) activities would be conducted, and an awareness audio-visual presentation will be made. The budget for the camp as per the guidelines is Rs.5000. It is expected that the ORW looking after the site will oversee the camp and ensure participation. The ORW will require an advance to conduct the activity.

- Journal Book
- Cash Book
- Bank Book
- Ledger Book
- Approved budget estimates as per Guidelines
- Bank Pass Book reconciliation
- Register for advance payments
- Register for fixed assets
- Stock register for consumables
- Requisition formats
- Travel reimbursement format
- Statement of expenditure
- Voucher

contd...
Group I
1. What would the PM need to monitor to ensure that the health camp is a success?
2. What documents from the list above would be affected and which would need the PM’s authorization?

Group 2
1. What would be the role of the PM in the given situation both programmatically and financially?
2. Apart from the above documents, what program documents would the PM need to monitor/maintain?

Case study 2 (for Groups 3 & 4)
During a hotspot meeting, an ORW was required to offer the participants tea and snacks which he purchased with the advance he had been provided, against a cash memo, for a sum of Rs.190. He sought the permission of the PM and submitted the bills for reimbursement to the Accountant after getting the necessary approval. Before the Accountant could reimburse the money he sought the PM’s help to understand the reason for this payment. The PM produced all the relevant documents after which the payment was passed and thereafter booked in the Book of Account and finally figured in the Statement of Expenditure to be submitted.

Group 3
What relevant documents would the Project Manager have provided in order to convince the Accountant?

Group 4
Arrange the list of documents given below in order of occurrence and entry, both Financial and Programmatic, for the above hotspot meeting.

- Cash Book
- Approved budget estimates as per Guidelines
- Register for fixed assets
- Budget control
- Program plan
- Stock register for consumables
- Bank Book
- Ledger Book
- Expense report
- Report of the vent
- Outreach workers’ report
- Authorization from the program head for the expense
- Requisition formats
- Travel reimbursement format
- Statement of expenditure
- Voucher
- Available unspent balance
- Bank Pass Book reconciliation
- Register for Advance Payments
- Signature list of participants
Step 4: **Group work**
The participants are regrouped into two new groups and are requested to work on the following case study based group work.

**Case study 3**
An NGO wanted to purchase a TV for its DIC and requested suppliers to submit quotations for the same. In all, five quotations were received.

The quotes received were as follows:

1. **Fancy Traders**: SONY 26” flat Screen TV with 1year on-site guarantee– Rs. 22,000; taxes extra. Needs cash payment, will not accept cheque.

2. **Sri Hari Enterprise**: SONY 26” flat Screen TV with 1-year onsite guarantee– Rs. 23,200; taxes included.

3. **Lilarams**: SONY 26” flat Screen TV with 1-year on-site guarantee – Rs. 19,000; taxes included; no receipt to be given.

4. **Give me More**: SONY 32” flat Screen TV with 1-year guarantee– Rs. 18,000; taxes included.

5. **Harry’s Hut**: SONY 26” flat Screen TV with 1 year on-site guarantee– Rs. 23,200; taxes included, plus one washing machine free.

The Accountant prepared a comparative statement of the above and the selection was to be made for the purchase of the TV.

**Group**
What would be the correct process to follow? To whom should the comparative statement be given for sanction?

**Group**
Which of the quotes are valid and why? Which in your opinion is the best option and why?

The facilitator wraps up the session with rest of the presentation on financial planning.
A PM’s Take Away

A PM must be aware of the process being followed from the time plans and budgets are made to the time SOE are submitted since they are the ones responsible for authorizing payments.

A PM needs to understand both the Program Activities and the Financial Accounting System; and how the two should be linked and the trail established, as he/she will be the one to authorize the trail.

A PM must realize that he/she is an integral part of the accounting trail, as without the requisite programmatic trail all accounting is baseless.
Annexures

1. Pre- and Post-training Questionnaire with Answers
2. Day-wise Feedback Forms
3. Handouts on Co-morbidities
4. IDU Monitoring Indicators
Multiple-Choice Questions for Pre- and Post-Training Assessment

(The correct answers are underlined here, a copy of the questionnaire without the correct answers underlined is provided in the CD. The facilitator/training coordinator is requested to choose 15 to 20 questions, take print outs of the same and provide to the participants for their tests)

Please tick the correct answer *(There may be more than one correct answer)*:

1. Which of the following is NOT a criterion for diagnosing drug dependence?
   a. Evidence of tolerance (i.e. need to take a higher amount of drug)
   b. Withdrawal symptoms in the absence of drug
   c. Poor social and occupational performance due to indulging in substance use
   d. Use of an illegal substance

2. Which of the following statements are TRUE about the third phase of National AIDS Control Programme (NACP III) in India?
   a. The goal of NACP III is to contain the epidemic of HIV in India
   b. NACP III commenced in the year 2005
   c. The emphasis of NACP III is on prevention
   d. About 50% of all the high-risk groups will be covered in NACP III to halt the HIV epidemic in India

3. What is the prevalence rate of HIV among IDUs in India?
   a. 0–5%
   b. 5–10%
   c. 10–15%
   d. >20%

4. Which of the following statements are FALSE about NACP III for drug-using population?
   a. NACP III recognizes injecting drug-using population as one of the high-risk groups for HIV
   b. Both NSEP as well as OST are articulated in NACP III for service provision
   c. A TI for drug-using population aims to reach out to all the drug users, including alcohol users
   d. Referral to detoxification services are provided for in the IDU TI program
5. One of the following is TRUE with regard to injecting drugs:
   a. Reusing the needles/syringes is not associated with any physical risk
   b. The risk for an IDU is only with sharing of needles/syringes
   c. Non-availability of cleaning materials before injecting poses a risk for an IDU
   d. An IDU always finds a clean neighbourhood and enough time for injecting

6. One of the following statements related to Hepatitis C is true:
   a. Hepatitis can be caused only by the Hepatitis C virus
   b. Liver is a non-essential organ of the body
   c. All Hepatitis virus infections are fatal in nature
   d. Sharing of contaminated needles and syringes is the cause of Hepatitis C

7. One of the following statements related to mental illness is true:
   a. Drug use is more commonly associated with mental illness
   b. One cannot be cured of mental illness; prevention is the only option
   c. Only people with character defects/weak personalities can get mental illness
   d. Psychosis is not associated with person talking to himself without any reason

8. The punishment under the NDPS Act differs as per the quantity of drugs involved:
   a. True
   b. False

9. What are the steps in conducting outreach?
   a. Delivering services in the field
   b. Creating an enabling environment
   c. Documenting and analysing data
   d. All of the above

10. A Spot Analysis Tool can be used to get the following information:
    a. Number of IDUs that come to the DIC
    b. Number of IDUs in the hotspot
    c. Frequency of injections
    d. The different services available in a hotspot
    e. Profile of IDUs

11. What should one do in case of needle-stick injury?
    a. Wash the injured site with soap and water
    b. Suck or lick the injured site
    c. Begin PEP within 72 hours
    d. Both a and c
12. Which one is a safe injecting practice?
   a. Injecting in the abdominal region
   b. Injecting in neck, groin
   c. Rotating injecting sites
   d. Sharing needles, syringes and other injecting equipment

13. The final choice for selecting a location for an IDU DIC depends upon:
   a. Proximity of proposed site to IDU hotspots and services
   b. Acceptability of site to the IDUs
   c. Acceptability of site to the general community
   d. All of the above

14. IDUs are very poor when it comes to adhering to ART drugs as compared to non-IDUs:
   a. Agree
   b. Somewhat agree
   c. Disagree

15. Why is referral and networking important?
   a. IDU TI programmes cannot meet all the needs of IDUs
   b. IDUs are often ignored of existing health care facilities
   c. IDUs may be prevented from accessing services provided by TIs
   d. All of the above

16. Which of the following linkages is not provided through the TI?
   a. ICTC linkages (VCTC, PPTCT)
   b. ART linkages
   c. Hep C management
   d. OI management

17. What are the common STIs?
   a. Syphilis
   b. Gonorrhoea
   c. Chancroid
   d. Herpes
   e. LGV
   f. All of the above

18. What is the one correct thing to do while helping a client with overdose?
   a. Leave someone having overdose alone
   b. Put him/her in a recovery position
c. Inject salt water
d. Give him a drink or induce vomiting

19. Which one is not correct regarding ART services?
   a. All HIV positive IDUs are referred to ART centre
   b. All HIV positive IDUs need not be registered at the ART centre
   c. All HIV positive IDUs eligible for treatment are initiated on ART
   d. Those not eligible for ART get their CD4 cell count checked regularly

20. Which of the following statements related to Monitoring and Evaluation is true:
   a. It clarifies the impact of the project
   b. It provides managers with information needed for day to day decisions
   c. It provides early warning about problems
   d. All of the above

21. Which of the following activities is not necessary for monitoring by a PM?
   a. Regular field visit
   b. Checking all project based registers regularly
   c. Conducting Referral analysis meetings
   d. Advocacy planning
   e. All of the above

22. Which of the following is untrue?
   a. OST is cost effective
   b. OST substitutes a legal drug with an illegal one
   c. OST helps in adherence to ART
   d. OST can help only opioid users

23. Why is documentation required?
   a. Tracking the epidemic
   b. To assess progress of program
   c. To identify strengths and weakness
   d. To check effectiveness
   e. All of the above

24. What is the role of PM in Procurement?
   a. Involvement of PM in the process of tendering/ selection of comparative quotations
   b. Formation of procurement committee
   c. Follow procurement guidelines
   d. All of the above
# Feedback Form – Day 1

Date:  
Participant’s Name (Optional):

<table>
<thead>
<tr>
<th>Session</th>
<th>Particulars</th>
<th>Feedback</th>
<th>Remarks*</th>
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<td>Good</td>
<td>Ok</td>
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<tr>
<td>Overall response to sessions</td>
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</tr>
<tr>
<td>1</td>
<td>Introduction of the Participants and the Training program</td>
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<tr>
<td>2</td>
<td>Understanding Drug Use</td>
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<td>3</td>
<td>Understanding the Community - IDU related Vulnerabilities</td>
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<td>4</td>
<td>Understanding Targeted Interventions for Injecting Drug Users</td>
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<td>5</td>
<td>Understanding Staff Roles Including Roles of Project Manager</td>
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Most useful topics

Topics not found very useful

Any other comments

* Please comment on duration, content, methodology and visual aids
Feedback Form – Day 2

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Participant’s Name (Optional):  

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Most useful topics

Topics not found very useful

Any other comments

* Please comment on duration, content, methodology and visual aids
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Most useful topics

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Topics not found very useful

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Any other comments

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* Please comment on duration, content, methodology and visual aids
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<td>Planning and Implementing the Work Plan</td>
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Most useful topics

Topics not found very useful

Any other comments

*Please comment on duration, content, methodology and visual aids*
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<td>6</td>
<td>Open Session</td>
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</table>

*Please comment on duration, content, methodology and visual aids*
Handout on Co-morbidities

HEPATITIS

- Hepatitis is *inflammation of liver*
  - Liver can be inflamed by toxins, infection, alcohol, etc.
- Liver is a vital organ of the body.
  - Liver helps in processing food, storing iron, fighting infections and other functions
- Liver can re-grow, if injured. However, when liver is inflamed chronically, it causes scarring, called fibrosis.
  - Extensive scarring and re-growth of liver leads to a condition called ‘cirrhosis’
  - The end-stage of cirrhosis is liver failure, which leads to symptoms such as jaundice, collection of fluid in abdomen, easy bleeding, toxins entering bloodstream and brain which can make the individual comatose
- Five types of viral hepatitis: A, B, C, D, E (summarized in table)

<table>
<thead>
<tr>
<th>Type of virus</th>
<th>Route of transmission</th>
<th>Prognosis</th>
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<tbody>
<tr>
<td>A</td>
<td>Eating unhygienic food</td>
<td>Transient; very good prognosis</td>
</tr>
<tr>
<td>B</td>
<td>Injection, sexual</td>
<td>Chronic infection</td>
</tr>
<tr>
<td>C</td>
<td>Injection, sexual</td>
<td>Chronic infection</td>
</tr>
<tr>
<td>D</td>
<td>Occurs along with Hep B</td>
<td>Worsens prognosis of Hep B</td>
</tr>
<tr>
<td>E</td>
<td>Unhygienic food</td>
<td>Poorer than Hep A</td>
</tr>
</tbody>
</table>

Hepatitis C

- Blood-borne infection of the liver caused by a virus

Transmission of Hep C

- In majority of cases, it is caused by sharing of contaminated injecting equipment
- Other injecting equipment such as spoons, tourniquets, swabs, water in addition to N/S
- Contamination of hands while mixing of drug can also transmit Hep C
- Transfusion of infected blood and blood products
- There is 5% chance that Hep C can be transmitted from infected mother to baby
- Unprotected sex
- Hep C is not transmitted through casual contact (sneezing, hugging, cough, sharing of utensils and drinking glasses)

Stages of infection

- Acute: Some infected individuals have symptoms during this stage:
  - Nausea, vomiting, jaundice (yellowish eyes and skin), swollen stomach or ankles, tiredness, fever, loss of appetite, diarrhoea, dark colour urine – ‘Acute hepatitis’
  - 25% of individuals clear the virus from their body within 2 years of infection
Chronic: 75% of infected individuals will have chronic hepatitis with presence of virus in body and ability to transmit it to others. Symptoms in this stage are:
- Yellowish eyes and skin, a longer than usual amount of time for bleeding to stop, swollen stomach or ankles, tiredness, nausea, weakness, loss of appetite, weight loss and spiderlike blood vessels that develop on the skin
- About 1–5% develop liver failure or liver cancer

Diagnosis
- Through blood test – ELISA for detecting antibodies
- Should ideally be done 3 to 6 weeks after possible exposure
- Diagnosis of active hepatitis is confirmed through a RNA PCR test which measures the amount of virus in the body of the infected individual
- Genotype tests to detect the subtype of Hep C virus that is present in the individual - this is important so as to know whether the individual will respond to treatment or not.

Management of Hep C
- Not everybody requires treatment
- Success rate is only 30–40%
- Treatment is currently very costly in India
- Treatment involves a combination of injection interferon (plain or pegylated) and an anti-viral medication tablet Ribavarin; a treatment cycle lasts for 24–48 weeks
- For Hep C infected IDU clients, fatty foods should be avoided, and alcohol is STRICLY prohibited

Prevention of Hep C
- Every IDU should use safe injecting equipment (not only N/S, but also others), and should inject safely
- Use a condom during sex
- Do not use another person’s toothbrush, razor or anything else that has blood on it
- Do not donate blood or blood products if infected with Hep C
- Use gloves if one has to touch another person’s blood
MENTAL ILLNESS

There are various kinds of mental illnesses that can coexist with drug dependence in an IDU

Examples of mental illnesses: Depression, anxiety disorders, psychosis, etc.

- **Depression** is a very commonly occurring mental illness
  Everyone feels sad at some point of time, but depression is a morbid state of sadness that affects the productivity and normal functioning of an individual
  The following symptoms are present throughout the day for at least two weeks continuously, leading to difficulty in work OR personal suffering:
    - Low mood/sadness
    - Reduced energy
    - Reduced interest in work and pleasure
    - Reduced concentration
    - Disturbed sleep
    - Loss of appetite
    - Reduced self-esteem and confidence
    - Feeling guilty even for small mistakes
    - Feeling hopeless and helpless
    - Suicidal acts/attempts

- **Anxiety disorders**
  - Anxiety is unreasonable fear, or fear which is more than what is expected in the given situation. Almost everyone experiences fear or nervousness at one time or the other. The fear is called an illness if it:
    - Affects the individual’s work and social life
    - Occurs without any reason
    - Symptoms of anxiety disorders:
      - Excessive unrealistic worrying
      - Trembling/shaking
      - Churning stomach
      - Nausea
      - Diarrhoea
      - Headache, backache
      - Palpitations (increased heart rate)
      - Restlessness
      - Tires easily
      - Poor concentration
Examples of anxiety disorders:
- Phobias (irrational fear of a specific object, animal or situation, e.g. phobia for heights, spiders, water, exams)
- Panic disorder: Repeated panic attacks (state of extreme anxiety and fear with sense of dying without any reason)
- Obsessive compulsive disorder (e.g., the individual may have repeated thoughts of being dirty/unclean and the person washes his hands repeatedly)

Psychosis
- Characterized by a loss of sense of reality, disorganization in thoughts, perception and behaviour
  Example: Schizophrenia, acute psychosis
- Some of the symptoms of psychosis include:
  - Delusions: False beliefs of the person despite evidence to the contrary; e.g., Belief of being attacked; belief that one is very powerful; belief that others are talking against one
  - Hallucinations: Hallucinations means seeing or hearing things that seem real, but are not in fact happening E.g. a person may hear voices talking against him/swearing at him when in reality nobody is talking, and others around the person are not able to hear it

Providing services to the IDU presenting with mental illness
- If the IDU presents with one of the symptoms of mental illness, refer to the counsellor/doctor of the TI → refer to psychiatrist if available at the nearby hospital
- Educate the client that:
  - Mental illness is treatable
  - Having a mental illness does not mean that the person has some defect of willpower
  - Instill hope that the outcome of mental illnesses such as depression and anxiety is good, if treated for adequate duration
- Reinforce risk reduction message, as the chances of sharing N/S are increased due to despair
- Seek support of family during this crisis of the IDU
- Regularly follow up with IDU and support him/her during the follow-up phase
TUBERCULOSIS

- Tuberculosis (TB) can affect any body part – usually affects lungs; other sites: lymph nodes, bone, brain, spinal cord, genital-urinary system, etc.
- TB is contagious and spreads through air
  - Transmitted from one person to another through droplets
  - When an infected person sneezes, coughs or talks, tiny droplets of saliva/mucus spread to another person, who can get infected
- If not treated, each infected person with active TB will infect 10–15 persons every year
- TB is not transmitted by touching clothes or shaking hands with an infected person
- Symptoms of active TB include generalized tiredness/weakness, weight loss, fever, night sweats, cough, chest pain, coughing up of sputum, coughing blood, shortness of breath
- Diagnosis based on symptoms, chest X-ray, sputum examination, skin test
- Treatment
  - Nearest TB centre under RNTCP
  - DOTS
  - Duration 9–12 months for complete cure
  - Person becomes non-infectious within 3 weeks of initiating treatment
- Multi-drug resistant TB (MDR-TB): Form of TB that is difficult and expensive to treat since it fails to respond to standard treatment
- IDU related issues for TB
  - IDUs have a very high TB incidence rate
  - Reasons are many – poverty, homelessness, poor living conditions, low immunity, poor nutrition, high HIV rates
  - Early symptoms of TB may be mistaken for other conditions:
    - Example
      - Weight loss, weakness or tiredness also associated with general debility
      - Cough, chest pain and chronic bronchitis also associated with co-morbid smoking
- For those on treatment for TB
  - Counselling for adherence is very important
Annexure 4

IDU MONITORING INDICATORS

Performance Indicators for NGOs contracted for TI with various SACS/DACS

All NGOs contracted for the year 2009-10 shall have certain performance indicators which they shall agree upon while contracting with the SACS/DACS. These performance indicators are based on the NACO’s MIS tools, Costing Guidelines and the Operational Guidelines for targeted interventions, NACO, 2007.

- The NGOs’ performance indicators include various components such as: Outreach, condoms, STI/Clinical, enabling environment and community mobilization
- In case of a core composite TI, the NGO shall report on all the relevant indicators. For example, in case of a composite TI of FSW and MSM, the NGO shall report on the indicators for both FSW and MSM outlined below

Some notes on key indicators

- Estimated number of HRGs (based on mapping): This indicator is the total estimate of individual HRGs mapped in a specific geographical coverage area as per state mapping estimates. Methods of size estimation include: mapping, PSA, capture and recapture methods. The methodology used to conduct estimation must be articulated by the group doing the size estimation and the updated figure should be entered along with target group, source, month and year of study. This methodology should be in line with the Operational Guidelines for targeted interventions, NACO, 2007
- The “denominator”: This denominator represents the basis for assessing a TI’s performance. The denominator is the annual target given by SACS in the signed contract.
- The supporting documents for updating the information related to performance indicators: The information for each set of performance indicators will come from various documents/registers. The TI NGOs have to ensure the compilation of data from various documents/registers as mentioned against the respective indicators. Also ensure that the documents/registers are updated from time to time.
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<th>Target</th>
<th>Frequency of Reporting</th>
<th>Data Source</th>
<th>Definition</th>
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<td>1</td>
<td>Outreach</td>
<td>Estimated no. of HRGs (based on mapping)</td>
<td></td>
<td>One time</td>
<td>Mapping data given by NACO/SACS</td>
<td>The total estimate of individual HRGs mapped in a specific geographical coverage area. Methods of size estimation include: Mapping, PSA, capture and recapture methods</td>
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<tr>
<td>2</td>
<td></td>
<td>Denominator (target approved by SACS)</td>
<td>As per MOU</td>
<td>One time</td>
<td>Project proposal/ MOU of the project</td>
<td>The denominator is the sum of the current coverage of the NGO and the annual incremental coverage targets, i.e., the total no. of HRGs which have been covered under this TI for the year</td>
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<td>No. of HRGs ever contacted (at least once) with project services</td>
<td>100% of the target (As per MOU).</td>
<td>Monthly (Cumulative)</td>
<td>ORW/PE daily Summary Sheet</td>
<td>Number of total contacts (Cumulative) ever made by the project and provided any kind of services</td>
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<td>% of regular contacts (HRGs met and given any project services at least twice in a month)</td>
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<td>Monthly</td>
<td>ORW/PE daily Summary Sheet</td>
<td>Number of HRGs contacted through outreach activities each month divided by the denominator</td>
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<td>50% for TIs in 1\textsuperscript{st} year of implementation</td>
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<td>70% for TIs in 2\textsuperscript{nd} year of implementation but not completed 3 years</td>
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<td>80% for TIs who have completed 3 years of implementation and above</td>
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<td>% of hotspot sites that have updated micro plan</td>
<td>All hotspots have a micro plan updated on quarterly basis</td>
<td>Quarterly</td>
<td>Quarterly review reports/ micro plan</td>
<td>Every quarter, the micro plan has to be updated/modified based on the reviews</td>
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<td>NSEP</td>
<td>% of HRGs who are injecting daily and are provided at least one needle and one syringe everyday</td>
<td>100% of identified HRGs who are injecting daily</td>
<td>Monthly</td>
<td>PE daily diary/tracking sheet, ORW field diary/ORW Summary Sheet</td>
<td>Number of HRGs provided one needle and one syringe everyday divided by no. of HRGs injecting daily, identified through micro planning</td>
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<td>% of needles and syringes returned—&quot;needle and syringe exchange rate&quot;</td>
<td>40% for TIs in 1st year of implementation</td>
<td>Monthly</td>
<td>P/E and ORW diary for IDUs along with records from the DIC &amp; needle and syringe register</td>
<td>Number of needles and syringes returned divided by number of needles and syringes distributed (combined DIC and Outreach)</td>
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<td>60% for TIs in the 2nd year of implementation but not completed 3 years</td>
<td>Monthly</td>
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<td>80% for TIs who have completed 3 years and above</td>
<td>Monthly</td>
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<td>8</td>
<td>STI Care</td>
<td>% of HRGs who visited STI clinic (in DIC)</td>
<td>10% for TIs in 1st year of implementation</td>
<td>Monthly</td>
<td>Health card/patient record register/STI records</td>
<td>No. of HRG visited STI clinic during the month divided by denominator</td>
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<td>20% for TIs in the 2nd year of implementation but not completed 3 years</td>
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<td>30% for TIs who have completed 3 years of implementation and above</td>
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<td>9</td>
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<td>% of HRG who visited STI clinic for RMC</td>
<td>Quarterly</td>
<td>Patient register/ Health Card./ STI records</td>
<td>No. of HRG visited to STI clinic during the quarter for regular medical check-up (RMC) divided by the denominator</td>
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<td>40% for TIs in the 2nd year of implementation but not completed 3 years</td>
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<td>60% for TIs who have completed 3 years of implementation and above</td>
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<td>% who come for syphilis screening at least once in the year</td>
<td>Annually</td>
<td></td>
<td>No. of HRGs who are screened for syphilis at least once in the year divided by the denominator</td>
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<td><strong>Abscess management</strong> Number of HRGs who received abscess management in the month</td>
<td>Monthly</td>
<td>Doctor’s/ Nurse’s Record Sheet, DIC Activity Sheet</td>
<td>No. of HRGs who received abscess management in the month divided by denominator (1st year target was kept low due to low awareness about abscess management and will increase in the 2nd year as awareness increases and after adopting good practices expected fall in abscess cases hence target is low for 3rd year)</td>
</tr>
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<td></td>
<td>5% for TIs in 1st year of implementation</td>
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<td>10% for TIs in the 2nd year of implementation but not completed 3 years</td>
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<td>5% for TIs who have completed 3 years of implementation and above</td>
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<tr>
<td>12</td>
<td><strong>OST (Applicable only for those TIs which have been given target for providing OST)</strong></td>
<td>No. of OST slots provided by the SACS</td>
<td>As per MOU</td>
<td>Annually</td>
<td>MOU</td>
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<tr>
<td>13</td>
<td></td>
<td>No. of HRGs registered for OST</td>
<td>100% of the target</td>
<td>Monthly</td>
<td>Client register</td>
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<td>14</td>
<td></td>
<td>Total no. of HRGs daily receiving OST</td>
<td>60% for TIs in 1st year of implementation</td>
<td>Monthly</td>
<td>Client’s dose sheet and dispensing register</td>
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<td>80% for TIs in the 2nd year of implementation but not completed 3 years</td>
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<td>90% for TIs who have completed 3 years of implementation and above</td>
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<td>15</td>
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<td>No. of HRGs reporting injecting of drugs while on OST treatment</td>
<td>20% for TIs in 1st year of implementation</td>
<td>Monthly</td>
<td>Client follow-up form</td>
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<td>10% for TIs in the 2nd year of implementation but not completed 3 years</td>
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<td>5% for TIs who have completed 3 years of implementation and above</td>
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<th>Target</th>
<th>Frequency of Reporting</th>
<th>Data Source</th>
<th>Definition</th>
</tr>
</thead>
</table>
| 16  |      | Number of clients who “dropped out” of OST treatment | 25% for TIs in 1st year of implementation  
15% for TIs in the 2nd year of  
10% for TIs who have completed 3 years of implementation and above | Monthly | Client file and client’s dose sheet | No. of clients who “dropped out” of OST treatment divided by OST target  
(Dropout is defined as HRG missing his dose continuously for more than 7 days) |
| 17  | Condoms | Percentage of HRGs who received condoms from Project as per estimated demand | 100% of estimated demand | Monthly | Condom distribution record, individual tracking records | No. of condoms distributed to the HRG from the project (including, distribution through peer, outlets, social marketing etc.) divided by the estimated monthly demand  
*Estimate of Demand* is (No. of HRG * Sexual Acts per week * 4) |
| 18  | Linkages | % of HRG referred twice during the year to ICTC | 60% for TI in the 1st year of intervention  
60% for TIs in the 2nd year of implementation but not completed 3 years  
90% for TIs who have completed 3 years of implementation and above | Annually | Referral slip/referral registers/PE daily diary cum tracking sheet/ORW field visit diary | *Total no. of HRGs referred twice during the year divided by the denominator*  
(contd...
<table>
<thead>
<tr>
<th>Area</th>
<th>No.</th>
<th>Frequency of Reporting</th>
<th>Target</th>
<th>Indicator</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>19</td>
<td>Annually</td>
<td>30% for TIs in the 1st year of implementation</td>
<td>% of HRGs tested twice for HIV at ICTC</td>
<td>Number of HRGs tested twice at ICTCs divided by the denominator</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>60% for TIs in the 2nd year of implementation but not completed 3 years</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>70% for TIs who have completed 3 years of implementation and above</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>20</td>
<td>Annually</td>
<td>100%</td>
<td>% registered at ART (of those tested positive)</td>
<td>No. of individuals registered with ART centre divided by the no. of HRGs who tested HIV positive during the year</td>
</tr>
<tr>
<td>21</td>
<td>21</td>
<td>Annually</td>
<td>100%</td>
<td>% registered at TB/DOTS (of those diagnosed)</td>
<td>No. of TB cases registered with TB/DOTS divided by the no. of TB cases identified during the year</td>
</tr>
</tbody>
</table>

Annexures
<table>
<thead>
<tr>
<th>No.</th>
<th>Area</th>
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<th>Target</th>
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<th>Data Source</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>Detoxification</td>
<td>% of HRG referred to detoxification</td>
<td>2% for TI in the 1&lt;sup&gt;st&lt;/sup&gt; year of implementation</td>
<td>Annually</td>
<td>Referral format (for IDUs)</td>
<td>No. of clients referred for detoxification divided by total number of clients accessing any kind of services (may be separately specified for client receiving NSEP/OST)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5% for TIs in the 2&lt;sup&gt;nd&lt;/sup&gt; year of implementation but not completed 3 years</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>10% for TIs who have completed 3 years of implementation and above</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Enabling Environment</td>
<td>Crisis management team formed</td>
<td>20% of violence reported has been addressed- for TI in the 1&lt;sup&gt;st&lt;/sup&gt; year of implementation</td>
<td>Monthly</td>
<td>Harassment report/ Advocacy activity register</td>
<td>Violations include any incident that violates Indian law where one or more community members are subject to extortion, abuse, violence or unlawful arrest by police or others</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5% of violence reported have been addressed- for TIs in the 2&lt;sup&gt;nd&lt;/sup&gt; year of implementation but not completed 3 years</td>
<td></td>
<td></td>
<td><em>Tracking should be done regularly through peers and consolidated by NGO/CBO in a harassment report register and the NGO should determine, in consultation with the community, if the reported incident is a rights violation before reporting it here</em></td>
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</tbody>
</table>

contd...
<table>
<thead>
<tr>
<th>No.</th>
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</thead>
<tbody>
<tr>
<td>24</td>
<td>Community Mobilization</td>
<td>% of hotspots where group meetings were organized with at least 10 HRGs</td>
<td>Group meetings were conducted in 80% of the hotspots</td>
<td>Monthly</td>
<td>PE and ORW daily report, meeting registers</td>
<td>In every hotspot, at least one group meeting is to be conducted each month. on the issues relating to the specific hotspot</td>
</tr>
<tr>
<td>25</td>
<td></td>
<td>Number of meetings/events held with more than 50% of the HRGs</td>
<td>Twice in a year</td>
<td>Yearly</td>
<td>Event register/group meeting register and Minutes of SHG/CBO/community events meetings</td>
<td>No. of meetings/events held for &gt;50 HRGs</td>
</tr>
<tr>
<td>26</td>
<td></td>
<td>Meeting at DIC level</td>
<td>Two meetings per month in DIC with 30-40 HRGs</td>
<td>Monthly</td>
<td>Meeting register/ORW daily report</td>
<td>DIC register, meeting register, ORW and PEs daily reports</td>
</tr>
</tbody>
</table>
Further Reading Material

1. NACO operational guidelines for integrated counselling and testing centres
3. Operations Manual for Strategic information Management Unit
4. Core indicators for monitoring & evaluation -National AIDS Control Programme – Phase III
5. Standard operating procedure on Drop-In Centres for injecting drug users, published by UNODC
7. Standard operating procedure on “Needle Syringe Exchange Program for Injecting Drug Users” published by UNODC.
8. Standard operating procedure on “Outreach for Injecting Drug Users” published by UNODC.
10. Training Manual on Peer Educators published by UNODC
11. Training Manual on Outreach Workers published by UNODC.
STAYING SAFE
A Manual to Train Project Managers in IDU Interventions

TRAINING MODULE
Project HIFAZAT: Strengthen the capacity, reach and quality of IDU harm reduction services